

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Allied Services Transitional Rehab Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 475 Morgan Highway Scranton, PA 18508	
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, and staff interviews, it was determined that the facility failed to develop and implement a baseline person-centered care plan within 48 hours of admission that addressed immediate clinical needs for one of one resident reviewed (Resident 52). Findings include: A review of the facility provided policy entitled Resident Comprehensive Care Plan last reviewed by the facility on October 25, 2025, indicated the facility will develop a comprehensive care plan, initiated on admission and reviewed after completion of each comprehensive assessment and quarterly assessment for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs. The objective of the care plan is to address residents' needs, strengths, and preferences and to attain the residents' highest practicable physical, mental, and psychosocial well-being. The policy indicated there will be 24-hour involvement in the Plan of Care. Resident needs, problems, and concerns will be updated by appropriate team members as frequently as necessary. A review of Resident 52's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included urinary retention (a condition in which the bladder is unable to fully empty urine), UTI (urinary tract infection, an infection in any part of the urinary system), and severe sepsis (occurs when one's immune system has a dangerous reaction to an infection and causes extensive inflammation throughout the body that can lead to tissue damage, organ failure and even death). Further clinical record review revealed a physician's order dated December 5, 2025, at 2:45 PM, to catheter (is a device that drains urine from the bladder into a collection bag outside of the body when one cannot urinate on their own and consists of a thin, flexible rubber or plastic tube that goes through the urethra into the bladder) care every shift for good hygiene and cleanse with soap and water, and to irrigate catheter for blockage as needed (PRN) with 30 ml NSS (normal saline solution). A review of a history and physical assessment completed by the facility's Certified Registered Nurse Practitioner (CRNP) dated December 5, 2025, at 7:33 PM, indicated Resident 52 was seen by urology (specialized in urinary conditions) while hospitalized and required a Foley catheter due to urinary retention. The facility was able to provide justification for the continued use of a Foley catheter. However, Resident 52's physician orders failed to reflect an order for the continued use of a Foley catheter for management of urinary retention. A review of Resident 52's person-centered plan of care that was initiated on December 5, 2025, and in place as baseline care plan, failed to develop a care plan that included the resident's need for a Foley catheter and indicate person-centered interventions for proper care and services required to safely and hygienically manage the presence of a catheter. The facility failed to ensure Resident 52's plan of care was fully developed to reflect the resident's need for use of a Foley catheter and develop individualized interventions for proper care and services required to manage the presence of a catheter. During interviews with the facility's Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 11, 2025, at 10:50 AM, the above information was reviewed and confirmed. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.5(f)(iii) Medical records.		

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 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 a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to fully develop a person-centered comprehensive care plan to meet the individualized needs for one resident out of 8 sampled (Resident 21). Findings included: A review of the facility provided policy entitled Resident Comprehensive Care Plan last reviewed by the facility on October 25, 2025, indicated the facility will develop a comprehensive care plan, initiated on admission and reviewed after completion of each comprehensive assessment and quarterly assessment for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs. The objective of the care plan is to address residents' needs, strengths, and preferences and to attain the residents' highest practicable physical, mental, and psychosocial well-being. The policy indicated there will be 24-hour involvement in the Plan of Care. Resident needs, problems, and concerns will be updated by appropriate team members as frequently as necessary. A review of Resident 21's clinical record revealed Resident 21 was admitted to the facility on [DATE], with diagnoses including acute diastolic congestive heart failure (a condition where the heart is not able to pump blood and fluid builds up in the lungs and other areas of the body) and Circadian Rhythm Sleep Disorder (a condition that disrupts or affect ones natural sleep-wake cycle). A clinical record review of physician's orders dated December 1, 2025, revealed a physician's order for Melatonin (an over-the-counter pill commonly used to help individuals who have difficulty sleeping and used to adjust the body's internal clock to support sleep) 3 mg, one tablet every evening at bedtime for Resident 21's difficulty obtaining adequate rest and sleep. Further review of the clinical record revealed Resident 21's care plan did not include any information addressing the resident's lack of ability to get adequate rest and sleep. The absence of a resident centered care plan addressing Resident 21's inability to sleep contradicts the facility policy which identifies that any psychosocial needs as well as moods and behaviors will be incorporated into the comprehensive care plan. An interview with the Nursing Home Administrator (NHA) and Direct of Nursing (DON) on December 11, 2025, at 10:45 AM confirmed Resident 21's care plan did not reflect resident centered psychosocial and clinical needs nor was there 24-hour involvement in the care plan as the care plan lacked updated information. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.5(f)(iii) Medical records.		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to complete and accurate Minimum Data Set (MDS) assessment for one of eight residents reviewed (Resident 21). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (dated October 2025) provides instructions and guidelines for completing the Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care). The RAI manual requires the MDS 3.0 assessment accurately reflects the resident's status. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. According to the RAI manual, Section I of the MDS emphasizes that active diagnoses are to be included on the assessment. Specifically, items in Section I code diseases or active diagnosis that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death. Active diagnosis guides the plan of care since one of the important MDS functions is to present an accurate picture of the resident's current health status according to the RAI manual. A review of Resident 21's clinical record revealed Resident 21 was admitted to the facility on [DATE], with diagnoses including acute diastolic congestive heart failure (a condition where the heart cannot pump blood and fluid builds up in the lungs and other areas of the body). Further clinical record review revealed a physician order dated December 1, 2025, for Melatonin 3 milligrams (mg) by mouth at bedtime. Melatonin is an over-the-counter medication commonly used to help regulate sleep by supporting the body's natural sleep-wake cycle. Review of the electronic medication administration record confirmed Resident 21 received Melatonin 3 mg each evening beginning December 1, 2025. Additional review of the clinical record revealed an admission diagnosis of Circadian Rhythm Sleep Disorder, active as of November 28, 2025. Circadian Rhythm Sleep Disorder is a condition in which an individual's internal biological clock is disrupted, resulting in difficulty falling asleep, staying asleep, or achieving adequate restorative sleep. This diagnosis was consistent with the ordered and administered medication to facilitate sleep for Resident 21. Review of Resident 21's admission MDS dated [DATE], revealed that Section I was signed as completed by the Registered Nurse Assessment Coordinator (RNAC) on December 8, 2025. The MDS did not include the active diagnosis of Circadian Rhythm Sleep Disorder. The omission of this diagnosis resulted in the MDS not accurately reflecting Resident 21's current medical treatments, specifically the use of medication to facilitate sleep, and did not accurately represent the resident's mood or behavior status as it related to the inability to attain adequate rest. Further clinical review of the admission MDS revealed all MDS sections were complete and signed by the RNAC as complete on December 9, 2025. Subsequently, the admission MDS was successfully transmitted to the database on December 10, 2025, according to the assessment history. The MDS completed on December 9, 2025, and submitted on December 10, 2025, did not accurately include Resident 21's current diagnosis related to current medical treatment and the resident's mood or behavior status, as required by the RAI manual to facilitate sleep as it relates to the ability to attain adequate rest. An interview conducted on December 11, 2025, at 10:45 AM with the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the electronically submitted MDS did not include the diagnosis of Circadian Rhythm Sleep Disorder and therefore did not accurately represent Resident 21's medical treatments and mood or behavior status at the time of submission. An interview conducted on December 11, 2025, at 12:30 PM with the RNAC confirmed that the admission MDS was not coded accurately. 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.5(f)(iii) Medical records.		