

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER Robert Packer Hospital Skilled Care and Rehabilit		STREET ADDRESS, CITY, STATE, ZIP CODE 91 Hospital Drive Towanda, PA 18848	
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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview it was determined that the facility failed to maintain documentation of staff COVID-19 vaccination status, and provide evidence that staff were offered the COVID-19 vaccine or information on obtaining the COVID-19 vaccine for two of two staff reviewed. (Employees 1 and 10) Findings include: Interview with Employee 4, Infection preventionist on January 13, 2026, at 12:00 PM revealed that she educated staff regarding COVID-19 vaccine recommendations on December 15, 2025, but that she did not offer the vaccine or provide the staff with information on where to get the vaccine. She also indicated that she is unable to provide evidence that she maintained staff documentation of screening, education, offering of COVID-19 vaccinations, and their current COVID-19 vaccination status. Interview of Employee 10 nurse aide, on January 13, 2026, at 1:22 PM revealed that she has not been offered COVID-19 vaccine or provided with information on where to obtain the COVID-19 vaccine, since 2021 when COVID first started. Interview of Employee 1, licensed practical nurse, on January 13, 2026, at 1:24 PM revealed that she has not been offered COVID-19 vaccine or provided with information where to obtain one since she was hired three years ago. The facility failed to offer staff the COVID-19 vaccine or provide them with information on where to obtain the vaccine, and failed to maintain staff documentation of screening, education, offering of COVID-19 vaccinations, and their current COVID-19 vaccination status. The surveyor reviewed the above noted findings with the Nursing Home Administrator on January 13, 2026, at 1:45 PM. 28 Pa. Code 211.12(d)(1)(3)(5) 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview it was determined that the facility failed to provide the highest practicable care for a central venous catheter for one of two residents reviewed for central venous catheter concerns (Resident 41). Findings include: Observation of Resident 41 on January 10, 2026, at 2:35 PM revealed an intravenous access site covered by a dressing on his left arm. Observation of Resident 41 and Resident 41's room revealed no signage that indicated there were any restrictions to using his left arm for blood pressure assessments or for venipuncture for blood draws for laboratory testing. There was no emergency kit (e.g. compression dressing supplies) visible in Resident 41's room. Due to cognitive deficits, Resident 41 was unable to provide information regarding his left arm intravenous site. Resource information available from the Mayo Clinic (https://www.mayoclinic.org; Peripherally inserted central catheter (PICC) line - Mayo Clinic) listed risks of peripherally inserted central catheter (PICC, thin, soft, flexible tube inserted through a vein the arm and passed through to the larger veins near the heart for the administration of fluids or medication) line use which can include bleeding, damage to veins in the arm, blood clots, or a blocked or broken PICC line. PICC line protection measures included avoiding getting the PICC line wet and no blood pressure readings taken on the affected arm. The surveyor requested any facility policy or procedure related to the planning of care for a resident with a central line intravenous access device during an interview with the Nursing Home Administrator and the Director of Nursing on January 12, 2026, at 2:00 PM. Review of the facility policy entitled, SNF Central Venous Catheter Policy, revealed that the policy was dated January 12, 2026. The policy stipulated that staff will not take blood pressure assessments or draw blood from the affected arm. The policy did not indicate the procedure to ensure all providers of care were informed of any limb restrictions during the use of a PICC line (e.g. disposable bracelets, signage, care plan, physician order, etc.). The policy did not include immediate care necessary for the potential complications of breaks in the line or bleeding (e.g., emergency kit at bedside). The policy indicated that the facility utilized the Lippincott procedure resource to develop their policy. Email communication with the Nursing Home Administrator on January 13, 2026, at 1:22 PM indicated that the facility did not have a policy or procedure regarding the care and services of a PICC line before the surveyor's questioning. Review of the facility policy entitled, Blood Pressure Measurement, last revised February 24, 2025, stipulated staff should not apply a blood pressure cuff over a PICC or midline catheter (intravenous access inserted into a peripheral vein in the upper arm, the catheter tip is positioned at or near the level of the armpit). The policy stipulated that the staff could use a blood pressure cuff distal to the PICC insertion site. The policy listed 37 references used to develop the policy. The surveyor requested the references that related to PICC care and services used to develop facility policies during an interview with the Director of Nursing on January 13, 2026, at 11:24 AM. The facility did not provide the references during the onsite survey. Clinical record review for Resident 41 revealed nursing documentation dated January 5, 2026, at 7:50 PM that Resident 41 was scheduled for an appointment with interventional radiology for a PICC line insertion. Nursing documentation dated January 6, 2026, at 5:19 PM revealed that Resident 41 had new orders to place a PICC line and begin Daptomycin (antibiotic used to treat complicated bacterial infections) intravenously every day for 14 days and Ertapenem (antibiotic used to treat severe infections) intravenously every day for 14 days. A physician's order dated January 7, 2026, instructed staff to perform a heparin lock flush injection (an anticoagulant medication that prevents clotting) daily when the intravenous line is capped (not in use). Review of Resident 41's plans of care available in his medical record did not indicate that staff initiated a plan of care that related to his PICC line. Observation of Resident 41's room on January 12, 2026, at 10:52 AM with Employee 1 (licensed practical nurse) and Employee 2 (nurse aide) verified that there were no measures readily visible to prevent staff from utilizing Resident 41's left arm for blood pressure assessments or venipuncture. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no medical supplies readily visible to use in the event of an emergency complication, such as bleeding or line breakage. Employees 1 and 2 indicated that they believed Resident 41's room should have a sign for staff to not use his left arm; and that a bag containing emergency medical supplies should be taped on the wall near his bed. The surveyor reviewed the above concerns regarding Resident 41's PICC line care and services during an interview with the Nursing Home Administrator and the Director of Nursing on January 12, 2026, at 2:00 PM. Interview with the Director of Nursing and Employee 4 (infection control/staff educator) on January 13, 2026, at 11:24 AM again reviewed the surveyor's concerns that routine prevention measures and emergency care procedures are not part of Resident 41's care plan, facility policies, or staff education materials. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to obtain routine vision services for one of three residents reviewed for vision concerns (Resident 5). Findings include: Observation of Resident 5 on January 11, 2026, at 10:54 AM revealed her to wear glasses. During an interview with Resident 5 on the date and time of the observation she stated that she, probably could use an exam to see if they need updating. Resident 5 stated that she did not believe that she received professional eye services in the past year. Clinical record review for Resident 5 revealed that the facility admitted her on May 15, 2024. Diagnoses listed for Resident 5 included: Diabetes mellitus (dated August 29, 2023, high blood sugar levels that can damage the tiny blood vessels in the eye) Hypertension (dated February 12, 2008, high blood pressure that can damage the blood vessels in the eye) Exudative age-related macular degeneration, left eye, with active choroidal neovascularization (dated July 26, 2019, wet AMD, membranes develop under the eye's retina that can leak fluid and blood and, if left untreated, can cause a blinding scar) A physician's order dated September 5, 2025, instructed staff to consult the facility's contracted provider that provides dental, eye, and podiatry services. Comments included in the order instructed staff to, Include the results of the evaluation, testing and/or treatment in the patient's medical record at the location for review. The surveyor requested evidence of professional eye care services provided for Resident 5 in the past year during an interview with the Director of Nursing and the Nursing Home Administrator on January 11, 2026, at 2:00 PM. Interview with the Director of Nursing on January 13, 2026, at 12:05 PM confirmed that Resident 5 consented to services from the facility's contracted provider for vision services on August 27, 2025. Resident 5 became eligible for Medicaid-provided services on September 25, 2025. The facility had no evidence that the contracted provider provided services since Resident 5's admission to the facility. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement an intervention to heal pressure ulcers for one of two residents reviewed for pressure ulcer concerns (Resident 41). Findings include: Observation of Resident 41 on January 10, 2026, at 2:37 PM revealed him to be in his bed. An Air Element pump unit (medical device that controls the settings of a specialty mattress to permit the mattress to stay fully inflated or alternate the air pressure in air cells to partially deflate and inflate, avoiding prolonged pressure on any single point beneath the resident to help prevent pressure ulcers; with static pressure mode, all of the air cells are equally inflated) that hung from a footboard at the base of his bed included a lit button that indicated the mattress was set to Static. Clinical record review for Resident 41 revealed nursing documentation dated August 30, 2025, at 7:31 PM that Resident 41's deep tissue pressure injury (tissue necrosis/death that develops when soft tissue is compressed between a bony prominence and an external surface for an extended period) on his left outer heel measured 3.3 centimeters (cm) by 1.8 cm; and was red, purple, boggy, and painful to touch. Resident 41 stated that it had been painful for at least a week. Nursing documentation dated September 23, 2025, at 11:14 AM indicated that staff obtained a new physician's order for an air mattress. A physician's order dated September 23, 2025, at 11:20 AM instructed that Resident 41 was to have an alternating air mattress; and that staff were to check the inflation every shift. Nursing documentation dated October 15, 2025, at 12:26 PM indicated that staff assessed Resident 41's left heel; that the scab (unhealthy leathery wound surface) was off the heel, that the wound was larger, and that staff made an appointment for the facility's contracted wound consultants. Nursing documentation dated October 16, 2025, at 10:51 AM revealed that Resident 41's left heel was, very sore with dark area and open area to heel and surrounding tissue red and painful to touch. Purulent (yellow or discolored drainage from a wound that is usually indicative of infection) drainage noted. The physician ordered staff to culture the wound for infection. Nursing documentation dated October 20, 2025, at 12:43 PM revealed that Resident 41's wound culture results indicated an infection with MRSA (Methicillin-resistant Staphylococcus aureus, bacteria that are genetically distinct from other strains of Staphylococcus aureus; is responsible for several difficult-to-treat infections in humans because the bacteria is resistant to, and cannot be treated with, commonly used antibiotics). Nursing documentation dated December 31, 2025, at 3:49 PM revealed that Resident 41 returned from his appointments with the infectious disease and wound care consultant providers and would have a wound culture. Nursing documentation dated January 2, 2026, at 10:09 AM revealed that the tissue exam done on December 31, 2025, was positive for bacteria that included staphylococcus aureus. Clinical record review for Resident 41 revealed nursing documentation dated January 5, 2026, at 7:50 PM that Resident 41 was scheduled for an appointment with interventional radiology for a PICC line (PICC, thin, soft, flexible tube inserted through a vein the arm and passed through to the larger veins near the heart for the administration of fluids or medication) insertion. Nursing documentation dated January 6, 2026, at 5:19 PM revealed that Resident 41 had new orders to place a PICC line and begin Daptomycin (antibiotic used to treat complicated bacterial infections) intravenously every day for 14 days and Ertapenem (antibiotic used to treat severe infections) intravenously every day for 14 days. Review of an active plan of care developed by the facility on March 3, 2025, to address Resident 41's risk for skin breakdown listed interventions that included: Provide pressure-relief mattress, started March 3, 2025 Bed foot board removed for pressure relief, started August 21, 2025 The plan of care was not updated to reflect the implementation of an alternating air mattress that included the device pump (hanging from the bed's footboard); or the appropriate settings necessary to ensure staff maintained the mattress on the alternating pressure (not static) settings. Observation of Resident 41's left heel wound care on January 12, 2026, at 10:52 AM with Employee 1 (licensed practical nurse) and Employee 2 (nurse aide) indicated that neither staff were knowledgeable regarding the appropriate settings necessary on (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Air Element pump to implement an alternating pressure surface when Resident 41 was in bed. Clinical record review with Employee 1 on January 12, 2026, at 10:58 AM confirmed that Resident 41's physician orders required that staff implement an alternating air mattress; and that staff were to check the inflation every shift. Interview with Employee 9 (licensed practical nurse) with Employee 1 on January 12, 2026, at 11:10 AM indicated that if the Static button on Resident 41's mattress pump is engaged (lit) it means that the mattress is not in alternating pressure mode. The interview indicated that Employee 3 (licensed practical nurse) was the nurse assigned to Resident 41's care on this shift. Interview with Employee 3 on January 12, 2026, at 11:20 AM revealed that she was not knowledgeable regarding the appropriate settings necessary on the Air Element pump to implement an alternating pressure surface when Resident 41 was in bed; that she, .would have to look it up. Employee 3 stated that she checks the inflation of the mattress (per the physician's order) by pressing on the surface of the mattress to ensure that it is inflated. She does not review the settings on the pump to ensure any particular setting (e.g., if the Static button is engaged). Review of Resident 41's treatment administration record revealed that Employee 3 signed for the assessment of the mattress inflation on the following dates and times during the last 30 days: December 20, 2025, at 1:27 PMDecember 27, 2025, at 1:27 PMDecember 29, 2025, at 2:06 PMJanuary 2, 2026, at 9:12 PMJanuary 3, 2026, at 1:50 PMJanuary 10, 2026, at 1:45 PM Review of the Air Element manufacturer's manual confirmed that the Static Mode on the mattress is used to pause alternation when sitting, transferring, or during the mattress setup. Employee 1 revised Resident 41's physician order regarding the alternating air mattress on January 12, 2026, at 12:20 PM (following the surveyor's questioning) to include instructions for staff to check that the static button is always in the off position to ensure that the air alternating mode is on. The surveyor reviewed the above concerns regarding the appropriate implementation and staff knowledge regarding the appropriate settings of the alternating air mattress for Resident 41 during an interview with the Director of Nursing and the Nursing Home Administrator on January 12, 2026, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure preventative fall interventions were implemented for one of two residents reviewed for falls (Resident 39). Findings include: This deficiency is cited as past non-compliance. Clinical record review for Resident 39 revealed a fall risk assessment dated [DATE], that indicated she was a high fall risk. Review of Resident 39's care plan entitled Potential for Falls secondary to needing walker to ambulate, decreased vision, and occasional incontinence, dated November 23, 2025, revealed that she was to have a chair alarm and her call bell in reach. Review of a facility reported incident revealed that on November 24, 2025, at 3:30 PM Resident 39 was not present in her room during room rounds at change of shift by the licensed practical nurse. It was reported the nurse walked around the unit looking for Resident 39 when she heard help me coming from the shower room. She entered the shower room and found Resident 39 naked in the shower chair under the running water, shivering. The water temperature was noted to be 96 degrees. Resident was dried, dressed, and assessed and was noted to have no injury or ill effects. The director of nursing interviewed Employee 7, nurse aide, on November 24, 2025. Review of the interview notes revealed that Employee 7 indicated that she did leave Resident 39 in the shower but made arrangements for Employee 8, nurse aide, to finish the shower. Review of Employee 8's statement dated November 24, 2025, indicated that she told Employee 7 that she could not do it because she had a hall to herself and would not be able to leave that hall to go do the shower which was in a different hall. Interview of Resident 39 related to the event on November 24, 2025, on January 12, 2026, at 3:15 PM revealed that the nurse aide, Employee 7 assisted her in the shower and helped her wash her hair and body and then stated it was time for her to go home and that someone else would be into finish the shower. She said that Employee 7 then left. She said that she got cold and upset. She said it really stressed her out. She said she did not have any bell to ring so all she could do was yell for help and eventually another staff member came to help her. She estimated she was in the shower at least an hour or more. Surveyor inquired about her chair alarm and walker, and she indicated the alarm was not on her because she was in the shower and she did not know where her walker was. Interview with the Nursing Home Administrator on January 12, 2026, at 8:45 AM revealed that Resident 39 was to have one person with her in the shower and she was to have a chair alarm at all times because she was a fall risk. She confirmed that Resident 39 was left alone in the shower by Employee 7, with no call bell in reach, her walker was not present, and she did not have a chair alarm on. Review of the facility's investigation into Resident 39's event revealed that Employee 7 was suspended during the investigation and her employment was terminated on December 25, 2025. The facility educated all nursing staff on November 24-25, 2025, on not letting resident's unattended in the shower room and bathing/shower safety related to fall prevention. The facility failed to implement care planned fall preventative measures for Resident 39. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure appropriate labeling of medication and implement measures for controlled substance accountability during medication administration for four of eight residents observed for medication administration (Residents 7, 8, 28, and 34). Findings include: The current facility policy entitled, Medication Administration, Procedures for Medication Administration, General Procedures to Follow for all Medications, revealed that the staff are to read the medication label three times before pouring the medication. After administration, staff are to return to the medication cart and document the administration in the Medication Administration Record (MAR). Observation of a medication administration pass on January 10, 2026, at 11:53 AM revealed Employee 5 (licensed practical nurse) prepared Carboxymethylcellulose Sodium ophthalmic solution (Refresh Plus, lubricant used to relieve burning, irritation, and discomfort caused by dry eyes) eye drops for Resident 34. The label on the box of medication did not include which (or both) eye(s) staff were to administer the medication. Employee 5 entered Resident 34's room to administer the medication; however, Resident 34 was in her bathroom. Employee 5 returned to the medication cart without administering the medication on January 10, 2026, at 12:02 PM. Clinical record review for Resident 34 revealed that the physician order dated May 27, 2025, instructed staff to administer one drop of the Refresh Plus medication four times a day; however, the order did not include instructions if the medication was ordered for one or both eyes. The order included that the associated diagnoses for the medication was for a macula scar of the posterior pole of the right eye (abnormality of the internal structures of the eye that affects vision). Review of Resident 34's medication administration record indicated that Employee 5 documented the administration of the eye drop medication on January 10, 2026, at 11:54 AM; however, Employee 5 did not administer the medication at that time due to the Resident's unavailability while she was in the bathroom. Interview with Employee 5 on January 11, 2026, at 10:00 AM indicated that she administered Resident 34's eye drop medication in both eyes (after the surveyor's medication administration observations). Employee 5 confirmed that the MAR, the medication label, and the physician order for the medication did not specify the eye(s) that required the treatment. Employee 5 indicated that it may have been an error that she documented the administration at the time the resident was in the bathroom. The current facility policy entitled, Medication Administration, Preparation and General Guidelines, Controlled Medications, revealed that when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record: Date and time of administration Amount administered Signature of the nurse administering the dose, completed after the medication is actually administered Observation of a medication administration pass on January 10, 2026, at 11:56 AM revealed Employee 5 accessed the locked controlled substance drawer in the medication cart to obtain Hydrocodone-APAP (combination medication that includes hydrocodone, opioid pain reliever, and acetaminophen, a non-opioid pain reliever) 5/325 milligrams (mg) for Resident 8. Employee 5 removed the medication from the supply and secured the narcotic box, crushed the medication, and left the medication cart to administer the medication to Resident 8 while he was in the common dining area on January 10, 2026, at 11:59 AM. Employee 5 did not record the administration on the controlled substance accountability record. Interview with Employee 5 on January 10, 2026, at 1:51 PM (approximately two hours after the observed administration) confirmed that she did not record Resident 8's Hydrocodone-APAP medication use at the time of the administration. Employee 5 updated the supply count on the document at the time of the interview. Observation of a medication administration pass on January 10, 2026, at 1:14 PM revealed Employee 5 accessed the locked controlled substance drawer in the medication cart to obtain Clonazepam 0.5 (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg (benzodiazepine medication used to treat seizures and panic disorders) for Resident 28. Employee 5 removed the medication from the supply and secured the narcotic box, crushed the medication, and left the medication cart to administer the medication to Resident 28. Employee 5 did not record the administration on the controlled substance accountability record. Interview with Employee 5 on January 10, 2026, at 1:52 PM confirmed that she did not record Resident 28's Clonazepam medication use at the time of the administration. Employee 5 updated the supply count on the document at the time of the interview. Observation of a medication administration pass on January 10, 2026, at 1:37 PM revealed Employee 5 accessed the locked controlled substance drawer in the medication cart to obtain Tramadol HCL (narcotic analgesic) 50 mg for Resident 7. Employee 5 removed the medication from the supply, secured the narcotic box, and left the medication cart to administer the medication to Resident 7 who was in the common activity room. Employee 5 did not record the administration on the controlled substance accountability record. Interview with Employee 5 on January 10, 2026, at 1:53 PM confirmed that she did not record Resident 7's Tramadol HCL medication use at the time of the administration. Employee 5 updated the supply count on the document at the time of the interview. The surveyor reviewed the above concerns regarding medication labeling and controlled substance accountability procedures during an interview with the Nursing Home Administrator and the Director of Nursing on January 11, 2026, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide dental care services for one of six residents reviewed for dental concerns (Resident 5). Findings include: Observation of Resident 5 on January 11, 2026, at 10:54 AM revealed her to have natural teeth. During an interview with Resident 5 on the date and time of the observation she stated that she, .cracked them (teeth), don't know how, a couple of them were pulled. Resident 5 stated that she did not believe that she received professional dental services in the facility since her admission. Clinical record review for Resident 5 revealed that the facility admitted her on May 15, 2024. A physician's order dated September 5, 2025, instructed staff to consult the facility's contracted provider that provides dental, eye, and podiatry services. Comments included in the order instructed staff to, Include the results of the evaluation, testing and/or treatment in the patient's medical record at the location for review. The surveyor requested evidence of professional dental care services provided for Resident 5 in the past year during an interview with the Director of Nursing and the Nursing Home Administrator on January 11, 2026, at 2:00 PM. Interview with the Director of Nursing on January 13, 2026, at 12:05 PM confirmed that Resident 5 consented to services from the facility's contracted provider for dental services on August 27, 2025. Resident 5 became eligible for Medicaid-provided services on September 25, 2025. The facility had no evidence that the contracted provider provided services since Resident 5's admission to the facility. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER Robert Packer Hospital Skilled Care and Rehabilitt		STREET ADDRESS, CITY, STATE, ZIP CODE 91 Hospital Drive Towanda, PA 18848	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on a review of select facility policies and procedures, clinical record review, observation, and family and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection related to enhanced barrier precautions for one of one resident reviewed for indwelling urinary catheter concerns (Resident 1) and handwashing for three of eight residents reviewed for medication administration (Residents 7, 28, and 34). Findings include: The facility policy entitled, Enhanced Barrier Precautions (EBP), dated June 3, 2025, revealed that resident care facilities adhere to enhanced barrier precautions (EBP) based on the recommendations provided by the Centers for Disease Control and Prevention (CDC). EBP refers to an infection control intervention designed to reduce transmission of MDROs (multi-drug-resistant organisms) that employ targeted gown and glove use during high-contact resident care activities, especially for those at increased risk of acquiring or spreading an MDRO. EBP are used in conjunction with standard precautions and expand the use of PPE (personal protective equipment such as gowns, gloves, and eye protection) to donning a gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with an indwelling medical device. Examples of an indwelling medical device include urinary catheters. High-contact resident care activities include urinary catheter device care. Clinical record review for Resident 1 revealed a physician's order dated February 6, 2025, for staff to change his Foley catheter (flexible tubing inserted through the penis to the bladder to drain urine) every 30 days. Review of a plan of care started by the facility on January 8, 2026, to address enhanced barrier precautions due to an indwelling urinary catheter indicated that signage, PPE, and trash receptacles would be in Resident 1's room. A gown and gloves would be worn for all high-contact activities such as personal care and any contact with invasive devices such as an indwelling catheter. Observation of Resident 1 on January 10, 2026, at 2:56 PM revealed no visible urinary collection bag or tubing. Interview with Employee 3 (licensed practical nurse) on January 10, 2026, at 3:04 PM revealed that Resident 1 does not typically allow staff to discontinue the smaller urinary collection bag secured on his leg to connect a larger urinary collection bag. Interview with Resident 1's wife on January 11, 2026, at 11:33 AM revealed that Resident 1 required urinary catheterization before his admission to the facility. Resident 1's wife confirmed that Resident 1 preferred the smaller urinary collection bag that is secured to his leg rather than have tubing exposed that can catch on objects in his environment. Observation of Resident 1 on January 11, 2026, at 11:50 AM revealed Employee 6 propelled him in his wheelchair from the hallway into his bathroom. Employee 6 did not obtain PPE from the organizer on Resident 1's room door. Continued observation on January 11, 2026, at 11:55 AM revealed Employee 6 exited Resident 1's bathroom with Resident 1 without visible PPE. Interview with Employee 6 on January 11, 2026, at 11:56 AM confirmed that she did not use PPE during her interaction with Resident 1; however, she took him into the bathroom to empty the urine from his urinary collection bag. The surveyor reviewed the above concerns regarding EBP not utilized for Resident 1's care during an interview with the Director of Nursing and the Nursing Home Administrator on January 12, 2026, at 2:00 PM. Observation of a medication administration pass for Resident 28 on January 10, 2026, at 1:18 PM revealed Employee 5 (licensed practical nurse) donned gloves to prepare and administer medications to Resident 28. Employee 5 removed the gloves after the medication administration and returned to the medication cart where she touched the medication cart surfaces, the mouse connected to the computer on the medication cart, and the medication cart keys without performing hand hygiene. Continued observation of the medication administration pass on January 10, 2026, at 1:34 PM revealed Employee 5 wore gloves to administer medications to Resident 7 while she was in the common activity room. Employee 5 removed her gloves and entered the staff bathroom to wash her hands. Employee 5 utilized her clean, but wet, hand to turn off the faucet before obtaining a disposable towel to dry her hands. Employee 5 returned to the medication cart, donned new gloves, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and prepared additional medication to administer to Resident 7. Employee 5 wore the gloves to administer the medication to Resident 7 while she continued to sit in the common activity room. After administering the medication to Resident 7, Employee 5 wore the gloves until she returned to the medication cart, used her gloved hand to use a pen to document paperwork on the medication cart, then removed her gloves. Without performing hand hygiene, Employee 5 used the mouse connected to the medication cart computer. Continued observation of the medication administration pass on January 10, 2026, at 1:41 PM revealed Employee 5 donned gloves to prepare medications for Resident 34. Employee 5 left the medication cart with gloved hands to administer medications in Resident 34's room and until she returned to the medication cart. Employee 5 removed the gloves and used the mouse connected to the medication cart computer before utilizing alcohol sanitizer and applying new gloves. Interview with Employee 5 on January 10, 2026, at 1:49 PM confirmed that it is the facility's policy to immediately perform hand hygiene (with soap and water or alcohol hand sanitizer) when gloves are removed. Employee 5 also confirmed that it is the expectation that staff do not touch the potentially contaminated surfaces of the sink faucet after washing hands without obtaining a disposable towel to do so. Employee 5 confirmed that she did not perform appropriate hand hygiene during the medication administration pass observed. The surveyor reviewed the above infection control concerns during an interview with the Nursing Home Administrator and the Director of Nursing on January 11, 2026, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		