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

August 4, 2026

[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 05/29/2026 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: *SHERWOOD OAKS* **License #**: *45776* **License Expiration**: *12/08/2026*

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: *Other* **Date**: *10/28/1982* **Issued By**: *Dept. of Labor & Industry*

Type: *I-2* **Date**: *08/10/2010* **Issued By**: *Cranberry Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *92* **Waking Staff**: *69*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *05/29/2026*

Inspection Dates and Department Representative

05/29/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *77* **Residents Served**: *63*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Oak Grove* **Capacity**: *30* **Residents Served**: *29*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

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

Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

05/29/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/28/2026*

07/07/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/03/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/03/2026*

Inspections / Reviews *(continued)*

08/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/03/2026*

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

Resident [redacted] resides in the Secure Dementia Care Unit (SDCU). [redacted] medical evaluation, dated [redacted], indicates multiple diagnoses to include [redacted] with [redacted]. Staff interviews indicate resident [redacted] has a history of [redacted], [redacted], and [redacted] into other resident bedrooms.

On [redacted] at approximately 6:20p.m,. staff person A was walking past resident [redacted]s bedroom in the SDCU and heard someone yell for help. When staff person A entered resident [redacted] room, resident [redacted] was laying on the floor on [redacted] right side and resident [redacted] was kicking [redacted] Staff person A separated the residents and notified the nurse who assessed resident [redacted] and assisted [redacted] off the ground and back into [redacted] Broda chair. Resident [redacted] indicated resident [redacted] entered [redacted] room, grabbed [redacted] by the arm, and pulled [redacted] out of [redacted] Broda chair, causing [redacted] to fall on the floor, and proceeded to kick [redacted] Resident [redacted] sustained multiple injuries to include an approximate 0.4cm x 0.5cm skin laceration to [redacted] right-hand, which was cleaned and bandaged, bruising on [redacted] right elbow, approximately 2.5 inches x 1.5 inch, and bruising to [redacted] right knee, approximately 1.8cm x 1cm.

Plan of Correction ***Accept [redacted] - 07/07/2026)***

This is an uncommon occurrence in our community.
The nurse and personal care assistant took immediate action upon discovery of the situation and separated the two residents involved. The nurse then attended to the injuries of resident [redacted] Staff members began documenting fifteen-minute checks for resident [redacted] on 5/27/26 following this incident and have continued ongoing with an expected termination of the checks on 7/1/26 if no further incidents are noted. A magnetic STOP sign and motion sensor were positioned at resident [redacted]s room door on 5/28/26 by the nurse. Both residents were evaluated by our nurse practitioner on 5/28/26. The PCHA contacted resident [redacted]s POA on 5/28/26 stating 1:1 support is required for [redacted] mother due to behaviors that escalate when [redacted] does not have 1:1 continuous interaction. The 1:1 support by family members continued each day through 6/19/26 during resident [redacted]s awake hours. Resident [redacted] was evaluated for hospice services and was admitted by [redacted] POA on 6/2/26. This enabled resident [redacted] to receive services in collaboration with the Sherwood Oaks team to address [redacted] behaviors. A care team meeting for resident [redacted] on 6/16/26 determined interventions for resident [redacted] have been successful and the POA could reduce the hours on 6/20/26 should no further incidents occur and ultimately this is what occurred. The family provides 1:1 support from dinnertime to bedtime each day and this will be re-evaluated on July 1, 2026 by the care team.
PCHA documented nursing training on 6/25/26 by MK, Behavior Health Nurse Specialist from Western Psychiatric Institute and Clinic who provided education on a Residential Therapeutic Environment. This included a review of neurocognitive domains and specific examples of interventions within our current resident population.
The PCHA has completed and documented random rounding on this dementia care unit three times a week beginning 5/28/26 to observe resident and staff interactions. These observations were reviewed at the 6/25/26 nursing meeting as part of the education provided. Rounding by the PCHA is a routine practice and for purposes of this incident will be documented through 7/31/26.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented [redacted] - 08/04/2026)

227d - Support Plan Medical/Dental

2. 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 [redacted]s initial support plan, completed on [redacted] does not indicate the care and services the home will provide to address the resident's behaviors of verbal aggression, physical violence, destructive behavior and excessive wandering into other residents' rooms. The resident had a history of these behaviors with at least 22 documented incidents from April 2026 through the end of May when resident [redacted] entered the room of resident [redacted] and physically assaulted [redacted] causing resident [redacted] and a [redacted]. Staff documentation and interviews indicate that the home was aware of the resident's behaviors.

Plan of Correction ***Accept [redacted] - 07/07/2026)***

Our nursing and medical team have engaged in numerous care plan discussions and implemented action plans regarding resident [redacted]s behaviors over the past several months. However, thorough documentation containing this information was not completed. On 5/28/26, the nurse updated resident [redacted]s RASP to reflect the current interventions.
PCHA had a nursing meeting on June 11, 2026 to review the events of 5/27/26 and provided documented education of regulation 227.d. On 6/15/26, a visual resource was also created by the PCHA and stationed on the unit at the desktop computer demonstrating how to complete a care plan update in our electronic medical record.
The PCHA completed an audit of each resident chart on this unit to review accuracy of their assessment and care plan. The audit was completed and documented by 6/15/26. The PCHA is continuing to complete two documented random audits per week of resident assessments and care plans through 7/31/26 to ensure information is reflective of current interventions.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented [redacted] - 08/04/2026)