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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>395959 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>07/18/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Caring Place, The |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>103 N. Thirteenth Street<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day), failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer, and failed to have complete documentation related to a transfer for three of 20 residents reviewed (Residents R3, R31, and R105).</p> <p>Findings include:</p> <p>Review of facility policy entitled "Bed Hold Notice" dated 2/18/25, indicated "In the event a resident is transferred for hospitalization or therapeutic leave, the facility shall review its bed hold policy with the resident and/or designated resident representative. This review shall be accomplished at or prior to transfer."</p> <p>Review of facility policy entitled "Transfer/Discharge Documentation" dated 2/18/25, indicated "Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: The basis for transfer; contact information of practitioner; Resident representative information; Advance directive;"</p> <p>Review of Resident R3's clinical record revealed an admission date of 12/21/21, with diagnoses that included chronic obstructive pulmonary disease (a disease that obstructs air flow from the lungs), Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), and hypertension (high blood pressure).</p> <p>Review of Resident R3's clinical record revealed a progress note dated 5/15/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. His/her clinical record lacked evidence indicating that the resident and/or their representative were provided with a copy of the facility bed-hold policy upon transfer.</p> <p>Review of Resident R31's clinical record revealed an admission date of 11/27/24, with diagnoses that included atrial fibrillation (irregular heartbeat), heart failure, anxiety disorder, and hypertension.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of Resident R31's clinical record revealed progress notes dated 12/9/24, 2/14/25, 2/21/25, and 3/15/25, indicating transfers to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. The clinical record lacked evidence indicating that the resident and/or his/her representative were provided with a copy of the facility bed-hold policy upon transfer on 3/15/25, and had incomplete documentation related to the basis of transfer, interventions, and appropriate contacts on 2/14/25, 2/21/25, and 3/15/25.</p> <p>Review of Resident R105's clinical record revealed an admission date of 3/31/25, with diagnoses that included heart disease, atrial fibrillation, heart failure, hypertension, and anxiety.</p> <p>Review of Resident R105's clinical record revealed a progress note dated 6/12/25, indicating transfer to the hospital. The clinical record lacked evidence indicating that the resident and/or his/her representative were provided with a copy of the facility bed hold policy upon transfer.</p> <p>During an interview on 7/17/25, at 2:46 p.m. the Director of Nursing (DON) confirmed that the facility lacked evidence that Residents R3, R31, and R105 and/or their representatives were provided with a copy of the bed-hold policy upon transfer that included the cost per day; that the facility lacked evidence that Residents R3 and R31's necessary clinical information was provided to the receiving healthcare provider upon transfer; and that Resident R31's clinical record lacked complete documentation. The DON also confirmed that when the transfers occurred the resident and/or his/her representative should have been provided with a bed hold policy, clinical information should be provided to the receiving healthcare provider upon transfer, and documentation should be complete regarding transfers.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(c.3) (2) Resident rights</p> |   |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on review of facility policy, clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen and change/date oxygen tubing according to physician's orders for two of two residents reviewed for respiratory services (Residents R45 and R58). Findings include: Review of facility policy entitled Oxygen dated 2/18/25, indicated There must be a Physician's Order for oxygen use which includes the route and liter flow. Resident R45's clinical record revealed an admission date of 1/6/25, with diagnoses that included hypertension (high blood pressure), chronic respiratory failure, and muscle weakness. Additional review of the physician's orders revealed an order that reads change and date oxygen tubing weekly every night shift every Thurs. Observation on 7/16/25, at 9:21 a.m. revealed Resident R45's nasal cannula (oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery) was not dated. It was also noted that the humidifier solution cannister, which is attached to the oxygen concentrator was dated 7/4/25. During an interview at that time Licensed Practical Nurse (LPN) Employee E2 confirmed that the oxygen tubing was not dated and that the humidifier solution cannister was dated 7/4/25. Review of Resident R58's clinical record revealed an admission date of 3/8/24, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), asthma (a long-term lung disease that causes the airways to narrow and make it difficult to breath), and hypertension. Review of Resident R58's physician's orders dated 7/7/25, revealed an order for Oxygen at three liters/minute via nasal cannula as needed to maintain a SP02 (oxygen saturation) greater than 90%. Observations on 7/15/25, at 10:30 a.m. and again at 1:15 p.m. revealed Resident R58 lying in his/her bed with supplemental oxygen in place and the oxygen tank liter flow set at two liters/minute. Observations on 7/16/25, at 9:05 a.m., 9:35 a.m. and again at 10:25 a.m. revealed the resident lying in his/her bed with supplemental oxygen in place and the oxygen tank liter flow set at two liters/minute. During an interview on 7/16/25, at 10:25 a.m. LPN Employee E1 confirmed that Resident R58's oxygen tank was on and set at two liters/minute and was not in accordance with the physician's order dated 7/7/25, for oxygen at three liters/minute. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services</p> |   |  |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure medications were administered according to physician's orders for residents receiving dialysis (method of mechanically cleaning the blood) for one of two residents reviewed for dialysis (Resident R12). Findings include: Review of the facility policy Administering Medications, dated 2/18/25, indicated that medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The policy also indicated that if there were any concerns regarding the medications the prescriber would be contacted to discuss the concerns. Review of Resident R12's clinical record revealed an admission date of 2/22/25, with diagnoses that included hypertension (high blood pressure), muscle weakness, type II diabetes ( the body does not make enough insulin to control blood sugar), and end stage renal disease with dependance on renal dialysis, which required being away from the facility on Monday, Wednesday, and Friday each week for dialysis treatments. Review of physician's orders dated 4/3/25, indicated that Resident R12 was to have Hydralazine (a medication used to treat high blood pressure), 25 milligrams (mg) three times daily and Metformin (a medication used to treat high blood sugar levels), 500 mg two times daily. Review of June and July 2025, Medication Administration Records (MARs) revealed that Resident R12 did not receive the following medications as ordered with reason given as: Not in Facility Hydralazine and Metformin noon doses on 6/2/25, 6/4/25, 6/6/25, 6/9/25, 6/11/25, 6/13/25, 6/16/25, 6/18/25, 6/20/25, 6/23/25, 6/25/25, 6/27/25, 6/30/25, 7/2/25, 7/4/25, 7/7/25, 7/9/25, 7/11/25, 7/14/25, and 7/16/25. There was no documentation that the physician was notified of a need to hold or alter the time of administration for the above listed medications for Resident R12 on dialysis days. During an interview on 7/17/25, at 11:06 a.m. the Director of Nursing confirmed that the above medications for Resident R12 were not administered on dialysis days as ordered by the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for two of four medication carts reviewed and one of two medication rooms reviewed (first floor C-wing and second floor C-wing medication carts and second floor medication room). Review of facility policy entitled Medication Storage and Handling dated [DATE], indicated Medications will be monitored. to assure that they are not expired. Review of facility policy entitled Administering Medications dated [DATE], indicated When opening a multi-dose container, the date opened is recorded on the container. Review of Active liquid protein label indicated three-month shelf life from date open. Review of manufacturer's guidelines revealed that an open pen of Lispro Insulin must be used within 28 days after opening or be discarded. Review of manufacturer's guidelines revealed that an open vial of Lantus Insulin must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Observation of drug storage on [DATE], at 11:15 a.m. of the first floor C-wing medication cart revealed an open bottle of Ibuprofen (pain medication) with an expiration date of 5/2025, and an open bottle of Active liquid protein with no date indicating when the liquid protein was open. During an interview on [DATE], at the time of observation, Licensed Practical Nurse Employee E4 confirmed that the open bottle of Ibuprofen was expired, the open bottle of liquid protein lacked an open date, and staff were unable to determine the discard date. He/she also confirmed that the open bottle of Ibuprofen and open bottle of liquid protein should have been discarded. Observation of drug storage on [DATE], at 11:35 a.m. of the second floor C-wing medication cart revealed an open insulin pen of Lispro with an open date of [DATE], and an open vial of insulin Lantus with an open date of [DATE]. During an interview on [DATE], at the time of observation, LPN Employee E2 confirmed that the open insulin pen of Lispro and the open vial of insulin Lantus were beyond their use by dates. He/she also confirmed that the open insulin pen of Lispro and the open vial of insulin Lantus should have been discarded. Observation of drug storage on [DATE], at 11:55 a. m. of the second-floor medication room refrigerator revealed an open bottle of liquid Amoxicillin (antibiotic) with an expiration date of [DATE], four IV (intravenous) bags of Ceftriaxone (an antibiotic given through an IV line) with an expiration date of [DATE], and three IV bags of Cefazolin (an antibiotic given through an IV line) with an expiration date of [DATE]. During an interview on [DATE], at the time of observation with LPN's Employee E2 and E3, they confirmed that the open bottle of Amoxicillin, the four IV bags of Ceftriaxone and the three IV bags of Cefazolin were beyond their use by date and should have been discarded. 28. Pa. Code 201.18(b)(1) Management 28. Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services</p> |   |  |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to assure the call bell was accessible for one of 20 residents reviewed (Resident R103). Review of facility policy entitled Resident Call System dated 2/18/25, indicated Each resident is provided with a means to call staff directly for assistance from his/her bed. Review of Resident R103's clinical record revealed an admission date of 9/10/24, with diagnoses that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Observations on 7/16/25, at 9:05 a.m. revealed Resident R103 in their bed with the head of the bed elevated to a sitting position and his/her call bell was lying under his/her bed. Observation on 7/16/25, at 9:35 a.m. and again at 10:20 a.m. revealed Resident R103 was in their bed with the head of the bed in a slight elevated position and the call bell remained lying under his/her bed. During an interview on 7/16/25, at 10:20 a.m. Licensed Practical Nurse confirmed that Resident R103's call bell was lying under his/her bed and not accessible. He/she also confirmed that Resident R103 should always have access to his/her call bell. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management</p> |   |  |