STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396130	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitestone Care Center	370 White Stone Corner Road Stroudsburg, PA 18360

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's abuse prohibition policy, select investigative reports and staff interview, it was determined the facility failed to ensure the provision of care and services necessary to avoid physical harm and maintain the physical health of one resident out of two sampled (Resident 18) resulting in a serious injury, a fractured femur (thigh bone). This deficiency is cited as past non-compliance. Findings include: A review of the facility policy titled Pennsylvania Resident Abuse: Abuse, Neglect and Exploitation last reviewed by the facility on April 24, 2025, revealed it is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. The policy defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A clinical record review revealed that Resident 18 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions), history of falling, and muscle weakness. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 2, 2025, revealed that Resident 18 was severely cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment), required total staff assistance for activities of daily living (ADLs), bed mobility and transfers. A review of the resident's Point of Care information dated August 18, 2024, (POC- a nursing information system used to obtain specific care information for each resident) revealed the resident required assistance of two staff members for bed mobility and bathing, and that the bed should be kept in the lowest position for safety. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 18's care plan dated August 19, 2024, revealed a problem area in the category of ADLs with a goal to maintain maximum potential with ADLs. Interventions included the use of a left enabler bar (small siderail attached to the bed) to aide with repositioning, two staff for all bed mobility and bathing and toileting, and Hoyer lift (mechanical device used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by caregivers alone) transfers with two staff. Continued review of the care plan revealed a problem area in the category of falls with a goal for the resident to remain free from injury. Fall prevention interventions included bed in lowest position, bilateral bolsters, clutter-free environment, call light within reach, encourage resident to spend time in common area, and ensure accessible frequently used items. A nurse's progress note dated April 10, 2025, at 8:51 PM indicated that the resident was found lying on her left side on the floor. The floor was dry, the room was well lit, and the resident was unable to state what occurred. No visible injury was noted at the time. The physician and responsible party were notified. An IDT (Interdisciplinary Team) note dated April 11, 2025, at 11:10 AM, but recorded as a late entry on April 15, 2025, at 6:31 PM documented the resident had an unwitnessed fall out of bed. Employee 1, a nurse aide stated she was preparing to perform care on resident and left the bedside to retrieve a washcloth from the bathroom while the resident's bed was in an elevated position. Upon returning, the aide found the resident on the floor. The resident fell off the left side of the bed between bed and wall. She was found with her left side against the bed holding onto the enabler bar and sitting on her knees with legs bent under her. She was facing the back wall with her right side towards the window. She was leaning into the bed. The nurse called code apple (code called when there is a fall). This registered nurse (RN) was in hall and came into room to assess the resident. The resident showed no signs or symptoms of pain or discomfort. Neurological assessment was within normal limits and no noted injury. She was assisted to floor by two staff to position her onto Hoyer pad. RN supervisor came in at this time and assessed resident before she was lifted via Hoyer back into bed. RN supervisor did not note any injury either. Nurse aide was educated to follow plan of care and never to leave a resident unattended in an elevated bed. Resident was provided PM care by 2 staff after being put back into bed. Neuro checks were continued as per protocol. A nurse note dated April 13, 2025, at 6:23 PM revealed the resident had swelling of the right knee. No complaints or signs/symptoms of pain were documented. The physician was notified, and an x-ray was ordered. A physician note dated April 14, 2025, at 10:58 AM documented that the resident's x-ray confirmed a right femur fracture, and the physician ordered transfer to the emergency room for further evaluation. A review of the hospital CT scan report dated April 14, 2025, at 7:40 PM revealed a displaced and overlapping comminuted distal fracture of the right femur (a severe break where the bone shatters into multiple pieces and the fragments are misaligned; commonly resulting from high-impact trauma). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A witness statement dated April 10, 2025, by Employee 1, nurse aide confirmed the resident's bed was raised, and while waiting for another staff member to assist her, she went into the bathroom to get a washcloth. The resident was found on the floor when the aide returned. She immediately notified the nurse. A review of a witness statement dated April 10, 2025, (no time indicated) provided by the Director of Nursing (DON), revealed that upon entering Resident 18's room she observed the resident on the floor sitting on her knees with her legs folded underneath her. She was facing the wall with her right side to the window and holding onto the enabler bar on the side of the bed. The bed was in a high position and Employee 1 stated she walked away for a second to get a washcloth in the bathroom and came back to the resident on the floor. The resident was placed on her left side with a pillow under her head while the RN assessed her, and vital signs were taken. No signs or symptoms of injury or pain noted. The resident was lifted off the floor via a Hoyer lift and placed back in bed. PM care provided by two nurse aides. Employee 1 was educated never walk away from a resident when the bed is not in the lowest position, and Employee 1 voiced understanding. Review of the facility submitted PB-22 report (report form for the investigation of alleged abuse, neglect, misappropriation of property) dated April 15, 2025, documented that Employee 1 failed to follow the resident's plan of care and left the bedside with the bed in an elevated position, resulting in the fall. The facility substantiated neglect of Resident 18. Employee 1 was terminated. During an interview on April 29, 2025, at 11:00 AM, the Nursing Home Administrator (NHA) confirmed that the facility failed to ensure that Resident 18 received the services necessary to prevent a fall and avoid physical harm. The NHA confirmed that Employee 1 failed to follow the plan of care and left the resident unattended with the bed elevated, which directly resulted in the fall and subsequent femur fracture. This deficiency is cited as past non-compliance. The facility's corrective action plan included the following: 1. On April 10, 2025, at 8:15 PM, resident had an unwitnessed fall. On April 13, 2025, during routine post fall follow-up, the resident was noted to have a red and swollen right knee. The MD and RP were notified, and an x-ray was ordered. On April 14, 2025, an x-ray was performed, and the resident was noted to have a broken femur. The MD and RP were notified with a new order to send to the ER for evaluation. 2. To identify like residents that have potential to be affected the licensed nurses completed skin check on all incapable residents with a BIMS of 11-0 to ensure there are no s/s injuries of unknown origin which could represent abuse. To identify like residents that have the potential to be affected, the IDT/designee completed interviews with capable residents with a BIMS of 12-15. Interviews related to anyone providing care and elevating their bed and walking away. Has anyone ever left your bed elevated, and you felt unsafe? Do the residents feel safe? (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. To prevent this from happening again the IDT/designee will educate their employees on the abuse/neglect policy and following the plan of care. 4. To monitor and maintain ongoing compliance, the DON/designee will complete body audits on 5 random residents that are incapable with a BIMS of 11-0 weekly x 4, then monthly to ensure there are no s/s of injuries of unknown origin which could represent abuse. To monitor and maintain ongoing compliance, the IDT/designee will interview 5 capable residents with a BIMS of 12-15 weekly x 4, then monthly x 2 to ensure an interview is completed related to anyone hurting them, fallen and anyone pick you up without a nurse assessment, and do they feel safe? The facility's compliance date was April 15, 2025, and completion of corrective action plan noted above was confirmed during the survey ending April 29, 2025. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1)(3) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services