

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/02/2026
NAME OF PROVIDER OR SUPPLIER  Forest Hills Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 - Minimal harm or potential for 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

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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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a review of clinical records, the facility's abuse prohibition policy, select facility-provided investigative documentation, staff interviews, and direct observation, it was determined that the facility failed to ensure that one resident (Resident C2) was free from physical abuse perpetrated by another resident (Resident CR1), for one out of eleven residents sampled for abuse prevention. Findings include: A review of a facility policy entitled Abuse Policy last reviewed by the facility on April 22, 2025, indicated that residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment 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. Further review of a facility policy entitled One-to-One Supervision Guidelines last reviewed April 22, 2025, indicated it was the responsibility of the staff assigned to provide one to one continuous observation, and under the supervision and guidance of the nursing supervisor, and must keep the resident within the line of vision and within reach, and not be left alone (not even with family). A review of Resident CR1's clinical record revealed admission to the facility on December 10, 2025, with diagnoses to include intraspinal abscess (swelling and infection involving the spinal cord area) and granuloma (a localized area of inflammation that forms around infection or foreign material), chronic pain due to trauma, panic disorder (an anxiety disorder characterized by sudden and recurrent episodes of intense fear or discomfort), generalized weakness, and difficulty walking. A review of Resident CR1's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 16, 2025, indicated the resident was cognitively intact with a BIMS score of 15 (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 13-15 indicates intact cognition or no cognitive impairment). A review of Resident C2's clinical record revealed admission to the facility on June 6, 2022, with diagnoses that included cerebral palsy (a condition affecting movement and muscle coordination caused by early brain development changes), unspecified intellectual disability (a condition limiting intellectual functioning and independent living skills), conduct disorder (a pattern of aggressive or disruptive behaviors), and mood affective disorder (a condition affecting emotional regulation). A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated the resident was severely cognitively impaired with a BIMS score of 4, severe cognitive impairment. A review of Resident C2's comprehensive, person-centered care plan initiated on December 15, 2023, identified behavioral symptoms related to cognitive impairment, including sliding or placing self on the floor, impulsive actions, attention-seeking behaviors, thrusting self from the chair without warning, spitting, inappropriate verbal and physical behaviors, combative behavior during care, and yelling at others. To address these identified behaviors and reduce the risk of unsafe interactions, the facility developed interventions that included continuous one-to-one supervision, supervision during social and recreational activities, avoidance of environmental stimuli such as conversations, television, or radio programming that could trigger or escalate behaviors, referral to psychological or psychiatric services as indicated, and administration of medications as prescribed. A review of facility-provided investigative documentation completed by Employee 1 a Registered Nurse Supervisor and dated December 28, 2025, at 4:00 PM, indicated that Resident CR1 exited his room and approached the nurses' station, reporting that music being played on a laptop was bothering him. According to the documentation, Resident CR1 then removed the external speaker from the computer and threw it onto the floor. The documentation further indicated that Resident C2, who was identified as being on one-to-one supervision at the time, spit on Resident CR1, after which Resident CR1 spit back at Resident C2. The documentation reflected that Resident CR1 encouraged Resident C2 to repeat the behavior, and Resident C2 spit on Resident CR1 again. While staff attempted to redirect and separate Resident C2, the documentation indicated Resident CR1 began striking Resident C2 in the face multiple times. The investigative documentation further reflected that Resident C2 was taken to his room; however, Resident CR1 continued attempting to gain access to Resident C2's room by pushing on the door while a supervisor held it closed. The documentation indicated both residents were eventually separated and Resident CR1 returned to his room. Immediate actions documented by the facility included contacting the</p>		