STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395959	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Place, The	103 N. Thirteenth Street Franklin, PA 16323

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure that the physician reviewed the residents' total program of care including medications during physician visits for one of nine residents reviewed (Resident R1). Findings include: Review of facility policy entitled, Monthly Medication Regimen Review dated 9/25/23, indicated the intent, To ensure the resident's highest practicable level of physical, mental, and psychosocial well-being and prevent or minimize adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing. Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included multiple subsegmental pulmonary emboli (a blood clot in the lung(s) in more than one artery), muscle weakness, and hypertension (high blood pressure). Resident R1's progress notes revealed that he/she was sent to the emergency roiagnom on [DATE], due to a positive doppler scan indicating he/she had a deep vein thrombosis (blood clot) in his/her left lower extremity. Resident R1 returned to the facility on [DATE] with an order for the medication Eliquis (an anticoagulant/blood thinner) 5 milligrams (mg) two times a day for 74 doses. The Certified Registered Nurse Practitioner (CRNP) documented in the progress notes during his/her visits with Resident R1 on 12/28/23, 1/4/24, and 1/11/24, that Resident R1 was to remain on the anticoagulant medication long-term. Review of Resident R1's medication administration record (MAR) revealed Eliquis 5 mg twice a day was administered as ordered from 12/27/23, through 2/1/24. Resident R1 did not receive Eliquis 5 mg twice a day from 2/2/24, through 4/8/24. The CRNP documented in the progress notes during his/her visits with Resident R1 on 2/1/24, 2/16/24, and 3/1/24 that Resident R1 was receiving Eliquis 5 mg twice a day due to an extensive deep vein thrombosis in the left lower extremity. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Eliquis 5 mg twice a day was no longer on the current medication list during the identified visits as it had been discontinued after the 2/1/24, administered doses. During an interview on 4/17/24, at 11:40 a.m. the Director of Nursing confirmed that the CRNP did not review Resident R1's current medications during visits and/or communicate with nursing staff and/or the pharmacy to ensure the accuracy of the total program of care to include medications that Resident R1 was receiving. 28 Pa Code 201.14(a) Responsibility of Licensee 28 Pa Code 211.5(f)(iv) Medical records

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to properly conduct thorough monthly drug regimen reviews to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities for one of nine residents reviewed (Resident R1). Findings include: Review of a facility policy entitled, Monthly Medication Regimen Review dated 9/25/23, indicated, The licensed pharmacist conducting the medication regimen reviews will provide a written report of irregularities. This report will be provided to the attending physician, medical director, and director of nursing (DON). The report shall list the residents name, relevant medication, and irregularity the pharmacist has identified. Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included multiple subsegmental pulmonary emboli (a blood clot in the lung(s) in more than one artery), muscle weakness, and hypertension (high blood pressure). Resident R1's progress notes revealed that he/she was sent to the emergency roiagnom on [DATE], due to a positive doppler scan indicating he/she had a deep vein thrombosis (blood clot) in his/her left lower extremity. Resident R1 returned to the facility on [DATE], with an order for the medication Eliquis (an anticoagulant/blood thinner) 5 milligrams (mg) two times a day for 74 doses. Resident R1's clinical record revealed the licensed pharmacist performed a monthly regimen review on 1/5/24, and indicated that the Eliquis 5 mg twice a day for 74 doses was added due to deep vein thrombosis in the left lower extremity. Physician progress note from 1/11/24, included remain on anticoagulant long term. Review of Resident R1's February 2024 Medication Administration Record (MAR) revealed that the last administration of Eliquis 5 mg was on 2/1/24, with doses administered at 8:00 a.m. and 8:00 p.m. Physician progress note of 3/1/24 identified .recently placed on Eliquis due to LLE [extensive left lower extremity] DVT [deep vein thrombosis]. Review of Resident R1's March 2024 MAR revealed no indication that Eliquis was ordered or administered. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The monthly regimen reviews conducted on 2/5/24, and 3/19/24, were not thorough as they failed to identify documentation of irregularities regarding the Eliquis 5 mg. The medication twice a day had been discontinued abruptly yet Resident R1 had a history of pulmonary emboli and deep vein thrombosis in the left lower extremity. The progress notes completed by the Certified Registered Nurse Practitioner on 12/28/23, 1/4/24, 1/11/24, indicated Resident R1 was to remain on Eliquis 5 mg twice a day long-term and indicated Resident R1 remained on Eliquis 5 mg twice a day 2/1/24, 2/16/24, and 3/1/24, despite the order having been discontinued once the 2/1/24 doses were administered. Pharmacy review from 3/19/24-no irregularities noted and no reference to Eliquis for Resident R1. During an interview on 4/17/24, at 11:40 a.m. the Director of Nursing confirmed that the licensed pharmacist did not properly conduct a thorough monthly regimen review to prevent, identify, report, and resolve medication related problems, medication errors, or other irregularities for Resident R1. 28 Pa. Code 211.9(a)(1) Pharmacy Services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services