STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395324	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allied Services Meade Street Skilled Nursing	200 S. Meade Street Wilkes Barre, PA 18702

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, the Resident Assessment Instrument (RAI), and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of one resident out of 23 sampled (Resident 61). Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section J Health Conditions Subsection J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment indicates information from all relevant medical records received from facilities where the resident resided during the previous 6 months, any other medical records received are reviewed for evidence of resident falls. A clinical record review revealed Resident 61 was admitted to the facility on [DATE]. A review of the quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) Section J1900. Number of Fall Since Admission/Entry or Reentry or Prior Assessment, dated December 23, 2024, indicated Resident 61 had one fall with no injury and one fall with injury (except major injury). A clinical record review revealed Resident 61 had experienced three falls since the last MDS assessment. Resident 61 fell on [DATE], December 13, 2024, and December 18, 2024. During an interview on March 6, 2025, at approximately 1:30 PM, the Registered Nurse Assessment Coordinator (RNAC) confirmed the quarterly MDS assessment dated [DATE], failed to include all three falls Resident 61 experienced. During an interview on March 6, 2025, at approximately 1:45 PM, the Director of Nursing confirmed that Resident 61's quarterly MDS assessment dated [DATE], did not accurately include all falls experienced by the resident during the lookback period. 28 Pa. Code 211.5 (f)(iv) Medical records. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(2)(3) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306 Based on a review of clinical records and staff interviews, it was determined that the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders for one resident out of 24 residents reviewed (Resident 10) Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the Registered Nurse (RN) was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health care team by exercising sound judgment based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) document and maintain accurate records. A review of Resident 10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include hypertension (blood pressure that is higher than normal) and atrial fibrillation (a condition that causes the heart to beat irregularly and occasionally much faster than normal). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 23, 2025, revealed Resident 10 had moderately impaired cognition with a BIMS score of 10 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8-12 indicates cognition is moderately impaired). A physician's order dated February 8, 2025, directed staff to obtain Resident 10's blood pressure and heart rate weekly. However, a review of the resident's clinical record, including the task report (an electronic record that summarized planned resident-centered tasks completed by nursing), Medication Administration Record (MAR), and Treatment Administration Record (TAR), revealed no evidence that these vital signs were obtained as ordered. An interview with the Director of Nursing (DON) on March 6, 2025, at approximately 2:45 PM confirmed that the facility failed to ensure that Resident 10 received treatment and care in accordance with professional standards of practice. The DON acknowledged that the physician's orders were not followed, and there was no documentation to support that the required monitoring had been completed. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to monitor resident weights consistently and accurately to timely identify changes in nutritional parameters and timely implement nutritional interventions for two residents out of 24 sampled residents (Residents 24 and 90). Findings included: A review of a facility policy entitled Weighing Residents/Reporting Significant Weight Changes that was last reviewed by the facility October 1, 2024, indicated it was the policy of the facility to monitor weights on all residents and to investigate, report, and appropriately intervene when a weight change occurs that may impact the resident's well-being. The nurse and/or dietitian will check weights and verify if there has been a loss or gain of 5% of the total weight in one month or five pounds in one week. Reweights within 48-hours will be scheduled, if necessary. If a weight loss or gain occurs, the nurse will notify the dietitian, physician, and resident or resident representative (RP) and document the notification. The dietitian will reassess energy and hydration needs in a nutrition progress note, as necessary, and may recommend adjustments to the resident's nutrition plan of care (POC). The nurse will review the dietitian's recommendations related to the weight changes, notify the resident or RP of new orders, and document appropriately in the electronic medical record (EMR). A review of Resident 24's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), congestive heart failure (CHF a progressive heart disease that affects pumping action of the heart muscles and causes fatigue and shortness of breath), and pulmonary nodule (are areas of abnormal growth on the lungs and typically caused by infections, autoimmune diseases or cancer). The resident's weight on October 1, 2024, was 164.6 lbs. On October 9, 2024, the resident's weight was documented as 157.3 lbs. upon return from the hospital, indicating a 7.3 lb. (4.4%) weight loss in one week. A review of the clinical record failed to reveal documentation that a reweight was obtained within 48 hours per facility policy. A review of a nutrition progress note completed by the facility's registered dietitian (RD) on October 23, 2024 (14-days post weight loss), at 11:00 AM, indicated the weight loss was likely due to IV (intravenous) Lasix (diuretic medication that removes the build-up of fluid in the body) received during hospitalization . The RD recommended obtaining a reweight, monitoring weekly weights, and adding the resident to nutrition at risk (NAR) status. However, the clinical record lacked documentation that the reweight was completed, that weekly weights were implemented for NAR monitoring, or that the attending physician and resident/RP were notified of the weight change. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on March 7, 2025, at 10:30 AM, confirmed the facility could not provide documented evidence that a reweight was completed or that weekly weights were completed for NAR status monitoring after Resident 24's weight loss. Additionally, the DON confirmed there was no documented evidence that the resident's attending physician and resident or RP were notified of the weight changes. A review of Resident 90's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included endometrial cancer (also known as uterine cancer, a type of cancer that begins as a growth of cells in the uterus) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). On October 1, 2024, the resident's weight was recorded as 102.4 lbs. By October 7, 2024, the resident's weight had decreased to 96.7 lbs., indicating a significant weight loss of 5.6 lbs. (5.6%) within one week. Resident 90's weight record revealed that on October 1, 2024, the recorded weight was 102.4 lbs., on October 7, 2025, the recorded weight was 96.7 lbs., which showed a weight loss of 5.6 lbs. or 5.6% in one week. Further review of the clinical record revealed that on October 16, 2024, at 3:17 PM, 9-days after the weight loss occurred, the DON obtained orders for Boost (nutritional supplement) three times per day due to weight loss. However, there was no documented evidence that Resident 90's attending physician was timely notified of the significant weight loss of 5.6 lbs. or 5.6% in one week. Further review of the clinical record revealed that the RD did not complete a nutritional evaluation regarding the significant weight loss until November 4, 2024-28 days after the weight change. During an interview on March 7, 2025, at 11:40 AM, the DON confirmed that the facility failed to timely identify Resident 90's weight change, implement timely nutritional interventions, and notify the attending physician of the weight loss. These findings demonstrate that the facility failed to adhere to its own policy regarding timely weight monitoring, reweight verification, physician notification, and nutritional interventions. 28 Pa Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure that pain management is provided to residents consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one resident (Resident 61) out of 23 sampled. Findings include: A review of facility policy titled Pain Management, last reviewed by the facility on October 1, 2024, revealed it is the facility's policy to provide compassion, appropriate assessment, and intervention to control residents' pain by way of interdisciplinary approaches and using non-pharmacological and pharmacological methods. The policy also indicates the licensed nurse is responsible for the accurate assessment of the resident's pain, initiating the appropriate non-pharmacological and pharmacological pain interventions, evaluating the outcome of interventions, and ensuring that all documentation requirements are met. A clinical record review revealed Resident 61 was admitted to the facility on [DATE], with diagnoses that include osteoporosis (a condition in which the body loses more bone than it produces, leading to a decrease in bone density and strength) and peripheral vascular disease (a condition that occurs when the arteries or veins become narrowed or blocked, reducing blood flow to the extremities). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 23, 2024, revealed that Resident 61 is cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Resident 61's care plan, initiated on November 11, 2024, outlined a goal that pain would not interfere with her activities of daily living. Interventions included administering pain medication as prescribed and monitoring its effectiveness. A physician's order effective January 2, 2021, for Resident 61 to receive tramadol HCl tablet 50 mg (an opioid pain medication) with direction to give 50 mg orally one time a day at 6:00 PM for pain management. A clinical record review revealed a real-time medication administration record (the record indicates the actual time the resident received the medication) for Resident 61's tramadol HCl tablet 50 mg. The real-time medication record indicated Resident 61's tramadol HCl tablet 50 mg was administered late on the following dates and times: January 25, 2025, at 8:13 PM (2 hours and 13 minutes after the scheduled administration time) February 11, 2025, at 8:10 PM (2 hours and 10 minutes after the scheduled administration time) February 14, 2025, at 9:36 PM (3 hours and 36 minutes after the scheduled administration time) (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February 15, 2025, at 10:37 PM (4 hours and 37 minutes after the scheduled administration time) March 1, 2025, at 8:06 PM (2 hours and 6 minutes after the scheduled administration time) March 2, 2025, at 8:00 PM (2 hours after the scheduled administration time) During an interview on March 4, 2025, at 11:06 AM, Resident 61 indicated that her pain medications are sometimes administered late. She explained she takes pain medications at 6:00 PM to prevent her pain from disturbing her sleep. Resident 61 indicated that she usually falls asleep between 8:00 PM and 9:00 PM and when the medication is delayed, she is often awakened by staff administering the medication, which causes frustration. During an interview on March 6, 2025, at approximately 10:30 AM, the Director of Nursing (DON) confirmed Resident 61 was administered tramadol HCl Tablet 50 mg over 2 hours after the scheduled administration time on six separate occasions from January 25, 2025, through March 2, 2025. The DON confirmed it is the facility's responsibility to ensure pain management is provided to residents consistent with professional standards of practice, the residents' comprehensive care plan, and the residents' preferences. 28 Pa. Code 211.5 (f)(xi) Medical records. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306 Based on a review of clinical records, controlled medication records, select facility policy, and a staff interview, it was determined the facility failed to implement procedures to ensure the accuracy of controlled medication records for four residents out of 23 residents reviewed. (Residents 23, 61,76 and 350). Findings include: A review of facility policy titled Administration of Medication Schedule II-V Control Drugs, last reviewed by the facility on October 14, 2024, revealed the facility will comply with federal and state laws and regulations in the handling, storage, disposal, and record-keeping of Schedule II-V controlled medication. The policy indicates when a Schedule II-V 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, and remaining balance. The policy indicates that this is to be completed immediately after the medication is administered. A review of facility clinical records revealed the facility utilizes an individual Controlled Medication Utilization Record to track, monitor, and reconcile each controlled medication, such as Oxycodone. Further review of facility clinical records revealed the facility tracks medication administration for each resident by way of the Medication Administration Record (MAR). The MAR indicates the medication administered, time and date of administration, staff administering the medication, pain prior to the administration of medication, and clinical rationale for the administration of medication. A clinical record review revealed Resident 61 was admitted to the facility on [DATE], with diagnoses to include osteoporosis (a condition in which the body loses more bone than it produces, leading to a decrease in bone density and strength) and peripheral vascular disease (a condition that occurs when the arteries or veins become narrowed or blocked, reducing blood flow to the extremities). A physician's order for Resident 61 to receive tramadol HCl tablet 50 mg (schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse) with direction to give 50 mg orally one time a day at 6:00 PM for pain management, was initiated on January 2, 2021. Resident 61's individual controlled medication record documented that a dose of Tramadol HCl 50 mg was removed from the medication supply on January 10, 2025, at 6:00 PM. However, the MAR did not reflect administration of the medication, and a progress note indicated the dose was held due to the resident's lethargy. During an interview on March 6, 2025, at approximately 9:30 AM, the Director of Nursing (DON) confirmed there was no documented evidence the medication was administered or returned, leading to a discrepancy in medication accountability. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 350 was admitted to the facility on [DATE], with diagnoses that include atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and left femoral neck fracture (a break in the bone that connects the hip joint to the rest of the thigh bone). A physician's order for Resident 350 to receive Oxycodone HCL 5mg (a schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse) was initiated on December 2, 2024, with instructions to administer one tablet every 6 hours as needed for moderate pain. Resident 350's individual controlled medication record indicated that Oxycodone HCl 5 mg was removed and utilized on four separate occasions. January 12, 2025, at 8:00 PM February 2, 2025, at 9:30 AM February 11, 2025, at 7:22 PM February 13, 2025, at 8:00 PM However, the MAR did not contain documentation of administration for those dates. During an interview on March 6, 2025, at approximately 12:30 PM the DON was unable to explain the discrepancies and confirmed the facility failed to implement procedures to accurately reconcile controlled substances. A clinical record review revealed Resident 23 was admitted to the facility on [DATE], with diagnoses that include spinal stenosis (abnormal narrowing of the spinal canal that results in pressure on the spinal cord or nerve roots) and maxillary fracture (a break in the jawbone). A physician's order for Resident 23 to receive Oxycodone HCL 5 mg. (a schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse) was initiated on February 19,2025, with instructions to administer one tablet every six hours as needed for moderate to severe pain. Resident 23's individual controlled medication record documented that Oxycodone HCl 5 mg was removed from the supply on February 27, 2025, at 3:00 AM, but there was no corresponding entry in the MAR indicating administration of the medication. During an interview on March 6, 2025, at approximately 9:30 AM, the DON acknowledged the discrepancy and confirmed the facility failed to ensure compliance with controlled substance documentation policies A clinical record review revealed Resident 76 was admitted to the facility on [DATE], with diagnoses that include Intervertebral Disc Degeneration (a breakdown of the disks that separate the bones of the spine) and Diabetes Mellitus II (a metabolic disorder in which the body has high sugar levels for a prolonged period). A physician's order for Resident 76 to receive Hydrocodone Acetaminophen Oral Tablet 5-325 mg. (schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse) was initiated on January 13, 2025, with instructions to administer one tablet every six hours as needed for moderate pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 76's individual controlled medication record documented that Hydrocodone Acetaminophen 5-325 mg was removed from the supply on February 9, 2025, at 9:30 PM, and February 20, 2025, at 3:00 PM. However, there was no documented evidence in the MAR indicating the medication was administered. The DON confirmed the discrepancies and acknowledged the facility failed to implement effective procedures to reconcile controlled substance records. The facility failed to follow their own policy to ensure accurate documentation of controlled substances. 28 Pa Code 211.5(f)(xi) Medical records 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306 Based on a review of clinical records and staff interviews, it was determined the attending physician failed to act upon pharmacist-identified irregularities in the medication regimen of one of 24 residents sampled (Resident 10). Findings include: A review of clinical records revealed Resident 10 was admitted to the facility on [DATE], with diagnoses to include hypertension (blood pressure that is higher than normal) and atrial fibrillation (a condition that causes the heart to beat irregularly and occasionally much faster than normal). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 23, 2025, revealed that Resident 10 had moderately impaired cognition with a BIMS score of 10 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8-12 indicates cognition is moderately impaired). A review of a Consultant Pharmacist Medication Regimen Review dated November 2024 revealed that the consultant pharmacist identified irregularities in Resident 10's medication regimen, specifically noting the resident experienced six times the resident's heart rate was below 60 bpm (beats per minute) within a three-week period. The pharmacist recommended adding hold parameters to the resident's rate control medications to improve safety and prevent potential complications. Further review revealed that the facility's Certified Registered Nurse Practitioner (CRNP) responded to the pharmacy recommendation by noting to hold if HR (heart rate) is less than 60 bpm and notify the provider. However, the CRNP failed to specify which medication(s) this applied to, leaving the order ambiguous. Following questions asked during the survey with the Director of Nursing (DON) on March 6, 2025, at approximately 1:30 PM, it was identified that Resident 10's physician's order for Amiodarone HCL (an antiarrhythmic medication used for heart rate control) was revised to include the pharmacist's recommendations from November 20, 2024. However, a clinical record review revealed a discrepancy: A physician's order, written via telephone order by the DON, instructed staff to administer Amiodarone HCL 200 mg twice daily, with a hold parameter for HR less than 69 bpm, effective March 6, 2025. This did not align with the pharmacy's recommended hold parameter of HR less than 60 bpm, leading to a conflict in medication administration. A review of the Medication Administration Record (MAR) for March 2025 revealed that, on March 6, 2025, at 9:00 PM, the resident's recorded heart rate was 62 bpm, which resulted in the Amiodarone HCL being withheld, contrary to the pharmacist's recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When questioned, the DON confirmed there was a data entry error when inputting the hold parameters and that the correct order should have specified a hold if HR was less than 60 bpm and not 69 bpm. During an interview with the DON on March 7, 2025, at approximately 9:35 AM, the DON confirmed the CRNP failed to accurately respond to the pharmacist's recommendation, leading to delayed and inaccurate medication orders. The DON further confirmed the order was corrected to reflect the appropriate hold parameters following the surveyor's inquiry. The facility failed to ensure that the attending physician/CRNP acted upon pharmacist-identified medication irregularities in a timely and accurate manner. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c)(d)(3) Nursing services.