

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Allied Services Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility policy, and staff interviews, it was determined that the facility failed to assess and determine whether a resident could safely self-administer medications before permitting medications to be left at the bedside without staff supervision for one of 10 residents reviewed (Resident 1). Findings include: A review of the facility policy titled, Medication Administration, last reviewed August 20, 2025, revealed it was the facility's policy that medications were to be administered safely, timely, and as prescribed. A review of the facility policy titled Self-Administration of Medications, last reviewed August 20, 2025, revealed it was the facility policy that residents are reviewed on admission, when there is a change in status, and annually to determine a status for self-administration of medications. The policy revealed if it is determined by the interdisciplinary team that the resident is unable to carry out self-administration, the right to self-administer medications will be withdrawn. The policy further documented that each resident has the right to self-administer medications unless the interdisciplinary team has determined that the practice is unsafe. Clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses including pneumonia (an infection that causes inflammation and fluid accumulation in the lungs, making breathing difficult) and sepsis (a life-threatening condition in which the body's response to an infection causes widespread organ dysfunction). A review of Resident 1's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 8, 2026, revealed that Resident 1 was moderately cognitively impaired with a BIMS score of 11 (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). Clinical record review failed to identify documentation that the interdisciplinary team completed a self-administration of medications assessment upon admission or otherwise determined whether Resident 1 could safely self-administer medications. Observation conducted on July 28, 2026, at 8:46 AM revealed five medication tablets and capsules on the floor beneath Resident 1's bed next to the trash can. An empty medication cup was observed on the resident's bedside table. During an interview at the time of the observation, Resident 1 stated the nurse routinely placed medications on the bedside table and left the room before the medications were taken. Resident 1 stated he did not want to continue taking the medications because he did not know what they were for. The resident stated he attempted to throw the medications into the trash can but missed because of limited mobility. Employee 1, a Licensed Practical Nurse (LPN), confirmed she prepared the medications and brought them into Resident 1's room. Employee 1 stated she observed the resident begin taking the medications but could not confirm that she remained in the room until the resident swallowed them. Employee 1 could not explain why an empty medication cup remained on the bedside (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	table or why the medications were found on the floor. During the interview, Employee 1 identified three white speckled oblong tablets as glucosamine-chondroitin (a dietary supplement commonly used to support joint health) and two yellow capsules as gabapentin (a prescription medication commonly used to treat nerve pain and certain seizure disorders). Review of the physician's orders revealed Resident 1 had an active order for glucosamine-chondroitin 500 milligrams/400 milligrams, four tablets by mouth every morning, and gabapentin 300 milligrams by mouth three times daily. Review of the July 2026 Medication Administration Record (MAR) revealed Employee 1 initially documented both medications as administered. After Employee 1 was informed that the medications had been found on the floor, she revised the MAR documentation to indicate Resident 1 refused both the glucosamine-chondroitin and gabapentin. The findings were reviewed with the Nursing Home Administrator on July 28, 2026, at 1:00 PM. The facility failed to ensure the interdisciplinary team assessed and documented whether Resident 1 could safely self-administer medications before permitting medications to be left at the bedside without staff supervision and without confirming the resident had taken the medications. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services		