STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395475	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homeland Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 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 each resident the right to be free from physical abuse for one of three residents reviewed (Resident 1).Findings Include:Review of facility policy, titled Resident Abuse, Neglect, and Exploitation, with a revised date of July 2023, revealed It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.Review of Resident 1's clinical record revealed diagnoses that included intracranial injury (Traumatic Brain Injury [TBI] -an injury to the brain caused by an external force) and Parkinson's Disease (a progressive, neurodegenerative disorder of the central nervous system that primarily affects movement due to the death of brain cells that produce dopamine). Review of Resident 1's clinical record revealed a progress note dated January 28, 2026, at 10:47 PM, stating that a nurse aide (NA) reported that during PM care, Resident 1 became combative and the NA that was assisting with care (Employee 1) was hit in the face by Resident 1. The note further states that Employee 2 (NA) witnessed Employee 1 hit Resident 1 in the face after Resident 1 hit Employee 1. Employee 2 immediately reported what she witnessed to the nursing supervisor. Resident 1 was immediately assessed and redness was noted to the right cheek, with no bruising or skin tears noted. Resident 1 denied pain and had no change from baseline mental status. Vital signs were stable and notifications were made to the NHA (Nursing Home Administrator), DON (Director of Nursing), Compliance Officer (Employee 3), and the physician. Review of the DON witness statement revealed that on January 28, 2026, at approximately 7:30 PM, she received a phone call from the nursing supervisor who reported to her that Employee 1 hit Resident 1. The DON spoke to the reporting NA, Employee 2, who stated that Employee 1 smacked Resident 1 in the face hard. Employee 2 told the DON that Employee 1 was assisting Employee 2 with Resident 1's care. Employee 2 had a wet washcloth in her hand and Resident 1 pulled it from her hand and it hit Employee 1 in the face, and Employee 1 smacked Resident 1 in the face after she got hit. The DON's statement further stated that during the interview process with Employee 1, when asked if Employee 1 slapped Resident 1 she said yes, but it was a reaction. Review of Employee 3's witness statement dated January 28, 2026, revealed she received a call from the nursing supervisor about an allegation of physical abuse. The nursing supervisor was instructed to remove the alleged perpetrator, Employee 1, from the unit and to place the alleged perpetrator and the witness, Employee 2, in separate rooms. Employee 3 arrived at the facility at approximately 7:45 PM to conduct an immediate investigation. Employee 3 stated she asked Employee 1 if she knew why she was removed from the nursing unit. Employee 1 stated she did not and Employee 3 informed her it was due to an allegation that she slapped Resident 1. Employee 1 said Yes, I (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395475	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homeland Center	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responded. It was just a reaction. I know I was wrong but it was just a reaction and I feel bad but he hit me first. Employee 3 reminded Employee 1 of her NA training and that she can never respond. Employee 3's statement further stated that she informed Employee 1 that regardless of whether she is kicked, hit, punched, slapped, etc., you are trained to never respond. It is not permissible and is considered abuse. Employee 1 said she was wrong but it was just a reaction. Further review of Employee 3's witness statement revealed that English is not Employee 1's first language, so Employee 1 agreed to dictate her statement to Employee 3 to type and then Employee 3 would read it back to her. Employee 3 stated that Employee 1 began to change her story and said she did not slap him in the face, she pushed his hand away so he could not hit her again and that maybe that is how his face got hit. When asked if he hit her with the washcloth, she said he did not, it was with his hand.Employee 3's statement further revealed that she notified the police who then arrived at the facility for investigation. Employee 3 stated she requested that Employee 1 be charged with assault. Review of Employee 1's witness statement dated January 28, 2026, revealed Employee 2 asked her for assistance. She stated that they went to Resident 1's room and transferred him into bed. Employee 1 stated that it was hard to wash Resident 1 because he always fights people. He was trying to slap [Employee 2] and I saw it so I told [Employee 2] to move her face back so she would not get hit. Employee 1 stated that Resident 1 was in front of her, because she was holding him over for Employee 2 to put a brief on him. Employee 1's statement revealed He then just slapped me near my right eye. I was surprised and grabbed my face. He then used his foot to try and push me and then I reacted by pushing his arm away because he was about to slap me again. I then left the room.Review of Employee 2's witness statement dated January 28, 2026, revealed that she asked Employee 1 for help with Resident 1's nighttime routine. She stated that they put Resident 1 into bed and then he became combative, hitting both Employee 1 and 2. Employee 2 stated that she had a wet rag in her hand doing incontinence care and Resident 1 smacked the rag and it hit Employee 1. Employee 2 stated that As soon as it hit [Employee 1], she smacked him in the face with an open hand. After smacking him in the face she says, 'You think you're just going to keep hitting me!' Employee 2 stated she quickly finished Resident 1's care, Employee 1 left the room, Employee 2 ensured Resident 1 was okay and then Employee 2 went to report what she witnessed. Resident 1 was unable to be interviewed due to his diagnosis. Review of facility's investigation revealed The facility concluded the accused [nurse aide] was physically abusive to resident when she chose to hit him in return for his actions toward her. Resident's actions did not warrant her inappropriate reaction, and as such, they are considered Resident Abuse and will not be tolerated by Homeland Center. Further review revealed that Employee 1 was terminated on January 30, 2026. During an interview with Employee 3 and the DON on February 4, 2026, at 11:57 AM, they stated that the police have been to the facility to investigate but it will be up to the District Attorney on whether or not charges will be filed against Employee 1. Facility began refresher education on January 30, 2026, for aggressive behaviors and inappropriate responses to them, as well as abuse and abuse reporting. As of February 2, 2026, facility staff were educated on Dealing with Aggressive Behavior in the Elderly.Prior to the abbreviated survey, the facility failed to ensure residents were free from physical abuse, as evidenced by Employee 1 slapping Resident 1. The facility reported the incident timely, investigated the incident thoroughly, and initiated interventions in an effort to prevent a future incident. During the abbreviated survey, plan of correction documentation was reviewed. Staff interviews, resident interviews, resident record review, and observations revealed no abuse concerns.28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 201.29 (a) Resident rights