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	06/06/2025

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. Based on review of facility policy, facility documentation and clinical record, and staff interviews, it was determined that the facility failed to ensure that one of three residents reviewed (Resident R2) was free from neglect during care which resulted in actual harm of a left femur (upper leg) fracture. This deficiency is cited as past non-compliance. Findings include: A facility policy entitled, Abuse Prohibition dated 5/27/25, revealed that, Neglect is the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safety, adequate, and appropriate services, treatment and care, including but not limited to: nutrition, medication, therapies, and activities of daily living. Resident R2's clinical record revealed an admission date of 12/21/21, with diagnoses including stroke, Parkinson's Disease (brain disorder that causes gradual, progressive damage to parts of the brain over many years), and muscle weakness. Resident R2's physician's orders as of 5/19/25, revealed an order dated 2/02/24, to transfer to shower chair with assist of two, please follow instructions in tasks. Resident R2's Minimum Data Set (MDS- an assessment tool used to facilitate the management of care) Assessment, dated 4/15/25, under Section G, Functional Status revealed that Resident R2 required extensive assistance of two people to transfer between surfaces. Occupational Therapy documentation dated 5/15/25, indicated as of 5/07/25, Resident R2 required assistance of two staff and a walker to maintain his/her balance. Resident R2's Care Plan History revealed on 5/06/25, staff were instructed to transfer per therapy recommendations-see tasks for instructions. Resident R2's point of care documentation prior to 5/15/25, revealed that he/she was being transferred with a mechanical lift and assistance of two staff, and using a shower gurney. (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	Resident R2's departmental progress notes revealed that on 5/15/25, at 9:21 p.m. staff was called to the shower room to assess Resident R2 after he/she fell, and orders were received to transport Resident R2 to the Emergency Department. At 10:22 p.m. the facility was notified that Resident R2 was admitted to the hospital for treatment of a fractured left femur. Review of the investigation revealed that on 5/15/25, Nurse Aide (NA) Employee E1 reported that he/she was aware that Resident R2 was an assistance of two staff for transfers at the time of the fall and chose to transfer Resident R2 by himself/herself. During an interview on 6/05/25, at 10:40 a.m. the Regional Clinical Consultant and Nursing Home Administrator confirmed that after the investigation was completed, it was discovered that NA Employee E1 had knowingly transferred Resident R2 without the assistance of a second staff. The facility failed to ensure that Resident R2 was free from neglect resulting in actual harm of a left femur fracture from an improper transfer done independently and not with the required two-person assistance. This deficiency is cited as past non-compliance. The NA Employee E1 was removed from the schedule and would not be returning. On 5/15/25, the facility initiated re-educating staff of the abuse policy and conducting procedural competencies on locating the appropriate transfer status of residents prior to providing care. On 5/16/25, the facility initiated audits (observations) of staff completing resident transfers, and continued to audit resident transfers until 6/04/25 with transfers being completed accurately. During an interview on 6/05/25, at 1:30 p.m. the Director of Nursing, Nursing Home Administrator, and the Regional Clinical Consultant confirmed that there is additional training scheduled on 6/10/25, and that the incident is scheduled to be reviewed in Quality Assurance and Performance Improvement (QAPI- a data driven and proactive approach to quality improvement) meeting scheduled for 6/13/25. Interviews with NA Employees E3, E4, E5, E6, and E7 confirmed that they were re-educated a week or two ago on where to find information regarding a resident's transfer status and the facility abuse policy. The facility has demonstrated compliance since 6/04/25. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) 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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility documentation and clinical record, and staff interviews, it was determined that the facility failed to appropriately transfer a resident as identified in the plan of care for two of three residents reviewed (Residents R2 and R3), with one transfer which resulted in actual harm of a left femur (upper leg) fracture for one of three residents reviewed (Resident R2). This deficiency is cited as past non-compliance. Findings include: Resident R3's clinical record revealed an admission date of 3/20/25, with diagnoses that included respiratory failure, muscle weakness, abnormal gait and mobility, and need for personal care assistance. Resident R3's Admission/re-admission Nursing Evaluation Section 4 dated 3/20/25, revealed that he/she required the assistance of two staff to transfer. A Physical Therapy evaluation dated 3/20/25, indicated that Resident R3's baseline (starting) transfer ability was with moderate assistance of two. An Occupational Therapy evaluation dated 3/20/25, indicated that Resident R3's baseline toileting ability was toileting in bed, total assist, unsafe for toilet transfer due to O2 (oxygen) dropping. Resident R3's Care Plan History revealed that on 3/20/25, staff were instructed to transfer with walker and assist x 2 (two staff) ambulate with therapy only. Resident R3's Intervention/Task documentation dated March 2025 for transfer/toileting abilities, revealed that he/she required either assistance at level 02: Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort or assistance at level 01: Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity. Review of the facility investigation revealed that on 3/22/25, Nurse Aide (NA) Employee E3 reported that he/she attempted to transfer Resident R3 onto the toilet without the assistance of another staff member and that Resident R3's knees buckled and the resident was lowered to the floor. During an interview on 6/05/25, at 11:30 a.m. Occupational Therapist Employee E8 confirmed that Resident R3 was not yet assessed for safe toileting transfers on 3/22/25, and should have been provided a bed pan until safe transfer status was established. During an interview on 6/06/25, at 9:15 a.m. the Regional Clinical Consultant and Director of Nursing confirmed that there was no policy regarding following therapy transfer orders, but that staff are to refer to the resident's Kardex (plan of care) in the electronic health record. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident R2's clinical record revealed an admission date of 12/21/21, with diagnoses that included stroke, Parkinson's Disease (brain disorder that causes gradual, progressive damage to parts of the brain over many years), and muscle weakness. Resident R2's physician's orders as of 5/19/25, revealed an order dated 2/02/24, to transfer to shower chair with assist of two, please follow instructions in tasks. Resident R2's Minimum Data Set (MDS- an assessment tool used to facilitate the management of care) Assessment, dated 4/15/25, Section G, Functional Status revealed that Resident R2 required extensive assistance of two people to transfer between surfaces. Occupational Therapy documentation dated 5/15/25, indicated that as of 5/07/25, Resident R2 required assistance of two staff and a walker to maintain his/her balance. Resident R2's Care Plan History revealed that on 5/06/25, staff were instructed to transfer per therapy recommendations-see tasks for instructions. Resident R2's point of care documentation prior to 5/15/25, revealed that he/she was being transferred with a mechanical lift and assistance of two staff, and using a shower gurney. Resident R2's departmental progress notes revealed that on 5/15/25, at 9:21 p.m. staff was called to the shower room to assess Resident R2 after he/she fell, and orders were received to transport Resident R2 to the Emergency Department. At 10:22 p.m. the facility was notified that Resident R2 was admitted to the hospital for treatment of a fractured left femur. Review of the facility investigation revealed that on 5/15/25, the NA Employee E1 reported that he/she was aware that Resident R2 was assistance of two staff for transfers at the time of the fall and chose to transfer Resident R2 by himself/herself. During an interview on 6/05/25, at 10:40 a.m. the Regional Clinical Consultant and Nursing Home Administrator confirmed that after the investigation was completed, it was discovered that NA Employee E1 had knowingly transferred Resident R2 without the assistance of a second staff. The facility failed to ensure that Resident R2 was free of an accident that resulted in actual harm of a left femur fracture from an improper transfer done independently and not with the required two-person assistance. This deficiency is cited as past non-compliance. The NA Employee E1 was removed from the schedule and would not be returning. On 5/15/25, the facility initiated re-educating staff regarding safe transfers and conducting procedural competencies on locating the appropriate transfer status of residents prior to providing care. On 5/16/25, the facility initiated audits (observations) of staff completing resident transfers, and continued to audit resident transfers until 6/04/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/05/25, at 1:30 p.m. the Director of Nursing, Nursing Home Administrator, and the Regional Clinical Consultant confirmed that there is additional training scheduled on 6/10/25, and that the incident is scheduled to be reviewed in Quality Assurance and Performance Improvement (QAPI- a data driven and proactive approach to quality improvement) meeting scheduled for 6/13/25. Interviews with NA Employees E3, E4, E5, E6, and E7 confirmed that they were re-educated a week or two ago on where to find information regarding a resident's transfer status to prevent accidents. The facility has demonstrated compliance since 6/04/25. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) 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