STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A433	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gino J Merli Veterans Center	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on clinical record review, facility policy review, resident observation, and staff interviews, it was determined that the facility failed to ensure residents' drug regimens were free from unnecessary medications by administering duplicate antipsychotic therapy without documented clinical justification, and by failing to attempt gradual dose reductions where appropriate, for two residents (Residents 9 and 38). Findings include: A review of the facility policy titled Behavior Management Program, last reviewed in September 2024, revealed that the facility recognizes the importance of ensuring each resident's drug regimen is free from unnecessary medications. Accordingly, the interdisciplinary team will evaluate the resident's response to psychotropic medications on an ongoing basis. This evaluation will include, but is not limited to, monitoring the resident's mood and behaviors, assessing for side effects, and reviewing the outcomes of both pharmacological and non-pharmacological interventions. Mood and behavior monitoring will be documented in the resident's electronic medical record by nursing staff, and additional clinical progress notes will be entered by other interdisciplinary team members as needed. A review of Resident 9's clinical record revealed admission to the facility on [DATE], with diagnoses to include schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges) and Parkinson's disease (a movement disorder of the nervous system that worsens over time). A Quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 20, 2025, revealed the resident was moderately cognitively impaired with a BIMS score of 12 (brief interview for mental status, a tool to assess the resident's attention, orientation and ability to register and recall new information a score of 08-12 indicates moderate cognitive impairment). Physician's orders dated January 14, 2025, revealed the resident was prescribed: Ativan (an anti-anxiety medication) 0.5 mg three times daily, Fluvoxamine (an antidepressant) 50 mg at bedtime, (continued on next page)

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Seroquel (an antipsychotic) 400 mg at 8:00 a.m. and 425 mg at 4:00 p.m., and Haldol (an antipsychotic) 5 mg at bedtime. Review of the resident's clinical record revealed an antipsychotic medication review dated March 6, 2025, listing all four medications above. The review included a checked box stating that a dose reduction was contraindicated because the benefits outweighed the risks and that a reduction would likely impair the resident's function and/or cause psychiatric instability. However, the review lacked resident-specific documentation to support this assertion. There was no individualized clinical rationale provided to explain why a GDR had not been attempted for either Seroquel or Haldol, nor was there justification for the concurrent use of two antipsychotic medications. At the time of the survey ending June 6, 2025, there was no documentation from the physician to support the absence of a GDR attempt, nor any rationale substantiating the need for ongoing duplicate antipsychotic therapy in Resident 9's drug regimen contained in the clinical record. An interview with the Director of Nursing (DON) on June 6, 2025, at 9:30 a.m., confirmed the facility was unable to provide evidence the physician had documented a resident-specific justification for continued antipsychotic use at current dosages or for the necessity of prescribing both Seroquel and Haldol concurrently. The DON also confirmed that no GDR had been attempted. Clinical record revealed that Resident 38 was admitted to the facility on [DATE], with diagnosis to include Alzheimer's disease/Dementia (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks. It is the most common cause of dementia), anxiety, and the resident was also receiving hospice care. The documented hospice admitting diagnosis was end stage heart failure (heart failure occurs when the heart cannot pump enough blood to meet the body' s needs). A quarterly Minimum Data Set (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) assessment dated [DATE], identified the resident as severely cognitively impaired and noted behavioral symptoms including fidgeting, restlessness, and difficulty concentrating. Admission Physicians orders dated December 30, 2024, included Seroquel (an antipsychotic medication) 25 mg by mouth at night for dementia. A review of the Abnormal Involuntary Movement Scale (AIMS) assessment, dated December 30, 2024, revealed that Resident 38 did not exhibit any extrapyramidal symptoms upon admission to the facility. The AIMS is a 12-item, clinician-rated tool used to assess the severity of dyskinesia in patients taking neuroleptic (antipsychotic) medications. It specifically evaluates involuntary movements such as oral-facial tics (e.g., lip smacking, tongue thrusting), extremity and truncal movements (e.g., abnormal posture, pill-rolling with fingers, shuffling gait), and includes ratings for overall severity, level of incapacitation, the patient's awareness of the movements, and any distress they may be experiencing as a result. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Between January 1 and February 4, 2025, nursing documentation described behavioral expressions such as throwing dishes, attempting to exit her Broda chair, and verbal outbursts during care. The record noted that Resident 38 sustained two falls from bed in early January. On February 4, 2025, a hospice nurse and the facility's LPN (Employee 1) discussed the resident's behaviors, resulting in a request by the facility LPN for Haldol 1 mg twice daily. A facility Certified Registered Nurse Practitioner (CRNP) subsequently ordered Haldol 1 mg twice daily for dementia. A hospice nursing note dated February 11, 2025, documented that Employee 1 (LPN) requested an increase in Haldol to three times daily. The CRNP issued a new order on February 11, 2025, for Haldol 1 mg three times daily. Behavioral documentation on and after that date noted persistent agitation throwing the blanket off of her, covering her face with her hands and repetitive verbalizations about her husband, but no objective evidence was provided to support the escalation. On February 13, 2025, despite no documented behavioral episode, hospice recommended increasing Seroquel to 50 mg twice daily, more than double the original dose, resulting in duplicate antipsychotic therapy. Resident 38 sustained another fall on February 15, 2025, after attempting to exit her Broda chair unsafely. Nurses' notes continued to reflect persistent behaviors despite the increased psychoactive medications. On February 20, 2025, the CRNP doubled the Haldol dose to 2 mg three times daily. However, documented behaviors persisted without documented evidence of benefit or clinical reassessment. Nursing documentation continued to reflect persistent behavioral symptoms, including restlessness, throwing blankets, and calling out, through the date of survey. There was no evidence of hallucinations, delusions, or other psychotic symptoms that would warrant the use of antipsychotic medications as a treatment modality. Observation of the resident on June 6, 2025, at 10:00 AM revealed extrapyramidal symptoms, specifically pill-rolling movements of the fingers, which are known adverse effects of antipsychotic drugs. There was no evidence in the clinical record that the resident's medication regimen was reassessed in response to these symptoms. Despite the use of antipsychotic medications, the clinical record lacked evidence that the facility attempted behavioral strategies to address the resident's symptoms prior to initiating or escalating pharmacologic treatment. There was no documentation indicating that nonpharmacological approaches were trialed or considered and determined to be ineffective or inappropriate. In the absence of such efforts, the facility did not demonstrate that medication was necessary to manage the resident's condition. Furthermore, there was no clinical rationale provided by the prescriber explaining why alternative, less restrictive measures were not suitable. Without documentation supporting that behavioral interventions were ruled out as ineffective or clinically inappropriate, the facility failed to justify the necessity of the antipsychotic medication regimen. During an interview on June 6, 2025, at 11:00 AM, the Director of Nursing confirmed that there was no physician documentation supporting the clinical need for duplicate antipsychotic therapy or the repeated increases in dosage for Resident 38. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Despite the resident's hospice status, the increased use of Haldol and Seroquel was directed at managing behavioral expressions of cognitive impairment rather than addressing terminal agitation or psychiatric symptoms, without evidence of individualized assessment or consideration of alternative strategies. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.2 (3) Medical Director 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services