

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Somerset Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 228 Siemon Drive Somerset, PA 15501	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760</p> <p>Based on review of clinical records and facility investigation reports, as well as staff interviews, it was determined that the facility failed to provide an environment that was free of accident hazards for one of three residents (Resident 2) reviewed who ingested hand sanitizer, resulting in a blood alcohol level of 0.29.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident 2 revealed that she was a new admission to the facility on [DATE], from the hospital.</p> <p>A progress note for Resident 2, dated June 28, 2024, revealed that report was received from a hospital nurse. The resident was admitted to the hospital on June 19, 2024, for alcohol intoxication, hypotension (low blood pressure), and a fall in which she hit her head. A progress note for the resident, dated June 28, 2024, at 6:45 p.m. revealed that the resident arrived from the hospital via Med Van in stable condition.</p> <p>A hospital discharge summary for Resident 2, dated June 28, 2024, revealed that she had frequent ingestions of hand sanitizer or Listerine to become intoxicated and had frequent emergency department visits/admissions for the issue. The resident was brought to the hospital on this occasion after staff found a bottle of hand sanitizer in her room. On June 22, 2024, another empty container of hand sanitizer was found by the registered nurse, indicating that the resident was able to access more of it. Discharge diagnoses included ambulatory dysfunction and hand sanitizer poisoning.</p> <p>A baseline care plan for Resident 2, dated June 28, 2024, revealed that she had an Altered Mood State or Behavior due to a history of alcoholism and drinking sanitizer. Staff were to keep hand sanitizer out of the resident's room.</p> <p>An investigation report for Resident 2, dated July 1, 2024, 8:34 a.m. revealed that a nurse aide reported that when she walked the resident back to her bed from the bathroom and straightened up her bed pads, she found an empty bag of hand sanitizer that is normally in the hand sanitizer case on the wall. The resident denied drinking the hand sanitizer. She stated that a gentleman who was changing the hand sanitizer bag let her have it because she was not able to use the wall unit.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A statement completed by Nurse Aide 1, dated July 1, 2024, revealed that during breakfast she walked Resident 2 back to her bed from the bathroom. When she straightened up the bed pads so Resident 2 could get back into bed, she found an empty bag of hand sanitizer in her bed. The licensed practical nurse and Director of Nursing were notified.</p> <p>A nursing note for Resident 2, dated July 2, 2024, at 2:44 a.m., revealed that the nurse aide entered the resident's room and smelled hand sanitizer. The nurse aide found a water cup (the size they give water in for meds) full of sanitizer on the night stand. The licensed practical nurse reported seeing the cup earlier in her shift but thought it had water in it. Unsure if the resident ingested any of it, and it looked like it was still full and not touched. Will place in provider book to be seen for this behavior.</p> <p>A social service note for Resident 2, dated July 2, 2024, at 8:48 a.m., revealed that the writer met with the resident and with the Nursing Home Administrator. They discussed the issue with the hand sanitizer. Firm boundaries were set by the Nursing Home Administrator that she is not permitted hand sanitizer due to her history of drinking it.</p> <p>An Interdisciplinary Team note, dated July 2, 2024, at 9:43 a.m., revealed that Resident 2 was found with a cup of hand sanitizer in her room, and the cup was immediately removed by staff. Additional interventions were placed to remove extra cups from the resident's room and check the contents of the cups every shift, along with other interventions.</p> <p>A new care plan for Resident 2, dated July 2, 2024, revealed that she has a behavior problem of excessive drinking related to substance use disorder. The resident has accused staff of supplying hand sanitizer when they have not. The resident will not have hand sanitizer in her room. Staff were to monitor her room for cups and remove any that are unnecessary. Staff were to assist the resident to develop more appropriate methods of coping with thoughts of using substances, encourage the resident to express feelings appropriately, and educate the resident/family/caregivers on successful coping and interaction strategies such as participating in activities that encourage sobriety. The resident needs encouragement and active support by family/caregivers when the resident uses these strategies, and staff were to praise any indication of the resident's progress/improvement in behavior. The resident's triggers for substance use are stress and boredom. The resident's behavior is de-escalated by talking about feelings.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident 2, dated July 2, 2024, at 2:48 p.m., revealed that three empty bags of hand sanitizer and a cup containing hand sanitizer was found in her room. The resident continued to deny drinking the hand sanitizer. She opened her eyes to questions and answers questions, stated that she does not feel good, that her head hurts, and that she was sick in her stomach. Staff is currently sitting with her one-on-one. The Certified Registered Nurse Practitioner (CRNP - a registered nurse who has advanced education and clinical training in a health care specialty area) was updated, and orders were received for STAT (immediate) blood work that included an Ethanol (ETOH - a simple alcohol) level for ETOH abuse/drank hand sanitizer, complete blood count (CBC - a blood test that measures many different parts and features of your blood), comprehensive metabolic panel (CMP - a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working), check vitals every one-hour times four for monitoring for drinking hand sanitizer. Then check vitals every two hours times four, then every four hours times four for ETOH abuse/drank hand sanitizer. Neuro checks (a neurological exam that evaluates the brain and nervous system functioning) every four hours times 12 hours for ETOH abuse/drank hand sanitizer and one-on-one supervision every shift for ETOH abuse.</p> <p>A progress note for Resident 2, dated July 2, 2024, at 9:30 p.m., revealed that the CRNP was notified of the stat lab results, CBC, CMP, and an ETOH level of 0.29 milligrams per deciliter (mg/dL) (normal is 0-0.05 mg/dL). She was also made aware that they found a 4th bag of empty hand sanitizer in her room that the resident had hidden behind her pillow. The resident has had a one-on-one sitter since the previous bags were removed, so they know she has not taken any since previous discovery.</p> <p>A statement completed by Activity Aide 2, dated July 2, 2024, revealed that upon doing Resident 2's psychosocial evaluation, she noticed a bag of medical supplies in the corner. Another employee had mentioned her behavior, and I told her about the medical supplies. The Assistant Director of Nursing asked Activity Aide 2 to go in one-on-one with the resident. While in the room Activity Aide 2 noticed a gel-like substance in the resident's cup and when the Nursing Home Administrator came in, Activity Aide 2 gave her the cup that she removed from the resident's tabletop by the bed. Activity Aide 2 continued one-on-one until 4:32 p.m. when it was the end of the shift. The resident appears lethargic (a symptom that involves an unusual decrease in consciousness).</p> <p>A statement completed by Central Supply 3, dated July 2, 2024, revealed that she was informed that Resident 2 had wound care products in her room. Central Supply 3 checked with the Assistant Director of Nursing to see if she allowed them in her room because some of the products had alcohol in them. The Assistant Director of Nursing checked the electronic medical record and confirmed that she should not have wound care products because she does not have any wounds. Central Supply 3 went and found Resident 2's nurse aide (Nurse Aide 1) and asked if she could go along to find them. They went into the resident's room and asked if she had products. The resident was not making sense and just kept stating, The man, the man, the man. They found the wound products on her nightstand. On top of the wound products there was a bag of the resident's belongings. As Central Supply 3 went to grab the bag to move it, she saw one brand of hand sanitizer empty in the bag and asked the resident where it came from. Resident 2 stated the man twice. Then she just kept saying, I do not know. They went and got the Assistant Director of Nursing and The Director of Nursing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A statement completed by the Assistant Director of Nursing, dated July 2, 2024, revealed that Central Supply 3 came to the office and asked if Resident 2 should have wound supplies in her room. The Assistant Director of Nursing double checked the medical record and confirmed that the resident did not have any wounds. Central Supply 3 said that she was going to remove the supplies from the room. She immediately returned to the office and explained that she found an empty bag of hand sanitizer on top of the wound supplies. The Assistant Director of Nursing went to the resident's room and asked to go through her belongings. The Assistant Director of Nursing began looking and opened the drawer to the nightstand and found another empty bag of hand sanitizer. The Assistant Director of Nursing sent Central Supply 3 to notify the Director of Nursing and the Nursing Home Administrator of the findings. The Assistant Director of Nursing stayed with the resident to ensure her safety. While interviewing the resident, she appeared intoxicated. The Assistant Director of Nursing stayed with the resident while nursing staff contacted the physician for orders/instructions. The resident was placed on one-on-one observation. Activity Aide 2 came to the room and provided direct supervision.</p> <p>A statement completed by Account Manager/Housekeeping 4, dated July 2, 2024, revealed that she went into Resident 2's room to assist in cleaning the resident's room. While cleaning around her bed she picked up a backpack off the floor and found an almost empty bag of hand sanitizer, removed it from the room, and gave the hand sanitizer bag to the nurse.</p> <p>There was no documented evidence that after the first bag of hand sanitizer was found on July 1, 2024, or when the cup of hand sanitizer was found on July 2, 2024, that a thorough search of the resident's room and belongings was completed until the three additional bags of hand sanitizer were found.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on July 9, 2024, at 2:25 p.m. revealed that they were aware of Resident 2's history of drinking hand sanitizer prior to her admission, so they removed the hand sanitizer from the room that she was going to be in. They indicated that she was also in isolation so they removed the hand sanitizer from the isolation cart that was going to be outside of the resident's room. They confirmed that Resident 2's ETOH level was 0.29 mg/dL and that staff only performed a visual search of the resident's room after finding the first bag of hand sanitizer on July 1, 2024, and the cup of hand sanitizer on July 2, 2024. When the additional bags of hand sanitizer were found on July 2, 2024, they obtained the resident's permission to search her belongings and room, which resulted in finding one more bag of hand sanitizer. They indicated that the resident went on one-on-one supervision at that time until she was discharged to a rehab facility.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		