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	05/01/2026

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

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(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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, select facility policy review, and staff interviews, it was determined the facility failed to ensure residents were free from foreseeable accident hazards related to the unattended placement and unsupervised administration of medications for 2 of 21 residents reviewed (Resident 116 and Resident 136) on 1 of 4 units observed.Findings included: A review of the facility policy titled, Medication Administration, last reviewed August 20, 2025, revealed it is the facility policy that medications are administered in a safe and timely manner and as prescribed. A review of the facility policy titled Self-Administration of Medications, last reviewed August 20, 2025, revealed it is 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team that the resident is unable to carry out self-administration, the right to self-administer medications will be withdrawn.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 drugs unless the interdisciplinary team has determined that the practice is unsafe. A clinical record review revealed Resident 136 was admitted to the facility on [DATE], with diagnoses to include dementia (a progressive, irreversible syndrome causing decline in memory, thinking, and daily functioning) and hypertension (high blood pressure, is a chronic condition where blood force against artery walls is consistently too high). A clinical record review revealed a Self-Administration of Medication assessment dated [DATE], documenting Resident 136 was unable to safely administer medications, because the resident could not state the purpose of the medications, could not identify the correct dosage, and could not identify the scheduled administration times. A clinical record review revealed Resident 116 was admitted to the facility on [DATE], with diagnoses of lymphedema (chronic condition characterized by the buildup of lymph fluid, usually in the arms or legs, causing swelling, discomfort, and skin changes) and muscle weakness. A clinical record review revealed a Self-Administration of Medication assessment dated [DATE], revealed Resident 116 was unable to safely administer medications, because the resident could not state the purpose of the medications, could not identify the correct dosage, and could not identify the scheduled administration times. During an observation of the medication pass on April 29, 2026, at 08:26AM, Employee 5, Licensed Practical Nurse (LPN), prepared medications for Resident 136 by pouring the medications into a medication cup. Employee 5 entered the resident's room, placed the medication cup on the bedside table, instructed the resident to take the medications, exited the room, and began preparing medications for another resident outside the room. Observation revealed Employee 5 turned away from Resident 136 and did not remain present to supervise administration or verify the resident safely swallowed the medications. Observation revealed Employee 5 LPN subsequently prepared medications for Resident 116, entered the resident's room, identified the resident, placed a medication cup containing five pills on the bedside table, and exited the room without supervising medication administration or verifying the resident safely swallowed the medications. Resident 116 was observed pouring the medications from the medication cup directly onto the bedside table and ingesting the pills individually without staff supervision. Employee 5 did (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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	396074	A. Building B. Wing	05/01/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not return to the room to observe completion of medication administration. During an interview conducted on April 29, 2026, at 08:39AM, Employee 5 stated both residents could self-administer medications without assistance despite facility assessments identifying both residents as unable to safely self-administer medications. The facility failed to ensure medications remained under staff supervision and failed to ensure residents assessed as unable to safely self-administer medications were protected from foreseeable accident hazards associated with unattended medications at the bedside. These hazards included the potential for improper administration, choking, incomplete ingestion, medication misuse, or access to medications by another resident. The above findings were reviewed with the Nursing Home Administrator on April 29, 2026, at 1:00PM. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of the Resident Assessment Instrument (RAI) Manual, Minimum Data Set (MDS) assessments, and staff interviews, it was determined the facility failed to ensure Minimum Data Set assessments accurately reflected the clinical status of three of 37 residents reviewed (Residents 273, 302, and 303).Findings include: The Resident Assessment Instrument (RAI) Manual is the federally issued instruction manual that provides specific coding guidance for each item on the Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care). Facilities are required to code the MDS according to the specific instructions outlined in the RAI Manual to ensure accuracy, consistency, and regulatory compliance. The Resident Assessment Instrument (RAI) Manual, October 2025, Section J, indicates a major injury related to a fall includes, but is not limited to, traumatic bone fractures (broken bones), joint dislocations, internal organ injuries, head injuries, spinal cord injuries, amputations, and crush injuries. A clinical record review revealed Resident 303 was admitted to the facility on [DATE], with diagnoses that included traumatic subdural hemorrhage (bleeding caused by trauma between the brain and its outer covering). A nursing progress note dated March 19, 2026, at 3:33 PM revealed Resident 303 was transferred from the facility to the community emergency department after being found on the floor in the resident's room. Documentation indicated the resident sustained a 3.0 centimeter (cm) by 3.0 cm by 0.3 cm laceration (a cut or tear in the skin) to the back right side of the head with a moderate amount of bleeding A review of emergency department records dated March 20, 2026, revealed Resident 303 was diagnosed with an acute-on-chronic subdural hematoma (a new area of bleeding occurring in addition to an older collection of blood between the brain and its outer covering). A nursing progress note dated March 20, 2026, at 10:00 AM revealed Resident 303 returned to the facility with three staples placed in the back of the head to close the wound. A review of Resident 303's discharge-return not anticipated MDS assessment dated [DATE], Section J, Health Conditions, revealed the assessment indicated the resident had not experienced a fall with major injury (head injury as defined in the RAI) since the prior assessment. During an interview conducted on April 30, 2026, at 11:06 AM, the Registered Nurse Assessment Coordinator (RNAC, the nurse responsible for coordinating and completing MDS assessments) confirmed Resident 303 sustained a fall with major injury, including an acute-on-chronic subdural hematoma and head laceration requiring staples. The RNAC confirmed the March 21, 2026, MDS assessment was not coded accurately. A clinical record review revealed Resident 302 was admitted to the facility on [DATE], with dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A nursing progress note dated November 9, 2025, at 10:00 PM revealed Resident 302 was transferred to the emergency department following a fall in the resident's room. A nursing progress note dated November 10, 2025, at 7:15 AM revealed Resident 302 returned from the hospital and refused use of a sling for the right arm. A nursing progress note dated November 13, 2025, at 10:35 AM revealed the resident sustained a non-operative right humerus fracture (a broken upper arm bone that did not require surgery) related to the fall. A review of Resident 302's discharge-return not anticipated MDS assessment dated [DATE], Section J, Health Conditions, revealed the assessment indicated the resident had not experienced a fall with major injury since the prior assessment. Review of the RAI Manual, October 2025, revealed fractures are considered falls with major injury for MDS coding purposes. During an interview conducted on April 30, 2026, at 11:06 AM, the RNAC confirmed Resident 302 sustained a fall with major injury, including a right humerus fracture. The RNAC confirmed the November 14, 2025, MDS assessment was not coded accurately. A review of Resident 273's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (commonly referred to as a stroke caused by blockage of blood flow to the brain resulting in brain (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tissue damage) and long-term anticoagulant use (ongoing use of blood-thinning medication to prevent harmful blood clots). Review of physician orders revealed an order initially dated December 15, 2025, directed staff to administer Eliquis (Apixaban, a blood-thinning medication used to reduce the risk of blood clots and stroke) 5 milligrams (mg) by mouth twice daily to Resident 273 related to a history of cerebrovascular accident (stroke).A review of Resident 273's January 2026, February 2026, March 2026, and April 2026 Medication Administration Records (MAR, a clinical record used to document medication administration) revealed staff administered Apixaban 5 mg twice daily as ordered by the physician. A review of Resident 273's quarterly MDS assessment dated [DATE], revealed the assessment indicated the resident did not receive anticoagulant medication during the seven-day look-back period (the observation period used for MDS coding prior to completion of the assessment). During an interview conducted on April 30, 2026, at 1:05 PM, the RNAC confirmed Resident 273 received anticoagulant medication during the seven-day look-back period and confirmed the March 25, 2026, quarterly MDS assessment was not coded accurately.28 Pa. Code 211.5(f)(x)(xi) Medical records. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policies, and staff interviews, it was determined the facility failed to develop and revise a resident-centered comprehensive care plan to accurately reflect current discharge planning goals and preferences for one of 37 residents reviewed (Resident 93).Findings include: A review of the facility policy titled, Planned Discharge, last reviewed August 20, 2025, revealed it is the policy to identify residents with the potential for discharge and develop an interdisciplinary (involving multiple professional disciplines working together) care plan to support transition to the next level of care. The policy revealed discharge planning would be discussed during care plan conferences with involvement of the interdisciplinary team. Review of the facility policy titled, Resident-Centered Comprehensive Care Plan, last reviewed August 20, 2025, revealed the care plan would be reviewed and revised promptly when changes occurred in the resident's physical or psychosocial (mental, emotional, and social) well-being. The policy indicated resident needs, goals, problems, and concerns would be updated by appropriate staff as frequently as necessary. Clinical record review revealed Resident 93 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease without dyskinesia (a progressive disorder of the nervous system that affects movement and coordination, without abnormal involuntary body movements). A review of Resident 93's (quarterly) Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 22, 2026, revealed that Resident 93 was cognitively impaired with a BIMS score of 12 (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 range of 8-12 means moderate cognitive impairment indicating Resident 93 has noticeable problems with memory or thinking, but is not in the severe range). A review of Resident 93's comprehensive care plan dated February 13, 2025, and in effect at the time of the survey, identified the resident as a potential discharge to home. Interventions included anticipating discharge needs such as medical equipment and home health services, involving the resident in discharge planning, providing written and verbal education, and evaluating community resources to support discharge. Review of the clinical record revealed social services progress notes dated September 3, 2025, and November 21, 2025, documenting Resident 93's intended goal to be discharged from the facility. Review of a social services progress note dated January 20, 2026, documented Resident 93's discharge plan had changed due to the resident requiring ongoing care and supervision in the facility. The note further documented Resident 93 declined referral to community discharge resources and planned to remain in the facility. Despite documentation indicating Resident 93's discharge goals had changed from discharge to home to long-term placement within the facility, the active comprehensive care plan in effect during the survey continued to identify discharge to home as the resident's goal and continued to include discharge planning interventions inconsistent with the resident's current preferences and needs. During an interview conducted on April 30, 2026, at 11:07 AM, the Nursing Home Administrator stated Resident 93 was initially considered for discharge to the community but was no longer able to be safely discharged and planned to remain in the facility. The Nursing Home Administrator acknowledged the active care plan had not been revised to reflect the resident's current discharge goals and preferences in accordance with facility policy. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, care plan conference attendance documentation, facility policy, and staff interview, it was determined the facility failed to ensure comprehensive care plan conferences were conducted following Minimum Data Set (MDS) assessments for one of 37 residents reviewed (Resident 93).Findings include: The Resident Assessment Instrument (RAI) Manual (October 2025) is the federally issued instruction manual that provides guidance for completion of the Minimum Data Set (MDS, a federally mandated standardized assessment process conducted periodically to assess resident needs and guide care planning). According to the RAI Manual, the facility must develop a comprehensive care plan within seven days after completion of the comprehensive MDS assessment and must review and revise the care plan following each assessment. The RAI further indicates the facility is responsible for assisting residents to participate in the care planning process, including conducting care plan conferences for information exchange and decision-making. The RAI also requires the facility to provide advance notice of care planning conferences to the resident and resident representative, when applicable, to support participation in the process. A review of the facility policy titled Resident Centered Comprehensive Care Plan, last reviewed August 20, 2025, revealed the facility will provide a comprehensive care plan, initiated on admission and reviewed after completion of each comprehensive assessment and quarterly assessment for each resident. The policy indicated the care plan would include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive and quarterly assessments. The procedure reveals social services will be responsible for inviting residents, families or the resident representative to participate in the plan of care conference and encourage attendance. According to the procedure, each discipline will provide a brief update at the Plan of Care meeting. Clinical record review revealed Resident 93 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease without dyskinesia (a progressive disorder of the nervous system that affects movement and coordination, without abnormal involuntary body movements). A review of Resident 93's quarterly Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 93 was cognitively impaired with a BIMS score of 12 (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 range of 8-12 means moderate cognitive impairment indicating Resident 93 has noticeable problems with memory or thinking, but is not in the severe range). Review of the clinical record, including MDS assessments, revealed a quarterly MDS assessment was completed on November 23, 2025, and an annual MDS assessment was completed on January 20, 2026. Review of the clinical record, including interdisciplinary progress notes and care plan conference attendance/signature documentation, did not include evidence that care plan conferences were conducted following the November 23, 2025, quarterly MDS assessment or the January 20, 2026, annual MDS assessment. Review of the clinical record did not include evidence of care plan conference participation, information exchange, resident involvement in care planning, or documented efforts to engage Resident 93 and/or the resident representative in the care planning process following the November 23, 2025, and January 20, 2026, MDS assessments, as required by the RAI Manual and facility policy. During an interview conducted on April 30, 2026, at 11:07 AM, the Nursing Home Administrator (NHA) confirmed care plan conferences were not conducted following the November 2025 quarterly MDS assessment and the January 2026 annual MDS assessment for Resident 93. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12(d)(3) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined the facility failed to ensure evidence-based diagnostic criteria and accepted professional standards of clinical practice were utilized to establish a diagnosis of schizophrenia for one of 37 residents reviewed (Resident 13).Findings include: According to the Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, 2022, Diagnostic Criteria (DSM-5-TR, the standard guidebook used by mental health professionals in the United States and worldwide to diagnose mental health conditions) to diagnose schizophrenia (a chronic and severe mental disorder characterized by disturbances in thought processes, perceptions, emotional responsiveness, and social interactions), the following criteria must be met.Two or more of the following symptoms for a significant portion of time during a one-month period or less if successfully treated (at least one from 1 to 3 must be present):1. Delusions (false beliefs)2. Hallucinations (false perceptions)3. Disorganized speech (illogical communication)4. Grossly disorganized or catatonic behavior (impaired goal-directed actions or rigid body position)5. Negative symptoms (loss of normal emotional expression, flat affect)Functional impairment: Marked decline in work, interpersonal relations, or self-care. Continuous signs of disturbance for greater than 6 months, including greater than one month of active-phase symptoms. A clinical record review revealed Resident 13 was originally admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). A review of a Pennsylvania Preadmission Screening Resident Review Identification form (PASRR, a federal screening requirement that prevents the inappropriate institutionalization of individuals with mental illness or intellectual disabilities by ensuring they receive specialized care in the most appropriate, least restrictive setting) dated October 8, 2020, revealed Resident 13 has one serious mental illness indicated, Personality Disorder (a mental health condition characterized by enduring, rigid patterns of thinking, feeling, and behaving that deviate significantly from cultural expectations, causing distress or functional impairment). A review of Resident 13's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care), Section I Active Diagnoses dated May 18, 2025, revealed that Resident 13 does not have a medical diagnosis of schizophrenia. A review of a Pennsylvania Preadmission Screening Resident Review (PASRR) Identification form dated May 11, 2025, revealed Resident 13 had a schizophrenia diagnosis added after admission. The PASRR form was signed by Employee 10, Social Services. A physician's order dated November 27, 2025, for Perphenazine Oral Tablet 4 mg (an antipsychotic medication commonly used to treat symptoms of serious mental illness) with directions to administer 4 mg by mouth two times daily for mood disorder was initiated on May 11, 2025, and discontinued on May 23, 2025. A physician's order for Perphenazine Oral Tablet 4 mg with directions to give 4 mg by mouth two times a day for a diagnosis of schizophrenia initiated on November 27, 2025. Review of Resident 13's quarterly MDS assessment dated [DATE], revealed schizophrenia was coded as an active diagnosis in Section I. The comprehensive clinical record review failed to reveal documented psychiatric evaluations, psychological evaluations, physician documentation, diagnostic testing, behavioral assessments, symptom documentation, or other clinical evidence supporting that Resident 13 met DSM-5-TR diagnostic criteria for schizophrenia. Comprehensive clinical record review failed to reveal documentation of delusions, hallucinations, disorganized speech, grossly disorganized behavior, or negative symptoms consistent with schizophrenia.During an interview on May 1, 2026, at 9:15 AM, the above findings were reviewed with the Nursing Home Administrator (NHA). The facility was unable to provide physician documentation, psychiatric evaluation, psychological evaluation, (continued on next page)

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	396074	A. Building B. Wing	05/01/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavioral assessments, or other clinical diagnostic evidence supporting that Resident 13 met DSM-5-TR diagnostic criteria for schizophrenia. The facility failed to ensure evidence-based diagnostic criteria and accepted professional standards of clinical practice were utilized prior to identifying Resident 13 with schizophrenia. 28 Pa. Code 211.2(d)(3) Medical director. 28 Pa. Code 211.12(d)(3) Nursing services.

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	05/01/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy, a review of clinical records and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure licensed nurses administered medications according to physician ordered parameters for 2 of 21 residents reviewed (Resident 9 and Resident 258).Findings include: A review of the facility policy titled, Medication Administration, last reviewed August 20, 2025, revealed medications are to be administered as ordered by the physician and vital signs, including blood pressure and pulse, are to be obtained when ordered by the physician. Clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses including hypertension (high blood pressure that increases the workload on the heart and may damage organs over time) and presence of a cardiac pacemaker (a device implanted to help regulate the heart rhythm when the heart beats too slowly or irregularly). A review of Resident 9's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 27, 2026, revealed that Resident 9 was severely cognitively impaired with a BIMS score of 0 (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 00-07 indicates severe cognitive impairment and the interview could not be conducted because the resident was unable to engage with the questions). Review of Resident 9's physician orders revealed an order dated June 1, 2023, for Metoprolol Succinate Extended Release 25 milligrams (medication used to lower blood pressure and slow the heart rate) to administer one half tablet by mouth every morning and at bedtime for hypertension. The order directed staff to hold the medication if the systolic blood pressure (the top number of a blood pressure reading that measures pressure in the blood vessels when the heart contracts) was less than 100 millimeters of mercury (mm/Hg) and the heart rate was less than 60 beats per minute. Review of the December 2025 electronic Medication Administration Record (eMAR, a computerized medication documentation system) revealed the medication was not administered on the following dates: December 23, 2025, Blood pressure was 108/52 mm/Hg, heart rate was 59 beats per minute. December 24, 2025, Blood pressure was 94/56 mm/Hg, heart rate was 74 beats per minute. December 25, 2025, Blood pressure was 99/60, heart rate was 79 beats per minute. Review of the January 2026 eMAR revealed the medication was not administered on January 29, 2026, when the blood pressure was 90/60 millimeters of mercury and the heart rate was not obtained. Review of the March 2026 eMAR revealed the medication was not administered on March 31, 2026, when the blood pressure was 98/60 mm/Hg and the heart rate was 63 beats per minute. The eMAR documented the medication was held because the resident's blood pressure and heart rate were reportedly outside the physician ordered parameters. However, review of the physician order revealed both the systolic blood pressure and heart rate were required to be below the ordered parameters before the medication was to be withheld. On the above dates, both conditions were not present, and the medication should not have been withheld according to the physician's order. Additionally, on January 29, 2026, staff failed to obtain and evaluate the resident's heart rate prior to withholding the medication. Clinical record review revealed Resident 258 was admitted to the facility on [DATE], with diagnoses including chronic kidney disease (long term loss of kidney function) and hypertensive urgency (a severe elevation in blood pressure that requires prompt medical evaluation and treatment). A review of Resident 258's Quarterly MDS, dated [DATE], revealed that Resident 258 was cognitively intact with a BIMS score of 15 a score of 13 through 15 indicates intact cognition. A review of Resident 258's physician orders revealed an order for Amlodipine Besylate 2.5 milligrams (medication used to lower blood pressure by relaxing blood vessels) by mouth twice daily for hypertension. The order directed staff to hold the medication if the systolic blood pressure was less than 110 mm/Hg or if the heart rate was less than 60 beats per minute. Review of the eMAR revealed (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	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility staff administered the medication despite the resident's blood pressure readings falling below the physician ordered hold parameters on the following dates and times: February 10, 2026, at 8:00AM, blood pressure was 85/62 mm/Hg, and the heart rate was 80 beats per minute. February 15, 2026, at 8:00AM, blood pressure was 108/74 mm/Hg, and the heart rate was 88 beats per minute. March 22, 2026, at 8:00AM, blood pressure was 106/58 mm/Hg, and the heart rate was 91 beats per minute. April 6, 2026, at 8:00AM, blood pressure was 81/48 mm/Hg, and the heart rate was 82 beats per minute. April 11, 2026, at 8:00PM, blood pressure was 78/56 mm/Hg, and the heart rate was 90 beats per minute. April 19, 2026, at 8:00AM, blood pressure was 104/58 mm/Hg, and the heart rate was 88 beats per minute. Review of physician orders for Resident 258 revealed an order dated October 25, 2024, for Clonidine 0.1 milligrams (medication used to lower blood pressure) every 8 hours as needed for systolic blood pressure greater than 160 mm/Hg. Review of the eMAR revealed staff administered the as needed Clonidine to Resident 258 despite the resident's systolic blood pressure not exceeding the physician ordered parameter of greater than 160 on the following dates and times: February 9, 2026, at 10:00 PM, blood pressure was 108/58 mm/Hg. February 12, 2026, at 10:00 PM, blood pressure was 93/58 mm/Hg. February 13, 2026, at 06:00 AM, blood pressure was 131/81 mm/Hg. February 14, 2026, at 02:00 PM, blood pressure was 93/62 mm/Hg. March 8, 2026, at 10:00 PM, blood pressure was 134/68 mm/Hg. March 10, 2026, at 10:00 PM, blood pressure was 116/62 mm/Hg. March 16, 2026, at 10:00 PM, blood pressure was 102/56 mm/Hg. March 28, 2026, at 10:00 PM, blood pressure was 132/72 mm/Hg. April 3, 2026, at 10:00 PM, blood pressure was 152/74 mm/Hg. April 4, 2026, at 06:00 AM, blood pressure was 97/52 mm/Hg. April 25, 2026, at 06:00 AM, blood pressure was 124/64 mm/Hg. An interview with the Nursing Home Administrator conducted on April 30, 2026, at 1:30 PM reviewed the above findings related to the facility's failure to ensure nursing staff administered blood pressure medications according to physician ordered parameters. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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	05/01/2026

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on a review of clinical records, employee personnel records, facility policies and procedures, and staff interviews, it was determined the facility failed to develop, implement, and maintain an effective training program to ensure licensed nursing staff possessed the knowledge and demonstrated competencies necessary to safely initiate intravenous (IV) access for two of 37 residents reviewed (Resident 14 and Resident 290).Findings include: Federal regulation requires a facility to develop, implement, and maintain an effective training program for all new and existing staff. The training program must be based on the facility assessment (an evaluation conducted by the facility to identify the resident population and determine the knowledge and skills staff need to meet resident care needs). Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment (a comprehensive evaluation completed by the facility to determine the resident population served, the care and services residents require, and the staffing competencies, resources, and training necessary to meet those identified resident needs safely and effectively). Pennsylvania State Board of Nursing Regulations, Title 49, Chapter 21, require licensed nurses performing intravenous therapy to complete appropriate education, receive supervised clinical instruction, and demonstrate ongoing competency. Licensed Practical Nurses (LPNs) may only perform those nursing functions for which they have documented knowledge, skills, and abilities under appropriate supervision. A review of the facility policy titled Intravenous Therapy, last reviewed August 20, 2025, revealed it is the facility's policy to provide a means to maintain intravenous (IV) access (a small tube inserted into a vein to administer fluids or medications directly into the bloodstream) when necessary to carry out physician orders. The policy indicated a Registered Nurse (RN) may initiate an IV after completing three witnessed IV insertion attempts (sticks). The policy also indicated an LPN may initiate an IV after successfully completing an approved IV course and completing three witnessed IV insertion attempts. Within the policy, the term sticks referred to attempts to start an IV. A review of Resident 14's clinical record revealed a physician's order dated October 24, 2025, to place a one-time IV due to an upper respiratory infection (infection involving the nose, throat, or airways) and elevated white blood cell levels, which can indicate infection or inflammation (the body's response to injury or infection). A review of the electronic Medication Administration Record (eMAR, the computer-based system used to document medications and treatments administered to residents) and interdisciplinary progress notes revealed Employee 3, RN, initiated intravenous access with a 24-gauge needle (a small diameter needle commonly used for IV access) on October 24, 2025, at 9:00 PM in Resident 14's right forearm. A review of Resident 290's clinical record revealed a physician's order dated January 5, 2026, to place a one-time IV for hydration (providing fluids to maintain normal body function and prevent dehydration). A review of the eMAR and interdisciplinary progress notes revealed Employee 4, LPN, initiated intravenous access with a 24-gauge needle on January 5, 2026, at 4:01 PM in Resident 290's right forearm. A review of employee personnel records revealed:Employee 3, RN, began employment at the facility on July 7, 2014. The personnel file did not contain documented competency validation demonstrating completion of the three supervised IV insertion attempts required by facility policy prior to initiating IV access for Resident 14. Employee 4, LPN, began employment at the facility on December 27, 2010. The personnel file did not contain documented competency validation demonstrating completion of the three supervised IV insertion attempts required by facility policy prior to initiating IV access for Resident 290. During an interview conducted on May 1, 2026, at 8:00 AM, the Nursing Home Administrator (NHA) acknowledged the facility could not provide documentation demonstrating the required IV competency validation outlined in the facility policy. Specifically, the facility was unable to provide evidence that Employee 3, RN, or Employee 4, LPN, completed the required three witnessed IV insertion attempts prior to independently initiating IV access for Resident (continued on next page)

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	396074	A. Building B. Wing	05/01/2026

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

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14 and Resident 290. 28 Pa. Code 201.20(a) Staff Development. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.