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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, observations, facility policy and staff interviews, it was determined that the facility failed to identify that a resident was free from physical restraint due to locking the wheelchair as a restraint for one of the one resident reviewed. (Resident R70)Findings include:A review of the facility policy titled, Restrain Management Protocol revised August 2023 revealed The purpose of this protocol is to provide guidance to the Department of Military and Veterans Affairs (DMVA), Bureau of Veterans Homes (BVH), State Veterans Homes (SVHs) to maintain the resident's right to be free from any physical or chemical restraints that are implemented for discipline or convenience and not required to treat a medical condition.A review of the clinical record revealed that Resident R70 was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side. (Hemiplegia refers to complete paralysis of one side of the body, while hemiparesis indicates weakness on one side.)On July 21, 2025, at 11:36 a.m., Resident R70 was sitting in the dining room waiting for his meal to be served. During the interview, Resident R70 revealed that his left hand is contracted, and he is unable to reach the wheelchair lock to move himself closer to the dining table with his right hand. Resident R70 reported, I can't do anything, can you please unlock my wheelchair?On July 21, 2025, at 11:46 a.m., nurse aide, Employee E6 brought lunch to Resident R70. The resident requested, Can you please unlock my wheelchair so I can sit closer to the dining table and propel myself with my feet? Employee E6 unlocked the wheelchair and left it unlocked while Resident R70 ate his lunch. After finishing, Resident R70 propelled himself with his feet and exited the dining room. When asked how often staff lock his wheelchair from the back, Resident R70 responded, Too often.On July 22, 2025, at 9:19 a.m., an interview was held with the Director of Nursing, Employee E2, and the Therapy Director, Employee E7, who confirmed that the resident's left hand is contracted, and the right hand is nonfunctional, preventing him from unlocking the wheelchair brakes located on the sides of the wheelchair. On June 24, 2025, Resident R70 was assessed for a Broda pedal wheelchair with a pressure relief cushion for functional mobility; however, his inability to reach and unlock the wheelchair brakes was not assessed. Resident R70 depends on staff to lock and unlock his wheelchair. Employee E2 reported that staff should only be locking the wheelchair during transfers, and that for the remainder of the time, Resident R70 should be independent and able to propel himself freely. Employees E3 and E7 reported that they will update the order to reflect that Resident R70's wheelchair should not be locked restraining him from being mobile unless he is being transferred.28 Pa. Code 211. 8(c)(1) Use of Restraints.28 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

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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.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of clinical record, observations, and staff interview, it was determined that the facility failed to ensure the proper care of a resident with an indwelling urinary catheter for one of three residents observed with urinary catheters. (Resident R143) Findings include:Review of Resident R143's clinical record revealed Resident R143 was admitted to the facility on December17, 2024 with a diagnosis that included hemiplegia (total paralysis on one side of body) and hemiparesis (partial weakness on one side of body), obstructive and reflux uropathy (urine can't flow normally through urinary tract due to blockage), edema (swelling caused by too much fluid trapped in the body's tissue). Observation on July 21, 2025 at 11:25 revealed Resident R143 in his/her wheelchair in the hallway with his/her urinary catheter bag (collects urine from at tube inserted into the bladder) dragging on the floor.28 Pa. Code 211.12(d)(1) Nursing services Observation on July 21, 2025 at 11:35 p.m. revealed Resident R143 in the dining room with his/her urinary catheter on the floor. Interview on July 21, 2025 at 11:39 p.m. with Employee E5, Licensed Practical Nurse, confirmed Resident R143's urinary catheter should be properly secured and not on the floor.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on resident interviews, meal tray observations, and staff interviews, it was determined that the facility failed to provide palatable, appealing and attractive meals during lunch for one of one meal observations (lunch meal).Findings include:On July 21, 2025, at 12:31 p.m., observation and interview with Resident R52 revealed that he was served three pierogies with kielbasa for lunch and was unable to cut through the skin of the kielbasa. Resident R52 also reported that the pierogies appeared dry and were difficult to cut. He stated, The kielbasa is overcooked, and the pierogies are too hard to cut. Resident R52 only attempted to scoop out the soft potatoes from one pierogi and appeared visibly upset.On July 21, 2025, at 12:54 p.m., a test tray was conducted by the Dietary Director, Employee E3, to assess the palatability of the pierogies and kielbasa. The kielbasa was too hard to cut, and the pierogies were dry and difficult to cut through. Employee E3 reported that the facility could improve the meal by cutting the kielbasa into smaller pieces and adding more butter or margarine to soften the pierogies. The meal was also not visually appealing, as the kielbasa and pierogies were served with wax beans, all of which were a similar beige color, making the plate look bland and unappetizing.28 PA. Code 211.10(a)(b)(c)(d) Resident care policies28 PA. Code 201.18(b)(1)(3) Management28 PA. Code 201.14(a) Responsibility of licensee

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, review of facility's menu and staff interviews, it was determined that the facility failed to meet resident's food preference for three of three residents reviewed. (Residents R111, R89, R98). Findings include:On July 21, 2025, at 11:50 a.m., an interview with Resident R111 stated, This is the second time this week we only have salads to choose from for dinner, no hot food.On July 21, 2025, at 12:24 p.m., an interview with Resident R89 revealed that, based on the current menu, only cold items would be available for dinner. Resident R89 took the menu off the table and reported that cold salads would be served for dinner, and that residents, including himself, would prefer one hot meal to be offered. A review of the grievance form for Resident R98, filed on June 9, 2025, revealed a concern related to the dinner menu on that date. Resident R98 reported that there were two cold options on the dinner menu and stated he/she spoke with someone from dietary, who explained that the menu comes from headquarters. The resolution, completed on June 12, 2025, was to ensure that at least one hot entree item would be available for dinner. However, on July 22, 2025, there were still two cold options listed on the dinner menu.On July 22, 2025, at approximately 9:15 a.m. the Dietary Director, Employee E3, confirmed that based on the current Week 2 menu for Monday's dinner on July 21, 2025, the facility served egg salad sandwiches and chicken salad on wheat. The Week 1 menu showed that Monday's dinner included ham and Swiss sandwiches and egg salad sandwiches. This same week Thursday's dinner included seafood salad on a croissant and egg salad on wheat. There was no hot dinner meal available to residents.28 Pa Code 201.14(a) Responsibility of licensee

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, policy review, and staff interviews, it was determined the facility failed to develop and implement a water management program for the prevention, detection, and control of waterborne contaminants such as Legionella (a bacteria that may cause [legionnaires disease, a serious type of pneumonia).Findings include: Review of Centers for Disease Control and Prevention (CDC) guideline for “Water Management and Healthcare Facilities” Revealed “Legionella water management programs identify hazardous conditions and include taking steps to minimize the growth and spread of Legionella in the building water system. Having a water management program is now an industry standard for large buildings in the United States” Review of Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Memo titled “ Requirement to reduce legionella risk in healthcare facility water systems to prevent cases and outbreaks of legionella disease” Dated July 6 2018, Revealed “ Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of legionella and other opportunistic pathogens in water. This policy memorandum applies to hospitals, critical access hospitals CAHS and long term care LTC. However, this policy memorandum is also intended to provide general awareness for all healthcare organizations facilities must have water management plans and documentation that at minimum ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (eg: Pneumonias, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. - Develops and implements a water management program that considers the ASHRAE Industry standards and the CDC Toolkit - Specifies testing protocols in acceptable ranges for control measures, and documents the results of testing and corrective action taken when control limits are not maintained - Maintains compliance and other acceptable federal, state and local requirements. Interview with Employee 1 July 24, 2025, at 10:00 AM confirm the facility failed to ensure water testing and compliance of water management plan. The facility was not able to provide documented evidence that water testing was completed. 28 Pa. Code 211.12(d)(3)(5) Nursing Services. 28 Pa. Code 201. 14 (a) Responsibility of licensee