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	12/11/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations of the physical environment, interviews with staff and reviews of clinical records, hospital records and policies and procedures, it was determined that the facility failed to provide adequate supervision to prevent an unauthorized leave from the nursing unit resulting in a resident elopement from one of five residents reviewed. (Resident CI1)Findings include:A review of the policy and procedure titled elopement and wandering dated November 2023 revealed that it was the responsibility of the facility staff to identify residents who are at risk of unsafe wandering and prevent harm from elopement and wandering. The policy said that the facility staff were responsible for clinically assessing each resident and identifying who was at risk for elopement and wandering. The policy said that for those residents identified at risk for wandering, elopement and other safety issues that strategies and interventions to maintain the safety of the resident would be implemented. The policy indicated that each resident would be assessed upon admission, re-admission, an elopement attempt, quarterly and annually.A review of the hospital record dated July 11, 2025, for Resident CI1 revealed that this resident was diagnosed with chronic schizophrenia (mental disease characterized by loss of reality contact), bipolar disorder (condition in which a person has periods of depression and period of being extremely happy), anxiety disorder and seizure disorder. Clinical record review revealed that Resident CI1 revealed that this resident was admitted to the facility on [DATE]. Review of Resident CI1's physician documentation dated September 24, 2025, revealed that the resident was admitted from a behavioral health hospital after being treated for behavioral issues of aggression, and verbal expressions of suicide and homicide ideations. Resident CI1 was alert with the ability to follow simple commands. The resident had ambulatory disfunction, wandering behaviors and required assistance with activities of daily living (transfers, ambulation, eating, grooming and bathing). The physician's care plan was to monitor Resident CI1's behavior.Clinical record review for Resident CI1 revealed that upon admission to the facility on September 23, 2025, the licensed nurse, Employee E3 documented that this resident was at high risk for elopement; however, there was no documentation to indicate that care planning was developed immediately and instituted for Resident CI1's safety needs and behavioral issues of elopement/wandering risk. It was confirmed during an interview at 10:30 a.m., on October 15, 2025, with the Licensed nurse, Employee E3, who completed this assessment that a care plan to include a wander guard placement, supervision and diversional activities to prevent an unauthorized leave from the nursing unit was not implemented for Resident CI1.Review of documentation submitted to the State Survey Agency on September 30, 2025, revealed that on September 29, 2025, at approx. 5:55pm the dietary aid came to the unit to collect dinner trays. As she was leaving the unit and getting on the elevator, Resident CI1 got on the elevator and pushed the button for the basement. The dietary staff went back on the unit to alert the nurse and nurse aides. At approx. 6:00pm a family member saw the resident sitting on a rollator in the parking lot. Staff took resident into independent living and alerted nursing staff. Nursing staff arrived to take resident back to unit. The resident exited a door in the independent living section of the campus that was not locked, and (he/she) did not need to pass the receptionist.Clinical record review revealed that on September 29, 2025, Resident CI1 left the nursing unit in a wheelchair at 5:40 p.m., through the locked/ code alarmed doors on the second-floor nursing unit. The resident was able to go through the doors in his wheelchair, because the dietary staff member allowed Resident CI1 through the locked/code alarmed doors. The witness statement provided by the dietary staff member indicated that Resident CI1 then got onto the elevator to the first floor with the dietary staff member. The nursing progress notes for September 29, 2025, indicated that the nursing staff found the wheelchair belonging to Resident CI1 on the first floor outside the dining area. The resident took a rollator walker from outside the dining area and used it to ambulate to another elevator on the first floor to get himself to the basement area of the facility. At the basement level the resident exited the building. The resident then crossed an active roadway to a parking lot and was found seated on the rollator walker without shoes (barefoot). A dietary staff member, Employee E8 said that he took Resident CI1 inside the building from the parking lot at about 6:00 p.m., on September 29, 2025. Employee E8 indicated that Resident CI1 was behaving confused. Employee E8 also reported not being able to positively identify Resident CI1 since the resident had no identification. A witness statement documented and reported on September 30, 2025, by the director of nursing, Employee E2 revealed that when asked about the wandering and elopement from the nursing unit on September 29, 2025, Resident CI1 said that he did not know where