

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F 0000		
F 0584 SS=D	Findings of an abbreviated complaint survey completed on June 27, 2025, at Forest Park Nursing and Rehabilitation identified that the facility 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 0584		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025	
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION STATE LICENSE NUMBER: 060802		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1.Facility is unable to retroactively correct temperatures in Laurel Lane and Evergreen Spa. Facility had been taking random temperatures throughout the facility although none taken in resident bathrooms. Routine maintenance had not been conducted on exhaust belts. Maintenance Director is responsible for this routine Vents had been cleaned. 2.Facility purchased 5 fans on 6/27/25 and placed in facility including Laurel Lane and Evergreen spas. Residents and staff were encouraged to keep bathroom doors open when not in use. Maintenance Department changed out heat lamps and replaced with regular light bulbs in resident bathrooms. Facility had company out to check on air conditioning units as well as ventilation system. Exhaust belts were replaced. Portable a/c units purchased for Laurel Lane and Evergreen spas were installed. 3.NHA/Designee will educate the	Completion Date: 07/15/2025 Status: APPROVED Date: 07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
STATE LICENSE NUMBER: 060802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	Maintenance Department on the importance of maintaining comfortable and safe temperature levels in the facilities including routine maintenance on ventilation system including exhaust belts. Maintenance Director/designee will report quarterly task compliance to NHA to ensure tasks are being completed. 4. Maintenance Director/Designee will audit random facility temperatures of resident rooms and bathrooms and facility spa rooms 3 x a week for two months then monthly for two months to ensure temperatures are between 71 and 81. NHA will audit maintenance records quarterly to ensure ventilation system including exhaust belts is being maintained. Results of these audits will be reviewed by the Quality Assurance Performance Improvement Committee for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025	
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION STATE LICENSE NUMBER: 060802		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0584 SS=D	Continued from page 3 Based on observations as well as resident and staff interviews, it was determined that the facility failed to maintain a safe, comfortable, and home-like interior in two of three unit spas (Evergreen and Laurel Lane). Findings include: Interview with Resident 3 on June 25, 2025, at 12:30 PM, she stated the temperature in the bathroom in her room and the spa are is hot. Observation with Employee 1 on June 25, 2025, in the Laurel spa at 2:23 PM, revealed the ambient temperature registered 85.8 degrees Fahrenheit. Audible fan noise noted. Spa shower noted to be dry. Observation in the Evergreen spa at 2:38 PM, revealed the ambient temperature registered 85 degrees Fahrenheit. Audible fan noise noted. Spa shower noted to be dry.	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION STATE LICENSE NUMBER: 060802			STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0584 SS=D	Continued from page 4 The surveyor discussed the concern of the temperature in the Laurel and Evergreen spa with the Nursing Home Administrator on June 25, 2025, a 2:45 PM. No further information was provided. 28 Pa. Code 201.18 (b)(1)(3)(e)(2.1) Management	F 0584			

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520		P 5520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
STATE LICENSE NUMBER: 060802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. Facility is unable to retroactively correct the nurse aide ratios for June 21 & 22, 2025. 2. Nursing Home Administrator/designee will have a daily staffing meeting with the Director of Nursing and facility Nursing Scheduler to review daily staffing schedules to ensure compliance with staffing regulations, discuss potential barriers to meeting required staffing ratios and identify strategies to meet staffing ratios including but not limited to recruitment efforts, bonus structure, use of agency and overtime hours. 3. Nursing Home Administrator/designee will educate Director of Nursing and facility Nursing Scheduler on P5520 and the importance of ensuring compliance with nurse aide ratios as mandated by state laws regarding mandated minimum staffing requirements. 4. Nursing Home Administrator/designee will audit	Completion Date: 07/15/2025 Status: APPROVED Date: 07/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
STATE LICENSE NUMBER: 060802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 2	P 5520	daily nursing staffing ratios to ensure nurse aide ratios are in compliance with mandated state laws regarding minimum staffing ratios. These audits will be conducted weekly for 4 weeks and monthly for 2 months. Results of these audits will be reviewed by the Quality Assurance Performance Improvement committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025	
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION STATE LICENSE NUMBER: 060802		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	<p>Continued from page 3</p> <p>Based on staffing documents and staff interview, it was determined that the facility failed to ensure a required minimum of one Nurse Aide (NA) per 10 residents on Day shift (June 22nd, 2025), one NA per 11 residents on Evening shift (June 21, 2025), and one NA per 15 residents on Night shift (June 21st and 22nd, 2025).</p> <p>Findings include:</p> <p>Review of facility staffing ratio and resident census information for June 20 through 23, 2025, revealed the following NA ratios, which did not meet the minimum NA ratio required for the resident census on the following shifts:</p> <p>June 21, 2025, evening and night shifts - 107 residents and 9.13 NAs on evening shift, which did not meet the required ration of 9.73 on evening shift. Night shift 107 residents and 6.52 NAs, which did not meet the ratio of 7.13.</p> <p>June 22, 2025, day and night shift- 107 residents</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
STATE LICENSE NUMBER: 060802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 4 and 10.62 NAs on day shift, which did not meet the required ratio of 10.70 on day shift. Night shift 107 residents and 5.54 NAs, which did not meet the ratio of 7.13. Interview with the Nursing Home Administrator on June 27, 2025, at 1:24 PM, it was revealed that the facility had numerous call offs and wasn't able to fulfill the available hours.	P 5520		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
STATE LICENSE NUMBER: 060802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5640	Continued from page 5 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1.Facility is unable to retroactively correct the minimal direct care hours for June 21 & 22, 2025. 2.Nursing Home Administrator will have a daily staffing meeting with Director of Nursing and facility Nursing Scheduler to review daily staffing schedules to ensure compliance with staffing regulations, discuss potential barriers to meeting required staffing ratios and identify strategies to meet staffing ratios including but not limited to recruitment efforts, bonus structure, use of agency and overtime hours. 3.Nursing Home Administrator/designee will educate Director of Nursing and facility Nursing Scheduler on P5640 and the importance of ensuring compliance with minimum of 3.2 hours of direct resident care as mandated by state laws regarding mandated minimum staffing requirements. 4.Nursing Home Administrator will	Completion Date: 07/15/2025 Status: APPROVED Date: 07/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION STATE LICENSE NUMBER: 060802			STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
P 5640	Continued from page 6	P 5640	audit daily nursing staffing ratios to ensure facility in compliance with mandated state laws regarding minimum of 3.2 hours of direct resident care hours. These audits will be conducted weekly for 4 weeks and monthly for 2 months. Results of these audits will be reviewed by the Quality Assurance Performance Improvement committee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/27/2025
NAME OF PROVIDER OR SUPPLIER: FOREST PARK NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 WALNUT BOTTOM ROAD CARLISLE, PA 17013		
STATE LICENSE NUMBER: 060802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5640	Continued from page 7 Based on review of nursing schedules, review of staffing information furnished by the facility, and staff interview, it was determined that the facility failed to ensure the total number of nursing care hours provided in each 24-hour period be a minimum of 3.20 hours of direct care for each resident for two of four days reviewed (June 21st and 22nd, 2025). Findings Include: Nursing time schedules and staffing information provided by the facility dated June 20th through 23rd, 2025, revealed that the facility provided only: 3.01 hours of direct care for each resident on June 21, 2025, and 3.17 hours of direct care for each resident on June 22, 2025; not meeting the standard of 3.20 hours of direct care for each resident. During an interview with the Nursing Home Administrator on June 27, 2025, at 1:24 PM, it was confirmed that the facility was below the required minimum PPD.	P 5640		



Certified End Page

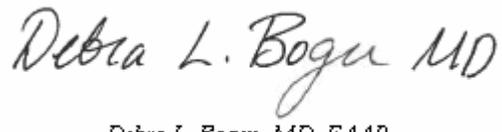
FOREST PARK NURSING AND REHABILITATION

STATE LICENSE NUMBER: 060802

SURVEY EXIT DATE: 06/27/2025

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, 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