

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

August 20, 2026

[REDACTED]
PRESBYTERIAN SENIORCARE
[REDACTED]
[REDACTED]

RE: WOODSIDE PLACE OF
WASHINGTON OF PRESBYTERIAN
SENIORCARE
954 REDSTONE ROAD
WASHINGTON, PA, 15301
LICENSE/COC#: 45099

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/20/2026 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: WOODSIDE PLACE OF WASHINGTON OF
PRESBYTERIAN SENIORCARE

License #: 45099

License Expiration: 02/24/2027

Address: 954 REDSTONE ROAD, WASHINGTON, PA 15301

County: WASHINGTON

Region: WESTERN

Administrator

Name:

Phone:

Email:

Legal Entity

Name: PRESBYTERIAN SENIORCARE

Address:

Phone:

Email:

Certificate(s) of Occupancy

Type: I-2

Date: 12/12/2019

Issued By: South Strabane Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 68

Waking Staff: 51

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Incident

Exit Conference Date: 07/21/2026

Inspection Dates and Department Representative

07/20/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 36

Residents Served: 34

Special Care Unit

In Residence: Yes

Area: Entire facility

Capacity: 36

Residents Served: 34

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 34

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 34

Have Physical Disability: 0

Inspections / Reviews

07/20/2026 Partial

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 08/17/2026

08/12/2026 - POC Submission

Submitted By:

Date Submitted: 08/19/2026

Reviewer:

Follow-Up Type: POC Submission

Follow-Up Date: 08/14/2026

Inspections / Reviews (*continued*)

08/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/19/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/19/2026

08/20/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/19/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

42b Abuse/Neglect**1. 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

During incontinence checks on [REDACTED] at approximately 4:30 a.m., resident [REDACTED] did not want to get up to use the rest room. Direct care staff person A asked direct care staff person B if they could put a brief on resident [REDACTED] while [REDACTED] was in [REDACTED] bed. Staff person B replied "No [REDACTED] pissed [REDACTED] [REDACTED] can get up and go to the bathroom, that's what [REDACTED] has two legs for". Resident [REDACTED] can transfer and ambulate independently; however, staff person B grabbed resident [REDACTED] by the feet, rolling the resident from [REDACTED] side to [REDACTED] back and turning [REDACTED] 90 degrees in the bed.

Staff person B then yanked resident [REDACTED] by the feet twice to move [REDACTED] closer to the foot of the bed to get [REDACTED] out of bed to the bathroom. Staff person B proceeded to pull resident [REDACTED] up by the arms to get [REDACTED] out of bed, positioned [REDACTED] on resident's side and dragged resident [REDACTED] to the bathroom with [REDACTED] feet shuffling. Resident [REDACTED] was then forcefully put on the toilet by staff person B. During the transfer, resident [REDACTED] was having a bowel movement which staff person B said, "See, that's why you needed to get your [REDACTED] into the bathroom." Resident [REDACTED] was kicking at staff person B while [REDACTED] was on the toilet. Resident [REDACTED] was observed by staff person A to be trembling during this interaction.

Plan of Correction**Accept [REDACTED] - 08/14/2026)**

Upon learning of Staff Person B's actions, Resident Services Director, [REDACTED] RN, made an immediate report to AAA and DHS. Staff Member B was immediately suspended pending investigation. An internal investigation was completed, and termination request for Staff Person B was submitted to corporate HR Director on 08/10/2026. Staff Person B's employment with the home was terminated on 8/12/2026.

All staff were in serviced on the home's policy related to 2800.42(b) on 07/13/2026 by [REDACTED] RN. Content of in service and sign in sheet will be maintained in the home. All staff are currently educated on abuse prevention and reporting upon hire and annually. The administrator has created a questionnaire, and private interviews will be conducted of three residents a week for three weeks and three residents a month for three months having begun on 07/13/2026 by the Resident Services Director and taken on by the Administrator on 08/03/2026 to ensure compliance with Regulation 2800.42(b). Documentation shall be maintained in the home. Components of 2800.42(b) will be discussed in our Quality Assurance and Improvement meeting.

Licensee's Proposed Overall Completion Date: 08/14/2026**Implemented [REDACTED] 08/20/2026)**