

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 07/12/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on clinical record review, review of policy and procedures and staff interviews, it was determined that the facility failed to ensure that residents were offered an opportunity to develop an advance directive for one of 13 residents reviewed. (Residents R94).</p> <p>Findings include:</p> <p>Review of the facility policy Advance Directive (revised [DATE]) reviewed in part the following:</p> <ol style="list-style-type: none"> 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives and applicable state law. 3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. 4. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information. 5. Each resident will also be informed that the facility's policies do not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive. <p>Review of clinical record revealed that the resident was admitted on [DATE]</p> <p>Review of the electronic clinical record for Resident R94, revealed a section for code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) was not completed. No code status was included.</p> <p>Review of physician order for Resident R94 revealed no evidence that the facility obtained an order for a code status.</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
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital record for Resident R94 dated [DATE], revealed that the residents code status was documented as DNR/DNI. ((Do Not Resuscitate, it instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating). /Do Not Intubate (no breathing tube will be placed.)</p> <p>Continued review of the clinical record revealed that there was no documented evidence that resident's family was given opportunity to formulate an advance directive or clarified the hospital code status to implement the residents wishes after admission to the facility.</p> <p>Interview with the Assistant Director of Nursing on [DATE], at 12:14 p.m., confirmed that Resident R94's code status of DNR/DNI in the hospital was not implemented in the facility and resident's family was not given opportunity to formulate an advance directive.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on review of facility policies and clinical records and staff interviews, it was determined that the facility failed to ensure that a baseline care plan was developed and implemented, and that a written summary of the baseline care plan was provided to the resident and/or the resident's representative for 7 of 13 residents reviewed (Residents R148, R147, R153, R97 and R94).</p> <p>Findings include:</p> <p>Review of facility policy Care Plans, Comprehensive Person-Centered, revised March 2022, reveals that assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change.</p> <p>Review of Resident R148's clinical record revealed that the resident was admitted to facility on June 23, 2024. Review of Wound- weekly observation tool, completed on June 25, 2024 by facility's nurse practitioner, Employee E15, revealed resident was assessed to have suspected deep tissue injury (SDTI) on sacrum, 7 cm in length and 4 cm width, 0.1 cm depth, with treatment plan to cleanse with normal saline solution, pat dry, apply Triad paste, leave open to air.</p> <p>Review of R1148's care plan revealed no evidence of goals or interventions for sacral wound.</p> <p>Review of Resident R147's clinical record on July 11, 2024 revealed that he was admitted to facility on June 24, 2024 and was order the use of an indwelling urinary catheter care every shift.</p> <p>Review of R147's care plan revealed no evidence of goals or interventions regarding urinary catheter care.</p> <p>Review of Resident R153's clinical records revealed that that the resident was admitted to the facility on [DATE]. Resident R153 had a skin check assessment completed on June 28, 2024 at 5:02 p.m. which revealed pink peri area, and bilateral heels red and blanchable.</p> <p>Review of R153's care plan revealed no evidence of goals or interventions regarding her heels or peri area care.</p> <p>A review of Resident R97's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis, including altered mental status dementia and dehydration.</p> <p>Continued review of the clinical record revealed no documented evidence that a baseline line care was developed within 48 hours of resident's admission and resident and/or the resident's representative received a written summary of the baseline care plan. Baseline care plan assessment was not completed.</p> <p>Review of clinical record for Resident R97 dated June 21, 2021, revealed a question if resident representative reviewed and received a copy of the baseline care plan. The response was documented as made aware will discuss in care conference.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the care plan revealed no documented evidence that the resident representative received a written summary of the baseline care plan.</p> <p>A review of Resident R94's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis, including anemia and chronic kidney disease.</p> <p>Continued review of the clinical record for Resident R94 revealed no documented evidence that a baseline care plan was developed within 48 hours of resident's admission and resident and/or the resident's representative received a written summary of the baseline care plan. Baseline care plan assessment was not completed.</p> <p>Review of clinical record for Resident R97 dated June 21, 2021, revealed a question if resident representative reviewed and received a copy of the baseline care plan. There was no evidence that the resident or representative received a copy of the care plan.</p> <p>A request was made to the Assistant Director of Nursing on July 11, 2024, at 12:14 p.m., for a copy of the baseline care plan for Resident R94 and Resident R97, and evidence that resident/resident representative received a copy of the baseline care plan.</p> <p>Facility did not provide any evidence that a baseline care plan was developed for Resident R94 and Resident R97, and resident/resident representative received a copy of the baseline care plan.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop a personal center care plan related to elopement for one of 13 residents reviewed. (Resident R97)</p> <p>Findings include:</p> <p>A review of Resident R97's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis, including altered mental status dementia (progressive degenerative disease of the brain resulting in loss of reality function) and dehydration (lack of sufficient body fluid).</p> <p>Review of care plan for Resident R97 dated July 21, 2024, revealed that the resident had impaired cognitive function/ dementia or impaired thought process.</p> <p>Review of Resident R97's admission assessment revealed an instruction section which indicated Response of Ambulatory and Disoriented/intermittent confusion will score resident at risk for elopement.</p> <p>Review of progress note for Resident R97 dated July 5, 2024, revealed that resident was noted with wandering behavior and exit seeking behavior.</p> <p>Review of a social service progress note dated July 8, 2024 revealed that the resident requested to go home.</p> <p>Observation of Resident R97 on July 9, 2024, and July 10, 2024, on second floor nursing unit revealed that the resident was ambulatory and was wandering in the unit.</p> <p>Interview with the Assistant Director of Nursing on July 11, 2024, at 12:14 p.m., confirmed that Resident R97 was at risk for elopement and the facility did not have a care plan or intervention for elopement prevention.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46993</p> <p>Based on review of clinical record, review of facility policies, review of documentation, and interview with staff, it was determined that the facility failed to timely assess a resident for respiratory distress and failed to ensure that emergency transportation services were provided in a timely manner for one of 13 residents reviewed (Resident R158). This failure resulted in an Immediate Jeopardy situation for Resident R158 who experienced a change in condition related to respiratory distress and did not receive a timely nursing assessment and was not transferred in a timely manner to emergency room and subsequently died . (Resident R158)</p> <p>Findings include:</p> <p>Review of facility policy Change in Condition, revised [DATE], revealed that The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition; need to transfer the resident to a hospital/treatment center. The nurse will confirm with the physician to clarify the mode of emergency transport requested by the physician according to the level of emergency indicated (911 emergency transport vs. non-emergency transport.</p> <p>Review of facility policy Oxygen Administration, revised [DATE], indicates to verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.</p> <p>Review of Resident R158's clinical record revealed that he was admitted to facility on [DATE]. Resident R158 resided in a memory care unit and was admitted to emergency room for respiratory issues prior to admission to the facility. Continued review of Resident R158's clinical record revealed that the resident was admitted with the diagnoses of status post abscess incision and drainage of right posterior shoulder. He was started on antibiotics and admitted to facility for rehabilitative services. The resident had a past medical history of Alzheimer's disease (progressive degenerative disease of the brain), type 2 diabetes (failure of the body to produce insulin), and high blood pressure.</p> <p>Review of facility provide investigation report, completed [DATE], revealed that on [DATE], at approximately 3:00 p.m. Resident R158's spouse expressed concern to nursing staff about R158's breathing status. Review of statement from day shift licensed nurse, who was assigned to care for Resident R158 on [DATE], Employee E13, stated On Thursday [DATE] at approximately 1537 (3:37 p.m.) as I was on my way out of unit I overheard pt's (patient) spouse telling charge nurse that her husband was not breathing well, I turned around and asked charge nurse to go and assess pt's lungs, obtain VS (vital signs) and call MD (physician), and I left unit.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with licensed nurse, Employee E4, who was assigned to care for Resident R158 on evening shift (, d+[DATE] shift) on [DATE], revealed that Resident R158's spouse approached her during shift report and she continued to focus on taking report because she did not know who that woman was. Further during interview with Employee E4 revealed that at approximately 7:00 p.m., she went to assess the resident whose pulse oximeter (SpO2) reading was between 60% and 70%. At that point, Employee E4 administered 2L (liters) of oxygen and then increased it to 5L of oxygen which resulted in between 80% and 85% SpO2. Employee E4 stated that she contacted physician on call and called non-emergency transport for transfer to medical center. Further interview with Employee E4 revealed that at approximately 8:10 p.m., the resident was picked up by non-emergent transportation and coded (cardiac arrest) on the facility's parking lot at which point, the non-emergent transportation staff called 911 (Medical Emergency Services). The Resident expired at 9:47 p.m., and was taken back to facility.</p> <p>Interview with Nursing Supervisor, Employee E5, who was assigned to work on the medication cart on the evening shift of [DATE], revealed that at approximately 6:40 p.m., she was approached by Employee E4 who reported that a resident on her unit was having respiratory distress in a non-emergent manner. Employee E5 went to see Resident R158 and stated she could hear the resident's heavy breathing upon approaching resident's room and observed Resident R158 using accessory muscles. Nursing Supervisor, Employee E5 instructed Licensed nurse, Employee E4 to administer oxygen and call the physician. Nursing Supervisor, Employee E5 also confirmed that non-emergency staff called 911 when Resident R158 coded on the parking lot. Further interview with Employee E5 revealed that she spoke with resident's spouse the following day who reported that during day shift on [DATE] she expressed concern about her husband's breathing issues to four nurses and that no one went to see him. Nursing Supervisor, Employee E5 stated that Licensed nurse, Employee E4 worked as a supervisor at times and she expected this nurse to know when to call 911.</p> <p>Interview with facility's Director of Nursing, Employee E2, on [DATE], at approximately 11:45 a.m. revealed that the physician who was on call on [DATE] evening shift returned call at 7:38 p.m In the meantime the resident remained at facility, emergency services were not contacted until physician called back, at which point, Licensed nurse, Employee E4 contacted non-emergency transportation.</p> <p>Review of Resident R158's nursing notes, completed by Licensed nurse, Employee E4, dated [DATE], at 6:21 p.m. noted that Resident R158 is very tense and shaking</p> <p>Review of nursing note dated [DATE], at 8:10 p.m. completed by Nursing Supervisor, Employee E5, revealed that Resident R158's charge nurse report a change of condition. This nurse went to assess resident and noted resident was labor breathing on auscultation scattered crackles heard. HOB (head of the bed) elevated, POX 91% on room air. 2L of O2 (oxygen) administered via nasal cannula. MD was called upon returning the call MD give order to send resident to ED for eval. This nurse prints necessary paperwork and give it to charge nurse.</p> <p>Continued review of nursing notes dated [DATE], at 10:12 p.m. completed by Nursing Supervisor, Employee E5, revealed that charge nurse (Employee E4) called this nurse to inform her transport return to the building with resident's body. This nurse went up to the unit and observed resident on the stretcher body totally covered and was told resident coded in the (non-emergency transportation) ambulance, (emergency transportation) rescue assisted with CPR (cardio pulmonary resuscitation) and doctor from (medical center) pronounced him deceased at 9:47 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of employee discipline report, completed on [DATE], regarding incident on [DATE] revealed that Licensed nurse, Employee E4 was disciplined for violating facility's Group 4 violations #1 - any deviations from a resident's course or treatment that creates the risk of, or results in serious or substantial harm to the resident.</p> <p>Based on above findings, an Immediate Jeopardy to the safety of Resident 158 was identified for the facility's failure to ensure that a resident with a change in condition received timely nursing assessment and timely transportation to the emergency room . An Immediate Jeopardy template (a document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator on [DATE], at 1:16 p.m.</p> <p>The facility initiated a plan of correction to address the failure of ensuring that a resident received timely emergency services. Facility plan of correction included the following:</p> <ol style="list-style-type: none"> 1. Current residing resident's at facility were assessed for change in condition and physician notified in timely manner with appropriate interventions initiated if indicated. 2. Facility initiated a comprehensive Quality Assurance/Performance Improvement Plan to ensure that residents in the facility who experience change in condition are immediately assessed with appropriate and timely physician notification, and to ensure that physician ordered interventions are immediately initiated with appropriate use of emergency transport services in accordance with professional standards of practice. 3. Facility conducted audits of emergency transfers starting on [DATE], which remain ongoing to ensure that the change in condition was appropriately identified and assessed with physician notification and the appropriate emergency transfer services were utilized in a timely manner with continuous monitoring of the resident until such time. 4. Facility policy regarding a resident's change in condition was revised on [DATE], to include when emergency services (911) vs private ambulance services for emergencies should be utilized, ensuring that physician orders for transfers are clarified with the preferred method of transportation for transfer, and that the resident is continuously monitored for nay additional changes in condition until emergency transport has arrived with appropriate updates on changes to the physician as necessary. 5. Facility licensed nurse received education on [DATE], with 100% completion to be done by [DATE], from director of nursing/designee on ensuring timely identification of a resident's change in condition, timely and appropriate physician notification , timely implementation of physician ordered interventions, identifying when it is appropriate to utilize 911 emergency services vs private emergency services, ensuring that physician orders for transfers are clarified with the preferred method of transportation for transfer, and that the resident is continuously monitored for any additional changes in condition until emergency transport has arrived with appropriate updates on changes to the physician as necessary. 6. The nurses involved in this incident were immediately educated and disciplined. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>7. The QAPI committee will continue to meet to identify root causes, and to initiate improvements to the facility's process and procedures relate to timely identification of a resident's change in condition, timely and appropriate physician notification, timely implementation of physician ordered interventions and identifying when it is appropriate to utilize 911 emergency services vs private emergency services, ensuring that physician orders for transfers are clarified with the preferred method of transportation for transfers, and that the resident is continuously monitored for any additional changes in condition until emergency transport has arrived with appropriate updates on changes to the physician as necessary. Audits will occur weekly x 4 weeks, bi-weekly x 2 months, then monthly x 2 months to ensure the facility remains in compliance.</p> <p>Review of facility documentation revealed that the corrective action plan was immediately developed and initiated on [DATE]. Audits were initiated to assess residents and facility updated their policy. In-service training provided for nursing staff.</p> <p>Interviews were conducted with nursing staff from First floor and Second floor nursing units and nursing staff reported that they received in-service training on protocol for residents change in status. It was confirmed during interview that they were able to recognize importance of timely assessments, signs of respiratory distress which requires emergency services and timely notification of 911 services.</p> <p>The immediate jeopardy was lifted on [DATE], at 4:36 p.m</p> <p>28 Pa Code 211.12(c) Nursing Services</p> <p>28 Pa Code 211.12(d)(1)(2)(3)(5)Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>41471</p> <p>Based on the review of clinical records and interviews with staff, it was determined that the facility failed to ensure that pain management was provided consistent with physician orders for one of one resident reviewed for pain management. (Resident R98)</p> <p>Findings include:</p> <p>Interview with Resident R98 on July 10, 2024, at 9:53 a.m. revealed that she was not receiving pain medication as ordered. She stated when she was not receiving pain medication when her pain level was 10 of a scale of 10. It also affected her activities and sleep. She stated did not receive her morphine sulfate pain medication for over 48 hours. Resident stated she has pain to lower back, right leg, and left leg pain radiates down to the foot.</p> <p>Review of physician orders for Resident R98 for July 2024, revealed orders for the following pain medications: Lyrica 150 milligrams (mg) every 12 hour for chronic pain; Morphine sulfate 15 mg every 8 hour for chronic pain; and Oxycodone 10 mg every 6 hour for chronic pain.</p> <p>Review of Medication Administration Record for the month of July 2024 revealed that on July 8, 2024, at 9:00 a.m. resident did not receive Lyrica as ordered by the physician.</p> <p>Review of Medication Administration Record for the month of July 2024 revealed that resident did not receive Morphine Sulfate as ordered by the physician on July 2, 2024, at 10:00 p.m. July 3, 2024 at 2:00 p.m., July 6, 2024 at 2 p.m. and 10:00 p.m., July 7 at 6:00 a.m., July 8 at 6:00 a.m., 2:00 p.m. and 10 p.m.</p> <p>Review of Medication Administration Record for the month of July 2024 revealed that resident did not receive Oxycodone as ordered by the physician on July 7, 2024 at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 pm, July 8, 2024 at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 pm, July 9:00 at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m., July 10, 2024 at 6:00 p.m., and July 11, 2024 at 6:00 a.m.</p> <p>Review of clinical record revealed that medication was not available to be administered.</p> <p>Interview with the Assistant Director of Nursing on July 11, 2024, at 12:14 p.m., confirmed that Resident R98 did not receive pain medication as ordered by the physician. Assistant Director of Nursing stated facility had issues with pharmacy services as medications were not delivered in a timely manner.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) (5)Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to conduct accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage, failed to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for one of two residents (Residents R97).</p> <p>Findings include:</p> <p>A review of Resident R97's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis, including altered mental status dementia and dehydration.</p> <p>Review of care plan for Resident R97 dated July 21, 2024, revealed that the resident had impaired cognitive function/ dementia or impaired thought process.</p> <p>During an observation on 7/10/24, at 11:26 a.m. there were bilateral upper side rails on Resident R97's bed.</p> <p>Review of a side rail/entrapment risk evaluation for Resident R97 dated June 21, 2024 revealed that the resident was using the side rail for support or positioning and the resident wanted the siderails raised. Intervention was documented as the resident wanted side rails raised. Resident was using quarter side rail on both sides. Further review of the assessment under the entrapment risk which required clear documented reasoning revealed that resident was able to get out of bed unsupervised. Continued review of the risk of entrapment revealed a question if the resident have dementia, confusion, learning disability, agitation, unable to comprehend or distress staff documented no. However, this question was not answered accurately to identify the risk of resident's dementia and impaired thought process as indicated in the care plan.</p> <p>Continued review of the Resident R97's clinical record revealed no documented evidence that the resident/resident representative was informed of the risks and benefits of bed rails.</p> <p>Clinical record also contained no evidence that the facility obtained informed consent prior to the use of side rails.</p> <p>Interview with the Assistant Director of Nursing (ADON) on July 11, 2024, at 12:14 p.m., confirmed that Resident R97's bed rail evaluation was completed inaccurate, and the facility did not review the risks and benefits of bed rail with the resident/resident representatives. ADON also confirmed that there was no informed consent available from resident representative prior to the use of bed rail.</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12 (d) (1)(3)(5) Nursing services.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.10(c)(d) Resident care policies.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>41471</p> <p>Based on review of clinical records, review of facility's policy and staff interview, it was determined that the facility did not ensure that a drug regimen review was conducted at least monthly and did not ensure the attending physician's reviewed/responded to pharmacist's recommendations for one of five residents reviewed. (Resident R13)</p> <p>Findings include:</p> <p>Review of facility's policy medication regimen reviews, revealed that the consultant pharmacist performs a medication regimen review (MMR) for every resident in the facility receiving medication, and MRR's are done upon admission and at least monthly thereafter, or more frequently if indicated. Reviews for short-stay individuals are done upon admission and as needed to identify individuals with potential medication-related issues and for those who may be experiencing adverse consequences from their medications.</p> <p>Review of Resident R13's clinical records revealed no evidence of medication regimen review completed upon admission since June 8, 2024. Facility unable to provide evidence of MRR completion upon request.</p> <p>Review of Resident R9's medication regimen review, unknown date, completed by consultant pharmacist - employee E16, revealed that Resident R9 was requested to be evaluated for continued use of Pantoprazole 40mg daily, with reference note: increased risk of fractures with long-term use of proton pump inhibitors (PPI) FDA requirement for PPI use includes a warning about this possibility. Prolonged treatment may lead to Vitamin B12 malabsorption and hypomagnesemia. The use of PPI may increase the risk of CDAD (clostridium difficile-associated diarrhea.)</p> <p>Further review of MRR revealed no evidence of physician acknowledgement/response.</p> <p>28 Pa. Code 211.9(k)Pharmacy services</p> <p>28 Pa. Code 211.12(d)(3)Nursing services</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>41471</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that laboratory study results were promptly obtained as ordered by the physician for one of 13 clinical records reviewed (Resident R94).</p> <p>Findings include:</p> <p>Interview with Resident R94's daughter on June 9, 2024 at 1:07 p.m. stated resident was more confused and fell 2 days ago. Daughter stated she was concerned that the resident might be anemic, and she requested blood work on Sunday. Daughter stated the blood was collected on Monday morning and still don't have the result.</p> <p>Review of Resident R94's physician progress note dated July 8, 2024 revealed that resident was anemic and monitor H&H (also known as a hemoglobin and hematocrit test, provides information about the blood's oxygen-carrying capacity)</p> <p>Review of physician order dated July 5, 2024 revealed an order to complete blood work CBC (complete blood count), CMP (complete metabolic panel) and Magnesium on July 8, 2024.</p> <p>Interview with Licensed Practical Nurse, Employee E18 on June 9, 2024 at 1:25 p.m. stated facility did not have blood test results for Resident R94 which was collected on July 8, 2024.</p> <p>On July 10, 2024, review of Resident R94's laboratory result was completed which revealed that the blood was collected on June 8, 2024, at 6:54 a.m., result was reported on July 8, 2024 at 10:51 p.m.</p> <p>Further review of the lab result revealed that hemoglobin was low at 7.4 (normal range 11.3 to 15.7), BUN (Blood Urea Nitrogen-kidney function indicator often indicates dehydration)) 50 normal range 9-23.</p> <p>Review of clinical record revealed no evidence that the facility notified Resident R94's abnormal result to the physician until July 9, 2024 at 2:00 p.m.</p> <p>Interview with the Assistant Director of Nursing (ADON) on July 11, 2024, at 12:14 p.m., stated facility had issue with lab result getting in a timely manner. Facility should receive the lab results on the same day when it was collected.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p> <p>28 Pa. Coded 211.12(d)(5) Nursing services</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41471</p> <p>Based on review of facility policy, observations, and interviews with staff, it was determined that the facility did not ensure that food was stored and served in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of undated facility policy titled, Food Storage indicated that Food is stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination. Freezer temperature: temperature of for freezer should be 0 degrees or below and must be recorded daily</p> <p>An initial tour of the Food Service Department conducted on July 9, 2024, at 9:52 a.m. with Employee E19, Food Service Manager, revealed the following:</p> <p>Observations of the refrigerator inside the kitchen contained hot dogs buns with use by date of June 29, 2024,</p> <p>Inside the refrigerator there was a vegetable tray with no date</p> <p>A tray of cake with no date.</p> <p>A tray of Fresh fruit cup with use by date of July 8, 2024.</p> <p>Lettuce with use by date of July 8, 2024.</p> <p>Observation of the walk-in refrigerator revealed that the door was not completely closed. The temperature read 24-degree Fahrenheit.</p> <p>Employee E19 stated facility received delivery in the morning and the delivery staff left the freezer door opened which caused the high temperature.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.6 (f) Dietary Services</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>41471</p> <p>Based on observations and interviews with staff, it was determined that the facility failed to ensure that garbage was disposed of properly.</p> <p>Findings include:</p> <p>Observation in the receiving area and the garbage disposal area on July 9, 2024, at 10:30 a.m. with Employee E19, Food Service Manager, revealed one dumpster with the lid open revealing contents. There was brown colored liquid leaking from one dumpster, the leak created a stagnant brown colored liquid outside the dumpster on the floor. There were flies observed around the liquid.</p> <p>A follow up observation with regional dietary staff, Employee E19, on June 10, 2024, at 1:55 p.m. revealed the brown colored liquid was still present next to the dumpster and there was trash from the kitchen on the floor next to the dumpster.</p> <p>29 Pa. Code 201.18 (b)(1) Management</p>

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>41471</p> <p>Review of facility documentation, state legislation, and interview with staff, it was determined that the facility failed to conduct a review of reportable infection to PA-PASR and report as indicated for two of six months reviewed. (May 2024 and June 2024)</p> <p>Findings Include:</p> <p>Review of act 52 of 2007 Medical Care Availability and Reduction of Error (MCARE) act chapter 4. Health care-associated infections 40 p.s. S 1303.401 - 1303.411 (2007) revealed that S 1303.404. Health care facility reporting (a) NURSING HOME REPORTING. - In addition to reporting pursuant to The Health Care Facilities Act, a nursing home shall also electronically report health care-associated infection data to the department and the authority using nationally recognized standards based on CDC definitions, provided that the data is reported on a patient-specific basis in the form, with the time for reporting and format as determined by the department and the authority</p> <p>The Pennsylvania Patient Safety Authority developed the Pennsylvania Patient Safety Reporting System, known as PA-PSRS (pronounced PAY-sirs), a secure, web-based system that permits healthcare facilities to submit reports of what Act 13 of 2002, Act 30 of 2006 and Act 52 of 2007 defines as Serious Events and Incidents. More than 525 healthcare facilities are subject to Act 13 of 2002 and Act 30 of 2006 requirements. Over 700 nursing homes must report HAIs to the Authority and the Department of Health.</p> <p>Review of facility documentation from the month of May 2024 revealed that the facility had a total of 14 inhouse acquired infections (HAI-Hospital Acquired Infections).</p> <p>Review of facility documentation from the month of June 2024 revealed that the facility had a total of 5 inhouse acquired infections (HAI-Hospital Acquired Infections).</p> <p>Review of facility documentation revealed no evidence that the facility reported HAI's to PA-PASR as required or evaluate the infection to determine the infections met the criteria to be reported.</p> <p>Interview with Director of Nursing on July 11, 2024, at 11:16 a.m. confirmed that the facility did not review HAI infections to determine if the infections met the criteria and reported to PA-PASR as required.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on a review of clinical records, it was determined that the facility failed to ensure that elopement assessments was accurately completed for one of 13 residents reviewed (Resident R97)</p> <p>Findings include:</p> <p>A review of Resident R97's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis, including altered mental status dementia (progressive degenerative disease of the brain resulting in loss of reality function) and dehydration (lack of sufficient body fluid).</p> <p>Review of care plan for Resident R97 dated July 21, 2024, revealed that the resident had impaired cognitive function/ dementia or impaired thought process.</p> <p>Review of Resident R97's admission assessment dated [DATE] revealed an elopement assessment which was not completed accurately. For a question Predisposing Disease it was documented as none present. However, an instruction for predisposing condition included Dementia, Organic Brain Syndrome, Alzheimer's disease, Mental Illness and Traumatic Brain Injury. Resident was diagnosed with Dementia which was not included in the assessment. As a result of this response resident had a total assessment score of 8 (above 10 was considered at risk for elopement).</p> <p>Further review of the assessment revealed an instruction section which indicated Response of Ambulatory and Disoriented/intermittent confusion will score resident at risk for elopement. Resident was documented in assessment as ambulatory however impaired thought process or impaired cognitive function was not included in the assessment. It was documented was 0 to cognitive process which indicated responsive to redirection/cueing.</p> <p>Review of progress note for Resident R97 dated July 5, 2024, revealed that resident was noted with wandering behavior and exit seeking behavior.</p> <p>Review of a social service progress note dated July 8, 2024 revealed that the resident requested to go home.</p> <p>Observation of Resident R97 on July 9, 2024, and July 10, 2024, on second floor nursing unit revealed that the resident was ambulatory and was wandering in the unit.</p> <p>28 Pa. Code 211.5(f)(ix) Medical records</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on observations, review of facility policy and interview with staff, it was determined that facility did not ensure to maintain infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for three of 13 residents reviewed. (Resident R148, R147 and Resident R96)</p> <p>Findings include:</p> <p>Review of facility policy Enhanced Barrier Precautions (EBP) , revealed that EBP's are indicated for residents with any of the following: wounds or indwelling medical devices, regardless of : multidrug resistant organisms (MDRO's) colonization status; infection or colonization with an MDRO when contact precautions do not otherwise apply</p> <p>Effective implementation of EBP requires staff training on the proper use of personal protective equipment and the availability of PPE and hand hygiene supplies at the point of care.</p> <p>Review of facility policy Laundry, Bedding, Soiled, dated July 2009 revealed that Place contaminated laundry in a bag or container at the location where it is used</p> <p>During observation of medication administration on July 10, 2024, at 8:45 a.m., observed licensed nurse, employee E10, tend to both residents in room [ROOM NUMBER] on first floor unit - R148 and R147, wearing the same gown. Both residents, R148 and R147 were on EBP's.</p> <p>Observation of Resident R96's room on July 9, 2024, at 10:35 a.m., revealed that an aide was providing incontinence care with no gowns. There was a sign outside the resident door indicated that the resident was on Enhanced Barrier Precaution.</p> <p>Further observation of the second floor on July 9, 2024, at 10:40 a.m., revealed that a therapy staff was leaving the room with soiled linen in her hand without any bags or containers.</p> <p>This observation was confirmed by the Employee E21, Licensed Practical Nurse. on July 9, 2024, at 10:45 a. m. Employee E21 staff staff should bag used linen prior to transport or before taking it to the hall way</p> <p>28 Pa Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>41471</p> <p>Based on a review of facility documentation, facility policies and staff interviews, it was determined that the facility failed to maintain an effective antibiotic stewardship program that includes a system that includes antibiotic use protocols and a system to effectively monitor antibiotic usage for five of five months of antibiotic stewardship program data reviewed. (February 2024, March 2024, April 2024, May 2024 and June 2024).</p> <p>Findings Include:</p> <p>Review of facility policy Antibiotic Stewardship dated December 2016 , revealed that Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program.</p> <p>Further review of facility policy and protocol revealed that the facility policy did not include a system that includes antibiotic use protocols.</p> <p>A review of CDC (Centers for Disease Control and Prevention) guidelines, The core element of Antibiotic Stewardship for Nursing Homes, revealed that Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. 1. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.2 The Centers for Disease Control and Prevention (CDC) recommends that all acute care hospitals implement an antibiotic stewardship program (ASP) and outlined the seven core elements which are necessary for implementing successful ASPs.2 CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use.</p> <p>Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g., acceptance) may help determine whether feedback is effective in changing prescribing behaviors.</p> <p>Integrate the dispensing and consultant pharmacists into the clinical care team as key partners in supporting antibiotic stewardship in nursing homes. Pharmacists can provide assistance in ensuring antibiotics are ordered appropriately, reviewing culture data, and developing antibiotic monitoring and infection management guidance in collaboration with nursing and clinical leaders.</p> <p>Identify clinical situations which may be driving inappropriate courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians.</p> <p>Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions. Some antibiotic use measures (e.g., prevalence surveys) provide a snap-shot of information; while others, like nursing home initiated antibiotic starts and days of therapy (DOT) are calculated and tracked on an ongoing basis. Selecting which antibiotic use measure to track should be based on the type of practice intervention being implemented. Interventions designed to shorten the duration of antibiotic courses, or discontinue antibiotics based on post-prescription review (i.e., antibiotic time-out), may not necessarily change the rate of antibiotic starts, but would decrease the antibiotic DOT.</p> <p>Review of facility documentation from the month of February 2024 revealed that the facility had a total of 17 antibiotic orders. All 17 of those orders did not have any symptoms documented on the facility infection surveillance tool. It was also revealed that the surveillance tool did not contain a stop date, total days of therapy, outcome and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage.</p> <p>Review of facility documentation from the month of March 2024 revealed that the facility had a total of 15 antibiotic orders. All 15 of those orders did not have any symptoms documented on the facility infection surveillance tool. It was also revealed that the surveillance tool did not contain a stop date, total days of therapy, outcome and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage.</p> <p>Review of facility documentation from the month of April 2024 revealed that the facility had a total of 21 antibiotic orders. All 21 of those orders did not have any symptoms documented on the facility infection surveillance tool. It was also revealed that the surveillance tool did not contain, outcome and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage.</p> <p>Review of facility documentation from the month of May 2024 revealed that the facility had a total of 37 antibiotic orders. All 37 of those orders did not have any symptoms documented on the facility infection surveillance tool. It was also revealed that the surveillance tool did not contain, outcome and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage.</p> <p>Review of facility documentation from the month of June 2024 revealed that the facility had a total of 12 antibiotic orders. All 12 of those orders did not have any symptoms documented on the facility infection surveillance tool. It was also revealed that the surveillance tool did not contain, outcome and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage.</p> <p>Interview with Director of Nursing on July 11, 2024, at 11:16 a.m. confirmed the above finding.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>(continued on next page)</p>		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1)(5) Nursing services		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to offer and/or provide the pneumococcal immunization to five of five residents reviewed (Resident R11, R3, R96, R23 and R20).</p> <p>Findings include:</p> <p>Review of facility policy Pneumococcal vaccine dated October 2019 revealed that Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record.</p> <p>Review of Resident R11's immunization records revealed no evidence that the resident received the pneumococcal vaccine, or the facility offered the pneumococcal vaccine. Resident was [AGE] years old.</p> <p>Review of Resident R3's immunization records revealed no evidence that the resident received the pneumococcal vaccine, or the facility offered the pneumococcal vaccine. Resident was [AGE] years old.</p> <p>Review of Resident R20's immunization records revealed no evidence that the resident received the pneumococcal vaccine, or the facility offered the pneumococcal vaccine. Resident was [AGE] years old.</p> <p>Review of Resident R96's immunization records revealed no evidence that the resident received the pneumococcal vaccine, or the facility offered the pneumococcal vaccine. Resident was [AGE] years old.</p> <p>Review of Resident 23's immunization records revealed no evidence that the resident received the pneumococcal vaccine, or the facility offered the pneumococcal vaccine. Resident was [AGE] years old.</p> <p>Interview with the Assistant Director of Nursing on July 12, 2024, at 12:14 p.m., confirmed that, Resident R11, R3, R96, R23 and R20 did not receive pneumococcal vaccine, or the facility offered the pneumococcal vaccine.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee</p> <p>28 Pa Code: 211.12 (d)(1)(5) Nursing services</p>		

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 07/12/2024
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 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>46993</p> <p>Based on observations, review of clinical records, review of facility provided documentation and interview with staff and residents, it was determined that facility did not ensure to include as part of its Quality Assurance and Performance Improvement (QAPI) program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program for five of five employees reviewed (Employees E6, E7, E8, E9, and E10)</p> <p>Findings include:</p> <p>Review of Employee E7 and Employee E8's nurse aide personnel files revealed no evidence of training related to facility's QAPI program.</p> <p>Review of licensed nurse personnel files of Employee E6, Employee E9 and Employee E10 revealed no evidence of training provided regarding facility's QAPI program.</p> <p>Findings confirmed with facility's administrator on July 12, 2024.</p> <p>28 Pa Code 201.14(a)Responsibility of licensee</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 201.20(a)(c)Staff development</p>