

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  01/29/2026
NAME OF PROVIDER OR SUPPLIER  Holland Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of information submitted by the facility, hospital records, clinical records, policy and procedures, and interviews with residents and staff, it was determined the facility failed to ensure resident received adequate assistance and supervision with assistive devices to prevent accidents for one of eight residents reviewed for falls and functional abilities. Resident CL1 fell during an attempted improper transfer with staff causing the resident actual harm. (Resident CL1). Findings include: Review of the facility's undated policy and procedure titled Comprehensive person-centered care plans revealed it was the responsibility of the interdisciplinary care team to develop and implement a care plan for each resident with measurable objectives and time frames to meet the resident's physical, psychosocial and functional needs. The policy indicated that the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy also said each resident had the right to participate in the care planning process. The policy said that the care plan was to describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, psychosocial well-being of each resident. Review of the facility's policy and procedure titled Accident and incident investigation and reporting dated July 2017 revealed it was the responsibility of the administrator to investigate and report all accidents and incidents involving residents. The policy indicated that the nursing supervisor was responsible for initiation of the documentation and investigation of the incident. The director of nursing was responsible for ensuring that a complete report was submitted to the administrator. The administrative staff was responsible to review the incident with the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. Review of Resident CL1's closed clinical record revealed an admission comprehensive assessment (MDS-an assessment of care needs) dated January 5, 2026, indicating resident CL1 was cognitively intact. The assessment indicated that Resident CL1's functional abilities for transferring from chair/bed to chair transfer (ability to and from a bed to a chair or wheelchair) was dependent (helper does all the effort or the assistance of 2 or more helpers was required to complete the activity). Review of Resident CL1's closed clinical record revealed physical therapist assessment dated [DATE], indicating Resident CL1 had abnormalities of gait and mobility and a history of recurrent falls with no osseous of the left ankle. The therapist documented Resident CL1 was at risk for falls, requiring a mechanical lift (Hoyer lift) for all transfers. The physical therapist indicated nursing was notified of the total dependence transfer status of Resident CL1. Continued review revealed as of January 7, 2026, the physical therapy department was documenting transfer for Resident CL1 continued to be total dependence on staff, with the use of a mechanical lift. Review of Resident CL1's closed clinical record for January 6, 2026, revealed a physiatrist progress note indicating Resident CL1 was cognitively intact. The physiatrist note indicated the plan was for continued physical and</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 395432	If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>occupational therapy for rehabilitation for Resident CL1. Review of Resident CL1's clinical record for January 8, 2026, revealed a physician's progress note that indicated Resident CL1 was alert and oriented, follows commands without any gross focal deficits. Review of Resident CL1's clinical record revealed a comprehensive care plan that indicated Resident CL1 was at risk for accident hazards with reduced balance, strength and activity tolerance. The care plan revealed Resident CL1 had reduced ability to perform functional mobility and activities of daily living. The intervention indicated to use mechanical lift (Hoyer lift) for all transfers. The care plan indicated the care giver, nursing staff, were educated of this intervention to prevent falls. Review of information dated January 8, 2026, submitted by the facility on January 9, 2026, revealed that on January 8, 2026, at 3:00 p.m., Resident CL1 was sitting in a wheelchair in their bedroom and rang the call light/bell. The nursing staff responded to the call light/bell on January 8, 2026. The nursing assistant, Employee E5, reported that Resident CL1 was starting to slide and that Resident CL1 wanted to go back to bed. On January 8, 2026, the nursing assistant placed the walker in front of Resident CL1 and upon standing, Resident CL1 fell to the floor. Review of Resident CL1's clinical record including nursing progress notes for January 8, 2026, revealed Resident CL1 was sent to the emergency room post fall. Review of Resident CL1's hospital record for January 8, 2026, revealed Resident CL1 was diagnosed with a comminuted distal fibular shaft fracture of the right leg, transverse fracture of the medial malleolus, and dislocation of the tibiotalar joint (the joint that connects the foot to the lower leg) of the right leg. The resident required surgical repair of the fractures. Interview with the director of the therapy department, Employee E6, at 1:00 p.m., on January 29, 2026, confirmed Resident CL1 required the use of a mechanical lift (Hoyer lift) for transfers from the wheelchair to the bed. The therapist also confirmed the care plan had been discussed with the nursing staff and the care plan identified Resident CL1, was identified at risk for falls. The director of therapy also reported the nursing staff failed to implement the interventions and assistive device (Hoyer lift) as indicated on the care plan. Interview with Nursing Assistant, Employee E5, at 3:30 p.m., on January 29, 2026, revealed they were unaware Resident CL1 required a mechanical lift (Hoyer lift) and assistance of two or more staff members for safe transfers from the wheelchair to the bed. The nursing assistant confirmed that upon entering Resident CL1's bedroom on January 8, 2026, the resident requested assistance to get back into bed. The nursing assistant, Employee E5 said that the resident was sitting in proper up right positioning in her wheelchair. The nursing assistant reported that while assisting Resident CL1 to stand from the wheelchair to then transfer the resident, alone into the bed, Resident CL1 fell to the floor. The nursing assistant reported there was blood on the floor near Resident CL1, after the fall. Review of Resident CL1's closed clinical record revealed A nursing progress notes dated January 8, 2026, which revealed that Resident CL1 was sent emergently to the hospital and was admitted for an open fracture of the right ankle. The failure by nurse aide, Employee E5 to use a mechanical lift (hoyer lift) to transfer Resident CL1 from the wheelchair into the bed by Employee E5 by herself caused physical injury to Resident CL1 who fell to the floor with blood noted near Resident CL1, after the fall. Resident CL1 was diagnosed with a comminuted distal fibular shaft fracture of the right leg, transverse fracture of the medial malleolus, and dislocation of the tibiotalar joint (the joint that connects the foot to the lower leg) of the right leg. The resident required surgical repair of the fractures. 28 PA. Code 201.18(b)(1)(3)(e)(1) Management 28 PA. Code 211.10(a)(b)(c)(d) resident care policies 28 PA. Code 211.12(d)(1)(3)(5) Nursing services</p>		