STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A436	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Veteran's Home	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records and interviews with staff, it was determined that the facility failed to follow and or clarify physician's orders relating to advance directives for one of eight residents reviewed. (resident r 168)Findings include:Review of the facility document Advanced Healthcare Directives dated [DATE], revealed the purpose of this protocol is to provide guidance for the facility, regarding honoring the resident's choice and self-determination related to their advanced healthcare directives. The components of this policy are defined as the following: The Pa. POLST, Pennsylvania physician orders for life sustaining treatment, a voluntary, portable medical order designed to support individuals transitioning between health care facilities or living in the community by communicating choices for care at the end of life. It is a document designed to help health care providers honor the wishes of their patients. A do not resuscitate, DNR order is a legally recognized order that means a person has decided not to have cardiopulmonary resuscitation CPR attempted on them if their heart or breathing stops. A resident's wishes including DNR and DNI (Do not intubate) preference are conveyed as a medical order in a POLST form and a legal representative refers to an individual who has been appointed as the resident's guardian by a court, has been appointed as the president's health care agent pursuant to a health care power of attorney, or is the resident health care representative pursuant to 20 Pa. C.S. 5461. Review of facility reported to the State Agency dated [DATE], revealed that on [DATE], at approximately 04:00 am. a nurse aide entered the resident's room and discovered that Resident R168 was unresponsive. The nursing assistant then notified nurse who immediately followed protocol; airway, breathing, and circulation were checked, vitals were unable to be obtained, code cart brought into the room, oxygen was administered, and chest compression were started. Nurse supervisor arrived in room as question Resident R168's code status, Resident R168's code status was officially do not resuscitated (DNR). Review of Resident R168's clinical record revealed Resident 168's POLST form dated [DATE], signed by Resident R168 power of attorney, resident's son. Interview with NHA Employee E1, on [DATE], at 09:40 a.m. confirmed that there was a miscommunication regarding the resident code status. - 28 Pa. Code 201.18(a)(b)(1)(3) Management28 Pa. Code 211.12 (d) (1)(5) Nursing Services

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A436	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Valley Veteran's Home	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical record, observation and staff interviews, it was determined that the facility failed to provide adequate supervision for one of one resident observed who utilized outdoor relaxation time. (Resident R21). Findings:A review of the facility policy titled Outdoor Relaxation for Nursing Care Residents, revised July 2025, revealed: Residents who are not at risk for elopement/wandering will be able to enjoy the outdoor areas that are within the boundaries between daylight hours, from sunrise to sunset, for safety purposes.A review of the clinical record revealed that Resident R21 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, psychotic disturbance, mood disturbance and anxiety, unspecified sensorineural hearing loss, and major depressive disorder, single episode.On July 21, 2025, at 9:00 a.m. and 3:01 p.m., observations showed that three to four residents were sitting outside with no staff supervision.On July 22, 2025, at 10:30 a.m., an observation was conducted with Employee E8, during which Resident R21 was seen coming onto the porch, passing the cones that were set up to designate a safe zone for sitting outside, and propelling himself in his wheelchair around the oval road independently. During this time, three cars were entering the facility grounds, and Resident R21 began propelling toward the curb instead of remaining in the designated area. Employee E8 confirmed that it was not safe for Resident R21 to be propelling himself such a distance without supervision.On July 22, 2025, at 10:47 a.m., an interview was conducted with Resident R21, who reported that he completes four laps around the oval road in the morning and two in the afternoon, totaling approximately one mile per day. The resident is hard of hearing and was not wearing his hearing aids during his time outside. He reported feeling safe while taking his daily wheelchair walks but suggested that having a flag on his wheelchair or wearing a safety vest would make him more visible to oncoming traffic and improve his safety.On July 22, 2025, at 2:45 p.m., a meeting was held with the Administrator, Employee E1, and the Director of Nursing, Employee E2, who confirmed that it was unsafe for Resident R21 to propel himself around the oval road without supervision and in the presence of oncoming traffic.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201. 18(b)(1)(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing services.