STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395270	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Nursing and Rehabilitation	700 Walnut Bottom Road Carlisle, PA 17013

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49123 Based on clinical record review, facility document review, hospital record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided after a change in condition for two of 11 residents reviewed (Residents 4 and 5). This failure resulted in continued decline of one resident (Resident 4), which required an emergency transfer to the hospital for low blood oxygen levels and difficulty breathing which contributed to cardiac arrest and resulted in death. This failure placed the residents residing on one of four units (Laurel Lane) in an immediate jeopardy situation. Findings include: Review of the current facility policy, titled Change in a Resident's Condition or Status, revealed the policy statement was, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The Policy Interpretation and Implementation, section revealed, 1. The nurse will notify the resident's attending physician or physician on call when there has ben a(an) .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly .8. The nurse will record the resident's medical record information relative to changes in the resident's medical/mental condition or status . Review of Resident 4's clinical record revealed diagnoses that included hypertension (elevated/high blood pressure) and peripheral vascular disease (narrowing or blocking of blood vessels, which results in decreased blood flow to the body's extremities). Review of the facility's schedule and assignments for the night shift of November 26 into the 27, 2024, revealed that Employee 4 (Licensed Practical Nurse) was the only nurse assigned to Resident 4's unit during that shift. Review of Resident 4's progress notes revealed a note that was entered on November 27, 2024, at 5:50 AM, Employee 4 documented, resident [oxygen saturation] was 88% head of bed was up and resident voiced his struggle to breath [Registered Nurse] aware now on oxygen @2L [liters per minute]. At 5:59 AM, Employee 4 documented resident on 2L oxygen and o2 [saturation] now at 91%. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 4's physician orders revealed that Resident 4 did not have an order for supplemental oxygen on November 27, 2024. Further review of the clinical record revealed no evidence that the Registered Nurse was made aware or assessed the Resident. Review of Resident 4's progress notes revealed that on November 27, 2024, at 7:14 AM, Employee 7 (Registered Nurse) who was the dayshift RN, documented a Situation, Background, Assessment, and Recommendation (SBAR) note which revealed assessment findings of blood pressure 88/49 (normally less than 120/80; however, considered low when below 90/60), pulse of 102 (normal range 60 to 100 beats per minute), respiration rate 46 (normal range between 12 to 20), and oxygen saturation while on supplemental oxygen via nasal cannula was 73% (normal range between 95 and 100%). Further review of the SBAR note completed by Employee 7 stated, At [6:45 AM], RN alerted by LPN [Licensed Practical Nurse] that resident was having [shortness of breath] with decrease in [oxygen] saturation at 77% on [room air], reported began at [3:30 AM]. Placed on 2L [nasal cannula] by LPN on duty, repeat [oxygen saturation] at [6:45 AM] 73%. [Oxygen] increased to 5L, [oxygen saturation] 78%. Color = pale and resident continued to report pain in abdomen. No [blood sugar] noted . As a result of the assessment findings, Employee 7 notified the attending physician and received an order to send Resident 4 to the hospital for further evaluation. Review of the clinical record for Resident 4 revealed no vital signs documented on November 26 or November 27, 2024, prior to 6:45 AM, entered by Employee 7. During a staff interview on December 5, 2024, at approximately 2:42 PM, Employee 5 (Licensed Practical Nurse) stated that between the hours of 5:00 AM and 6:00 AM, Employee 4 had called Employee 5's unit to speak with the night shift RN supervisor (Employee 6). During that call, Employee 4 stated that she needed to speak with Employee 6 regarding a Resident's complaints of difficulty breathing. Employee 5 stated that Employee 6 was not available at that time but would inform Employee 6. During a staff interview on December 5, 2024, at approximately 3:40 PM, Employee 6 stated that he did not recall being informed of Resident 4's change of condition on November 27, 2024. During a staff interview on December 5, 2024, at approximately 2:50 PM, Employee 7 (Registered Nurse) revealed that she had arrived at the building for the 7:00 AM to 3:00 PM shift on November 27, 2024. At which time she called the unit that Employee 4 was working on as the nurse. Employee 7 stated that she had called the unit to remind nursing staff to complete documentation. Employee 7 stated that at the time of that phone call, Employee 4 reported that Resident 4 was having difficulty breathing and needed oxygen via nasal cannula. It was at that time that Employee 7 went to Resident 4 to assess the Resident condition. During the interview, Employee 7 said that Employee 4 stated that Resident 4 initially had complaints of difficulty breathing and approximately 3:30 AM on November 27, 2024, and had low oxygen saturation that required the use of supplemental oxygen via nasal cannula. Employee 7 stated that Employee 4 reported notifying Employee 6. Review of hospital records revealed that upon arriving at the hospital, Resident 4's pulse was 114, respiratory rate was 38, blood pressure was 81/51, oxygen saturation was 100% and pain level was 10. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the laboratory blood studies performed on Resident 4 revealed the following values: hemoglobin (cellular component responsible for carrying oxygen) 6.0 (reference normal range 12.8 to 16.6); venous (blood returning to the heart) pH 7.14 (acidic range, normal reference range 7.32 to 7.42); venous PcO2 (measure of carbon dioxide levels in the blood returning to the heart) less than 15 (reference normal range 37 to 47); and troponin (protein in the heart muscle cells that is released when the heart sustains damage) 4, 231 (reference normal range less than 20). Review of the hospital notes stated, .On examination patient is toxic appearing. He appears to be very ill and pale. He has diffuse abdominal pain .Patient was very pale and I was concerned that he was having hypovolemic shock secondary to bleeding. Patient hemoglobin came back at 6 .In the setting of the patient's poor function prior to the cardiac arrest including elevated troponin, severe lactic acidosis, low hemoglobin and patient's age and comorbidities I was concerned that the patient would not have a good neurological outcome. Cardiac arrest resuscitation efforts were stopped at [9:35 AM]. Time of death was [9:35 AM]. Employee 4 failed to notify the RN supervisor and/or the attending/on-call physician of Resident 4's change in condition, which required medical intervention. Review of Resident 5's clinical record revealed diagnoses that included pneumonitis (inflammation of lung tissue), resistance to multiple antimicrobial drugs (condition where bacteria within the body develops resistance to a wide range of antibiotics causing the medications to be ineffective for treating infections), and COVID-19 (respiratory virus characterized by fever and cough and is capable of progressing to severe symptoms). Review of Resident 5's physician orders revealed that Resident 5 had an order for supplemental oxygen at 2 liters per minute via nasal cannula to maintain oxygen saturation above 90%, dated November 17, 2024 and Albuterol sulfate nebulization solution 3 milliliters via nebulizer every four hours as needed for shortness of breath/wheezing. Review of the facility's schedule and assignments for the night shift of November 26 into the 27, 2024, revealed that Employee 4 was the only nurse assigned to Resident 5's unit during that shift. Review of Resident 5's progress notes revealed a note dated November 18, 2024, at 5:38 PM, that stated Resident 5 tested positive for COVID-19 and was receiving Levaquin (antibiotic medication) for pneumonia. Further review of Resident 5's progress notes revealed a note dated November 27, 2024, 6:00 AM, Employee 4 documented, resident [complained of] not being able to breath checked oxygen he was on 3L [liters] stats [oxygen saturation] at 77%, increased oxygen to 5L now at 92%. Further review of Resident 5's clinical record revealed no evidence that the Registered Nurse was made aware and assessed the Resident. Review of Resident 5's medication administration record (MAR - document utilized to record when medications are administered) for November 2024, revealed no nebulizer treatments were documented as administered during the night shift hours for November 26 or 27, 2024. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of Resident 5's MAR revealed no documentation that supplemental oxygen had been administered during the month of November 2024. Review of Resident 5's progress notes revealed that on November 27, 2024, at 9:35 AM, Employee 7, documented a SBAR note which revealed assessment findings of blood pressure 127/65, pulse of 44, respiration rate 22, and oxygen saturation while on supplemental oxygen via nasal cannula was 92%. Further review of the SBAR note completed by Employee 7 (Dayshift RN) stated, During this nurse's review of 24hr report, it was noted that resident [4] c/o SOB [shortness of breath] at 0600 and was placed on 5L NC for O2 sat of 77%. With this nurses's assessment at 0920, resident sitting in w/c, no acute distress noted. Duoneb given .LS [lung sounds] with positive wheezing to right upper lobe. Employee 7 notified the physician. No new orders were received. A progress note dated November 27, 2024, at 11:37 AM, stated the physician was in and evaluated Resident 5. New orders were obtained for stat (medical term used when an order is to be completed immediately) blood work and a chest x-ray. A progress note dated November 27, 2024, at 8:55 PM, stated the physician review Resident 5's chest x-ray and blood work. The chest x-ray indicated bilateral lower lobe pneumonia, worsening. New orders received for Lasix (medication used to treat fluid retention) and Zithromax (antibiotic medication) and repeat blood work in two weeks. Review of the electronic health record revealed the vitals section did not contain any vital signs documented on November 26 or 27, 2024, prior to 9:36 AM entered by Employee 7. Review of the facility's schedule and assignments for the night shift of December 1 into the 2, 2024, revealed that Employee 4 was the only nurse assigned to Resident 5's unit during that shift. Review of Resident 5's progress notes revealed a note dated December 2, 2024, at 4:15 AM, Employee 4 documented, resident constantly screaming for help when asked what he needs he state he doesn't know [nurse aides] and nurse did multiple attempts in trying to make him comfortable resident continue to just scream but denies pain. Further review of Resident 5's clinical record revealed no evidence that Employee 4 notified the RN Supervisor. An additional note dated December 2, 2024, at 6:19 AM, revealed Employee 4 documented, oxygen [saturation] at 92 now with increase in O2 from 3L to 4.5L. A progress note entered December 2, 2024, at 6:33 AM, revealed Employee 8 (RN) documented, .O2 sat was checked at 78% during the night, given the [as-needed] albuterol breathing treatment and O2 increased to 4.5 L via NC [nasal canula]. Increasingly coughing wet cough but no sputum. Further review of Resident 5's clinical record revealed no evidence that Employee 8 notified the attending/on-call physician of Resident 5's change of condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 5's progress notes revealed that on December 2, 2024, at 1:01 PM, Employee 7 (Registered Nurse) who was the dayshift RN, documented a SBAR note which revealed assessment findings of blood pressure 104/60, pulse of 52, respiration rate 24, and oxygen saturation while on supplemental oxygen via nasal cannula was 90%. Further review of the SBAR note completed by Employee 7 stated, Resident yelling out throughout shift and previous shift per hand off of care report. When asking resident what is wrong and why yelling he states, 'I don't know' . Employee 7 notified the attending physician and received orders for a urinalysis and culture and to initiate IV (intravenous) fluid, one liter of normal sterile saline at 60 cubic centimeters (metric unit of measure) per hour. Review of the electronic health record revealed the vitals section did not contain any vital signs documented on December 2, 2024, prior to 10:40 AM. Review of Resident 5's MAR for December 2024, revealed Employee 4 documented a nebulizer treatment was administered at 3:08 AM on December 2, 2024. Further review of Resident 5's MAR revealed no documentation that supplemental oxygen had been administered as of December 2, 2024. Employee 4 failed to notify the RN supervisor of Resident 5's change in condition on November 27, 2024, and December 2, 2024, which required medical interventions and Employee 8 failed to notify the attending/on-call physician of Resident 4's change in condition on December 2, 2024, which required medical intervention. The failure to notify the RN supervisor and/or the attending/on-call physician of a change in condition placed the other residents who resided on the unit, under the care of Employee 4, in an Immediate Jeopardy situation. The Nursing Home Administrator (NHA) was provided the immediate jeopardy template on December 6, 2024, at 12:40 PM, and an immediate action plan was requested. On December 6, 2024, at 4:43 PM, the facility's immediate action plan was accepted, which included: 1. Education was provided to Employee 4 verbally on November 27, 2024, and in written form on December 2, 2024. 2. Education has been given to licensed nursing staff on change in condition protocol including the need for LPNs and RN's as charge nurses to notify the RN Supervisor immediately, including Physician notification and orders. Any New/Agency Staff will be educated on the same protocol on arrival December 5 and 6, 2024. 3. Facility wide audit will be completed of current residents by review of the facility's 24 hour shift report to ensure that any resident with a change in condition has had an RN assessment with notification of the physician on completed on December 6, 2024. 4. Every shift the Director of Nursing or designee will review the 24 hour shift report for any changes in condition and will ensure that an RN assessment and physician notification was completed for four weeks. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On December 6, 2024, at 5:27 PM, the Immediate Jeopardy was lifted during the onsite survey after ensuring that the immediate action plan had been implemented. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49123 Based on clinical record review, observations, facility document review, staff interviews, and facility policy review, it was determined that the facility displayed past non-compliance by failing to implement interventions, supervision, and effective safety measures to prevent elopement of a resident identified as being at risk for elopement and exhibiting exit seeking behaviors (Resident 1). Resident 1 was found lying in the parking lot of the facility and was medically compromised as evidenced by a low body temperature and abrasions. This failure placed a total of five residents in an Immediate Jeopardy situation who were identified as at risk for elopement and not on a locked unit (Residents 1, 6, 7, 9, and 10). Findings include: Review of facility policy, titled Wandering and Elopements, undated, read, in part; The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Review of Resident 1's clinical record revealed diagnoses that included encephalopathy (a disturbance in brain function causing confusion, memory loss, and a decline in the ability to reason), mild cognitive impairment, and alcohol abuse. Review of Resident 1's physician orders revealed orders dated March 19, 2024, for an alarming security bracelet (Wander guard, SecureCare, Accutech), with placement checks every shift and function checks every night shift. Further review of Resident 1's physician orders revealed an order dated August 30, 2024, for frequent monitoring, every 15-minute checks for behaviors/safety. Review of documentation in Resident 1's clinical record for the past 30 days indicated Resident 1 was independent with ambulation. Further review of Resident 1's clinical record revealed an assessment titled wandering risk scale, dated April 1, 2024. The assessment indicated Resident 1 was at high risk for wandering and to continue use of wander guard. An additional assessment titled elopement/wandering risk, dated May 22, 2024, indicated Resident 1 was at risk for elopement and to implement plan of care for unsafe wandering/exit seeking behavior. Review of Resident 1's nursing progress notes revealed a note dated November 16, 2024, at 7:40 PM, that indicated Resident 1 was wanting to go home, asking a nurse aide for a beer, exhibiting increased behaviors, exit seeking, and setting off door alarms. Further review of Resident 1's progress notes revealed a note dated November 30, 2024, at 6:42 PM, that Resident 1 was found lying on the ground in front of the building by a visitor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An additional progress note dated November 30, 2024, at 6:45 PM, indicated Resident 1 was brought in through the front lobby entrance by two staff and placed in a wheelchair. A Registered nurse assessment was completed, and Resident 1 was noted to have abrasions to the tip of his left middle finger, the top of his left hand, left eyebrow, left cheek, and left knee. The areas were cleaned with normal sterile saline. Resident 1's left middle finger was wrapped with gauze and the other abrasions were left open to air. Resident 1's initial vital signs were temperature 92.9 degrees Fahrenheit (F), blood pressure 180/110, pulse 50, and oxygen saturation 82% on room air (Normal vital signs are as follows: temperature 97.8 - 99.1 degrees F, blood pressure 90/60 - 120/80, pulse 60 - 100 beats per minute, oxygen saturation 95 - 100%). Resident 1 was noted to have appeared shaky and cool to touch. Resident 1 was changed into warm clothes and covered in blankets. Vital signs were reassessed: temperature 96.8 degrees, blood pressure 175/102, pulse 90, and oxygen saturation 95% on room air. Resident 1 denied pain, but wincing was noted with right arm movement when applying a sweater. The physician was notified and no new orders were received. A progress note dated December 1, 2024, at 9:51 AM, indicated Resident 1 was incontinent of urine and needed extensive assistance to sit up in bed, which was not Resident 1's baseline. According to the Cleveland Clinic, hypothermia is a condition that occurs when body temperature drops below 95 degrees F. The average normal body temperature is 98.6 F. Hypothermia symptoms include: shivering and chattering teeth, exhaustion, clumsiness/slow movements and reactions, sleepiness, week pulse, fast heart rate, rapid breathing, pale skin color, confusion and poor judgment/loss of awareness, excessive urination, and trouble speaking. Review of the facility provided incident report under section titled Immediate Action Taken revealed: RN assessment completed. Resident taken into shower room, hands cleaned and noted abrasion to tip of left middle finger 2 cm x 2 cm, top of left-hand abrasion 1.5 cm x 1.5 cm, left eyebrow abrasion 2 cm x 1 cm, left cheek abrasion 0.5 cm x 0.5 cm, left knee abrasion 1 cm x 1 cm. Areas cleansed with NSS (normal sterile saline) and left open to air, left middle finger wrapped with gauze and secured with tape. Review of witness statements provided by the facility indicated Resident 1 was last seen by a nursing assistant in his room eating around 5:10 PM and that no door alarms had sounded. The witness statements also revealed that Resident 1 was wearing a blue sweat suit with a blue zip-up hoody, tan slipper socks, and a hat at the time he was found outside. Review of facility provided document titled Safety Check, revealed on November 30, 2024, Resident 1 was on every 15 minutes safety checks and is documented as checked at 5:30 PM and 5:45 PM. Review of Resident 1's care plan revealed that Resident 1's care plan was not updated to reflect wandering and being at risk for elopement with additional interventions until December 2, 2024, which was two days after Resident 1 eloped from the facility. Resident 1's care plan included the following focus areas: 1) At risk for behavior symptoms related to alcoholism, encephalopathy, adjustment disorder, depression, initiated on October 2, 2022. 2) At risk for changes in mood related to anxiety, depression, alcohol abuse, and adjustment disorder, may feel down, initiated on October 2, 2022. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) At risk for falls due to history of falls, impaired balance/poor coordination, initiated October 2, 2022. 4) At risk for substance abuse history of alcohol abuse, initiated October 14, 2022. 5) Inappropriate physical/social sexual behavior towards Resident by another female resident. History of attempting to enter a female resident's room needing redirection and reminders of inappropriate behaviors. May wander around the unit, initiated November 14, 2022. Intervention for wander guard to right arm, initiated May 31, 2023. Further review of Resident 1's clinical record revealed that an Elopement Risk assessment was completed on December 2, 2024, after the elopement occurred, which indicated that Resident 1 was assessed as High Risk. During an interview with the Director of Nursing (DON) on December 4, 2024, at 10:03 AM, the DON indicated that Resident 1 exited though a side door that is used by staff and family members. The door does not have a wander guard alarm but does have an alarm that sounds if opened without entering a code. After the code is entered there is an eight second delay before the alarm resets. It is believed the Resident followed a visitor out of the door. During the interview, the DON indicated that after Resident 1 was found outside on November 30, 2024, the maintenance department was called in and all exterior doors were inspected, all were found to be functioning properly. The facility also contacted the door company, and an inspection was completed on December 2, 2024. The door was found to be functioning properly. The DON reported she performed a full system check of the wander guard system on November 30, 2024, and the system was found to be functioning properly. During an additional interview with the DON on December 4, 2024, at 12:30 PM, the DON revealed Resident 1 had been found lying on the ground in the fire lane in front of the building. She also revealed that the side exit door on Laurel Lane is primarily used by staff because the time clock is located by the door. She stated that a few frequently visiting family members had obtained the code for the door and at least four different families used the door that day without staff assistance. The DON stated that it was the expectation of the facility that family members are not given the code to locked doors. She also indicated that the code had been changed on November 30, 2024, and only maintenance and administration have the new code. An interview with Employee 1 on December 4, 2024, at approximately 11:48 AM, revealed he had been called in the evening of November 30, 2024, and was to inspect all exit doors. Employee 1 indicated that his inspection revealed all doors and alarms were functioning properly. Employee 1 also indicated that the code for the exit door on Laurel Lane had been changed on November 30, 2024. Assessment of the side exit door located on the Laurel Lanes unit on December 4, 2024, at approximately 11:45 AM, revealed the door had been covered with clear plastic that was taped around the top and edges of the door, with a zipper down the center. The code box had been covered with caution tape and signage was present indicating the door was not to be used. Upon opening the door, by pushing on a metal bump bar (a type of door opening mechanism which allows a door to open by pushing a bar), a loud alarm sounded, and a code was required to be entered to silence the alarm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Information provided by the facility indicated that there are four additional residents identified as elopement risks that reside on the unlocked units (Residents 6, 7, 9, and 10). Review of the clinical records for Resident 6, 7, 9, and 10 revealed orders for a Wander guard and to check placement and function every shift. The facility is located on a main road with a one way half circle drive at the front of the building. There is a parking lot on the right side of the building, parking lots on each side of the lobby in front of the building, and a portico located at the main front entrance outside of the door that vehicles drive through. Outside temperatures on November 30, 2024, for the facility's location, per online historical data, was high of 37 degrees F and a low of 24 F. The facility failed to implement interventions, supervision, and effective safety measures to prevent elopement. The DON was provided the immediate jeopardy template on December 4, 2024 at 2:04 PM, and an immediate action plan was requested. The facility initiated immediate interventions on November 30, 2024, after the incident. Documents and actions provided by the facility to address the Immediate Jeopardy included: The code to the side door was changed on November 30, 2024. The new code was only given to the maintenance department and administration. All staff and families were notified on November 30, 2024, that that door is no longer in use and that anyone seeking entryway or exit should go to the main entrance. The door was closed via signage to noticeably display its lack of service as an exit/entry and only to be used as an emergency exit as of November 30, 2024. All staff were educated on awareness of residents' whereabouts when entering or leaving an exit area. Staff were educated not to provide the code to doors to family members. A letter was sent to all family members that they are only to use the main entrance to enter or exit. All residents assessed as elopement risks were identified and their wander guards checked for functionality. Audits were initiated on November 30, 2024, and will be done weekly on the residents with wander guards for placement and function and also of the exit doors for function. Additionally, a QAA committee meeting was held on December 2, 2024, to review the investigation process and develop additional recommendations. The facility's plan was reviewed on December 4, 2024, during the onsite survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395270	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Nursing and Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On December 4, 2024, at 4:32 PM, the facility's immediate action plan was accepted, which included: 1) On November 30, 2024, the code to the side door was changed. The new code was not given to staff or visitors. 2) All staff and families have been notified that that door is no longer in use. The door has been closed via signage to noticeably display its lack of service as an exit/entry and only to be used as an emergency exit as of November 30, 2024. 3) All staff have been educated on awareness of residents' whereabouts when entering or leaving an exit area starting November 30, 2024, completed December 4, 2024. 4) Signs have been placed since the occurrence stating the door is presently not in use as an exit/entry and only to be used as an emergency exit and that anyone seeking entryway or exit should go to the main entrance as of November 30, 2024. 5) Education included that staff are not to provide the code to doors to family members. A letter has also been sent to all family members that they are only to use the main entrance to enter or exit the facility as of November 30, 2024. 6) All residents assessed as elopement risk have been identified and their wander guards checked for functionality December 2, 2024. 7) Audits will be done weekly on the resident with wander guards for placement and function and also of the exit doors for function started November 30, 2024. 8) The above ensure that any resident that is at risk is secured from exiting from the side door. Facility staff were interviewed during the onsite survey regarding the facility's Immediate Action Plan and demonstrated knowledge of education regarding using the main front door for entry and exit of the building, only using the side door for an emergency exit, not providing visitors with door codes, and being aware of their surroundings when entering and exiting the building. The Immediate Jeopardy was lifted on December 4, 2024, at 4:40 PM, after ensuring that the immediate action plan had been implemented. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services