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	04/15/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, staff interview and review of facility policy, the facility failed to ensure Resident R3 was free of abuse from Resident R2, who was known to have an aggressive behavior. This failure resulted in actual harm to Resident R3 who was shoved by Resident R2, resulting in a fall sustaining a left eyebrow abrasion, forehead bruising, and a left humeral head fracture for one of six residents reviewed. (Resident R3)Findings include: Review of the facility policy title Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property updated August 7, 2023 revealed It is the purpose of protocol to give guidance to the Department of Military and Veterans Affairs (DMVA), Bureau of Veterans Homes (BVH), State Veterans Homes (SVHs) to provide protections for the health, safety, welfare, and rights of each resident residing in the SVH by prohibiting and preventing abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, involuntary seclusion and any physical or chemical restraints not required to treat a resident's medical condition. Continued review of the policy revealed that ABUSE: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. SERIOUS BODILY INJURY: An injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as a surgery, hospitalization or physical rehabilitation; or an injury resulting from criminal sexual abuse. SERIOUS PHYSICAL INJURY: An injury that causes a person severe pain or significantly impairs a person's functioning, either permanently or temporarily. Review of Resident R2's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Dementia (progressive disease of the brain) with agitation, Post Traumatic Stress Disorder (condition that may occur after experiencing or witnessing a scary or dangerous event), and Adjustment Disorder with mixed anxiety and depressed mood (condition where someone has both anxiety and sadness in response to a stressful life change or event). Review of Resident R2's MDS, dated [DATE], revealed a BIMS score of 3, indicating severe cognitive impairment. Review of Resident R2's comprehensive care plan, initiated March 18, 2024, and revised April 2, 2026, revealed Resident R2 had a history of physical and verbal altercations with other residents. The care plan identified, the resident could be impulsive, experience rapid mood changes, become angry or upset with staff, and become verbally abusive when needs were not met promptly. The care plan further indicated the resident exhibited territorial behaviors, including believing other residents' rooms belonged to him/her. Review of information submitted by the facility to the State Survey Agency, dated March 23, 2026, revealed Resident R3 was involved in a resident-to-resident altercation on March 23, 2026, in which Resident R2 pushed Resident R3, causing (continued on next page)

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	him/her to fall to the floor. The facility substantiated resident abuse and concluded that both residents were cognitively impaired and that Resident R2 did push Resident R3 due to confusion about the bedroom. Upon assessment, Resident R3 sustained a left eyebrow abrasion, forehead bruising, and complaints of left shoulder pain. Review of nursing documentation from March 23, 2026, through April 1, 2026, revealed Resident R3 received pain medication, neurological monitoring, and x-ray evaluation, which did not identify any acute fracture at that time. Continued review of nursing documentation revealed Resident R3 continued to express complaints of left leg pain, additional imaging was obtained on April 1, 2026. Resident R3 was transferred to the hospital on April 1, 2026, and returned on April 2, 2026, with a diagnosis of a left humeral head fracture. The facility investigation, completed April 3, 2026, determined the allegation was substantiated and confirmed the fracture resulted from the altercation. Interventions implemented following the incident included increased monitoring of Resident R2, staff education on de-escalation and supervision, medication review, and care plan updates. Review of the facility's summary and review for Resident R2 revealed the following events and interventions for Resident R2: The resident has a documented history of confusion, impulsivity, and behavioral disturbances, including multiple resident-to-resident altercations:11/08/24 Incident:Resident reported that he asked (Resident R2) to pick up a fallen picture for him. (Resident R2) refused and an altercation ensued. AP alerted staff to Resident requiring assistance in bedroom but did not indicate any concerns of an altercation. Resident room was changed at Resident request, but Resident also had a history of false allegations. Unsubstantiated.03/03/2025 Incident:The resident was involved in an altercation initiated by (Resident R2) resulting in physical harm and a fall. The incident was substantiated. Interventions: Room change, separation from aggressor, initiation of purposeful rounding, psychiatric evaluation, and medication adjustments. 11/26/2025 Incident:A second substantiated altercation occurred with the same resident (Resident R2), resulting in a confirmed rib fracture. Interventions: Continued monitoring, pain management, reinforced separation strategies, and staff education on supervision during high-risk periods.Recent Incident of March 23, 2026 (Alpha Ave Unit):Resident pushed another resident despite prior interventions, indicating ongoing behavioral escalation and poor impulse control. Review of Resident R2's progress notes revealed Resident R2 was transferred from Delta unit to Alpha Ave (secured, smaller, cognitively supportive environment) on November 21, 2025. During an interview on April 13, 2026, at approximately 1:00 p.m., Employee E3, Administrator, stated the facility believed adequate interventions had been implemented for Resident R2. Email communication with the Director of Nursing, dated April 15, 2026, revealed Resident R2 was on one-hour safety checks prior to the March 23, 2026 incident and was last seen by the nurse in his room at 3:49 p.m. At 4:01 p.m., Resident R3 was at the nurse's station, seen directly by staff through 4:03pm, then Resident R3 walked down the hall. Resident R2 was walking in the hallway; Nurses were at the nursing station at that time. At 4:04 p.m., both parties in room; 4:05pm, Resident R3 falls out of room. Staff responded immediately at 4:05 pm. The facility failed to provide ensure that Resident R3 was free of abuse from Resident R2, who was known to have with an aggressive history. This failure resulted in actual harm to Resident R3 who sustained a fall after being pushed by Resident R2, resulting in a left eyebrow abrasion, forehead bruising, and a left humeral head fracture. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 clinical records, facility documentation, and staff interview, it was determined that the facility failed to provide adequate supervision to Resident R1, who was at risk for falls related to decreased mobility, and poor safety awareness, This failure resulted in actual harm, to Resident R1 who sustained a fall and was diagnosed with a hip fracture for one of 30 residents reviewed for one of six residents reviewed. (Resident R1) Findings include: Review of Resident R1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including Dementia (decline in cognitive function that interferes with daily life), Chronic Obstructive Pulmonary Disease (COPD - airway disease that restricts breathing), and Generalized Anxiety disorder. Review of Resident R1's Minimum Data Set (MDS - federally mandated resident assessment and care screening), dated January 21, 2026, revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Review of Resident R1's comprehensive care plan, initiated August 4, 2025, revealed the resident was at risk for falls related to decreased mobility, poor safety awareness, and opioid drug use. Further review of Resident R1's care plan revealed the resident was at risk for activities of daily living (ADL) deficit related to decreased mobility and cognitive impairment. Interventions, dated February 13, 2026, revealed the resident required one person assist for transfers. Review of information submitted by the facility to the State Survey Agency, dated April 06, 2026, revealed during routine care, the nurse aide turned away from the resident to place soiled clothing in a hamper. Upon turning back, the resident was observed sitting on the floor. Further review revealed an x-ray confirmed an acute left subcapital (bone break just below the head of the femur - aka: thigh bone) hip fracture with associated soft tissue swelling. Review of facility's investigation revealed Employee E1, Nurse Aide, had completed a bed bath and dressing, and the resident was seated on the edge of the bed with feet on the floor while preparing for transfer to a wheelchair. During this time, the nurse aide turned away to place soiled linens in a hamper. The resident then attempted to transfer independently and was found on the floor. Review of Employee E1, Nurse Aide, witness statement, dated April 06, 2026, revealed On April 6, 2026, I went into room [XXX] to provide care. I gave resident a bed bath and got (him/her) dressed. The resident is one assist and able to transport with assistance. Resident was sitting on the side of (his/her) bed with both feet on the floor. Wheelchair was locked and facing (him/her). I then turned to place resident dirty clothing in the bin. Upon facing the resident I saw (him/her) sitting on the floor. I asked (resident) if (he/she) was okay, (resident) responded yes. I then proceeded to help (him/her) to (his/her) feet and assisted (resident) in sitting in the wheelchair. I then notified the nurse. Review of facility provided employee education for Employee E1, Nurse Aide, revealed the root cause of the incident was identified as turning away from a high fall-risk resident during care, resulting in lack of supervision. Education provided indicated staff should ensure residents are placed in a safe position prior to stepping away and complete transfers before attending to other tasks. Interview with Employee E2, Occupational Therapist, on April 13, 2026, at approximately 10:25 a.m. confirmed the resident required one-person assistance for transfers for safety. Interview with Resident R1's family representative on April 13, 2026, approximately 11:30 a.m. confirmed the resident had a history of falls and was considered high risk. Interview with Employee E3, Administrator, on April 13, 2026, approximately 11:45 a.m. confirmed the nurse aide turned away from the resident while the resident was seated on the side of the bed in vulnerable position. The facility failed to provide adequate supervision to Resident R1, was at risk for falls related to decreased mobility, and poor safety awareness. This failure resulted in actual harm, to Resident R1 who sustained a fall and diagnosed with a hip fracture. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services