

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 02/25/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>33879</p> <p>Based on clinical record review, facility document review, and resident and staff interviews, it was determined that the facility failed to provide assistance with activities of daily living for three of six residents reviewed (Residents 4, 12, and 13).</p> <p>Findings include:</p> <p>During a resident interview on February 24, 2025, Resident 4 stated that he had not been receiving showers or baths twice a week as he is supposed to receive.</p> <p>Review of Resident 4's comprehensive plan of care revealed Resident 4 was care planned to receive limited assistance with bathing from staff.</p> <p>Review of Resident 4's Nurse Aide task documentation revealed that no shower/bathing documentation for January 29, 2025; February 12, 15, and 22, 2025. Review of the document revealed that the shower/bathing task for February 1, 2025, was marked as, Not applicable.</p> <p>During a resident interview on February 24, 2025, Resident 12 stated, No, when asked if she was receiving a shower or bath twice a week.</p> <p>Review of Resident 12's comprehensive plan of care revealed that Resident 12 required extensive assistance from staff to perform shower or bathing activities.</p> <p>Review of Resident 12's Nurse Aide task documentation revealed no shower/bathing documentation for January 30, 2025; February 3, 6, 13, 17, and 20, 2025.</p> <p>During a resident interview on February 24, 2025, Resident 13 stated she did not receive showers regularly.</p> <p>Review of Resident 13's comprehensive plan of care revealed Resident 13 required limited assistance by staff for showering or bathing.</p> <p>Review of Resident 13's Nurse Aide task documentation revealed no shower/bathing documentation for February 8, 12, and 22, 2025. Further, staff documented Not Applicable, for January 29, 2025, and February 15, 2025.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Facility document, titled Report Sheet Laurel Lane, revealed it stated Resident 4's shower schedule was to be Wednesday and Saturdays on the 3:00 PM to 11:00 PM shift, Resident 12's shower schedule was Monday and Thursday on the 7:00 AM to 3:00 PM shift, and Resident 13's shower schedule was on Wednesday and Saturday on the 3:00 PM to 11:00 PM shift.</p> <p>During a staff interview on February 25, 2025, at approximately 3:00 PM, Director of Nursing (DON) revealed that there was discrepancies in the shower schedules between the Report Sheet Laurel Lane and the electronic health records for residents. During the interview, the DON revealed it was the facility's expectation that residents receive assistance with showering or bathing as scheduled.</p> <p>28 Pa code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>33879</p> <p>Based on policy review, clinical record review, observations, and staff interview, it was determined that the facility failed to ensure appropriate care and services were provided for an indwelling urinary catheter for one of two residents reviewed for urinary catheter (Resident 1).</p> <p>Findings include:</p> <p>Review of facility policy, titled Catheter Care, Urinary, last revised September, 2014, revealed that subsection, Infection Control, stated, b. Be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose into the cells for nourishment) and cerebral infarct (commonly known as stroke, sudden interruption of the blood flow to the brain leading to cell death).</p> <p>During multiple observations on February 24, 2025, between 10:13 AM and approximately 2:15 PM, it was observed, from the hallway, that Resident 1's foley catheter (tube inserted into the bladder to facilitate the removal of urine into a container) collection container was laying on the floor.</p> <p>During the observations, multiple staff were observed passing Resident 1's room and were in line of sight of Resident 1's foley catheter collection container that was on the floor.</p> <p>During a staff interview on February 25, 2025, at approximately 3:00 PM, Director of Nursing revealed it was the facility's expectation that Resident 1's collection container would be kept off the floor.</p> <p>28 Pa code 211.12(1)(5) Nursing services</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>33879</p> <p>Based on observations, clinical record review, facility document and policy review, and resident and staff interviews, it was determined that the facility failed to provide a sufficient number of staff for the administration of medications for one of four units observed, which resulted in the missed or late administration of medications for four of 12 residents reviewed for medication administration (Residents 4, 5, 9, and 10).</p> <p>Findings include:</p> <p>Review of the facility policy, titled Administering Medications, last revised April, 2019, revealed the policy statement was, Medications are administered in a safe and timely manner, and as prescribed. Review of the policy revealed it included, 3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .4. Medications are administered in accordance with prescriber orders, including any required time frame .5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions; and c. honoring resident choices and preferences, consistent with his or her care plan .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>During observations of the Laurel Lane unit on February 24, 2025, between approximately 9:30 AM and 10:30 AM, Employee 1 (Licensed Practical Nurse [LPN]) was observed performing medication administration. During a staff interview with Employee 1 at approximately 10:30 AM, Employee 1 indicated that she was late for her shift that morning and was providing the morning medications.</p> <p>Based on review of facility documentation, it was identified that Employee 1 was scheduled to work the day shift, starting at 7:00 AM, as the medication nurse for Laurel Lane.</p> <p>During an interview with Resident 4, who resided on Laurel Lane, on February 24, 2025, at approximately 11:25 AM, revealed that he was not provided his insulin with his morning meal. Resident 4 also stated that he consumed his morning meal. During the interview, Resident 4 stated he was waiting for his lunch to be served and he had not received his insulin that was to be administered with his lunch meal yet.</p> <p>During a staff interview on February 24, 2025, at approximately 11:40 AM, Employee 7 (LPN) revealed that he had assumed responsibility for medication administration on Laurel Lane from Employee 1. At that time, Employee 7 was asked if he was provided a report from Employee 1 regarding Residents who had not received medications that were scheduled for morning administration. At that time, Employee 7 provided a facility document, titled Report Sheet Laurel Lane.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a staff interview with Employee 2 (Registered Nurse Unit Manager) on February 24, 2025, at approximately 12:00 PM, it was revealed that Employee 1 had notified the facility via phone that she would not be at the facility on time to start the 7:00 AM to 3:00 PM shift. Employee 2 revealed that in the absence of Employee 1, she was assigned the responsibility of the medication cart and medication administration. Employee 2 revealed that she performed shift change with the prior shift nurse and was given the keys to the medication cart at approximately 7:00 AM that morning. During the staff interview, Employee 2 indicated that her responsibilities as a Registered Nurse Unit Manager needed to be completed (progress note completion and laboratory result reviews). As a result, Employee 2 was unable to start medication administration timely. Employee 2 revealed that she was able to provide morning medications to two residents on Laurel Lane prior to Employee 1 arriving and assuming responsibility for the Laurel Lane medication cart. Employee 2 stated that Employee 1 arrived sometime between 9:00 AM and 9:30 AM. During the interview, Employee 2 stated that Employee 1 is frequently late for her shift.</p> <p>Review of Resident 4's clinical record revealed diagnoses that included hypertension (elevated/high blood pressure) and diabetes mellitus type two (decreased ability of the body to produce and/or utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).</p> <p>Review of Resident 4's physician orders revealed an order for insulin lispro, 4 units to be injected with meals for type two diabetes.</p> <p>Review of the manufacturer's medication information for insulin lispro, the medication should be administered by injection, within 15 minutes before a meal or immediately after a meal.</p> <p>At approximately 11:40 AM, Resident 4 was observed to be eating lunch.</p> <p>During a follow-up interview with Resident 4 on February 24, 2025, at approximately 12:47 PM, Resident 4 stated he had not received any insulin injections for either his breakfast or lunch meals.</p> <p>Review of Resident 4's medication administration record (MAR - documentation tool utilized to record that physician orders were administered at the scheduled times) and accompanying administration time documentation for February 24, 2025, revealed that Resident 4 did not receive a dose of insulin lispro until 2:29 PM and did not receive the medication with meals as ordered.</p> <p>Review of Resident 5's clinical record revealed diagnoses that included hypertension and type two diabetes mellitus.</p> <p>Review of Resident 5's physician orders revealed an order for hydralazine (medication used to treat high blood pressure) 25 milligrams (mg - metric unit of measure) to be administered four times a day. Review of the order revealed the schedule administration times were 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM.</p> <p>Review of Resident 5's MAR and accompanying documentation revealed Resident 5 did not receive the scheduled morning medications until 11:49 AM on February 24, 2025, and a missed administration of the 8:00 AM hydralazine 25 mg medication.</p> <p>Review of Resident 9's clinical record revealed diagnoses that included Parkinson's disease (progress, degenerative neurological disorder that affects movement, balance, and other bodily functions).</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 9's physician orders revealed an order for carbidopa-levodopa (combination medication used to treat Parkinson's disease) two tablets four times a day for Parkinson's disease.</p> <p>Review of the order revealed the scheduled administration times were 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM.</p> <p>Review of Resident 9's MAR and accompanying documentation revealed Resident 9 did not receive scheduled morning medications until 11:55 AM on February 24, 2025, resulting in the missed administration of the 8:00 AM carbidopa-levodopa medication.</p> <p>Review of Resident 10's clinical record revealed diagnoses that included congestive heart failure (disease process of the heart that results in decreased ability of the heart to pump blood through the body) and type two diabetes mellitus.</p> <p>Review of Resident 10's physician orders revealed Resident 10 was ordered 8 units of insulin lispro to be injected with meals.</p> <p>Resident 10's lunch meal on February 24, 2025, was served at approximately 11:40 AM.</p> <p>Review of Resident 10's MAR and accompanying documentation revealed Resident 10 did not receive her lunch meal dose of insulin lispro until 12:58 PM, more than an hour after the start of lunch service.</p> <p>During a staff interview on February 25, 2025, at approximately 11:30 AM, Director of Nursing revealed it was the facility's expectation that the facility have the available staff to provide medications timely to residents.</p> <p>28 Pa code 201.18(b)(1)(3) Management</p> <p>28 Pa code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>46253</p> <p>Based on observations and staff interviews, it was determined that the facility failed to post the required daily staffing in a prominent place for review by the residents and visitors.</p> <p>Findings include:</p> <p>An observation on February 24, 2025, at approximately 10:40 AM, revealed that the required posting of daily staffing was located on the upper left-hand corner of the fully opened door of the Human Resources Office. There were approximately four other postings noted, which were located beside and below the daily staffing posting. With the door being in a fully opened position, the location of the daily posting, and the location of the other posted documents, the daily staffing posting was not clearly visible in a prominent location for review by residents or visitors to see.</p> <p>During an immediate staff interview with Employee 3 (Human Resource Director) on February 24, 2025, at approximately 10:40 AM, Employee 3 indicated that this was not where the posting of daily staffing would normally be located, but because of facility renovations and newly painted walls, this was where it had been temporarily placed. Employee 3 indicated that the posting was usually displayed in the entrance hallway.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing on February 25, 2025, at 11:20 AM, the NHA confirmed that the required daily staffing posting should have been posted in a clearly visible area for residents and visitors to view. She said that there had been recent renovations and that they were in the process of putting all items in the proper locations to include the posting of staffing hours.</p> <p>42 CFR 483.35(g)(2)(ii) Nursing Staff Information</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to provide pharmaceutical services to accurately acquire, receive, dispense, and administer drugs to meet the needs of each resident for four of four residents reviewed (Residents 1, 6, 7, and 8).</p> <p>Findings include:</p> <p>Review of Resident 1's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), history of liver transplant, and respiratory failure (long term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body).</p> <p>Review of Resident 1's January 2025 Medication Administration Record (MAR) revealed that on January 31st, day shift, 15 medications (a total of 18 doses) were coded 9- see progress notes.</p> <p>Review of Resident 1's progress notes revealed two notes dated January 31, 2025, which indicated that the medications were unavailable and awaiting delivery from pharmacy.</p> <p>Review of Resident 1's clinical record revealed that the Resident was hospitalized on [DATE], and returned to the facility on [DATE], at 11:24 AM.</p> <p>Review of Resident 1's February 2025 MAR revealed that on February 20th, evening shift, four medications (a total of 4 doses) and on February 21st, night shift, one medication (a total of 1 dose) were coded 9- see progress notes.</p> <p>Review of Resident 1's progress notes revealed five notes dated February 20, 2025, and one note dated February 21, 2025, which indicated that the medications were unavailable and awaiting delivery from pharmacy.</p> <p>In an email communication received from the Director of Nursing (DON) on February 25, 2025, at 1:25 PM, she indicated that Resident 1's medications may not have been available in the facility back-up supply and, therefore, they would have waited for the pharmacy to deliver the medications.</p> <p>Review of Resident 6's clinical record revealed diagnoses that included non-pressure chronic ulcer of the right lower leg and hypertension (high blood pressure).</p> <p>Review of Resident 6's clinical record revealed that the Resident was hospitalized on [DATE], and returned to the facility on [DATE], at 7:00 PM.</p> <p>Review of Resident 6's hospital medication list indicated that one of her medications was to specifically start on the evening shift of February 17, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 6's February 2025 MAR revealed that the medication that was to start on the February 17, 2025, on evening shift, was entered to be started on day shift on February 18, 2025. In addition, it was documented that on February 18th, day shift, that a one-time order was entered for half the ordered dose of medication, which was documented as being administered on February 18th at 1:10 PM.</p> <p>An additional one-time order was entered on February 18, 2025, that also indicated that half the ordered dose was to be administer on February 18th day shift at 2:15 PM, but was documented as being administered on February 19th at 7:02 AM.</p> <p>Further review of Resident 6's February 2025 MAR revealed that on February 17th, evening shift, one additional medication (total of 1 dose) was coded 9- see progress notes.</p> <p>Review of Resident 6's progress notes revealed a note dated February 17, 2025, which indicated the medication was unavailable and awaiting delivery from pharmacy.</p> <p>Further review of Resident 6's progress notes revealed a note dated February 18, 2025, which indicated the medication that should have started on February 17th, evening shift, per hospital paperwork, was held the morning of February 18th because clarification was needed from the pharmacy on medication delivered.</p> <p>In an email communication received from the DON on February 25, 2025, at 1:40 PM, she indicated that Resident 6's medications were not late in arriving but there was a discrepancy in the instruction versus the order and staff reached out to MD but received a late response. She also indicated that, to her knowledge, Resident 6 received the correct dosage of medication and that she cannot speak to why pharmacy deliveries are not timely.</p> <p>Review of Resident 7's clinical record revealed that the Resident was admitted to the facility on [DATE], at 4:15 PM, with diagnoses that included kidney failure and hypertension.</p> <p>Review of Resident 7's February 2025 MAR revealed that on February 19, 2025, evening shift, two medications (a total of 2 doses) were coded 9- see progress notes.</p> <p>Review of Resident 7's progress notes revealed two notes dated February 19, 2025, which indicated that the medications were unavailable and awaiting delivery from pharmacy.</p> <p>In an email communication received from the DON on February 25, 2025, at 1:41 PM, she indicated that she could not answer to why pharmacy deliveries for Resident 7 were not timely.</p> <p>Review of Resident 8's clinical record revealed that the Resident was readmitted to the facility on [DATE], at 5:42 PM, with diagnoses that included hypertension and chronic kidney disease (longstanding disease of the kidneys leading to renal failure).</p> <p>Review of Resident 8's February 2025 MAR revealed that on February 20, 2025, on evening shift, two medications (a total of 2 doses); on February 21, 2025, on night shift, three medications (a total of 3 doses); on February 21, 2025, day shift, three medications (a total of 4 doses); and on February 22, 2025, day shift, two medications (a total of 3 doses) were coded 9- see progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 8's progress notes revealed two notes dated February 20, 2025; 7 notes dated February 21, 2025; and 3 notes dated February 22, 2025, which indicated that the medications were unavailable and awaiting delivery from pharmacy.</p> <p>During a staff interview with the NHA and DON on February 25, 2025, from 3:00 PM to 3:40 PM, the DON indicated that the pharmacy cut-off times for medication orders are 10:30 AM and 9:00 PM, and that pharmacy deliveries are usually 4 hours after order cut-off time. The DON indicated that for Resident 1, she had talked with the pharmacy and that his medications were delivered, but the nurse may not have recognized the generic name of the medication the pharmacy sent. The DON indicated that for Resident 6, her medication order was not entered in the format the pharmacy needed it to be and that the order had to be corrected for the pharmacy. The DON confirmed that Resident 6's medications were not administered timely, and maybe the nurse that signed for the one-time order as being administered on [DATE]th was just a delay in documentation. The DON indicated that she believed Resident 6 received the correct full medication dose within a 4-5 hour timeframe on February 18th. The DON indicated that for Resident 8, one medication was sent in the wrong form (pill instead of liquid). She indicated that the pharmacy said that they delivered all medications at the same time and that she could not answer as to why Resident 8 did not receive all his ordered medications. The DON indicated that she would expect nursing staff to administer medications at ordered times, to properly document medication administration, and to notify a resident's physician if there was an issue. The NHA indicated that the facility staff were not aware of any back-up pharmacy contracts being in place and, therefore, had not utilized them to obtain resident medications. The NHA confirmed that she would expect resident medications to be received in a timely manner.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1)(d)(f)(4)Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>33879</p> <p>Based on clinical record review, facility document review, facility policy review, and staff interviews, it was determined that the facility failed to ensure the resident record was complete and accurately documented for one of three residents reviewed for change in medical condition (Resident 14).</p> <p>Findings include:</p> <p>Review of facility policy, titled Change in Resident's Condition or Status, last revised February 2021, revealed subsection 8 stated, The nurse will record in the resident's medical record information relative to a change in the resident's medical/mental condition or status.</p> <p>Review of facility education provided to staff, dated December 5, 2024, with the topic of, Change in Residents Condition or Status, revealed the education included, Any changes in condition must be reported to [Registered Nurse] supervisor/Unit manager immediately so an assessment can be completed. When a change in condition has been identified a [user defined assessment form] must be completed.</p> <p>Review of Resident 14's clinical record revealed diagnoses that included congestive heart failure (disease process of the heart that results in a decrease in the ability of the heart to pump blood throughout the body) and hypertension (elevated/high blood pressure).</p> <p>During a staff interview on February 25, 2025, at approximately 11:30 AM, Director of Nursing (DON) revealed that on the morning of February 24, 2025, Resident 14 was experiencing a change in medical condition exhibited by vomiting. DON revealed that Employee 2 (Registered Nurse Unit Manager) was notified and performed an assessment of Resident 14.</p> <p>Review of facility document, titled Report Sheet Laurel Lane, revealed an unidentified staff member hand wrote, [Resident 14] loose stools - light brown .vomit - white[sic] .immodium [medication used to treat diarrhea]/Zofran [medication used to treat nausea and vomiting] [as-needed] 0910[AM].</p> <p>Review of Resident 14's medication administration record (MAR - documentation tool utilized to record when physician orders are completed or administered), along with narrative addition contained in the interdisciplinary progress notes, revealed that Employee 2 documented administering the as needed Zofran on February 24, 2025, at 9:14 AM, with an accompanying eMAR (electron medication administration) note, which stated, Emesis [medical term for vomit] after eating breakfast. [NAME] in color. However, no documented administration of Immodium for the morning of February 24, 2025, was found.</p> <p>Further, review of Resident 14's clinical record revealed no documentation of an assessment by Employee 2.</p> <p>Review of Resident 14's documented vital signs (heart rate, respiratory rate, blood pressure, temperature, oxygen saturation levels) revealed no vital signs were documented on the day of February 24, 2025. Finally, there was no documentation that facility staff notified the attending physician of Resident 14's change in condition on the morning of February 24, 2025.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a staff interview on February 25, 2025, at approximately 3:00 PM, DON revealed that an assessment by Employee 2 should have included vital signs and should have been documented in the clinical record. DON also revealed that Employee 2 should have documented that the attending physician was notified of the change in medical condition.</p> <p>28 Pa code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879</p> <p>Based on observations, facility document review, policy review, and staff interviews, it was determined that the facility failed to establish and maintain an infection prevention and control program for two of four unit hallways observed (Evergreen Way and Laurel Lane).</p> <p>Findings include:</p> <p>Upon entrance to the facility on [DATE], at approximately 9:00 AM, it was observed that the facility had a posted sign that the facility was under infectious disease outbreak procedure and that masks were required within the facility.</p> <p>During an interview directly after entering the building, Nursing Home Administrator confirmed that visitors and staff should be wearing masks while in the building.</p> <p>During observations of the Laurel Lane unit on February 24, 2025, between approximately 9:30 AM, and 10:30 AM, it was observed that Employee 1 was not wearing a mask. During the observations, Employee 1 was observed entering multiple resident rooms providing medications to residents.</p> <p>During multiple observations on February 24, 2025, between approximately 9:30 AM and 2:20 PM, Employee 6 was observed not wearing a mask and entering multiple resident rooms on the Evergreen Way hall.</p> <p>During a staff interview on February 25, 2025, at approximately 11:30 AM, Director of Nursing (DON) confirmed that staff should have been wearing a mask while in the building.</p> <p>Review of facility policy, titled Administering Medications, last revised April 2019, revealed the policy statement was, Medications are administered in a safe and timely manner, and as prescribed. Subsection 25 of the policy stated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc. for the administration of medications, as applicable.</p> <p>During general observations on February 24, 2025, at approximately 10:10 AM, Employee 1 was observed preparing medications for Resident 2. During the preparation, Employee 1 was observed dispensing medication tablets from a multidose container into her ungloved hand, then placing the tablet into the medication cup. Employee 1 was subsequently observed entering Resident 2's room and administering Resident 2's medications.</p> <p>Again, during observation at approximately 10:30 AM, Employee 1 was observed dispensing two medications from a multidose container into her ungloved hand, then placing the medication into the medication cup in preparation for administration to Resident 11. Employee 1 was subsequently observed entering Resident 11's room to administer the medication.</p> <p>During a staff interview on February 25, 2025, at approximately 11:30 AM, the DON revealed it was the facility's expectation that staff do no handle medications for administration with their bare hands.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa code 211.12(d)(1)(5) Nursing services		

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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.</p> <p>46253</p> <p>Based on observations and resident and staff interviews, it was determined that the facility failed to provide sufficient space for residents to participate and observe an activity for one of one activity observed in the Florida Room lounge.</p> <p>Findings include:</p> <p>Observation on February 24, 2025, at approximately 10:35 AM, revealed that the morning activity of Bean Bag Toss was being held in the lounge outside of the Florida Room. There were 14 residents seated near one another at one end of room, and Resident 3 was noted to be sitting in the doorway to the room. There was also two activity staff present assisting with the activity. In addition to the activity that was occurring, there was a resident-use computer sitting on an overbed table where Resident 4 was observed sitting in his wheelchair using the computer.</p> <p>Subsequent observation of Resident 3 at approximately 10:54 AM, revealed Resident 3 was sitting in the hallway, and a separate resident was sitting in the door frame participating in the activity.</p> <p>During an interview with Resident 3, Resident 3 stated that she was participating in the activity but had to move so that other residents had the opportunity to participate. During the interview, Resident 3 stated she hoped she could rejoin the activity that was being conducted.</p> <p>During an interview with the Nursing Home Administrator (NHA) on February 24, 2025, at approximately 11:30 AM, the NHA indicated that the facility was temporarily using the Florida Room lounge area for the morning activity because the heat was still in process of being repaired in the Activity Room. She indicated that the vendor was on-site working on the heating issue today.</p> <p>Interview with Employee 5 (Activity Aide) on February 24, 2025, at 1:10 PM, he indicated that he had been employed at the facility for approximately 3 weeks. He indicated that they use the Main Dining Room for the afternoon activities, but they had been using the Florida Room for the morning activity since about day 5 of his employment. He said that having the morning activity in the Main Dining Room interrupts dining staff from setting the room up for lunch.</p> <p>Interview with Resident 4 in the Florida room at the resident-use computer station, on February 24, 2025, at 2:50 PM, Resident 4 indicated that he felt the Florida Room was often too cramped for residents to fully participate in the activities. He also indicated that he was the resident who primarily uses the resident-use computer station and that it is hard for him to access it at times when activities are occurring in the Florida Room. He said that he feels that others invade his space when an activity occurs, and he wants to utilize the computer.</p> <p>(continued on next page)</p>		

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<p>F 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the NHA on February 25, 2025, at 11:23 AM, the NHA confirmed that residents were being switched out of the activity due to the limited space not accommodating the number of residents that wanted to participate. During the interview, the NHA confirmed that spaces being utilized for activities should be able to accommodate all residents wishing to participate and/or observe an activity. She also confirmed that a resident should not have to leave the activity to allow another resident space to participate.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p>		