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	07/18/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-provided investigation reports, staff interviews, and facility policies, it was determined the facility failed to implement and monitor planned fall prevention interventions for one of 32 sampled residents (Resident 70), resulting in multiple falls. Clinical record review revealed that Resident 70 was admitted to the facility on [DATE], with diagnosis to include, end stage COPD (Chronic Obstructive Pulmonary Disease, a progressive lung disease), and was receiving hospice services.A review of a five-day admission Minimum Data Set (MDS a federally required standardized assessment) dated June 16, 2025, documented a Brief Interview for Mental Status (BIMS a cognitive assessment tool) score of 13 (a score of 13 to 15 indicates the resident is cognitively intact). The MDS also identified that the resident had an indwelling Foley catheter (a plastic tube inserted into the bladder to drain urine) and required staff assistance with activities of daily living.A care plan-initiated June 10, 2025, identified the resident as being at risk for falls. Interventions included maintaining a hazard-free environment, ensuring bed in the lowest locked position, call bell and needed items within reach, reinforcing call bell use, and use of non-slip footwear. The care plan also addressed the resident's indwelling Foley catheter.A review of facility investigative documentation dated June 11, 2025, at 7:35 AM, Resident 70 documented that the resident was found kneeling on the floor on the right side of her bed. She stated she was reaching to get something off the floor. She sustained a skin tear to the right elbow area. The Physician was notified. She had an indwelling foley catheter in place at that time and was noted to be wearing non-skid socks. New interventions after the fall interventions included referrals to occupational and physical therapy and issuance of a reacher device.A review of a nurse's note dated June 26, 2025, 12:57 P.M. indicated the hospice nurse assigned to the resident made the recommendation to discontinue the foley catheter and complete a voiding trial (removal of the urethral catheter and an assessment of the patient's ability to urinate without it). The Physician was contacted and the foley catheter was removed June 26, 2025, at 2:18 PM. However, the nursing staff failed to complete a bladder assessment or initiate the voiding trial, as recommended.On June 29, 2025, at 12:45 AM, the resident was found on the floor between the beds in her room. She stated, I had to go to the bathroom. The intervention put in place post-fall was to offer toileting and out-of-bed assistance on the 11:00 PM to 7:00 AM shift. There was no documented evidence that a bladder assessment or voiding trial had been completed to support the appropriateness of this intervention.A review of a witness statement by Employee 1 (nursing assistant) dated June 29, 2025, at 2:00 AM, documented that the resident had been awake and sitting up in bed earlier that shift and declined assistance, including toileting. A review of a facility investigation dated July 1, 2025, at 7:30 AM revealed Resident 70 was again found on the floor in her room, between the two beds. She had been sitting on the edge of the bed. She stated, I was trying to get to the bathroom. New interventions implemented at the time of the fall included implementing a bowel and bladder tracker (assessment of bowel and bladder function in order to identify elimination issues and to formulate a plan to maintain or improve elimination continence).On July 2, 2025, at 12:30 PM, the resident was found seated on the floor outside of the bathroom door. She stated, I was going to do something. The planned intervention was to educate the resident on call bell use, and to continue the previously ordered bladder tracker. However, at the time of the survey, there was no documented evidence that this intervention had been implemented.There was no evidence at the time of the survey that the facility implemented and monitored the effectiveness of the planned interventions, including toileting schedules, elimination tracking, and post-catheter care, to prevent repeated falls.During an interview July 17, 2025, at 1:00 P.M., the Director of Nursing confirmed that planned interventions were not timely implemented to prevent falls for Resident 70. Cross refer F 69028 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to evaluate the clinical necessity of an indwelling urinary catheter and failed to follow its own policies for catheter removal and bladder assessment for one of 35 sampled residents (Resident 70).A review of the facility's policy titled Urinary Catheter Insertion, Care, Irrigation, and Removal, last reviewed August 2024, indicated that indwelling bladder catheterization may only be used to relieve urinary retention not treatable by other means or to collect a urine specimen when a resident is unable to provide one midstream. The facility will attempt catheter removal, if medically able, and establish a toileting plan to address incontinence or urinary frequency. The indwelling catheter assessment tool will be used to determine whether the resident has a clinical condition which indicates the need for the indwelling catheter. If the criteria are not met, nursing staff are to notify the physician for either an order to remove the catheter or rationale for its continued use. Discuss with the Physician alternate methods of continence management including intermittent catheterization, or a toileting plan. The procedure for removal of the indwelling catheter included, after catheter removal, a licensed nurse must complete a bladder assessment within three to seven days to determine whether the resident is a candidate for a toileting plan. Clinical record review revealed that Resident 70 was admitted to the facility on [DATE], with diagnosis to include, end stage COPD (Chronic Obstructive Pulmonary Disease, a progressive lung disease). The clinical record noted the presence of an indwelling Foley catheter at the time of admission. A review of a five-day, admission minimum data set assessment (Minimum Data Set a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 16, 2025, revealed a BIMS score (Brief Interview for Mental Status an assessment tool to assess cognitive function) of 13 (a score of 13 to 15 indicates the resident is cognitively intact). The assessment confirmed the presence of a Foley catheter (a plastic tube inserted into the bladder with an associated collection bag to collect urine) and indicated that the resident required assistance with activities of daily living and was receiving hospice care. A review of a nursing bladder assessment dated [DATE], indicated the resident had an indwelling Foley catheter but did not include a documented diagnosis or clinical rationale to support its continued use. A subsequent post-admission bladder assessment dated [DATE], documented no change in the resident's urinary status, and the indwelling catheter remained in place. There was still no documented clinical justification for its continued use. A review of the resident's care plan dated June 9, 2025, under Activities of Daily Living, included toileting with the assistance of one staff member. A nursing progress note dated June 26, 2025, at 12:57 PM, documented that the resident's hospice nurse recommended discontinuing the Foley catheter and initiating a voiding trial (the process of removing the urethral catheter and monitoring for spontaneous urination). The physician was contacted, and the Foley catheter was removed at 2:18 PM the same day. However, there was no documentation that nursing staff completed a bladder assessment or initiated a voiding trial following catheter removal, as required by facility policy. Following the removal of the Foley catheter, Resident 70 experienced three documented falls while attempting to get to the bathroom:June 29, 2025-fall from bed while attempting to get to the bathroomJuly 1, 2025-fall from bed while attempting to get to the bathroomJuly 2, 2025-fall from bed while attempting to get to the bathroom A bladder assessment dated [DATE], noted the resident exhibited mixed urinary continence and included a plan to offer toileting before and after meals, at bedtime (HS), and when awake during overnight (11 PM to 7 AM) rounds. However, there was no documented bladder tracker to support this continence pattern or care plan. During an interview conducted on July 18, 2025, at 11:00 AM, the Director of Nursing (DON) indicated Resident 70 had been admitted to the facility with a Foley catheter. She confirmed there was no documented diagnosis or clinical justification for the catheter and acknowledged the facility's policy for catheter removal and follow-up bladder assessment had not been followed.Cross refer F 68928 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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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** Based on review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to complete a comprehensive nutritional assessment and monitor resident weights consistently and accurately to timely identify changes in nutritional status and implement appropriate interventions to address weight loss for one of thirty-five residents reviewed for nutritional status and weight loss. (Resident 75).A review of the facility policy titled Weighing Residents/Reporting Significant Weight Changes, last reviewed in March 2025, indicated that when a resident experiences a weight change of 5% or more in one month, nursing and/or the dietitian will reweigh the resident within 48 hours to verify the change. If verified, the dietitian is expected to reassess the resident's energy and hydration needs, adjust the care plan as necessary, and document the assessment and interventions in the electronic medical record.A review of Resident 75's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including moderate calorie-protein malnutrition (a condition in which the body does not receive or absorb enough nutrients to function properly) and dementia (a group of symptoms that affect memory, reasoning, and daily functioning). A review of Resident 75's documented weights showed the following:04/02/2025: 96.8 lbs.05/05/2025: 90.5 lbs.This reflects a 6.5% weight loss over a 33-day period, meeting the facility's threshold for significant weight loss requiring reweigh, reassessment, and possible care plan revision.However, a review of the resident's comprehensive person-centered care plan, initiated on June 20, 2022, and last revised on March 25, 2025, revealed no updates or revisions to reflect the significant weight loss noted on May 5, 2025. The plan of care already identified the resident as at risk for nutritional deficits due to her diagnoses and history of weight loss. Interventions included periodic weight monitoring and notification to the registered dietitian (RD), physician, and family in the event of significant changes. Despite this, there was no evidence of reassessment, documented physician notification, or implementation of revised nutritional interventions following the documented May 5, 2025, weight.Further review revealed the Registered Dietitian did not document the resident's significant weight loss until July 17, 2025, over two months after the weight loss occurred. The July 17 RD note acknowledged the weight change from April to May but did not recommend new interventions, stating that weight had been stable since May, and that the current plan of care would be continued. This delay in identifying and responding to the resident's nutritional decline is inconsistent with the facility's policy and fails to demonstrate timely reassessment or mitigation of nutritional risk.In an interview conducted on July 19, 2025, the above findings were reviewed with the Nursing Home Administrator.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** Based on select facility policy, clinical record review and staff interview, it was determined the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis and failed to ensure the physician orders were followed for one residents (Resident 166) of 35 residents reviewed. A review of the clinical record revealed that Resident 166 was admitted to the facility on [DATE], with diagnoses to include malignant neoplasm of the lung (a form of cancer affecting lung tissue). The resident had a current physician order initially dated June 4, 2025, for hydrocodone-acetaminophen (a narcotic pain medication) 10-325 mg tablet one tablet every four hours as needed, for moderate pain, defined in the order as pain rated between 5 and 7 on a pain scale (a numeric rating tool commonly used in healthcare to measure a resident's self-reported level of pain. 0 indicates no pain and 10 indicates the worst possible pain).A review of the resident's June 2025 Medication Administration Record (MAR) revealed staff administered the narcotic pain medication 19 times for the month of June. Documentation showed that non-pharmacological interventions were not attempted or documented prior to any of these 19 administrations, as required by standard nursing practice and pain management guidelines.Additionally, the MAR documented the narcotic pain medication was administered outside the parameters of the physician's order on the following dates:June 5, 2025, administered for a pain level of 9 (which is categorized as severe pain, not moderate).June 17, 2025, administered for a pain level of 0 (indicating no pain).June 18, 2025, administered for a pain level of 2 (mild pain).A review of the resident's July 2025 MAR revealed staff administered the narcotic pain medication five times for the month of June. Again, none of the documented administrations included evidence that non-pharmacological interventions were attempted or proven ineffective prior to medication use.These findings were reviewed with the Nursing Home Administrator during an interview conducted on July 18, 2025, at approximately 2:00 PM. The review confirmed that the facility failed to ensure pain medications were administered in accordance with physician orders and that non-pharmacological interventions were not consistently attempted or documented prior to the administration of as-needed narcotic pain medications.28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, review of select facility policy, and staff interviews, it was determined the facility failed to ensure staff followed appropriate infection control practices during the administration of medications for two of four residents observed during the administration of medications. (Residents 26 and 99) on the One North nursing unit. A review of facility policy titled Infection Control Policy and Procedure last reviewed by the facility on August 12, 2024, indicated the Infection Control Intervention Protocol is established and maintained for the detection, control and prevention healthcare associated infections. The elements of the protocol consist of infection criteria, standard and transmission-based precautions, hand hygiene, surveillance, infection control and prevention. On July 17, 2025, at 8:14 AM, an observation revealed that Employee 2, a Licensed Practical Nurse (LPN), was administering morning medications to Resident 99. While removing Vitamin D2 (1.25 mg capsule) from a medication package, the capsule fell onto the medication cart. Employee 2 picked up the capsule with his bare hand, without washing his hands or putting on gloves, and placed it into the resident's medication cup. The same observation revealed that a Senna 8.6 mg tablet fell onto the cart while being dispensed from a stock bottle. Employee 2 again picked up the tablet with his bare hand and placed it into the medication cup, without first washing his hands or using gloves. Lastly, Employee 2 pushed a Lorazepam 0.5 mg tablet from the medication card directly into his bare hand and placed it in the resident's medication cup, again without hand hygiene or glove use, before administering the medications to Resident 99. A subsequent observation at 8:35 AM revealed that Employee 2 was administering medications to Resident 26. A Furosemide 20 mg tablet fell onto the medication cart during preparation. Employee 2 picked up the tablet with his bare hand, without washing his hands or wearing gloves, and placed it into Resident 26's medication cup prior to administration. An interview was conducted with the Nursing Home Administrator (NHA) on July 17, 2025, at approximately 11:15 AM. The above findings related to Employee 2's failure to follow proper infection control practices during medication administration were reviewed at that time.28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.28 Pa. Code 211. 10(c)(d) Resident care policies.