STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395270	A. BLDG: 00 B. WING:	02/14/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOREST PARK NURSING AND REHABILITATION STATE LICENSE NUMBER: **060802**	**700 WALNUT BOTTOM ROAD** **CARLISLE, PA 17013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an abbreviated complaint survey completed on February 14, 2025, it was determined that Forest Park Nursing and Rehabilitation was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0600 SS=K		F 0600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0600 SS=K	Continued from page 1 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	1.Facility is unable to retroactively correct issue for Resident #1. 2.DON/Designee audited current resident code status to ensure the order and POLST match on 2/13/25, there are no residents with hospital wrist bands and no special instructions in PCC regarding code status. DON/Designee provided immediate orientation/education to licensed agency and facility staff currently working in the facility on 2/13/25 regarding facility policies on resident code status, copy of floor plan including location of crash carts, oxygen, and other emergency supplies as well as how to meet EMS at the front door after calling 911 if receptionist is not on duty. Education included the following information: if a resident has change in condition, the nurse refers to the order and the POLST. If there is no order and no POLST, resident is automatic full code. If resident is a full code and CPR is to be initiated, code is called immediately, All	Completion Date: **03/11/2025** Status: **APPROVED** Date: **03/06/2025**

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F 0600 SS=K	Continued from page 2	F 0600	available licensed staff are to be present and CPR initiated and not stopped until EMS arrives and instructed to do so. Do not freely type a special instruction in PCC regarding code status. When a resident is admitted or readmitted to facility from the hospital, all hospital bracelets are to be removed. This education/orientation was forwarded to agencies 2/14/25 for signatures prior to start of shift. DON/Designee will provide orientation/education to any additional licensed agency and facility staff prior to the start of their shift to include facility policies on resident code status, copy of floor plan including location of crash carts, oxygen, and other emergency supplies as well as how to meet EMS at the front door after calling 911 if receptionist is not on duty. Education will include the following information: if a resident has change in condition, the nurse refers to the order and the POLST. If there is no order and no POLST, resident is automatic full code. If resident is a	

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F 0600 SS=K	Continued from page 3	F 0600	full code and CPR is to be initiated, code is called immediately, All available licensed staff are to be present and CPR initiated and not stopped until EMS arrives and instructed to do so. Do not freely type a special instruction in PCC regarding code status. When a resident is admitted or readmitted to facility from the hospital, all hospital bracelets are to be removed. Directed In-service was conducted by approved company for F-tag 600 Freedom from Abuse, Neglect, and Exploitation will be conducted on 2/27/25 for licensed nursing staff. Staff will show evidence of understanding by completion of quiz. Staff that cannot attend directed in-service will be provided with education and test to complete prior to working on next scheduled shift. 3.HR Director/Designee will review schedule daily to ensure licensed agency and staff scheduled have completed the orientation or will complete prior to start of shift for	

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F 0600 SS=K	Continued from page 4	F 0600	new agency staff. As part of new admission process, licensed nurse will review code status documentation to ensure facility code status policy is followed. As part of the post admission record review for new admissions, the IDT will review new admission records to ensure code status documentation reflects resident's correct code status and the facility code status/POLST process was appropriately followed 4.DON/Designee will audit 10 resident charts weekly for 2 months, then monthly for 3 months to ensure resident have code status in order and if there is a POLST that it matches the order. NHA/Designee will audit licensed agency staff for completed orientation weekly for 2 months, then monthly for 2 months. Results of audit will be reviewed by QAPI committee for any recommendations.	

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F 0600 SS=K	Continued from page 5 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to protect the residents' right to be free from neglect by failing to provide orientation and/or training to agency staff and failed to ensure agency staff responded to a medical emergency, which resulted in a delay in emergency services to a resident who went unresponsive (Resident 1). This failure placed a total of 48 residents in an immediate jeopardy situation who would require emergency intervention if found unresponsive (Residents 2-49). Findings Include: Review of facility policy, titled "Identifying Neglect", dated April 2021, revealed, "'Neglect' is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical pain, mental anguish, or emotional distress. Any situation in which te resident's care needs are known (or should be known) by staff (based on assessment and care planning), and those needs are not met due	F 0600		

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F 0600 SS=K	Continued from page 6 to other circumstances, can be defined as neglect. Circumstances that can lead to neglect include: a. failure to monitor or supervise residents; b. lack of training on a specific care interventions or use and care of needed equipment." Review of facility policy, titled "Emergency Procedure - Cardiopulmonary Resuscitation", with a revision date of February 2018, revealed, "If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: a. it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g., rigor mortis)." Review of Resident 1's clinical record revealed diagnoses that included alcoholic cirrhosis of the liver with ascites (a condition where chronic alcohol abuse damages the liver, leading to the accumulation	F 0600		

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F 0600 SS=K	Continued from page 7 of fluid in the abdominal cavity), congestive heart failure (CHF - a chronic condition where the heart muscle is weakened and cannot pump blood effectively, leading to a buildup of fluid in the lungs, legs, and other parts of the body), Type 2 Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar/glucose as a fuel), and pneumonia (lung infection). Review of Resident 1's physician orders revealed an order, dated February 4, 2025, for Full Code, meaning if Resident 1 is found unresponsive and without a pulse, CPR (cardiopulmonary resuscitation) is to be performed. Review of Resident 1's POLST form (Pennsylvania Orders for Life-Sustaining Treatment), revealed that if Resident 1 was found without a pulse and not breathing, Resident 1's wishes were for CPR/attempt resuscitation. Resident 1 signed the POLST form on February 4, 2025. The POLST form was also signed by Resident 1's physician.	F 0600		

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F 0600 SS=K	Continued from page 8 Review of Resident 1's progress notes revealed a note, written by Resident 1's nurse, Employee 1 (Licensed Practical Nurse), dated February 7, 2025, stated that at approximately 8:40 PM, Employee 1 was informed by a nurse aide that Resident 1 "did not appear to be himself." Employee 1's note stated that upon assessment, Resident 1 appeared pale and with tachypnea (rapid breathing). The note further stated that Resident 1's blood glucose was 64 (normal is 70-99), blood pressure 86/44 (normal 120/80), temperature 97.1, respiratory rate 38 (normal 12-20). No pulse was documented and Employee 1 stated she was unable to obtain an oxygen saturation. The note further stated that Employee 1 immediately notified the nursing supervisor and supplied oxygen to the Resident at 2 L (liters). Review of Resident 1's progress notes revealed a note, written by the RN (registered nurse) supervisor, Employee 3, dated February 7, 2025. The note stated that at approximately 8:45 PM,	F 0600		

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F 0600 SS=K	Continued from page 9 Resident 1's nurse asked Employee 3 to check on Resident 1. Upon assessment, Resident 1 was noted to be pale, sweaty, short of breath and his respiratory rate was 30. The note stated Resident 1 was talking but with labored breathing and he denied pain. Vital signs at this time were documented as temperature 97.1, heart rate 101 (normal 60-100), blood pressure 86/44, unable to obtain an oxygen saturation and oxygen was applied at 4 L via nasal cannula. Employee 3 notified Resident 1's physician and an order was received to transfer Resident 1 to the hospital and 911 was called. Further review of Employee 3's progress note stated that she was then called to the room by a nurse aide who stated that Resident 1 was unresponsive. The note further stated that Resident 1 was found unresponsive and without a pulse. EMS (emergency medical services) arrived and CPR was initiated. Resuscitation efforts continued without success and Resident was pronounced deceased at 9:21 PM.	F 0600		

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F 0600 SS=K	Continued from page 10 During a telephone interview with Resident 1's nurse, Employee 1 (Agency LPN), on February 12, 2025, at 10:11 AM, Employee 1 stated that she was at the nursing station and was told that Resident 1 "wasn't looking good." She stated she immediately went to assess the Resident and stated that "he didn't look good." Employee 1 stated that she assessed the Resident, took his vital signs and informed the RN supervisor (Employee 3). Employee 1 stated that Employee 3 assessed Resident 1 and at this time, he was responsive. Employee 1 stated that Employee 3 notified the physician and called 911 and that Employee 1 put oxygen on Resident 1. Employee 1 stated she was unable to recall anything else that happened after that. Employee 1 stated she did not know who started chest compressions. Employee 1 was asked if she was in the room when EMS arrived or went into the room after EMS was already there, and she replied "I can't recall at this very moment." Employee 1 was unable to provide any additional information at that time, stating "I can't remember everything that happened" and "I'm trying to	F 0600		

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F 0600 SS=K	Continued from page 11 remember everything accurately." Review of Employee 1's CPR certification revealed she was issued her CPR certification in July 2023, with an expiration date of July 2025. During a telephone interview with Employee 2 (Nurse Aide) on February 12, 2025, at 11:50 AM, she stated that Resident 1 was having trouble breathing so she notified Resident 1's nurse, Employee 1. She stated that Employee 1 came into the room to assess Resident 1. She stated Employee 1 then notified Employee 3, who also assessed Resident 1, who was still responsive at this time. Employee 2 stated that Employee 3 made the comment "Let me call his family and see what they want done with him." Employee 2 stated there was confusion, as Resident 1 was wearing a bracelet on his arm that said DNR but his POLST said to perform CPR. Employee 2 stated that Resident 1 may have come back from the hospital with the DNR band in place, as she wasn't aware of the facility using those bands. Employee 2 stated she	F 0600		

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F 0600 SS=K	Continued from page 12 then left Resident 1's room to tend to her other residents and she thinks that Employee 1 was still in Resident 1's room at that time. Employee 2 stated she was not present when EMS arrived and was not present when CPR was started. During a telephone interview with Employee 3 (Agency RN) on February 12, 2025, at 1:33 PM, she stated that she assessed Resident 1 upon the request of Employee 1. Employee 3's assessment revealed that Resident 1 was having difficulty breathing, but he was responsive, talking and had a pulse. Employee 3 instructed Employee 1 to put Resident 1 on oxygen while she went out to call the physician. Employee 3 stated that Employee 1 was then asking where all of the supplies were for the oxygen and that another employee had to get the oxygen tank for Employee 1. Employee 3 stated the physician ordered Resident 1 to be sent to the hospital. Employee 3 stated she was then questioning Resident 1's code status. She stated that Resident 1's physician order said full code and the POLST said to perform CPR but Resident 1 was	F 0600		

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F 0600 SS=K	Continued from page 13 wearing a DNR bracelet and in his electronic clinical record, it said full code but had "special instructions" underneath the full code that said DNR with limited interventions. Employee 3 stated that Resident 1 had a recent hospital stay, being readmitted to the facility on February 3, 2025, and, at that time, changed his POLST, indicating he wanted CPR. She stated although the POLST said CPR, the bracelet and the "special instructions" in the chart were misleading. Employee 3 stated she then called the Director of Nursing (DON) to apprise her of Resident 1's change in condition and to question the code status. Employee 3 stated the DON instructed her to follow the POLST. Employee 3 then stated that as she was on the phone with the DON, she observed EMS had arrived in the building and were down at the end of the hallway. At this same time, she stated a nurse aide called out to her to come to Resident 1's room. Employee 3 stated she immediately entered Resident 1's room and found that he was unresponsive, warm, not breathing and had no pulse. Employee 3 stated that at that time, EMS	F 0600		

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F 0600 SS=K	Continued from page 14 arrived and they started chest compressions. She stated CPR was performed but was unsuccessful and Resident was pronounced deceased. During this interview, Employee 3 was asked where Employee 1 was during this time and what her role was. Employee 3 stated she didn't know where Employee 1 was and stated that she was not in Resident 1's room when Employee 3 went back in his room and found him unresponsive. Employee 3 stated she did not feel there was a delay in Resident 1's care but she did have a concern that it was mostly agency staff present. Review of facility's staffing deployment sheet, dated February 7, 2025, for evening shift, revealed that one of one RNs was agency and two of four LPNs were agency staff. During a telephone interview with Emergency Response Personnel 1 (ERP) on February 12, 2025, at 2:02 PM, she stated that EMS was dispatched to a call at the facility for someone who	F 0600		

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F 0600 SS=K	Continued from page 15 was having "trouble breathing." She stated that upon arrival, there was nobody at the door to meet them and let them in. She stated they had to ring the door bell and wait, and it was a painter who was in the building who let them in. She stated that upon arrival to the nursing unit, she observed the charge nurse (Employee 3), on the phone and looking through a chart. She stated that upon entering the Resident's room, no staff were present in the room. ERP 1 stated that Resident 1 felt warm and they placed him on the monitor, which said PEA (pulseless electrical activity- a life-threatening condition where the heart's electrical activity is present but there is no pulse). ERP 1 stated that she initiated chest compressions. EPR 1 then stated that an unidentified staff member was standing in the Resident's doorway. EPR 1 asked her if she could help do chest compressions. She stated the employee looked away shyly and left the room. EPR 1 stated she continued with compressions until a nurse from a different unit came to assist and relieve her. EPR 1 stated she was then able to assist her partner to place an intraosseous line (IO-a hollow needle	F 0600		

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	395270	A. BLDG: __00_____ B. WING: _____	02/14/2025

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F 0600 SS=K	Continued from page 16 inserted into the bone marrow to deliver fluids, medications, and blood products), start an airway, and give medications. She stated they continued resuscitation for approximately 25 minutes before terminating efforts and pronouncing the Resident deceased. Email correspondence received on February 12, 2025 at 3:06 PM, ERP 2 stated no one was in the room when they arrived to Resident 1's room. During a telephone interview with Employee 4 (Nurse Aide) on February 12, 2025, at 3:34 PM, she stated that when EMS arrived, there were no staff members present in Resident 1's room. She stated that she thought the RN and LPN were confused about what to do, because Resident 1 was wearing a DNR bracelet. Employee 4 stated that after EMS arrived, nurses from other units came to assist with compressions. In a follow-up telephone interview with Employee 3, on February 13, 2025, at 8:40 AM, she stated that	F 0600		

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F 0600 SS=K	Continued from page 17 after she found Resident 1 to be not breathing and without a pulse, she ran out of the room to get the code cart. When Employee 3 was asked why she didn't immediately start chest compressions, she stated "because EMS was right there", she didn't know if any of the nurse aides, or any of the agency staff, would know where the crash cart was, and she did not know where Resident 1's nurse, Employee 1, was. Employee 3 stated that Employee 1 was not involved in Resident 1's resuscitation efforts. The facility failed to ensure that Resident 1 was free from neglect and provided the necessary emergency services. Employee 1 was assigned to work on the unit that Resident 1 resided on. She was aware of the Resident's decline during her assessment and that EMS was called for transport to the hospital. There was no evidence that Employee 1 followed up with Resident 1 to check his status. When Resident 1 was found without a pule or respirations and CPR was initiated, Employee 1 did not assist and staff on the unit did not know where she was.	F 0600		

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F 0600 SS=K	Continued from page 18 Additionally, when Employee 3 found Resident 1 without a pulse, she did not immediately start CPR, instead she left the room to obtain the Crash cart. During the onsite survey on February 13, 2025, at 1:16 PM, in an interview with Employee 5 (LPN, agency) stated that she did not know where the crash cart or emergency equipment is located, and she would ask a RN where they are located. She also revealed she would look for a resident's code status on the POLST form. During an interview with Employee 6 (LPN, agency) on February 13, 2025, at 1:20 PM, she stated her first time at the facility was a couple of months ago and she had been working at the facility this week and last week. She further revealed she did not know where the oxygen room was and knew where the crash cart was on the other unit she usually works on, but not on the unit she was currently working. She revealed that in the event of an emergency, she would run to the other unit to get the crash cart and notify to Registered Nurse on duty.	F 0600		

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F 0600 SS=K	Continued from page 19 She stated she would look for code status in physician orders and in the hard chart. She stated she had not received any orientation to the facility, such as a facility tour or orientation to facility policies. During an interview with the Nursing Home Administrator (NHA) and DON, on February 13, 2025, at 2:55 PM, the NHA stated that when the receptionist is not present, visitors need to ring the doorbell, which is only heard in the lobby area, not at the nursing stations. She stated that visitors would then have to call the facility's main number and when someone picked up the phone, that person would then need to walk to the front door to let them in. The NHA stated that if someone is calling 911, someone should be at the door waiting for EMS to arrive. She stated that she is not sure if agency staff would know to send someone to the door to wait for EMS. At that time, the DON stated that staff are supposed to look at a resident's orders and POLST, to determine their code status. The DON stated that if there is a discrepancy, staff are	F 0600		

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F 0600 SS=K	Continued from page 20 instructed to go by the POLST. The NHA stated that when agency comes to the building for the first time, they are not given any orientation or tour of the facility. The facility failed to provide orientation and/or training to agency staff. They failed to ensure agency staff responded correctly to a medical emergency. This resulted in a delay in emergency services to a resident who went unresponsive, placing 48 other residents in an immediate jeopardy situation, who requested CPR be administered in the event that they were to suddenly become unresponsive and pulseless. Review of facility provided documentation revealaed that Residents 2-49 were a full code and requested CPR. The NHA and DON were notified of the immediate jeopardy situation on February 13, 2025, at 3:00 PM, and were provided the immediate jeopardy template. An immediate action plan was requested.	F 0600		

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F 0600 SS=K	Continued from page 21 On February 13, 2025, at 5:12 PM, the facility's immediate action plan was accepted, which included: DON/Designee will provide immediate orientation/education to licensed agency and facility staff currently working in the facility to include facility policies on resident code status, copy of floor plan including location of crash carts, oxygen, and other emergency supplies as well as how to meet EMS at the front door after calling 911 if receptionist is not on duty. Education will include the following information: if a resident has change in condition, the nurse refers to the order and the POLST. If there is no order and no POLST, resident is automatic full code. If resident is a full code and CPR is to be initiated, code is called immediately, All available licensed staff are to be present and CPR initiated and not stopped until EMS arrives and instructed to do so. Do not freely type a special instruction in PCC regarding code status. When a resident is admitted or readmitted to	F 0600		

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F 0600 SS=K	Continued from page 22 facility from the hospital, all hospital bracelets are to be removed. DON/Designee will provide orientation/education to any additional licensed agency and facility staff prior to the start of their shift to include facility policies on resident code status, copy of floor plan including location of crash carts, oxygen, and other emergency supplies as well a how to meet EMS at the front door after calling 911 if receptionist is not on duty. Education will include the following information: if a resident has change in condition, the nurse refers to the order and the POLST. If there is no order and no POLST, resident is automatic full code. If resident is a full code and CPR is to be initiated, code is called immediately, All available licensed staff are to be present and CPR initiated and not stopped until EMS arrives and instructed to do so. Do not freely type a special instruction in PCC regarding code status. When a resident is admitted or readmitted to facility from the hospital, all hospital bracelets are to be removed.	F 0600		

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F 0600 SS=K	Continued from page 23 Human Resources Director/Designee will review schedule daily to ensure licensed agency and staff scheduled have completed the orientation or will complete prior to start of shift for new agency staff. This education/orientation will be forwarded to agencies for signatures prior to start of shift. DON/Designee will audit current resident code status to ensure the order and POLST match, there are no residents with hospital wrist bands and no special instructions in PCC regarding code status. DON/Designee will audit 10 resident charts weekly for 2 months, then monthly for 3 months to ensure resident have code status in order and if there is a POLST that it matches the order. NHA/Designee will audit licensed agency staff for completed orientation weekly for 2 months, then monthly for 2 months. Results of audit will be reviewed by QAPI committee for any recommendations.	F 0600		

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F 0600 SS=K	Continued from page 24 Date of compliance will be February 14, 2025. On February 14, 2025, at 10:53 AM, the Immediate Jeopardy was lifted during an onsite survey after ensuring that the immediate action plan had been implemented. Staff interviews on February 14, 2025, revealed the facility had re-educated staff on facility policy regarding resident code status, the locations of crash carts, oxygen and other emergency supplies, the process for removal of hospital wrist band upon admission, the process for meeting emergency services at the door when the receptionist is not on duty, and abuse and neglect policies. Interviews were conducted with three RNs and three LPNs. All were able to verbalize understanding of the education points. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0600		

Certified End Page

FOREST PARK NURSING AND REHABILITATION

STATE LICENSE NUMBER: 060802

SURVEY EXIT DATE: 02/14/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY