STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395464	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hills Rehabilitation & Healthcare Center	1000 Evergreen Avenue Weatherly, PA 18255

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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
	395464	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hills Rehabilitation & Healthcare Center	1000 Evergreen Avenue Weatherly, PA 18255

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, the facility's abuse prohibition policy, and select facility investigative documentation and staff interview, it was determined the facility failed to ensure that one resident (Resident 1) was free from physical abuse perpetrated by another resident (Resident 2) out of 6 residents sampled for abuse prevention, which resulted in serious harm and injury, a fractured humerus (arm) and femur (leg). This deficiency is cited as past non-compliance.Findings include: A review of a facility policy entitled Abuse Policy last reviewed by the facility on April 22, 2025, revealed the residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.A review of Resident 2's clinical record revealed admission to the facility on March 29, 2022, with diagnoses to include dementia with behavioral disturbance (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania or hypomania] and lows [depression]).A quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 10, 2025, indicated that the resident was severely cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment).Review of Resident 2's care plan, initiated on January 20, 2022, indicated the resident exhibits verbal and physical agitation and aggression (combative with cares such as striking out at staff, loud verbal outbursts, disruptive to self and others, spits on others, screams at others, and makes accusatory statements). The planned interventions were to administer mediations as ordered, allow time to respond, approach slowly and slightly to the side, be aware of resident's personal space, gain resident's attention before speaking, give clear and concise explanations, leave resident if behavioral interventions are not working, provide diversional activities, remove from public area when behavior is disruptive, speak in a low-pitch, calm and reassuring tone, and use consistent routines and caregivers. A review of Resident 1's clinical record revealed admission to the facility on June 11, 2019, with diagnoses to include dementia, mood disorder, and chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe).A quarterly Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 4, severe cognitive impairment.A review of the care plan, initially dated December 26, 2023, indicated that Resident 1 was at risk for alterations in psychosocial well-being. The risk was related to unsettled relationships and conflicts, verbal and physical agitation, and aggression toward other residents and roommates. The care plan documented that Resident 1 had a history of making rude or hostile comments directed toward staff and others, being verbally abusive to roommates, and having previously struck a roommate. These behaviors were identified as being associated with the resident's cognitive impairment and history of substance abuse.A review of a nursing progress note dated August 7, 2025, at 10:35 PM revealed documentation that a fall code had been announced. The note indicated that nursing staff entered Resident 1's room and observed Resident 1 lying on her left side on the floor while yelling out. Resident 2 was documented as ambulating near the doorway of the room. The note further indicated that Resident 1 stated Resident 2 had been in her bathroom, and when she stood from her wheelchair and approached the bathroom, Resident 2 exited and pushed her, causing her to fall. The documentation indicated Resident 1 complained of pain in her left shoulder and hip, with vital signs noted to be stable. Staff separated the residents, initiated neurological checks (series of assessments performed at regular intervals to monitor a resident's nervous system) along with every 15-minute observation checks, notified the physician and guardian, and ordered diagnostic x-rays.A review of facility investigative documentation dated August 8, 2025, at 10:30 AM revealed that the facility classified the incident as physical abuse. The documentation indicated that Resident 1, identified as the victim of the aggression, was in her room when Resident 2, identified as the aggressor, exited the bathroom, pushed Resident 1, and caused her to fall to the floor. Resident 1 was noted to have called for help, and staff