STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215245	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homewood Living Frederick	7407 Willow Road Frederick, MD 21702

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interview, it was determined that the facility failed to ensure staff practiced infection prevention and control measures in the laundry area. This was evident for 1 of 1 laundry area and has the potential to affect all residents.1) An observation in the laundry area on 7/17/25 at 8:54 AM revealed Laundry Aid #15 was in the washer room (dirty area) and failed to wash or sanitize her hands when she came to the clean side. She took a pile of clean towels from the folding table, placed them on a cart and then continued to fold laundry.An interview was conducted with Laundry Aid #15 at the time of the observation on 7/17/25 at 8:54 AM. When asked she confirmed she had not washed or sanitized her hands when leaving the dirty area to come to the clean area. In addition, she continued to fold clean laundry without sanitizing or washing her hands after it was brought to her attention.On 7/17/25 at 9:00 AM Housekeeping Supervisor #16, Project Manager #17, and Environmental Services Director #18 were made aware of the observation and the employee continuing to fold clean laundry. She stated the laundry aid should have washed or sanitized her hands. She stated she would address this concern immediately.2) On 7/17/25 at 8:11 AM an observation of the laundry area was conducted. The area where dirty laundry was received had a stack of boxes on the floor in the right corner adjacent to the doorway. There were refill bottles of Purell hand sanitizer and 3 packages of table clothes stored on the shelf above the dirty laundry bins. To the left, was an alcove with shelving that stored new supplies and clean items. Also, there was a labeling machine, and staff used this area to label the resident's personal clothing. A doorway separated the receiving area from the room with the washers. The door was open and there were multiple blankets and a shower curtain hanging on the door. During this observation, Laundry Aid #15 was asked if they were clean or dirty and she reported they were clean items that could not be dried so staff draped them on the door to dry. She proceeded to remove them from the door and take them to the clean side to fold and place them on a clean cart. She failed to wash her hands and started folding clean laundry.There were foam cushions without covers laying on top of a washer and a shoe. Between the washer and the wall (where the hand sink was located) there was a blue plastic bin with a sheet laying half in and half out and under it were mop heads. Also, there was a bin of mop heads beside it. Over in the corner, to the right of the doorway were mops and buckets with a sign that read, dietary mops.An observation of the clean side with the dryers revealed several linen carts that had the covers draped open and some had linen on them. The folding table had clean laundry that had been folded. There were carts with residents' personal clothing hanging in them and they were draped open. These items were potentially contaminated since there was no separation between the clean and dirty areas.A closet off the clean area had the door closed and inside were clean linens. There were 2 boxes being stored on the floor.The concerns were reviewed with the Housekeeping Supervisor #16 on 7/17/25 at 8:35 AM in the laundry area. She reported she was aware that clean supplies should not be stored in the dirty area and that boxes should not be on the floor. She stated she had taken the position over within the week and had not had time to make changes. Program Manager #17 and Environmental Services Director #18 joined the interview and were made aware of the concerns.The concerns were reviewed with the Director of Nursing at the time of exit on 7/21/25 at 2:30 PM.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, it was determined that the facility failed to maintain a safe and clean area to process the dirty laundry. This was evident for 1 of 1 laundry areas observed.The findings include:On 7/17/25 at 8:11 AM an observation of the laundry area revealed in the dirty laundry processing area there was a missing ceiling tile in the right corner adjacent to the doorway to the washer room. There were 7 ceiling tiles around this area that had brownish colored stains on them. In addition, there was dried, brownish substance stains that ran down the wall near this corner and 2 trashcans on a shelf below the area that had dried, brownish substance running down the sides of them. The shelf that held the trashcans had a dried, brownish substance on it.An interview with the Housekeeping Supervisor #16, Project Manager #17, and Environmental Services Director (ESD) #18 on 7/17/25 at 8:35 AM revealed there was a juice machine that had leaked on the floor above the area. ESD #18 reported that they were aware of the damage and the need to clean the area. The concerns were reviewed; however, he offered no rationale as to why the area had not been cleaned and repaired. The concerns were reviewed with the Director of Nursing at the time of exit on 7/21/25 at 2:30 PM.