Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

September 8, 2025

[redacted], ADMINISTRATOR
SOMERSET SENIOR LIVING OPERATING COMPANY LLC
166 SIEMON DRIVE
SOMERSET, PA, 15501

RE: SOMERSET SENIOR LIVING
166 SIEMON DRIVE
SOMERSET, PA, 15501
LICENSE/COC#: 33880

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/22/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SOMERSET SENIOR LIVING* **License #**: *33880* **License Expiration**: *06/22/2026*

Address: *166 SIEMON DRIVE, SOMERSET, PA 15501*

County: *SOMERSET* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *SOMERSET SENIOR LIVING OPERATING COMPANY LLC*

Address: *166 SIEMON DRIVE, SOMERSET, PA, 15501*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/16/2000* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *36* **Waking Staff**: *27*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *07/22/2025*

Inspection Dates and Department Representative

07/22/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served**: *29*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *29*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

07/22/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/22/2025*

08/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/05/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/21/2025*

Inspections / Reviews *(continued)*

08/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/05/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/12/2025*

09/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/05/2025*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The door located at the end of the hallway, leading to housekeeping and the boiler room, had extensive rust on the bottom of the door, and the door frame was rotted. The door did not open or close properly because of this damage.

Plan of Correction ***Accept ([redacted] - 08/19/2025)***

Emergency Exit door located outside the Generator Room was noted to have significant rusting along the base of the door. Surveyor was able to open the door, but the rusting hindered the closing of the door. Maintenance was immediately notified of the damage to the door, who in turn notified Procurement department to order a new door. A replacement door was ordered on July 29, 2025. Door was delivered on August 12, 2025. Maintenance will complete the installation no later than August 31, 2025. Administrator reeducated the Maintenance Director on regulation 88(a) on August 14, 2025. Maintenance Director to complete an initial audit of the surfaces in the facility no later than August 31, 2025. Monthly Audits of a minimum of 4 random areas to be completed by Maintenance Director or Designee, will begin after September 1, 2025, and continue for 6 months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/08/2025)

91 - Telephone Numbers

2. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident rooms 102, 106 and 203.

Plan of Correction ***Accept ([redacted] - 08/19/2025)***

Rooms 102, 106, and 203 were noted by Surveyor to be without emergency numbers posted by the residents' phones. Administrator immediately corrected this deficiency on July 15, 2025, when it was noted. All staff will be reeducated on this regulation no later than August 31, 2025. Full Audit of all rooms was completed by Medication Technicians on August 13, 2025. Random audits of at least 3 rooms monthly will be completed by the Administrator or Designee. These audits will begin after September 1, 2025, and will continue for 6 months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/08/2025)

132d - Evacuation

3. Requirements

2600.

132d - Evacuation *(continued)*

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 6/24/25 at 3:34 PM, the evacuation time was 6 minutes and 10 seconds. However, the home's maximum evacuation time is 6 minutes.

Repeated Violation - 7/2/24, et al

Plan of Correction ***Directed (- 08/19/2025)***

On June 24,2025, Facility conducted a fire drill and failed to evacuate the facility within the maximum evacuation time, which was 6 minutes. Facility completed a verbal reeducation with the staff on June 25, 2025, and a repeat drill was successfully completed on June 27, 2025, with an evacuation time of 5 minutes and 50 seconds. All staff to be formally reeducated on fire drill protocols no later than August 31, 2025. Monthly fire drills will continue, as required, and will be audited monthly for 6 months by the Administrator or Designee to begin after September 1, 2025, to ensure ongoing compliance.

Proposed Overall Completion Date: 08/31/2025

Directed Completion Date: *09/05/2025*

Implemented (- 09/08/2025)

132e - Fire Drill Sleeping Hours

4. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 5/29/25 at 11:15 PM. The previous sleeping hours fire drill was conducted on 11/13/24 at 5:00 AM.

Plan of Correction ***Accept (- 08/19/2025)***

Sleeping Hours fire drills conducted in November of 2024 and May of 2025 were not completed within exactly 6 months of each other to the precise date. Administrator and Director of Wellness, who are solely responsible for scheduling fire drills, were reeducated on the regulations surrounding fire drills on July 31, 2025. Next sleeping hours fire drill will be held in early November 2025, prior to November 28, 2025. Monthly fire drills will be audited monthly for 6 months by the Administrator or Designee to begin after September 1, 2025, to ensure ongoing compliance.

Proposed Overall Completion Date: 08/31/2025

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented (- 09/08/2025)

132h - Designated Meeting Place

5. Requirements

2600.

132h - Designated Meeting Place *(continued)*

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 6/24/25 at 3:34 PM, there were 28 residents in the home. However, only 26 residents were evacuated.

Plan of Correction ***Accept (- 08/19/2025)***

On June 24,2025, Facility conducted a fire drill and failed to evacuate two of the residents. Facility completed a verbal reeducation with the staff on June 25, 2025, and a repeat drill was successfully completed on June 27, 2025. All staff to be formally reeducated on fire drill protocols no later than August 31, 2025. Residents to be reeducated on fire drill procedures and evacuation requirements by Activities Director during August Resident Council meeting on August 29, 2025. Administrator and Director of Wellness to continue to educate individual residents and families upon admission and during each RASP review. Monthly fire drills will be audited monthly for 6 months by the Administrator or Designee to begin after September 1, 2025, to ensure ongoing compliance.

Proposed Overall Completion Date: 08/31/2025

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented (- 09/08/2025)

141a 1-10 Medical Evaluation Information

6. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #6's initial medical evaluation, dated did not include special health or dietary needs.

Plan of Correction ***Accept (- 08/19/2025)***

Resident #6's initial DME was noted to be without a diet order on July 15, 2025. PCP office was notified of the need for a diet order clarification via fax on July 29, 2025. Order was received on July 31, 2025. Administrator and Director of Wellness, who are solely responsible for the completion of these forms, were reeducated on the new DME forms and regulations surrounding the forms on July 31, 2025. Full Audit of all current DMEs completed by Administrator on August 1, 2025. Administrator or Director of Wellness will complete quarterly audits of all current DMEs for 1 year starting on November 1, 2025, and continuing for 3 quarters (through August 2026) to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2025*

141a 1-10 Medical Evaluation Information *(continued)*

Implemented ([redacted] - 09/08/2025)

183b - Meds and Syringes Locked

7. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/22/25, at approximately 10:15 AM, antifungal powder prescribed for resident #3 was unlocked, unattended, and accessible in resident #3's room.

Plan of Correction ***Accept ([redacted] - 08/19/2025)***

Antifungal powder was found in Resident #3's restroom on July 15, 2025. Administrator removed the powder from the resident's room and locked it in the appropriate med cart. Director of Wellness completed a whole house sweep on July 24, 2025, to ensure no other medications were inappropriately placed in resident rooms. Facility staff will be reeducated on medication storage policy no later than August 31, 2025. Hospice Staff who visit the facility will be reeducated no later than August 31, 2025. Random audits of 3 rooms monthly begin after September 1, 2025, and will be conducted for 6 months by Administrator or Designee to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/08/2025)

183d - Prescription Current

8. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 7/22/25, triple antibiotic ointment prescribed for resident #2 was in the home's South Hall medication cart; however, this medication was discontinued.

Plan of Correction ***Accept ([redacted] - 08/19/2025)***

Antibacterial cream was noted to be in the medication cart for Resident #2, however, no active order for the treatment existed. Cream was removed from the medication cart by the Director of Wellness on July 15, 2025. Medication was discontinued by Home Health on November 11, 2024, but was never removed from the cart. Staff will be reeducated on the medication storage procedures no later than August 31, 2025. Administrator and Director of Wellness completed a full audit of medications in storage on August 12, 2025. Monthly Audits of Medication Storage will be completed by Administrator or Director of Wellness for six months to begin after September 1, 2025, to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/08/2025)

185a - Implement Storage Procedures

9. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 is prescribed Senna-S tablet 8.6-50 mg as needed for constipation. On 7/22/25, this medication was not available in the home.

Resident #2 is prescribed blood glucose monitoring two times a day before breakfast and dinner. On 7/10/25, at 7:35 PM, the resident's glucometer had a blood glucose reading of 137. However, there was no blood glucose reading documented in the resident's July 2025 medication administration record.

On 2/2/25, at 10:00 PM, the medication technicians on shift did not complete narcotic counts as required by the home's narcotic policy.

On 5/16/25, a discrepancy was found on resident #3's prescribed Ativan's narcotic count sheet. As a result of the home's internal investigation, four of the medication technicians acknowledged narcotic counts between 5/14/25 and 5/15/25 were not conducted as required by the home's narcotic policy.

Repeated Violation - 7/2/24, et al

Plan of Correction ***Accept ([redacted] - 08/19/2025)***

Upon reviewing Resident #2's prescribed medications, it was noted that the prescribed PRN Senna-S was not available in the cart. Director of Wellness obtained the medication for the resident on July 15, 2025. Director of Wellness, or designee, will conduct a monthly audit on the availability of all PRN medications to begin after September1, 2025 for 6 months to ensure ongoing compliance.

Upon reviewing Resident # 2's glucometer readings, an additional reading was noted in the glucometer that was not documented in the resident's medical record. All Medication Technicians will be reeducated on implement storage procedures, and documentation no later than August 31, 2025. As the facility currently has only one diabetic resident, the Director of Wellness will complete monthly audits of glucometer readings for 3 months to begin after September 1, 2025, to ensure ongoing compliance.

Facility Medication Technicians did not conduct proper narcotic counts on 2/2/25, 5/14/25, and 5/15/25. Facility Medication Technicians were previously re-educated on the narcotic count policy in February of 2025. The staff identified in May of 2025 as not having completed narcotic counts were disciplined per facility handbook. All Medication Technicians will be reeducated on proper narcotic count procedures no later than August 31, 2025. Administrator will conduct weekly audits of narcotic count sheets for 1 month to begin after September 1, 2025, and will continue monthly audits to begin after October 1, 2025, and continuing for 5 additional months to ensure ongoing compliance.

Proposed Overall Completion Date: 08/31/2025

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented ([redacted] - 09/08/2025)

225a - Assessment 15 Days

10. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #2 was admitted to the home on [redacted]; however, the resident's assessment was not completed until [redacted]

Resident #2's initial medical evaluation, dated [redacted] states the resident cannot safely use and avoid poisonous material. However, resident #2's initial assessment, dated [redacted] states the resident has no problem with safely using and avoiding poisonous material.

Plan of Correction ***Accept ([redacted] - 08/19/2025)***

Initial RASP Assessment date on Resident #2 's was not completed within 15 days of their admission. Administrator and Director of Wellness, who are the staff solely responsible for this regulation, reeducated themselves on the RASP forms and regulations surrounding due dates on July 31, 2025. Both Administrator and Director of Wellness will sign off on new RASPs going forward to ensure all assessments are completed within the 15-day window to maintain compliance going forward.
Resident #2 's physician noted on their initial DME that the resident was not safe around poisonous materials. However, resident's RASP indicated that the resident was safe around poisonous materials. Resident's RASP was appended by Administrator on July 30, 2025, to indicate that the resident is not safe around poisonous materials. Whole house audit of DMEs and RASPs for continuity was completed by Administrator on August 1, 2025. Both Administrator and Director of Wellness will sign and review new DMEs and RASPs going forward to ensure continuity. Quarterly audits of all current DMEs and RASPS will be conducted by the Administrator or Director of Wellness to begin after November 1, 2025, and will continue for 3 quarters (through August of 2026) to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/08/2025)

227d - Support Plan Medical/Dental

11. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #4's current support plan, dated [redacted] did not include resident #4 has been receiving hospice services since [redacted] and utilizes a hoyer life.

Plan of Correction ***Accept ([redacted] - 08/19/2025)***

Resident #4's Significant Change RASP was completed on [redacted]. After [redacted] significant change, [redacted] transfer needs changed, and no addendum was completed to update RASP. Administrator rectified the error and completed the addendum on July 15, 2025. Administrator and Director of Wellness, who are solely responsible for

227d - Support Plan Medical/Dental (continued)

RASPS and addendums, reeducated themselves on the regulations surrounding RASPs and consulted the RCG regarding addendums on July 31, 2025. Administrator completed a full audit of all current support plans to ensure they are up to date, which was completed on August 18, 2025. Administrator or Director of Wellness will complete quarterly audits of all current support plans to begin after November 1, 2025, and to continue for 3 quarters (through August of 2026) to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented ([redacted] - 09/08/2025)