STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395898	A. BLDG: 00 B. WING:	01/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HOMEWOOD AT PLUM CREEK STATE LICENSE NUMBER: **342202**	**425 WESTMINSTER AVENUE** **HANOVER, PA 17331**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights survey completed on January 23, 2025, it was determined that Homewood at Plum Creek 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 0000		
F 0558 SS=D		F 0558		

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.

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F 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	"Preparation and evaluation of the enclosed plan of correction set forth in these documents does not constitute admission or agreement by the provider of the truth of the facts alleged or concluded set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of Federal and State law. F-0558- Reasonable Accommodations Needs/Preferences 1. Resident #4 – DON provided education that in the future, the aide should notify her team leader that she was in another emergent situation so another person could respond to the residents' needs. Resident #87 re-education given to the aide to ensure the call light was always within reach for resident. 2. All other resident rooms were checked on both units on 1/23/2024 and all call lights were within reach and no other concerns were	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0558 SS=D	Continued from page 2	F 0558	identified with residents receiving services with reasonable accommodations of resident needs and preferences. 3. Policy for Call Lights- Answering has been reviewed and revised by the DON. Education provided via Relias computer education system to Healthcare staff on the revised policy to include not turning off the call light until the resident needs have been met, call lights should be within reach at all times and the importance of residents receiving services with reasonable accommodations of resident needs and preferences. This education will be completed by 2/21/2025. 4. Audits will be completed by the QA coordinator monitoring for residents receiving services with reasonable accommodations of resident needs and preferences/call lights within reach/call lights turned off when resident needs met. Audits will be done weekly X2 weeks, bi-weekly x2 weeks then	

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F 0558 SS=D	Continued from page 3	F 0558	monthly x2. Any immediate concern will be brought to DON for immediate attention and re-education. Audits will be reviewed at QA Meetings All corrective actions will be completed by 2/25/25	

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F 0558 SS=D	Continued from page 4 Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the right to receive services with reasonable accommodation of resident needs for one of 22 residents reviewed (Resident 4), and failed to ensure that resident needs were accommodated regarding call bell accessibility for one of 22 residents reviewed (Residents 87). Findings include: Review of facility policy, titled "Call Lights-Answering", last reviewed April 18, 2024, read, in part, "Purpose: To identify and respond to the residents needs. Procedure: call bell will be answered timely. When leaving the room, check to see that the call signal will be within the resident's reach." Review of Resident 4's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease,	F 0558		

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F 0558 SS=D	Continued from page 5 marked by memory disorders, personality changes, and impaired reasoning), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), and anxiety disorder (a persistent feeling of worry, nervousness, or unease). Observation of Resident 4's room on January 21, 2025, at 1:06 PM, revealed her call light was on above her room. Interview with Resident 4 on January 21, 2025, at 1:10 PM, revealed she needed to use the rest room. Observation in the hallway on January 21, 2025, at 1:14 PM, the surveyor observed Employee 1 (Registered Nurse) enter residents 4's room to administer a medication. The surveyor heard Resident 4 tell Employee 1 she needed to use the restroom, Employee 1 replied, "I will let them know." Employee 1 turned off Resident 4's call light and exited the room.	F 0558		

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F 0558 SS=D	Continued from page 6 Observation on January 21, 2025, at 1:21 PM, the surveyor observed Employee 2 (Nurse Aide) walk past Resident 4's room and Employee 1 in the hallway. Employee 1 did not notify Employee 2 that Resident 4 needed to use the rest room. During an interview with Employee 1 on January 21, 2025, at 1:28 PM, the surveyor inquired if she was going to notify nurse aide staff that Resident 4 needed to use the restroom and if she had turned off Resident 4's call bell. Employee 1 replied that she did notify a nurse aide and turned off Resident 4's call bell. Observation on January 21, 2025, at 1:28 PM, Employee 1 called Employee 3 (Nurse Aide) to ask for assistance for Resident 4. Observation on January 21, 2025, at 1:29 PM, revealed Employee 3 was entering Resident 4's room to provide assistance. Interview with the Director of Nursing (DON) on	F 0558		

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F 0558 SS=D	Continued from page 7 January 23, 2025, at 10:18 AM, revealed Employee 1 notified Employee 3 that Resident 4 needed assistance after she left the room via their communication devices, but Employee 3 was busy with an emergent situation for another resident, so she was unable to assist Resident 4 at that time and was delayed in assisting her. During a follow-up interview with the DON on January 23, 2025, at 1:11 PM, the surveyor revealed the concern with Employee 1 turning off Resident 4's call bell before her needs were met and lack of prompt response until surveyor inquiry. No further information was provided. Review of Resident 87's clinical record revealed diagnoses that included macular degeneration (a vision impairment resulting from deterioration of the central part of retina, a thin layer at the back of the eye on the inner side), age related nuclear cataract (hardening and cloudy eye lens leading to vision changes), and hypertension (high blood pressure).	F 0558		

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F 0558 SS=D	Continued from page 8 Observation in Resident 87's room on January 21, 2025, at 10:32 AM, revealed she was in her bed eating breakfast and her call bell was out of reach, laying on her recliner. Review of Resident 87's care plan revealed a focus area of, "I have had falls related to poor safety awareness", with a start date of January 17, 2025, with an intervention for "please keep my frequently used items within reach", with a start date of January 17, 2025. Interview with the DON on January 23, 2025, at 1:09 PM, revealed she would expect Resident 87's call bell to be in reach. 28 Pa code 201.29(a) Resident Rights 28 Pa Code 211.12(d)(1) Nursing Services	F 0558		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 9 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	"Preparation and evaluation of the enclosed plan of correction set forth in these documents does not constitute admission or agreement by the provider of the truth of the facts alleged or concluded set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of Federal and State law. F-0641- Accuracy of Assessments 1.Resident #49 MDS was modified on 1/22/25 removing that the resident had been treated for PTSD in section I6100. DON did a written education for the LPNAC that entered this incorrectly 2. All assessments completed in the past 14 days were audited for accuracy in section I6100 with no other errors identified. 3. Policies for Resident Assessments and comprehensive Assessments has been reviewed and will be revised as needed by the DON.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0641 SS=D	Continued from page 10	F 0641	Re-education provided to the MDS team by the DON on 1/31/2025 on accuracy of assessments per the RAI manual. Ongoing MDS training courses will be scheduled for the MDS team as offered and appropriate. 4. MDS's completed by the LPNAC will be audited by RNAC for accuracy. Audits will be completed on random sections of the MDS completed by the LPNAC. 5 assessments will be audited bi-weekly X2, then monthly x3 in coordination with residents MDS schedule. MDS will be modified if any errors identified. Any error identified will be brought to DON attention immediately. Audits will be reviewed at QA Meetings All corrective actions will be completed by 2/25/25	

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F 0641 SS=D	Continued from page 11 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 25 residents reviewed (Resident 49). Findings Include: Review of Resident 49's clinical record revealed diagnoses that included cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain tissue to die) and gastro-esophageal reflux disease (a chronic condition where stomach contents flow back up into the esophagus, causing irritation and various symptoms). Review of Resident 49's quarterly MDS (Minimum Data Set is part of federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated November 8, 2024, revealed in Section I6100. Post Traumatic Stress Disorder (PTSD), that Resident 49 has been treated for PTSD in the previous 7 days while a resident.	F 0641		

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F 0641 SS=D	Continued from page 12 Review of Resident 49's electronic medical record failed to reveal any treatment for PTSD. Review of Resident 49's care plan failed to reveal any care plan for PTSD. Interview with the Director of Nursing on January 22, 2025, at 9:58 AM, revealed that Resident 49's MDS completed on November 8, 2024, was marked in error and that Resident 49 does not have any history of PTSD and an MDS correction will be completed. 28 Pa Code 211.12 (d)(3)(5) Nursing Services	F 0641		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 13 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	"Preparation and evaluation of the enclosed plan of correction set forth in these documents does not constitute admission or agreement by the provider of the truth of the facts alleged or concluded set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of Federal and State law. F-0684-Quality of Care 1.Resident 41's Physician orders/eTAR was reviewed and discussed with physician and resident. Physician changed order to PRN on 1/22/25. 2. All Resident treatment orders were reviewed to ensure the facility had implemented resident-directed care and treatment consistent with Physician's orders. No other discrepancies were identified. 3. Policies on Care Plans-Comprehensive Person-Centered and Nursing	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0684 SS=D	Continued from page 14	F 0684	Documentation were reviewed and will have necessary revisions made by DON. Re-education provided to the Licensed nurses via Relias. Re-education to include reviewing the policies-Nursing Documentation and Care Plans- Comprehensive Person-Centered with a focus to include that residents receive any treatment ordered by the physician or the physician must be updated per policy of refusals or unnecessary treatment. Education will be completed by 2/21/25. 4. Treatments and Resident obervations will be audited by QA Coordinator to ensure they are following the resident care plan and physician orders. Monitoring will include nurse observation to ensure treatment or appliance is in place. 5 Audits will be done weekly X2 weeks, bi-weekly x2 weeks then monthly x2. Any immediate concern will be brought to DON for immediate attention and re-education. Audits will be reviewed at QA Meetings	

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F 0684 SS=D	Continued from page 15	F 0684	All corrective actions will be completed by 2/25/25	

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F 0684 SS=D	Continued from page 16 Based on observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to implement resident-directed care and treatment consistent with the resident's physician orders and care plan for one of 22 residents reviewed (Resident 41). Findings include: Review of Resident 41's clinical record revealed diagnoses that included congestive heart failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should), localized edema (swelling caused due to excess fluid accumulation), and muscle weakness. Interview with Resident 41 on January 21, 2025, at 10:17 AM, revealed he has had issues with fluid retention in his legs. Review of Resident 41's physician orders revealed an order for "Tubi grips to bilateral lower extremities (BLE), on AM off HS (evening)- twice a day for	F 0684		

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F 0684 SS=D	Continued from page 17 edema," with a start date of September 20, 2024. Review of Resident 41's care plan revealed a focus area of, "I require limited to extensive assistance with my bathing, grooming, dressing, supervision, and set up with mobility and eating related to CHF and unsteady gait", with an intervention for "Tubi grips on AM off HS to BLE", with a start date of October 31, 2024. Observation of Resident 41 on January 21, 2025, at 12:18 PM, revealed he was in bed eating lunch, he had edema to his lower extremities, and his Tubi grips were not in place. Observation of Resident 41 on January 22, 2025, at 10:15 AM, revealed he was in his wheelchair, he had edema to his lower extremities, and his Tubi grips were not in place. Interview with Resident 41 on January 22, 2025, at 12:20 PM, revealed he has not worn Tubi grips to his legs in over a month since he has had a lot off	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395898	A. BLDG: 00 B. WING:	01/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HOMEWOOD AT PLUM CREEK STATE LICENSE NUMBER: **342202**	**425 WESTMINSTER AVENUE HANOVER, PA 17331**

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F 0684 SS=D	Continued from page 18 weight loss and his edema has improved. Review of Resident 41's TAR (Treatment Administration Record- documentation for treatments/medication administered or monitored) revealed his physician order for Tubi grips was signed off that they were in place on January 21 and 22, 2025. During an interview with the Director of Nursing on January 23, 2025, at 10:33 AM, she revealed Resident 41 used to have a lot of edema but it has really gone down, so they changed his physician order on January 22, 2025, to be as needed. She further revealed she would expect the order not to be signed that the Tubi grips were in place when they were not. 28 Pa Code 211.12(d)(1)(3)(5) Nursing Services	F 0684		
F 0732 SS=A		F 0732		

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HOMEWOOD AT PLUM CREEK STATE LICENSE NUMBER: **342202**	**425 WESTMINSTER AVENUE** **HANOVER, PA 17331**

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F 0732 SS=A	Continued from page 19 483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 0732	"Preparation and evaluation of the enclosed plan of correction set forth in these documents does not constitute admission or agreement by the provider of the truth of the facts alleged or concluded set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of Federal and State law. 1. The facility name has been added. 2. No Plan of correction. 3. Master template form will be used for each staff posting. 4. No Plan of correction.	Completion Date: **02/05/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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HOMEWOOD AT PLUM CREEK STATE LICENSE NUMBER: **342202**	**425 WESTMINSTER AVENUE HANOVER, PA 17331**

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F 0732 SS=A	Continued from page 20 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that all required data was included in the daily staffing posting. The findings include: Observations of the Daily Nursing Staff Postings on January 21, 2025, at 10:27 AM, and on January 22, 2025, at 9:35 AM, revealed that the facility name was not included in the postings. In email correspondence received from the Director of Nursing on January 22, 2025, at 4:03 PM, a corrected copy of the posting was provided. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0732		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HOMEWOOD AT PLUM CREEK STATE LICENSE NUMBER: **342202**	**425 WESTMINSTER AVENUE HANOVER, PA 17331**

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F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 22 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	"Preparation and evaluation of the enclosed plan of correction set forth in these documents does not constitute admission or agreement by the provider of the truth of the facts alleged or concluded set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of Federal and State law. F-0758- Free from Unnecessary Psychotropic meds/PRN use 1.Resident #4 PRN order for antipsychotic medication was reviewed with physician and discontinued on 1/23/25 2.All PRN psychotropic orders were reviewed to ensure the order had an appropriate stop date per regulatory compliance. No other discrepancies found. 3.Policies for Psychotropic and Anti-psychotic Medications reviewed and any necessary revisions made by DON.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HOMEWOOD AT PLUM CREEK STATE LICENSE NUMBER: **342202**	**425 WESTMINSTER AVENUE HANOVER, PA 17331**

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F 0758 SS=D	Continued from page 23 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	Re-education to all Licensed Nurses on Psychotropic Medication use including every PRN order having a 14 day stop date will be provided via Relias to be completed by 2/21/2025. 4.QA Coordinator will review all new PRN psychotropic orders for a 14 day stop date. Audits will be done weekly X2 weeks, bi-weekly x2 weeks then monthly x2. Any immediate concern will be brought to DON for immediate attention and re-education. Audits will be reviewed at QA Meetings All corrective actions will be completed by 2/25/25	

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F 0758 SS=D	Continued from page 24 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure PRN (as needed) orders for anti-psychotic drugs are limited to 14 days for one of five residents reviewed for unnecessary medications (Resident 4). Findings include: Review of facility policy, titled "Antipsychotic Medication Use", last reviewed April 18, 2024, read, in part, "Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and document the rationale for continued use. The duration of the PRN order will be indicated in the order. " Review of Resident 4's clinical record revealed	F 0758		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HOMEWOOD AT PLUM CREEK STATE LICENSE NUMBER: 342202	425 WESTMINSTER AVENUE HANOVER, PA 17331

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F 0758 SS=D	Continued from page 25 diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), and anxiety disorder (a persistent feeling of worry, nervousness, or unease). Review of Resident 26's physician orders on January 21, 2025, revealed an order for "Seroquel (antipsychotic medication) 25 mg tablet -12.5 mg by mouth twice daily as needed for hallucinations", with a start date of December 31, 2024, and no stop date. During an interview with the Director of Nursing (DON) on January 23, 2025, at 10:14 AM, she revealed Resident 4 was assessed by the practitioner on January 13, 2025, with a noted plan to continue medications as recommended by psych services, and that her next appointment with them was in February. The surveyor revealed the concern	F 0758		

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F 0758 SS=D	Continued from page 26 with the lack of a 14 day stop date on the PRN Seroquel order and lack of a new order past 14 days. Follow-up interview with the DON on January 23, 2025, at 1:06 PM, she revealed she would expect the facility to comply with the regulation for a stop date of 14 days for PRN antipsychotic medications without exception. 28 Pa code 211.9(a)(1) Pharmacy services 28 Pa code 211.12(d)(1)(3)(5) Nursing services	F 0758		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 27 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	"Preparation and evaluation of the enclosed plan of correction set forth in these documents does not constitute admission or agreement by the provider of the truth of the facts alleged or concluded set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of Federal and State law. F-0880 Infection Prevention and Control 1.Resident #46 – Re-Education provided to the staff member on proper donning of PPE for Droplet precautions by Infection Preventionist. Resident # 68 Re-Education provided to the staff member on proper doffing of PPE for Droplet precautions by Infection Preventionist. 2. All resident rooms on precautions were checked to ensure PPE donning and doffing set up was done per facility policy and staff were	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0880 SS=E	Continued from page 28 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	following the correct procedures. No other discrepancies found. Donning and Doffing was reviewed with staff by Infection Preventionist on 1/23/25. 3. Policy on Infection Control will be reviewed and revised as necessary by DON. Re-education will be provided to the Healthcare staff on Infection Control and proper donning and doffing of PPE via Relias with education completed by 2/21/25. 4. QA Coordinator will audit for proper donning and doffing of PPE. 5 donning or doffing audits will be done weekly X2 weeks, bi-weekly x2 weeks then monthly x2. Any immediate concern will be brought to DON for immediate attention and re-education. Audits will be reviewed at QA Meetings All Corrective actions will be completed by 2/25/25	

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F 0880 SS=E	Continued from page 29	F 0880		

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F 0880 SS=E	Continued from page 30 Based on facility policy review, observations, clinical record review, and staff interview, it was determined that the facility failed to implement infection control practices to help prevent the development and transmission of infectious diseases for two of two residents on droplet precautions (Resident 46 and 68). Findings include: Review of facility policy, titled "Infection Control Policy", last reviewed April 18, 2024, read, in part, "Purpose: The objectives of our infection control policies and procedures are to: Prevent and control the spread of communicable/contagious diseases. Establish guidelines to follow in the implementation of transmission-based precautions. It shall be the responsibility of the Administrator and Director of Nursing (DON) through the Quality Improvement committee, to assure that infection control policies and procedures are implemented and followed." Review of facility document, titled "Droplet	F 0880		

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F 0880 SS=E	Continued from page 31 Precautions", posted outside of Resident 46 and 68's rooms, revealed "Everyone must clean their hands before entering & leaving room. Make sure their eyes nose and mouth are fully covered before room entry. Remove face protection before room exit." Review of Resident 46's clinical record revealed diagnoses that included influenza (a disease caused by virus infecting the respiratory tract), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and chronic kidney disease (a condition characterized by a gradual loss of kidney function). Observation on January 21, 2025, at 12:16 PM, revealed Employee 4 (Nurse Aide) was bringing Resident 46's lunch tray into her room, he did not put on eye protection prior to room entry. Review of Resident 68's clinical record revealed diagnoses that included influenza, congestive heart failure, and muscle weakness.	F 0880		

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F 0880 SS=E	Continued from page 32 Observation on January 22, 2025, at 12:24 PM, revealed Employee 5 (Nurse Aide) was bringing Resident 68's lunch tray into his room. After leaving the room, she disposed of her face shield outside of the room in a trash bin outside of the room. During an interview with the DON on January 23, 2025, at 10:39 AM, she revealed the disposal bin for personal protective equipment (PPE) should have been stored inside Resident 68's room, and she would expect PPE to be worn appropriately by staff. 28 Pa Code 201.18(b)(1) Management. 28 Pa Code 211.12(d)(1)(5) Nursing Services.	F 0880		

Certified End Page

HOMEWOOD AT PLUM CREEK

STATE LICENSE NUMBER: 342202

SURVEY EXIT DATE: 01/23/2025

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