

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 03/13/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of foodborne illness in the food and nutrition services department and on three of four resident pantry areas (Area 1, Area 3, and Area 4). Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). During the initial tour of the food and nutrition services department conducted with the facility's registered dietitian (RD) on March 10, 2026, at 9:20 AM revealed the perimeter floor areas of the kitchen including under the stainless steel counter next to the juice machine, under equipment located in the cooks area, and under the ice machine were visibly soiled with a heavy buildup of dirt and debris. An observation on the Area Two resident area on March 10, 2026, at 12:40 PM during the lunch meal revealed the lower rims and rubber bumpers of two food delivery carts were visibly soiled. An observation on the Area Three resident area on March 12, 2026, at 12:15 PM during the lunch meal revealed the lower rim and rubber bumper of one food delivery cart was visibly soiled. Observation on March 12, 2026, at 12:20 PM of the Area Three resident food pantry revealed a stringy thick black substance hanging from the end of the ice machine's condensation drain hose (a hose that transports moisture produced by the ice machine to a floor drain). There was food splatter adhered to the interior surface of the pantry microwave. There was an accumulation of debris under three ceiling light shields located in the pantry. Observation on March 12, 2026, at 12:30 PM of the Area Four resident food pantry revealed the top interior surface of the microwave had a worn appearance and a buildup of food splatter. Observation on March 12, 2026, at 12:45 PM of the Area One resident food pantry revealed the ice machine had two condensation hoses which were both visibly soiled with bluish and black colored substances. The floor area under and surrounding the ice machine was visibly soiled. There was an accumulation of debris under two ceiling light shields located in the pantry. During an interview on March 12, 2026, at 1:30 PM the Nursing Home Administrator confirmed that the ice machines and resident pantry areas were to be maintained in a sanitary manner. Observation conducted with the food service director (FSD) on March 13, 2026, at 11:00 AM of the dish room in the food and nutrition services department revealed a two-foot strip of vinyl molding which had pulled away from the wall area behind the dishwasher. There was a buildup of dirt on the concrete wall area in front of the dishwasher. Interview with the FSD at the time of the observation confirmed the food and nutrition services department was to be maintained in a sanitary manner to minimize the potential to introduce contaminants into food and prevent the potential for foodborne illness. 28 Pa. Code 201.18(e)(2.1) Management. 28 Pa. Code 211.6 (f) Dietary 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy review, and staff interview, it was determined the facility failed to ensure a resident was free of chemical restraints that were not necessary to treat the resident's medical symptoms, were without justification, and did not demonstrate individualized, nonpharmacological approaches to care for one out of 36 residents reviewed (Resident 39). Findings include: A review of the facility policy titled Psychotropic Medication Use, last reviewed by the facility on February 24, 2026, revealed it is the facility policy to ensure residents do not receive psychotropic medication (medications that affect the chemical makeup of the brain and nervous system, altering mood, cognition, and perception) that are not clinically indicated and necessary to treat a specific condition documented in the medical record. The policy also indicates that behavioral and other non-pharmacological approaches (approaches used to manage symptoms or behaviors, such as environmental, behavioral, or comfort measures) are used to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction. Psychotropic medication may be considered appropriate when non-pharmacological approaches have been attempted but did not relieve the medical symptoms that are presenting a danger or significant distress. The clinical record review revealed Resident 39 was admitted to the facility on [DATE], with diagnoses that include cerebral palsy (a group of permanent movement and posture disorders caused by abnormal brain development or damage to the developing brain) and intellectual disabilities (a lifelong condition characterized by significant limitations in both intellectual functioning, such as learning, reasoning, and problem-solving, and adaptive behavior). A review of Resident 39's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 1, 2026, revealed that Resident 39 was severely cognitively impaired with a BIMS score of 03 (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 00 to 07 indicates severe cognitive impairment). A review of the comprehensive care plan revealed Resident 39 had a problem with inappropriate verbal and physical behaviors related to cognitive impairment (a condition that affects memory, understanding, and decision-making) and intellectual disability. Documented behaviors included attempting to grab female staff, combative behavior during care, spitting at staff and others, screaming, inappropriate exposure, and striking out at staff and others. The care plan, initiated December 29, 2025, included interventions such as continuous supervision by one staff member, administration of medications as ordered, use of distraction techniques, playing soft music, allowing the resident to calm in his room, and providing visual stimuli such as observing birds. A review of physician orders revealed lorazepam gel 0.5 mg/ml was prescribed on January 8, 2026, with directions to apply to the posterior neck (back of the neck) every eight hours as needed for anxiety, agitation, or aggression related to anxiety disorder. Lorazepam is a psychotropic medication (a drug that affects the brain and alters mood, behavior, or perception) and is classified as a central nervous system depressant, meaning it slows brain activity and produces calming and sedative effects. The method of administration of lorazepam in topical gel form to the posterior neck allowed for rapid application without the resident's awareness or ability to refuse, particularly given the resident's cognitive impairment. This method limited the resident's opportunity to participate in decision-making. The order was discontinued and reinitiated on January 23, 2026, discontinued again on February 10, 2026, and reinitiated on February 10, 2026, with the same directions. The clinical record failed to demonstrate that the facility defined Resident 39's specific behavioral expressions of anxiety, agitation, or aggression in measurable and observable terms to guide staff in determining when administration of lorazepam gel was clinically indicated. Without defined parameters, staff lacked (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	objective criteria to ensure the medication was administered appropriately and consistently. A review of the medication administration record dated January 2026 revealed Resident 39 was administered lorazepam gel 0.5 mg/ml on the following dates: January 10, 2026, at 08:12 AM January 12, 2026, at 11:44 AM January 13, 2026, at 11:09 AM January 14, 2026, at 10:01 AM January 15, 2026, at 07:46 AM January 15, 2026, at 02:09 PM January 18, 2026, at 02:30 PM January 19, 2026, at 11:13 AM January 20, 2026, at 08:03 AM January 21, 2026, at 08:23 AM January 30, 2026, at 12:56 PM A review of the medication administration record dated February 2026 revealed Resident 39 was administered lorazepam gel 0.5 mg/ml on the following dates: February 1, 2026, at 01:51 AM February 2, 2026, at 02:01 AM February 10, 2026, at 02:31 PM February 15, 2026, at 08:57 AM February 20, 2026, at 01:02 PM February 23, 2026, at 08:00 AM February 24, 2026, at 11:44 AM Review of Resident 39's medical record revealed no evidence non-pharmacological interventions were attempted and found to be ineffective prior to each use of lorazepam gel 0.5 mg/ml on the 18 aforementioned psychotropic medication administrations. During an interview on March 13, 2026, at 9:50 AM, the above information was reviewed with the Director of Nursing. The DON could not provide documented evidence that the facility utilized non-pharmacological interventions prior to administering lorazepam gel 0.5 mg/ml 18 times from January 10, 2026, through February 24, 2026. Also, the director of nursing could not provide documented evidence that the facility defined Resident 39's behavioral expression of anxiety, agitation, or aggression that objectively indicated the appropriate use for lorazepam gel 0.5 mg/ml. The facility did not ensure Resident 39 was free of unnecessary psychotropic medication and did not demonstrate that individualized, nonpharmacological approaches were used before administering PRN (as needed) psychotropic medication. 28 Pa. Code 211.2(3) Medical director. 28 Pa. Code 211.5(ii)(xi) Clinical records. 28 Pa. Code 211.8(e) Use of restraints. 28 Pa. Code 211.9(1) Pharmacy services. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services.		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the clinical record review, select facility policy review, documentation provided by the facility, and staff interview, it was determined the facility failed to ensure that the attending physician documented required visits by writing, signing, and dating a physician progress note for each visit, in accordance with professional standards of practice and facility policy, for five of 36 sampled residents (Residents 8, 68, 132, 161, and 166). Findings include: A review of the facility Physician Progress Notes Policy, last reviewed February 24, 2026, indicated that physician progress notes must be maintained for each resident residing in the facility. Physician progress notes reflect the resident's progress and response to his or her care plan, medications, etc. The resident's attending physician must write, sign, and date the physician's progress notes upon each visit. A review of the clinical record revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (the most common form of arthritis, occurring when the protective cartilage cushioning the ends of bones wears down over time). Review of the clinical record for Resident 8 revealed a physician progress note dated June 28, 2025. There were no further documented physician progress notes. There were no additional physician progress notes documented in the clinical record following that date. Upon surveyor inquiry on March 11, 2026, the facility provided physician progress notes faxed to the facility on March 11, 2026, which indicated the physician visited Resident 8 on August 2, 2025; August 23, 2025; September 6, 2025; September 20, 2025; October 11, 2025; October 18, 2025; November 16, 2025; December 27, 2025; January 31, 2026; and March 7, 2026. These visits were not supported by timely written, signed, and dated physician progress notes maintained in the clinical record at the time of review. A review of the clinical record revealed that Resident 161 was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and hypertension (high blood pressure). Review of the clinical record of resident 161 revealed a physician progress note dated June 28, 2025, with no additional documented physician progress notes thereafter. Upon surveyor inquiry on March 11, 2026, the facility provided physician progress notes faxed to the facility on March 11, 2026, which indicated the physician visited Resident 161 on August 2, 2025; September 6, 2025; October 11, 2025; November 16, 2025; and January 31, 2026. These visits were not supported by timely written, signed, and dated physician progress notes maintained in the clinical record at the time of review. A review of the clinical record revealed that Resident 68 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions) and Parkinsonism (a group of neurological disorders that cause movement problems similar to those seen in Parkinson's disease, such as tremors, slow movement, and stiffness). Review of Resident 68's clinical record revealed a physician progress note dated June 7, 2025, with no additional documented physician progress notes thereafter. Upon surveyor inquiry on March 11, 2026, the facility provided physician progress notes faxed to the facility on March 11, 2026, which indicated the physician visited Resident 68 on June 12, 2025; June 26, 2025; August 16, 2025; August 23, 2025; September 20, 2025; October 25, 2025; November 29, 2025; December 13, 2025; January 10, 2026; and February 14, 2026. These visits were not supported by timely written, signed, and dated physician progress notes maintained in the clinical record at the time of review. A clinical record review revealed Resident 132 was admitted to the facility on [DATE], with diagnoses that included anoxic brain damage (a serious type of acquired brain injury caused by a total interruption of oxygen supply to the brain, leading to cell death). A review of Resident 132's clinical record revealed a physician progress note dated June 14, 2025, with no additional documented physician progress notes thereafter. Upon surveyor inquiry on March 12, 2026, the facility provided physician progress notes (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	faxed to the facility on March 12, 2026, which indicated the physician visited Resident 132 on July 19, 2025; August 23, 2025; October 4, 2025; November 8, 2025; January 17, 2026; and February 21, 2026. These visits were not supported by timely written, signed, and dated physician progress notes maintained in the clinical record at the time of review. A clinical record review revealed Resident 166 was admitted to the facility on [DATE], with diagnoses that include dementia. Review of the clinical record revealed a physician progress note dated June 14, 2025, with no additional documented physician progress notes thereafter. Upon surveyor inquiry on March 12, 2026, the facility provided physician progress notes faxed to the facility on March 12, 2026, which indicated the physician visited Resident 166 on July 19, 2025; August 23, 2025; October 4, 2025; November 8, 2025; December 20, 2025; January 17, 2026; and February 21, 2026. These visits were not supported by timely written, signed, and dated physician progress notes maintained in the clinical record at the time of review. An interview with the Director of Nursing on March 11, 2026, at 11:00 AM confirmed that physicians are expected to write, sign, and date a physician progress note at each visit. The Director of Nursing confirmed that the physician visited Residents 8, 68, 132, 161, and 166 as required; however, the physician did not consistently provide written, signed, and dated progress notes after each visit for inclusion in the residents' clinical records. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.2 (d)(8) Medical director. 28 Pa. Code 211.5 (f)(ii)(iv) Medical records.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on clinical record review, policy review, observations, and staff interviews, it was determined the facility failed to identify the use of a physical restraint and failed to implement the facility policy regarding restraints for one of 36 sampled residents (Resident 56). Findings include: Clinical record review revealed that Resident 56 had diagnoses of dementia (a condition that affects memory, thinking, and decision-making abilities) and a history of falls. A review of Resident 56's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 16, 2026, revealed that Resident 56 was unable to be interviewed and required partial to moderate assistance with sitting and standing at the side of the bed. Review of the facility policy titled Use of Restraints, last reviewed February 24, 2026, revealed that restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. When the use of a restraint is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. A restraint is defined as a device or equipment that an individual cannot remove, which restricts freedom of movement. Restraints may only be used if the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve symptoms. Care plans will reflect the use of restraints and interventions implemented to systematically eliminate the need for restraint. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident/resident representative. Once a restraint is initiated, the resident is to be observed at least every 30 minutes by nursing personnel, and the resident's condition documented in the clinical record. The opportunity for motion and exercise will be provided for a period of not less than 10 minutes during every 2 hours the restraint is applied. Documentation regarding the restraint shall include full documentation of the episode leading to the use of physical restraint, a detailed description of the medical symptoms, how the restraint benefits the resident, the type of restraint, the length of effectiveness, observations, range of motion (movement of joints to maintain flexibility and prevent stiffness) provided, and repositioning efforts. A review of the care plan dated January 16, 2026, indicated Resident 56 was at risk for falls and included interventions such as bed and chair alarms (to alert staff of unsafe, unassisted attempts to get out of bed or chair), maintaining the bed in a low position, and use of a floor mat. The care plan did not include the use of a mattress placed directly on the floor. Observations conducted on March 10, 2026, at 10:00 AM, March 11, 2026, at 9:00 AM, and March 12, 2026, at 11:26 AM revealed Resident 56 lying on a mattress placed directly on the floor which reduced the height of the sleeping surface to floor level and may limit the resident's ability to independently reposition, transfer, or rise from the sleeping surface. Review of Resident 56's current physician orders and the care plan failed to identify the purpose of placing the mattress on the floor, failed to include this intervention, and failed to show evidence of an interdisciplinary team evaluation prior to implementation. The clinical record lacked documentation to indicate assessment of potential effects on the resident's mobility (ability to move independently). During an interview on March 12, 2026, at 12:30 PM, the Director of Nursing (DON) stated the mattress was placed on the floor in an effort to reduce the risk of falls and indicated this decision was not evaluated by the interdisciplinary team it was a decision to keep the resident safe. The DON was unable to provide information at the time of this interview if placing a mattress on the floor, thus reducing vertical height, reducing the resident's mobility or if this was evaluated prior to the initiation of the bed mattress on the floor. During an interview on March 13, 2026, at 10:30 AM, the Director of Nursing stated the placement of (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the mattress on the floor reduced Resident 56's bed mobility (ability to move and reposition in bed) creating a potential restraint. The clinical record failed to indicate that a physician order was obtained for this intervention and failed to show physician involvement in the decision-making process. The clinical record lacked documentation to demonstrate that the use of a mattress placed directly on the floor was assessed as the least restrictive intervention or that alternative interventions were attempted and determined ineffective. The clinical record failed to show the intervention was incorporated into the current care plan, failed to show the resident or resident representative was notified of the change or that consent was obtained prior to implementation, and failed to include documentation of ongoing monitoring, including observations of the resident's condition and safety at regular intervals while the intervention was in place. During an interview on March 13, 2026, at 1:00 PM, the Director of Nursing stated the facility had not identified the placement of the mattress on the floor as a restraint and was unable to provide documentation to indicate the facility implemented its policy related to restraint use for this intervention. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing service. 28 Pa. Code 211.8(c.1)(1)(2)(3)(i)(ii)(d)(e) Use of Restraints		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on the clinical record and select policy review, documentation provided by the facility and staff interview, it was determined the facility failed to timely identify and address risk factors for the development of a pressure ulcer and failed to implement and sustain effective interventions to prevent recurrence for one of 36 sampled residents (Resident 3). Findings include: Clinical record review revealed that Resident 3 had diagnoses including dementia (a decline in cognitive function affecting memory and decision making), failure to thrive (a condition characterized by weight loss, poor appetite, and decline in physical functioning), and finger contractures (a condition in which the fingers are permanently bent inward toward the palm, limiting the ability to open the hand and increasing the risk for pressure and skin injury). A review of Resident 3's annual Minimum Data Set assessment, or MDS, a federally mandated standardized assessment process conducted periodically to plan resident care, dated February 18, 2026, indicated Resident 3 was unable to participate in an interview due to cognitive impairment. A care plan dated February 18, 2026, identified Resident 3 as being at risk for skin breakdown, including the palms of the hands related to finger contractures. Interventions included the use of palm protectors (hand splints designed to reduce pressure and prevent the fingers from curling tightly into the palm). The care plan directed that the devices were to be worn in each hand at all times and removed periodically for skin observation and hygiene. Review of nurse aide documentation for February 2026 indicated that skin checks of the palms were to be completed once per shift. This required removal of the palm protectors to assess skin condition, evaluate positioning, and identify early signs of pressure or injury. Review of investigative documentation provided by the facility dated February 12, 2026, at 6:10 PM revealed that a nurse aide removed the palm protectors and identified an open area between the right thumb and index finger. The documentation identified the root cause as rubbing from the palm protector and the resident's fingernails. The facility indicated that alternative palm protectors without straps would be implemented and that the resident's fingernails would be trimmed. Review of a nurse's note dated February 13, 2026, at 6:52 AM documented that the open area appeared related to pressure from the strap of the palm protector. An occupational therapy evaluation dated February 17, 2026, indicated that Resident 3 was referred for treatment due to skin breakdown between the right thumb and index finger associated with the use of palm guards. The evaluation documented implementation of an alternative device without straps to prevent recurrence. There was no documented clinical rationale explaining why a device without a strap was not initially considered, given the resident's inability to independently open the hand due to contractures. A wound evaluation completed by a wound care physician on February 16, 2026, identified the wound as a Stage III pressure ulcer. A Stage III pressure ulcer is defined as full-thickness skin loss, meaning the outer layer of skin (epidermis) and underlying layer (dermis) are lost, and the injury extends into the tissue beneath. The wound measured 0.3 centimeters (cm) by 1.1 cm by 0.3 cm and contained 15 percent slough (dead, non-viable tissue that appears yellow, tan, or stringy and can delay healing). The evaluating wound specialist identified the cause of the ulcer as pressure from the resident's fingernails. Review of the facility's policy titled Pressure Ulcers/Skin Breakdown, last reviewed February 24, 2026, indicated that nursing staff and practitioner are responsible for identifying and assessing significant risk factors for pressure ulcer development, and implementing appropriate interventions. Observations of Resident 3 on March 11, 2026, at 10:30 AM and March 12, 2026, at 11:30 AM revealed that the fingernails of the right hand were long and sharp, in need of trimming. These findings were consistent with a previously identified contributing factor to the development of the Stage III pressure ulcer on February 12, 2026. Interview with the Director of Nursing (DON) on March 13, 2026, at 11:00 AM did not include evidence that the facility evaluated whether once-per-shift skin observation was sufficient for a resident with contracted fingers and with a device previously identified as a source of pressure. There was no documented evidence that the facility analyzed how the palm protector strap contributed to pressure, (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such as improper application, fit, or condition of the device, to guide appropriate corrective interventions including staff education or equipment replacement. The DON was unable to provide evidence that the facility implemented and monitored effective interventions to maintain the resident's fingernails in a trimmed and safe condition following identification of fingernails as a root cause of the pressure ulcer. The resident's fingernails were not trimmed until March 12, 2026, at 11:30 AM, after surveyor observation and notification. The facility failed to ensure that identified risk factors, including pressure from medical devices and untrimmed fingernails, were consistently addressed, monitored, and revised as necessary and failed to ensure that interventions were effective and sustained to prevent recurrence, which resulted in a potentially avoidable Stage III pressure ulcer in accordance with facility policy. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing service.		

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, select facility policy, and staff and resident interviews, it was determined the facility failed to consistently provide timely and necessary foot care for one of 36 residents sampled (Resident 66). Findings include: A review of the facility policy Care of Fingernails and Toenails, last reviewed by the facility on February 24, 2026, revealed it is the purpose of the policy to clean the nail bed, keep nails trimmed, and prevent infections. General guidelines in the policy included watching for and reporting any changes in the color of the skin around the nail bed, blueness of the nails, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. The policy also indicated reporting to the nurse supervisor if there is evidence of ingrown nails, infections, or pain or if nails are too hard or too thick to cut with ease. Clinical record review revealed Resident 66 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident 66's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 14, 2025, revealed that Resident 66 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 through 15 indicates cognition is intact). A physician's order indicating Resident 66 may have a consultation with follow-up treatment as indicated for podiatry services was initiated on December 10, 2025. A clinical record review revealed Resident 66's last podiatry (branch of medical care focused on assessment, diagnosis, and treatment of conditions affecting the feet, ankles and lower extremities) visit was on December 22, 2025. An observation on March 10, 2026, at 11:42 AM revealed Resident 66's toenails, on both feet, were thickened, yellowed, and extended past the tips of his toes, and the surface of the nails was rough and uneven. The skin on Resident 66's toes was thick and scaling across the top and side of the toes. The skin appeared dry, flaky, and crusty with a white-gray chalky appearance. Resident 66 indicated that he has diabetes, and he was upset because he has not seen the podiatrist recently. He explained that he is not receiving routine foot care. Resident 66 indicated that the length of his toenails causes him discomfort. During the interview, Resident 66 indicated that he independently ambulates and is not currently receiving physical therapy services. During an interview on March 13, 2026, at 9:50 AM, the above information was reviewed with the director of nursing (DON). The DON was unable to provide documented evidence that Resident 66 received podiatry care and services to ensure his feet were well-kept, free of signs of infection, and his foot discomfort was addressed. The facility failed to ensure Resident 66 was provided podiatry services to meet his foot care needs. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff and resident interviews, it was determined the facility failed to ensure residents received necessary behavioral health services, including trauma-informed evaluation and follow-up psychological services, to attain or maintain their highest practicable mental and psychosocial well-being for two of 36 sampled residents (Residents 66 and 22). Findings include: A review of the facility policy titled Behavioral Health Services, last reviewed by the facility on February 24, 2026, revealed the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Residents who exhibit signs of emotional or psychosocial distress receive services and support that address their needs and goals for care. A review of the facility policy titled Trauma-Informed and Culturally Competent Care, last reviewed by the facility on February 24, 2026, revealed it is the facility policy to address the needs of trauma survivors by minimizing triggers or re-traumatization. Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to all effects of all types of trauma. Traumatic events, which may affect residents during their lifetime, include interpersonal or community violence. A trigger is a highly individualized, psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. Assessment involves an in-depth process of evaluating the presence of symptoms and their relationship to trauma, as well as the identification of triggers. A clinical record review revealed Resident 66 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and depression (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of Resident 66's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 14, 2025, revealed that Resident 66 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 through 15 indicates cognition is intact). A review of an admission evaluation form dated December 9, 2025, revealed Resident 66 had never experienced a traumatic event and did not have a diagnosis of post-traumatic stress disorder. However, psychology progress notes dated December 15, 2025, December 29, 2025, January 5, 2026, January 19, 2026, February 23, 2026, and March 9, 2026, consistently documented that Resident 66 reported a history of trauma, specifically that he had been recently mugged. Review of Resident 66's clinical record failed to identify documented evidence that the facility completed a trauma assessment, evaluated the presence of trauma-related symptoms, or identified potential triggers following these repeated reports. During an interview on March 10, 2026, at 11:25 AM, Resident 66 indicated that he was assaulted and mugged when he was living at a homeless shelter prior to his admission to the facility. He explained that he continues to be bothered by the experience even months after the occurrence. During an interview on March 13, 2026, at 9:50 AM, the above information was reviewed with the nursing home administrator (NHA) and director of nursing (DON). The DON and NHA were unable to provide documented evidence the facility completed an assessment of trauma symptoms, evaluated the relationship of symptoms to the reported trauma, or identified triggers following documentation beginning December 15, 2025 for Resident 66. A clinical record review revealed Resident 22 was (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE], with diagnoses that include bipolar disorder (a mental health disorder that causes unusual shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts), generalized anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning), and borderline personality disorder (a serious mental health condition characterized by long-term instability in moods, relationships, self-image, and behavior). A review of Resident 22's quarterly MDS assessment dated [DATE], revealed that Resident 22 was cognitively intact with a BIMS score of 15 (a score of 13 through 15 indicates cognition is intact). A review of the care plan initiated October 24, 2025, identified Resident 22 with impaired psychiatric and mood status and included interventions such as behavioral health consults (psychological services) as needed. A physician's order dated November 11, 2025, indicated psychological evaluation and treatment as appropriate for Resident 22. A psychological services note dated February 9, 2026, documented that Resident 22 received supportive psychotherapy (a type of counseling focused on emotional support and coping), stress management, and solution-focused therapy (a goal-directed approach to problem solving). The note recommended continued treatment for three to six months and follow-up within two to three weeks. Review of the clinical record revealed no documented evidence that Resident 22 received a follow-up psychological services appointment or session as recommended in the psychological services note dated February 9, 2026. During an interview on March 10, 2026, at 10:50 AM Resident 22 indicated that he has bipolar depression and is currently not receiving counseling or therapy. Resident 22 explained that he believes he would benefit from additional sessions. During an interview on March 13, 2026, at 9:50 AM, the above information was reviewed with the nursing home administrator (NHA) and director of nursing (DON). The NHA and DON were unable to provide documented evidence that the facility arranged or ensured completion of the recommended follow-up psychological services. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to ensure that current and accurate nurse staffing information was posted in the facility at the beginning of each shift. Findings Include: Observations in the facility first floor lobby and second floor lobby on March 11, 2026, at 1:25 PM and March 12, 2026, at 8:10 AM revealed that the facility's nurse staffing information was not posted in the facility's designated area. An interview with the Assistant Director of Nursing on March 12, 2026, at 8:20 AM revealed that the nurse staffing information should be posted daily at the beginning of each shift in a prominent location. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.		