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	12/17/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review and staff interview, it was determined that the facility failed to provide care and services in accordance with professional standards of practice to ensure the resident's highest level of well-being for three of nine residents reviewed (Residents 7, 8 and 9). Findings Include:Review of Resident 7's clinical record revealed diagnoses that included hypertension (high blood pressure) and hyperlipidemia (high cholesterol). Review of Resident 7's TAR (Treatment Administration Record), dated November 2025, revealed the following orders: weekly body audit, every evening shift every Friday; cleanse left heel pressure wound with normal saline solution, apply betadine and leave open to air, every day and evening shift; catheter care every shift; enhanced barrier precautions due to Foley catheter every shift; monitor for signs and symptoms of a UTI (urinary tract infection) and notify physician of changes, every shift; and offloading heel boots at all times, every shift. Further review of Resident 7's TAR revealed that on November 21, 2025, there was no signature on the TAR, indicating that the following treatments were performed on day shift: weekly body audit; left heel pressure wound dressing change; catheter care; enhanced barrier precautions; and offloading heel boots.On November 21, 2025, during evening shift, there was no signature on the TAR indicating that the following treatments were performed: left heel pressure wound dressing change; catheter care; enhanced barrier precautions; and offloading heel boots. On November 24, 2025, on night shift, there is no evidence that the following treatments were performed for Resident 7, as there was no signature on the TAR, indicating that they were completed: catheter care; and monitoring for signs and symptoms of a UTI. On November 27, 2025, on day shift, there is no evidence that the following treatments were performed for Resident 7, as there was no signature on the TAR, indicating that they were completed: left heel pressure wound dressing change; catheter care; enhanced barrier precautions; monitor for signs and symptoms of a UTI; and offloading heel boots. Review of Resident 8's clinical record revealed diagnoses that included Alzheimer's Disease and hyperlipidemia. Review of Resident 8's November 2025 TAR revealed the following orders: alarming security bracelet, check placement every shift, and if Resident avoids laying flat due to shortness of breath, answer yes or no, every shift. Further review of Resident 8's TAR revealed that on November 21, 2025, on day and evening shift, and on November 27, 2025, on day shift, there was no signature indicating that the placement of the security bracelet was checked and no yes or no answer if Resident avoided laying flat. Review of Resident 9's clinical record revealed diagnoses that included hypertension and bipolar disorder (a mental health condition that causes extreme mood swings). Review of Resident 9's November 2025 TAR revealed the following orders: alarming security bracelet, check placement every shift, and if Resident avoids laying flat due to shortness of breath, answer yes or no, every shift.Further review of Resident 9's TAR revealed that on November 21, 2025, on day and evening shift, and on November 27, 2025, on day shift, there was no signature indicating that the placement of the security bracelet was checked and no yes or no answer if resident avoided laying flat.During an interview with the Nursing Home Administrator on December 17, 2025, at 2:51 PM, she stated that she would expect treatments be completed as ordered and signed off on the Resident's TAR. She further stated that she contacted the nurse assigned on those days and shifts to see if the treatments were completed, but she received no response back. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services