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

March 9, 2026

[redacted]
SOMERSET SENIOR LIVING OPERATING COMPANY LLC
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/03/2026 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: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/16/2000* **Issued By**: *labor & Inudstry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *02/03/2026*

Inspection Dates and Department Representative

02/03/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served**: *27*

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**: *27*

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

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

02/03/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/21/2026*

02/19/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/27/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/02/2026*

Inspections / Reviews *(continued)*

03/09/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/27/2026*

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

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at approximately 10:30 AM, residents [redacted] and [redacted] were found in resident [redacted] room unclothed from the waist down. Resident [redacted] acknowledged touching resident [redacted] private areas. Resident [redacted] was interviewed but was unable to recall the incident.

Weeks prior to this incident, resident [redacted] had made inappropriate sexual comments and gestures towards staff members which were repeated and escalating. However, these behaviors were not reported to the administrator of the home.

Plan of Correction ***Accept [redacted] - 02/19/2026)***

After the incident on Monday, January 19, 2026, Resident [redacted] was relocated from the South Hall Wing of the facility, where Resident 2 resides, to a room on the West Hall Wing of the facility. This was to ensure the safety of all residents and to ensure both parties could maintain as typical a routine as possible. PCP of Resident [redacted] was notified and once a return call was received, orders were received to rule out a medical reason for the change in behavior. 15-minute checks continued on Resident [redacted] to ensure continued safety of all parties. Resident [redacted] began making suicidal statements at approximately 12:45pm. Administrator placed resident on 1:1 to ensure [redacted] was no harm to himself. Somerset County Crisis was notified of these statements, and the mobile Crisis unit was deployed to the facility to assess the situation. PSP [redacted] arrived at the facility to complete their investigation. [redacted] interviewed both parties involved, as well as the staff members present in the facility. Crisis team reported to Administrator that they did not believe Resident [redacted] was a danger to himself or others and did not believe the verbalized self-harm plans were a feasible act [redacted] could complete. Crisis staff left the facility with instructions to call them again should any other statements or behaviors be noted. 1:1 discontinued at that time. Resident [redacted] opted to have meals in [redacted] room for the time being, to ensure that space could be maintained between both parties. Resident RASP amended by Administrator to include 15-minute checks, DCS to accompany Resident if [redacted] needs to be in common areas of the facility, to monitor closely for any change in behaviors, and the reeducation provided by Administrator to Resident 1 that [redacted] is not to enter any room that does not belong to himself or [redacted] [redacted] who is also a resident.
Resident [redacted]s family requested [redacted] be transferred to UPMC Somerset ER for evaluation and a sexual assault assessment. Resident was transferred to the ER via EMS, accompanied by family, at approximately 3:30pm, after PSP was finished with their interviews. Resident [redacted] returned to the facility at approximately 6:30pm with no new orders. Per family report, ER staff did not complete a sexual assault examination due to the Resident not providing verbal consent. No other paperwork was provided from the visit. Upon return, Resident [redacted] 15-minute checks were reinstated once family left the facility. Resident RASP amended to include those safety checks, to update the request for no male caregivers, and to monitor closely for any change in behaviors.
On Tuesday January 20, 2026: Both residents continued on 15-minute checks with no noted issues. Resident [redacted] PCP returned phone call and ordered a urinalysis to be completed as first step in ruling out any medical reason for this change in behavior. Follow up appointment scheduled for 1/27/2026. Viaquest hospice in to see Resident [redacted] on this date. New orders received for further medical work-up, including increased visits from nursing staff, social work visits, and a chest x-ray, as well as medication review. 15-minute checks continued throughout the day and night. AAA Caseworker visited on this date to follow-up with both parties. Per AAA, Resident [redacted] did admit to the events from

42b Abuse (continued)

Monday January 19th. Resident [redacted] also stated that [redacted] believed Resident [redacted] to be interested in [redacted] advances and stated [redacted] had entered [redacted] room the previous week. No staff witnesses to any prior encounters were noted. No alert & oriented residents could recall any prior encounters between both parties. One family member noted that Resident [redacted] attempted to enter a different resident's room the week prior, but that family member stopped [redacted] from entering. This event was not reported to Administration at the time it occurred, and the family member could not recall the date or time. Administrator surveyed all [redacted] residents on the South Hall Unit, and no other reports of another resident entering their room could be found. Staff could not recall any incidents of that nature, either. DOW [redacted] did note seeing Resident [redacted] walking the length of South Hall on Friday, January 16, 2026, but did not witness [redacted] entering any rooms other than [redacted] own.

Resident [redacted] scheduled for a follow up appointment with [redacted] PCP on Thursday, January 22, 2026. Per AAA, Resident [redacted] could not provide any account of the prior incident. Behaviors being monitored by staff. Increase in anxiety noted last evening upon return from the ER. 15 Minute checks decreased to hourly for Resident [redacted] at 2:30pm on January 20, 2026 in order to return Resident [redacted] to a more normal routine with staff.

On Wednesday, January 21, 2026, Both Residents continued on previous safety plans and procedures. No additional behaviors reported for either resident.

On Thursday, January 22, 2026, Hospice Chaplain met with Administrator regarding Resident [redacted]. Chaplain is to increase [redacted] visits with the Resident and [redacted] [redacted] to 3 times weekly. 15 Minute checks decreased to half hour checks at 12:00pm for Resident [redacted]. Resident [redacted] continues on 1:1 visits and is to be accompanied at all times if [redacted] attends [redacted] preferred activities. Preliminary Urinalysis results received and showed no infection. Resident [redacted] to follow up with PCP on this date. No new behaviors noted. No new orders received.

On Monday, January 26, 2026, No behaviors noted from Resident [redacted] over the weekend. Checks changed to ½ hour at 11:00am on this date. Resident [redacted] encouraged to attend activities of preference when 1:1 with Activity Director. Resident [redacted] is not to be left unattended in group settings when Resident [redacted] is present.

No behaviors noted from Resident [redacted] over the weekend. Hourly checks continue. Resident has resumed [redacted] baseline routine around the facility, attending groups activities of choice and utilizing preferred common areas.

Plan of Care for both residents is ongoing.

On Friday, February 13, 2026, Routine checks on Resident [redacted] discontinued on this date. Routine checks for Resident [redacted] continue, due to the death of [redacted] [redacted] on this date, to monitor for any additional changes in behavior.

On Monday, February 16, 2026, Routine Checks on Resident [redacted] changed to hourly, as they seem to be creating more anxiety for the Resident since [redacted] death. Behavior monitoring and increased visits from Hospice to continue.

All Direct Care Staff are to complete online Mandatory Abuse Reporting training through the Pennsylvania Department of Aging Learning Management System no later than February 28, 2026. Employee Handbook sections related to Employee Abuse Prevention to be reviewed with Direct Care Staff at Staff Meeting on February 26, 2026, or individually by March 13, 2026.

All Direct Care Staff are to complete Resident Rights training via presentation from the National Long Term Care Ombudsman Resource Center Website no later than February 28, 2026. Resident Rights to be reviewed with all Direct Care Staff at Staff Meeting on February 26, 2026, or Individually by March 13, 2026.

To improve communication between Direct Care Staff and Administrator/Director of Wellness, all Direct Care Staff are to be trained on PointClickCare's Clinical Alert system in the PointOfCare module. All Direct Care Staff are to watch the PointClickCare training video no later than February 28, 2026. All staff to be in serviced on the process either at the next Staff Meetings on February 26, 2026, or individually by March 13, 2026. Implementation of this communication system by facility staff to occur upon in service, with full implementation to be expected starting no later than March 31, 2026.

Licensee's Proposed Overall Completion Date: *03/31/2026*

42b Abuse *(continued)*

Implemented [redacted] - 03/09/2026)