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	05/01/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record reviews, facility documentation review, and staff interviews, it was determined that the facility failed to implement a comprehensive person-centered care plan for three of four residents reviewed (Residents 1, 2, and 3).Findings include: Review of Resident 1's clinical record revealed diagnoses that included displaced malleolar fracture of right lower leg with healing, muscle weakness, and unspecified abnormalities of gait and mobility. Review of Resident 1's care plan focus for ADL (activities of daily living) self-care deficit related to physical limitations dated March 3, 2026. Interventions included, but were not limited to, toileting with assistance of two, dated March 3, 2026; squat pivot transfer with no weightbearing on right lower extremity with two assist, dated March 3, 2026, which was revised to transfer with one assist and slide board with no weightbearing on right lower extremity on March 11, 2026. Review of Resident 1's clinical record revealed a progress note dated March 11, 2026, at 3:27 PM, which indicated that she was found to have a bruise on the right side of her body measuring 10 centimeters (cm) x 10 cm; and two small bruises under her left arm, both measuring 0.5 cm x 0.5 cm. The note further indicated that Resident 1 said that they were from being transferred. She said that some people wrap their arms around her and others go under her arms. Review of Resident 1's nurse aide task documentation for March 3-11, 2026, revealed that on March 10, 2026, (the day before the bruises were noted) she was not documented as having assistance of two with chair/ bed to chair transfers for both the day and evening shift. Further review of Resident 1's aide task documentation for March 3-31, 2026, revealed that on 11 occasions she was not documented as having assistance of two with toileting (March 8-evening and night shift; March 14-day shift; March 15-day and evening shift; March 16-evening shift; March 19-evening shift; March 24-night shift; March 26-evening shift; March 28-day shift; and March 30-evening shift). Review of the facility provided incident report dated March 11, 2026, at 11:45 AM, indicated the same findings as the March 11, 2026, 3:27 PM, nurse's note. The incident report further indicated the immediate intervention was that nurse aides were educated that Resident 1 was to always be a two-assist transfer. It further indicated that therapy had been asked to evaluate Resident 1's transfer status and changed her to a slide board transfer with one assist. Review of Resident 1's nurse aide task documentation for April 1-11, 2026, revealed that on seven occasions she was not documented as having assistance of two with toileting (April 1-evening shift; April 2-night shift; April 7-day and evening shift; April 8-evening shift; April 9-evening shift; and April 11-day shift). Review of Resident 2's clinical record revealed diagnoses that included obesity, muscle weakness, unsteadiness on feet, and difficulty walking. Review of Resident 2's care plan revealed a care plan focus for ADL self-care deficit related to impaired mobility, dated December 3, 2024. Interventions included, but were not limited to, transfer with a mechanical lift and two person assist, with an initiated date of April 11, 2025. Review of Resident 2's nurse aide task documentation for March 2026 revealed that on six occasions she was not documented as having assistance of two with bed to chair transfers (March 10-evening shift; March 15-evening shift; March 19-night shift; March 20-day shift; March 24-day shift; and March 29-night shift). Review of Resident 2's nurse aide task documentation for April 2026 revealed that on four occasions she was not documented as having assistance of two with (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chair/ bed to chair transfers (April 2-evening shift; April 12-day and evening shift; and April 19-evening shift). Review of Resident 3's clinical record revealed diagnoses that included dementia (a chronic disorder of mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), muscle weakness, and unspecified abnormalities of gait and mobility. Review of Resident 3's care plan revealed a care plan focus for ADL self-care deficit related to physical limitations, dated October 5, 2025. Interventions included, but were not limited to, transfer with assist of one, ambulation with assistance of one, and toileting with assistance of one, all dated March 12, 2026. Review of Resident 3's nurse aide task documentation for March 12-31, 2026, revealed the following:1) on 20 occasions she was documented as being independent with chair/ bed to chair transfers (March 14-day shift; March 15-evening and night shift; March 16-evening and night shift; March 17-evening shift; March 18-night shift; March 20-day shift; March 22-night shift; March 23-all three shifts; March 24-evening and night shift; March 25-night shift; March 29-day and evening shift; March 30-evening and night shift; and March 31-evening shift); and2) on 21 occasions she was documented as being independent with toileting (March 14-day shift; March 15-all three shifts; March 16-evening and night shift; March 17-evening and night shift; March 18-night shift; March 20-day shift; March 22-night shift; March 23-night shift; March 24-evening and night shift; March 25-night shift; March 28-day shift; March 29 day and evening shift; March 30-evening and night shift; and March 31-evening shift). Review of Resident 3's nurse aide task documentation for April 2026, revealed the following the following:1) on 31 occasions she was documented as being independent with chair/ bed to chair transfers (April 1-night shift; April 6-day and night shift; April 7-evening and night shift; April 8-night shift; April 9-evening shift; April 10-night shift; April 12-evening and night shift; April 13-evening shift; April 14-evening and night shift; April 15-night shift; April 16-evening and night shift; April 18-day shift; April 19-day and evening shift; April 20-all three shifts; April 21-evening and night shift; April 22-night shift; April 26-night shift; April 27-evening and night shift; April 28-evening and night shift; and April 29-evening shift); and2) on 32 occasions she was documented as being independent with toileting (April 6-day and night shift; April 7-evening and night shift; April 8-night shift; April 9-evening shift; April 10 day and night shift; April 12-all three shifts; April 13-evening and night shift; April 14-evening and night shift; April 15-night shift; April 16-evening and night shift; April 18-day shift; April 19-day and evening shift; April 20-evening and night shift; April 21-evening and night shift; April 22-night shift; April 26-night shift; April 27-evening and night shift; April 28-evening and night shift; and April 29-night shift). During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 30, 2026, at 11:45 AM, the DON indicated that for Resident 1 no staff member admitted to transferring her with only one assist. She said that they had therapy evaluate Resident 1 and they changed her transfer status to a slide board with one assist. During a staff interview with the NHA and DON on April 30, 2026, at 1:34 PM, the DON acknowledged that nurse aide documentation was not in accordance with Residents 1, 2, and 3's care plans. The DON further indicated that the facility has hired several nurse aides recently and that she believes it is documentation errors and that staff are following the Residents' care plans or they would have more incidents occurring. During a final interview with the NHA on May 1, 2026, at 3:17 PM, the NHA confirmed that she would expect staff to follow a resident's comprehensive care plan. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy reviews, clinical record reviews, facility documentation review, hospital records review, and staff interviews, it was determined that the facility failed to ensure wound care and services were provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of four residents reviewed (Resident 1), which resulted in actual harm as evidenced by the need for surgical intervention for exposed hardware from a surgically repaired fracture for Resident 1.Findings include: Review of facility policy, titled Surgery-Related (Pre- and Postoperative) Management- Clinical Protocol, revealed, in part, The staff and physician will monitor for, and address, postoperative risks and complications such as infection, deep vein thrombosis, cardiac arrhythmia, bleeding, failure of surgical wounds to heal, urosepsis from indwelling catheters inserted in the hospital, delirium, depression, etc. Review of Resident 1's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included a surgically repaired displaced malleolar (ankle) fracture of right lower leg, muscle weakness, and unspecified abnormalities of gait and mobility. Review of Resident 1's clinical record revealed that at the time of her admission, she had a surgical dressing to her right ankle that was not to be removed until her follow-up appointment with her orthopedic surgeon on March 12, 2026. Review of Resident 1's orthopedic consultation report dated March 12, 2026, revealed that her staples were removed and steri-strips (thin adhesive bandages that help seal minor wounds by pulling skin edges together without touching the wound itself) were applied. The report further indicated that she was placed in a tall hard cam boot (boot that allows a fractured ankle to heal which lessens the amount of force placed on the ankle) that she should wear all the time, but it could be removed daily for skin checks by the nurses and in physical therapy for range of motion of the ankle. Additional recommendations included physical therapy and occupational therapy, she could shower with the boot off while sitting, and that gauze kerlix and an ace wrap were to be placed around the ankle inside the boot to protect the incisions. It also indicated that the steri-strips could be removed when they start to fall off. A follow-up was scheduled for four weeks with repeat x-rays of the ankle. Review of Resident 1's physician orders revealed an order for Resident ankle to be wrapped q [every] 2 days, with ABD pads, kerlix and ace wraps to protect skin under the cam boot and to monitor skin closely while healing. Cam boot can be removed gently while in bed and put back on immediately after dressing change. Document skin check every day shift, dated March 13, 2025, with a start date of March 15, 2026. Review of Resident 1's Treatment Administration Record (TAR) for March 2026 revealed that the treatment as ordered above was not documented as being completed on March 26 and 27, 2026. March 26 was coded as 9 see progress note and March 27, 2026, was blank. Review of Resident 1's progress notes revealed that the corresponding note for her March 26, 2026, wound care failed to indicate why the treatment was not completed. This review also failed to reveal any documentation as to why the treatment was not completed on March 27, 2026. Review of Resident 1's TAR for April 2026 revealed that the ordered treatment was not documented as being completed on April 8, 2026, which was blank. Review of Resident 1's progress notes failed to reveal any documentation as to why the treatment was not completed on April 8, 2026. Further review of Resident 1's clinical record failed to reveal any documentation by nursing staff of the presence of a surgical wound/incision or an assessment of her surgical wound to her right ankle from the time the dressing was removed on March 12, 2026. Review of the daily skilled progress notes documented that her skin was intact. Review of Resident 1's physician's progress notes after her dressing was removed at her orthopedic appointment on March 12, 2026, revealed that she was seen by her physician on March 20, 2026, and April 6, 10, and 12, 2026. All these notes failed to include any acknowledgement of a surgical wound on her right ankle or any assessment of the surgical wound. Review of Resident 1's weekly body audit (skin check) forms revealed that they were completed on March 12, 16, 19, 26, 2026, and April 2, 2026. Review of these (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	forms failed to include any documentation of Resident 1's surgical wound or the presence of a dressing, even though Section A2 indicated to note any areas of alteration in skin integrity and Section B1 indicated to note any additional comments on skin integrity. In, addition, her April 9, 2026, body audit was not completed. Review of Resident 1's clinical record progress note dated April 9, 2026, indicated that the Resident refused her shower and, therefore, the body audit was not completed. Review of Resident 1's clinical record progress note dated April 12, 2026, at 10:24 AM, revealed that Resident 1 was transferred to the hospital after a change in condition. Resident 1 was complaining of increased weakness and tremors/shakes and staff had observed Resident 1 shaking during her transfer out of bed. Review of Resident 1's hospital emergency room records dated April 12, 2026, indicated Postoperative incision noted on the right ankle. Medial appears fine without any surrounding cellulitis or discharge. Right lateral incision actually has an exposed screw. Family believes this is new. Pictures were included in the hospital records that showed a circular opening in the surgical wound between two steri-strips and the top of the exposed screw. The screw was not protruding from the skin but rather was slightly below the skin level and the skin was curled down around the edges of the screw. Review of Resident 1's initial hospital orthopedic consultation at the hospital dated April 12, 2026, revealed Upon inspection the ED provider noticed the pts surgical incision on her right lower ankle had dehisced with exposed hardware. A consult was made to orthopedics. Pt and family state they are unsure when the wound became dehisced. They state the pt resides at a nursing facility where her dressings have been managed regularly. Their last discussion with the staff about her wound was a few days ago and they were told it looks ok. Pt is 25% partial weight bearing of the RLE in her cam boot. She denies any drainage from the wound or significant pain around it. Further review of Resident 1's hospital records revealed that she had surgery on April 18, 2026, to replace the hardware from her right ankle after her medical conditions were stabilized. The note also indicated that Resident 1 had been discharged from the hospital to another facility on April 19, 2026. Further review of Resident 1's clinical record progress notes revealed a late entry nurse's note dated April 12, 2026, at 1:58 PM, with a created date of April 15, 2026 (three days after Resident 1 was transferred to the hospital and the facility was made aware of the screw being exposed in the ankle in the emergency room), which indicated Late note following wound care on this resident to the RLE on 04/12/2026. At the time this nurse completed wound care, there was nothing protruding, hurting, or leaking. This nurse palpated the entire space of the extremity with the only finding being dry flaky skin before I replaced and secured the ACE wrap and boot to the residents comfort. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 30, 2026, at 1:34 PM, the DON confirmed that nurses should still complete a weekly body audit (skin check) even if the residents refuse bath/shower. In discussion about Resident 1's surgical wound not being documented as being present or any actual assessment of the wound anywhere in the clinical record after her surgical dressing removed until the late note dated April 12, 2026, with a created date of April 15, 2026, the DON indicated that the nurse who performed the wound care on the morning of April 12, 2026, was adamant that there was no opening in the skin and no screw protruding when she completed the wound care prior to the Resident being sent out to the hospital. The DON indicated that the nurse said that the skin was dry and flaky. The DON confirmed that she had the nurse make a late entry to describe the Resident's surgical wound. During a staff interview with the NHA and DON on April 30, 2026, at 2:15 PM, the DON indicated that if a resident has any complications with surgical wounds or other non-pressure wounds, they are referred to the facility's wound consultant. The DON confirmed that Resident 1 was not seen by the wound consultant other than for a baseline admission evaluation. She said that since Resident 1 had no complications with her surgical wound and, therefore, a referral was not made to the wound consultant. The DON confirmed that there were no wound assessments documented in Resident 1's clinical record of her surgical wound. She said that if staff had noted any changes, they would have documented the changes and referred her to the wound consultant. The DON further indicated that (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	since the order did not trigger staff to do a skin sheet when assessing the wound, she would have expected staff to have documented a note describing the wound daily as indicated in the physician's order. During a staff interview with the NHA and DON on April 30, 2025, at 3:00 PM, the DON indicated that she had spoken to Employee 2 and that she had said that she thought Resident 1's wound was healed since steri-strips were placed. During a staff interview with Employee 1 (Licensed Practical Nurse) on May 1, 2026, at 11:52 AM, he indicated that Resident 1 had a boot on her right leg and that there was a treatment ordered for the surgical wound. Employee 1 said that he remembered asking for clarification about Resident 1's wound treatment orders because it was confusing since part of the order said every two days and then another part said every day. Employee 1 said that when he asked for clarification of the order, he was told to do the dressing every day. Employee 1 said that he last observed Resident 1's wound on April 10, 2026, and that he did not note that the wound was opened with a screw exposed. Employee 1 further indicated that if he had seen that he would have reported it. When asked where he documented the daily skin check of the wound, Employee 1 indicated that he saw the wound, but he had not documented anything about the wound appearance or condition. During a staff interview with Employee 2 (Licensed Practical Nurse), the NHA, and the DON on May 1, 2026, at 12:30 PM, Employee 2 indicated that Resident 1's surgical wound care was completed on day shift and that she had never actually observed Resident 1's surgical wound. Employee 2 confirmed that she was the nurse who had completed all Resident 1's skin checks. Employee 2 said that since the treatment was being documented elsewhere, she did not document the presence of the dressing on the skin check forms that she completed and that she never removed Resident 1's dressing since it was done on day shift. Employee 2 said she was told to only indicate on the skin check form any new skin issues. During a staff interview with the NHA and DON on May 1, 2026, at 1:45 PM, they both confirmed that there was no documentation of any assessment of Resident 1's surgical wound by nursing staff or her physician from the time the surgical dressing was removed on March 12, 2026, by her orthopedic surgeon, and when she was transferred to the hospital on April 12, 2026. They also confirmed that the only note regarding the surgical wound was the late note that the nurse created on April 15, 2026, with an effective date of April 12, 2026. They both confirmed that they had no additional information to provide regarding Resident 1's surgical wound. During a final staff interview with the NHA on May 1, 2026, at 3:17 PM, she confirmed that she would expect nursing staff to have documented a daily assessment of Resident 1's surgical wound as per the physician's order. She also confirmed that she would have expected Resident 1's physician to have assessed the incision on his visits and documented his assessment of the wound as well. The facility failed to properly assess, monitor, and document the status of Resident 1's surgical wound. The wound re-opened and the orthopedic hardware was exposed, which resulted in Resident 1 requiring surgical intervention to repair. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.