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	02/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 20 sampled (Resident 74). Findings included: A review of Resident 74's clinical record revealed the resident was admitted to the facility on [DATE], and discharged from the facility on November 15, 2024. A review of Resident 74's Discharge MDS assessment dated [DATE], revealed in Section A 2105 Discharge Status that Resident 74 was discharged to a short-term general hospital. A review of a discharge nurses note dated November 15, 2024, at 5:38 PM revealed the resident was discharged home on November 15, 2024, with her son. An interview with the director of nursing on January 30, 2025, at approximately 9:30 AM confirmed the resident's MDS Assessment was inaccurate. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and interviews with staff, it was determined the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as usual body weight, unless the resident's clinical condition demonstrates that is not possible, for one out of 20 residents sampled (Resident 1). Findings include: A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and chronic kidney disease (gradual loss of kidney function). A review of a significant change in status Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 16, 2025, revealed Resident 1 was moderately cognitively impaired with a BIMS score of 8 (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 8-12 indicates cognition moderately impaired). Resident 1's care plan, initiated on April 22, 2024, identified increased nutrition and hydration risk related to chronic kidney disease, overweight body mass index, and variable intake at times. The goal was to ensure the resident remained free from unplanned significant weight changes, with interventions including: Respecting the resident's dietary choices, Offering alternate foods if less than 50% of a meal was consumed, and Monitoring for increased nutritional intervention needs. A clinical record review revealed Resident 1 weighed 151 pounds on July 3, 2024, and weighed 136 pounds on August 6, 2024, which is a -9.9% (15-pound) loss of weight in 34 days. The facility conducted a re-weight on August 7, 2024, and determined Resident 1 weighed 132.2 pounds, which is a -12.25% (18.5-pound) weight loss in 35 days. A progress note dated August 9, 2024, at 8:42 AM indicated Resident 1's weight was previously stable over five months at 147-151 pounds. The resident was identified for a 10% weight loss over 30 days and 9% over 90 days. Her body mass index (BMI-a measure of body fat based on weight and height) is 24.87 (the normal range for BMI is 18.5 to 24.9). The resident's diet had been provided as ordered; her meal intake was noted to be variable, ranging from 25 to 100%. Recommending her NAS (no added salt) diet restriction was discontinued, provide 8 oz boost four times a day, and monitor weight weekly. Notify the physician and resident representative of significant weight changes. Follow up with the interdisciplinary team. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated August 13, 2024, at 11:43 AM indicated the resident had a 10% decrease in weight. The resident's NAS diet restriction was discontinued, an 8 oz boost supplemental drink was added, and weekly weight monitoring was implemented. A clinical record review revealed Resident 1 continued to lose weight from August 6, 2024, through December 3, 2024: 136.0 pounds on August 6, 2024 131.6 pounds on September 2, 2024 130.0 pounds on October 2, 2024 129.0 pounds on November 6, 2024 128.8 pounds on December 3, 2024 A progress note dated December 17, 2024, at 3:44 AM indicated Resident 1 experienced loose, watery stools twice, and the Registered Nurse (RN) Supervisor was notified. The note revealed an order to collect a stool sample was to be entered into the clinical record. However, further record review revealed no documented evidence that a physician's order for a stool sample was entered or that the resident's loose stool was addressed. The clinical record also lacked documentation clarifying whether a stool sample was deemed unnecessary. During an interview on January 30, 2025, at approximately 12:00 PM, the Director of Nursing (DON) indicated the resident no longer had loose stool, so the order was not initiated, and the stool sample never occurred. The DON was not able to provide thorough documented evidence of Resident 1's stool consistency from December 17, 2024, through January 8, 2025. A review of the facility's vitals report from November 8, 2024, through January 8, 2025, indicated Resident 1 had 133 recorded bowel movements (formed, soft, loose, etc.); however, the facility documented stool consistency in only 22 instances, making it impossible to determine the onset, frequency, and severity of diarrhea The facility failed to record the necessary clinical documentation to determine the onset, frequency, and pervasiveness of Resident 1's diarrhea/loose stools. A physician progress note dated January 8, 2025, at 11:37 AM, indicated Resident 1 reported loose stools for two months, which worsened over the last 7-10 days. The note indicated facility nursing staff confirmed Resident 1's complaints of diarrhea. A progress note dated January 10, 2025, at 11:14 AM indicated Resident 1 has stable weight over five months; however, had experienced a 14% weight loss over 180 days, despite receiving a regular diet, nutritional supplements, and fluids. She was receiving 8 oz of food caloric supplement twice a day and 8 oz of fluids three times a day with medication pass. The resident accepted supplementation and fluids; 75-100% are consumed on most days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documented fluid intake averaged [PHONE NUMBER] ml daily and due to worsening loose stools, the physician recommended: Increasing fluids, 8 oz four times a day Discontinuing the current caloric supplement, and Providing an alternative nutritional supplement twice a day and Weekly weights for close monitoring. A physician's progress note dated January 13, 2025, at 12:03 PM indicated Resident 1 was seen for a follow-up on diarrhea and dehydration. The note indicated Resident 1 had a history of chronic kidney disease. The note indicated lab results from January 10, 2025, showed the resident was dehydrated. The resident reported feeling slightly improved but still experiencing diarrhea. A progress note dated January 17, 2025, at 4:00 PM indicated Resident 1 was reweighed and determined to be 115.5 pounds, confirming a 10% weight loss within 30 days and a 23% weight loss in 180 days, despite nutritional interventions. Further clinical record review revealed Resident 1 weighed 128.8 pounds on December 3, 2024, and weighed 115.5 pounds on January 15, 2025, which is a 10.33% (13.3 pounds) loss in 43 days and 23.5% (35. 5 pounds) in 195 days. During an interview on January 30, 2025, at approximately 12:00 PM, the Director of Nursing (DON) confirmed the facility staff did not consistently document Resident 1's bowel movements, and Resident 1's clinical record lacked the documented evidence to determine or evaluate how long Resident 1 was experiencing loose stool or diarrhea. The DON was unable to provide evidence that Resident 1's diarrhea and loose stool (December 17, 2024) were addressed timely. The DON was unable to provide documented evidence that Resident 1's loss of weight or dehydration was unavoidable. The DON confirmed it is the facility's responsibility to ensure residents maintain acceptable parameters of nutritional status, such as body weight and electrolyte balance 28 Pa Code 211.5 (f)(ii)(iii)(x) Medical records. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on clinical record review and staff interview, the facility failed to promptly provide laboratory results to the ordering practitioner for one out of the 20 residents sampled (Resident 1). Findings include: A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and chronic kidney disease (gradual loss of kidney function). A review of a significant change in status Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 16, 2025, revealed that Resident 1 is moderately cognitively impaired with a BIMS score of 8 (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 8-12 indicates cognition moderately impaired). A physician progress note dated January 8, 2025, at 11:37 AM documented Resident 1 was seen for increased diarrhea. which had worsened over the past 7-10 days. The resident also indicated she had been slightly nauseated and has had some pressure in her lower abdominal area. The note indicated facility nursing staff confirmed Resident 1's complaints of diarrhea. A progress note from the same day at 7:38 PM indicated a new order for Lomotil 5 mg every six hours for three days and a laboratory panel, including a complete blood count (CBC-complete blood count, CMP-comprehensive metabolic panel, MAG-magnesium blood test). A physician's order for Resident 1 to have CBC, CMP, and MAG twice a day (3:00 PM to 11:00 PM; 11:00 PM to 7:00 AM) was initiated on January 8, 2025, at 7:34 PM. A clinical laboratory report indicated Resident 1's sample for CBC, CMP, and MAG was collected on January 9, 2025, at 6:43 AM and reported back to the facility the same day at 1:45 PM. However, further record review revealed no documented evidence that the physician received, reviewed, or acted upon the results for approximately 24 hours On January 13, 2025, at 12:03 PM, the physician documented that Resident 1's laboratory results from January 9, 2025, indicated significant dehydration, with a blood urea nitrogen (BUN- a blood test that measures the amount of urea nitrogen in the blood) of 59, creatinine (a waste product produced by muscle breakdown) 1.46, potassium slightly decreased at 3.4 (amount of potassium in the blood), and glomerular filtration rate (GFR-measures how well the kidneys are filtering waste products from the blood) 18. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Despite these findings, a physician's order for a midline catheter (a type of intravenous catheter allowing for the administration of medications or fluids directly into the bloodstream) insertion was not initiated until January 10, 2025, at 8:38 PM, approximately 30 hours after the laboratory results were reported A physician's order for Resident 1 to receive supplemental fluids with directions to administer 240 ml four times a day was initiated on January 10, 2025. This order was revised from a previous ongoing order from 240 ml three times a day to 240 ml four times a day, initiated in November 2024. A physician's order for Resident 1 to be administered continuous infusion normal saline solution (NSS) 0.9% at 50 ml/hr for one liter was initiated on January 10, 2025, at 11:36 PM. A progress note dated January 10, 2025, at 10:25 PM revealed midline to left upper arm placed for Resident 1. The physician's progress note dated January 13, 2025, at 12:03 PM indicated that Resident 1's furosemide, a diuretic medication, had been held. The resident had received one liter of normal saline solution, which had been well tolerated. Laboratory tests had been redrawn on January 11, 2025, with results showing potassium at 4.5, BUN at 60, creatinine at 2.25, and GFR at 20. Furosemide had remained on hold pending further lab results. Additional laboratory tests had been scheduled for January 14, 2025. The resident had also been scheduled to receive an additional liter of normal saline prior to the next lab draw. The resident had been in no acute distress and had stated that she felt better than the previous week. She had also reported that her diarrhea had slowed down slightly. A review of Resident 1's Medication Administration Record for January 2025 revealed Resident 1 received furosemide (a diuretic medication) 20 mg tablet on January 10, 2025, at 9:00 AM. after the facility had laboratory results indicating dehydration. Subsequent doses were held per physician orders. A review of Resident 1's Medication Administration Record for January 2025 indicated that Resident 1 had received 240 ml of additional fluids on January 10, 2025, at 1:00 PM and during each subsequent shift as ordered until January 15, 2025. However, the revision of the additional fluid treatment had been implemented 23 hours after the laboratory report date, which had indicated that Resident 1 exhibited markers of dehydration. Additionally, the review of Resident 1's Medication Administration Record for January 2025 showed that Resident 1 had received continuous intravenous (IV) NSS 0.9% at 50 ml/hr beginning on the day shift of January 11, 2025, and during each subsequent shift as ordered until January 14, 2025. However, the continuous IV treatment had been initiated more than 40 hours after the laboratory report date, which had indicated that Resident 1 exhibited markers of dehydration. During an interview on January 30, 2025, at approximately 12:00 PM, the Director of Nursing (DON) explained that on January 10, 2025, Resident 1 dislodged her IV line, causing an additional delay in treatment. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on January 30, 2025, at approximately 12:00 PM, the Director of Nursing (DON) confirmed the physician documented that Resident 1's laboratory result indicated significant dehydration. The DON was unable to explain why there was a delay in implementing interventions and treatment to address Resident 1's dehydration. The DON confirmed it is the facility's responsibility to ensure the physician is promptly provided with laboratory results. 28 Pa Code 211.2 (d)(3) Medical director. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa Code 211.12 (d)(3) Nursing services.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on clinical record review and staff interviews, the facility failed to ensure the timely provision and/or procurement of radiology/diagnostic services to meet the needs of one of 20 residents sampled (Resident 64). Findings include: Review of Resident 64's clinical record revealed the resident was admitted to the facility on [DATE], with the diagnoses to include unspecified deep vein thrombosis (condition where a blood clot forms in a deep vein, typically in the lower legs), gout (form of inflammatory arthritis), anxiety and was cognitively intact. Review of Resident 64's clinical record revealed a progress note dated January 18, 2025, indicating the resident had a fall and subsequently complained of right shoulder pain. The physician ordered an x-ray of the right shoulder to rule out a fracture. A review of the resident's clinical record conducted during the survey on January 29, 2025, confirmed that the ordered x-ray had not been completed. On January 29, 2025, a STAT x-ray of the right shoulder was ordered; however, as of 8:30 PM, the mobile x-ray company had not completed the imaging. At approximately 9:00 PM, Resident 64 was sent to the emergency room for the x-ray. According to the clinical record, upon arrival at the emergency room , Resident 64 refused the right shoulder x-ray and instead requested imaging of the left shoulder. The left shoulder x-ray was completed and was negative for acute fracture. During an interview on January 30, 2025, at approximately 10:30 AM, the Director of Nursing confirmed that the x-ray was not completed as originally ordered. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services