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	11/08/2024

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 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** 47356 Based on review of facility policies, facility documentation and review of clinical records, and staff interviews, it was determined that the facility failed to appropriately transfer a resident to ensure the resident was free from neglect which resulted in actual harm of a fracture of the right humeral head of the right shoulder for one of 13 residents reviewed (Resident R1). Findings include: The Mechanical Lifts and Slings policy, dated 2/05/24, revealed, Mechanical lift transfer status will be maintained indicating the use of a full mechanical lift or sit to stand mechanical lift. Transfer Status will also be documented in the Plan of Care. Two or more aides must be used for all full mechanical lift transfers. The Identifying Resident Neglect policy, dated 2/05/24, revealed, Neglect includes cases where the facility's indifference to or disregard for resident care, comfort, or safety results in (or could have resulted in) physical harm, pain, mental anguish or emotional distress. A review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included cerebral infarction due to embolism (a stroke due to a blood clot in the brain), muscle weakness, and major depressive disorder. A review of Resident R1's order summary revealed a physician's order dated 4/14/23, to utilize a mechanical lift with two staff for transfers. A review of Resident R1's ADL (Activities of Daily Living) Self Care Performance Deficit care plan, date initiated 4/25/23, revealed, mechanical lift and assist of two for transfers. A review of Resident R1's clinical record revealed a nursing note written by Registered Nurse (RN) Employee E2, dated 10/27/24, at 2:42 a.m. Called to resident room by LPN [Licensed Practical Nurse] to assess right arm and shoulder d/t [due to] increased pain. Resident has a history of CVA [cerebrovascular accident] which effected right side. Right arm has limited ROM [range of motion] since CVA. Right shoulder appears swollen, no increased warmth. Scarring to shoulder from previous surgery. Resident states shoulder is always swollen but is more painful at this time than usual. No recent falls or known injuries. Ice applied to site and Tylenol given by LPN. Will discuss with on call MD [medical doctor] in a.m. r/t [related to] need for Xray. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident R1's clinical record revealed a nursing note written by LPN Employee E4, dated 10/27/24, at 2:57 p.m. CRNP [Certified Registered Nurse Practitioner] Employee E5 notified of increased right shoulder and arm pain per LPN. Verbal orders to continue with current pain management regimen and ice as needed. Floor staff updated. A review of Resident R1's clinical record revealed a nursing note dated 10/28/24, at 1:52 p.m. indicating a new order for an X-Ray of the right shoulder was received. The X-Ray was completed on 10/29/24. Review of information submitted by the facility, dated 10/29/24, revealed that an X-Ray of Resident R1's right arm was ordered because he/she was guarding his/her right arm. The X-Ray was completed and dictated on 10/29/24, with results indicating there was an acute minimally impacted fracture of the base of the humeral head in the right shoulder. The result was reported to the Medical Director and Director of Nursing (DON) and at that time an investigation on the weekend of 10/26/24 and 10/27/24 began. The investigation revealed that agency NA Employee E1 was asked to assist another NA Employee E4 with a transfer. When NA Employee E4 arrived to Resident R1's room agency NA Employee E1 already had Resident R1 in bed. It was confirmed that agency NA Employee E1 transferred Resident R1 with no mechanical assistance, independent of any other support. A review of the investigation revealed that NA Employee E4 provided a written statement with an incident date of 10/26/24, and a time of 1:30 p.m. which revealed, It was after lunch and I asked [NA Employee E1] for help to lay [Resident R1] down in bed. When I walked in the room with the lift [NA Employee E1] had a hold of [Resident R1] with his/her hands under his/her arms picking him/her up. I ran over to the side of the bed to help finish transferring him/her. When we got him/her laying down [Resident R1] was saying his/her arm was hurting him/her. [NA Employee E1] was saying something and rubbing his/her arm. We finished changing him/her and got him/her comfortable. This written statement was signed dated 10/29/24. A review of the investigation revealed that agency NA Employee E1 signed the facility's orientation policy related to ensuring staff know where to locate transfer status to ensure safe transfer of all residents on 9/20/24. A review of documentation submitted by the facility, dated 10/29/24, revealed that the facility initiated an investigation and the agency NA Employee E1 was removed from the schedule and would not be returning. During an interview on 11/07/24, at approximately 2:10 p.m. the Nursing Home Administrator (NHA) and DON confirmed that the agency NA Employee E1 had transferred Resident R1 independently and did not use a lift as ordered and care planned. The facility failed to ensure that Resident R1 was provided adequate assistance in accordance with their physician orders and care plan to utilize a mechanical lift and free from neglect, causing a fracture of the right humeral head of the right shoulder from an improper transfer. This deficiency is cited as past non-compliance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24, the facility initiated education for all nursing staff including RN's, LPN's, and NA's to ensure that resident transfers are performed per resident care plans and physician's orders. This plan included the following: Immediate Suspension and Do Not Return of agency NA Employee E1. Immediate education regarding checking transfer status before ambulating or transferring a resident was provided to nursing staff which included RN's, LPN's, and NA's, which occurred from 10/29/24, through 11/06/24. Review of all resident transfer status completed by the Assistant Director of Nursing RN Employee E12 in conjunction with the Therapy Department on 10/31/24. All staff included in the education also completed competencies conducted by the Management Team. Interviews with RN Employee E12, LPN Employees E6, E7, and E8 and NA Employees E9, E10, and E11, confirmed the facility initiated education and competencies starting 10/29/24, which included education on checking transfer status before ambulating or transferring a resident and performing a return demonstration to ensure proper knowledge and technique. Audits were conducted to ensure residents are transferred per their care plans and physician orders, which occurred on all shifts and on all units from 11/05/24, through 11/06/24 with all transfers performed appropriately. The facility has demonstrated compliance with using correct transfer status for residents since 11/06/24. During an interview with the NHA and the DON on 11/07/24, at approximately 2:15 p.m. and review of the facility's immediate actions, education, competencies, and audits, it was verified that the facility had implemented a plan of correction to ensure residents are free from neglect regarding transfer status of residents and had achieved substantial compliance. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services