

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

August 28, 2026

[REDACTED]
NORTHLAND HEIGHTS LLC
[REDACTED]
[REDACTED]

RE: NORTHLAND HEIGHTS
4859 MCKNIGHT ROAD
PITTSBURGH, PA, 15237
LICENSE/COC#: 45084

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/17/2026 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: NORTHLAND HEIGHTS

License #: 45084

License Expiration: 08/01/2027

Address: 4859 MCKNIGHT ROAD, PITTSBURGH, PA 15237

County: ALLEGHENY

Region: WESTERN

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: NORTHLAND HEIGHTS LLC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 115

Waking Staff: 86

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Incident

Exit Conference Date: 07/31/2026

Inspection Dates and Department Representative

07/17/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 123

Residents Served: 77

Special Care Unit

In Residence: Yes

Area: Second Floor

Capacity: 19

Residents Served: 17

Hospice

Current Residents: 13

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 75

Diagnosed with Mental Illness: 4

Diagnosed with Intellectual Disability: 2

Have Mobility Need: 38

Have Physical Disability: 1

Inspections / Reviews

07/17/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/14/2026

08/12/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/11/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/18/2026

Inspections / Reviews (*continued*)

08/17/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/17/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/30/2026

08/17/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/17/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/30/2026

08/28/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/27/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c Incident reporting

1. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED] at approximately 8:00pm, resident [REDACTED] reported to direct care staff person A that direct care staff person C had yelled at resident [REDACTED] earlier in the shift while direct care staff person C was providing care to resident [REDACTED]. Direct care staff person A indicated resident [REDACTED] was upset by the incident. However, this incident was not reported to the Department.

Plan of Correction

Directed [REDACTED] - 08/17/2026)

No incident occurred on 6/24/26.

On July 3, 2026, during the investigation of the events reported to have occurred on July 2, 2026, Staff Member A informed the Executive Director that Resident [REDACTED] had previously communicated an incident that Staff Member A believed may have occurred on June 29 or June 30, 2026. Upon receiving this information, the Executive Director ensured that a statement regarding the alleged incident was obtained and included in the investigation documentation and reporting within 24 hours of the notification.

The Executive Director immediately provided reeducation to Staff Member A regarding the requirements of the Older Adult Protective Services Act, including mandatory reporting responsibilities and timeframes.

Plan of Correction:

All staff will continue their annual training on Reportable Incidents.

Executive Director retrained Staff Member A on 8/6/26 by the completion of additional and documented training on the Older Adult Protective Services Act, including mandatory reporting responsibilities and timeframes, and regulatory requirements- Completed 8/6/26 by the Executive Director.

All staff will have a review of Reportable Incidents (2800.16) with a focus on timely reporting. Executive Director, Department Managers, and Shift Supervisors are responsible for completion. (DIRECTED: All staff shall be re-educated by the administrator on 2800.16a and 2800.16c by 8/30/26. Documentation of the staff education shall be kept. [REDACTED] 8/17/26).

2800.16 to be reviewed with Department Managers Weekly for 4 weeks and monthly for 5 months for long-term monitoring. This will be reviewed and documented by the Executive Director. (DIRECTED: The audits shall begin on 8/20/26. [REDACTED] 8/17/26)

2800.16 to be reviewed during nursing staff shift huddle during each shift daily for 30 days, weekly for 4 weeks, and monthly for 4 months. This will be reviewed and documented by the Shift Supervisor and overseen by the Director of Nursing. (DIRECTED: The audits shall begin on 8/20/26. [REDACTED] 8/17/26)

Documentation of all staff education will be kept.

16c Incident reporting (continued)

DIRECTED: By 8/20/26: The administrator shall submit the incident to the Department that resident [REDACTED] reported to direct care staff person A on 6/24/26. Documentation of the incident, as well as documentation of the submission of the incident to the Department, shall be kept [REDACTED] 8/17/26.

Proposed Overall Completion Date: 09/04/2026

Directed Completion Date: 08/30/2026

Implemented [REDACTED] - 08/28/2026)

42b Abuse/Neglect**2. Requirements**

2800.

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 9:00am, resident [REDACTED]'s hospice aide discovered bilateral bruising on both of resident [REDACTED]'s upper arms, which were not present when the hospice aide saw resident [REDACTED] during the day on [REDACTED]. Resident [REDACTED] reported to the hospice aide that on the night of [REDACTED], a staff person grabbed [REDACTED] arms, squeezed them and threw [REDACTED] into [REDACTED] wheelchair while providing care to resident [REDACTED] in resident [REDACTED]'s bathroom. Direct care staff person B, licensed practical nurse, assessed resident [REDACTED]'s arms on [REDACTED] and noted resident [REDACTED] had dark purple bruising on [REDACTED] left and right biceps. Resident [REDACTED] was able to give a description of the staff person and it was determined the staff person involved was direct care staff person C. Resident [REDACTED] indicated the incident made [REDACTED] feel anxious and fearful.

Repeated Violation [REDACTED]

Plan of Correction

Directed [REDACTED] - 08/17/2026)

Upon becoming aware of the allegation of abuse, the Executive Director immediately implemented measures to ensure the safety and well being of Resident [REDACTED] and all other residents. This included promptly initiating an internal investigation, notifying all appropriate and required parties in accordance with regulatory requirements, and suspending the staff member identified in the allegation pending the outcome of the investigations.

The law enforcement investigation concluded with an unfounded finding, and no criminal charges were filed.

Additionally, the Older Adult Protective Services investigation resulted in an unconfirmed finding. Nevertheless, out of an abundance of caution and in alignment with the residence's commitment to resident safety, the employee's employment was terminated on July 17, 2026.

The individual is no longer employed by the residence and has since obtained employment with another senior living facility.

Plan of Correction:

Termination of direct care staff person C on July 17, 2026.

42b Abuse/Neglect (continued)

All staff will continue their annual training on Reportable Incidents, Resident Rights, and OAPSA.

All staff will have a review of Reportable Incidents (2800.16), Resident Rights (2800.42 focus on the right to be free from abuse/neglect), and OAPSA. Executive Director, Department Managers, and Shift Supervisors are responsible for completion. (DIRECTED: By 8/30/26: The administrator shall re educate all current staff persons on resident rights, which includes the residents' right to be free from abuse and neglect. Documentation of the staff education shall be kept. [REDACTED] 8/17/26).

2800.16, 2800.42, and OAPSA to be reviewed with Department Managers Weekly for 4 weeks and monthly for 5 months for long term monitoring. This will be reviewed and documented by the Executive Director. (DIRECTED: The reviews shall begin on 8/20/26. [REDACTED] 8/17/26).

2800.16, 2800.42, and OAPSA to be reviewed during nursing staff shift huddle during each shift daily for 30 days, weekly for 4 weeks, and monthly for 4 months for long term monitoring. This will be reviewed and documented by the Shift Supervisor and overseen by the Director of Nursing. (DIRECTED: The reviews shall begin on 8/20/26. [REDACTED] 8/17/26).

DIRECTED: Beginning on 8/20/26: The administrator shall interview at least 5 different residents, in private, per week for 1 month then monthly thereafter to ensure resident rights are protected and that residents are free from abuse/neglect. Documentation of the interviews shall be kept for 2 months. [REDACTED] 8/17/26

Documentation of all staff education will be kept.

Proposed Overall Completion Date: 09/04/2026

Directed Completion Date: 08/30/2026

Implemented ([REDACTED] - 08/28/2026)