STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395259	A. BLDG: __--_____ B. WING: _____	12/03/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
STATESMAN HEALTH & REHABILITATION CENTER STATE LICENSE NUMBER: **193702**	**2629 TRENTON ROAD LEVITTOWN, PA 19056**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000 SS=E	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 3, 2024, at Statesman Health & Rehabilitation Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

STATESMAN HEALTH & REHABILITATION CENTER

STATE LICENSE NUMBER: 193702

SURVEY EXIT DATE: 12/03/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID# 193702 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 3, 2024, it was determined that Statesman Health & Rehabilitation Center was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type II (000), unprotected non-combustible building, that is fully sprinklered.	K 0000		
K 0222 SS=E		K 0222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0222 SS=E	Continued from page 1 NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door	K 0222	0222 C and B wing hallway doors adjusted to release after 15 seconds Maintenance Staff educated that emergency exit doors must release after 15 seconds. Maintenance staff will test 3 emergency exit doors weekly to assure they release after 15 seconds x 90days. Any doors that do not release will be adjusted/repaired.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **12/18/2024**

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K 0222 SS=E	Continued from page 2 assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 0222		

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K 0222 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain emergency exit doors, affecting 2 of 5 emergency exit doors. Findings Include: 1. Observations on December 3, 2024, between 10:38 a.m. and 10:47 a.m., revealed the following deficiencies: a. 10:38 a.m., C wing hallway emergency exit door next to the boiler room failed to release after 15 seconds as indicated on sign posted. b. 10:47 a.m., B wing hallway emergency exit next to the storage room failed to release after 15 seconds as indicated on sign posted. Exit Interview with the Administrator and Maintenance Director on December 3, 2024, at 12:00 p.m., confirmed failure to maintain emergency exit doors.	K 0222		

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K 0222 SS=E	Continued from page 4	K 0222		
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 0321	0321 B wing storage door adjusted to latch smoke tight. Maintenance staff educated that storage room doors must latch smoke tight. Maintenance staff will audit 3 storage room doors to assure each door latches smoke tight and adjust/repair as necessary.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **12/18/2024**

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K 0321 SS=E	Continued from page 5 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain hazardous areas, affecting one of four smoke compartments. Findings include: Observation on December 3, 2024, at 10:46 a.m., revealed the B wing storage room door failed to latch smoke tight Exit Interview with the Administrator and Maintenance Director on December 3, 2024, at 12:00 p.m., confirmed failure to maintain hazardous areas.	K 0321		
K 0345 SS=F		K 0345		

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K 0345 SS=F	Continued from page 6 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	0345 A wing strobes adjusted to be in synchronization, batteries in the main FACP replaced, and sensitivity testing completed. Maintenance Staff and vendor educated to timely repairs following inspections. Maintenance Director will schedule all repairs with vendor immediately following inspections so repairs will be made timely.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **12/18/2024**

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K 0345 SS=F	Continued from page 7 Based on document review and interview, it was determined the facility failed to maintain the fire alarm system, affecting the entire facility. Findings include: Documentation reviewed on December 3, 2024, at 9:30 a.m., revealed the September 2024, annual fire alarm inspection report listed the following deficiencies, which remained uncorrected at the time of survey: a. The A-wing strobes were out of synchronization and shall be investigated and corrected ASAP; b. The (2) 12V9AH batteries in the Main FACP failed and shall be replaced ASAP; c. The system is past due for sensitivity testing. This shall be done ASAP. Exit Interview with the Administrator and Maintenance Director on December 3, 2024, at 12:00 p.m., confirmed the fire alarm deficiencies.	K 0345		

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K 0345 SS=F	Continued from page 8	K 0345		
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	0353 FDC hydrotest completed. Maintenance Staff and vendor educated to timely repairs following inspections. NHA will audit that Maintenance Director schedules all repairs with vendor immediately following inspections so repairs will be made timely.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **12/18/2024**

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K 0353 SS=F	Continued from page 9 Based on document review and interview, it was determined the facility failed to maintain automatic sprinkler system components, affecting the entire facility. Findings include: Document review on December 3, 2024, at 9:00 a.m., revealed the October 2024 sprinkler inspection report listed the following deficiency, which remained uncorrected at time of survey: There is no record of an FDC hydrotest. FDC Needs to be Hydrotested July 19 2024 and September 16, 2024. Exit Interview with the Administrator and Maintenance Director on December 3, 2024, at 12:00 p.m., confirmed the sprinkler system deficiency.	K 0353		

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K 0761 SS=F	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	0761 Annual Fire Door Inspection completed and doors adjusted/repaired as needed. Maintenance staff educated that Annual Fire Door Inspection must be completed annually. NHA will audit that Maintenance staff will routinely inspect 3 Fire Doors weekly x 90 days to assure they are closing and latching properly.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **12/18/2024**

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K 0761 SS=F	Continued from page 11 Based on document review and interview, it was determined the facility failed to properly conduct the required annual fire door inspection, for one required inspection. Findings include: Document review on December 3, 2024, at 9:00 a.m., revealed the facility lacked documentation showing an annual fire door inspection was performed. Exit Interview with the Administrator and Maintenance Director on December 3, 2024, at 12:00 p.m., confirmed the missing documentation.	K 0761		
K 0918 SS=F		K 0918		

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K 0918 SS=F	Continued from page 12 NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	0918 Monthly battery conductance testing completed. 3 year 4 hour generator load test completed. Maintenance staff educated that a 3 year 4 hour load test must be completed on the generator. Maintenance will schedule the next 3yr 4 hour load test with vendor immediately following the completion of load test.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **12/18/2024**

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K 0918 SS=F	Continued from page 13 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

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STATESMAN HEALTH & REHABILITATION CENTER STATE LICENSE NUMBER: **193702**	**2629 TRENTON ROAD LEVITTOWN, PA 19056**

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K 0918 SS=F	Continued from page 14 Based on document review and interview, it was determined the facility failed to maintain required testing of emergency generator components, affecting one generator. Findings Include: Document review on December 3, 2024, at 9:00 a.m., revealed the facility lacked verifying documentation of the following emergency generator maintenance items: a. monthly battery conductance testing. b. 3-year 4-hour load test. Exit Interview with the Administrator and Maintenance Director on December 3, 2024, at 12:00 p.m., confirmed the missing documentation.	K 0918		

Certified End Page

STATESMAN HEALTH & REHABILITATION CENTER

STATE LICENSE NUMBER: 193702

SURVEY EXIT DATE: 12/03/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

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THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395259	A. BLDG: 02 B. WING:	12/03/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
STATESMAN HEALTH & REHABILITATION CENTER STATE LICENSE NUMBER: **193702**	**2629 TRENTON ROAD** **LEVITTOWN, PA 19056**

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K 0000	INITIAL COMMENT Facility ID# 193702 Component 02 Physical Therapy Addition Based on a Medicare/Medicaid Recertification Survey completed on December 3, 2024, it was determined that Statesman Health & Rehabilitation Center was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (111), protected wood frame building, that is fully sprinklered.	K 0000		
K 0222 SS=E		K 0222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0222 SS=E	Continued from page 1 NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door	K 0222	0222 C and B wing hallway doors adjusted to release after 15 seconds. Maintenance Staff educated that emergency exit doors must release after 15 seconds. Maintenance staff will test 3 emergency exit doors weekly to assure they release after 15 seconds x 90days. Any doors that do not release will be adjusted/repaired.	Completion Date: **01/15/2025** Status: **APPROVED** Date: **12/18/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0222 SS=E	Continued from page 2 assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0222 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain emergency exit doors, affecting 1 of 2 emergency exit doors. Findings Include: Observations on December 3, 2024, at 11:17 a.m., revealed the therapy front entrance emergency exit door next to the clinical reimbursement office failed to release after 15 seconds as indicated on sign posted. Exit Interview with the Administrator and Maintenance Director on December 3, 2024, at 12:00 p.m., confirmed failure to maintain emergency exit doors.	K 0222		

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