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	05/01/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interview, it was determined that the facility failed to accurately update the State Survey Agency on the outcome of an investigation for one of two residents reviewed (Resident R56). Findings include: Review of Resident R56's clinical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of encephalopathy (condition that affects how the brain works, causing confusion, memory problems, or changes in behavior due to illness, injury, or toxins), asthma, and muscle weakness. Review of information submitted by the Department, dated February 16, 2026, revealed on February 16, 2026 Resident R56 asked to be taken to the bathroom. CNA took the resident into the bathroom. At the time resident was in her wheelchair. During the transfer, resident stated her legs were getting weak and resident was lowered to the floor by CNA. Review of facility investigation follow up submitted revealed an x-ray was completed and revealed the resident sustained a posterior dislocation of femoral head prosthesis. Further review revealed the facility reported that the resident was provided with the appropriate level of assistance for toilet transfers, and therefore the CNA was not neglectful. Review of Resident R56's care plan, dated February 12, 2026, revealed the resident requires assist of 2 during transfers using rolling walker for safety. Interview on April 49, 2026 at 10:00 a.m. with Physical Therapist, Employee E3, confirmed Resident R57 required an assist of 2 during transfers at the time when Resident R57 had his/her fall on February 16, 2026. Interview on April 29, 2026 at 12:05 p.m. with Administrator, Employee E1, confirmed Resident R57's transfer status was not accurately reported to the state agency. 28 Pa Code 201.18(b)(3) Management 28 PA. Code 211.12(c) Nursing services

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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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. Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to ensure safety interventions for falls were in place for one of three residents reviewed for falls (Resident R7).Findings include:Clinical record review revealed Resident R7 was admitted to the facility December 28, 2025 with a diagnosis of cerebral infarction (type of stroke that happens when blood flow to part of the brain is blocked, causing brain cells to be damaged or die), muscle weakness, and lack of coordination. Review of Resident R7's clinical record revealed an order, dated January 17, 2026, for floor mats to be down when the resident is in bed. Review of Resident R7's physician notes, dated April 10, 2026, revealed Resident R7 requires full assistance with ADLs. Maintain strict fall precautions and safety measures (e.g., fall mats).Observation on April 30, 2026 at approximately 09:30 a.m. revealed Resident R7 lying in bed and no floor mats in place Further observation on May 01, 2026 at approximately 8:40 a.m. revealed Resident R7 lying in bed with no floor mats in place. Interview on May 01, 2026 at 8:45 a.m. with Director of Nursing, Employee E2, confirmed no floor mats were in place while Resident R7 was lying in bed. 28 Pa. Code 211.10 (d) Resident Care Policies. 28 Pa. Code 211.12 (d)(5) Nursing Services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and interview with staff, it was determined the facility failed to ensure pain medication was administered in accordance with the physician's order for two of two residents reviewed for pain management. (Resident R20 and Resident R27)Findings Include:Review of Resident R20's clinical record revealed Resident R20 was admitted to the facility on [DATE] with a diagnosis of cirrhosis of liver (condition where the liver becomes scarred and damaged over time, making it harder for the liver to work properly), lack of coordination, and rheumatoid arthritis (long-term disease where the body's immune system attacks the joints, causing pain, swelling, stiffness, and sometimes joint damage). Review of Resident R20's clinical record revealed physician's order for Oxycodone 10 mg milligrams to be given every 6 hours as needed for severe pain for 14 days, pain scale 7-10. Review of Resident R20's April 2026 Medication Administration Record (MAR) revealed that the as needed pain medication Oxycodone 10 mg was administered out of the parameter ordered by the physician as follows:April 2, 2026- Pain level 4April 3, 2026- Pain level 4April 5, 2026- Pain level 0April 7, 2026- Pain level 5Review of Resident R27's clinical record revealed Resident R27 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe because airflow in and out of the lungs is blocked), type 2 diabetes mellitus (long-term condition where the body does not use insulin properly, causing high blood sugar levels), and chronic pain syndrome.Review of Resident R27's clinical record revealed physician's order for Roxicodone 15 mg milligrams to be given every 6 hours as needed for severe pain, pain scale 7-10. Review of Resident R27's April 2026 Medication Administration Record (MAR) revealed that the as needed pain medication Roxicodone 15 mg was administered out of the parameter ordered by the physician as follows:April 5, 2026- Pain level 0April 8, 2026- Pain level 3April 10, 2026- Pain level 3April 11, 2026- Pain level 4Interview on April 30, 2026, at 10:47 a.m. with Director of Nursing, Employee E2, confirmed Resident R20 and R27's pain medication was not administered in accordance with physician's order.28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and interview with staff , it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for two of two residents sampled for post-traumatic stress disorder (PTSD). (Resident R4 and R18).Findings include:Review of facility policy Trauma-Informed Care, no date, revealed the facility is committed to incorporating trauma-informed care practices into all aspects of its operations, recognizing the widespread impact of trauma and understanding pathways to recovery. Care will be provided in a manner that prevents re-traumatization and promotes healing and empowerment. Further review of facility policy revealed the facility will incorporate trauma screening into resident assessments to identify potential trauma histories and develop individualized care plans that account for trauma-related needs, preferences, and triggers.Review of Resident R4's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), post-traumatic stress disorder (PTSD) (a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal loss), and emphysema (lung disease where the tiny air sacs in the lungs become damaged, making it hard to breathe and get enough oxygen . Review of Resident R4's current care plan, dated July 07, 2025 , revealed the care plan did not address possible triggers that may cause re-traumatization.Review of Resident R18's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses of anemia (condition where your body does not have enough healthy red blood cells to carry oxygen properly, which can make you feel tired, weak, or short of breath) , post-traumatic stress disorder, and depression.Review of Resident R18's current care plan, dated October 24, 2025, revealed the care plan did not address possible triggers that may cause re-traumatization.Interview with the Director of Nursing, Employee E2, on April 30, 2026, at 10:45 a.m. confirmed Resident R4 and Resident R18's care plans did not include possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observations, review of clinical records, review of facility documentation and interviews with residents and staff, it was determined that the facility failed to ensure skilled competencies were completed for three of six nursing personnel files reviewed (Employee E5, Employee E6 and Employee E7). Findings include:Review of facility contract with Nursing Agency, dated February 19, 2024, revealed under Supervision and Safety of Professionals: As between the parties, client (facility) and not Nurse Agency, shall be soley responsible for supervising and ensuring the safety of professionals while they are present at any of the Client's facilities. Without limiting the generality of the foregoing. Client shall: (i) provide all necessary and appropriate training and orientation materials to professionals, including, as applicable, client's policies and procedures regarding injury and illness prevention, fire safety, administering medications, charting and recordkeeping, and patient rights. During an interview with Employee E4 on April 30, 2026 at 8:52 a.m., revealed that Resident R34 had received Oxycodone/ acetaminophen 5mg /325mg according to the individual narcotic record on April 29, 2026 at 8:00 p.m. and on April 30, 2026 at 02:30 a.m.; No documented evidence of medication administered according to Resident R34's Medication Administration Record (MAR).Further review of Resident R34's individual narcotic record and Medication Administration Record (MAR), revealed 18 incidents between the dates of April 8, 2026 and April 30, 2026 that resident R34's medication administration record does not reflect the individual narcotic record.Interview with Employee E2, Director of Nursing on April 30, 2026 at 12:30p.m. confirmed findings and stated Nurses are supposed to check both the Medication administration record and the individual narcotic log in case a mistake like this happens to confirm the last time the resident received the medication.Review of randomly selected agency nurse personnel files revealed that Employee E5, Registered Nurse, revealed that the Annual Nurse Competency Check form, dated October 29,2025 is signed only by Employee E5. Further review revealed that there was no documentation available to indicate if Employee E5 was evaluated for competency related to medication management.Review of randomly selected agency nurse personnel files revealed that Employee E6, Registered Nurse, revealed that the Annual Nurse Competency Check form, dated July 30, 2025, is signed only by Employee E6. Further review revealed that there was no documentation available to indicate if Employee E6 was evaluated for competency related to medication management.Review of randomly selected agency nurse personnel files revealed that Employee E7, Licensed Practical Nurse, revealed that the Annual Nurse Competency Check form, dated September 10, 2025, is signed only by Employee E7. Further review revealed that there was no documentation available to indicate if Employee E7 was evaluated for competency related to medication management.Interview on with Employee E2, Director of Nursing (DON) on May 1, 2026, at 1:00 p.m., revealed when agency staff comes to facility, they review a packet with the DON and sign off that they understand the policies, I only have one copy so they don't keep it, but we review it and they sign it. Confirmed no documentation available to indicate if medication management was evaluated or demonstrated to prove competency for Employee E5, Employee E6 or Employee E7.28 Pa. Code S 201.20 (6)(b) Staff Development.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with staff, and clinical record reviews, it was determined that the facility failed to ensure that clinical records were accurately documented for 4 of four residents reviewed. (Resident R20, Resident R27, Resident R34, Resident R61) Findings include:Review of facility policy titled, Administering Medication, revised April 2020, revealed As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route of administration; d. the injection site(if applicable); e. any complaints or symptoms for which the drug is administered; F. Any results achieved and when those results were observed; and g. the signature and title of the person administering the drug.Review of Resident R20's clinical record revealed resident was admitted to the facility on [DATE], with diagnosis of need for assistance with personal care, rheumatoid arthritis.Review of Resident R20's physician orders revealed order for Oxycodone 10mg 1 tablet by mouth every 6 hours as needed for pain.Comparison of Resident R20's Individual Narcotic Record and Medication Administration Record, between the dates of April 4, 2026, through April 30, 2026, revealed according to individual Narcotic Record resident R20 received the medication four times and there is no evidence of administration in the resident's medication administration record. Dates include the following:April 2, 2026, at 10:30 p.m.April 3, 2026, at 4:30 a.m.April 4, 2026, at 9:00 p.m.April 7, 2026, at 6:00 p.m.Review of Resident R27's clinical record revealed resident was admitted to the facility on [DATE], with diagnosis of pneumonia, chronic pain syndrome.Review of Resident R27's physician orders revealed order for Oxycodone 15mg tablet by mouth every 6 hours for severe pain 7-10Comparison of Resident R27's Individual Narcotic Record and Medication Administration Record, between the dates of April 5, 2026, through April 29, 2026, revealed according to individual Narcotic Record resident R27 received the medication fourteen times and there is no evidence of administration in the resident's medication administration record. Dates include the following:April 7, 2026, at 9:00 a.m.April 9, 2026, at 9:00 p.m.April 15, 2026, at 1:50 p.m.April 15, 2026, at 10:00 p.m.April 16, 2026, at 9:00 p.m.April 19, 2026, at 10:06 a.m.April 21, 2026, at 3:00 a.m.April 21, 2026, at 8:00 p.m.April 22, 2026, at 10:00 p.m.April 23, 2026, at 11:00 p.m.April 24, 2026, at 9:00 p.m.April 25, 2026, at 4:00 a.m.April 26, 2026, at 2:00 a.m.April 29, 2026, at 2:00 p.m.Review of Resident R34's clinical record revealed resident admitted to the facility on [DATE], with diagnosis of, Lack of coordination, muscle weakness.Review of Resident R34's physician orders revealed order for Oxycodone-Acetaminophen tablet 5-325mg give 1 tablet by mouth every 6 hours as needed for pain (5-10).Comparison of Resident R34's Individual Narcotic Record and Medication Administration Record, between the dates of April 8, 2026, through April 30, 2026, revealed according to individual Narcotic Record resident R34 received the medication eighteen times and there is no evidence of administration in the resident's medication administration record. Dates include the following:April 12, 2026, at 12:10 a.m.April 12, 2026, at 06:32 a.m.April 13, 2026, at 1:10 a.m.April 13, 2026, at 2:45 a.m.April 15, 2026, at 1:00 p.m.April 16, 2026, at 10:30 a.m.April 16, 2026, at 05:00 a.m.April 22, 2026, at 12:30 a.m.April 22, 2026, at 2:30 a.m.April 23, 2026, at 6:30 a.m.April 23, 2026, at 1:30 p.m.April 25, 2026, at 4:30 p.m.April 27, 2026, at 4:45 p.m.April 28, 2026, at 5:00 p.m.April 29, 2026, at 8:00 p.m.April 30, 2026, at 4:30 a.m.Interview with Employee E2, Director of Nursing on April 30, 2026 at 12:30p.m. confirmed findings and stated Nurses are supposed to check both the Medication administration record and the individual narcotic log in case a mistake like this happens to confirm the last time the resident received the medication.Review of Resident R61's clinical record revealed resident was admitted to the facility on [DATE], with diagnosis of Chronic kidney disease.Review of Resident R61's hospital discharge records, dated October 24, 2025, revealed a current medication order for Gabapentin 100mg capsule, give 200 mg by mouth 3 times a dayReview of Resident R61's clinical (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record revealed that resident was ordered for Gabapentin capsule 100mg, give 2 capsule by mouth one time a day for neuropathy.Interview with Employee E2, Director of Nursing on April 28, 2026 at 12:00 p.m., confirmed the medication was transcribed incorrectly from the discharge records. 28 PA. Code 211.10 (d) Resident care policies