

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39A433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Gino J Merli Veterans Center		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Penn Avenue Scranton, PA 18503	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, select facility policies, documentation provided by the facility, and resident and staff interviews, it was determined that the facility failed to adequately assess a resident's safety needs and implement adequate safety measures for a resident identified as at risk for falls, including a fall with multiple abrasions and a cervical spine fracture for one out of three residents sampled (Resident 1) which caused actual harm.</p> <p>Findings include:</p> <p>A review of the facility policy titled Fall Prevention Program, last reviewed by the facility June 4, 2024, revealed it is the policy of the facility to assist in fall management and prevention, reducing the risk of serious injury from falls while in conjunction optimizing each resident's freedom of mobility and/or using the least restrictive method supporting resident mobility and quality of life. The policy indicated the falls prevention program is a full-facility program including active engagement by all disciplines 24 hours a day, seven days a week.</p> <p>Also, the policy indicated therapy will screen all residents upon readmission to review for fall risk factors.</p> <p>The policy indicated a fall risk acuity observation will be completed in the electronic health record (EHR) by the licensed staff nurse upon resident readmission for all nursing care residents.</p> <p>Furthermore, the policy indicated an individualized, person-centered nursing care plan will be initiated and/or updated by the interdisciplinary team upon readmission.</p> <p>A review of the facility policy titled Wheelchair Use, last reviewed by the facility on November 4, 2024, revealed it is the facility's policy to support residents in achieving or maintaining their highest practicable physical, mental, and psychosocial well-being by encouraging their independence and assisting them with their mobility and seating needs.</p> <p>The policy indicated occupational therapy will determine if leg rests (support devices on wheelchairs that support the lower legs/feet and prevent slipping) are required at all times during transport on or off the unit and will determine if one or two leg rests are required for all residents utilizing a wheelchair.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses including chronic kidney disease (gradual loss of kidney function), dependence on renal dialysis, and an acquired absence of the right leg below the knee.</p> <p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 25, 2025, revealed that Resident 1 is cognitively 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 cognition is intact).</p> <p>A physician's order for Resident 1 to receive Acetaminophen 325 mg with directions to administer two tablets (650 mg) as needed for mild pain 1 through 4 initiated on July 19, 2022.</p> <p>A physician's order for Resident 1 to receive Tramadol (an opioid pain medication used to treat moderate to severe pain) tablet 50 mg with directions to give as needed for pain or discomfort level 4 through 10 initiated on July 1, 2024.</p> <p>A care plan indicated Resident 1 is at risk for injury from falls initiated on June 24, 2019. Interventions implemented to assist Resident 1 to be free from injury include a wheelchair with leg rests for transportation and PRN (as needed) implemented on March 10, 2023.</p> <p>During an interview on May 13, 2025, at approximately 12:55 PM, the Director of Rehabilitation Services explained the intervention for as-needed leg rests: leg rests should be utilized when being pushed by facility staff and not self-ambulating on and off the nursing unit.</p> <p>An external hospital discharge document dated April 26, 2025, at 3:10 PM, revealed Resident 1 was admitted to the hospital on [DATE], with shortness of breath. He was diagnosed with acute hypoxic respiratory failure (lungs are unable to adequately transfer oxygen into the blood, resulting in low blood oxygen levels), likely secondary to heart failure exacerbation. The resident underwent a bilateral thoracentesis (a medical procedure where a needle is inserted into the area between the lungs and the chest wall to remove fluid) on April 25, 2025. Two liters of fluid was drained from the right side of his lungs, and one and a half liters of fluid was drained from the left side of his lungs. Resident 1 was to be discharged back to the facility according to this hospital record review.</p> <p>The external hospital discharge document dated April 26, 2025, indicated, Special Instructions: Use caution when standing or walking since you are at an increased risk for falls.</p> <p>A review of a progress note dated April 26, 2025, at 5:15 PM, revealed that Resident 1's vital signs were recorded as follows: temperature 98.4&deg;F, pulse 60 beats per minute, and respirations 20 per minute. The note documented that the resident had multiple discolored areas on both the right and left arms, which were noted as possibly resulting from intravenous access sites and blood draws during his recent hospital stay. The resident denied experiencing pain to those areas. Two dressings were observed to be intact on the right and left back. The note indicated that the Certified Registered Nurse Practitioner (CRNP) had been made aware and would assess the resident on April 28, 2025. Additionally, the resident was noted to have an 8.2 cm x 4.0 cm bruise on the left abdomen and a 15.2 cm x 6.0 cm bruise on the right abdomen, with no reported pain. The note documented that a call was placed to the discharging hospital to obtain discharge orders and a summary. The resident was documented as being in bed and resting, with a weight to be obtained.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the clinical record revealed no other documented evidence of a comprehensive assessment of Resident 1's care needs upon return from the hospital, including any evaluation of fall risk or the need to update the resident's care plan.</p> <p>During an interview conducted on May 13, 2025, at approximately 1:45 PM, the Director of Nursing (DON) stated that she was unable to provide any documentation reflecting that the facility assessed Resident 1's clinical status or fall risk upon his return from the community hospital on April 26, 2025.</p> <p>A review of a progress note dated April 26, 2025, at 7:00 PM, indicated that Resident 1 sustained a fall from a wheelchair while being weighed. The note documented that the resident sustained a 0.1 cm x 0.1 cm area to the right pinky. The area was cleansed with normal saline and left open to air. Additional open areas were documented as follows:</p> <p>Left knee: 1.5 cm x 1.0 cm</p> <p>Left wrist, outer aspect: 2.5 cm x 1.5 cm</p> <p>Left hand, posterior aspect above right finger: 1.0 cm x 1.0 cm</p> <p>Right hand: 2.0 cm x 1.5 cm</p> <p>Right elbow: 2.0 cm x 1.5 cm</p> <p>Forehead: 0.1 cm x 0.1 cm</p> <p>Treatment orders included cleansing the areas with normal saline, patting dry, applying wound dressing and gauze, and wrapping the affected areas daily until healed. Two blood blisters noted on the mid-forehead were to be left open to air. The note further indicated that the resident's power of attorney and the Certified Registered Nurse Practitioner were notified of the event.</p> <p>Employee 1, Nurse Aide (NA), in a signed statement dated May 4, 2025, stated that on April 26, 2025, at approximately 6:45 PM, she was instructed by Employee 3, LPN, to weigh Resident 1 because he returned from the hospital. She stated she transferred him into the weighing chair, and he leaned forward and fell. Staff assisted him back to his personal wheelchair.</p> <p>During a telephone interview conducted on May 19, 2025 (completed on this date due to the inability to contact the employee during the survey), Employee 1, Nurse Aide (NA), stated that on the day of the incident, she transported Resident 1 from his bedroom to the facility's scale room. She reported that she and Employee 2, NA, utilized a sit-to-stand mechanical lift to transfer Resident 1 from his wheelchair into the scale chair. Employee 1 noted that Resident 1 was wearing his prosthetic leg at the time. She stated that safety devices, such as leg rests, were not transferred from the resident's personal wheelchair to the weight chair and confirmed that the weight chair did not have leg rests in place.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Employee 1 explained that while she was pushing Resident 1 forward onto the wheelchair scale, his leg did a flop on the scale and he suddenly leaned forward and fell. She stated the incident occurred too quickly for her to stop him. Although she was unsure whether he struck the wall, she recalled seeing him on the floor asking for help. Employee 1 stated that following the fall, she observed skin tears on Resident 1's arms and a scrape on his forehead. She reported that nurses assessed the resident and that she assisted other staff in transferring Resident 1 back into his wheelchair.</p> <p>A witness statement dated April 26, 2025, provided by Employee 2, Nurse Aide (NA), revealed that on the evening of April 26, 2025, a nurse requested assistance in weighing Resident 1. Employee 2 stated that she assisted another nurse aide (Employee 1) in the process. After Resident 1 was placed on to the scale wheelchair, the other aide pushed him forward onto the scale. At that time, Resident 1 leaned forward and fell out of the chair. Employee 2 reported that she immediately left the room to seek additional help.</p> <p>During an interview conducted on May 13, 2025, at 10:41 AM, Employee 2, NA, stated that Resident 1 returned to the facility at approximately 6:00 PM on April 26, 2025, following a recent hospital stay. She reported that Resident 1 appeared weaker than usual and did not seem himself. Employee 2 stated that she and her coworker, Employee 1, NA, got Resident 1 out of bed and brought him into the designated weighing room. She confirmed that they transferred him from his personal wheelchair into the facility's designated weight chair, which did not have any safety features such as leg rests. Employee 2 stated the facility does not routinely transfer leg rests or other safety devices from residents' personal wheelchairs to the weight chair. She recalled that as Employee 1 pushed the resident forward onto the scale, Resident 1 fell forward and struck his face against the wall. According to Employee 2, Resident 1 then called out, Get me up. I'm okay! She stated that she left the room to get help, while Employee 1 remained with the resident until licensed staff arrived to assess him.</p> <p>A witness statement dated April 26, 2025, provided by Employee 3, Licensed Practical Nurse (LPN), revealed that on April 26, 2025, she was called into the scale room while Resident 1 was being weighed as per protocol, following his return from the hospital. Upon entering the room, Employee 3 observed Resident 1 lying on the floor. She noted several areas of injury, including bleeding to the left wrist, left hand, right hand, right elbow, left knee, and forehead. Two blood blisters were also observed on the mid-forehead.</p> <p>Employee 3 stated that she notified the Registered Nurse Supervisor (RNS) and the Certified Registered Nurse Practitioner (CRNP) immediately. She indicated that the registered nurse assessed the resident at the scene, and Resident 1 was then assisted back into his wheelchair. Employee 3 reported that treatments for the injuries were initiated and in progress at the time of her statement.</p> <p>A witness statement dated April 26, 2025, provided by Employee 4, Nurse Aide (NA), revealed that while returning from the scale room, she heard another nurse aide calling for assistance. Upon entering the room, she observed Resident 1 rolling on the floor from front to back. She confirmed that two other nurse aides and an LPN were already present in the room.</p> <p>Employee 4 stated that Resident 1 was lifted from the floor and transferred back into his wheelchair using a mechanical lift. No additional details regarding the cause of the fall or the specific circumstances prior to her arrival were provided in her statement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A witness statement dated April 26, 2025, provided by Employee 5, Registered Nurse (RN), revealed that she was called to the unit by a nurse aide who reported that Resident 1 had fallen. Upon entering the scale room, Employee 5 observed that multiple nursing staff, including nurse aides and an LPN, were present. She noted that the weight scale had been moved forward by a nurse to create space for a full-body mechanical lift.</p> <p>Employee 5 reported that Resident 1 was lying on his back and partially on his right side on the window side of the bathroom, which is where the scale is typically stored. She observed multiple skin tears on both arms and the left knee. A bump was also noted on the mid-forehead. Resident 1 stated that he had leaned forward and fell. A neurological assessment was completed and found to be within normal limits. All visible wounds were treated with ointment and dressings. Employee 5 stated that the Assistant Director of Nursing (ADON) and the CRNP were made aware of the incident, and that the resident was assisted back into his wheelchair without any further complaints.</p> <p>A review of the facility's closed-circuit video footage on May 13, 2025, at approximately 1:30 PM, revealed that on April 26, 2025, Employee 1, NA, and Employee 2, NA, were observed entering the scale room with Resident 1. Resident 1 was being transported in his personal wheelchair into the scale room. Resident 1's personal wheelchair was observed with the safety leg rest attached. The resident transfer as described by Employee 2, NA, from his personal wheelchair to the facility weight chair was not observable in the video footage because the door to the scale room was closed. The fall event as described in the above witness statements was not observable because the door to the scale room was closed. Employee 2, NA, was seen exiting the room gesturing for assistance. When the shower room door was opened, Resident 1 was observed on the floor, and staff were seen entering and exiting the room.</p> <p>A review of post-incident documentation revealed that the resident sustained a cervical fracture due to the fall. A review of care plan interventions and physician orders did not include a directive to transfer the resident into an alternate chair for weighing, nor was there documented justification for not utilizing the resident's personal wheelchair during the use of the scale. No individualized safety measures were identified specific to the use of a scale in combination with his prosthetic limb.</p> <p>The facility utilized a [NAME] Lake 350-10-7 Single Ramp Wheelchair Platform Scale, a medical-grade device specifically designed to comply with accessibility standards under the Americans with Disabilities Act (ADA). ADA Accessibility Guidelines for Medical Diagnostic Equipment (MDE) require that such equipment accommodate individuals who use mobility devices, including wheelchairs and prosthetics, without necessitating an unsafe or burdensome transfer. The scale features a wide, low-profile platform with an integrated access ramp, enabling direct roll-on entry using the resident's own personal wheelchair. Maintaining the resident in their personal wheelchair is essential to prevent disruption of individualized positioning supports, such as properly adjusted backrests, lateral supports, and leg rests. These features are particularly critical for residents with lower-limb prosthetic devices, where improper seating or limb stabilization can lead to imbalance, shifting of the prosthesis, and increased fall risk. The use of an unfamiliar chair-such as a scale-assigned weight chair lacking individualized safety devices, such as leg rests, contradicts best practices for accessibility and resident safety, and violates the intended use of ADA-compliant scale equipment. Weighing procedures must ensure wheelchair brakes are engaged, prosthetic limbs are stabilized, and staff remain in attendance throughout the process. Failure to implement these precautions and utilize the scale as designed exposed Resident 1 to a preventable accident hazard.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>A progress note dated April 27, 2025, at 3:45 AM indicated resident complaints of 8 out of 10 generalized body pain unrelieved with rest, repositioning, or fluids. As needed, Tramadol (an opioid pain medication) was administered, and additional fluids provided. Resident repositions with head of bed elevated and all safety measures in place.</p> <p>A review of Resident 1's medication administration record (MAR) revealed he was administered Tramadol 50 mg at 3:34 AM on April 27, 2025, for a pain level 8 out of 10.</p> <p>A progress note dated April 27, 2025, at 5:33 AM indicated the as-needed Tramadol was effective for generalized body pain. Resident 1 had no complaints of pain or discomfort. Resident in bed, all safety measures in place.</p> <p>A review of Resident 1's medication administration record (MAR) revealed he was administered acetaminophen 650 mg on April 27, 2025, at 12:39 PM for a pain level 3 out of 10.</p> <p>A progress note dated April 27, 2025, at 1:09 PM indicated the Certified Registered Nurse Practitioner (CRNP) was made aware of resident complaints of pain. New physician's orders were indicated for an X-ray of the skull and neck, a complete blood count, and a basic metabolic panel. The note indicated the power of attorney was made aware.</p> <p>A progress note dated April 27, 2025, at 1:34 PM indicated as-needed Tylenol was ineffective. Resident 1 had complaints of pain on a rated 8 out of 10. Nonpharmacological interventions were also ineffective. The resident was administered Tramadol at this time.</p> <p>A review of Resident 1's medication administration record (MAR) revealed he was administered Tramadol 50 mg at 1:31 PM on April 27, 2025, for a pain level 8 out of 10.</p> <p>A progress note dated April 27, 2025, at 4:32 PM indicated x-ray results of the head and neck were received by the facility. A CT scan (computed tomography scan - a medical imaging technique that uses x-rays to create detailed, cross-sectional images of organs, bones, and soft tissue) is recommended for skull x-rays. No acute fracture or subluxation (a partial or incomplete dislocation of a joint, where the bones forming the joint are still partially in contact) by plain radiography (x-ray). Moderate cervical (related to neck or spine) degenerative changes on cervical x-ray. The CRNP was made aware, and a new physician order was noted to send Resident 1 for a CT scan. The note indicated the power of attorney was made aware. The resident indicated he had no pain while lying down but indicted he had pain on his left side when moved. The note indicated the resident had no pain or discomfort in his head or neck at this time. A progress note dated April 27, 2025, at 5:10 PM revealed Resident 1 left via stretcher to the community hospital.</p> <p>A review of community hospital documentation revealed a neurological consultation dated April 28, 2025, indicating the cervical spine CT imaging confirmed a Type 2 odontoid fracture (a bony extension on the C2 bone in the neck) with some posterior angulation (a bending or tilting of a bone or fracture fragment towards the back side) and also what appears to be a chronic [NAME] type fracture of C1 (a non-acute fracture in the C1/first bone in the neck). His neurologic examination was grossly normal.</p> <p>A community hospital consultation note dated April 28, 2025, at 10:20 AM, indicating impressions following CT imaging of spine included:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. C1 anterior (front) arch fracture (C1 is a bone in the neck). Bilateral C1 posterior (back) arch fractures, which involve the expected bilateral vertebral artery course (path or trajectory of the vertebral arteries).</p> <p>2. Type 2 odontoid process fracture (a bony extension on the C2 bone in the neck) with displaced/angulated fracture fragment.</p> <p>3. No additional cervical spine fracture.</p> <p>The community hospital consultation note dated April 28, 2025, at 10:20 AM indicated Resident 1, a [AGE] year-old male, presented after a fall yesterday, striking his head. CT head showing a likely chronic [NAME] fracture and a Type 2 odontoid process fracture. Recommendations include no acute neurosurgical intervention required at this time, a soft collar (a soft cervical collar or neck brace is a device used to support the neck and limit movement) for three months, and follow-up outpatient 6-8 weeks with flexion-extension x-rays.</p> <p>A community hospital Discharge summary dated [DATE], indicated Resident 1 presented for evaluation following a fall from a chair to the scale. The summary included a report that the resident was dropped during this event. (It is unclear from the discharge summary where the allegation the resident was dropped originated. Documentation provided by the facility, interviews with Resident 1 and employees, and a review of clinical records regarding the incident revealed no clear evidence the resident was dropped. Instead, the investigation revealed the resident fell out of a wheelchair while being pushed on to a scale.) The discharge summary further noted the resident struck his forehead on a concrete wall, mostly landing on his right side. As per neurosurgery findings documented in the summary, a CT of the cervical spine showed a likely chronic [NAME] fracture and a Type 2 odontoid process fracture, with no neurological deficit. Recommendations from neurosurgery included a soft collar for 3 months and outpatient follow-up in 6-8 weeks with flexion-extension x-rays prior to the visit, with a follow-up visit scheduled for June 23, 2025.</p> <p>During a resident interview on May 13, 2025, at 1:20 PM, Resident 1 indicated on April 26, 2025, he returned from the hospital and needed to be weighed. He explained when the staff pushed him to the scale, he fell forward and hit his head off the wall. Resident 1 was not able to recall what wheelchair he was in when he was weighed that day. He was not able to identify any other factors that may have resulted in him falling. Resident 1 explained that ever since the fall, he has had neck pain. He described the pain as jolting and rated it as 10 out of 10.</p> <p>During an interview on May 13, 2025, at approximately 1:45 PM, the Director of Nursing (DON) confirmed is the facility's policy to adequately assess a resident's safety and care needs and implement adequate safety measures for a resident identified as at risk for falls. The DON confirmed that upon re-admission on [DATE], Resident 1's care needs should have been reassessed, including any changes to his fall risk acuity. The DON confirmed that upon readmission on [DATE], there was no documented evidence the facility assessed Resident 1's safety and care needs prior to his fall resulting in a cervical fracture and pain. The DON also confirmed the wheelchair from which the resident fell did not have a leg rest in place at the time of the fall.</p> <p>(continued on next page)</p>		

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