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	07/02/2026

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policies, clinical records, and staff interview it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital and 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), for five of six residents reviewed (Residents R2, R5, R43, R55, and R94).Findings include:Review of facility policy entitled Transfer/Discharge - Emergency dated 1/14/26, indicated Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:Notify the resident's attending physicianNotify the receiving facility.Prepare the resident for transferPrepare a transfer form to send with the residentNotify the representative.Assist in obtaining transportOthers as appropriate or as necessaryReview of facility policy entitled Bed-Holds and Returns dated 1/14/26, indicated Prior to a transfer written information will be given to the resident and the resident representatives that explains in detail:The rights and limitations of the resident regarding bed-holdThe reserve bed payment policy.The facility per diem rate required to hold the bedThe details of the transferResident R2's clinical record revealed an admission date of 6/18/24, with diagnoses that included heart failure, atrial fibrillation (irregular heartbeat), and dementia (a disease that causes memory loss, cognitive decline, and behavior changes that impair daily functioning).Resident R2's clinical record revealed progress notes dated 3/24/26, and 6/23/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R5's clinical record revealed an admission date of 12/26/20, with diagnoses that included unspecified cerebrovascular disease (residual effects that remain after an acute cerebrovascular event, such as a stroke, intracerebral hemorrhage, or transient ischemic attack), respiratory failure, dementia, and swallowing difficulty. Review of Resident R5's progress notes revealed notes dated 5/10/26, indicating he/she was transferred to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon the transfer on 5/10/26. Resident R43's clinical record revealed an admission date of 6/21/24, with diagnoses including sepsis (bacterial infection in the blood), pneumonitis (lung inflammation caused by exposure to environmental substances or certain medications, not by an infection) due to inhalation of food and vomit, and swallowing difficulty. Review of Resident R43's progress notes revealed notes dated 5/28/26, indicating he/she was transferred to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon the transfer on 5/28/26. Resident R55's clinical record revealed an admission date of 4/24/26, with diagnoses including depression, hypertension (high blood pressure), and muscle weakness. Review of Resident R55's progress notes dated (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/29/26, and 6/17/26, indicating he/she was transferred to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon the transfer on 5/29/26, and 6/17/26. Resident R94's clinical record revealed an admission date of 11/18/24, with diagnoses that included hypertension, dementia, and heart failure. Review of Resident R94's progress notes revealed notes dated 11/13/25, 1/4/26, and 4/10/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 11/13/25, 1/4/26, and 4/10/26. During an interview on 7/1/26, at 2:25 p.m. the Director of Nursing (DON) confirmed that Residents R2, R5, R43, R55, and R94 clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider and Residents R5, R43, R55, and R94 clinical records lacked evidence indicating that he/she and/or his/her representatives were provided with a copy of the bed-hold policy upon transfer. The DON also confirmed when the transfers occurred clinical information should have been provided to the receiving healthcare provider and bed hold policy should have been provided to the resident/representative upon transfer. 28 Pa. Code 201.18(e)(1) Management28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for five of 30 residents reviewed (Residents R10, R39, R42, R55, and R79).Findings include: Review of facility policy entitled Baseline Care Plan dated 1/14/26, revealed, The resident and their representative will be provided a summary of the baseline care plan that includes, but is not limited to the following:The initial goals of the resident;A summary of the resident's medications and dietary instructions;Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; andAny updated information based on the details of the comprehensive care plan, as necessary. Review of Resident R10's clinical record revealed an admission date of 11/24/25, with diagnoses including closed fracture with routine healing (right hip fracture), dementia (a disease that causes memory loss, cognitive decline, and behavior changes that impair daily functioning), and unsteadiness on feet. Resident R10's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R10 and/or their representative. Review of Resident R39's clinical record revealed an admission date of 4/13/26, with diagnoses including diabetes (a health condition that is caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Resident R39's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R39 and/or their representative. Review of Resident R42's clinical record revealed an admission date of 6/19/26, with diagnoses including depression, diabetes, and hypertension. Resident R42's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R42 and/or their representative. Review of Resident R55's clinical record revealed an admission date of 4/24/26, with diagnoses including depression, hypertension, and muscle weakness. Resident R55's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R55 and/or their representative. Review of Resident R79's clinical record revealed an admission date of 6/4/26, with diagnoses including heart failure, muscle weakness, and unsteadiness on feet. Resident R79's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R79 and/or their representative. During an interview on 7/01/26, at 10:45 a.m. the Nursing Home Administrator confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Residents R10, R39, R42, R55, and R79 and/or their representatives. 28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a clinical rationale for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14-days and failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to the administration of a PRN psychotropic medication for one of six residents reviewed (Resident R8). Findings include: A facility policy entitled Psychotropic Medication Use dated 1/14/26, revealed Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications., and PRN orders for psychotropic medications are limited to 14 days. Review of Resident R8's clinical record revealed an admission date of 12/31/25, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), delusional disorder (a mental health condition that includes delusions a false belief based on an incorrect interpretation of reality), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R8's physician's orders revealed an order dated 6/9/26, to administer Lorazepam (anti-anxiety medication) 0.5 mg (milligrams) every four hours PRN for anxiety and lacked the required clinical rationale for continued use beyond 14 days. Review of Resident R8's June 2026, medication administration record revealed that the PRN Lorazepam was used on 6/24/26, and 6/30/26. The clinical record lacked evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Lorazepam for the administrations on 6/24/26, and 6/30/26. During an interview on 7/1/26, at 12:58 p.m. the Director of Nursing (DON) confirmed that Resident R8's PRN Lorazepam lacked the required stop date within 14 days. Interview on 7/2/26, at 9:20 a.m. the Assistant DON confirmed that Resident R8's PRN Lorazepam lacked evidence of a clinical rationale for continued use beyond 14 days and lacked evidence that non-pharmacological interventions were being attempted prior to administering the PRN Lorazepam. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for 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 clinical records, facility policy and documents, and staff interviews, it was determined that the facility failed to perform a transfer in a safe manner for one of 30 residents reviewed (Resident R62).Findings include: A facility policy entitled Resident Transfer Status dated 1/14/26, indicated that resident transfer status will be communicated to all nursing staff through Activity of Daily Living (ADL) flow sheets, assignment sheet, electronic health record (task list, Kardex), etc. Resident R62's clinical record revealed an admission date of 2/14/25, with diagnoses including heart disease, muscle weakness, abnormal gait and mobility, need for assistance with personal care, and a history of falling. Resident R62's clinical record included a Fall Risk Evaluation dated 5/19/26, which indicated that he/she was always alert to person, place, time and situation; that resident was in a chair all or most of time and oriented; was unable to independently come to a standing position; a resulted in a score of six (borderline moderate risk). Resident R62's care plan entitled ADL Self-Care Performance Deficit r/t weakness, limited mobility dated 9/02/25, included an intervention dated 9/02/25, to transfer per therapy recommendation-see tasks for instructions. Resident R62's tasks included instructions for transfer/mobility devices: transfers with assistance of two and walker. Resident R62's Kardex Report (quick-reference documentation system used by nurses to summarize essential patient information for efficient care management) indicated that he/she was to be transferred with extensive physical assistance from two people, can make themselves understood and can understand others. Resident R62's most recent Minimum Data Set (standardized tool used in nursing homes to evaluate residents' health, functional status, and care needs) with an Assessment Reference Date of 5/12/26, Section G- Functional Abilities subsection GG0170 Mobility Item E (chair/bed-to-chair transfer) indicated that he/she required substantial/maximal assistance. Resident R62's departmental progress note dated 6/27/26, at 6:28 p.m. indicated that at 4:00 p.m. he/she was being transferred by a nurse aide, lost his/her balance, was lowered to the floor, and struck his/her left face on the windowsill, and sustained a skin tear to his/her left cheek, and bruising around the left eye, left temple, back of the left hand, and right forearm. The departmental progress note lacked evidence that Resident R62 was being transferred by two staff members. Review of the facility investigation dated 6/26/26, included a witness statement form dated 6/26/26, at 4:00 p.m. written by the nurse aide involved in the incident and indicated that while he/she was transferring Resident R62 the resident could no longer stand and was falling, and the nurse aide lowered Resident R62 to the floor and in the process the resident's cheek got scratched by hitting the window sill. The witness statement lacks evidence that Resident R62 was being transferred by two staff members. The facility investigation dated 6/29/26, included a written statement by licensed staff that included nurse aide assigned to resident reports to this writer he/she was attempting to transfer resident from recliner to wheelchair when resident lost balance and began to fall, nurse aide lowered resident to the floor, resident hit left side of face on the windowsill as they went down. The statement lacked evidence that Resident R62 was being transferred by two staff members. Resident R62's departmental progress note dated 6/27/26, at 10:38 p.m. indicated that he/she experiences pain when someone touches his/her face. During an interview on 6/30/26, at 9:30 a.m. Resident R62 confirmed that there was only one staff member present during the transfer on 6/26/26, when he/she fell. During an interview on 6/30/26, at 9:35 a.m. Resident R62's roommate with a Basic Interview for Mental Status (BIMS-standardized cognitive assessment used primarily in nursing homes and long-term care settings to evaluate memory, orientation, and recall in elderly residents) score of 15 (intact cognition) confirmed that he/she witnessed the incident and that there was only one staff member present during the transfer on 6/26/26, when Resident R62 fell and hit his/her face on the windowsill. Review of the facility incident report, clinical record, and resident interviews revealed lack of evidence that two staff members were assisting Resident R62 to transfer (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 6/26/26, when he/she fell. During an interview on 7/02/26, at 12:25 p.m. the Director of Nursing confirmed that Resident R62 was to be transferred with the assistance of two staff members. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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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. Based on review of facility policy, manufacturer's guidelines, observation, and staff interview, it was determined that the facility failed to ensure medications were properly dated when opened in one of two medication rooms reviewed (First Floor Main Medication Room). Findings include: Review of a facility policy entitled Labeling of Medication Containers dated 1/14/26, revealed Labels for stock medications include all necessary information such as:.d. the expiration date when applicable. Manufacturer's recommendations for Tubersol PPD (solution used for tuberculosis testing upon admission and for employment), indicated that vials which are entered and in use for 30 days should be discarded. Observation on 6/29/26, at 10:32 a.m. of the First Floor Main Medication room refrigerator revealed an opened vial of Tubersol without an open date, therefore staff were unable to determine the expiration date. At that time, the Assistant Director of Nursing confirmed that the open vial of Tubersol lacked an open date. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services