

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Allied Services Center City Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 80 E. Northampton Street Wilkes Barre, PA 18701	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on review of select facility policy, observations, and resident and staff interviews, it was determined that the facility failed to ensure that residents had reasonable and safe access to operate their over-the-bed lighting for four residents out of 21 residents reviewed (Residents 32, 50, 9, and 41). Findings include: The facility policy titled Environment last reviewed by the facility on October 1, 2025, indicated that the facility shall provide extra lighting to provide sufficient light to assist residents with tasks such as reading, and provide lighting for residents who need to find their way from the bed to the bathroom at night. During observations conducted on November 13, 2025, at 9:45 AM, it was noted that Residents 32, 41 and 9 had over-the-bed lighting fixtures; however, each fixture had a pull cord measuring two inches in length, making the light inaccessible to residents. An interview with Resident 41 during the observation revealed that she was unable to reach the over-the-bed light while in bed or while seated in the wheelchair. She stated, I would really like to. In fact, I need to. I get up a lot during the night and take myself to the bathroom, and I should have a light on so I can see what I'm doing. During an observation of Resident 50's room on November 13, 2025, at 10:15 AM, it was revealed that although an extension chain had been attached to the over-the-bed light, the resident's bed was positioned too far away for her to reach it. Resident 50 explained that the cord was not long enough for her to access from either the bed or wheelchair. She reported that her physical limitations, including upper body contractures (permanent tightening of muscles, tendons, ligaments or skin that limits normal movement) and deformities, further limited her reach. She stated, I like to read at night. When I'm done, I need to call the staff to turn it off. Sometimes I fall asleep before they come to turn it off and they wake me up to ask what I need. If they could give me a long enough cord, that would be very helpful. During an interview with the Nursing Home Administrator on November 14, 2025, at 9:30 AM, it was confirmed that the facility failed to ensure resident access to operate over-the-bed lights for multiple residents, representing a failure to accommodate individual needs and preferences. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined that the facility failed to timely identify weight loss, failed to ensure weekly weights were obtained as required by policy for prompt intervention for two of 21 sampled residents (Residents 15 and 22), and failed to implement individualized nutritional support measures based on a resident's stated preferences to maintain or improve nutritional parameters for one resident (Resident 8) out of three sampled residents for weight loss. Findings include: A review of the facility's policy titled Weighing Residents/Reporting Significant Weight Changes, last reviewed by the facility on October 1, 2025, revealed it is the facility policy to monitor weights on all residents. The policy indicated the facility will investigate, report, and appropriately intervene when a weight change occurs that may impact the residents' well-being. Further review of the policy revealed the facility will obtain residents' weights on admission and weekly for four weeks. The nurse and/or dietician will check the weights and verify if there was a loss or gain of 5% of total weight in one month, or 5 pounds in one week. A re-weight within 48 hours will be performed to verify actual weight loss. A clinical record review revealed Resident 15 was admitted to the facility on [DATE], with a diagnosis of a fracture of the lower end of the right radius (a break in the larger forearm bone near the wrist). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated October 29, 2025, revealed the resident was cognitively intact, with a BIMS (Brief Interview for Mental Status, a tool to assess cognitive function) score of 13 (a score of 13 to 15 indicates cognition is intact). A review of Resident 15's October 23, 2025, weight record revealed that Resident 15 weighed 151.6 pounds on admission, 150.8 pounds on October 31, 2025, and 144.6 pounds on November 3, 2025. This represents a seven pound loss since admission and a weight loss of 6.2 pounds in one week. The clinical record did not contain evidence that the facility completed a reweight within forty-eight hours as required by facility policy for a weight loss of five pounds in one week. The clinical record also did not contain evidence that the facility implemented interventions to prevent further weight loss. There was no documentation of weights or reweighs after November 3, 2025. The surveyor notified the facility on November 13, 2025, at 10:30 AM that no weights had been documented since November 3, 2025, despite the policy requirement for weekly weights on four occasions after admission. After inquiries made during the survey, the facility weighed the resident and recorded a weight of 144 pounds. During an interview with Resident 15 on November 12, 2025, at 11:30 AM, the resident stated she was right hand dominant and that eating with a cast on her right arm was difficult. The resident stated she was not eating as much as she normally would at home. During an interview on November 13, 2025, at 1:30 PM, the Director of Nursing (DON) was unable to provide evidence that the facility timely identified Resident 15's weight loss and that interventions or discussion of the weight loss to prevent further weight loss was identified or completed prior to inquiries made during the survey. A clinical record review revealed Resident 22 was admitted to the facility on [DATE], with a diagnosis of a urinary tract infection. A review of the weight record dated October 27, 2025, revealed an admission weight of 221.8 pounds. A subsequent weight dated November 2, 2025, revealed a weight of 217.9 pounds. Based on the facility policy, a weekly weight was required on November 9, 2025. No weight was obtained at that time. The weight was not obtained until November 13, 2025, at 9:30 AM, after notification by the surveyor, at which time the resident weighed 212.2 pounds. A review of a progress note dated November 13, 2025, at 2:30 PM, revealed that the resident's meal completion was as low as 26 percent. There was no evidence that the facility obtained Resident 22's weekly weights as required by policy to identify weight loss or initiate appropriate interventions, including discussion with staff or the resident. During an interview on November 14, 2025, at 10:00 AM, the DON was unable to provide evidence that the facility's Weighing Residents/Reporting Significant Weight Changes policy was implemented to timely (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identify weight loss. A clinical record review revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses that included status post left above-knee amputation, right below-knee amputation, diabetes (a condition where the body has too much sugar, known as glucose, in the blood because it can't effectively use insulin, a hormone that helps glucose get into cells for energy), and peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage, or spasms in a blood vessel). A review of an admission Minimum Data Set assessment (MDS dated [DATE], revealed the resident was cognitively intact, with a BIMS score of 14, indicating intact cognition. The resident's care plan initiated September 18, 2025, and revised October 3, 2025, identified risk factors for weight loss that included decreased appetite, significant weight loss, diabetes, and recent amputation. The stated goals included maintaining or increasing weight, consuming more than fifty percent of meals, adhering to a therapeutic diet (meal plan designed to manage or treat a specific medical condition), and taking prescribed nutritional supplements (a product taken orally to supplement the diet with extra vitamins, minerals, calories, protein, or other substances to improve nutritional intake). Interventions planned included providing meal alternatives when meals were refused, administering dietary supplements, weighing the resident weekly for four weeks and then monthly, and reporting decreased meal intake. A review of the resident's weight record revealed the following recorded weights: September 18, 2025: 179 pounds (completed three days after admission) September 23, 2025: 172.6 pounds (3.5% weight loss) October 1, 2025: 164.6 pounds (8% weight loss in 15 days) October 3, 2025: 164.4 pounds (reweight for October 1, 2025, 8.2% weight loss in 17 days) October 6, 2025: 161.4 pounds October 13, 2025: 160.7 pounds October 20, 2025: 160.6 pounds November 4, 2025: 160.2 pounds (10.5% significant weight loss in 47 days). A review of a nutritional weight warning note dated October 3, 2025, revealed that the resident had a significant weight loss of 14.2 pounds, which is 8.2 percent, in less than one month. The registered dietitian (RD) recommended Glucerna (a nutritional drink for people with diabetes, which provides extra calories, protein, and nutrients) once daily to prevent further weight loss. A review of a nutritional weight warning note dated October 14, 2025, revealed that the resident continued to lose weight, with an additional loss of 3.7 pounds, which was 2.2 percent, since the October 3, 2025, note. The registered dietitian discontinued the Glucerna supplement and recommended no sugar added Mighty Shakes (a nutritional drink without added sugar that provides extra calories, proteins, and nutrients) with meals to prevent further weight loss. A review of the resident's Task Documentation Record from October 14 through October 31, 2025, revealed that staff documented the resident consumed between 0 percent and 100 percent of the Glucerna supplement once daily, despite Glucerna being discontinued on October 14, 2025. Staff also documented consumption of Mighty Shakes three times per day during this same period. A review of the resident's Task Documentation Record from November 1 through November 13, 2025, revealed that staff continued to document the resident consumed between 0 percent and 100 percent of the Glucerna supplement once daily, although the supplement remained discontinued. Staff also documented the resident consumed between 0 percent and 100 percent of the Mighty Shakes three times per day. During an interview with Resident 8 on November 13, 2025, at 2:15 PM, the resident stated that he was aware he had lost weight. The resident stated he did not like the Mighty Shakes because he felt they raised his blood sugar. The resident stated he preferred Glucerna and reported he had not received Glucerna in some time. An interview with the foodservice director (FSD) on November 13, 2025, at 2:45 PM confirmed that Glucerna was discontinued on October 14, 2025, and that Mighty Shakes three times per day were initiated by the registered dietitian. The Foodservice Director was unable to provide documented evidence that the resident's preferences were considered prior to discontinuing the Glucerna supplement. An interview with the director of nursing (DON) on November 14, 2025, at 9:00 AM confirmed that staff were responsible for accurately documenting on the resident's Task Documentation Record to accurately reflect what is consumed by a resident. The Director of Nursing confirmed that Glucerna continued to appear on the resident's October and November Task Documentation Records despite being discontinued on October 14, 2025. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.5 (f)(ii)(iii)(x) Medical records. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined that the facility failed to provide person-centered care as prescribed to meet the current clinical needs and failed to follow physician orders for the management of a Peripherally Inserted Central Catheter (PICC) line for three of 21 sampled residents (Residents 12, 75, and 76). Findings include: A review of the facility policy entitled Central Venous Catheter/PICC Care/Flush/Medication Administration, last reviewed October 1, 2025, indicated the facility is to provide dressing changes, medication, and flushes to residents with a PICC line access (a thin flexible tube that is inserted into a large vein to the heart to deliver medications and other therapies into the bloodstream) and that all residents with a PICC lines will have emergency care measures in place in the event of line breakage or dislodgement. Dressing changes are to be made weekly and as needed with the extension tubing, if applicable, stabilization device, if applicable, and cap change, unless ordered otherwise by the physician. Further review revealed that the PICC line should be flushed with 10 milliliters (ml) of normal saline prior to medication being administered and after the medication is complete to flush with 10 ml of normal saline. All residents with a PICC line will have a clamp and dressing kit taped to the back of their bed's headboard or wall, and placement of these emergency items will be checked every shift by the designated nurse and documented on the Medication Administration Record (MAR). A review of clinical records revealed Resident 12 was admitted to the facility on [DATE], with diagnoses to include osteomyelitis (bone infection) of the lumbar spine and sepsis due to Escherichia coli (E. coli, a bacterium) and was receiving intravenous (IV, within the vein) antibiotics through a PICC line. A physician order dated October 12, 2025, directed that an emergency PICC line kit be kept at the bedside and on the resident's wheelchair and checked every shift. An emergency PICC line kit is a small set of supplies kept immediately available for residents who have a PICC line. The emergency kit contains a sterile clamp and dressing materials used to quickly secure the catheter site if the PICC line becomes loose, breaks, leaks, or is accidentally pulled out. The kit is necessary because a disruption of the PICC line can allow air or bacteria to enter the bloodstream or cause bleeding. Immediate access to the clamp and dressing allows staff to stabilize the site until a medical provider can evaluate the resident. Keeping this kit at the bedside or wheelchair enables staff to respond without delay and reduces the risk of infection, catheter occlusion, loss of IV access, or other complications. A review of Resident 12's MARs (medication administration record) for October and November 2025 indicated that nursing staff documented the presence of the emergency PICC line kit at bedside and on the wheelchair each shift from October 12, 2025, through November 12, 2025. However, an observation conducted on November 12, 2025, at 11:00 AM, revealed that no emergency PICC supplies were present at the bedside or on the wheelchair. An interview with Employee 2, Registered Nurse, on November 12, 2025, at 11:30 AM, confirmed that Resident 12 had a physician's order for emergency PICC line supplies but that no such supplies were present. A physician order for Resident 12, dated October 12, 2025, noted an order for ceftriaxone (an antibiotic) 2000 milligrams (mg) intravenous one time daily for sepsis due to E. coli until November 13, 2025. A physician order for Resident 12, dated October 12, 2025, noted an order for Sodium Chloride 0.9% flush and to use 10 ml intravenously every shift to maintain patency. A review of Resident 12's physicians' orders and October and November 2025 MARs failed to indicate the resident's PICC line was flushed before and after the administration of each IV antibiotic as per facility policy. A review of clinical records revealed Resident 75 was admitted to the facility on [DATE], with diagnoses to include sepsis (a medical emergency where the body has an overwhelming inflammatory response to an infection, which can damage tissues and organs) due to methicillin-susceptible Staphylococcus aureus (MSSA, a type of Staphylococcus aureus that responds to certain antibiotics), that was present in a left pleural effusion (buildup of excess fluid in the space between the lungs and chest wall) and was (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving intravenous antibiotics through a PICC line. A review of physician orders dated November 8, 2025, revealed orders for an emergency PICC line kit to be kept at the bedside and on the resident's wheelchair and to be checked every shift. A review of Resident 75's Treatment Administration Record (TAR) for November 2025 indicated that nursing staff documented the emergency PICC line kit at the bedside and on the wheelchair as present each shift from November 8, 2025, through November 12, 2025. However, an observation conducted on November 12, 2025, at 11:05 AM, revealed no emergency PICC line supplies were available in the resident's room or on the wheelchair. An interview with Employee 2, Registered Nurse, on November 12, 2025, at 11:30 AM, confirmed that the emergency supplies were not present despite the physician order. Further review of physician orders dated November 8, 2025, indicated that the resident's PICC dressing and caps were to be changed weekly on Saturdays and as needed. Observation of the resident's PICC line dressing on November 14, 2025, at 9:10 AM, in the presence of Employee 1, Registered Nurse, revealed that the dressing was last changed on November 5, 2025. Employee 1 stated that the dressing should have been changed on November 12, 2025, seven days after the last change. A physician order for Resident 75 dated November 8, 2025, revealed an order for Cefazolin Sodium (an antibiotic) 2 grams (gm) intravenous every eight hours related to sepsis until December 9, 2025. A physician order for Resident 75, dated November 8, 2025, noted an order for Sodium Chloride 0.9% flush and to use 10 ml intravenously every shift to maintain patency. A review of Resident 75's physicians' orders and the November 2025 MAR failed to indicate the resident's PICC line was flushed before and after the administration of each IV antibiotic as per facility policy. A review of the clinical record revealed that Resident 76 was admitted to the facility on [DATE], with diagnoses that included MSSA after having a right knee replacement surgery on October 7, 2025, and was receiving intravenous antibiotics through a PICC line. A physician order for Resident 76 dated November 7, 2025, revealed an order for Cefazolin Sodium (an antibiotic) 2 gm intravenous every eight hours related to wound infection until December 13, 2025. A physician order for Resident 76, dated November 7, 2025, noted an order for Sodium Chloride 0.9% flush and to use 10 ml intravenously every shift to maintain patency (ensuring the line remains open and fluids can be administered without blockage). A review of Resident 76's physicians' orders and the November 2025 MAR failed to indicate the resident's PICC line was flushed before and after the administration of each IV antibiotic as per facility policy. During an interview with the Director of Nursing on November 14, 2025, at 11:00 AM the above findings were reviewed and confirmed regarding Resident 12, Resident 75 and Resident 76's PICC lines. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, review of select facility policy, and staff interviews, it was determined the facility failed to implement and adhere to procedures to ensure acceptable storage for medications on one of three nursing units (Nursing Unit 3). Findings include: A review of the facility policy titled Disposition of Medications: Discontinued Medications, last reviewed by the facility on October 1, 2025, revealed it is the policy of the facility that under circumstances where medications are discontinued by physician order, a resident is transferred or discharged and does not take medications with him or her, or in the event of a resident's death, the medications are marked as discontinued with a label closure. Medications can be disposed of on-site with a witness and completion of the medication disposition form or returned to the pharmacy for disposal with that document. The facility policy indicated medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up for destruction by the pharmacy. An observation on November 14, 2025, at 10:21 AM revealed an unsecured drawer in the Unit 3 Nursing Station. Employee 1, Registered Nurse (RN), indicated that she had no knowledge of medications stored in that drawer in the nursing station. Employee 1, RN, explained that medications for disposition should be secured in the medication room and not in a drawer at the nursing station. The unsecured drawer contained a brown paper bag with the following medications: 3 tablets Baclofen 10 mg-a muscle relaxer used to reduce muscle spasms.1 tablet Sertraline 50 mg-an antidepressant used for mood and anxiety.8 tablets Midodrine 25 mg-a medication used to raise low blood pressure.4 tablets Levetiracetam 250 mg-a seizure-prevention medication.2 tablets Levetiracetam 500 mg-a seizure-prevention medication.3 tablets Atorvastatin 40 mg-a cholesterol-lowering medication.1 tablet Atorvastatin 80 mg-a cholesterol-lowering medication.1 tablet Ezetimibe 10 mg-a medication used to lower cholesterol.1 tablet Tamsulosin 0.4 mg- a medication used to improve urination in prostate problems.1 tablet Trazodone 50 mg-a sleep and mood medication.1 tablet Allopurinol 300 mg-a medication used to prevent gout.1 tablet Plavix (clopidogrel) 75 mg-a blood-thinner used to prevent clots.1 tablet Mirtazapine 7.5 mg-a mood medication that can also help appetite and sleep.1 tablet Thera-M-a daily multivitamin.4 tablets Pantoprazole 40 mg-a medication used to reduce stomach acid and treat reflux.12 tablets Meclizine 25 mg-a medication used to treat dizziness or vertigo.7 tablets Apixaban 2.5 mg -a blood-thinner used to prevent clots and stroke.1 tablet Apixaban 5 mg-a blood-thinner used to prevent clots and stroke.4 tablets Atenolol 25 mg-a heart and blood pressure medication.7 tablets Folic acid 1 mg-a vitamin used to treat or prevent deficiency.1 tablet Donepezil 10 mg-a medication used for memory problems in dementia.1 tablet Gabapentin 100 mg-a medication used for nerve pain or seizures.1 tablet Memantine 10 mg-a medication used for memory and thinking problems in dementia.1 tablet Metoprolol 25 mg-a heart and blood pressure medication.1 Humalog insulin pen-rapid-acting insulin used to lower blood sugar.1 tablet Buspirone 5 mg-a medication used to treat anxiety. During an interview on November 14, 2025, at 10:35 AM, Employee 2, RN, indicated that she stored the medications in the Unit 3 nursing station drawer because she left the unit to attend a meeting. Employee 2, RN, explained that it is facility policy to secure medications for disposition in the medication storage room. An interview with the Director of Nursing on November 14, 2025, at 11:45 AM confirmed that the facility failed to ensure acceptable storage of medications for disposition, as required by facility policy. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.9(j.1)(3) Pharmacy services. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observations, and staff interviews, it was determined the facility failed to consistently implement measures planned to prevent the development of pressure sores for one resident out of 21 residents sampled (Resident 76). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists who specialize in the diagnosis, treatment, and care of adults. The largest medical specialty organization and second-largest physician group in the United States, Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility policy titled Wound Management/Pressure Reduction, last reviewed October 1, 2025, indicated it is the policy of the facility to assess each resident's potential for skin breakdown based on clinical risk factors, and the plan of care will be established to address prevention and treatment as needed, and that all residents will have a prevention or specialty mattress as needed. Further review revealed to apply pressure-relieving boots, heel/elbow protectors, or heel elevators as recommended by the wound nurse practitioner, therapist, or physician. A review of the clinical record revealed that Resident 76 was admitted to the facility on [DATE] with diagnoses that included methicillin susceptible staphylococcus aureus (MSSA, a type of bacterial infection caused by staphylococcus aureus bacteria that are susceptible to treatment with methicillin and other beta-lactam antibiotics) after having a right knee replacement surgery on October 7, 2025, and required use of a right knee immobilizer (a brace that holds the knee joint straight to prevent bending). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 10, 2025, revealed that Resident 76 was cognitively intact with a BIMS score of 15 (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). A review of the resident's care plan, initiated November 7, 2025, revealed a potential skin breakdown related to alteration in mobility due to recent surgery and that Resident 76 had actual skin breakdown caused by pressure with the presence of a Stage II ulcer (partial-thickness skin loss with loss of the outermost layer of the skin, usually shallow with a pink to red wound base) to the coccyx (the small bone at the very bottom of the spine) noted on admission. A Braden Scale for Predicting Pressure Sore Risk form on admission dated November 7, 2025, identified Resident 76 as being at moderate risk for pressure injury development. Physician's orders dated November 8, 2025, included a pressure-reducing mattress for the bed, a pressure-reducing cushion for the chair, and a Prevalon boot (a medical device designed to protect the heels and prevent pressure ulcers) for the right lower extremity while in bed. An observation of Resident 76 on November 12, 2025, at 11:00 AM revealed the resident lying down in bed wearing a right knee immobilizer, without the presence of a Prevalon boot on the right lower extremity. Observation of Resident 76's room revealed no Prevalon boot. A second observation on November 13, 2025, at 9:00 AM revealed Resident 76 was lying down in bed wearing a right knee immobilizer, without the presence of a Prevalon boot on the right lower extremity, which was confirmed by Employee 6, Licensed Practical Nurse. An interview with the resident revealed he never had a Prevalon boot placed on his right lower extremity (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Allied Services Center City Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 80 E. Northampton Street Wilkes Barre, PA 18701	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since being admitted to the facility. A review of Resident 76's treatment administration record (TAR) from November 2025 indicated the Prevalon boot on the right lower extremity was documented as being on the resident from November 8, 2025, through November 12, 2025, with no documentation of refusals noted. During an interview with the Nursing Home Administrator on November 13, 2025, at 9:45 AM, it was confirmed the facility did not consistently implement the planned interventions to prevent a right heel pressure ulcer for Resident 76. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility policy, and resident and staff interviews, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility to the extent possible for one resident out of 21 residents sampled (Resident 2). Findings include: A review of the facility policy titled Restorative Nursing Program, last reviewed by the facility on October 1, 2025, revealed it is the facility's policy to assist residents in maintaining or achieving the highest level of functioning through the intervention of restorative nursing. The policy indicates therapy will develop and recommend a plan of care, certified nursing aides are responsible for ensuring the program is performed per the plan of care, and the restorative nurse or designee will be responsible for overseeing the restorative aides. A clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that include chronic kidney failure (gradual loss of kidney function) and neuropathy (damage to the peripheral nervous system, which carries signals between the brain and the rest of the body). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 7, 2025, revealed that Resident 2 was 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 to 15 indicates cognition is intact). A physical therapy Discharge summary dated [DATE], revealed discharge recommendations for Resident 2 to receive 24-hour care and a functional maintenance program (a program designed to help the resident maintain their current level of physical ability and prevent decline through routine, targeted exercises or activities) and restorative nursing program(a nursing-led program providing ongoing, repetitive exercises to help the resident maintain or improve physical function after skilled therapy ends). A review of Resident 2's plan of care revealed a focus indicating he would receive a restorative nursing program with active range of motion (AROM exercises in which the resident moves their own joints through their available range without assistance)) and passive range of motion (PROM exercises in which staff move the resident's joints for them because the resident cannot move the joints independently) initiated on September 29, 2025. The plan of care indicated Resident 2 would receive the following exercises: (1) 15 left lower extremity (LLE) AROM hip flexion repetitions for two sets(2) 15 abduction and adduction repetitions for two sets(3) 15 knee flexion and extension repetitions for two sets(4) 15 right lower extremity (RLE) AROM and PROM hip flexion repetitions for two sets(5) 15 abduction and adduction repetitions for two sets(6) 15 knee flexion and extension repetitions for two sets During an interview on November 12, 2025, at 11:20 AM, Resident 2 indicated that he no longer receives therapy services at the facility. He explained that he does not receive any restorative nursing program interventions such as passive range of motion (PROM) or active range of motion (AROM) exercises. Resident 2 indicated he has not had any restorative nursing exercises for over a month. A review of Resident 2's documentation survey report (an electronic health record that indicates tasks completed for resident care) dated November 2025, revealed the facility provided the resident with 15 to 30 minutes of active range of motion exercises on each day from November 1, 2025, through November 13, 2025. The document indicated that Employee 3, Nurse Aide (NA), provided Resident 2 with 15 minutes of active range of motion exercise on November 13, 2025, at 11:28 AM. During an interview on November 13, 2025, at 11:32 AM, Resident 2 indicated that he had not received any restorative nursing interventions that morning and he further stated he had not received any exercises with staff since therapy ended over a month ago. During an interview on November 13, 2025, at 11:44 AM, Employee 3 (Nursing Assistant) confirmed she did not provide Resident 2 with the 15 minutes of active range of motion exercises identified in his care plan. She acknowledged she documented the intervention as (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed in the resident's medical record even though it had not been provided. Employee 3 confirmed it is not the facility's policy for staff to document completion of care plan interventions before they are carried out. During an interview on November 13, 2025, at 12:05 PM, the findings were reviewed with the Director of Nursing. The Director of Nursing confirmed it is not the facility's policy for staff to document care plan interventions as completed prior to implementation. The Director of Nursing acknowledged the facility did not ensure that Resident 2's restorative nursing program interventions were implemented as outlined in his plan of care and did not ensure that Resident 2 was provided with the services needed to maintain mobility to the extent possible. 28 Pa. Code: 211.5(f)(ix) Medical records. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa Code 211.12(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** Based on a review of clinical records, select facility policy, controlled substance records, and staff and resident interviews, it was determined that the facility failed to follow physician orders, complete timely pain assessments, implement measures to reduce or alleviate pain, reassess the effectiveness of pain interventions within a reasonable time frame, and accurately document these activities in the clinical record for three of 21 sampled residents (Residents 15, 45, and 23). Findings include: A review of the facility's policy entitled Pain Management Process, last reviewed by the facility on October 1, 2025, indicated that the facility was to ensure resident comfort and that documentation of assessments, interventions, and outcomes utilized to control pain would be established. Resident pain levels are to be assessed by staff utilizing a numeric pain scale. Residents who can verbalize their degree of pain would be directed to provide a numerical number between zero and ten. Zero (0) would indicate no pain. A numeric number between one and four (1-4) would indicate mild pain. A numeric number between five and seven (5-7) would indicate moderate pain. A numeric number between eight and ten (8-10) would indicate severe pain. According to the policy, the physician would be notified of the resident's assessed pain levels, and then medications for the degree of pain would then be prescribed. The Pain Management Process policy directs staff to attempt non-pharmacological interventions (non-medication-related interventions to relieve pain such as repositioning, heat or cold packs, massage and relaxation techniques) prior to administration of pain medications and to document the results. If non-pharmacological interventions were not successful, a licensed nurse would then document that a medication was administered and would reassess the resident to evaluate the effectiveness of the pain relief within a reasonable time frame. A clinical record review revealed that Resident 15 was admitted to the facility on [DATE], with a diagnosis of a fracture of the lower end of the right radius (a break in the larger forearm bone near the wrist). A physician's order dated October 23, 2025, directed staff to administer hydromorphone 2.0 milligrams (an opioid pain-relieving medication) every four hours as needed for moderate to severe pain. A review of the Individual Resident's Controlled Substance Record dated October 27, 2025, showed the resident received hydromorphone at 11:40 PM. A review of nursing documentation initiated on October 23, 2025, failed to show documentation of the resident's pain level at the time of administration, any attempted non-pharmacologic measures prior to administration, or any reassessment of the resident's pain relief after the medication was provided. During an interview on November 14, 2025, at 11:00 AM, the Director of Nursing (DON) was unable to produce evidence that staff implemented the facility's pain management policy for Resident 15. A clinical record review revealed that Resident 45 was readmitted to the facility on [DATE], with a diagnosis of fibromyalgia (a chronic condition that causes widespread pain and fatigue) and had recent history of falls. A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 12, 2025, revealed that Resident 45 was cognitively intact with a BIMS score of 15 (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). A review of nursing documentation dated November 11, 2025, at 9:35 PM, revealed that Resident 45 was prescribed Hydrocodone 10-325 milligrams (an opioid pain-relieving medication) with directions to give one tablet by mouth every six hours as needed for a moderate pain level of five through seven (5-7) and Hydrocodone Oral Tablet 10-325 milligrams with directions to give two tablets by mouth every six hours as needed for severe pain of eight through ten (8-10). A subsequent nurse's note dated November 12, 2025, at 1:41 AM documented that at 11:30 PM on November 11, 2025, the resident was yelling out for pain medication, but staff informed her that the ordered medication was not available in the facility and would need to be delivered by the pharmacy. Review of the November 2025 controlled (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substance record showed that the resident did not receive the medication until 12:36 AM, more than one hour after staff were notified of her pain, confirming a delay in administration. The Director of Nursing confirmed on November 13, 2025, at 1:30 PM that the ordered medication was not kept on-site and had to be obtained from the pharmacy once staff communicated the need. Further review of the clinical record revealed no documentation that staff notified the physician about the medication's unavailability or requested alternative pain intervention during the delay. At the time the resident requested pain relief, her pain was assessed at a level 7 (moderate pain), requiring the administration of one tablet; however, the controlled substance record showed that two tablets were administered, constituting an incorrect dose. During an interview on November 14, 2025, at 9:30 AM, the resident confirmed receiving two tablets. During an interview on November 13, 2025, at 1:30 PM, the Director of Nursing confirmed both the delay and the incorrect dosage. A clinical record review revealed that Resident 23 was admitted to the facility on [DATE], with a diagnosis to include osteoarthritis (degenerative joint disease where the cartilage that cushions the ends of the bones wears down, leading to pain). A physician's order dated November 6, 2025, revealed that Resident 23 was to be administered Tylenol 650 mg (an over-the-counter pain reliever) as needed for mild pain. A review of nursing documentation dated November 6, 2025, at 2:15 PM revealed that Resident 23 requested pain medication for neck discomfort. Further review of the clinical record and the Medication Administration Record (MAR), dated November 2025, failed to indicate that the resident's pain level was assessed on the numeric scale, that non-pharmacological interventions were offered, or that pain medication was administered. A review of Resident 23's care plan dated November 1, 2025, showed that planned interventions included administering pain medication as ordered and documenting its effectiveness. During an interview on November 14, 2025, at 11:30 AM, the DON was unable to provide evidence that Resident 23's pain was fully evaluated or that interventions were timely implemented to relieve the pain. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services.		