

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848
STATE LICENSE NUMBER: 650202	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0684 SS=G	Based on an Abbreviated Survey in response to a Complaint Investigation completed on January 6, 2025, it was determined that Robert Packer Hospital Skilled Care and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0684		

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

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 1 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Action Steps: 1. The Robert Packer Hospital (RPH) Skilled Nursing Unit Administrator is responsible for this action plan. 2. The Director of Nursing for the Skilled Nursing Unit completed Audits of current residents for Physician ordered Lactulose and parameters 3. The Director of Nursing for the Skilled Nursing Unit completed an audit of current residents to determine any other residents that might be affected. Audit of current residents included Number of stool occurrence and consistency; no other residents affected. 4. Updated Change in resident condition policy to include suggestion of notification to physician of 2 or more loose/watery stools within 12 hours was completed and approved. 5. Weekly BM paper tool utilized in addition to EMR for tracking started on 1/15/2025 6. Additional Electronic report created to assist with monitoring	Completion Date: 01/22/2025 Status: APPROVED Date: 01/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 2	F 0684	<p>Bowel consistency and Occurrence daily on 1/14/2025</p> <p>7. Education to all nursing staff provided on reporting a change in condition including a change in Bowel consistency completed 01/17/2025</p> <p>8. All Nursing Staff education provided on requirement to follow physicians' orders completed 01/17/2025.</p> <p>9. The Director of Nursing will continue to audit resident medical records for Bowel consistency and occurrences and that appropriate notification to physician is documented.</p> <p>10. The Director of Nursing will continue to reinforce the importance of following orders related to administration of Lactulose with all nursing staff during staff meetings, and daily huddles.</p> <p>11. The Director of Nursing will review any non-compliant findings with the staff involved. Any trends identified will be addressed with the staff per the progressive disciplinary process if appropriate.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 3	F 0684	<p>12. Audits will continue to be reported by the Skilled Nursing DON at scheduled Quality assurance performance improvement meetings weekly x 12, then monthly x 9</p> <p>13. The Administrator of the Skilled Nursing Unit will continue to report audit compliance quarterly to the RPH Patient Safety and Quality committee.</p> <p>14. Directed In service is scheduled for 01/21/2025 through PADONA</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 4 Based on closed clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care for a resident's change in condition that resulted in hospitalization and death for one of three residents reviewed causing actual harm (Resident CR1). Findings include: Closed clinical record review for Resident CR1 revealed that the facility admitted her on November 23, 2024. A physician's order dated November 23, 2024, instructed staff to administer Lactulose (laxative used to treat chronic constipation and brain abnormalities due to liver failure) three times a day and "hold for loose stools." A review of bowel movement history documentation (electronic documentation completed by nurse aide staff of residents' bowel movements) revealed that Resident CR1 was continent of bowel movements	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025	
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER STATE LICENSE NUMBER: 650202		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 5 on November 28 and 30, 2024; and December 1, 2024. Staff documented that these bowel movements were soft or formed. Documentation on December 2, 2024, at 11:32 AM noted that Resident CR1 had two occurrences of incontinence of a large amount of loose stool. Nurse aide staff documented on December 2, 2024, at 2:12 PM, 7:12 PM, and 11:30 PM, an additional seven occurrences of loose stool. Review of Resident CR1's medication administration record (MAR, electronic documentation by licensed nursing staff of the administration of medications) revealed that licensed staff documented the administration of the Lactulose medication on December 2, 2024, at 2:00 PM and 10:00 PM (despite Resident CR1's loose stools). Nurse aide staff continued to document on December 3, 2024, at 1:30 AM, 3:51 AM, 2:10 PM, and 6:28 PM, that Resident CR1 had a total of	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025	
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER STATE LICENSE NUMBER: 650202		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	<p>Continued from page 6</p> <p>10 incontinent episodes of stool with mucous present. The staff documented specifically that the stool was loose on two of the occasions. The staff did not include an assessment of the stool consistency for the other eight occurrences.</p> <p>Review of Resident CR1's MAR indicated that licensed staff documented the administration of the Lactulose medication on December 3, 2024, at 8:00 AM, 2:00 PM, and 8:00 PM (despite Resident CR1's loose stools).</p> <p>Nurse aide staff documented that Resident CR1 had five incontinent episodes of yellow stool on December 4, 2024, at 6:14 AM. The staff did not document the consistency of the stool for those five episodes. Nurse aide staff documented an additional three occurrences of watery stool with mucous present on December 4, 2024, at 1:34 PM.</p> <p>Review of Resident CR1's MAR indicated that licensed staff documented the administration of the Lactulose medication on December 4, 2024, at 8:00</p>	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 7 AM and 2:00 PM (despite Resident CR1's eight episodes of bowel incontinence on this date). A physician's progress note dated December 4, 2024, at 6:05 PM documented that Resident CR1 was negative for constipation, diarrhea, and nausea. There was no evidence in Resident CR1's clinical record that nurse aide staff informed licensed staff of Resident CR1's numerous loose stools or that licensed staff notified the physician of this change in Resident CR1's condition. There was no evidence that licensed staff reviewed the nurse aide documentation regarding the loose stools prior to administering the lactulose. Nurse aide staff continued to document a total of seven incontinent episodes of loose stools with mucous present on December 4, 2024, at 9:44 PM and 11:46 PM and December 5, 2024, at 5:16 AM. Licensed staff documented the administration of the	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 8 Lactulose medication on December 4, 2024, at 8:00 PM and December 5, 2024, at 8:00 AM, 2:00 PM, and 8:00 PM. Nurse aide staff documented a total of 11 occurrences of incontinent loose or watery stools from December 6, 2024, at 1:34 PM, to December 8, 2024, at 2:21 PM. Licensed staff documented the administration of the Lactulose medication three times daily from December 6, 2024, at 8:00 AM, through December 8, 2024, at 2:00 PM. Nursing documentation dated December 8, 2024, at 6:15 PM revealed that Resident CR1 had increased lethargy (decrease in consciousness and altered mental abilities) and confusion. "Previous assessment, resident was alert and able to answer questions." Resident CR1 had significant abdominal distention and increased swelling to her lower extremities. The documentation noted that, "Resident moving bowels;" however, did not note	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 9 the numerous episodes of loose stools over the previous seven days. Staff contacted emergency medical services to send Resident CR1 to the hospital emergency room. A laboratory report dated December 8, 2024, at 11:26 PM indicated Resident CR1's stool specimen was positive for C. difficile toxin (bacterial infection of the colon that produces toxins that damage the cells of the intestinal lining causing inflammation (colitis) and causes symptoms that range from diarrhea to life-threatening damage to the colon). Hospital emergency department physician documentation dated December 8, 2024, noted that laboratory testing of Resident CR1's stool was positive for C. difficile toxin, that she had a severely elevated white blood cell count (the immune system is stimulated by conditions such as infection, inflammation, or injury), and that her abdominal CT (medical scan that uses x-rays to create images of the abdominal organs) showed extensive colitis (intestinal inflammation). The final impression	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 10 documented by the provider was, "C. difficile colitis." Clinical impressions included C. difficile colitis and sepsis (infection detected in the bloodstream) with acute organ dysfunction (severe injury to an organ) without septic shock (most severe stage of sepsis that often includes multiple organ failure). A history and physical assessment by the hospital physician dated December 9, 2024, at 1:20 PM documented Resident CR1's diagnoses as toxic megacolon (serious complication of severe colitis that is characterized by a very dilated colon) secondary to C. difficile colitis and acute metabolic encephalopathy (brain dysfunction caused by an underlying condition) secondary to the previous (toxic megacolon secondary to C. difficile colitis) and decompensated cirrhosis (liver damage). Death report documentation by the hospital physician certified that Resident CR1 died on December 9, 2024, at 2:13 PM due to cardiopulmonary arrest (the stopping of effective	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395333	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/06/2025
NAME OF PROVIDER OR SUPPLIER: ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATIONCENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 91 HOSPITAL DRIVE TOWANDA, PA 18848		
STATE LICENSE NUMBER: 650202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=G	Continued from page 11 breathing and blood circulation) as a consequence of septic shock because of colitis. The surveyor reviewed concerns that nurse aide staff did not inform licensed nursing staff of Resident CR1's change in condition (numerous loose stools) during interviews with the Nursing Home Administrator on January 6, 2025, at 2:40 PM and 3:13 PM. The interview also reported the surveyor's concerns that there was no evidence that nursing staff notified Resident CR1's physician of the change in Resident CR1's condition. Interview with the Nursing Home Administrator and the Director of Nursing on January 6, 2025, at 3:33 PM confirmed the above findings for Resident CR1. 483.25 Quality of Care Previously cited deficiency 3/8/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		



Certified End Page

ROBERT PACKER HOSPITAL SKILLED CARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 650202

SURVEY EXIT DATE: 01/06/2025

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



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY