

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 02/23/2026
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident/resident representative in advance of the risks and benefits of psychotropic medications (medications that affect the persons mental state, emotions and behavior) and the treatment alternatives prior to initiating the administration of the medication for one of 6 residents reviewed (Resident 4). Findings include: A facility policy related to psychotropic medications, dated February 4, 2026, indicated that prior to initiating or increasing psychotropic medications, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications (psychotropic medications used to treat mental health disorders), in advance of such initiation or increase. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated January 28, 2026, revealed that the resident was cognitively impaired, was sometimes understood and was able to usually understand others, had no behavioral symptoms, received hospice services, received psychotropic medications, including antipsychotic and antidepressant medications and had diagnoses that included anxiety, depression and dementia. A nursing note for Resident 4, dated October 30, 2025, at 7:30 p.m. indicated that the resident had a new order per hospice to increase his Seroquel (an antipsychotic medication) to 50 milligrams (mg) twice daily for behaviors. Physician's orders for Resident 4, dated October 31, 2025, included an order for the resident to receive 50 mg of Seroquel twice daily. Physician's orders for Resident 4, dated January 27, 2026, included an order for the resident to receive 100 mg of Seroquel twice daily. There was no documented evidence in Resident 4's clinical record to indicate that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased doses of Seroquel. Interview with the Director of Nursing on February 19, 2026, at 3:17 p.m., confirmed that there was no documented evidence in Resident 4's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased doses on Seroquel. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395398	If continuation sheet Page 1 of 5

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</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 the resident representative was notified timely about a change in condition for one of six residents reviewed (Resident 2). Findings include: The facility's policy regarding notification of changes, dated February 4, 2026, indicated that the facility will notify the resident's representative when there is a change requiring notification. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated July 26, 2025, indicated that the resident was cognitively impaired and required assistance from staff for daily care needs. The resident's care plan, updated July 26, 2025, revealed that the resident was at risk for falls. A nursing note for Resident 2, dated August 1, 2025, revealed that the resident fell in his room. A nursing note dated August 9, 2025, revealed that Resident 2 was found on his knees in his room and that he had a bruised elbow. A nursing note dated August 15, 2025 revealed that the resident was found on the floor in his room and that he had tripped over the oxygen tubing. There was no documented evidence that Resident 2's daughter/power of attorney was notified regarding the falls on August 1, August 9, or August 15. Interview with the Director of Nursing on February 19, 2026 at 1:34 p.m. revealed that Resident 2's daughter was not notified regarding the falls and that she should have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</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>Based on clinical record reviews, as well as staff interviews, it was determined that the facility failed to follow physician's orders for one of six residents reviewed (Resident 2). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 2, dated July 26, 2025, revealed that the resident was cognitively impaired, required assistance with care needs, and had diagnoses that included a gastrointestinal bleed (stomach). Physician's orders for Resident 2, dated August 7, 2025, included an order for staff to obtain the residents stool three times and check for hidden blood. A review of Resident 2's Treatment Administration Record, dated August 2025, revealed that staff did not obtain and test any stool samples from the resident as ordered. Interview with the Director of Nursing on February 19, 2026 at 1:34 p.m. revealed that staff did not obtain any stool samples and check the for blood for Resident 2 and that they should have. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>Based on review of facility policies, clinical records, observations and staff interviews, it was determined that the facility failed to ensure that a resident's environment remained free of accident hazards by failing to ensure care-planned interventions were in place and that fall risk assessments were completed for one of six residents reviewed (Resident 1), and failed to implement interventions after a fall for one of six residents reviewed (Resident 4). Findings include: The facility's policy regarding fall prevention dated February 4, 2026, indicated that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A fall risk assessment is to be completed every 90 days and as indicated when a resident has a change in condition. The nurse will indicate the residents fall risk and initiate interventions on the care plan in accordance with residents' level of risk. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 20, 2025, revealed that the resident was severely cognitively impaired, was dependent on staff for daily care needs and assistance of one staff for transfers. A care plan for Resident 1 dated September 25, 2025, revealed that the resident was a fall risk and was to be provided with a weighted blanket to help decrease anxiety/ restlessness. A fall investigation report for Resident 1, dated September 24, 2025, revealed that the resident had an unwitnessed fall with prevention interventions in place. A weighted blanket to decrease anxiety and restlessness was added as a new intervention to prevent future falls, and the care plan was updated. A review of Resident 1's clinical record revealed that fall risk assessments were completed on January 2 and September 5, 2025. There was no documented evidence that fall risk assessments were completed every 90 days per facility policy. Observation of Resident 1 on February 19, 2026, at 11:30 a.m. revealed that the resident was lying in bed and did not have a weighted blanket. Interview with Licensed Practical Nurse 1 on February 19, 2025, at 2:47 p.m. revealed that she was not aware that Resident 1 was supposed to have a weighted blanket. Interview with the Nursing Home Administrator on February 19, 2026, at 2:52 p.m. confirmed that the resident should have had fall risk assessments completed every 90 days and that she should have a weighted blanket. A quarterly MDS assessment for Resident 4, dated January 28, 2026, revealed that the resident was cognitively impaired, was sometimes understood and was able to usually understand others, was dependent with transfers, had a history of falls and had a diagnosis of dementia. A nursing note for Resident 4, dated October 20, 2025, at 10:28 p.m. revealed that the resident had an assisted fall at approximately 10:15 p.m. while staff was assisting him in a transfer. The resident was going from his recliner, to his bed and became weak during the transfer. He was lowered to the floor and assessed for injury. The resident was assisted to his bed for p.m. care. Review of Resident 4's transfer status at the time of the fall revealed that the resident was a two assist for transfers with the use a pivot disc (designed to make transfers easier for individuals who are able to stand but cannot readily move their legs). An incident report for Resident 4, dated October 20, 2025, indicated that no witness statements were found and there was no fall investigation completed post fall to identify contributing factors related to the fall. There was no documented evidence that a thorough investigation was completed to ensure that staff were transferring Resident 4 appropriately at the time of his fall, and there was there was no documented evidence that fall interventions were implemented after his fall to minimize his risk of further falls. Interview with the Director of Nursing on February 19, 2026, at 4:30 p.m. confirmed that she did not have any witness statements or any further investigation reports completed post fall that ensured staff were transferring Resident 4 correctly at the time of his fall on October 20, 2025,</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and confirmed that there was no documented evidence that fall interventions were implemented after his fall to minimize his risk of further falls. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>