

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 12/12/2025
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and review of facility policy, it was determined that the facility failed to ensure that residents drug regimen reviews were free from unnecessary drugs related to an increased medication dosage for one out of seven residents reviewed. (Resident R1) Findings Include: Review of facility policy titled, Medication Controlled Drug Administration Record Disposal of Schedule CII-CV Medications with a revision date of July 19, 2024 states, Policy-All schedule CII-CV medications will be counted by the outgoing and incoming nurses responsible for the medication cart at shift change on each unit . Under procedure the policy states, 1. Each medication nurse will complete a narcotic count at the beginning and the end of the shift for their medication cart. The nurse on duty and the relieving nurse will sign off on the Controlled Drugs-Count Record verifying all narcotics are accounted for and that the total for each Controlled Substance Administration Record matches the master Weekly Unit Controls Reports by Resident sheet . Review of the facility policy titled, Medication Administration Protocol with a revision date of December 3, 2024 states, Purpose- It is policy of this facility that all residents shall obtain their prescribed medications from our pharmacy. Exceptions to this will include medications prescribed to our residents and received from outside specialty clinics. All outside prescribed medications will have the approval of our attending physicians and the appropriate physician ' s order will be received prior to starting that medication .Review of facility documentation provided titled, Narcotic Fill Procedure undated states, Tech Duties- 1. Pulls appropriate product 2. Places one label on box or blister-places another label on narcotic administration sheet. Further review states, Pharm Duties- 1. Visually verifies correct selection 2. Brings filled product to narc log folders. 3. Looks up record sheet and re-verifies product against log sheet item details. 4. Deduction of product on appropriate log sheet is done and resident details written as place holder awaiting return receipt label. 5. Initials sign/receipt label 6. After round signed receipt label is placed on log sheet . Review of Resident R s clinical record revealed the resident was re-admitted to the facility on [DATE] after hospitalization with the following diagnoses: Unspecified seizures, Opioid use disorder in remission, Hypertension (high blood pressure), and Major Depressive Disorder. Review of facility witness statement from Chief Pharmacist, Employee E8 states, A fax request for Suboxone 2 milligrams (mg) was received on September 19, 2025. The label was generated, and the technician labeled the incorrect Suboxone package (Suboxone 8mg package). Unfortunately, it slipped the pharmacist verification process. The receiving nurse who signed off on the Suboxone did not catch the order as well. The resident was on hospital leave on September 19, 2025, and per protocol narcotic was stored until the patient returned. Resident returned approximately October 4, 2025 and when previous order re-activated, the incorrect fill was started. Interview on October 21, 2024 with the Director of Nursing Employee E2 and the Nursing Home Administrator Employee E1 revealed the resident was sent out to the emergency room for evaluation to the suboxone clinic being closed at the time of the medication dose increase discovery. After evaluation it was found that Resident R1 had no adverse effects from the medication dose increase. After being seen in the emergency room Resident R1 was given a taper dose as follows: Suboxone Day 1 to Day 5: 12mg/day Day 6 to Day 10: 8mg/day Day 11:4 mg/day.On October 21, 2021 at 1:03 p.m. it was confirmed by the Director of Nursing Employee E2 and the Chief Pharmacist Employee E8 that there were errors on dose verification from several staff including the pharmacist and nurses.28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		