

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

March 24, 2025

[REDACTED]
PITTSBURGH LIFETIME CARE COMMUNITY
[REDACTED]

RE: SHERWOOD OAKS
100 & 500 NORMAN DRIVE
CRANBERRY TOWNSHIP, PA, 16066
LICENSE/COC#: 45776

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/05/2024, 12/09/2024 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: SHERWOOD OAKS License #: 45776 License Expiration: 12/08/2025
 Address: 100 & 500 NORMAN DRIVE, CRANBERRY TOWNSHIP, PA 16066
 County: BUTLER Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: PITTSBURGH LIFETIME CARE COMMUNITY
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: R-4	Date: 10/28/1982	Issued By: L&I
Type: R-3	Date: 01/19/2024	Issued By: Cranberry TWP
Type: Other	Date: 09/01/2015	Issued By: Cranberry TWP

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 89 Waking Staff: 67

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint, Incident Exit Conference Date: 12/16/2024

Inspection Dates and Department Representative

12/05/2024 - On-Site: [REDACTED]
 12/09/2024 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 77 Residents Served: 60

Secured Dementia Care Unit
 In Home: Yes Area: Oak Grove Capacity: 30 Residents Served: 29

Hospice
 Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 60
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 1
Have Mobility Need: 29	Have Physical Disability: 0

Inspections / Reviews

12/05/2024 Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/16/2025

Inspections / Reviews *(continued)*

01/31/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/10/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 02/07/2025

02/18/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/10/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/10/2025

03/24/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/10/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] at 8:00 pm., resident [redacted] came out of [redacted] bedroom without [redacted] rollator, upset and unsteady on [redacted] feet. When staff person A attempted to assist resident [redacted] the resident became angry, refused [redacted] rollator, and walked about the secure dementia care area (SDCU) looking for a way out. Staff person A assisted resident [redacted] to a chair, where the resident, still angry, kicked staff person A in the stomach. Resident [redacted] continued to walk unsteadily around the SDCU. Staff person A went to the bathroom and when [redacted] returned, [redacted] did not see resident [redacted]. Staff searched the SDCU and found resident [redacted] in the bathroom of the tv/sitting area, with the door locked from the inside. Staff person A propped a chair under the locked bathroom door handle and attended to other residents. Staff person B alerted staff person C that a chair was blocking the bathroom door. Staff person C removed the chair, found the door was locked, and approached staff person A, the only staff person with a key to unlock the door. Staff person C acquired the key from staff person A, unlocked the door, and observed resident [redacted] standing at the door opening, holding onto [redacted] rollator, uninjured. However, this allegation of abuse was not reported to the local Area Agency on Aging until [redacted]

Plan of Correction

Accept ([redacted] - 02/17/2025)

It is important to note the resident sustained no injury because of this event. On 12/2/2025, this incident was reported immediately to Butler County Protective Services by the administrator when brought forth by Staff person B. Staff person A had not worked since 11/29/2024 and was officially suspended from employment by the PCHA on 12/3/2024 pending investigation. See the attached suspension letter. Education on abuse reporting requirements is being reviewed by the PCHA 1:1 with all direct care staff on our personal care units. The staff education includes that upon discovery or receipt of a report of abuse, the home must immediately report suspected abuse to the local Area Agency on Aging. Education will be completed by January 31, 2025 as evidenced by a confirmation signed by each employee. The PCHA is compiling a final list of completion dates for submission after 1/31/2025. Beginning 2/10/25 and continuing each weekday, the PCHA or designee will review and sign off each incident report to ensure any suspected abuse of a resident served in the home is immediately reported to the local Area Agency on Aging. This information is maintained within our EMR.

Proposed Overall Completion Date: 02/10/2025

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented ([redacted] - 03/24/2025)

15c - Supervision

2. Requirements

2600.

15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

15c Supervision (continued)

Description of Violation

On [REDACTED] at 8:00 pm., resident [REDACTED] came out of [REDACTED] bedroom without [REDACTED] rollator, upset and unsteady on [REDACTED] feet. When staff person A attempted to assist resident [REDACTED] the resident became angry, refused [REDACTED] rollator, and walked about the SDCU looking for a way out. Staff person A assisted resident [REDACTED] to a chair, where the resident, still angry, kicked staff person A in the stomach. Resident [REDACTED] continued to walk unsteadily around the SDCU. Staff person A went to the bathroom and when [REDACTED] returned, [REDACTED] did not see resident [REDACTED]. Staff searched the SDCU and found resident [REDACTED] in the bathroom of the tv/sitting area, with the door locked from the inside.

Staff person A propped a chair under the locked bathroom door handle and attended to other residents. Staff person B alerted staff person C that a chair was blocking the bathroom door. Staff person C removed the chair, found the door was locked, and approached staff person A, the only staff person with a key to unlock the door. Staff person C acquired the key from staff person A, unlocked the door, and observed resident [REDACTED] standing at the door opening, holding onto [REDACTED] rollator, uninjured. However, staff person A was not suspended/placed on a plan of supervision until [REDACTED]

Plan of Correction

Accept ([REDACTED] - 02/17/2025)

Upon receiving the report alleging abuse, the PCHA immediately confirmed Staff person A was not working 12/2/2024. Official written notification from our organizations human resources department was provided to staff person A by PCHA on 12/3/2024. On 12/5/2024, the PCHA notified staff person A they were terminated from employment and follow up with written notification sent in the mail. Both letters are attached.

The PCHA completed education on 12/6/2024 with two supervisors, who also hold their PCHA license, regarding regulation 2600.15.c to ensure understanding. The education includes upon discovery or receipt of an allegation of abuse of a resident involving one of our staff members, we shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident and the home shall immediately submit to the BHSL Northwest Regional Office a plan of supervision or notice of suspension of the affected staff person. Evidence of education was completed on a training record and attached. In the absence of the PCHA, these two supervisors would initiate the plan of supervision or suspension.

Proposed Overall Completion Date: 02/07/2025

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented ([REDACTED] - 03/24/2025)

16c - Written Incident Report

3. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED], at 8:00 pm., resident [REDACTED] came out of [REDACTED] bedroom without [REDACTED] rollator, upset and unsteady on [REDACTED] feet. When staff person A attempted to assist resident [REDACTED] the resident became angry, refused [REDACTED] rollator, and walked about the SDCU looking for a way out. Staff person A assisted resident [REDACTED] to a chair, where the resident, still angry, kicked staff person A in the stomach. Resident [REDACTED] continued to walk unsteadily around the SDCU. Staff person A went to the bathroom and when [REDACTED] returned, [REDACTED] did not see resident [REDACTED]. Staff searched the SDCU and found resident [REDACTED] in the bathroom of the tv/sitting area, with the door locked from the inside.

Staff person A propped a chair under the locked bathroom door handle and attended to other residents. Staff person

16c Written Incident Report (continued)

B alerted staff person C that a chair was blocking the bathroom door. Staff person C removed the chair, found the door was locked, and approached staff person A, the only staff person with a key to unlock the door. Staff person C acquired the key from staff person A, unlocked the door, and observed resident [REDACTED] standing at the door opening, holding onto [REDACTED] rollator, uninjured. However, this allegation of abuse was not reported to the Department until [REDACTED].

Plan of Correction

Accept ([REDACTED] - 02/17/2025)

It is important to note the resident sustained no injury because of this event. On 12/2/2025, this incident was reported immediately to Butler County Protective Services by the administrator when brought forth by Staff person B. Staff person A had not worked since 11/29/2024 and the PCHA confirmed [REDACTED] was not working when the report was received 12/2/2024. Staff person A was suspended from employment on 12/3/2024 by the PCHA pending investigation. See the attached suspension letter.

Education on abuse reporting requirements is being reviewed 1:1 by the PCHA with all direct care staff on our personal care units. The staff education includes that upon discovery or receipt of a report of abuse, the home must immediately report suspected abuse to BHSL within 24 hours. Education will be completed by January 31, 2025, as evidenced by a confirmation signed by each employee. The PCHA is compiling a final list of completion dates for submission after 1/31/2025.

Beginning 2/10/25 and continuing each weekday, the PCHA or designee will review and sign off each incident report to ensure any suspected abuse of a resident served in the home is immediately reported to the local Area Agency on Aging. This information is maintained within our EMR.

Proposed Overall Completion Date: 02/10/2025

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented ([REDACTED] - 03/24/2025)

42b - Abuse

4. 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

Resident [REDACTED] resides in the SDCU. [REDACTED] resident assessment and support plan, dated [REDACTED], includes diagnoses of [REDACTED], and [REDACTED].

Resident [REDACTED] uses a rollator for ambulating and requires prompting when moving from one place to another.

On [REDACTED], at 8:00 pm., resident [REDACTED] came out of [REDACTED] bedroom without [REDACTED] rollator, upset and unsteady on [REDACTED] feet. When staff person A attempted to assist resident [REDACTED] the resident became angry, refused [REDACTED] rollator, and walked about the SDCU looking for a way out. Staff person A assisted resident [REDACTED] to a chair, where the resident, still angry, kicked staff person A in the stomach. Resident [REDACTED] continued to walk unsteadily around the SDCU. Staff person A went to the bathroom and when [REDACTED] returned, [REDACTED] did not see resident [REDACTED]. Staff searched the SDCU and found resident [REDACTED] in the bathroom of the tv/sitting area, with the door locked from the inside.

Staff person A propped a chair under the locked bathroom door handle and attended to other residents. Staff person B alerted staff person C that a chair was blocking the bathroom door. Staff person C removed the chair, found the door was locked, and approached staff person A, the only staff person with a key to unlock the door. Staff person C acquired the key from staff person A, unlocked the door, and observed resident [REDACTED] standing at the door opening, holding onto [REDACTED].

42b - Abuse (continued)

rollator, uninjured.

Plan of Correction

Directed () - 02/18/2025)

Staff persons A & B intervened in this event on 11/29/24 immediately upon realizing what was occurring. Resident was unharmed and was able to resume normal activity. Upon notification to the PCHA on 12/2/24, the event was reported to protective services and confirmed staff person A had not worked since 11/29/24 and was placed on suspension 12/3/2024. Upon conclusion of the investigation, staff person A was terminated from employment and had no additional contact with our residents. Staff person A suspension and termination letters are attached. PCHA or designee randomly rounds with varying days and times on all units to observe resident and employee interactions. PCHA (or designated leader) rounding activities are documented at least three times a week from December 3, 2024 and will concluded January 31, 2025. Rounding by the PCHA or designee will continue ongoing 3x/week. The PCHA will submit the documentation for submission after 1/31/2025.

By March 31, 2025, the Butler County Ombudsman or designee from the Area Agency on Aging will complete staff retraining on resident rights. The PCHA will ensure the training is scheduled by February 17, 2025, and training documentation will be maintained.

Proposed Overall Completion Date: 03/31/2025- 2/18/25

Directed:

Completion dates cannot extend beyond 20 days. The completion date has been updated to 3/10/25.

2/18/25

Directed Completion Date: 03/10/2025

Implemented () - 03/24/2025)

201 - Positive Interventions

5. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident resides in the SDCU. resident assessment and support plan, dated includes diagnoses of , and .

Resident uses a rollator for ambulating and requires prompting when moving from one place to another.

On , at 8:00 pm., resident came out of bedroom without rollator, upset and unsteady on feet. When staff person A attempted to assist resident the resident became angry, refused rollator, and walked about the SDCU looking for a way out. Staff person A assisted resident to a chair, where the resident, still angry, kicked staff person A in the stomach. Resident continued to walk unsteadily around the SDCU. Staff person A went to the bathroom and when returned, did not see resident Staff searched the SDCU and found resident in the bathroom of the tv/sitting area, with the door locked from the inside.

201 - Positive Interventions (continued)

Staff person A propped a chair under the locked bathroom door handle and attended to other residents. Staff person B alerted staff person C that a chair was blocking the bathroom door. Staff person C removed the chair, found the door was locked, and approached staff person A, the only staff person with a key to unlock the door. Staff person C acquired the key from staff person A, unlocked the door, and observed resident [REDACTED] standing at the door opening, holding onto [REDACTED] rollator, uninjured.

Plan of Correction

Accept ([REDACTED] - 02/17/2025)

Resident was provided reassurance and support by staff persons B and C immediately on 11/29/2024 following the above listed events.

On 1/16/2025, the PCHA assigned the education lesson " Dementia Care: Challenging Behaviors and Direct Care Staff " in our Relias education program. All staff were assigned the completion deadline of February 28, 2025. A final report of staff names and completion dates will be available via Relias after 2/28/2025.

PCHA or designee randomly rounds with varying days and times on all units to observe resident and employee interactions. PCHA (or designated leader) rounding activities are documented at least three times a week from December 3, 2024 and will concluded January 31, 2025. The PCHA will submit the documentation after 1/31/2025. Rounding will continue beyond then by the PCHA or designee 3x/week.

Proposed Overall Completion Date: 02/10/2025

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented ([REDACTED] - 03/24/2025)

202 - Prohibitions

6. Requirements

2600.

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move [REDACTED] arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompt [REDACTED] escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

Resident [REDACTED] resides in the SDCU. [REDACTED] resident assessment and support plan, dated [REDACTED], includes diagnoses of [REDACTED], and [REDACTED].

202 Prohibitions (continued)

Resident [redacted] uses a rollator for ambulating and requires prompting when moving from one place to another.

On [redacted], at 8:00 pm., resident [redacted] came out of [redacted] bedroom without [redacted] rollator, upset and unsteady on [redacted] feet. When staff person A attempted to assist resident [redacted] the resident became angry, refused [redacted] rollator, and walked about the SDCU looking for a way out. Staff person A assisted resident [redacted] to a chair, where the resident, still angry, kicked staff person A in the stomach. Resident [redacted] continued to walk unsteadily around the SDCU. Staff person A went to the bathroom and when [redacted] returned, [redacted] did not see resident [redacted]. Staff searched the SDCU and found resident [redacted] in the bathroom of the tv/sitting area, with the door locked from the inside.

Staff person A propped a chair under the locked bathroom door handle and attended to other residents. Staff person B alerted staff person C that a chair was blocking the bathroom door. Staff person C removed the chair, found the door was locked, and approached staff person A, the only staff person with a key to unlock the door. Staff person C acquired the key from staff person A, unlocked the door, and observed resident [redacted] standing at the door opening, holding onto [redacted] rollator, uninjured.

Plan of Correction

Accept ([redacted] - 02/17/2025)

Resident was provided reassurance and support by staff persons B and C immediately on 11/29/2024 following the above listed events.

On 1/16/2025, the PCHA assigned the education lesson " Dementia Care: Understanding Communication" in our Relias education program. All staff were assigned the completion deadline of February 28, 2025. A final report of staff names and completion dates will be available via Relias after 2/28/2025.

PCHA or designee randomly rounds with varying days and times on all units to observe resident and employee interactions. PCHA (or designated leader) rounding activities are documented at least three times a week from December 3, 2024 and will concluded January 31, 2025. The PCHA will submit the documentation for submission after 1/31/2025. Rounding by the PCHA or designee will continue beyond that date 3x/week.

Proposed Overall Completion Date: 02/10/2025

Licensee's Proposed Overall Completion Date: 02/10/2025

Implemented ([redacted] - 03/24/2025)

231b - Medical Evaluation

7. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the SDCU on [redacted]; however, the resident's medical evaluation, dated [redacted], did not indicate the need for a SDCU.

Resident [redacted] was admitted to the SDCU on [redacted]; however, the resident's medical evaluation, dated [redacted], was not completed within 60 days prior to admission and did not indicate the need for a SDCU.

231b Medical Evaluation (continued)

Plan of Correction

Accept (█ - 01/31/2025)

On 12/5/2024, the nurse on duty had the above noted DMEs updated to indicate the need for SDU. On 12/6/2024, the PCHA audited all resident charts on the SDUs to ensure the DMEs were completed accurately. Documentation of this audit is attached.

On February 5, 2025 at our scheduled nurses meeting, regulation 2600.231.b and examples presented in this violation will be reviewed with our nursing staff by the PCHA. The nurses are responsible to ensure completion of resident DMEs. Evidence of completion will be obtained 2/5/25 with staff sign in at the meeting.

The PCHA is reviewing all DMEs upon move into the SDU for thorough completion. Documentation beginning with the audit on 12/6/2024 and reviews through 1/31/2025 will be maintained for evidence of completion.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented (█ - 03/24/2025)

234b - Support Plan Needs Elements

8. Requirements

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident █ has had 4 unwitnessed falls from █ to █, one resulting in hitting █ head. However, the resident's support plan, dated █, does not address this change in condition.

Resident █ has issues with irritability, agitation, and aggression toward staff. However, the resident's support plan, dated █, does not address these behaviors.

Resident █ has issues with irritably, agitation and aggression toward staff and resident █. However, the resident's support plan, dated █ does not address these issues.

Plan of Correction

Accept (█ - 01/31/2025)

All three residents had their RASP updated 1/16/2025 by the nurse on duty addressing the listed behaviors. See the attached documents verifying completion.

The nurses are responsible to complete resident RASPs. On February 5, 2025 at our scheduled nurses meeting, regulation 2600.234.b and examples presented in this violation will be reviewed with our nursing staff by the PCHA. Evidence of completion will be obtained 2/5/25 with staff sign in at the meeting.

The PCHA will audit resident RASPs based on observations and staff reports to ensure behaviors are thoroughly documented. These audits will be completed twice a week by the PCHA or designee to begin 1/16/25 and conclude 2/28/25. Documentation of the audits will be maintained and reviewed at the March 5, 2025 nurses' meeting.

Licensee's Proposed Overall Completion Date: 03/06/2025

Implemented (█ - 03/24/2025)