

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Whitestone Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on review of the Resident Assessment Instrument (RAI) Manual, clinical records, and staff interviews, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) for two of 30 residents sampled (Resident 4 and Resident 11). Findings include: The Long-Term Care Facility RAI User's Manual, which provides instructions and guidelines for completing the MDS dated [DATE], requires the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. A clinical records review revealed Resident 4 was admitted to the facility on [DATE], with diagnoses including Hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (death of brain tissue caused by a lack of blood flow) affecting right dominant side. A quarterly MDS dated [DATE], revealed section GG-0115 (section related to functional abilities, the ability to perform tasks and activities necessary for daily living) indicated Resident 4 experienced no impairment in range of motion (ROM) (referring to the full movement of a joint or series of joints, measured in degrees) for upper and lower extremities. An observation of Resident 4 on December 4, 2025, at 8:50 AM revealed Resident 4's right upper extremity (including arm, wrist, and fingers) to be in a flexed (bent) position, close to Resident 4's upper body. Further observation of Resident 4 revealed the resident did not move her right upper extremity and used only her left upper extremity for all aspects of daily living, including moving her wheelchair. An interview with the Registered Nurse Assessment Coordinator (RNAC) on December 4, 2025, at 1:12 PM revealed the RNAC acknowledged the quarterly MDS did not accurately reflect the limited range of motion of the right upper extremity for Resident 4. A review of Resident 11's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included unspecified fracture (a break in the bone) of third lumbar vertebra (bone in the lower spine), subsequent encounter for fracture with routine healing. A review of the resident's progress notes indicate Resident 11 was admitted from the acute care facility, after a fall at home with L3 Burst Fracture (a severe spinal injury where the third lumbar vertebra shatters from extreme force). The admission MDS dated [DATE], revealed section J (section addressing fall history), question J1700 Fall History on Admission/ Entry or Reentry indicated Resident 11 did not have any fracture related to a fall in the six months prior to admission/ entry or reentry despite the resident having a fall at home resulting in a fracture. An interview with the RNAC on December 4, 2025, at 2:00 PM, revealed the RNAC acknowledged the admission MDS did not accurately reflect the fall with fracture prior to admission. 28 Pa. Code 211.5(f)(iii) Medical records 28 Pa. Code 211.12(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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: Facility ID: 396130
		If continuation sheet Page 1 of 4

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included specific and individualized interventions to address skin integrity needs for one out of 20 residents sampled (Resident 69). Findings include: A clinical record review revealed Resident 69 was admitted to the facility on [DATE], with diagnoses which included Depression (a common mental disorder. It involves a depressed mood or loss of pleasure or interest in activities for long periods of time.) and anxiety (a feeling of fear, dread, and uneasiness). A review of a Psychiatry progress note dated April 30, 2025, revealed the resident had a diagnosis of excoriation (skin picking disorder). The resident was experiencing increased skin picking related to anxiety. Further it was revealed the resident was embarrassed about the condition and covered her scars and open areas on her forehead with a mask or Band-Aid. The progress note recommended for staff to utilize non-pharmacologic interventions, supportive care, and redirection as needed. A review of the progress notes from April 2025 to December 2025, revealed the resident continued to have episodes of skin picking throughout the stay. A review of the resident's clinical record revealed no documented evidence the facility developed and implemented a person centered care plan to reflect Resident 69's skin integrity related to her skin picking disorder. The care plan failed to identify tools/nonpharmacological interventions for staff to attempt to prevent further occurrence of skin picking. During an interview on December 4, 2025, at 11:00 AM, the Director of Nursing and the Surveyor reviewed the above findings of skin integrity related to her anxiety disorder and confirmed Resident 69's comprehensive person-centered care plan did not reflect the resident's skin integrity needs. 28 Pa Code 211.12 (d)(1)(3) Nursing services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on a review of select facility policy, controlled drug shift count records, and staff interview, it was determined the facility failed to implement procedures to promote accurate controlled medication records on one of two medication carts observed. Findings include: A review of a facility policy entitled Inventory Control of Controlled Substances last reviewed April 24, 2025, revealed the facility should ensure the incoming and outgoing nurses count all Schedule II controlled substances (medications with a high potential for abuse, but it has a currently accepted medical use in the U.S. or a currently accepted medical use with severe restrictions) and any medications with potential for abuse or diversion at the change of each shift. A review of the facility Shift verification of Controlled Substance Count form for the first-floor A hall Nursing Unit medication cart revealed the following: July 28, 2025, the evening shift outgoing nurse failed to sign that the narcotic count was completed and correct. August 9, 2025, the day shift outgoing nurse failed to sign that the narcotic count was completed and correct. September 17, 2025, the day shift outgoing nurse failed to sign that the narcotic count was completed and correct. September 23, 2025, the day shift outgoing nurse failed to sign that the narcotic count was completed and correct. September 24, 2025, the evening shift outgoing nurse failed to sign that the narcotic count was completed and correct. November 11, 2025, the day shift outgoing nurse failed to sign that the narcotic count was completed and correct. An interview with Employee 2 RN (Registered Nurse) on December 4, 2025, at 9:00 AM confirmed the narcotic sheet for the first-floor A hall nursing unit medication cart was not signed off by the outgoing nurses on the above dates identified. An interview was conducted on December 4, 2025, at 11:00 AM, with the Nursing Home Administrator (NHA) to review the above findings related to the facility's failure to demonstrate consistent implementation of procedures for promoting accurate controlled drug records. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing service 28 Pa Code 211.9 (c)(k) Pharmacy services 28 Pa Code 211.5(f)(x) Clinical records 28 Pa. Code 211.10(a) Resident Care Policies		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy, observations, and staff interview it was determined the facility failed to ensure that biologicals were stored within the expiration date in one of two medication storage areas. Findings include: Review of the facility policy entitled Storage and Expiration Dating of Medications and Biologicals last reviewed [DATE], stated the facility will store medications and biologicals that have an expired date on the label and have not been retained longer than recommended by manufacturer or supplier guidelines. An observation of the medication storage room located on the second floor nursing unit on [DATE], at 11:24 AM in the presence of Employee 1 LPN (license practical nurse) revealed one sterile dressing change kit which expired on [DATE] and four sterile dressing kits which expired on [DATE]. An interview with the Nursing Home Administrator on [DATE], at 2:00 PM acknowledged the above findings that the biologicals were not maintained within the expiration dates. 28 Pa Code 211.12(d)(1) Nursing services. 28 Pa Code 211.9(a)(1)(k) Pharmacy services		