Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, which resulted from the State Veterans Home Unannounced On-Site or Announced Virtual Survey, is a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or LSC Identifying Information.) Title 38 CFR Part 51 Federal Regulations for SVHs. §51.210, §51.390, §51.475 Administration, resident personal funds protected in §51.70 (c)(1-6), and all required VA and life safety standards in 38 CFR Part 51.

General Information:

Facility Name: Delaware Valley Veterans' Home

Location: 2701 Southampton Road Philadelphia, PA 19154

Onsite / Virtual: Onsite

Dates of Survey: 3/23/22 - 3/25/22

Nursing Home / Domiciliary / Adult Day Health Care: NH

Survey Class: Recognition

Total Available Beds: 130

Census on First Day of Survey: 122

Deficiency	Findings
	Initial Comments: A VA Recognition survey was conducted from March 23, 2022, through March 25, 2022, at the Delaware Valley Veterans' Home. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§51.100(a)Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observations, interviews, and record review, the facility failed to ensure dignity was provided to four (4) out of 17 residents sampled on the [LOCATION]. The facility failed to ensure that two (2) of three (3) residents (Residents #6 and Resident #14) were all served lunch at the same time while sitting at the same table. The facility also failed to ensure that staff did not refer to a resident (Resident #4) who needed assistance with eating as a "feeder." The findings included: 1. During lunch meal observation in the dining room on 3/23/22 between 11:35 a.m.-12:17 p.m., three (3) residents (Resident #6, Resident #13 and Resident #14) were seated at the second-round table in the middle row from the right side of the room. Resident #13 was observed to start his/her lunch at 11:35 a.m. while the other two (2) residents (Resident #6 and Resident #14) sat at the table and watched Resident #13 eat. At 11:50

	a.m., Residents #6 and Resident #14 were served their lunch meals. At the time Resident #6's and Resident #14's lunch trays were served; Resident #13 was more than half done with his/her lunch. All three (3) residents were alert yet confused and unable to be interviewed. Resident #6 was admitted to the facility on [DATE] with diagnoses including Aphasia, and General Anxiety Disorder (GAD). Review of Resident #6's Admission Minimum Data Set (MDS) Assessment dated [DATE] revealed that they were unable to complete a resident interview due to short- and long-term memory problems. Resident #13 was admitted to the facility on [DATE] with diagnoses including Parkinson's and Schizoaffective Disorder. Review of Resident #13's Admission MDS Assessment dated [DATE], revealed that they could not be interviewed due to having short- and long-term memory problems. Resident #14 was admitted to the facility on [DATE] with a diagnosis including Parkinson's Disease. Review of Resident #14's Admission MDS Assessment dated [DATE], revealed that he/she had a Brief Interview for Mental Status (BIMS) of 10, which meant he/she was moderately impaired cognitively. 2. During a random observation on the [LOCATION] long hallway on 3/23/22 at 12:18 p.m., the surveyor asked [Licensed Nurse A], the whereabouts of Resident #4 was since the surveyor did not see them in the dining room. [Licensed Nurse A] stated that Resident #4 was still in activities and referred to Resident #4 as a "feeder" because they needed assistance with their dining activity, which indicated the resident would be eating in the dining room. Resident #4 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease and Dysphagia. Review of Resident #4's Admission MDS Assessment dated [DATE] revealed that he/she could not be interviewed due to short- and long-term memory problems. In an interview with [Administrative Nurse A] on 3/24/22 at 2:21 p.m., they revealed that it was not appropriate to call a resident a "feeder" but said that "bad habits die hard." Also, [Administrative Nurse A] confirmed that all three (3) residents at the table were to be served at the same time. Throughout the

	interview, [Administrative Nurse A] continued to state that the staff "just know." In an interview with [Administrative Staff A] on 3/24/22 at 4:00 p.m., they stated that they did random dining observations and indicated there had been no concerns with dignity in the past three (3) months. Review of the Annual Employee Education Prevention of Resident Abuse and Resident Rights Competency 2022 dated 2/3/22 revealed that [Licensed Nurse A] was educated on resident rights, including dignity concerns.
§51.140(h) Sanitary conditions. The facility must: 1. Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; 2. Store, prepare, distribute, and serve food under sanitary conditions; and 3. Dispose of garbage and refuse properly. Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected – All	Based on observations, interviews, and a review of the facility's documentation and policy, it was determined the facility failed to ensure temperatures of food items intended for consumption were at the proper temperatures. The findings included: Review of the facility's policy titled "Delaware Valley Veterans Home Dietetic Services Policy and Procedure Manual" dated 7/27/07, revealed under the "Procedure" section, "Staff is issued thermometers to take temperature of food prior to food service Prior to cafeteria meal service food service workers shall take temperatures of all hot food and potentially dangerous cold foods. Examples include cream cheese cottage cheese, luncheon meats etc (et cetera) Hot foods must be at least 140 degrees. If hot food does not meet 140degree threshold it must be reheated to 165 degrees…Cold food will be served at 40 degrees or lower" On 3/23/22 at approximately 10:15 a.m. during a tour of the facility's kitchen, the temperature of the corned beef registered at 47 degrees Fahrenheit (F) and the temperature of the macaroni salad was 70 degrees F. On 3/23/22 at approximately 11:45 a.m. temperatures taken on the B-wing service line prior to serving revealed the temperature of the chopped fish was 132 degrees F and chopped vegetables 120 degrees F on the hot holding side of the line and on the cold holding side of the service line the temperature of the macaroni salad registered 42 degrees F and Asian salad at 50.5 degrees F. During an interview Employee #5 confirmed that the foods identified were not being held at the proper temperatures.
§51.190(b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of	Based on observations, interviews, record review, and review of facility policy, the facility failed to ensure that staff wore masks properly, failed to ensure that proper hand hygiene was completed between resident (Residents #6 and Resident #13) interactions by staff in the dining room, and failed to ensure that

infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected – All	appropriate hand washing was completed to prevent cross-contamination. The findings included: Review of facility policy titled "Hand Hygiene Policy" with revision date of 5/2/2020, indicated that hand hygiene should be performed with soap and water "when hands are visibly dirty or feel sticky, after handling stool or emesis, after known or suspected exposure to bacteria or viruses such as C-Diff. or Norovirus, before and after eating, after using a restroom, and before and after providing resident care." Review of policy related to "Standard, Droplet, and Airborne Precaution, including eye protection" revised 2/5/21, indicated how to wash hands with soap and water, which included: "turn on water and wet hands, apply soap to hands and rub together vigorously for at least 20 seconds covering all surfaces of the hands and fingers…rinse hands with water and use a paper towel to dry, use paper towel to turn off faucet…and dispose of paper towel…" Review of facility policy titled, "Resident Care Policies and Procedures, Hand Hygiene" with revised date of 2/5/21 indicated that "staff members should perform hand hygiene using alcohol-based sanitizer (ABHS) before and after all resident contact, contact with potentially infectious material, and before putting and removing personal protective equipment (PPE) including gloves. Hand hygiene also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, staff will use soap and water before returning to ABHS." Further review indicated that staff members will medically be cleared, trained, and fit tested for respiratory protective devices such as N95 respirator. On training will be used OSHA training videos that demonstrate appropriate application and use of Mask N95: ensure that the mask has secure ties or elastic band at the middle of the head and neck, fit the flexible band snugly over the bridge of the nose, fit the mask snugly to the face and below the chin, ensure facial does not cause gaps or impact the seal between the mask and the face chin, disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door, and if reusable respirators are used they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to use." Review of "2022 Handwashing Competency" dated 8/27/21 for Certified Nursing Assistant (CNA) #2 revealed that he/she completed handwashing without any concerns (i.e., turning off the faucet with a paper towel).

	Review of the "Training Attendance Record" dated 5/10/21 for handwashing and personal protective equipment (PPE) indicated that CNA #2 attended this in-service; however, there was no evidence that the Director of Nursing (DON) and/or the Administrator attended this in-service. Review of the "Annual Mandatory Employee Education 2022 Training Plan and Calendar" indicated that in April/May/June, infection control and prevention including bloodborne pathogens, standard precautions, food handling/satiation, Coronavirus disease (COVID), handwashing and PPE for all staff would be completed. During daily exit conference with the facility staff on 3/23/22 between 2:45 p.m. - 3:00 p.m., [Administrative Nurse A] was seated at the head of the conference table to the left side of the team leader of the survey, moving their mask up over their nose at least five (5) times (the mask was observed to fall below his/her nose, and then halfway down his/her mouth). During lunch meal observation on 3/23/22 between 11:35 a.m.-12:17 p.m., it was observed that in the middle row, second table from the right of the dining room, near the handwashing sink, Resident #6 and Resident #13 were seated at the table ready to eat lunch. Upon start of the meal service, Resident #13 was observed to be eating their lunch meal by themselves. At 11:50 a.m., Resident #6 was served and observed to start feeding themself after staff set up. At 12:05 p.m., [Certified Nurse Aide A] came over to the table and started to assist Resident #6 with their meal. [Certified Nurse Aide A] pulled up a chair next to Resident #6's right side, sat down, and picked up the resident's utensils that Resident #6 had been using with their bare right hand. There was no evidence that [Certified Nurse Aide A] washed hands and/or sanitized prior to this. At 12:08 p.m., CNA [Certified Nurse Aide A] got up and went over to Resident #13 who was feeding themself and cleared the resident's used plate and utensils away, then came back to the chair and started assisting Resident #6 again. All of this was done without washing hands and/or sanitizing. At 12:11 p.m., [Certified Nurse Aide A] got up again, obtained four (4) vanilla pudding servings from the tray line, and distributed to a resident at the first table on the right side of the dining room in the middle row, gave another one (1) to another resident at the third table in the middle row from the right side of the dining room, gave one (1) each to Resident #13 and Resident #14. Then [Certified Nurse Aide A] went back to their seat at the table and started assisting Resident #6 without washing and/or sanitizing their hands. At 12:14 p.m., [Certified Nurse Aide A] got up from the table, went over to a wood hutch in the back of the dining room, put gloves on, and obtained two (2) sanitary wipes. CNA #2 came back to Resident #6, wiped their mouth and both their hands with the

	wipes. With the same gloves, [Certified Nurse Aide A] moved the resident's Broda chair away from the table and stopped halfway to the doorway (back to the B-wing), removed their gloves and went to the handwashing sink. Upon arrival at the handwashing sink, [Certified Nurse Aide A] turned on both the hot and cold water, completed hand washing once for approximately 15 seconds, turned off the right-side faucet with their bare right hand, then turned off the left side faucet with their bare right hand, and then obtained a few paper towels with his/her bare right hand from the wall-mounted paper towel holder. [Certified Nurse Aide A] dried their hands, then came back to Resident #6, who was pushed in their Broda chair out into the hallway/nursing station area on the B-wing. [Certified Nurse Aide A] did not return to the dining room. During an interview with [Administrative Staff B] on 3/24/22 at 11:59 a.m., as they spoke with the survey team in the conference room, [Administrative Staff B] was observed to remove the right side of their mask to speak, allowing it to hang away from their mouth. In an interview with [Certified Nurse Aide A] on 3/23/22 at 12:55 p.m., they indicated that they have been at the facility for the past two (2) years. [Certified Nurse Aide A] stated that prior to entering every room, they were to change their gloves and wash their hands. [Certified Nurse Aide A] also indicated that they were to wash their hands prior to entering the dining room and before exiting the dining room. [Certified Nurse Aide A] indicated that handwashing should be completed between residents as well; however, they stated that this did not always happen. [Certified Nurse Aide A] stated that sometimes it got busy, but they were not touching any food. [Certified Nurse Aide A] stated they were unsure of the date of the last in-service, but said as courses came up, then they completed them. When the surveyor asked about the handwashing process, [Certified Nurse Aide A] went into an empty resident's room and was observed to turn on both the hot and cold water and let them run for approximately two (2) minutes. After letting the water run, [Certified Nurse Aide A] washed their hands with soap and water for 15 seconds, rinsed and repeated for another 15 seconds. After this, [Certified Nurse Aide A] obtained three (3) paper towels from the towel dispenser on the wall, and dried their hands, then obtained another towel, and turned off both faucets. In an interview with [Administrative Nurse A] on 3/24/22 between 2:21 p.m.- 2:56 p.m., they stated that hand washing should be completed when gloves are removed, between residents during dining, and after performing activities of daily living (ADL) care. [Administrative Nurse A] stated that they always thought there were issues and that staff had to have

	reminders. [Administrative Nurse A] indicated that they were going to get posters and put up in the dining room for hand hygiene. Also, [Administrative Nurse A] indicated that they were going to increase in-services for staff. [Administrative Nurse A] indicated that there were plenty of hand sanitizers around the unit and that all staff carry individual hand sanitizers. [Administrative Nurse A] further stated that masks were always to be worn over the nose; however, during interview with [Administrative Nurse A], they were again observed pulling their mask up over their nose. In an interview with [Administrative Staff A] on 3/24/22 at 4:00 p.m., they indicated that they did random dining room observations on every shift daily, to ensure staff are doing what they need to be doing, such has changing gloves, demonstrating appropriate hand hygiene, and maintaining a resident's dignity. They indicated that they have not had any concerns with hand hygiene and/or dignity during their observations in the past three (3) months. After these observations, they sent an email to [Administrative Nurse A], [Administrative Staff B], [Administrative Nurse B], [Administrative Nurse C], [Administrative Staff C, and [Administrative Nurse D], indicating if there were any issues during the observations. In an interview with [Administrative Coordinator D] on 3/25/22 at 10:46 a.m., they indicated that there was a set calendar that the staff went by yearly for their education requirements. There was a topic for each month, and the year started off with abuse training. The yearly training was different due to fitting it with the national standards at that time. If there was an issue noticed with an employee, then "on the spot" training was completed, which was retained in the employee file. The infection control training contained such things as handwashing and PPE use. The handwashing competency was reviewed with the supervisors and then the supervisors completed the competency of staff on their shifts, indicating that the Center for Disease Control (CDC) guidelines were followed. They stated when washing hands, the staff were to turn off the faucet with a paper towel. They were able to verbalize staff were to always wear their masks covering their nose and mouth. They indicated staff had to have reminders of doing this all the time.
§51.200(a) Life safety from fire The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety	Based on observation and interview, the facility failed to protect a fire barrier through-penetration with a firestop system or device in accordance with the code. The deficient practice affected the smoke compartment, staff, and all residents. The facility has a capacity for 41 beds with a census of 22 on the day of the survey. The findings included:

Code and NFPA 99, Health Care Facilities Code. Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected – All	Observation during the building inspection tour on 3/24/22 at 10:12 a.m. of the B Unit, a cable penetration pass through of communication wires in the two (2) hour fire barrier above the double-doors into the facility's administrative wing was not protected by a firestop system or device as required by section 8.3.5.1 of NFPA 101, Life Safety Code. Interview at that time with [Maintenance Staff A] revealed that they were not aware that the penetration was not sealed with a firestopping material or firestop system. The census of 22 was verified by [Administrative Staff B] on 3/23/22. The findings were acknowledged by the and verified by [Administrative Nurse A] and [Maintenance Staff A] during the exit interview on 3/25/22 at 1:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **8.3.5.1* Firestop Systems and Devices Required.** Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, *Standard Test Method for Fire Tests of Through Penetration Fire Stops*, or ANSI/UL 1479, *Standard for Fire Tests of Through-Penetration Firestops*, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m^2) between the exposed and the unexposed surface of the test assembly.