

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

September 10, 2026

[REDACTED]
WELLTOWER OPCO GROUP LLC

[REDACTED]
ATTN LICENSING
[REDACTED]

RE: HEMSLEY HOUSE PERSONAL &
MEMORY CARE OF MCCANDLESS
900 LINCOLN CLUB DRIVE
PITTSBURGH, PA, 15237
LICENSE/COC#: 44880

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/27/2026 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: HEMSLEY HOUSE PERSONAL & MEMORY CARE OF MCCANDLESS **License #:** 44880 **License Expiration:** 12/15/2026
Address: 900 LINCOLN CLUB DRIVE, PITTSBURGH, PA 15237
County: ALLEGHENY **Region:** WESTERN

Administrator

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

Legal Entity

Name: WELLTOWER OPCO GROUP LLC

Address: [REDACTED]

Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-1	Date: 04/03/1967	Issued By: PA Dept of L & I
Type: I-2	Date: 11/19/2008	Issued By: Twp of McCandless
Type: I-2	Date: 01/31/2020	Issued By: Twp of McCandless

Staffing Hours

Resident Support Staff: 54 **Total Daily Staff:** 112 **Waking Staff:** 84

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 07/27/2026

Inspection Dates and Department Representative

07/27/2026 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 153 **Residents Served:** 53

Secured Dementia Care Unit

In Home: Yes **Area:** 3rd Fl **Capacity:** 40 **Residents Served:** 24

Hospice

Current Residents: 15

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 53
Diagnosed with Mental Illness: 1	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 5	Have Physical Disability: 0

Inspections / Reviews

07/27/2026 Partial

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

Inspections / Reviews (*continued*)

09/01/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/12/2026

09/10/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/09/2026

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

On [REDACTED] at approximately 7:51 a.m., resident [REDACTED] pressed the alarm button for assistance in room [REDACTED]. Direct care staff person A telephoned staff member E, who was still driving into the facility, to inform [REDACTED] that room [REDACTED] call bell was ringing and that they needed someone else to respond to the call. Staff member E contacted direct care staff person D and instructed direct care staff person D along with direct staff person C who were working on the 4th floor to respond to room [REDACTED].

At approximately 9:00 a.m., direct care staff C and D arrived at room [REDACTED], and discovered resident [REDACTED] was in bed lying on [REDACTED] side facing the window unresponsive and not breathing. At approximately 9:01 a.m., 911 was called. At approximately 9:09 a.m., the ambulance personnel arrived at the patient's bedside and determined the resident was [REDACTED].

Plan of Correction**Accept [REDACTED] - 09/01/2026)**

Immediately following these incidents investigation, the Residence Director terminated staff person A on [REDACTED]. Following the termination of Staff Member A, Staff Member B abandoned employment and was officially terminated on 7/9/2026.

Resident [REDACTED] was a DNR and coroners report confirmed resident dies of natural causes. Copy of death certificate will be kept as part of the residents file.

On 7/6/2026, the Maintenance Director performed an inspection of the existing call bell system to confirm hardware functionality. The facility is currently transitioning from the previous alert model to a voice-enabled call bell system through PalCare. This upgrade is configured to automatically dispatch alert notifications to both the Residence Director and the Health Care Director if a call bell goes unanswered for 15 minutes.

On 8/27/2026, Residence Director conducted a training with current staff regarding call bell response protocols. DCS was instructed that if they are unable to go in to a residents room for any reason they are to walkie for additional assistance from other staff members. Staff was also made aware that failure to respond to resident calls bells in a timely fashion would result in corrective action. Documentation shall be maintained.

Starting 8/31/2026, the Residence Director or designee will run the call bell report twice a day for 2 weeks and then daily for 2 weeks to ensure the call bells are answered in an appropriate amount of time. Documentation shall be maintained.

On 8/11/2026, the Regional Health Care Director came and did a training with current staff on Abuse and Neglect and covered the requirements found in 2600.42b. Documentation shall be maintained.

On 9/16/2026, the Residence Director or designee, will review the above findings for 2600.42.b during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be maintained.

Licensee's Proposed Overall Completion Date: 09/11/2026

42b Abuse (continued)

Implemented [REDACTED] - 09/10/2026)