

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

June 11, 2026

[REDACTED]
SNH PENN TENANT LLC

[REDACTED]
TWO NEWTON PLACE
[REDACTED]

RE: OVERLOOK GREEN
5250 MEADOWGREEN DRIVE
PITTSBURGH, PA, 15236
LICENSE/COC#: 45057

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/09/2026 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: OVERLOOK GREEN License #: 45057 License Expiration: 07/01/2026
 Address: 5250 MEADOWGREEN DRIVE, PITTSBURGH, PA 15236
 County: ALLEGHENY Region: WESTERN

Administrator

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

Legal Entity

Name: SNH PENN TENANT LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 02/23/1994 Issued By: Labor and Industry
 Type: I-2 Date: 03/14/2018 Issued By: Whitehall Borough

Staffing Hours

Resident Support Staff: 65 Total Daily Staff: 143 Waking Staff: 107

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint Exit Conference Date: 04/09/2026

Inspection Dates and Department Representative

04/09/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 128 Residents Served: 65
 Secured Dementia Care Unit
 In Home: Yes Area: Memory Care Capacity: 23 Residents Served: 11
 Hospice
 Current Residents: 8
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 64
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 13 Have Physical Disability: 0

Inspections / Reviews

04/09/2026 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/10/2026

05/11/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 06/03/2026
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/15/2026

Inspections / Reviews *(continued)*

05/18/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/03/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/29/2026

06/11/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/03/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. 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 approximately 12:30pm, an agent from the local Area Agency on Aging investigated an allegation of neglect involving resident [redacted]; however, this incident was not reported to the Department until [redacted]

Repeated Violation [redacted]

Plan of Correction

Directed ([redacted] 05/18/2026)

- The Administrator and Director of Health & Wellness were re-educated on 5/10/26 by the Executive Director regarding the requirement to report all reportable incidents within 24 hours in accordance with regulation 2600.16(c). Documentation of the education will be maintained in the facility education records.
- The incident involving Resident [redacted] was reviewed to ensure all required documentation and reporting were completed.
- A reportable incident tracking log and daily incident review process were implemented on 5/11/26 to monitor all incidents requiring notification to the Department.
- The Administrator or designee will review all incident reports daily to ensure timely reporting compliance. Incident log audits will be conducted weekly beginning 5/11/26 and continuing for 90 days through 8/11/26 by the Executive Director.
- Results of the audits will be documented and reviewed during the next Quality - Management meeting scheduled for 5/29/26 and monthly thereafter. Documentation of all Quality Management reviews will be maintained by the facility.
- Any missed or late reports will result in immediate retraining and corrective action.

Proposed Overall Completion Date: 05/15/2026

Directed Completion Date: 05/29/2026

Implemented [redacted] - 06/11/2026)

141b1 - Annual Medical Evaluation

2. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident's [redacted] most recent medical evaluation, dated [redacted], does not include a determination that resident [redacted]'s needs can be met safely at the personal care home. This section of resident [redacted]'s medical evaluation is blank.

Plan of Correction

Accept [redacted] - 05/18/2026)

- Resident [redacted]'s medical evaluation was reviewed with the physician and corrected on 4/9/26 to include documentation confirming the resident’s needs can be safely met by the home.

141b1 Annual Medical Evaluation (continued)

Effective 5/11/26, the Director of Health & Wellness or designee will review all medical evaluations for completeness within 24 hours of receipt and prior to filing in the resident record.

Monthly audits of 20% of resident medical evaluations will begin on 5/15/26 and continue for 90 days through 8/10/26. Audits will be completed by the Director of Health & Wellness or designee.

Audits will verify all required sections are completed, including the safe placement determination.

Findings will be documented and reviewed by administration to ensure ongoing compliance and accuracy.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented (█ - 06/11/2026)

224a - Preadmission Screen Form

3. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident █ preadmission screening form, dated █ does not include a determination that the needs of the resident can be met by the services provided by the home. This section of resident █'s preadmission screening is blank.

Plan of Correction

Accepted █/18/2026)

Resident █ preadmission screening form was corrected immediately on 4/9/26 to include documentation that the resident's needs can be met by the services provided by the home.

Admissions staff and nursing management were re educated on 4/10/26 by the Executive Director regarding completion requirements for all preadmission screening documentation prior to admission. Documentation of the staff education will be maintained in the facility education records.

All current resident records will be audited by the Executive Director or designee for completed preadmission screening documentation by 5/21/26. Any identified deficiencies will be corrected immediately.

All new admissions will undergo a 100% chart review by the Executive Director or designee beginning 5/11/26 and continuing for 90 days through 8/10/26.

Reviews will verify completion of all required preadmission screening sections prior to filing in the resident record.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented █ - 06/11/2026)

225a - Assessment 15 Days

4. 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 █ assessment, dated █ does not include an assessment of resident # █ dental or dietary needs. These sections of resident █'s assessment are blank.

225a - Assessment 15 Days (continued)

Plan of Correction

Accept [REDACTED] - 05/18/2026

- Resident [REDACTED] assessment was updated immediately on 4/9/26 to include dental and dietary needs.
- Nursing staff responsible for assessments were re-educated on 4/10/26 by the Director of Health & Wellness regarding completion of all assessment sections, including dental and dietary needs. Documentation of the staff education will be maintained in the facility education records.
- All current resident assessments were audited by the Director of Health & Wellness by 5/15/26 to ensure all required assessment sections were completed. Any identified deficiencies will be corrected immediately.
- The Director of Health & Wellness or designee will begin weekly audits of all new resident assessments on 5/11/26 and continue weekly for 90 days through 8/11/26.
- Audit results will be documented and maintained, and corrective coaching will be provided as needed.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented [REDACTED] - 06/11/2026

227g -Support Plan Signatures

5. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [REDACTED]'s most recent support plan, dated [REDACTED] is not signed by resident [REDACTED] and does not indicate if resident [REDACTED] was unable to participate, declined to participate, refused to sign or was unable to sign.

Repeated Violation [REDACTED] et. al.

Plan of Correction

Accept [REDACTED] - 05/18/2026

- Resident [REDACTED]'s support plan was updated on 4/9/26 to include resident participation documentation and appropriate signature/notation regarding ability or refusal to sign.
- Staff responsible for support plan completion were re-educated on 4/10/26 by the Director of Health & Wellness regarding signature requirements and documentation standards under regulation 2600.227(g). Documentation of the staff education will be maintained in the facility education records.
- All current resident support plans were audited by the Director of Health & Wellness or designee by 5/15/26 to ensure required signatures and participation documentation were present. Any identified deficiencies will be corrected immediately.
- Monthly audits of 20% of resident support plans will begin on 5/15/26 and continue for 90 days through 8/10/26 by the Director of Health & Wellness or designee.
- Audits will verify required signatures and participation documentation are present.
- Deficiencies identified during audits will be corrected immediately, and additional staff education will be provided as warranted.

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented [REDACTED] - 06/11/2026

233c - Key-Locking Devices

6. Requirements

2600.

233c - Key-Locking Devices (continued)

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

At 11:04am, the directions for operating the home's locking mechanism were not conspicuously posted near the external courtyard gate, located in the home's secured dementia care unit (SDCU) courtyard.

Plan of Correction**Accept ([REDACTED] - 05/18/2026)**

- *The violation was immediately corrected and verified by the inspector on 4/9/26 by conspicuously posting the door/gate code and operating directions at the secured dementia care unit courtyard egress in accordance with regulation 2600.233(c).*
- *The Executive Director provided re-education to maintenance staff and department leadership on 4/10/26 regarding posting requirements for all locking devices that prevent immediate egress. Documentation of the staff education will be maintained in the facility education records.*
- *Weekly environmental rounds will begin on 5/11/26 and continue for 90 days through 8/11/26, and then monthly thereafter.*
- *Environmental rounds will include verification that all secured dementia care unit doors and all other exits with locking devices have required operational postings in place and visible.*
- *Findings will be documented on the facility safety audit tool.*
- *Missing postings identified during rounds will be corrected immediately upon discovery.*

Licensee's Proposed Overall Completion Date: 05/15/2026

Implemented [REDACTED] 06/11/2026)