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| 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 11/20/2024 |
| 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) |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>19102</p> <p>Based on review of clinical records and facility investigations, as well as staff interviews, it was determined that the facility failed to revise residents' care plans with individualized interventions to address their care needs for one of seven residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 3, 2024, revealed that the resident sometimes could make himself understood, sometimes could understand others, was cognitively impaired, and had diagnoses that included dementia and a stroke. The resident's care plan, dated April 21, 2021, revealed that he required a mechanical lift with the assistance of two staff for transfers.</p> <p>A facility investigation, dated November 11, 2024, at 6:20 p.m., revealed that staff was attempting to transfer Resident 1 to his wheelchair during active fire evacuation. They were unable to safely transfer him to his chair without more assistance, so he was lowered to the floor with two staff members present. A draw sheet was then placed under the resident and four persons transferred the resident from the floor to the chair. Resident 1 complained of pain on his left side at the time of transfer. There were no injuries observed at the time of the incident.</p> <p>A nursing note, dated November 12, 2024, at 12:42 a.m., revealed that Resident 1 complained of pain all over, especially to the lower back, left hip, and left leg. He yelled when the nurse touched his leg. New orders were received for x-rays of the lumbar spine, left hip, and left femur.</p> <p>An x-ray report, dated November 12, 2024, revealed that the resident's left hip had an acute (recent) displaced (out of line) intertrochanteric (the upper part of the thigh bone) fracture.</p> <p>The care plan for Resident 1, revised on November 13, 2024, indicated that the resident required one assist with transfers.</p> <p>Interview with Nurse Aide 1 on November 19, 2024, at 1:21 p.m. confirmed that Resident 1 currently and always required a mechanical lift for transfers.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview with Nurse Aide 2 on November 19, 2024, at 1:25 p.m. confirmed that Resident 1 required a mechanical lift for transfers and was never a one assist for transfers as long as she could remember.</p> <p>Interview with the Director of Rehabilitation on November 19, 2024, at 12:20 p.m. revealed that Resident 1 always required a mechanical lift for transfers, especially now with a current fracture.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>31760</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that pressure ulcers were monitored for one of seven residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>The facility's policy regarding prevention of pressure injuries, dated March 19, 2024, revealed that the resident was to be assessed on admission for existing pressure injury risk factors, and repeat the assessment weekly and upon any changes.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated October 20, 2024, revealed that the resident was understood, could understand others, and had one Stage 1 pressure injury (a mild pressure-related skin change that appears as a reddened area that does not turn white when pressed), as well as one unstageable pressure injury (a full-thickness tissue loss that is covered by a layer of dead tissue) that was present upon admission. The resident's care plan, dated October 15, 2024, indicated that the resident has a right lateral malleolus (the bony bump on the outside of the right ankle) pressure wound, as well as a potential risk for skin integrity issues due to decreased mobility and fragile skin. Staff was to document weekly, which was to include the measurement of each area of the skin breakdown's width, length, depth, type of tissue, and exudate (fluid that leaks out of blood vessels into nearby tissues) and any other notable changes or observations.</p> <p>Physician's orders for Resident 2, dated October 14, 2024, included an order for staff to cleanse the resident's left heel wound with Normal Sterile Saline (NSS - a mixture of water and salt), then apply betadine gauze to the open area, and cover with foam dressing every shift and as needed for dislodgment/soilage.</p> <p>A nursing note for Resident 2, dated October 14, 2024, revealed that the resident arrived to the facility from the hospital via stretcher. Dressings were intact to his left heel and his right Achilles area.</p> <p>An admission assessment for Resident 2, dated October 14, 2024, revealed that the resident had a surgical incision dressing in place to his right outer ankle and a pressure area that was covered with a large adhesive foam dressing to his left heel. However, there was no documented evidence of any description and/or measurements of the pressure area to his left heel.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A Certified Registered Nurse Practitioner (CRNP - a registered nurse who has advanced education and clinical training in a health care specialty area) note for Resident 2, dated October 17, 2024, revealed that the resident was seen that day in follow up of weakness and pain. The right ankle/heel wound at site of the debridement (a medical procedure that removes damaged, dead, or infected tissue from a wound to help it heal) and the calcaneotomy (a surgical procedure that removes part or all of the heel bone to treat conditions like chronic osteomyelitis or non-healing foot ulcers) was observed. There was no drainage and it appeared to be healing when compared to photos provided by the previous facility. The left heel was noted to have a small open area with minimal amount of serosanguinous drainage (a normal, thin, watery fluid that leaks from a wound or incision site and is a combination of blood and serum, the liquid part of blood).</p> <p>A CRNP note for Resident 2, dated October 23, 2024, revealed that the resident was seen that day in follow up of weakness and pain. The right ankle/heel wound at site of the debridement and the calcaneotomy was observed. There was no drainage and it appeared to be healing when compared to photos provided by the previous facility. The left heel is noted to have a small open area with minimal amount of serosanguinous drainage.</p> <p>A Wound CRNP note for Resident 2, dated November 8, 2024, revealed that the resident had a wound to his left lateral foot, which was unstageable and measured four centimeters (cm) by four cm by 16 cm.</p> <p>Resident 2's Treatment Administration Records (TARs) for October and November 2024 revealed that staff cleansed the resident's left heel wound with NSS, applied the betadine gauze to the open area, and covered with a foam dressing twice a day from October 15, 2024, through November 11, 2024.</p> <p>However, there was no documented evidence that the pressure wound to Resident 2's left heel was measured weekly from admission and/or that the wound was assessed weekly after October 23, 2024, until November 8, 2024.</p> <p>Interview with the Nursing Home Administrator on November 19, 2024, at 5:10 p.m. confirmed that there was no documented evidence that the pressure wound to Resident 2's left heel was measured weekly from admission and/or that the pressure wound was assessed weekly after October 23, 2024, until November 8, 2024.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p> | | |

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| <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>19102</p> <p>Based on review of fire safety plans, clinical records, and investigative reports, as well as staff interviews, it was determined that the facility failed to ensure that safe transfer techniques were used in accordance with their care plans and emergency evacuation plans for one of seven residents reviewed (Resident 1) who required the use of a mechanical lift for transfers, resulting in a left hip fracture.</p> <p>Findings include:</p> <p>The facility's current Fire Response Plan revealed for emergency removal of a resident from bed when working alone revealed that staff were to slip both arms under the resident's body and pull the resident towards the edge of the bed then drop to their knee nearest the head. Staff were to pull the lower half of the resident's body from the bed so that the extended knee supported the resident's hips. Staff were to use both arms to lower the resident's upper body to the floor, let the resident's legs slide gently to the blanket, and pull the resident from the room head first.</p> <p>The facility's current Emergency Evacuation Plan revealed that residents in immediate danger were to be evacuated to a safe location. Staff were to use good judgement with the transfer of residents. Next staff were to continue to evacuate residents to their designated outside area. Nurse aides would assist in the evacuation of residents to designated outside evacuation areas for each wing, as directed. Staff were to use good judgement with the transfer of residents to the safest mode of transportation to evacuate the facility or area.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 3, 2024, revealed that the resident sometimes could make himself understood, sometimes could understand others, was cognitively impaired, and had diagnoses that included dementia and a stroke. The resident's care plan, revised April 21, 2021, revealed that he required a mechanical lift with the assistance of two staff for transfers.</p> <p>A functional ability and goals form, completed by the Director of Rehabilitation, dated August 25, 2024, revealed that Resident 1 was dependent on staff for transfers from the chair/bed to chair and tub/shower.</p> <p>A facility investigation, dated November 11, 2024, at 6:20 p.m., indicated that staff was attempting to transfer Resident 1 to his wheelchair during an active fire evacuation. They were unable to safely transfer him to his chair without more assistance, so he was lowered to the floor with two staff members present. A draw sheet was then placed under the resident and four persons transferred the resident from the floor to the chair. Resident 1 complained of pain on his left side at the time of the transfer. There were no injuries observed at the time of the incident.</p> <p>A nursing note, dated November 12, 2024, at 12:42 a.m., revealed that Resident 1 complained of pain all over, especially to the lower back, left hip, and left leg. He yelled when the nurse touched his leg. New orders were received for x-rays of the lumbar spine, left hip, and left femur.</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>An x-ray report, dated November 12, 2024, revealed that the resident's left hip had an acute (recent) displaced (out of line) intertrochanteric (the upper part of the thigh bone) fracture.</p> <p>A written statement by Licensed Practical Nurse 3, dated November 12, 2024, revealed that Nurse Aide 4 went in to transfer Resident 1 into his wheelchair. The resident had his legs out over the side of the bed and was lying back on the bed. Nurse Aide 4 asked her to help him transfer Resident 1 and she told him that she had to get gloves. In the meantime Nurse Aide 4 bear hugged Resident 1 to lift him up, he was dead weight, and his legs buckled under him. She told Nurse Aide 4 to lower the resident to the floor so he did not fall.</p> <p>A written statement by Nurse Aide 4 on November 14, 2024, revealed that C wing began to fill up with smoke and they started to get residents out during the evacuation. He and a nurse picked up Resident 1 after they sat him up. When they tried to turn him to put the wheelchair under him, his legs gave out underneath him, so they laid him down on his back.</p> <p>The facility's employee orientation checklist, dated September 5 2024, revealed that Nurse Aide 4 completed training regarding fire safety and evacuation procedures.</p> <p>Interview with the Director of Rehabilitation on November 19, 2024, at 12:20 p.m. revealed that Resident 1 always required a mechanical lift for transfers and that transferring the resident out of bed with a one assist, stand and pivot, during the fire drill was not appropriate.</p> <p>Interview with Licensed Practical Nurse 3 on November 19, 2024, at 12:36 p.m. revealed that Nurse Aide 4 came to the door and asked for help to transfer Resident 1. The resident's legs were off the bed and he was lying flat on the bed, and she told him give her a minute. Nurse Aide 4 then bear hugged Resident 1, and she could see the resident was going down. She could not help lift Resident 1, since he was dead weight, and she told Nurse Aide 4 to lower Resident 1 to the floor and she would get help. She confirmed that Nurse Aide 4 lifted Resident 1 and when he turned to put the resident in his chair, she could see the resident going down. She confirmed that Resident 1 was a mechanical lift and always was a lift, and Nurse Aide 4 bear hugged Resident 1 and tried to transfer him by himself.</p> <p>Interview with Nurse Aide 4 on November 19, 2024, at 4:33 p.m. confirmed that he did bear hug Resident 1 to get him up and into his wheelchair. He reported that Licensed Practical Nurse 3 did not physically help to stand him, but tried to get the wheelchair under the resident, but when he could not get the resident into the chair, she then told him to lay the resident down. He stated that he was aware that Resident 1 was a mechanical lift.</p> <p>Interview with the Director of Nursing on November 19, 2024, at 2:46 p.m. confirmed that Nurse Aide 4 did not transfer Resident 1 out of bed with a mechanical lift due to a fire evacuation. She was not sure if the resident was a mechanical lift or could assist with transfers.</p> <p>Interview with the Nursing Home Administrator on November 19, 2024, at 4:05 p.m. revealed that she was not aware that Nurse Aide 4 bear hugged Resident 1 and attempted to transfer him out of bed by himself.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p> | | |