Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

August 1, 2025

[REDACTED], REGIONAL ADMINISTRATOR
CRANBERRY PLACE
1201 CUMBERLAND ROAD
[REDACTED]
PITTSBURGH, PA, 15237

RE: CUMBERLAND CROSSING MANOR
1201 CUMBERLAND ROAD
PITTSBURGH, PA, 15237
LICENSE/COC#: 44616

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/10/2025, 06/11/2025 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: *CUMBERLAND CROSSING MANOR* **License #**: *44616* **License Expiration**: *06/30/2026*

Address: *1201 CUMBERLAND ROAD, PITTSBURGH, PA 15237*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *CRANBERRY PLACE*

Address: *1201 CUMBERLAND ROAD, , PITTSBURGH, PA, 15237*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/09/1998* **Issued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *125* **Waking Staff**: *94*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/11/2025*

Inspection Dates and Department Representative

06/10/2025 - On-Site:

06/11/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *78*

Special Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *78*

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

Have Mobility Need: *47* **Have Physical Disability**: *0*

Inspections / Reviews

06/10/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/06/2025*

07/14/2025 - POC Submission

Submitted By: **Date Submitted**: *07/31/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/31/2025*

Inspections / Reviews *(continued)*

08/01/2025 - Document Submission

Submitted By: [redacted]

Date Submitted: *07/31/2025*

Reviewer: [redacted]

Follow-Up Type: *Not Required*

17 Record confidentiality

1. Requirements

2800.

17. Confidentiality of Records - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 6/11/25 at 11:30 a.m., there were three binders in an unlocked plastic bin attached to the side of the "1-North" medication cart. The bin has a hinged lid that was open, and no locking device was on the bin. The medication cart was observed unattended several times throughout the day. There was a black binder titled "1 North Narcotic Count" and had count sheets for several residents' medications to include:

** Resident #1 – Tramadol HCL tab 50mg – Take ½ tablet (25mg) by mouth every 8 hours as needed for severe pain for 30 days*

** Resident #2 – Clonazepam Tab 0.5mg – Take 1 tablet by mouth once daily diagnosis anxiety*

** Resident #3- 5mg Ambien – Amount received 10*

There was a teal binder in the bin attached to the medication cart that is reportedly the "charge nurse" binder that contained resident information to include resident room numbers, names, "Med style/liquid" and special needs as follows:

** Resident #1 - "Voltaren Gel 1% (Ankle); Bordered Gauze (R Elbow)"*

** Resident #2 - "DIABETIC; UPMC Your Care"; "TUBI"*

** Resident #4 - "Crush/Thin"; "Diclofenac 1% (R hand)"*

Plan of Correction ***Accept (█ - 07/14/2025)***

Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

1. The medication carts were fitted with locks for each bin to contain nursing binders containing Resident Confidential information. Locks were placed on all medication carts 6/12/25. Keys for locks were placed on specific medication cart keys for medpasser utilization.

2. All medpassers(Licensed staff and medication technicians will be re-educated by the Director of Resident Care(DRC) and/or designee on importance of securing medcart during shift. Specifically, the need to lock all aspects of cart during medpass and when sitting unacompanied. All education will be completed by 7/30/2025. Documentation of completion of training will be kept in accordance with 2800.65l.

3. The DRC and/or designee will conduct random audits of medcarts to ensure locked while unaccompanied and during medication pass daily for 2 weeks and weekly for 2 months to ensure compliance. Audits are to begin within 3 business days of the receipt of the accepted plan of correction.

4. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue weekly for 2 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

17 Record confidentiality *(continued)*

Implemented (- 08/01/2025)

65g Initial direct care training

2. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A began providing unsupervised assisted living services to residents in . However, staff person A did not complete the Department-approved direct care training course and pass the competency test until 6/12/25.

Plan of Correction ***Accept (- 07/14/2025)***

Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

1. Direct care staff person A was hired with previous experience working in Personal Care(2600) and stated completion of Direct Care competency. Employee was unable to secure document from prior employer. Completion of Direct Care training and competency test was completed 6/12/2025. Certificate of completion is part of complete HR personnel file.
2. Hiring managers work directly with HR(onboarding) for new hire to start. Noncertified/licensed nursing staff must provide certificate of completion or begin Direct Care Staff training and Competency test during the first 24 hours of employment. Administrator has reviewed with Director of Resident Care(DRC) 2800.65.g regulation, a new checklist has been created to audit nursing department new hire paperwork to ensure compliance of credentials and orientation. Documentation of completion of training will be kept in accordance with 2800.65.(l).
3. DRC, or designee, will audit nursing new hire checklist by day 3 of new hire orientation to ensure compliance. Audit of new hire checklist will be performed 2 times per month, coordinated with cadence of new hire start dates per month and will continue for 6 months to ensure compliance.
4. Nursing audits will be reviewed monthly during Safety Committee meetings. Records of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/01/2025)

95 Furniture & Equipment

3. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 6/10/25 at approximately 11:30 a.m., the bed enabler on resident #5's bed was slid under the mattress and not secured to the bed frame. Also, there was an opening in the enabler that measured approximately 5"X9 ½" and did

95 Furniture & Equipment (continued)

not have a cover on it.

Plan of Correction ***Accept (- 07/14/2025)***

Furniture and equipment must be in good repair, clean and free of hazards.
Resident 5 moved into community on without bed enabler. Residents family provided bed enabler that was not Department approved after 5/31/2025, verified with residents family, without consent of community.
1. Bed cane enabler was removed 6/12/25 and replaced with community provided, Department approved enabler for resident safety.
2. Bed cane inspection are part of Preventive Maintenace Checklist performed monthly by Maintenance Director. Interdisciplinary team coordinates placement of bed cane enablers for residents identified with specific need. Community keeps resident list indicating bed cane enablers for purpose of proper installation and routine inspection.
3. Nursing department and EVS/HK staff are conditioned to request work orders for maintenance to perform during all 3 shifts. Work orders include inspection and securing of enablers when/if needed. Work orders are same as request for light bulb, which occurs daily.
4. Administrator, or designee, will conduct audits of monthly Preventive Maintenance Checklist for known residents with bed cane enablers. Audits will continue for 6 months to ensure compliance. Audits findings will be reviewed at Monthly Safety meeting with a record reflected in meeting minutes. Records of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/01/2025)

100a Exterior – free of hazards

4. Requirements

2800.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

There is a fountain water feature outside the rear of the building accessible through the sunroom and dining room emergency exit doors. There is a fountain that drains into approximately 9 inches of water at the base of the fountain which has a block wall approximately 18" high. The diameter of the base is approximately 11-12 feet. The water in the base poses a drowning risk if a resident was to trip and fall into it.

Plan of Correction ***Accept (- 07/14/2025)***

The exterior of the building and building grounds or yard must be in good repair and free of hazards.

Community has exterior fountain the age of the building, 25 years, and is accessible in outdoor patio area. Signs are on both exit doors from the sunroom, Danger Water Hazard, to notify residents of water feature.
1. Procedure has been developed to properly assess safety around the water feature. All new residents will be assessed on their ability to safely avoid the water feature by the Director of Resident Care(DRC) through judgement/supervision portion of the support plan. The DRC, or the Resident Support Coordinator(RSC) will attach an addendum for all new admission's support plans that addresses if the resident is able to safely avoid the water feature. All current residents' support plans will be updated within the next 60 days to ensure that the facility follows the new procedure and is properly assessing resident's safety. Currently, the community does not have residents with WanderGuards. In the case that the community would have residents with WanderGuards, these individuals would be further monitored through an alarm system that is activated throughout the building to alert staff that a

100a Exterior – free of hazards (continued)

resident with WanderGuard is near any exit within the community, which does include the back sunroom. The community does have video camera monitoring the water feature as additional security measure.
2. Audits of Water Feature assessment will be performed by DRC, or designee, monthly to ensure compliance with admissions and current residents. Audits will be reviewed at monthly Safety Meeting. Records of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (█ - 08/01/2025)

101j7 Lighting/operable lamp

5. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 6/11/25 at approximately 11:45 a.m., resident █ in room #119 did not have access to a source of light that can be turned on/off at bedside. The round, battery operated push light on the wall near the bed did not turn on.

Plan of Correction ***Accept (█ - 07/14/2025)***

Each resident shall have the following in the living unit: 7. An operable lamp or other source of lighting that can be turned on at bedside.

Resident █ had battery operated push light on wall at bedside that did not turn on 6/11/25. New batteries were installed by maintenance on 6/11/25 when identified. Push light is operable with replacement batteries.
1. Community provides operable lamp at bedside for all residents. Some residents choose to place furniture in position in room that prevents reaching lamp on bedside, in those cases, community provides push button, battery powered puck style light.
2. Nursing department currently performs monthly audits for operable bedside lamps to ensure compliance. Previous audits did not include puck lights. New audit checklist includes: identifying residents with puck lights and are now included in monthly audit checklist.
3. Education has been provided to Maintenance reviewing light source at bedside per 101.j.7. Documentation of completion of training will be kept in accordance with 2800.65.(l).
4. Battery operated bedside lights are now included as part of Preventive Maintenace Checklist performed monthly by Maintenance Director. Interdisciplinary team coordinates placement of puck lights for residents identified with specific need.
5. Nursing department and EVS/HK staff are conditioned to request work orders for maintenance to perform during all 3 shifts. Work orders include inspection and battery replacement when/if needed. Work orders can be generated by any employee for maintenance, which occurs daily.
6. Administrator, or designee, will conduct audits of monthly Preventive Maintenance Checklist for known residents with bedside battery-operated lights. Audits will continue for 6 months to ensure compliance. Audits findings will be reviewed at Monthly Safety meeting with a record reflected in meeting minutes. Record of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

101j7 Lighting/operable lamp *(continued)*

Implemented (█ - 08/01/2025)

183d Current medications

6. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 6/11/25 at 11:42 a.m., there was blister pack of tramadol 50mg tablets with pharmacy label for resident #1 that indicated take ½ tablet by mouth every 8 hours as needed for severe pain for 30 days in the residence's "1 North" medication cart. The medication was filled on 12/23/24.

Repeat Violation 12/11/23 et al.

Plan of Correction ***Accept (█ - 07/14/2025)***

Only current prescriptions, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Analysis of the root cause as to why the medication had not been removed or destroyed was done immediately. The Tramadol found was destroyed and the med record pulled from the narc book. Additionally, all carts and med rooms were inspected to ensure no similar occurrences were repeated.
1. Our med carts and med rooms will be audited regularly at two-week intervals for exacting the labels are correct, the prescription matches the order, the items are labeled correctly with open dates on eye drops, liquids, ear drops, and insulin. If a med has a stop date, this will also be noted so as to extract the item from the cart. Missing items will be noted and reported to the pharmacy with a copy going to the Director of Resident Care(DRC).
2. Cart cleanliness will be maintained daily and reported bi-weekly to DRC by Resident Support Coordinator(RSC) or designee. Audits will be performed biweekly for 3 months to ensure ongoing compliance and to identify situations proactively. The timeline began immediately, and a copy of the audit tool will be rendered with education provided to all med techs and licensed personnel on the processes utilized for med acceptance, dispensing, documentation, discontinuance and destruction. Education will be completed by July 30, 2025. Documentation of completion of training will be kept in accordance with 2800.65l.
3. The Director of Pharmacy services is meeting with DRC and Administrator to ensure best practices are being followed in the AL community.
4. Audits will be assigned to be done with the expectation that each cart and med room will maintain compliance with realistic timelines and expectations. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (█ - 08/01/2025)

184a Resident meds labeled

7. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

184a Resident meds labeled *(continued)*

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribed Ipratropium/Sol albuterol – 1 vial inhale orally every 6 hours as needed for shortness of breath. However, on 6/11/25 at 11:15 a.m., there was a Ziploc bag containing several vials of this medication with a pharmacy label that indicated inhale contents of 1 vial via nebulizer 3 times daily for 5 days.

Resident #6 is ordered Sacubitril-Valsartan Oral tablet 97-103mg – Give 1 tablet by mouth two times a day for CHF. However, on 6/11/25 at 12:03 p.m., the pharmacy label on a bottle of this medication indicated Sacubitril-97 Valsartan 103 oral tablet 97-103mg – take ½ tablet by mouth twice a day for heart failure.

Resident #6 is ordered Metoprolol Tartrate Oral Tablet 100mg - Give 1 tablet by mouth two times a day for HTN. Hold for SBP,100 or HR<60. However, the pharmacy label for this medication does not include these parameters as indicated on the physician's orders.

Resident #6 is ordered Loperamide HCl Oral Capsule 3 mg – Give 1 capsule by mouth every 6 hours as needed for diarrhea. However, on 6/11/25 at 1:40 p.m., there was a blister pack of Loperamide 2mg capsules with pharmacy label for resident #6 that indicates - Give 1 capsule by mouth every 4 hours as needed for 3 days.

Resident #7 is ordered Felodipine ER 5 mg tab – Give 1 tab by mouth once a day for hypertension. Hold for SBP<120 or pulse<60. However, on 6/11/25, the pharmacy label for this medication only indicated Felodipine ER 5mg oral tab – take 1 tablet by mouth once daily. The label did not include the parameters as indicated on the physician's orders.

Repeat Violation 12/11/23 et al.

Plan of Correction ***Accept (█ - 07/14/2025)***

The original container for prescription medications shall be labeled with a pharmacy label that includes the following: 4. The prescribed dosage and instructions for administration.

1. Resident 2 had the albuterol removed and destroyed. The order for longevity of usage was dually noted and confirmed to be discontinued. Resident #6 had Valsarten order changed by the VA and sent us the wrong previous dosage. This was corrected immediately and entered in the MAR correctly to mirror the current correct dosage and dispensing instructions. Resident 6's metoprolol orders had the parameters for holding the med added to the label mirroring the current order. Additionally, loperamide HCl was confirmed to be 2mg every 4 hours as needed with a cutoff of 3 days. Resident #7 had Felodipine parameters added to the label mirroring the order and MAR.
2. Moving forward an investigation as to why these discrepancies occurred and how we can prevent them from recurring has ensued. A Quality Control project is in the works including our med techs, the pharmacy leaders, our charge nurses, the Resident Support Coordinator(RSC) and the Director of Resident Care(DRC). This coordinated project is for Root Cause Analysis to why it has occurred and how to exact processes to prevent for further violations. Our first meeting will occur by July 11, 2025.
3. Education for the med techs and nurses will be completed by July 30 on order completion, checking in meds with focus on accuracy of labeling and parameters transcribed on the MAR, packaging and administration of said meds with the five R's in mind to avoid medication errors. Documentation of completion of training will be kept in accordance with 2800.65l.
4. The cart audits will also be used to check accuracy. DRC or designee will conduct random audits of 3-4 residents MAR's 2 times per month to compare EMAR to medication labels to measure compliance. Audit findings will be

184a Resident meds labeled (continued)

reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 3 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (█ - 08/01/2025)

185a Storage procedures

8. Requirements

2800.
185.a. The residence 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 ordered Humalog Kwik inj 100/ml – Inject as per sliding scale: 151-175=3 units; 176-200=4 units; 201-225=5 units; 226-250=6 units; 251-300=8 units; 301-350=10 units; 351-400=13 units three times a day. However, the resident's blood glucose readings were incorrectly entered onto the resident's June 2025 MAR as follows:
** 6/6 at 9:33 a.m. the reading in the glucometer was 273; 278 was entered on the MAR*
** 6/7 at 8:58 a.m., the reading in the glucometer was 211; 201 was entered on the MAR*
** 6/9 at 11:06 a.m., the reading in the glucometer was 458; 453 was entered on the MAR*

Resident #4 is ordered blood glucose checks once daily. However, the resident's blood glucose readings were incorrectly entered onto the resident's June 2025 MAR as follows:
** 3/5/25 9:15 a.m. the reading in the glucometer was 114; 305 was entered on the MAR.*
** 3/8/25 10:20 a.m. the reading in the glucometer was 321; 318 was entered on the MAR.*
** 3/9/25 there was no reading in glucometer; 200 was entered on the MAR.*

Repeat Violation 12/11/23 et al.

Plan of Correction ***Accept (█ - 07/14/2025)***

The residence shall develop and implement procedures for the safe storage, access, security, distribution, and use of medications and medical equipment by trained staff persons.
1. All diabetic residents with glucose checks ordered will have their own pre-coded glucometer which is labeled with their name and room number and stored in their room. The schedule will be determined by the MD including frequency and sliding scale coverage for the reported measurement. The actual reading will be checked against the glucometer used to perform the test. Documentation of reading will in turn be checked for accuracy when entering.
2. All med techs and licensed nurses will be educated on glucometer checks, storage, preparation and documentation with a return demonstration occurring for competency measurement. All education will be completed by 7/30/2025. Documentation of completion of training will be kept in accordance with 2800.65l. This education will continue with all new med techs and licensed personnel as well as annually for medpassers.
3. Director of Resident Care or designee will audit weekly for one month then bi-weekly in an ongoing effort for accuracy for 3 months to ensure compliance. Resident 2 and resident 4 had their glucometers checked and both are in working order being stored in their rooms. Audits began 7/10/25. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.

185a Storage procedures *(continued)*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (█ - 08/01/2025)

187a Medication record

9. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
5. Dosage form.

Description of Violation

Resident #2 is ordered Gavilax pow – dissolve 1 capful (17GM) into 8 oz liquid and take by mouth daily as need for constipation. However, on 6/11/25 at 11:20 a.m., the June 2025 medication administration record (MAR) entry for this medication indicates – Gavilax Pow – give 1 dose orally as needed for constipation. The MAR does not include to mix the powder with liquid.

On 6/11/25, there was a Ziploc bag with packets (0.05oz) of Phos-Nak pow concentrate with pharmacy label for resident #6 that indicates - Add contents of 1 packet to 2.5 ounces of water, juice or other liquid. Mix well and drink by mouth twice daily. However, the resident's June 2025 MAR entry for this medication only indicates - give one packet by mouth two times a day. The MAR does not include the directions to mix the packet with water.

Plan of Correction ***Accept (█ - 07/14/2025)***

A medication record shall be kept to include the following for each resident for whom medication are administered:
5. Dosage form

1. Resident # 2 had their order checked and written for the Miralax in the appropriate dosing and dissolving medium inclusive of minimum ounces to dissolve. All residents who have this med were reviewed and adjusted for instructions accordingly. Each bottle of powder is labeled from pharmacy to dissolve with 8oz water. Directions to dissolve in water was added to EMAR for each resident 6/12/2025.
2. Education of all med techs and nurses will occur by July 30 to ensure accuracy for medication dispensing and their roles in transcription and reconciliation.
3. All orders should be checked for accuracy and upon receiving medication. Discrepancies should be reported by medpassers to pharmacy as identified and submitted to the Director of Resident Care weekly to rectify any issues.
4. DRC or designee will conduct random audits of 3-4 residents MAR's 2 times per month to compare EMAR to medication labels to measure compliance. Audit findings will be reviewed by the Administrator and/or designee monthly, beginning within 3 business days of receipt of the accepted plan of correction and will continue monthly for 3 months or until substantial compliance is achieved. Audits will be reviewed during monthly Safety Committee meeting. Record of Safety Meeting minutes are kept for review and regulatory compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (█ - 08/01/2025)