STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396074	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allied Services Skilled Nursing Center	303 Smallacombe Drive Scranton, PA 18501

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	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, hospital records prior to admission, select facility policies and procedures, facility-provided investigative documentation, and staff interview, it was determined the facility failed to accurately assess pressure injury risk, failed to implement appropriate preventative interventions, and failed to conduct timely and thorough skin assessments to prevent the development of pressure injuries for one resident (Resident CR1) of five residents reviewed.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 a facility policy titled Wound Management/Pressure Reduction last reviewed July 2025 revealed it is the policy of the facility to assess each resident's potential for skin breakdown based on clinical risk factors. The policy revealed upon discovery of a pressure ulcer, the investigation will be initiated, a plan of care will be established, the nurse will notify the wound nurse, and the residents will have a prevention or specialty mattress as needed. The policy further noted the Braden scale (a standardized assessment tool used to determine a resident's risk for developing pressure injuries by evaluating six risk factors including sensory perception, moisture, activity, mobility, nutrition, and friction/shear; scores range from 6-23, with lower scores indicating greater risk)will be done for every admission to the facility, and then every week for four (4) weeks. The policy details that weekly body checks will be done and recorded appropriately by certified nurse aides. The policy defines an unstageable pressure ulcer as ulcers that are covered with slough (a yellow, stringy material made of devitalized tissue, meaning dead tissue that has lost its blood supply) and eschar (a thick layer of dead tissue) and true depth cannot be determined. Once the ulcer is debrided (dead or damaged tissue removed) of slough and/or eschar such that the tissues involved can be determined, then the ulcer can be reclassified with proper ulcer stage (the true depth and extent of tissue damage can be determined). The ulcer does not have to be completely debrided or free of all slough and/or eschar in order to reclassify the stage. The policy detailed that if a skin area is identified, the information will reflect the type of skin impairment, the location, size, description, shape, drainage, odor, or necrosis. The policy indicated that if an unstageable pressure ulcer is identified, staff is to apply moist saline dressings every shift with dry sterile dressings, consult the wound care nurse, consult the physician, and consult the dietician for recommendations. A review of Resident CR1's clinical record revealed the resident was admitted to the facility on [DATE], with (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396074	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allied Services Skilled Nursing Center	303 Smallacombe Drive Scranton, PA 18501

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	diagnoses that included muscle weakness and difficulty walking. A review of Resident CR1's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 8, 2025, revealed that Resident CR1 was moderately cognitively impaired 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 through 12 indicates moderate cognitive impairment). The MDS revealed Resident CR1 was dependent on staff for multiple activities of daily living including toileting, bathing, upper and lower body dressing, bed mobility, and transfers. The assessment documented the resident required maximal assistance to roll in bed and was dependent on staff for transfers between the bed, chair, toilet, and shower. A review of CR 1's clinical record revealed an admission nursing evaluation, completed on December 1, 2025, at 6:01 PM documented the resident used a wheelchair as the primary means of mobility and required others to push the wheelchair. The admission nursing evaluation revealed the resident to have flesh tone, warm, normal moisture, and good skin turgor (skin's elasticity, or its ability to change shape and return to normal). The assessment revealed the resident was observed to have bruising on the lower abdomen, redness and rashes on the penis, groin, buttocks, sacrum, coccyx area, and redness on the heel of the foot. However, the clinical record lacked documentation describing the type of skin impairment, size, drainage, odor, or tissue characteristics of the identified areas as required by the facility's wound management policy. A review of hospital records prior to admission revealed that on November 25, 2025, a wound care provider evaluated Resident CR1 and documented the presence of edema (swelling caused by fluid accumulation) and erythema (redness caused by inflammation or increased blood flow) to the penis and groin area. The wound care provider documented a moist and macerated skin area (skin that becomes soft and damaged due to prolonged exposure to moisture) with some bleeding present. The hospital wound care provider documented the resident's coccyx, buttocks, and gluteal folds were red and blanching, meaning the skin temporarily turned white when pressure was applied and then returned to red, indicating irritation and early skin compromise. The wound care provider further documented the resident was at high risk for further skin breakdown due to decreased mobility, friction, shear, moisture, respiratory compromise, and multiple medical conditions. The wound care provider recommended to continue the low air loss bed Citadel (these systems are designed to manage microclimate meaning heat and moisture, prevent pressure injuries, and support rehabilitation through alternating pressure and constant air), apply Desitin (treatment that uses Zinc Oxide to form a thick, protective barrier, instantly sealing out moisture and reducing redness) to the groins, penis, inner and posterior thighs, sacrum, coccyx, and buttocks twice daily. The provider recommended alternating with barrier cream (protective, often thick topical products that shield skin from moisture, irritants, and bacteria, helping to treat or prevent skin breakdown). The provider also documented to avoid adult briefs, reposition the resident every two hours while in bed and every one hour while located in the chair. The provider also recommended using a tan waffle cushion (seat cushion designed to redistribute weight and reduce pressure on the skin) when out of bed to the chair if the Braden score was below 14. A review of therapy assessments dated December 2, 2025, revealed that physical therapy documented Resident CR1 required extensive assistance to complete sit-to-stand transfers due to weakness and decreased activity tolerance. Occupational therapy documented the resident required maximal assistance for bed mobility and transfers. A review of admission documentation revealed a Braden Score Evaluation on December 1, 2025, at 6:02PM. The evaluation documented Resident CR1 had no impairment regarding sensory perception, was often moist, must be assisted to the chair or wheelchair, had no limitation making major or frequent changes in position, and was able to move freely and required minimal assistance scoring the resident at an 18 (low risk). The Braden assessment findings documented by facility staff were inconsistent with the resident's clinical condition. The clinical record documented that the resident required maximal assistance for mobility and transfers and could not independently reposition in bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396074	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allied Services Skilled Nursing Center	303 Smallacombe Drive Scranton, PA 18501

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	or chair. A review of a second documented Braden Score Assessment completed on December 8, 2026, at 2:25PM, revealed CR1 had no impairment regarding sensory perception, was occasionally moist, was unable to walk, was able to make occasional changes in body or extremity position without assistance, and again the resident was able to move freely and required minimal assistance, documenting a score of 16 (low risk), despite therapy evaluations confirming the resident required maximal assistance for mobility and transfers. Based on the resident's documented functional status and the presence of a moisture-associated skin area identified upon admission, the Braden Scale categories for mobility, moisture, and activity would have reflected greater impairment than documented. Scoring the assessment consistent with the resident's documented condition would have resulted in a score of approximately 12, which indicates high risk for pressure injury development. A review of CR1s progress notes revealed a note dated December 17, 2025, documenting the resident was at risk for skin breakdown due to a documented moisture associated area, limited mobility, and incontinence. The progress note revealed the resident was educated about the need to frequently reposition himself to avoid skin breakdown, despite the clinical record confirming resident CR1 was cognitively impaired, and unable to reposition himself without assistance. A progress noted dated December 26, 2025, at 1:17PM, again documented Resident CR1 was at risk for skin breakdown due to a documented moisture associated area, limited mobility, and incontinence. The progress note revealed the resident was educated about the need to frequently reposition himself to avoid skin breakdown, despite the clinical record confirming resident CR1 was cognitively impaired, and unable to reposition himself without staff assistance. A progress note dated December 29, 2025, at 10:30AM revealed Resident CR1 was observed to have an unstageable pressure injury to the right gluteus (right buttock) measuring 3cm (centimeters) x 3cm x 0.1 cm. The wound bed was described as 100 percent purple with non-blanching tissue, meaning the skin did not turn white when pressure was applied, which indicates tissue damage and impaired blood circulation. The progress note then documented the resident was educated about the need to reposition frequently and offload (removing or reducing pressure from the area) the wound as often as possible to allow wound healing, the note documented a new order for a low-air loss mattress (a therapeutic support surface designed to redistribute pressure and circulate air to reduce moisture and heat helping to prevent and treat pressure injuries) and to continue repositioning the resident every two hours as previously ordered. The facility failed to accurately assess pressure injury risk and failed to implement recommended pressure-relieving interventions, which placed Resident CR1 at risk for pressure injury development. The clinical record later documented the presence of an unstageable pressure injury to the right gluteal area. An interview with The Nursing Home Administrator and Director of Nursing on March 11, 2026, at 1:15PM reviewed the above findings of the facility's related to the development of a pressure injury for Resident CR1. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.