

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2025
NAME OF PROVIDER OR SUPPLIER Homeland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 North Fifth Street Harrisburg, PA 17102	
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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to ensure that a comprehensive, person-centered care plan was implemented, which resulted in actual harm as evidenced by a fracture of the left hip and laceration for one of three residents reviewed (Resident 1). Findings Include: Review of facility policy, titled MDS Assessment Completion and Care Planning, last revised October 2024, read in part, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially when changes are made. Review of Resident 1's clinical record revealed diagnoses that included dementia (a decline in mental ability that interferes with daily life) and osteoporosis (bone disease causing bones to become weak, porous, and brittle). Review of Resident 1's fall care plan revealed the interventions for, tab alarm at all times in bed and chair, bilateral floor mattresses/alarming floor mats, low bed, can roll onto mattress beside bed at times which was last revised on August 15, 2025. Review of Resident 1's Kardex (quick reference tool utilized to identify a resident's care needs/preferences and assistance needed) revealed section titled, Safety, which stated, tab alarm at all times in bed and chair, bilateral floor mattresses/alarming floor mats, low bed, can roll onto mattress beside bed at times. Review of facility incident report dated December 15, 2025, revealed Resident 1 sustained an unwitnessed fall from bed at 4:15 PM. Review of the incident description revealed, resident rolled out of bed to floor. Bed was not in low position and mats were not on floor. Resident sustained a 4-5 cm laceration to left forehead. Review of Resident 1's interdisciplinary progress notes revealed that an assessment conducted by the Registered Nurse revealed Resident 1 sustained a 4.5-5 cm laceration to left forehead, bleeding noted from the laceration. The physician was notified and an order to send Resident 1 to the emergency room for evaluation and treatment was obtained. Review of Resident 1's hospital summary dated December 15, 2025, at 5:41 PM, revealed that the Resident was initially treated in the emergency department and was subsequently admitted to the hospital for an orthopedic consult and monitoring. Review of the emergency room physician's notes revealed Resident 1's 2 cm facial laceration was repaired with staples. X-ray results revealed Resident 1 suffered a mildly displaced fracture of the proximal left femoral metaphysis (hip fracture). Resident 1 was deemed not appropriate for surgical intervention due to multiple health factors. Review of a witness statement by Employee 1 (Certified Nurse Assistant assigned to Resident 1 at the time of the fall), dated December 15, 2025, revealed Employee 1 stated, in part, .I did put her to bed. I did place floor alarms on both sides. I also put the bed as low as it would go. I put her in bed at about 2 PM. Review of a second witness statement by Employee 1, dated December 16, 2025, revealed Employee 1 stated, On 12/15/25 at 2pm I put the resident to bed. I kept her body alarm that was on her chair on the lift pad as she was transferred so that it remained on her. Both floor alarms were down, I did fail to put the second fall mat down on the side her closet is on. Once in bed, I lowered her bed down as low as it would go. I left around 3:30 to get my food and saw her in bed. I returned maybe 5-10 minutes later and continued to my set assigned for 2nd shift. Review of witness statements from Employee 4 (CNA), Employee 5 (Licensed Practical Nurse [LPN]), and Employee 6 (Registered Nurse [RN]) revealed that when they responded to Resident 1's room after the fall, Resident 1's bed was observed in an elevated position, the fall mattresses were propped against the wall, and fall mat alarms were in place but not connected. During an interview with the Nursing Home Administrator (NHA) on December 29, 2025 at approximately 1:00 PM, he revealed that Employee 1 was an agency CNA and had completed orientation to the facility and training on November 25, 2025. Following the facility's investigation, it was determined that Employee 1 failed to follow Resident 1's plan of care, which resulted in Resident 1 falling from her bed and sustaining a left hip fracture and facial laceration. The facility notified Employee 1's agency and placed Employee 1 on the do not return list. The NHA revealed that he expected staff to follow residents' plans of care and that an all staff in-service was completed to review the importance of following care plans. Review of education documentation dated December 17 - 23, 2025, revealed that nurse aides and licensed staff were educated on the importance of alarms functioning mat placement and following care plans. During an interview with Employee 2 (Assistant</p>		