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	02/24/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the right to receive written notice, including the reason for the change, before the resident's room in the facility is changed for one of one resident reviewed (Resident 6).Findings include: Review of Resident 6's clinical record revealed diagnoses that included dysphagia (difficulty swallowing) and Gastroesophageal reflux disease (GERD - a chronic condition where stomach acid frequently flows back into the esophagus). Observation conducted of Resident 6 on February 18, 2026, revealed the Resident was residing in the locked dementia unit. Interview conducted with Resident 6 on February 18, 2026, at approximately 1:00 PM, revealed the Resident did not give consent to move rooms and was not provided with a written notice of the room change. Interview conducted with Employee 4 (Social Worker) on February18, 2026, at 1:25 PM, revealed that staff reported to him Resident 6 was going to get his money and car, and was going to leave the facility, so Employee 4 met with Resident 6, and Resident 6's POA (Power of Attorney) and decided to have Resident 6 move to the locked unit due to being an elopement risk. Employee 4 confirmed that Resident 6 had a wander guard on, however, the facility had issues in the past where residents walked out of the facility wearing a wander guard and, at the end of the day, did not want to put anything to chance. Employee 4 revealed that prior to the room change, Resident 6 was not having any issues in the room he was previously in. Review of Resident 6's admission MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes), revealed that Resident 6 has a BIMS (Brief interview of Mental Status) of 15, indicating normal thinking and memory. Review of Resident 6's clinical record revealed a progress note written on February 13, 2026, at 4:03 PM, that the Resident changed rooms. Review of Resident 6's clinical record revealed a progress note written on February 14, 2026, at 8:26 AM, that Resident 6 was upset and did not agree with the room change. During an interview conducted with the Nursing Home Administrator (NHA) on February 18, 2026, at approximately 1:45 PM, it was revealed that it was a late Friday afternoon and Resident 6 was upset and wanted to leave, so they decided to put Resident 6 in a locked unit, so he was not able to do so. NHA confirmed Resident 6 was wearing a wander guard. The facility was unable to provide a room change notification document that was provided to Resident 6 prior to changing rooms on February 13, 2026. Pa. code 211.12(d)(1) Nursing services

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, review of select facility documentation, and staff interviews, it was determined that the facility failed to implement interventions to ensure resident safety, which resulted in actual harm as evidenced by a frontal scalp laceration requiring sutures to repair for one of five residents reviewed (Resident 1).Findings include: Review of Resident 1's clinical record revealed diagnoses that included hemiplegia (a severe form of paralysis affecting one side of the body) and hypertension (high blood pressure). Review of Resident 1's current physician orders revealed an order for a scoop mattress, effective February 4, 2025. Review of Resident 1's current care plan revealed a focus area related to Resident's self-care performance deficit due to physical limitations, hemiplegia, muscle weakness, abnormal posture, history of CVA (cerebrovascular accident or stroke), dementia, and malformation of the spine. Further review revealed an active intervention that the Resident is to transfer with a Hoyer lift and two-person assist; as well as an intervention that the Resident requires a regular scoop mattress with extensive assist of two. Further review of Resident 1's current care plan revealed a focus area related to Resident being at risk for falls with an active intervention to maintain bed in low position. Review of Resident 1's clinical record revealed that for the bed mobility task the Resident is documented as being dependent on staff doing all of the effort, and the Resident does none of the effort to complete activity; or the assistance of two or more helpers is required for the Resident to complete the activity. Review of Resident 1's Annual MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes), dated December 7, 2025, revealed that Section GG - Functional Abilities; GG0170. Mobility, A. Roll left and right: the ability to roll from lying on back to left and right side and return to lying on back on the bed was marked 1. Dependent, indicating the helper does all of the effort and the Resident does none of the effort to complete the activity. Review of Resident 1's clinical record revealed a task for a body pillow to be placed on the right side at all times when in bed. Further review of the task revealed on February 9, 2026, at 11:08 AM, it was documented that the Resident's body pillow was not placed on the right side of the bed. Review of a facility provided fall incident report revealed that Resident 1 had an un-witnessed fall on February 9, 2026, at 7:40 PM. Further review of the incident report revealed that the Resident was observed laying prone on the floor between the bed and out wall, and sustained a laceration to frontal region at hairline, measuring approximately 4.0 centimeters (cm) by 4.0 cm by 0.1 cm. The incident report confirmed that the Resident required a mechanical lift with two-person assist. Further review revealed that Resident 1 was a two-person assist with cares, and the Resident only moves their right hand up and down occasionally, does not assist of movement with transfers, and has no bed movement per nurse aids for care. Further review of the incident report revealed Resident 1's bed was medium height. Resident 1 was sent to the Emergency Department for treatment, which resulted in the Resident needing 8 sutures for the laceration. Review of staff witness statement, revealed Employee 1 (Nurse Aid) saw Resident 1 before the fall, laying in the middle of her bed, and minutes later she was bleeding on the ground. Further review of Employee 1's statement revealed that Resident 1 was a total dependent and does not roll, lean, or move without maximal assistance. Employee 1 stated that they witnessed a clean brief on Resident 1's bed as if she was being changed. Review of Employee 2's (Nurse Aid) witness statement on February 9, 2026, revealed Employee 2 saw the Resident at 7:40 PM flip over on the floor and tried to pull her back and she kept leaning on that side of the bed. Review of Employee 3's (Nurse Aid) witness statement on February 9, 2026, revealed that they last saw Resident 1 at 7:40 PM, with her bed at waist level, wearing no brief, although there (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was a clean brief unfolded on the bed. Further review of the witness statement revealed Resident 1 does not turn on her own and was a two-person assist. Employee 3 revealed Employee 2 had gloves on when they came out of Resident 1's room during the time of the fall. During an interview with Employee 2 on February 18, 2026, at approximately 1:30 PM, revealed that Resident 1 was leaning off the bed, with the bed being in a tilted position, and had no body pillow to the right side of the bed. Employee 2 denied performing care to Resident 1 during the time of the fall. During an interview with the Nursing Home Administrator (NHA) on February 18, 2026, at approximately 1:45 PM, she revealed that it is her understanding that when Employee 2 went by Resident 1's room, Resident 1 was leaning over the bed with the bed tilted up and went to grab the Resident but could not get there in time. NHA was not able to identify how Resident 1 was leaning to the side if she is not able to move in bed without assistance. The facility failed to implement interventions to assure Resident safety, resulting in actual harm as evidenced by a laceration to a Resident's scalp, requiring sutures. 28 Pa. Code 201.18(b)(1)(e)(1) Management28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing services