Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

July 6, 2026

[redacted]
TWINING RETIREMENT COMMUNITY LLC
[redacted]

RE: HOLLAND SENIOR LIVING COMMUNITY
1400 OLD JORDAN ROAD
HOLLAND, PA, 18966
LICENSE/COC#: 14657

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HOLLAND SENIOR LIVING COMMUNITY* **License #**: *14657* **License Expiration**: *08/30/2026*

Address: *1400 OLD JORDAN ROAD, HOLLAND, PA 18966*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *TWINING RETIREMENT COMMUNITY LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Incident* **Exit Conference Date**: *05/21/2026*

Inspection Dates and Department Representative

05/21/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *152* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care unit* **Capacity**: *27* **Residents Served**: *13*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *27* **Have Physical Disability**: *1*

Inspections / Reviews

05/21/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/20/2026*

06/22/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2026*

Inspections / Reviews *(continued)*

06/25/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/05/2026*

07/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted], at 9:13am, an agent of the Department requested access to the staff training file from staff person A. Staff person B, stated at approximately 1:00pm that the staff person that has the staff training was not responding. The staff training file for the staff person requested was not provided during the inspection.

Plan of Correction ***Accept [redacted] - 06/25/2026)***

Issue: Ancillary Training files were not available upon request by the DHS surveyor due to Director being out of the building. It was unknown where the files were kept for training.
Action: Immediately contacted Director of Community Life for all records of employees reporting to that position that participate in personal care home residents needs. Director stated [redacted] doesn't hold records of employees.
Plan: Administrator to hold all training paperwork copies as completed by directors with staff. Initial files are being copied by Human Resources and will be completed by 7/1/26. Inservice was attached in sep email. Please see attached for inservice of education to have all PC files copied for administrator.
Sustain: Audit by Admin or designee every 6 months to ensure training is completed by the Directors as attached.

Licensee's Proposed Overall Completion Date: *06/22/2026*

Implemented ([redacted] - 07/06/2026)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at approximately 11:15am, resident [redacted] fell out of their wheelchair while being transported to a physician appointment sustaining a broken nose and laceration to their left eyebrow. According to the driver, staff C, when the van stopped at a stop sign, the driver observed the resident on the floor of the van, noting an injury to the residents' nose and eyebrow. Some first aid was provided by staff C, who has no current certified first aid training. The resident does not recall having an over the shoulder strap initially or at any time that would have prevented the fall during the transportation event. Following the incident, upon arrival to meet the resident's family they reported the resident only had a lap belt for securing the wheelchair during the transport and no over shoulder strap to prevent falling out of the wheelchair. In addition, they also reported the resident's shirt was covered in blood.

Plan of Correction ***Accept [redacted] - 06/25/2026)***

Issue: Resident had a fall from [redacted] wheelchair while being transported in the bus suffering injury. Proper protocol was not followed.
Action: Staff member was inserviced by Admin with proper protocol including if a fall occurs to contact facility and take to Emergency Department. See attached. Plan: All drivers will be inserviced by Admin on protocol and

42b - Abuse (continued)

procedures by 6/25/26. Staff meetings will be conducted monthly by Admin or designee discussing situations of abuse / neglect during staff meetings. See attached.
Sustain: Audit by Admin or designee every 6 months to ensure training is compliant for all nursing staff. See attached. Additionally attaching the actual training that will be discussed during monthly staff meetings. Inservice sheets will reflect this.

Licensee's Proposed Overall Completion Date: *06/22/2026*

Implemented [redacted] 07/06/2026)

63d - Certified CPR Staff

4. Requirements

2600.
63.d. A staff person who is trained in fir[redacted]aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with [redacted] training, unless the resident has a do not resuscitate order.

Description of Violation

On [redacted],, resident [redacted] suffered an injury due to falling out of the wheelchair while being transported in the transportation bus. Staff person C was present and on duty at the time and provided first aid assistance to the resident without having a valid first aid certificate of training.

Plan of Correction ***Accept ([redacted] 06/22/2026)***

Issue: First aid administered by a staff member that does not have a current certificate for first aid.
Action: Have a certified staff member on the bus during trips until the drivers are certified.
Plan: Admin inserviced the drivers on first aid and CPR certifications if they would need to administer AFTER receiving their certification. All new drivers will need to be CPR / FIrst Aid certified. Contacted Heartsaver to put on schedule.
Sustain: Audit by Admin or designee every 6 months to ensure training is compliant for all nursing staff. See attached.

Licensee's Proposed Overall Completion Date: *06/18/2026*

Implemented [redacted] - 07/06/2026)

65g - Annual Training Content

5. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

65g Annual Training Content *(continued)*

6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training in the following during training year 2025:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights.*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).*
- *Falls and accident prevention.*
- *New population groups that are being served at the home that were not previously served, if applicable.*

Repeated Violation [redacted], et al.

Plan of Correction ***Accept [redacted] - 06/25/2026)***

Issue: Annual training documentation for Staff member C was not found.
Action: Annual training by Admin for Staff member C was immediately completed on 5/19/26.
Plan: Annual training for all ancillary staff under Community Life Wellness Director completed by Admin on 5/20/26.The Director of Community Life and Transportation or designee will ensure the annual training is completed by 6/22/26 as placed on schedule.
Sustain: Audit by Admin or designee every 6 months to ensure training is compliant for all Community Life staff. See attached.

Licensee's Proposed Overall Completion Date: *06/22/2026*

Implemented [redacted] 07/06/2026)

65i - Training Record

6. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home did not have the staff training record for the 2025 training year for staff person C, which included source, content, length of each course and copies of any certificates received.

Plan of Correction ***Accept [redacted] - 06/25/2026)***

Issue: Annual training documentation for Staff member C was not found.
Plan: Administrator has completed the annual training of both transporters as attached. The Director of Community Life and Transportation or designee will ensure the annual training is completed by 6/22/26 as placed on schedule.
Sustain: Audit by Admin or designee every 6 months to ensure training is compliant for all Community Life staff.

65i - Training Record (continued)

See attached.

Licensee's Proposed Overall Completion Date: *06/22/2026*

Implemented (- 07/06/2026)

101j5 - Bedside Table/Shelf

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident bed; the bedside table was located against the wall near the end of the bed and not within reach of the resident.

Plan of Correction ***Accept - 06/22/2026)***

Issue: The bedside table was not within reach.
Action: PCP was immediately notified to approve order for Bedside table with lamp at foot of bed as resident requested. In service initiated by DON with education on the room audits. Staff thought table and lamp were ok beside the bed not realizing that it needs to be at head of bed unless order received.
Plan: in service of all nursing staff on each area of the room audit for understanding was completed by DON by 6/4/26.
Any and all rooms that have a discrepancy will be corrected or have an order by 6/4/26 and care plan will be updated with same information.
Sustain: audits will be performed one unit once a week x4 weeks, then monthly thereafter if protocol is being followed by DON or designee ensuring home is complying with plan.

Licensee's Proposed Overall Completion Date: *06/18/2026*

Implemented 07/06/2026)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident does not have access to a source of light that can be turned on/off at bedside; the light source is on a table against the wall near the foot of the bed. The resident could not reach the lamb from the bed.

Plan of Correction ***Accept (06/22/2026)***

Issue: The lamp was not within reach.
Action: PCP was immediately notified to approve order for Bedside table with lamp at foot of bed as resident requested. In service initiated by DON with education on the room audits. Staff thought table and lamp were ok

101j7 - Lighting/Operable Lamp (continued)

beside the bed not realizing that it needs to be at head of bed unless order received.
Plan: in service of all nursing staff on each area of the room audit for understanding was completed by DON by 6/4/26.
All rooms were checked by the DON on 6/4/26 and care plan will be updated with same information.

Sustain: audits will be performed one unit once a week x4 weeks, then monthly thereafter if protocol is being followed by DON or designee ensuring home is complying with plan.

Licensee's Proposed Overall Completion Date: *06/18/2026*

Implemented ([redacted] 07/06/2026)

184b - Labeling OTC/CAM

9. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted], a bottle of Major Milk of Magnesia belonging to resident [redacted] was in the medication cart on the 2nd floor and was not labeled with the resident's name.

On [redacted], a bottle of Acetaminophen 325mg belonging to resident [redacted] was in the medication cart on the 2nd floor and was not labeled with the resident's name.

Both of the medications were labeled with the resident's room number.

Plan of Correction ***Accept ([redacted] - 06/22/2026)***

Issue: OTC medications only had a room number on it - missing residents name.
Action: DON / Admin immediately audited the carts ensuring all OTC bottles had residents room numbers as well as the names. Updated all the residents name as needed.
Plan: Inservice by DON to all full time med techs initiated and completed on 5/27/26 ensuring that the bottles have the names and room numbers on them prior to placing them in the med cart.
Sustain: audits will be performed one unit once a week x4 weeks, then monthly thereafter if protocol is being followed by DON or designee ensuring home is complying with plan.

Licensee's Proposed Overall Completion Date: *06/18/2026*

Implemented [redacted] - 07/06/2026)

227d - Support Plan Medical/Dental

10. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident [redacted], dated [redacted], indicates the resident has a need for transferring in and out of bed and ambulation. The resident's assessment dated [redacted] does not document all assisted devices the resident utilizes. The assessment indicates that the resident uses a walker and rollator walker. On [redacted] and [redacted], the resident was using a wheelchair.

Plan of Correction ***Accept [redacted] - 06/25/2026)***

Issue: The Care Plan did not indicate the wheelchair being used.
Action: As of 6/22, the Admin initiated the inservice for DON and nurses on updating the care plans with the DME properly listed. All care plans have been audited on 6/24 and information updated.
Plan: Inservice will be completed by Admin for all nurses and memory care coordinator by 7/1/26 due to their vacations. Education will show each section that would need updates and specifically with changes to using an assistive device.
Sustain: DON or designee shall audit once weekly x4, then monthly x2 to ensure accuracy of any change in condition of resident. Admin to sign off once weekly x4, then monthly x2 as a second check on accuracy.

Licensee's Proposed Overall Completion Date: *07/01/2026*

Implemented [redacted] - 07/06/2026)