

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: 395324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Allied Services Meade Street Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on a review of clinical records, select facility policies, observation, and staff interviews, it was determined that the facility failed to implement effective procedures to maintain accurate records of controlled medications to ensure timely acquisition and administration of prescribed medications for one resident (Resident 108) and failed to timely obtain and administer prescribed medications for one resident (Resident 115) out of 24 residents sampled. Findings include: A review of the facility policy titled Administration of Medication, Schedule II -V Controlled Drugs last reviewed by the facility on October 23, 2025, revealed the facility will comply with all federal and state laws and regulations, and other requirements related to handling, storage, disposal, and record keeping of Schedule II-V controlled narcotics. (Schedule II-V medications are drugs regulated by federal law due to their medical use and potential for misuse, with Schedule II medications having the highest risk. Narcotics are medications commonly used to treat moderate to severe pain and require strict monitoring due to the risk of dependence).The Licensed Nurse administering the medication immediately enters all the following on the administration recorder, the date and time of administration, amount administered, signature of the nurse administering the dose, and balance of remaining medication to ensure accurate tracking and accountability. A clinical record review revealed that Resident 108 was admitted to the facility on [DATE], with diagnoses that included peripheral vascular disease (a condition involving reduced blood flow to the limbs caused by narrowed or blocked blood vessels) and methicillin-resistant Staphylococcus aureus (MRSA) infection (a bacterial infection resistant to many common antibiotics). A review of physician orders revealed that on June 30, 2025, Resident 108 was prescribed Oxycodone HCL oral tablet 5 mg (a schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse and requires strict documentation and accountability), with instructions to administer one tablet every six hours as needed for moderate to severe pain.A review of facility records revealed the facility utilized an Individual Resident's Controlled Substance Record to track the receipt, use, and remaining balance of controlled medications. The facility also utilized a Medication Administration Record (MAR), which serves as the legal record documenting the administration of medications, including the medication given, date and time administered, and the staff member administering the medication. A comparison of Resident 108's Controlled Substance Record and the MAR from August 1, 2025, through January 2026, revealed discrepancies. The Controlled Substance Record reflected six entries indicating Oxycodone 5 mg was removed or utilized, while the MAR lacked corresponding documentation indicating the medication was administered. The discrepancies occurred on the following dates and times:October 22, 2025, at 11:30 AMDecember 16, 2025, at 8:00 PMDecember 18, 2025, at 8:00 AMDecember 22, 2025, at 8:00 PMDecember 23, 2025, at 8:00 PMJanuary 7, 2026, at 8:00 PMThe absence of corresponding MAR documentation indicated the facility failed to maintain accurate and reconciled records for a Schedule II controlled medication, as required by facility policy and professional standards. An interview conducted on January 16, 2026, at 11:45 AM, with the Director of Nursing (DON) included a review of the above findings related to the failure to reconcile Resident 108's controlled substance (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395324	If continuation sheet Page 1 of 3

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation. A clinical record review revealed that Resident 115 was admitted on [DATE], at 3:00 PM, with diagnoses that included acute on chronic systolic heart failure (a condition in which the heart cannot effectively pump blood over time), history of pulmonary embolism (a blood clot that blocks blood flow in the lungs), atrial fibrillation (AFib) (an irregular heart rhythm that increases the risk of stroke), presence of a pacemaker (a device that helps regulate heart rhythm), and chronic obstructive pulmonary disease (COPD) (a chronic lung condition that restricts airflow and breathing). A review of Resident 115's admission orders dated January 7, 2026, and confirmed by Employee 1, licensed practical nurse (LPN), revealed the following medications were prescribed for administration at 9:00 PM: Acetazolamide 500 mg twice daily, a diuretic used to reduce excess fluid and help control blood pressure. Aldactone (spironolactone) 35 mg twice daily, a diuretic that removes excess fluid while maintaining potassium balance. Eliquis (apixaban) 5 mg twice daily, a blood thinner used to reduce the risk of blood clots and stroke. Furosemide 40 mg twice daily, a diuretic used to treat fluid buildup in heart failure. Losartan 50 mg twice daily, a medication used to lower blood pressure. Metoprolol Succinate ER 25 mg twice daily, a medication used to control heart rate and blood pressure. These medications were prescribed to manage the resident's cardiac and circulatory conditions. The absence of documented administration created the potential for fluid overload, uncontrolled blood pressure, irregular heart rhythm, and increased risk of blood clot formation. A review of Resident 115's electronic Medication Administration Record (eMAR) for January 2026 revealed that the prescribed medications were not administered as ordered. Further review of the clinical record revealed documentation by Employee 1 on January 7, 2026, at 10:35 PM, indicating the medications were waiting on pharmacy delivery. The facility was unable to provide documented evidence that the January 7, 2026, 9:00 PM scheduled medications were administered as prescribed. A review of the facility's automated dispensing system (ADS) at the time of Resident 115's admission revealed that multiple prescribed medications were available within the system, including five (5) Eliquis 2.5 mg tablets, six (6) Furosemide 40 mg tablets, and six (6) metoprolol succinate ER tablets were available. An automated dispensing system is an electronic medication storage and dispensing system intended to provide timely access to medications and prevent delays in care. A review of a facility provided policy entitled Ordering and Receiving Medication: Ordering and Receiving Medications from Pharmacy last reviewed by the facility October 23, 2025, indicated medications and related products are ordered and received from the pharmacy. New medications, except for emergency or stat medications, are ordered as follows: (a) if needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within four (4) hours. (b) Timely delivery of new orders is required so that medication administration is not delayed. The emergency/starter kit is used when the resident needs medication prior to pharmacy delivery such as when the medication is urgently needed by the patient or when pharmacy delivery is delayed due to route schedule or a weather event. Use of the starter systems in a non-emergency must be communicated to the Pharmacy prior to administration. During an interview with the Director of Nursing on January 15, 2026, at 10:30 AM, the above findings were reviewed, including the failure to implement facility procedures for obtaining medications for a new admission and accessing medications available through the automated dispensing system. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.5(f)(xi) Medical records 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.12 (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** Based on a review of clinical records and staff interviews, it was determined that the facility failed to ensure documented clinical justification for the use of psychoactive medications for one of five sampled residents for unnecessary medication prescribing practices (Resident 81). Findings included: A review of Resident 81's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Lewy body dementia (a progressive brain disorder associated with problems in thinking, movement, behavior, and mood; visual hallucinations are a common symptom). A review of physician orders revealed that Resident 81 was prescribed multiple psychoactive medications (medications that affect brain activity, mood, or behavior). A physician order dated November 15, 2025, directed Lexapro 10 mg by mouth once daily for depression. This dose was increased to 25 mg by mouth once daily on December 3, 2025. An additional order dated December 3, 2025, directed Desyrel (Trazodone) 50 mg by mouth once daily for depression. Both medications are classified as antidepressants used to treat mood-related conditions. A review of the monthly consultant pharmacist medication regimen review dated December 21, 2025, documented that Resident 81 was receiving two antidepressant medications, Lexapro and Desyrel, for the same condition. The pharmacist noted concern for increased side effects when two or more medications of the same class are used concurrently and recommended documentation of the clinical need for combination therapy, including a risk-versus-benefit assessment. A review of the attending physician/prescriber response dated December 23, 2025, indicated disagreement with the pharmacist's recommendation. The only rationale documented was followed by psych. However, a review of Resident 81's clinical record revealed no documentation that the resident had been evaluated by psychology or psychiatric services since admission on [DATE]. The above findings were reviewed with the Director of Nursing on January 18, 2025, at 12:15 PM. At that time, no additional documentation was provided to demonstrate that Resident 81 had been seen by psychological or psychiatric services or that a documented risk-versus-benefit analysis supported the continued use of multiple antidepressant medications. 28 Pa. Code 211.2 (d) (3) Medical Director. 28 Pa. Code 211.5 (f) (ix) Medical records. 28 Pa. Code 211.9 (k) Pharmacy Services. 28 Pa. Code 211.12 (d)(1)(3) Nursing Services.		