LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 8/25/2025 FORM APPROVED 2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) NAME OF PROVIDER OR SUPPLIER: HOLLAND CENTER FOR REHABILITATION AND NURSING STATE LICENSE NUMBER: 071202		STREET ADDRESS,	(X2) MULTIPLE CONSTRUCTION: A. BLDG: _=_ B. WING: DRESS, CITY, STATE, ZIP CODE: DLE HOLLAND ROAD ND, PA 18966		EY	
(X4) ID SUMMARY STATEMEI PREFIX MUST BE PRECEE TAG IDEN		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
Based on a Revisit to Survey completed on determined that Holla and Nursing had no co	Based on a Revisit to an Emergency Prepared Survey completed on May 28, 2025, it was determined that Holland Center for Rehabilita and Nursing had no deficiencies as related to trequirements of 42 CFR 483.73.		E 0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE:

(X6) DATE:

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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Certified End Page

HOLLAND CENTER FOR REHABILITATION AND NURSING

STATE LICENSE NUMBER: 071202 SURVEY EXIT DATE: 07/16/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi

Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP Secretary of Health

Debia L. Bogu MD



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

PRINTED: 8/25/2025 FORM APPROVED 2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 395432			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/16/2025		
HOLLAND NURSING	VIDER OR SUPPLIER: O CENTER FOR REHABIL		STREET ADDRESS, 280 MIDDLE 1 HOLLAND, PA	HOLLAND			
STATE LICENSE NUMBER: 071202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D			PICIPNOV	II.			OVE)
PREFIX MUST BE PRECEEDED BY FULL REGULATORY C TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
K 0000	INITIAL COMMENT			K 0000			
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	_

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395432		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/16/2025	
HOLLANI NURSING	VIDER OR SUPPLIER: O CENTER FOR REHABII E NUMBER: 071202	LITATION AND	STREET ADDRESS, 280 MIDDLE HOLLAND, P	HOLLAND			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D FIX MUST BE PRECEEDED BY FULL REGULATORY (ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
K 0000	Facility ID# 071202 Component 01 Health Care Building Based on a Revisit to a Recertification Survey it was determined that Rehabilitation And Nu compliance with the for Life Safety Code for at occupancy. Compliance Protection Association required by 42 CFR 48 This is a three-story, T building, that is fully s	completed on May a Holland Center For rsing was not in substituting was not in substituting Regular and Example 1. The National and St. 1. Safety Code is 1.	stantial ts of the ealth care Fire	K 0000			
K 0131 SS=E				K 0131			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIE IDENTIFICATION NUMB					(X3) DATE SURVEY COMPLETED:		
		395432		B. WING:			
HOLLANI NURSING STATE LICENS	VIDER OR SUPPLIER: O CENTER FOR REHABII E NUMBER: 071202		STREET ADDRESS, 280 MIDDLE HOLLAND, P	HOLLAND A 18966			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
K 0131 SS=E	NFPA 101 Multiple Occupa Multiple Occupancies - Sec Sections of health care facil occupancies meet all of the o They are not intended to for purposes of housing, tree o They are separated from occupancies by construction having a mi rating in accordance with Chapter o The entire building is pro approved, supervised automatic sprinkler syste 9.7. Hospital outpatient surgical classified as an Ambulatory regardless of the number of 19.1.3.3, 42 CFR 482.41, 42 This REQUIREMENT is no	tions of Health Care Facities classified as other following: serve four or more inparatment, or customary acareas of health care nimum two hour fire research throughout by around in accordance with Secondary acareas are required the secondary acareas of health Care Occupancy patients served.	tients cess. sistance n ection	K 0131	The fire door with penetration been replaced. Other fire doors in the center checked to ensure that they a of penetrations. The Maintenance Director and designee will perform audits for four weeks and monthly months to ensure that the fire are free from penetrations. If of the audits will be reported QAPI.	r will be are free and/or weekly, for two e doors Results	Completion Date: 08/07/2025 Status: APPROVED Date: 08/08/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIEF IDENTIFICATION NUMBER (XI) PROVIDER/SUPPLIEF			A. BLDG: _		(X3) DATE SURVEY COMPLETED:		
		395432		B. WING: _		07/16/2025	
HOLLAND NURSING	VIDER OR SUPPLIER: OCENTER FOR REHABIL E NUMBER: 071202	ITATION AND	280 MIDDLE HOLLAND, P	HOLLAND			
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	TION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE DATE
K 0131	Continued from page 3			K 0131			
SS=E							
	Based on observation a	•					
	determined the facility						
	fire separations mainta		erating				
	affecting one of three le	evels.					
	Findings include:						
	Observation made on M	May 28, 2025, from	11:40				
	a.m. to 11:50 a.m. reve	•					
	deficiencies at the follo	owing locations:					
	a. 11:40 a.m., double fi						
	penetrations on door le	•					
	the metal door frame, i	•	vator				
	Lobby leading to laund	-					
	b. 11:50 a.m., fire door	•					
	extensive damage at ea		n the				
	basement, Elevator Lol	bby, Dry Storage.					
	Exit interview with the	Administrator and					
	Maintenance Director	on May 28, 2025, at	2:30				
	p.m., confirmed the fire	e door deficiencies.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			` ´ ´		COMPLETED:	
		395432			<u>VI.</u>	07/16/2025	
HOLLAND NURSING	VIDER OR SUPPLIER: OCENTER FOR REHABII	LITATION AND	STREET ADDRESS, 280 MIDDLE HOLLAND, P	HOLLAND			
STATE LICENS (X4) ID	E NUMBER: 071202 SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTI	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	COMPLETE DATE	
K 0131	Continued from page 4		K 0131				
SS=E	****** ****	*********	****				
	Based on an Onsite Re 2025, the following wa		uly 16,				
	Item b was not completed. The fire door w penetrations and extensive damage at each location, in the basement, Elevator Lobby, Storage.						
	Exit interview with the Maintenance Director a.m., confirmed the fire	on July 16, 2025, at					
	All other deficiencies l corrected.	isted under this tag	were				

CMS-2567L UXGG22 IF CONTINUATION SHEET Page 5 of 11

	OF DEFICIENCIES AND RECTION (POC)	identification number 395432		A. BLDG: _	01	COMPLETED: 07/16/2025	EY
HOLLANI NURSING	VIDER OR SUPPLIER: O CENTER FOR REHABII SE NUMBER: 071202	LITATION AND	STREET ADDRESS, 280 MIDDLE HOLLAND, P	HOLLAND			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		OULD BE	(X5) COMPLETE DATE
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:		K 0345	repaired so that it is not in tromode. 2) The facility will call our f protection company to repair panel should go into trouble 3)The Maintenance Director designee will perform audits for four weeks and monthly months to ensure that the fire	The facility will call our fire otection company to repair if the mel should go into trouble mode. The Maintenance Director and/or esignee will perform audits weekly, or four weeks and monthly for two onths to ensure that the fire panels e not in trouble. Results of the		

CMS-2567L UXGG22 IF CONTINUATION SHEET Page 6 of 11

	ATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE AN OF CORRECTION (POC) IDENTIFICATION NUMB			A. BLDG:01 B. WING:		(X3) DATE SURVEY COMPLETED:	
		395432		B. WING		07/16/2025	
HOLLAND NURSING	VIDER OR SUPPLIER: O CENTER FOR REHABIL E NUMBER: 071202	LITATION AND	280 MIDDLE HOLLAND, P	HOLLAND			
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE DATE
K 0345	Continued from page 6			K 0345			
SS=F							
	Based on observation r		-				
	determined the facility alarm system in proper						
	the entire facility.	operating condition	i, affecting				
	Findings Include:						
	1. Observation on May	28, 2025, at 1:45 p.	.m.,				
	revealed the facility fir	e alarm panel was ir	n trouble				
	mode at the time of sur	vey, front lobby off	ice area.				
	Exit interview with the	Administrator and					
	Maintenance Director	on May 28, 2025, at	2:30				
	p.m., confirmed the fire	e alarm panel troubl	e mode.				
	**************************************		****				
	Based on an Onsite Re	visit conducted on J	uly 16,				
	2025, the following wa	s determined:					
	Item 1 was not comple was in trouble mode at		-				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION: A. BLDG:01		(X3) DATE SURVEY COMPLETED:		
		395432				07/16/2025	
HOLLAND NURSING	VIDER OR SUPPLIER: O CENTER FOR REHABIL	LITATION AND	STREET ADDRESS, 280 MIDDLE HOLLAND, P	HOLLAND			
STATE LICENSE NUMBER: 071202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPREFIX MUST BE PRECEEDED BY FULL REGULATORY)				ID PREFIX TAC	PROVIDER'S PLAN OF CORRE		(X5) COMPLETE
PREFIX TAG		FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		DATE
K 0345	Continued from page 7			K 0345			
SS=F							
	Exit interview with the		0.45				
	Maintenance Director of a.m., confirmed that fin						
	mode.	re didini paner was n	ir trouble				
K 0911				K 0911			
SS=E							

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	INT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIES CORRECTION (POC) IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION: A. BLDG: _01		(X3) DATE SURVEY COMPLETED:	
		395432				07/16/2025	
HOLLANI NURSING	VIDER OR SUPPLIER: O CENTER FOR REHABII JE NUMBER: 071202	LITATION AND	STREET ADDRESS, 280 MIDDLE HOLLAND, F	HOLLAND			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
K 0911 SS=E	Continued from page 8 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:		sed by ation, A	к 0911	1) The electrical panel labele has been repaired so that it c and be easily opened. Storage has been removed fr front of electrical panel DP 2 DP4. 2) Other electrical panels has checked to ensure that there storage and that the latch car adn be easily opened. 3) The Maintenance Director designee will perform audits for four weeks and monthly months to ensure that the ele panels can latch and easily o and that there is no storage withree feet of the panels. Res the audits will be reported to	an latch com in 2 and ave been is no n close r and/or weekly, for two ectrical pen, within ults of	Completion Date: 08/07/2025 Status: APPROVED Date: 08/08/2025

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PLAN OF CORRECTION (POC) IDENTIFICATION NUMB		(XI) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER 395432		A. BLDG: _	_OI	(X3) DATE SURVEY COMPLETED: 07/16/2025	
HOLLAND NURSING	VIDER OR SUPPLIER: O CENTER FOR REHABII E NUMBER: 071202	LITATION AND	STREET ADDRESS, 280 MIDDLE HOLLAND, P	HOLLAND			
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
K 0911 SS=E	Based on observation a determined that the face protection of electrical levels. Findings include: 1. Observation on May revealed an open junct located in the basement 2. Observation made of p.m, revealed electric Room across from the Office: a. Two electrical panel being blocked by stora b. One electrical panel latch and could not be Exit interview with the Maintenance Director of the determined of the protector of the protection of t	viring, affecting on 28, 2025, at 12:14 pion box with expose t phone room. In May 28, 2025, at 1 al deficiencies at the Health Care Administrator and easily opened.	p.m., d wiring 12:50 e Storage istrators OP 4 broken	K 0911			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395432		B. WING: _		07/16/2025	
NAME OF PROVIDER OR SUPPLIER: HOLLAND CENTER FOR REHABILITATION AND NURSING STATE LICENSE NUMBER: 071202		STREET ADDRESS, 280 MIDDLE HOLLAND, P	HOLLAND				
STATE LICENS (X4) ID		OF DEFICIENCIES (EACH DE	EICIENCV	ID	PROVIDENCE N. AN OF CORRE	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF		PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
K 0911	Continued from page 10		K 0911				
SS=E							
	p.m., confirmed the ele	ectrical deficiencies.					
	**************************************	****					
	Based on an Onsite Revisit conducted on 2025, the following was determined:						
	Item 2 b was not comp labeled DP 4 had a mis		-				
	Exit interview with the Maintenance Director of a.m., confirmed the eleproperly.	on July 16, 2025, at					
	All other deficiencies l corrected.	isted under this tag v	were				

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Certified End Page

HOLLAND CENTER FOR REHABILITATION AND NURSING

STATE LICENSE NUMBER: 071202 SURVEY EXIT DATE: 07/16/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

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