

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER Statesman Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2629 Trenton Road Levittown, PA 19056	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947</p> <p>Based on staff and family interviews and the review of clinical records, it was determined that the facility failed to ensure that residents had the right to participate in the development and implementation of a person-centered plan of care for 2 out of 20 residents reviewed (Resident R61 and R71).</p> <p>Findings include:</p> <p>Review of October 2024 physician orders for Resident R61 indicated that the resident was admitted into to the facility on [DATE] with diagnosis of muscle weakness and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), pancreatitis (a condition in which the pancreas becomes inflamed); anemia (an individual does not have enough healthy red blood cells which can result in fatigue and unexplained weakness); paraplegia (a form of paralysis that affects the lower half of an individual's body and their ability to walk), heart failure (an individual's heart can't supply enough blood to meet the body's needs), deep vein thrombosis and end stage renal disease (the gradual loss of kidney function).</p> <p>Review of the resident's Admission Minimum Data Set Assessment (MDS- a periodic assessment of a resident's needs) dated July 7, 2024 indicated that the resident was alert and oriented.</p> <p>During a phone interview with Resident R61's mother/responsible party, on November 5, 2024 at 9:36 a.m. the resident's mother reported that she spoke with the social worker (Employee E13) in July 2024 regarding having the resident transferred closer to where the resident is from. The resident's mother reported that she never heard anything back from the social worker at the facility, so when she came up to the facility the Tuesday, Wednesday, and Thursday after Labor Day the resident's mother stated that she provided the social worker with a list of 6 facilities that are in the area of where the resident and his family resided, in addition to the names of and the names 3 dialysis centers. The resident's mother stated that she was calling up everyday and left voicemail messages for the social worker and the Director of Nursing (DON) to call her back to get an update on the status of Resident R61's discharge, but the resident's mother reported that she did not receive any phone calls back.</p> <p>The resident's mother was asked if she ever received a verbal notification from the social worker or anyone else from the facility regarding a care plan meeting, or a written notification from the facility for a care plan meeting regarding here son's care at the facility.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's clinical record did not show evidence of any documentation of the resident and/or his responsible party ever receiving any notification of a care plan meeting, or that any care plan meeting ever occurred since his admission on July 1, 2024.</p> <p>Review of the November 2021 physician orders for Resident R71 included the following diagnosis's: diabetes (a medical condition that occurs when an individual's blood sugar is too high); respiratory failure (a condition when an individual does not have enough oxygen in their blood and can result in symptoms that include, shortness of breath, confusion and fatigue) morbid obesity, in addition to heart failure, and end stage renal disease.</p> <p>Review of the resident's August 21, 2024 Quarterly MDS indicated that the resident was alert and oriented.</p> <p>During an interview with Resident R71 on November 8, 2024 at 2:13 p.m. reported that she has not had a care plan meeting in a while.</p> <p>Review of the resident's clinical record from February 2024 through November 2024 did not show evidence of any documentation of the resident and/or her responsible party ever receiving any notification of a care plan meeting, or that any care plan meeting ever occurred since his admission on July 1, 2024.</p> <p>During an interview with the social worker (Employee E13) on November 12, 2024 at 12:05 p.m. regarding the process for notifying residents and their responsible parties regarding care plan meetings, the social worker reported that she tries to give the resident and/or responsible party at least 30 days' notice, and will adjust the date/time as needed if it does not work for them. It was discussed with the social worker that there was no documentation regarding care plan notifications for Resident R61 and R71, or that a care plan occurred for Resident R61 and Resident R71. It was also discussed that Resident R61's mother reported that she had never been invited to one or attended one at any time during her resident's stay at the facility. It was also discussed with the social worker that Resident R71 reported that she was never invited to one or attended one anytime this year. It was confirmed by the social worker that no information could be produced to show evidence that either resident were invited to a meeting and had the right to participate in the development and implementation of his or her person-centered plan of care.</p> <p>The facility failed to ensure that Resident R61 and Resident R71 had the right to participate in the development and implementation of their person-centered plan of care.</p> <p>28 Pa Code 201.29 (c) Resident rights.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525</p> <p>Based on observations of care and services, reviews of clinical records and interviews with residents and staff, it was determined that the facility failed to provide care preferences and reasonable accommodations for the adaptive equipment used to enhance mobility and bathing for one of three residents reviewed. (Resident R10)</p> <p>Findings include:</p> <p>Review of Resident R10 annual comprehensive assessment (MDS-an assessment of care needs) dated August 16, 2024 indicated that Resident R10 was cognitively intact with impairments on both sides of lower extremities. The assessment revealed that the resident required maximal assistance with functional abilities for showering and bathing, the use of a wheelchair for ambulation. The resident was occasionally incontinent of bladder and occasionally experiencing pain. Continued review of the MDS revealed that the resident had a Stage II (ulcer involving loss of the top layers of the skin) pressure sore, the resident received physical therapy and that the established goal set was for the resident to be discharge to the community.</p> <p>Interview with Resident R10 at 11:00 a.m., on November 4, 2024 revealed that the resident did not get out of bed into his wheel chair; because he was not able to be positioned upright or properly with his back aligned and supported by the back of the chair, the mechanical lift sling that was used to transfer him from the bed to the wheel chair was small and rubbing against his skin during a transfer causing skin irritation. The resident verbalized that the chair itself was too small and uncomfortable; evidenced by getting caught as the nursing staff began a transfer with the mechanical lift either from the bed to the wheel chair or from the wheel chair to the bed.</p> <p>Further interview with Resident R10 revealed that the resident had not been accommodated with a shower for several months. The resident was informed by the nursing and physical therapy staff that he would not be able to fit through the doorway into the central shower room on the C wing nursing unit.</p> <p>Clinical record review revealed that the physical therapy staff evaluated Resident R10 on January 18, 2024 and indicated that this resident was able to sit in a wheel chair with an upright posture with elevating leg rests. At this time the therapy department indicated that Resident R10 was receiving range of motion exercises of the bilateral lower extremities to prevent joint contractures.</p> <p>Clinical record review revealed that the physical therapy department evaluated Resident R10 on August 15, 2024 and indicated that Resident R10 was able to use a draw sheet under legs while in bed with staff assistance and safely move to the edge of the bed for edge of the bed sitting.</p> <p>Clinical record review revealed that on August 22, 2024 the physical therapist assessed and educated Resident R10 and staff to institute bed mobility exercises to strengthen core muscles while in bed. The assessment indicated that modified abdominal crunches, throwing and catching a ball forward side to side and reaching for a ball from each side of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review for Resident R10 indicated that this resident was evaluated by the wound practitioner on October 29, 2024 and the evaluation indicated that this resident had a stage II pressure area located on the left buttock; measuring .8cm by .6 centimeters (cm) by .1 cm with 100% epithelialized tissue. The practitioner's recommendations for the nursing staff were to cleanse all skin folds with bathing. The practitioner also indicated that the importance of daily bathing was discussed with Resident R10 to prevent skin breakdown and infections of the tissues.</p> <p>Clinical record review revealed that on November 25, 2023 the physical therapy department measured Resident R10's body from hip to hip and the Resident was 35 inches. At this time the therapy department indicated that the bariatric wheel chair was 30 inches wide. Resident R10 reported to the therapy department that this bariatric wheel chair was too tight for him.</p> <p>Interview with the nursing staff (Employees E7, E8, E9 and E10) between 9:30 a.m. and 11:00 a.m., on November 4 through November 8, 2024 revealed that Resident R10 did not fit in the wheel chair provided for him by the physical therapy department. The nursing staff reported that it was too snug around the hip/waist area for Resident R10. The nursing staff also reported that they had not offered Resident R10 a shower with a bariatric shower chair; because the chairs they have on the C wing nursing unit were not bariatric designed.</p> <p>Observations of the bariatric shower chair that the facility had on the B wing nursing unit confirmed that this chair when used with Resident R10 was too large to fit through the shower room doorway on the nursing unit.</p> <p>Interview with the physical therapist, Employee E4 at 1: 00 p.m., on November 5, 2024 confirmed that the wheel chair as assigned to Resident R10 by the physical therapy department was trialed and tested on [DATE]. The results of the attempted seating were that the chair was too tight, not comfortable and ill-fitting for proper positioning and use by Resident R10.</p> <p>Clinical record review for Resident R10 revealed that there was no care plan developed to address accommodation of medical and physical needs for adaptive equipment to enhance mobility and bathing for Resident R10.</p> <p>Interview with Nursing Home Administrator, Employee E1 and the Director of nursing, Employee E2 at 2:00 p. m., on November 5, 2024 confirmed the lack of care plan development and implementation for the adaptive equipment (wheel chair and shower chair) and a restorative exercise program for bed mobility, draw sheet repositioning, turning and exercising upper and lower extremities and core strengthening with weighted ball tossing and lifting for Resident R10.</p> <p>28 Pa. Code 211.12(d)(1)(3) Nursing services</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 PA Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 PA Code 211.5(f)(ii)(iii)(viii)(ix) Medical records</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947</p> <p>Based on staff interview and the review of the clinical record, it was determined that the facility failed to ensure that a person-center plan of care was developed for a resident with a history of deep vein thrombosis (blood clots) and anticoagulant medications for 1 out of 20 residents reviewed (Resident R61).</p> <p>Findings include:</p> <p>Review of October 2024 physician orders for Resident R61 include the diagnose of muscle weakness, seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), pancreatitis (a condition in which the pancreas becomes inflamed); anemia (an individual does not have enough healthy red blood cells which can result in fatigue and unexplained weakness); paraplegia (a form of paralysis that affects the lower half of an individual's body and their ability to walk) and heart failure (an individual's heart can't supply enough blood to meet the body's needs). The resident also had a diagnoses of deep vein thrombosis and end stage renal disease (the gradual loss of kidney function).</p> <p>Review of September 2024 physician's order included a physician's order for Eliquis (a medication used to prevent serious blood clots from forming due to a certain irregular heartbeat) with a start date of August 30, 2024 and a discharge date of [DATE].</p> <p>Review of a nursing note dated September 18, 2024 at 2:02 p.m. indicated that the resident complained of being in pain and feeling uncomfortable while at dialysis. A review of a nursing note on September 18, 2024 at 9:40 p.m. indicated that the resident was admitted to the hospital with partial bowel obstruction.</p> <p>Review of the resident's hospital discharge summary dated September 27, 2024, indicated that the resident's Eliquis was held due to concerns to having low hemoglobin levels. The hospital indicated in the above referenced discharge summary that the resident's Eliquis management should be followed up with the resident's primary care physician. Follow up with PCP (primary care physician) regarding Eliquis management.</p> <p>Review of the resident's person-centered plan of care did not include an updated plan of care documenting that the resident was no longer being treated with any anticoagulants and did not include any services, treatments or interventions that may have needed to be implemented related to the changes in the resident's physician's orders.</p> <p>During a discussion with the Director of Nursing (DON) on November 12, 2024 at 4:00 p.m. that there was no person-centered plan of care for the resident related to the discharge of the resident's anticoagulant that was being prescribed to prevent blood clots.</p> <p>28 Pa. Code 211.12(c)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947</p> <p>Based on staff interviews, review of facility policy and the review of the clinical record, it was determined that the facility failed to develop and implement an effective discharge planning process for 1 out of 20 residents reviewed (Resident R61).</p> <p>Findings include:</p> <p>Review of the facility policy, Discharge Planning Policy, with a revision date of September 24, 2024, indicated that the discharge needs of each resident will be identified and will develop a discharge plan that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition the resident to post discharge care, and the reduction of factors leading to preventable readmissions. The policy also stated that the discharge plan will include: the regular re-evaluation of residents to identify changes that need to be made in the resident's discharge plan; the involvement of the interdisciplinary team (the physician, nurse, nurse aide, food and nutritional services staff), in addition to the resident and/or his/her responsible party.</p> <p>Review of October 2024 physician orders for Resident R61 indicated that the resident was admitted into to the facility on [DATE] with diagnosis that included muscle weakness, seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness); pancreatitis (a condition in which the pancreas becomes inflamed); anemia (a medical condition in which an individual does not have enough healthy red blood cells, and can which can result in fatigue and unexplained weakness); paraplegia (a form of paralysis that affects the lower half of an individual's body and their ability to walk), and heart failure (an individual's heart can't supply enough blood to meet the body's needs). The resident also had a diagnosis of deep vein thrombosis (blood clots) and end stage renal disease (the gradual loss of kidney function) that required hemodialysis treatment 3 times a week.</p> <p>During a phone interview with Resident R61's mother/responsible party, on November 5, 2024 at 9:36 a.m., the resident's mother reported that she spoke with the social worker (Employee E13) in July 2024 regarding having the resident transferred closer to where she and the resident are from. The resident's mother reported that she never heard anything back from the social worker at the facility, so when she came up to the facility the Tuesday, Wednesday, and Thursday after Labor Day in September 2024. The resident's mother reported during the interview that on one of the above referenced days that she visited her son, she provided the social worker with a list of 6 facilities and 3 dialysis centers that are in the area of where the resident previously resided prior to his transfer to the facility in July 2024. The resident's mother stated that she was calling up everyday and left voicemail messages for the social worker and the Director of Nursing (DON) to call her back to get an update on the status of Resident R61's discharge, but the resident's mother reported that she did not receive any phone calls back from either individual.</p> <p>Review of the resident's clinical record, including the resident's person-centered plan of care, did not include any evidence of the implementation and documentation of a discharge planning process for Resident R61.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the social worker on November 7, 2024 at 12:48 p.m. the social worker reported that the discharge plan for the resident was for the resident to be transferred back up to the area where the resident's mother was, and where he originally resided, prior to admission into the facility on [DATE]. The social worker also reported that the resident would also need to be connected to a dialysis center for his treatments. The social worker confirmed that there was no documentation in the clinical record, or in the resident's person-centered plan of care related to any discharge plan/planning for the resident that she completed on behalf of the resident.</p> <p>28 Pa. Code 201.29 (c) Resident rights</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947</p> <p>Based on staff interviews, review of facility policy and the review of clinical records, it was determined that the facility failed to notify the physician regarding a change in Resident R61's meal and fluid consumption for 1 out of 20 residents reviewed (Resident R61).</p> <p>Findings include:</p> <p>Review of the facility policy, Change in Condition, with a revision date of June 27, 2024, indicated that a resident's significant change in condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one are of the resident's health status and or requires interdisciplinary reviewed and /or revision to the care plan.</p> <p>The policy also indicated the physician and the resident/family and responsible party will be notified when there has been an accident involving the resident .a significant change in the resident's physician/emotional/mental condition and a need to alter the resident's treatment, including a change in provider orders .when there is a consistent refusal of treatment or medications. Continued review of the policy indicated that the nurse will gather information prior to contacting the physician with information that includes, but not limited to resident vital signs (temperature, pulse, respirations and pulse ox), most recent labs, a description of the problems and information on when the change in condition started. The policy also stated that the nurse will record d the information related to the change in condition and subsequent events and notifications in the resident's health records.</p> <p>Review of October 2024 physician orders for Resident R61 indicated that the resident was admitted into to the facility on [DATE] with diagnoses of muscle weakness and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), pancreatitis (a condition in which the pancreas becomes inflamed); anemia (an individual does not have enough healthy red blood cells which can result in fatigue and unexplained weakness); paraplegia (a form of paralysis that affects the lower half of an individual's body and their ability to walk) and heart failure (an individual's heart can't supply enough blood to meet the body's needs). The resident also had a diagnosis of deep vein thrombosis and end stage renal disease (the gradual loss of kidney function) that required hemodialysis treatment 3 times a week.</p> <p>Review of the resident's Admission Minimum Data Set Assessment (MDS- a periodic assessment of a resident's needs) dated July 7, 2024, indicated that the resident was alert and oriented.</p> <p>Review of the resident's clinical record indicated that the resident did not consume any meals on October 18, 2024. Breakfast was documented as not taken, Lunch was documented as not taken, and dinner was documented as not taken by the resident's nursing assistant. The resident was also documented as having consumed a total of 2 liquid supplements of 120 milliliters each (240 milliliter), and 2 servings of a fluid that equaled total 110 milliliters each (220 milliliters), which is a total of 15.5 ounces of a combination of fluids/supplements for that day.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's meal consumption log for October 18, 2024, also documented the resident as consuming, 76-100% of a third supplement.</p> <p>Continued review of the clinical record did not show evidence that the physician was notified of the resident's meal and fluid consumptions so any instructions, orders, and/or further assessments could be provided.</p> <p>During an interview on November 12, 2024, at 12:49 p.m. with the registered nurse supervisor (Employee E14) for Resident R61, Employee E14 reported that he worked 7:00 a.m. on October 18, 2024 until 7:00 p.m. on October 14, 2024. Employee E13 reported that the resident was transferred to his unit on October 18, 2024, and that he was not notified that he did not eat breakfast from the unit that he transferred from. It was discussed with Employee E14 that the resident was transferred to Employee E14's unit prior to lunch. Employee E14 also reported that he was not made aware by the resident's assigned nurse aide (Employee E15) that the resident did not eat lunch or dinner on October 18, 2024.</p> <p>28 Pa Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on review of clinical records, observations, interviews with staff and residents, it was determined that the facility failed to ensure the availability of necessary emergency tool kit for one resident, out of the six residents receiving hemodialysis (R36).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident R36 was admitted to the facility on [DATE], with a diagnosis of End Stage Renal Disease.</p> <p>Review of physician order for Resident R36, dated August 26, 2024, indicated an order to receive dialysis on Monday, Wednesday, and Friday. The physician order also indicated for an emergency tool kit (clamp, gauze, and tape) with the Resident R36, at all times during every shift, day shift, and night shift, at bedside.</p> <p>An observation and interview with Resident R36, on November 5, 2024, at 9:44 a.m., revealed there was no emergency tool kit located in the resident's room, or with the resident, or any Emergency Clamp at bedside.</p> <p>Absence of emergency tool kit was confirmed with Resident R36 and a Licensed Nurse, Employee E11, on November 5, 2024, at 9:46 a.m.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER Statesman Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2629 Trenton Road Levittown, PA 19056	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>39343</p> <p>Based on observation, interview, and clinical record review, it was determined that the facility failed to correctly administer medications in accordance with physician orders, for one of seven residents' medication administration observed, resulting in a significant medication error (Resident R21).</p> <p>Findings include:</p> <p>On November 6, 2024, at 10:28 a.m., observed that Employee E12, a Registered Nurse, administered to Resident R21, the medicine, Furosemide tablet 40 mg, one tablet by mouth.</p> <p>Review of physician order for R21, revealed an order to administer Furosemide tablet 40 mg, two tablets, by mouth, for Obstructive and Reflux Uropathy (Obstructive Uropathy occurs when urine cannot drain through the urinary tract; urine backs up into the kidneys and may cause them to become swollen. Obstructive Uropathy is a prevalent cause of acute kidney injury that can potentially lead to death or irreversible and permanent tissue damage leading to chronic kidney disease).</p> <p>At the time of the observation, interview with Employee E12, confirmed the above findings.</p> <p>The facility incurred a medication error rate of 3.85%.</p> <p>Pa Code:211.12(d)(1)(2)(5) Nursing Services.</p>