

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39A436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Delaware Valley Veteran's Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Southampton Rd Philadelphia, PA 19154	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to provide care and services for a resident with a diagnosis of diabetes and to assess a resident for hypoglycemia for one of three residents reviewed (Resident R1).</p> <p>Findings Include:</p> <p>Review of facility grievance dated September 3, 2024, revealed a complaint from resident I was sent out on an appointment to (Outside Provider) by myself with no aid, the DON (Director of Nursing) and supervisory reported that they had no staff was available to escort me to this appointment. Myself being a quad (quadriplegia-a person affected by paralysis of all four limbs) patient should never not have someone with me during these appointments. I am unable to do many things for myself and having someone with me makes me feel more secure. I needed assistance with my personal wheelchair and operating the elevator during my appointment. I felt dizzy and ended up in the ER (emergency room) where my sugar had dropped to 59 and they provided me with a snack and drink. This could have been avoided had I had been accompanied by a staff member during this appointment. I was out the building from 8am to 1:30 p.m. and missed lunch and had a light breakfast.</p> <p>Further review of the grievance revealed that I want a staff member to be provided to me for all of my future appointments, and because am a diabetic, I should also leave with a snack and drink especially since i was out from 730 am and did not return until after lunch.</p> <p>Review of clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnosis including Quadriplegia and type 2 diabetes mellitus (A long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of physician order for Resident R1 dated July 15, 2024, to check blood sugar as needed.</p> <p>Review of physician order for Resident R1 dated August 2, 2024, for insulin Lispro with blood sugar check and hold for blood sugar less than 130.</p> <p>Review of Medication Administration Record for September 3, 2024, revealed that resident's blood sugar was 181 at 7 a.m. and he received 16 units of insulin Lispro, Repaglinide tablet (antidiabetic medication) 1 mg on September 3, 2024, prior to the appointment which affected the blood sugar level. Resident also received 14 units of long acting on September 2, 2024, at bedtime which had a potential to affect the blood sugar.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of care plan for Resident R1 dated February 21, 2023, revealed that potential for hypo/hyperglycemia related to the diagnosis of Diabetes, episodes of non-compliance with blood sugar checks and with receiving insulin. Interventions included, check with medical provider to hold insulin and/or medication for skipped meals. Document if insulin or medication refused and notify medical provider. Monitor for adequate meal consumption and evening snacks.</p> <p>Interview with Resident R1 on September 10, 2024, at 10:00 a.m. revealed that he went to an appointment in the center city approximately has 2 hours of travel time which may take longer depending on traffic on September 3, 2024. Resident stated after the appointment he had to call for the transport to get back to the appointment center to pick him back to the facility. Resident stated he left for the appointment after eating a light breakfast. Resident stated he did not have any facility staff that accompanied him for the appointment which he stated he always needed. Resident stated facility did not send any snack or lunch for the appointment and did not have any estimate of when he would return back from appointment. Resident stated he waited after the appointment for transport back to the facility, when he was waiting his blood sugar dropped, and he was taken to emergency room with a blood sugar of 59. He stated they gave him juice and snack which brought the blood sugar back, but he did not know how much the was blood sugar.</p> <p>Resident stated when he returned back to the facility, he told the staff that about the low blood sugar episode. Resident stated facility did not recheck his blood sugar or gave him food when he returned. He stated the facility lunch time was 11:30 a.m. and he returned from the appointment around 1:30 p.m.</p> <p>Review of clinical record for Resident R1 revealed no evidence that the facility checked resident's blood sugar or gave him food when he returned from the appointment.</p> <p>Interview with the Director of Nursing, Employee E2 on September 10, 2024, at 11:30 a.m. stated Resident R1 should have blood sugar checked when he returned from the appointment and offered him lunch when he returned. Resident should have packed food to take for the appointment. Employee E2 confirmed that facility staff did not check his blood sugar when resident returned even after he notified the staff that his blood sugar was 59 at the appointment. Employee E2 stated residents' blood sugar check order and insulin order was not administered at the lunch time or when he returned to the facility.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on clinical record review and resident and staff interview, it was determined to ensure sufficient staff was available to accompany one of three sampled residents to a medical appointment. (Residents R1)</p> <p>Findings include:</p> <p>Review of clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnosis including Quadriplegia (a person affected by paralysis of all four limbs) and type 2 diabetes mellitus (A long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>The Minimum Data Set (MDS-Assessment of resident care needs) assessment dated [DATE], indicated that the resident had impaired range of motion on both of his upper and [NAME] extremities. Further review of the MDS revealed that the resident was dependent on the staff for eating, toileting, transfers, mobility except one placed in a motorized wheelchair.</p> <p>Review of care plan for Resident R1 dated June 16, 2022, revealed that the resident controlled the wheelchair with his chin. Resident was quadriplegic and required total assist to fasten and unfasten seatbelt.</p> <p>Review of facility grievance dated September 3, 2024, revealed a complaint from resident I was sent out on an appointment to (Outside Provider) by myself with no aid, the DON (Director of Nursing) and supervisory reported that they had no staff was available to escort me to this appointment. Myself being a quad (quadriplegia-a person affected by paralysis of all four limbs) patient should never not have someone with me during these appointments. I am unable to do many things for myself and having someone with me makes me feel more secure. I needed assistance with my personal wheelchair and operating the elevator during my appointment. I felt dizzy and ended up in the ER (emergency room) where my sugar had dropped to 59 and they provided me with a snack and drink. This could have been avoided had I had been accompanied by a staff member during this appointment. I was out the building from 8am to 1:30 p.m. and missed lunch and had a light breakfast.</p> <p>Further review of the grievance revealed that I want a staff member to be provided to me for all of my future appointments, and because am a diabetic, I should also leave with e snack and drink especially since i was out from 730 am and did not return until after lunch.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident R1 on September 10, 2024, at 10:00 a.m. revealed that he went to an appointment in the center city approximately has 2 hours of travel time which may take longer depending on traffic on September 3, 2024. Resident stated after the appointment he had to call for the transport to get back to the appointment center to pick him back to the facility. Resident stated the transport driver dropped him in front of the appointment place. He stated his appointment was on the second floor which required him to use the elevator and press the elevator button which he could not do. He stated he had to wait for someone to press the elevator button for him to go to the doctor's office on the second floor. Resident stated he experienced the same issue when he was coming back from the appointment.</p> <p>Interview with the Transportation Clerk, Employee E3 on September 10, 2024, at 10:30 a.m. stated facility set up a stretcher transportation for Resident R1 but a wheelchair van showed up to take the resident to the appointment which required the facility to send a staff member. However, facility send the resident without a staff member.</p> <p>Interview with the Director of Nursing, Employee E2 on September 10, 2024, at 11:30 a.m. stated Resident R1 should have a staff member to accompany him to assist him at the appointment. Employee E2 stated facility did not have enough staff on September 3, 2024 to send with Resident R1 for the appointment.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on a review of facility policy, observations, and staff interviews it was determined the facility failed to meet the daily nutritional and special dietary needs for one of three residents (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Scheduling and Transportation Process dated 12/7/23, indicated Weekly request will be sent to dietary department to provide early breakfast/lunch bag for residents prior to appointment.</p> <p>Review of facility grievance dated September 3, 2024, revealed a complaint from resident I was sent out on an appointment to (Outside Provider) by myself with no aid, the DON (Director of Nursing) and supervisory reported that they had no staff was available to escort me to this appointment. Myself being a quad (quadriplegia-a person affected by paralysis of all four limbs) patient should never not have someone with me during these appointments. I am unable to do many things for myself and having someone with me makes me feel more secure. I needed assistance with my personal wheelchair and operating the elevator during my appointment. I felt dizzy and ended up in the ER (emergency room) where my sugar had dropped to 59 and they provided me with a snack and drink. This could have been avoided had I had been accompanied by a staff member during this appointment. I was out the building from 8am to 1:30 p.m. and missed lunch and had a light breakfast.</p> <p>Further review of the grievance revealed that I want a staff member to be provided to me for all of my future appointments, and because am a diabetic, I should also leave with e snack and drink especially since i was out from 730 am and did not return until after lunch.</p> <p>Review of clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnosis including Quadriplegia and type 2 diabetes mellitus (A long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of care plan for Resident R1 dated February 21, 2023, revealed that potential for hypo/hyperglycemia related to the diagnosis of Diabetes, episodes of non-compliance with blood sugar checks and with receiving insulin. Interventions included, check with medical provider to hold insulin and/or medication for skipped meals. Document if insulin or medication refused and notify medical provider. Monitor for adequate meal consumption and evening snacks.</p> <p>Interview with Resident R1 on September 10, 2024, at 10:00 a.m. revealed that he went to an appointment in the center city approximately has 2 hours of travel time which may take longer depending on traffic on September 3, 2024. Resident stated he left for the appointment after eating a light breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident stated facility did not send any snack or lunch for the appointment and did not have any estimate of when he would return back from appointment. Resident stated he waited after the appointment for transport back to the facility, when he was waiting hi blood sugar dropped, and he was taken to emergency room with a blood sugar of 59. He stated they gave him juice and snack which bought the blood sugar back, but he did not know how much the was blood sugar.</p> <p>Resident stated when he returned back to the facility, he told the staff that about the low blood sugar episode. Resident stated facility did not recheck his blood sugar or gave him food when he returned. He stated the facility lunch time was 11:30 and he returned from the appointment around 1:30 p.m.</p> <p>Review of clinical record for Resident R1 revealed no evidence that the facility gave him food when he returned from the appointment.</p> <p>Review of meal intake documentation on September 3, 2024, revealed that the resident was not provided a lunch which was documented at 2:19 p.m. It was revealed that the resident was in the facility at the time of documentation.</p> <p>Interview with the Director of Nursing, Employee E2 on September 10, 2024, at 11:30 a.m. stated resident should have had packed food to take for the appointment and should have offered meal when he returned from the appointment before 2:00 p.m.</p> <p>28 Pa. Code: 201.18(b)(1)(e)(1) Management</p> <p>28 Pa. Code: 201.12(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code: 201.1(i)Resident rights.</p> <p>28 Pa Code: 211.6(c)(d) Dietary Services</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>41471</p> <p>Based on the review of facility policy, facility documentation and staff interviews, it was determined that the facility failed to ensure that services which was not offered by the facility was provided under an arrangement in writing for transportation of a resident to a medical appointment for one of three sample residents reviewed.</p> <p>Findings Include:</p> <p>Review of the facility policy Transportation to/from the (facility) dated May 12, 2024 revealed that The (facility) will have a contract with non-emergency wheelchair and stretcher transport for as needed use, including after hours or (facility) inability to provide he transportation.</p> <p>Review of facility grievance dated September 3, 2024, revealed a complaint from resident I was sent out on an appointment to (Outside Provider) by myself with no aid, the DON (Director of Nursing) and supervisory reported that they had no staff was available to escort me to this appointment. Myself being a quad (quadriplegia-a person affected by paralysis of all four limbs) patient should never not have someone with me during these appointments. I am unable to do many things for myself and having someone with me makes me feel more secure. I needed assistance with my personal wheelchair and operating the elevator during my appointment. I felt dizzy and ended up in the ER (emergency room) where my sugar had dropped to 59 and they provided me with a snack and drink. This could have been avoided had I had been accompanied by a staff member during this appointment. I was out the building from 8am to 1:30 p.m. and missed lunch and had a light breakfast.</p> <p>Further review of the grievance revealed that I want a staff member to be provided to me for all of my future appointments, and because am a diabetic, I should also leave with e snack and drink especially since I was out from 730 am and did not return until after lunch.</p> <p>Interview with Resident R1 on September 10, 2024, at 10:00 a.m. revealed that he went to an appointment in the center of the city on September 3, 2024. Resident stated after the appointment he had to call for the transport to get back to the appointment center to pick him back to the facility. Resident stated the transport driver dropped him in front of the appointment place. He stated his appointment was on the second floor which required him to use the elevator and press the elevator button which he could not do.</p> <p>A request for the transport agreement which was used by Resident R1 was requested to the facility administrator on September 10, 2024.</p> <p>Interview with the Director of Nursing, Employee E2 on September 10, 2024, at 11:00 a.m. stated facility did not have a transport agreement with the transport company used for Resident R1 on September 3, 2024.</p> <p>28 Pa. Code: 201.21(c) Use of Outside Resources</p>		