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	08/21/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming of residents dependent on staff for assistance with these activities of daily living for two of two residents reviewed (Residents 6 and 64). Findings include: Review of facility policy, titled Activities of Daily Living (ADLs), with a last review date of January 2025, revealed Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; and 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of Resident 6's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), Parkinson's disease (long term degenerative disorder of the central nervous system that mainly affects the motor system), and lack of coordination. Review of Resident 6's care plan revealed a focus for ADL Care Plan: Alteration in self-care related to Parkinson's, limited mobility, cognitive deficit with a last revised date of March 3, 2023. Interventions included, but were not limited to, Grooming: Dependent with shampoo, shave, nail care with a last revision date of November 30, 2024. Observation of Resident 6 on August 18, 2025, at 12:25 PM, revealed that she was up in her chair in the unit common area. She had visual facial hair noted on her upper lip. Follow-up observations of Resident 6 on August 19, 2025, at 9:53 AM, in the unit common area; August 20, 2025, at 12:12 PM, in the unit dining room; and August 21, 2025, at 9:37 AM, in the unit common area, all revealed that she was well-groomed with visual facial hair noted on her upper lip. During a staff interview with Employee 7 (Nurse Aide assigned to Resident 6) on August 21, 2025, at 9:42 AM, Employee 7 indicated that residents are usually shaved on shower days and that residents and/or their families can ask between showers if needed. Review of facility provided documentation revealed that Resident 6's bath/shower schedule was Monday and Thursday on day shift. Review of Resident 6's August care task documentation revealed that she had received personal hygiene every shift and failed to reveal any documentation of refusals of care. Review of Resident 64's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (CVA-a stroke-damage to the brain from interruption of its blood supply) affecting right dominant side, dementia, and generalized muscle weakness. Review of Resident 64's care plan revealed a focus for ADL Care Plan: Alteration in self-care related to weakness, dementia, CVA with hemiplegia with a last revision date of August 8, 2024. Interventions included, but were not limited to, Grooming: Assistance required with shampoo, shave, nail care with an initiated date of November 27, 2024. Observation of Resident 64 on August 19, 2025, at 10:50 AM, revealed that she was up in her chair in the unit common area. She had visual facial hair noted on her chin. Follow-up observations of Resident 64 on August 20, 2025, at 9:15 AM, in the unit common area; and August 21, 2025, at 9:38 AM, in the unit common area, revealed that she was well-groomed with visual facial hair noted on her chin. Review of facility provided documentation revealed that Resident 64's bath/shower schedule was Wednesday and Saturday on evening shift. Review of Resident 64's August care task documentation revealed that she had received personal hygiene every shift and failed to reveal any documentation of refusals of care. During a staff interview with the Nursing Home Administrator, the Assistant Nursing Home Administrator (ANHA), and the Director of Nursing (DON) on August 21, 2025, at 11:36 AM, the DON confirmed that Residents 6 and 64 should have been shaved on their shower days, or at least offered and documented if they refused. The ANHA indicated that Residents 6 and 64 had now been shaved. 28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to provide the highest practical well-being by not following physician orders for three of 22 residents reviewed (Residents 3, 8, and 84).Findings include: Review of Resident 3's clinical record revealed diagnoses that included dependence on renal dialysis (an artificial process for removing waste products and excess fluids from the body that is needed when the kidneys are not functioning properly), hypertension (high blood pressure), and weakness. Review of Resident 3's physician orders revealed an order for Midodrine HCl Oral Tablet 5 mg, Give 2 tablets by mouth every 8 hours as needed for hypotension (low blood pressure), give for SBP (systolic blood pressure) less than 120, with a start date May 5, 2025. Review of Resident 3's clinical record revealed a document titled Physician Orders with an order dated May 5, 2025, that read, Change Midodrine to 10 mg PRN (as needed) for SBP <120. Further review of Resident 3's clinical record revealed her SBP measure was below 120 on May 27; June 6, 25, 29; July 8; and August 13, 2025. Review of Resident 3's May-August 2025 MAR (Medication Administration Record- documentation for treatments/medication administered or monitored), revealed she did not receive any doses of the PRN midodrine order on May 27; June 6, 25, 29; July 8; and August 13, 2025. Interview with Employee 2 (Registered Nurse) on August 21, 2025, at 11:04 AM, she revealed the midodrine should have been given on the aforementioned dates and those were medication errors. During an interview with the Director of Nursing (DON) on August 21, 2025, at 11:39 AM, she revealed she would expect medications to be given per physician orders. Review of Resident 8's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side, enterocolitis (inflammation of the digestive tract) due to clostridium difficile (a bacteria that causes an infection of the colon, the longest part of the large intestine), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 8's clinical record revealed that her medication regimen was reviewed by the facility pharmacist on April 28, 2025. Review of the facility provided Consultant Pharmacist's Medication Regimen Review form revealed that the pharmacist noted that according to the MAR [Medication Administration Record] in PCC [Point Click Care-the facility's electronic health record] no vancomycin doses are scheduled to be administered on 5/9/2025, 5/17/25-5/24/25 or 6/1/2025-6/7/2025. There was a written notation in the Follow-Through section on this report that indicated transcribed correctly in PCC with no signature or date noted. Review of Resident 8's physician order history revealed the following orders dated April 14 2025: vancomycin 50mg/ml give 2.5 ml via PEG every 6 hours for 10 days (start on April 15, 2025 and stop on April 25, 2025); then give 2.5 ml every 8 hours for 7 days (start on April 25, 2025, and stop on May 2, 2025); then give 2.5 ml every 12 hours for 7 days (start on May 2, 2025, and stop on May 9, 2025); then give 2.5 ml daily for 7 days (start on May 10, 2025, and stop on May 17, 2025); then give 2.5 ml every 48 hours (start on May 25, 2025, and stop on June 1 , 2025); then give 2.5ml every 72 hours (start on June 8, 2025, and stop on June 15, 2025). There was no order entered for the week of May 17-24, 2025. Review of Resident 8's May 2025 MAR revealed that she received no doses of vancomycin on May 9, 2025. In addition, there was no entry for vancomycin to be delivered between May 17-May 24, 2025. During a staff interview with Employee 3 and Employee 4 on August 21, 2025, at 10:20 AM, Employee 3 confirmed that she had transcribed the order incorrectly and therefore Resident 8 did not receive all ordered doses of the vancomycin. She confirmed that Resident 8 did not receive any vancomycin on May 9, 2025, a total of 2 missed doses. She further indicated that during the week of May 18-24, 2025, Resident 8 should have started the every 48 hour dose and that the week of June 1-8, 2025, Resident 8 should have started the every 72 hour dose. She confirmed that Resident 8 missed a dose on May 19 and 21, 2025, a total of 2 missed doses as Resident 8 was transferred to the hospital for an acute illness on May 22, 2025, and did not return to the facility until June 3, 2025, at which time Resident 8's medication orders changed. During a staff interview with the Nursing Home Administrator, the Assistant Nursing Home Administrator, and the DON on August 21, 2025, at 11:36 AM, the DON confirmed that she would have expected Resident 8's medication order to have been transcribed correctly so that Resident 8 would have received her ordered doses of medications. Review of Resident 84's clinical record revealed diagnoses that included chronic kidney disease (when damaged kidneys cannot filter blood properly) and diabetes (a disease causing high blood

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to maintain an effective infection control program related to the preparation and administration of medications for two Residents observed (Residents 3 and 55).Findings include: Review of facility policy, titled IIB2: Oral Medication Administration, with a last review date of January 2025, revealed C. For solid medications: 1) Pour or push the correct number of tablets or capsules into the souffle cup, taking care to avoid touching the tablet or capsule, unless wearing gloves. During a medication pass observation on August 20, 2025, between 9:22 AM and 9:30 AM, Employee 6 was observed preparing and administering medications to Residents 3 and 55. When preparing medications, Employee 6 was observed using an ink pen to poke a hole in the back of the pill pouch on each blister pack, and then used the ink pen to poke the pill through from the front of the blister pack into the medication cup. She prepared and administered six medications to Resident 3, and 10 medications to Resident 55. During a staff interview with Employee 6 on August 20, 2025, at 9:40 AM, Employee 6 confirmed that she had used the pen to poke the back of the blister pack and could not be sure that the pen did not touch the pills. She said that the pills are hard to push through the blister pouches sometimes, and sometimes the back of the blister pack falls into the medication cup. During a staff interview with the Nursing Home Administrator, the Assistant Nursing Home Administrator, and the Director of Nursing (DON) on August 20, 2025, at 2:00 PM, the DON confirmed that Employee 6 should not have been using her ink pen to poke holes into the back of the medication blister packs to remove medications. 28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1)(2)(5) Nursing services