STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395581	A. BLDG: 00 B. WING:	01/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ALLIED SERVICES CENTER CITY SKILLED NURSING STATE LICENSE NUMBER: **600602**	**80 E NORTHAMPTON ST** **WILKES BARRE, PA 18701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance survey completed on January 10, 2025, it was determined that Allied Services Center City Skilled Nursing was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0641 SS=D		F 0641		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1.Resident 34 still resides at facility and her MDS has been modified. Resident 8 still resides at facility and her MDS has been modified to reflect her admission date. Resident 31 no longer resides at facility. His MDS has been modified. 2.The facility will complete an audit of the most recently completed MDS for each current resident, to ensure Sections K0300, A1700, and N0350 are coded correctly. 3.The DON/designee will provide education to the RNAC on MDS accuracy of Sections K0300, A1700, and N0350. 4.The Consultant RNAC/designee will perform weekly audits of sampled MDS Sections K0300, A1700, and N0350 to ensure they are coded correctly. Results will be reviewed at the facility's monthly QAPI meeting. Audits will continue until substantial compliance is reached.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0641 SS=D	Continued from page 2 Based on a review of clinical records, the Resident Assessment Instrument, and staff interview, it was determined the facility failed to ensure that Minimum Data Set Assessments accurately reflected the status of three residents out of 21 sampled (Residents 34, 8, and 31). Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section K0300 Weight Loss the facility is to record loss of 5% or more in the last month or loss of 10% or more in the last 6 months. A clinical record review revealed Resident 34 was admitted to the facility on March 25, 2021.	F 0641		

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F 0641 SS=D	Continued from page 3 A review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 31, 2024, indicated in Section K0200 that the resident's height was 64 inches and weight was 163 pounds. Review of Section K0300 indicated that Resident 34 did not experience a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Review of Resident 34's Weight Record revealed that on April 3, 2024, the resident weighed 181.2 pounds. On October 5, 2024, the resident weighed 163 pounds which is indicative of a 10.04 % significant weight loss in 6 months. During an interview on January 9, 2025, at 11:30 AM the Registered Dietitian (RD) confirmed that Resident 34 did experience a 10.04% weight loss between April 3, 2024, and the quarterly MDS Assessment dated October 31, 2024, Section	F 0641		

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F 0641 SS=D	Continued from page 4 K0300 was inaccurate. A clinical record review revealed that Resident 8 was admitted to the facility on December 9, 2020. A review of an annual MDS Assessment dated July 11, 2024, indicated in Section A1600 Most Recent Admission/Entry or Reentry into the facility noted the most recent entry date into the facility was July 4, 2024, and Section A 1700 Type of Entry indicated admission. Further review of the clinical record revealed that Resident 8 was transferred to the hospital on June 29, 2024, and readmitted to the facility on July 4, 2024. During an interview with the Registered Nurse Assessment Coordinator (RNAC) on January 10, 2024, at 10:30 AM confirmed that the annual MDS Assessment dated July 11, 2024, Section A 1700 Type of Entry was not accurate and was incorrectly coded as admission instead of reentry.	F 0641		

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F 0641 SS=D	Continued from page 5 A clinical record review revealed that Resident 31 was admitted to the facility on December 7, 2024. A review of an admission MDS dated December 14, 2024, Section N Medications N 0350, Insulin indicated Resident 31 received one insulin injection in the last seven days. Further clinical record review revealed no other documented evidence that Resident 31 was administered any insulin injections in the last seven days. The MDS was coded as the resident receiving insulin despite no physician order. During an interview on January 8, 2024, at 12:40 PM the Registered Nurse Assessment Coordinator (RNAC) confirmed that Resident 31 did not receive insulin as indicated in Resident 31's MDS assessment dated December 14, 2024, Section N 0350 Medications, Insulin. The RNAC confirmed the admission MDS assessment dated December 14, 2024, was coded in error as it relates to insulin.	F 0641		

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F 0641 SS=D	Continued from page 6 28 Pa. Code 211.5(f)(i) Medical records. 28 Pa. Code 211.12(d)(3) Nursing services.	F 0641		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1.Resident 22 will have TED stockings applied, per physician's orders. 2.The facility will complete an audit of residents with physicians' orders for TED stocking to ensure they are properly applied. 3.The DON/designee will provide education to licensed nurses about consistently following physicians' orders regarding the application and removal of TED stockings. 4.The DON/designee will perform weekly audits of sampled residents with physician orders for TED stockings to ensure proper application. Results will be reviewed at the facility's monthly QAPI meeting. Audits will continue until substantial compliance is reached.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0684 SS=D	Continued from page 7 Based on observations, a review of clinical records, and resident and staff interviews, it was determined the facility failed to provide person-centered care by failing to follow physician's orders for the consistent application of a prescribed therapeutic measure, compression stockings, for one resident of 21 sampled (Resident 22). Findings include: A review of Resident 22's clinical record revealed the resident was admitted to the facility on July 20, 2024, with diagnoses of cerebral infarction (a pathological process, also known as ischemic stroke, the result of disrupted blood flow to the brain) and essential hypertension (high blood pressure). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 23, 2024, revealed that Resident 22 is cognitively	F 0684		

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F 0684 SS=D	Continued from page 8 intact with a BIMS score of 14 (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 13-15 indicates intact cognition). A review of Resident 22's clinical record revealed a physician's order dated October 22, 2024, for "Ted Stockings (Thrombo-Embolus deterrent compression stockings, or anti-embolism stockings, which are specially designed to help reduce the risk of developing deep vein thrombosis (DVT) or blood clots in your lower leg after surgery) to be on in the morning and removed in the evening. During a resident interview on January 7, 2025, at 10:29 AM, Resident 22 reported that staff did not assist her with applying her TED stockings that day, despite a physician's order requiring their use. Observations made on January 7, 2025, at 10:29 AM and 1:39 PM revealed that Resident 22 was	F 0684		

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F 0684 SS=D	Continued from page 9 not wearing her TED stockings as ordered. A review of Resident 22's January 2025 "Treatment Administration Record" revealed that staff documented the TED stockings were applied at 6:00 AM on January 7, 2025. This documentation was inconsistent with the resident's statements and observed findings. On January 8, 2025, at 10:30 AM, Resident 22 stated she had to remind the nurse on duty to apply her TED stockings, indicating a lack of adherence to the prescribed care plan. She explained that if she does not tell the nurse, then they do not apply her TED stockings. On January 9, 2025, at 1:30 PM, the Director of Nursing confirmed that staff did not consistently follow the physician's orders regarding the application and removal of Resident 22's TED stockings.	F 0684		

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F 0684 SS=D	Continued from page 10 28 Pa. Code 211.5(f)(ix) Medical Records 28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services	F 0684		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 11 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	1.Resident 56 no longer resides at the facility. His medication order was revised to include pharmacist's recommendation prior to his discharge. 2.The facility will complete an audit of the most recent medication regimen reviews for all current residents, to ensure physician responses address the pharmacist's recommendation. 3.The DON/designee will educate physicians and their extenders on addressing pharmacy recommendations appropriately. 4.The DON/designee will perform monthly audits of sampled residents' medication regimen reviews to ensure appropriate responses were provided by physicians and physician extenders. Results will be reviewed at the facility's monthly QAPI meeting. Audits will continue until substantial compliance is reached.	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0756 SS=D	Continued from page 12 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=D	Continued from page 13 Based on a review of clinical records, facility-provided manufacturers' medication information, and staff interviews, it was determined the facility failed to demonstrate the physician timely acted upon irregularities identified by pharmacy services during drug regimen reviews for one resident out of the five sampled (Resident 56). Findings include: A clinical record review revealed Resident 56 was admitted to the facility on October 10, 2024, with diagnoses that included osteomyelitis (a bone infection) and gastro-esophageal reflux disease (GERD- a digestive disorder that occurs when stomach acid flows into the esophagus). A clinical record review revealed a pharmacy note to the attending physician or prescriber dated November 4, 2024, indicating that Resident 56 was prescribed sucralfate (an antiulcer medication) one gram every six hours for GERD. The note indicated the medication is usually administered on an empty	F 0756		

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F 0756 SS=D	Continued from page 14 stomach prior to meals and/or bedtimes to assure disintegration in the stomach acid and binding to stomach mucosa, forming a protective layer. If clinically appropriate for this patient, consider altering times of administration. A physician's response to the pharmacist indicating disagreement that Resident 56 has a gastrointestinal bleed. However, the response failed to address the pharmacist's recommendation for medication administration times to match the medication's manufacturer's direction. A review of facility provided medication information for sucralfate revealed recommended instructions for medication administration was 1 hour prior to meals and given on an empty stomach 1 hour before meals. A medical record review revealed no changes to physician's orders following recommendations by the pharmacist. A physician's order for Resident 56 to receive Carafate tablet 1 GM (sucralfate-an	F 0756		

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F 0756 SS=D	Continued from page 15 anti-ulcer medication) with direction to give 1 gram by mouth every six hours for gastric protection was initiated on December 17, 2024. During an interview on January 9, 2025, at approximately 10:00 AM, Employee 3, CRNP, indicated she reviewed the recommendation made by the pharmacist note from November 4, 2024. Employee 3, CRNP, was not able to provide a clinical rationale for disagreeing to consider altering times of Resident 56's sucralfate administration. Following questions asked during the survey, Resident 56's physician's order for sucralfate was revised to include recommendations indicated by the pharmacist from November 4, 2024. A clinical record review revealed a physician's order for Resident 56 to receive Carafate tablet 1 GM (sucralfate-an anti-ulcer medication) with direction to give one gram by mouth before meals and at bedtime for gastric protection initiated on January 9, 2025.	F 0756		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0756 SS=D	Continued from page 16 During an interview on January 10, 2025, at approximately 10:00 AM, the Nursing Home Administrator confirmed it is the facility's responsibility to ensure the physician timely acts upon irregularities identified by pharmacy services during drug regimen reviews. 28 Pa. Code 211.2 (d)(3)(9) Medical Director	F 0756		
F 0880 SS=E		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395581	A. BLDG: 00 B. WING:	01/10/2025

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F 0880 SS=E	Continued from page 17 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1.Resident 28's contact precautions were discontinued and enhanced barrier precautions were implemented with indicators applied to door. Resident 33 had appropriate enhanced barrier precaution indicators applied to door. Resident 56 discharged from facility. 3rd and 4th floor shower rooms were immediately cleaned. Items were removed from the floor and disposed of appropriately. Hair dryers were sanitized and stored appropriately. 2.The facility will complete an audit of current residents to ensure those requiring enhanced barrier precautions have appropriate indicators in place to ensure staff are aware. The facility will complete an audit of the shower rooms to ensure residents' personal products are stored properly. 3.The Infection Preventionist/designee will educate staff on the facility's on enhanced barrier precautions policy and protocol. The Infection	Completion Date: **02/25/2025** Status: **APPROVED** Date: **01/21/2025**

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F 0880 SS=E	Continued from page 18 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	Preventionist/designee will educate clinical staff on proper storage of resident personal items and hygiene products. 4.The Infection Preventionist/designee will perform weekly audits of sampled residents with enhanced barrier precautions to ensure there are proper indicators in place. The Infection Preventionist/designee will perform weekly audits of shower rooms to ensure the proper storage of resident personal items and hygiene products. Results will be reviewed at the facility's monthly QAPI meeting. Audits will continue until substantial compliance is reached.	

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F 0880 SS=E	Continued from page 19	F 0880		

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F 0880 SS=E	Continued from page 20 Based on a review of clinical records, select facility policy, observations, and resident and staff interviews, it was determined the facility failed to implement enhanced barrier infection control procedures for three residents out of the 21 residents sampled (Residents 28, 33, and 56) and failed to properly store resident hygiene and personal products in two out of three resident shower rooms (3rd and 4th floor shower rooms). Findings include: A review of facility policy titled "Enhanced Barrier Precautions," last reviewed by the facility on December 30, 2024, revealed it is the facility policy to expand the use of personal protective equipment and refer to the use of gowns and gloves during high-contact resident care activities that provided opportunities for transfer of multi-drug resistant organisms (MDROs) to staff hands and clothing. The policy indicates nursing home residents with wounds and indwelling medical devices are especially high risk for both the acquisition of and	F 0880		

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F 0880 SS=E	Continued from page 21 colonization with MDROs. The policy indicates any resident who requires enhanced barrier precautions will have a blue circle sticker on their door (indicating gowns and gloves are required when providing any high-contact resident care activities). A clinical record review revealed Resident 28 was admitted to the facility on October 30, 2024, with diagnoses that included 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) and chronic kidney disease (gradual loss of kidney function). A physician's order for Resident 28 to have isolation precautions-contact (interventions implemented to reduce the risk of spreading healthcare-associated infections) related to staphylococcus aureus MRSA (methicillin-resistant staphylococcus aureus- a bacteria resistant to antibiotic therapies) in urine initiated on December 29, 2024.	F 0880		

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F 0880 SS=E	Continued from page 22 An observation of Resident 28's room on January 7, 2025, at 11:15 AM, revealed no signs or postings identifying that Resident 28 was on enhanced barrier precautions or contact precautions. A clinical record review revealed Resident 33 was admitted to the facility on December 10, 2024, with diagnoses that included hemiplegia (paralysis on one side of the body). A physician's order for Resident 33 to have enhanced barrier precautions related to percutaneous endoscopic gastrostomy (PEG- an indwelling device that allows for the delivery of fluids, drugs, and nutrition to patients who are unable to eat orally) tube. An observation of Resident 33's room on January 7, 2025, at 11:59 AM, revealed no signs or postings identifying that Resident 33 was on enhanced barrier precautions. A clinical record review revealed Resident 56 was	F 0880		

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F 0880 SS=E	Continued from page 23 admitted to the facility on October 10, 2024, with diagnoses that included osteomyelitis (a bone infection). A physician's order for Resident 56 to have enhanced barrier precautions {related to indwelling urinary catheter} initiated on December 18, 2024. An observation of Resident 56's room on January 7, 2025, at 12:20 PM, revealed no signs or postings identifying that Resident 56 was on enhanced barrier precautions. During an interview on January 8, 2025, at 8:25 AM, Employee 1, Registered Nurse (RN), confirmed there was no signage or postings in Resident 28, 33, and 56's rooms or doorways indicating to staff that gown and gloves are required when providing any high-contact resident care activities. Employee 1, RN, indicated the rooms should be marked with a blue dot to indicate precautions are ordered and in place to prevent the spread of infections.	F 0880		

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F 0880 SS=E	Continued from page 24 During an interview on January 10, 2025, at approximately 9:00 AM, Employee 2, Infection Preventionist (IP), confirmed that Residents 28, 33, and 56's rooms should be identified to notify facility staff that additional personal protective equipment is required when providing any high-contact resident care activities in order to reduce the risk of spreading infections. During an interview on January 10, 2025, at approximately 10:00 AM, the Nursing Home Administrator confirmed it is the facility's responsibility to fully implement infection control procedures, including transmission-based precautions, and enhanced barrier precautions. An observation on January 7, 2025, at 11:09 AM in the 3rd-floor shower room, revealed two packages of resident incontinence briefs, a hair dryer, and sanitizing wipes stored on the shower room floor. An observation on January 7, 2025, at 12:08 PM in	F 0880		

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F 0880 SS=E	Continued from page 25 the 4th-floor shower room revealed three packages of resident incontinence briefs and one package of opened resident sanitizing wipes stored in the shower room bathtub. Also, four packages of resident incontinence briefs, multiple loose incontinence briefs, and a hairdryer were observed on the shower room floor. During an interview on January 7, 2025, at 12:10 PM, Employee 1, Registered Nurse (RN), confirmed the resident briefs and wipes should not be stored directly on the shower room floors or in the shower room bathtub. During an interview on January 10, 2025, at approximately 10:00 AM, the Nursing Home Administrator confirmed it is the facility's responsibility to fully implement infection control procedures, including the proper storage of resident hygiene and personal products to reduce the risk of spreading infections. The facility failed to ensure proper storge of these	F 0880		

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F 0880 SS=E	Continued from page 26 products by storing them on the floor. This practice poses a significant risk of contamination from dirt, dust and microbial pathogens compromising the cleanliness of these items. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa code 211.12 (d)(1)(5) Nursing services.	F 0880		

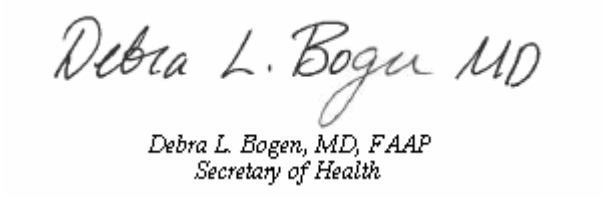
Certified End Page

ALLIED SERVICES CENTER CITY SKILLED NURSING

STATE LICENSE NUMBER: 600602

SURVEY EXIT DATE: 01/10/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY