STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395398	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Healthcare & Rehabilitation Center	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide the resident/resident's responsible party with complete information and supplies in preparation for discharge for one of 7 residents reviewed (Resident 1) who was discharged to home. Findings include: The facility's discharge planning policy, dated April 24, 2026, indicated that the discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plan for care after discharge. It must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. Upon discharge of a resident (other than in emergency to hospital or death) a discharge summary will be provided to the receiving care provider at the time the resident leaves the facility. Reconciliation of all pre-discharge medications with the resident's post discharge medication to include prescription and over the counter medications. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care and any post-discharge medical and non-medical services. For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident, and if applicable, the resident representative. These instructions must be discussed with the resident, and resident representative and conveyed in a language and manner they will understand. An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 2, 2026, revealed that the resident was cognitively intact, dependent for transfers, dressing, hygiene, toileting, putting on/taking off shoes, was not ambulatory, had an unstageable pressure ulcer (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) on admission, and had diagnoses including morbid obesity, malnutrition, diabetes and an unstageable pressure ulcer to right buttocks. A wound note for Resident 1, dated April 30, 2026, revealed the resident had an unstageable pressure ulcer to his right buttock measuring 5 centimeters (cm) x 2 cm x 0.1 cm. A physician's order, dated April 24, 2026, included an order to cleanse right buttocks with one fourth strength external solution 0.125 percent Dakins solution (a solution used to treat and prevent tissue infections), cover with Dakins moistened gauze, then bordered gauze dressing every day shift and as needed for soiling/dislodgment. The Treatment Administration Record (TAR) for Resident 1 for April 2026, revealed that Dakins was applied to the resident's right buttock on April 30, 2026. A wound note for Resident 1, dated April 30, 2026, revealed the resident had a new stage 2 pressure ulcer (pressure wound with superficial skin loss) to his left buttocks measuring 0.5 cm x 1 cm x 0.1 cm and recommended applying zinc (helps soothe, heal, and prevent skin irritations) and dry dressing. A nursing note for Resident 1, dated April 30, 2026, at 10:00 a.m. revealed that the resident was discharged to his home accompanied by his brother. His (continued on next page)

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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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications were given to him with education given on narcotic schedule and foley care and discharge instructions were sent. Review of Resident 1's discharge instructions, dated [DATE], revealed that he had a wound on his right buttock requiring treatment and there was no mention of the new stage 2 pressure ulcer to his left buttock requiring treatment. The was no documented evidence that wound care instructions were given to the resident or his brother to address the wounds to his right and left buttocks on discharge and no documented evidence that the wound care supplies and medications were given to the resident on discharge. Interview with the Assistant Director of Nursing and the Registered Nurse Assessment Coordinator on May 27, 2026, at 3:14 p.m. confirmed that there was no documented evidence that Resident 1 or his brother was made aware of the new stage 2 pressure ulcer to his left buttock requiring treatment, no documented evidence that wound care instructions were given to the resident or his brother on discharge and no documented evidence that the wound care supplies and medications were given to the resident on discharge. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for two of seven residents reviewed (Residents 6, 7). Findings include:The facility's policy regarding showers, revised April 24, 2026, revealed that all residents would be provided with showers as per preference, schedules and safety. After completion of the resident's shower, the nurse aide was to document utilizing the resident's electronic medical record and paper record, if refused, given or bed bath given.A quarterly admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated April 30, 2026, indicated that the resident was cognitively intact, able to understand and required supervision for showering. The resident's care plan, dated February 12, 2026, indicated that the resident required assistance with showers related to weakness associated with a new cancer diagnosis. Review of the nurse aide documentation and resident's shower records for May 2026, revealed that Resident 6 was to be showered twice a week on Tuesday and Saturday during the evening shift. However, there was no documented evidence as to why the resident refused showers on Saturday May 9 and Tuesday May 26, 2026, and why the shower on Saturday May 23, 2026, was documented as not applicable. A quarterly MDS assessment for Resident 7, dated May 11, 2026, indicated that the resident was cognitively intact, had diagnoses that included atrial fibrillation (an abnormal heart rhythm) and was dependent on staff for showering.Review of nurse aide documentation and the resident's shower records for April and May 2026, revealed that Resident 7 was to be showered twice a week during the day shift on Sundays and Wednesdays. However, there was no documented evidence that the resident received a shower on Sundays, May 10 and 17, and Wednesday May 13, 2026.Interview with the Assistant Director of Nursing on May 27, 2026, at 3:11 p.m. confirmed that there was no documented evidence that Residents 6 and 7 received showers as scheduled. In addition, she indicated that when a resident refuses a shower or bath then additional paperwork is to be filled out as to why, and this was not done. Also, not applicable regarding a shower or bath is never to be chosen in the documentation, and it was. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to follow treatment recommendations from wound consultations for one of 7 residents reviewed (Resident 1). Findings include: The facility's wound treatment management policy, dated April 24, 2026, indicated that to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 2, 2026, revealed that the resident was cognitively intact, dependent for transfers, dressing, hygiene, toileting, putting on/taking off shoes, was not ambulatory, had an unstageable pressure ulcer (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) on admission, and had diagnoses including morbid obesity, malnutrition, diabetes and an unstageable pressure ulcer to right buttocks. A wound note for Resident 1, dated April 24, 2026, revealed the resident had an unstageable pressure ulcer to his right buttock with treatments recommendations to cleanse the wound with wound cleanser/normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), apply medical grade honey (used in clinical settings to treat wounds, burns, and skin infections), then calcium alginate (a dressing used to wounds with a high amount of drainage) to base of the wound, and secure with bordered dressing daily and as needed. Continue with autolytic debridement (products that harness the body's natural enzymes to safely liquefy and dissolve dead necrotic tissue). A nursing note for Resident 1, dated April 24, 2026, at 11:00 a.m. revealed that the resident was seen during wound rounds by the wound consultant Certified Registered Nurse Practitioner (CRNP), and the treatment was changed to the pressure ulcer on his right buttock. The new order was for one fourth strength external solution 0.125 percent Dakins solution (a solution used to treat and prevent tissue infections), cover with Dakins moistened gauze, then bordered gauze dressing every day shift and as needed for soiling/dislodgment. The wound treatment order to the right buttocks to cleanse with normal saline, apply Medi honey then calcium alginate to the wound bed, and cover with bordered gauze dressing daily and as needed was discontinued. A physician's order, dated April 24, 2026, included an order to cleanse right buttocks with one fourth strength external solution 0.125 percent Dakins solution, cover with Dakins moistened gauze, then bordered gauze dressing every day shift and as needed for soiling/dislodgment. The Treatment Administration Record (TAR) for Resident 1 for April 2026, revealed that Dakins was applied to the resident's right buttock on April 30, 2026. A wound note for Resident 1, dated April 30, 2026, revealed the resident had an unstageable pressure ulcer to his right buttock and the current treatment was medi honey, calcium alginate and bordered dressing. Treatment recommendations were to continue to cleanse the wound with wound cleanser/normal saline, apply medical grade honey, then calcium alginate to base of the wound, and secure with bordered dressing daily and as needed. Continue with autolytic debridement. A review of Resident 1's Treatment Administration Records (TAR's) for April 2026 revealed that staff applied the Dakins treatment as ordered to the resident's right buttocks on April 25, 27, 28, 29, and 30. There was no documented evidence in Resident 1's clinical record that the wound consultant CRNP changed the treatment to his right buttocks to Dakins solution on April 24, 2026. Interview with Assistant Director of Nursing (ADON) and the Registered Nurse Assessment Coordinator on May 27, 2026, at 3:14 p.m. confirmed that there was no documented evidence that the wound consultant CRNP changed the treatment to Resident 1's right buttocks on April 24, 2026. The ADON confirmed that the wound consultant documented in two places that the wound care was to remain the same with no changes. She had no idea why the nurse changed the order. 28 Pa. Code 211.12(d)(5) Nursing Services.