

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  06/10/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on facility policy review, review of select facility documentation, and staff interviews, it was determined that the facility failed to ensure all alleged violations involving abuse were reported in a timely manner for two of three residents reviewed (Residents 1 and 2).</p> <p>Findings include:</p> <p>Review of facility policy, titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated April 2021, revealed If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>Review of facility policy, titled Resident-to-Resident Altercations, dated December 2016, revealed All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents, family members, visitors, or to the staff. Occurrences of such incidents shall be promptly reported to the nurse supervisor, director of nursing services, and to the administrator.</p> <p>Review of facility reported incident dated June 9, 2025, revealed that the Nursing Home Administrator (NHA) was made aware on June 9, 2025, at 8:45 AM, of possible resident-to-resident sexual abuse that occurred on June 7, 2025.</p> <p>Review of facility's investigation revealed an interview with Employee 4 (Housekeeper) on June 9, 2025, stating that over the weekend, she observed a female resident, possibly Resident 1, in Resident 2's room and it looked like they were kissing. Employee 4 denied seeing anything else occur and stated she could not recall where the female Resident's hands were placed. Employee 4 stated she told Employee 1 (Nurse Aide) who arrived in the room and told the Residents to stop.</p> <p>Review of Employee 1's witness statement, undated, revealed that on Saturday June 7, 2025, at approximately 2:30 PM, Employee 4 called Employee 1 to Resident 2's room. Employee 1 wrote in her statement that she observed Resident 1 in Resident 2's room, bent over Resident 2 with her hand on his penis. Employee 1 stated she walked Resident 1 back to her room and then told the nurse what she had just witnessed.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 395270	If continuation sheet Page 1 of 2

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility's interview with Employee 2 (RN-Registered Nurse) on June 9, 2025, revealed that on June 7, 2025, Employee 1 came out of the resident's room openly stating what she saw between the two residents . I told her I am not the Supervisor on duty, please go tell them. Further review of the interview revealed no details regarding what exactly Employee 1 witnessed occurring between the two residents.</p> <p>Review of facility's interview with Employee 6 (Nurse Aide) dated June 9, 2025, revealed The housekeepers called our attention to the room. [Employee 1] went in and immediately asked [Resident 1] to leave the room. She came out to the nurses' station telling [Employee 2] that she saw them making out, [Resident 1] was kissing [Resident 2], and she reached down towards his crotch. I did not hear her say she was touching any part of his body. At no time did I hear him [Employee 2] tell her to go tell the Supervisor.</p> <p>Review of facility's interview with Employee 3 (RN Supervisor) dated June 9, 2025, revealed that nobody informed her of any incident or inappropriate sexual encounters between Residents 1 and 2.</p> <p>Review of facility's interview with Employee 5 (Manager on duty) dated June 10, 2025, revealed Employee 1 had called her on June 7, 2025, and told her that she saw Resident 1's hands down Resident 2's pants. Employee 5 asked Employee 1 if she notified the supervisor and Employee 1 stated yes. Employee 5 stated I thought the supervisor was going to take the steps that needed to be done.</p> <p>Review of facility's follow up interview with Employee 1 dated June 10, 2025, revealed I told [Employee 2], I thought he was the supervisor, that [Residents 1 and 2] were making out. I told dayshift and second shift aides to keep the residents separated. I called [Employee 5] told her that [I] had just seen them making out and that [Employee 2] the supervisor had been notified.</p> <p>During an interview with the NHA on June 10, 2025, at 10:18 AM, she stated that she was not made aware of the resident-to-resident interaction that occurred on June 7, 2025, until June 9, 2025. She stated that she was informed of the incident at this time by Employee 5, who was the manager on duty on June 7, 2025. She further stated that Employee 1 reported the incident to Employee 2, but he was not the supervisor and the nursing supervisor denied any knowledge of the incident occurring.</p> <p>In a follow up interview with the NHA on June 10, 2025, at 12:41 PM, she stated that abuse allegations are to be reported immediately.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		