STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395432	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Center for Rehabilitation and Nursing	280 Middle Holland Road Holland, PA 18966

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 06525 Based on clinical record reviews, interviews with staff and review of policies and procedures and review of emergency medications and review of Pennsylvania Professional Nurse Practice Act., it was determined that the facility failed to meet professional standards of practice related to providing routine and emergency pain medication to meet the needs of one of seven residents reviewed. (Resident R1) Findings include: According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) requires the following: (a) The LPN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. (b) The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice. According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.11 Functions of the RN (Registered Nurse) requires the following: The registered nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. 21.18 A registered nurse shall undertake a specific practice only if the registered nurse has the necessary knowledge, preparation, experience and competency to properly execute the practice. Review of the undated policy and procedure titled delivery of medications from the pharmacy indicated that the facility was to call the pharmacy for medications that had to be delivered immediately. Review of the policy and procedure titled administering medications dated April 2020 revealed that medications were to be administered to residents in a safe and timely manner as prescribed by the physician. The policy indicated that licensed staff were responsible for administering medications to the residents. The policy said that medications were required to be administered by the prescriber keeping with required time frames of administration. (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: 395432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Center for Rehabilitation and Nursing	280 Middle Holland Road Holland, PA 18966

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication inventory log for August 13, 2024 revealed that seven, 15 milligrams (mg) tablets of Morphine sulfate,were being stored in the facility's emergency supplies. The medication inventory sheet also listed eight tablets of Oxycodone-acetaminophen 10- 325 mg. each tablet in the emergency medication supplies. Clinical record review revealed that Resident R1 arrived at the facility from the hospital on August 5, 2024. The resident had diagnoses of cerebral infarction (ischemic stroke causing blockage of the blood supply to the brain), hypertension(high blood pressure), malignant neoplasm of the ovary (cancer of the ovary), hemiparesis (paralysis on left side of the body), central pain syndrome (neurological condition caused by damage to the central nervous system, brain and spinal cord) and leukemia (cancer that causes anemia, low platelets and compromised immune system). Review of Resident R1's August 2024 physician's orders revealed an order for one 15 mg. tablet of Morphine sulfate to be administered twice a day at 9:00 a.m., and 9:00 p.m. for pain management. The physician had also ordered Oxycodone-acetaminophen 10-325 mg tablet every 4 hours as needed for moderate pain. Review of Resident R1's August 2024 Medication Administration Record revealed that the 9:00 p.m., dose of Morphine sulfate 15 mg was not administered for this resident as ordered by the physician on August 2, 2024. Continued review of the Medication Administration Record for Resident R1 indicating that the as needed pain medication (Oxycodone-acetaminophen 10-325 mg tablet every 4 hours) was not administered on August 2 or 3, 2024. Clinical record review revealed a nursing progress note dated August 3, 2024 that indicated Resident R1 reported to the nursing staff that she needed her pain medication. The nursing staff member told Resident R1 that the facility did not have the prescribed pain medication to administer to her on August 2, 2024 or August 3, 2024. Clinical record documentation on August 3, 2024 indicated that Resident R1 called the local police Department to report that she was being neglected; without any pain medication, to meet her needs, at the facility. Clinical record documentation indicated that Resident R1 also call emergency ambulance transport to take her back to hospital so that she could get the pain medication that she needed; since the facility was not providing routine or emergency medications for her as ordered by the physician for 9:00 p.m., on August 2, 2024. The nursing progress note also indicated that Resident R1 departed the facility at 12:44 a.m., with the emergency transport staff, for the hospital. Interview with the Director of Nursing, Employee E2, at 10:30 a.m., on August 13, 2024 confirmed that the nursing staff failed to administer routine or emergency pain medications for Resident R1 on August 2 and August 3, 2024 as prescribed by the physician for pain management. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services