

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Forest Park Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Walnut Bottom Road Carlisle, PA 17013	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>37013</p> <p>Based on observations and staff interviews, it was determined that the facility failed to ensure the resident's right to a clean, comfortable, and homelike environment in the multi-purpose room and four of four nursing units observed (Evergreen, Laurel Lane, Stepping Stones, and Chapelwood).</p> <p>Findings Include:</p> <p>Observation in the hallways on Laurel Lane, Evergreen, and Stepping Stones, on October 8, 2024, at 9:20 AM, revealed dried, dark spills on the floors throughout the hallways as well as miscellaneous debris on the floors.</p> <p>Observation of the hallway to the multi-purpose room on October 8, 2024, at 10:30 AM, revealed dark spots of dried liquid on the floor and a dead bug near the door to the courtyard. Observation of the multi-purpose room at this time revealed miscellaneous debris, including paper, food and dead bugs, on multiple places on the floor of the room.</p> <p>Observation of the Chapelwood unit on October 8, 2024, at 10:31 AM, revealed dark, dried spills on the hallway floor as well as miscellaneous debris on the floor.</p> <p>Additional observations of Evergreen, Laurel Lane, Stepping Stones, Chapelwood, and the multi-purpose room, on October 8, 2024, at 2:30 PM, revealed the same dried, dark spills, miscellaneous debris and dead bugs on the floors as was observed at 9:20 AM, 10:30 AM, and 10:31 AM.</p> <p>During an interview with Employee 1 (Housekeeper) on October 8, 2024, at 2:35 PM, Employee 1 stated that there are not enough housekeeping staff and she will not be able to clean all of her assigned rooms before her shift ends at 3:00 PM. She further stated that the multi-purpose hallway and room are not on her assignment for today.</p> <p>During an interview with Employee 2 (Housekeeper) on October 8, 2024, at 2:37 PM, Employee 2 stated she would not be able to finish all of her assigned rooms before her shift ends at 3:00 PM. She further stated that the multi-purpose hallway and room are not on her assignment for today and she wasn't sure who was responsible for cleaning those areas.</p> <p>On October 8, 2024, at 2:46 PM, observation was made alongside the Director of Nursing (DON) of the aforementioned areas.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On October 8, 2024, at 3:01 PM, the DON stated it was her expectation that housekeeping would be adequate.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>37116</p> <p>Based on observations, clinical record review, and staff interview, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice for one of five residents reviewed (Resident 4).</p> <p>Findings include:</p> <p>Review of Resident 4's clinical record revealed diagnoses that included normal pressure hydrocephalus (rare condition that causes excess fluid in the brain and affects gait, cognition, and bladder control) and dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life).</p> <p>Review of nursing progress notes dated July 3, 2024, revealed Resident 4 returned from her neurology appointment at 1230 PM, with recommendations that included starting Rytary (used to treat symptoms of Parkinson's Disease such as muscle stiffness, tremors, spasms, and poor muscle control) three times per day, and starting Gabapentin (used to treat seizures, nerve pain and restless leg syndrome) three times per day. Further review revealed that the physician was notified and was in agreement with the recommendations.</p> <p>Review of Resident 4's July 2024 Medication Administration Record revealed that an order for Rytary was written effective July 4, 2024, and that it was documented that Resident 4 received eight doses of Rytary between July 4 and 9, 2024.</p> <p>Review of Resident 4's neurology consultation report dated July 3, 2024, revealed she was seen on that date for a follow-up for ambulatory dysfunction and communicating hydrocephalus (occurs when the flow of cerebrospinal fluid is blocked after it leaves the ventricles of the brain). Further review revealed a recommendation was given to start Gabapentin three times per day for headaches. Also attached to the consult form was a printed prescription for Rytary extended release capsules 61.25 mg-245 mg, two caps three times per day for 90 days for a diagnoses of Parkinson's disease with dyskinesia (long-term movement disorder where the brain cells that control movement start to die and cause changes in how one moves, feels, and acts). The printed prescription form was noted to be for another patient of the neurologist, and not for Resident 4.</p> <p>Review of nursing progress notes dated July 9, 2024, revealed that nursing staff discovered the transcription error, the physician was notified at that time, the medication was discontinued, the Resident Representative was notified of the error, and that the Resident suffered no negative outcomes.</p> <p>Review of a physician progress note dated July 9, 2024, confirmed that he was notified that Resident 4 received five days of Rytary that was meant for another person, and that no adverse effects were noted.</p> <p>During an interview with the Director of Nursing on October 8, 2024, at 3:05 PM, she revealed the expectation that Resident 4's medication order should have been appropriately verified.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>(continued on next page)</p>		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services