

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 12/30/2024
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>43856</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to provide confidentiality of residents' personal health information during medication administration for one of nine residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>The facility policy regarding electronic health records, dated March 19, 2024, indicated that the resident's health information needs to remain private.</p> <p>Observations on December 30, 2024, at 9:05 a.m. revealed that Licensed Practical Nurse 1 was not near her medication cart. Resident 2's personal health information was visible on the computer screen, which was facing the hallway.</p> <p>Interview with Licensed Practical Nurse 1 on December 30, 2024, at 9:11 a.m. confirmed that she should have covered the resident's personal information when leaving the medication cart by securing the computer screen.</p> <p>Interview with the Director of Nursing on December 30, 2024, at 12:31 p.m. confirmed that the computer screen with Resident 2's personal health information should have been covered when the nurse was not attending the medication cart.</p> <p>28 Pa. Code 211.5(b) Clinical Records.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>43856</p> <p>Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were stored in a secure manner for two of three medication carts reviewed (A unit long hall cart and C unit cart).</p> <p>Findings include:</p> <p>The facility's policy on administering medications, dated March 19, 2024, indicated that during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.</p> <p>Observations on December 30, 2024, at 8:54 a.m. revealed that the medication cart for A unit long hall was in the hallway, against the wall, unlocked and unattended. A medication cup containing various medications was stored on top of the medication cart. Interview with Licensed Practical Nurse 2 on December 30, 2024, at 8:57 a.m. indicated that she was called away by a nurse aide and confirmed that the medication cart should have been locked when unattended and confirmed that the medication cup containing various medications should not have been left unattended on top of the cart.</p> <p>Interview with the Director of Nursing on December 30, 2024, at 12:37 p.m. confirmed that the medication cart for A unit long hall should have been locked when unattended and confirmed that the medication cup containing various medications should not have been left unattended on top of the cart.</p> <p>Observations on December 30, 2024, at 9:05 a.m. revealed that the medication cart for C Unit was unlocked. Interview with Licensed Practical Nurse 1 at 9:11 a.m. revealed that she went to care for a resident and during that time the cart was unattended.</p> <p>Interview with the Director of Nursing on December 30, 2024, at 12:31 p.m. confirmed that the medication cart on the C Unit should have been secured when staff were not present.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>43856</p> <p>Based on review of clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to honor food preferences for one of nine residents reviewed (Resident 5).</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 5, dated December 7, 2024, indicated that the resident was cognitively intact, was clearly understood and able to clearly understand others, and was independent with care needs.</p> <p>An interview with Resident 5 on December 30, 2024, at 9:19 a.m. revealed that she was no longer able to get yogurt and a banana for breakfast. She indicated that she gets too many eggs and does not like eggs, and that prior to the new owners taking over, she was able to get yogurt and a banana for breakfast daily.</p> <p>Interview with the Dietary Manager on December 30, 2024, at 12:01 p.m. revealed that she was not permitted to purchase yogurt and bananas when the new owners took over. She indicated that if Resident 5 wanted these items, the family would have to bring them in and store them in the resident's refrigerator on the unit.</p> <p>Interview with the Dietary Manager on December 30, 2024, at 1:54 p.m. revealed that her boss indicated that they would provide yogurt and bananas for nutritional intervention if needed, but not necessarily for preference.</p> <p>Interview with the Dietary Manager on December 30, 2024, at 2:12 p.m. revealed that Resident 5's preferences for a banana and yogurt were listed on her special request list, but the banana was removed and replaced with canned fruit when bananas were made unavailable. She revealed that there was no food replacement for the yogurt that she was no longer permitted to get; however, she did indicate that she was given permission this day to order a case of yogurt and bananas.</p> <p>28 Pa. Code 211.6(b) Dietary Services.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>43856</p> <p>Based on a review of facility policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that the residents were provided with nightly snacks in accordance with their preferences for seven of nine residents reviewed (Residents 1, 2, 3, 4, 5, 7, 8).</p> <p>Findings include:</p> <p>A facility policy on snack serving dated, March 19, 2024, revealed that snacks will be provided to residents between meals, per resident's request, and at nighttime.</p> <p>A review of resident council meeting minutes for November and December 2024 revealed that residents stated they were not being provided with evening snacks and would like to be.</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 25, 2024, indicated that the resident was cognitively intact, understood, was understood by others, was independent for eating, and had diagnoses that included hemiparesis (a medical condition where there is weakness or paralysis on one side of the body).</p> <p>Review of Resident 1's clinical record for November and December 2024 revealed that the resident was not provided with an evening snack on November 8, 2024, and December 17, and 27, 2024.</p> <p>A Quarterly MDS assessment for Resident 2, dated December 2, 2024, indicated that the resident was cognitively intact, understood and was understood by others, was independent for eating, and had diagnoses that diabetes.</p> <p>Review of Resident 2's clinical record for November and December 2024 revealed that the resident was not provided with an evening snack on November 2, 11, 16, 19, 21, 25, 2024, and December 1, 5, 6, 12, 23, and 25, 2024.</p> <p>Interview with Resident 2 on December 30, 2024, at 8:54 a.m. revealed that she does not get a snack every evening and would prefer to have one.</p> <p>A quarterly MDS assessment for Resident 3, dated November 2, 2024, indicated that the resident was cognitively intact, was understood and was able to understand others, was independent for eating, and had a diagnosis of diabetes.</p> <p>Review of Resident 3's clinical record for November and December 2024 revealed that the resident was not provided with an evening snack on November 6, 8, and 20, 2024, and December 14 and 20, 2024.</p> <p>Interview with Resident 3 on December 30, 2024, at 10:09 a.m. revealed that it's 50/50 when it comes to getting snacks and that they are not offered all the time.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An annual MDS assessment for Resident 4, dated November 19, 2024, indicated that the resident was cognitively intact, was understood and was able to understand others, and was independent for eating.</p> <p>Review of Resident 4's clinical record for November and December 2024 revealed that the resident was not provided with an evening snack on November 6 and 8, 2024, and December 20, 2024.</p> <p>A quarterly MDS assessment for Resident 5, dated December 7, 2024, indicated that the resident was cognitively intact, was clearly understood and able to clearly understand others, and was independent for eating.</p> <p>Review of Resident 5's clinical record for November and December 2024 revealed that the resident was not provided with an evening snack on November 6, 8 and 20, 2024, and December 20, 2024.</p> <p>Interview with Resident 5 on December 30, 2024, at 9:19 a.m. revealed that snacks are rarely passed, and there are minimal snacks available.</p> <p>An admission MDS assessment for Resident 7, dated November 7, 2024, indicated that the resident was cognitively impaired, sometimes understands and is sometimes understood, and was dependent on staff for eating.</p> <p>Review of Resident 7's clinical record for November and December 2024 revealed that the resident was not provided with an evening snack on November 9, 11, 15, 19, 21, 26, 27, 30, 2024, and December 5, 7, 16, 17, 21, 25, 26, 30, and 31, 2024.</p> <p>A quarterly MDS assessment for Resident 8, dated November 13, 2024, indicated that the resident was cognitively intact, was clearly understood and able to clearly understand others, was independent for eating, and had diagnoses that included diabetes and protein calorie malnutrition.</p> <p>Review of Resident 8's clinical record for November and December 2024 revealed that the resident was not provided with an evening snack for the entire month of November 2024, and December 20 and 27, 2024.</p> <p>Interview with Resident 8 on December 30, 2024, at 11:33 a.m. revealed that he gets snacks but not every day.</p> <p>Interview with Director of Nursing on December 30, 2024, at 12:50 p.m. confirmed that residents were requesting evening snacks and were not getting them. She indicated that snacks should be provided when asked and offered nightly.</p> <p>28 Pa. Code 201.29(i) Resident Rights.</p>		