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

October 28, 2025

[redacted]
PRESBYTERIAN SENIOR CARE INC
[redacted]

RE: WESTMINSTER PLACE OF OAKMONT
1215 HULTON ROAD
OAKMONT, PA, 15139
LICENSE/COC#: 42962

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/29/2025 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: *WESTMINSTER PLACE OF OAKMONT* **License #**: *42962* **License Expiration**: *06/30/2026*

Address: *1215 HULTON ROAD, OAKMONT, PA 15139*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *PRESBYTERIAN SENIOR CARE INC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/07/2015* **Issued By**: *Borough of Oakmont*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *87* **Waking Staff**: *65*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *09/29/2025*

Inspection Dates and Department Representative

09/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

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

Have Mobility Need: *14* **Have Physical Disability**: *0*

Inspections / Reviews

09/29/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/18/2025*

10/20/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/25/2025*

Inspections / Reviews *(continued)*

10/28/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/28/2025*

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 12:09 a.m., staff members A and B were in the hallway when resident [redacted] and resident [redacted] were coming down the third-floor south hallway arguing back and forth. Resident [redacted] informed both staff members that resident [redacted] had hit [redacted] on the head with [redacted] own cane causing an injury. When resident [redacted] removed [redacted] hat, the staff observed a silver dollar sized skin tear on the left side of [redacted] forehead above [redacted] left eye. When staff members questioned resident [redacted] about the assault, resident [redacted] did admit that [redacted] did hit resident [redacted] in the head with [redacted] own cane. The crisis center was contacted and consulted. The family hired a private sitter to assist with the residents and their outbursts. Due to the loud violent disruptions and complaints from other residents, the home has served resident [redacted] and resident [redacted] power of attorneys with a 30-day written notice to relocate the residents to another facility.

On [redacted] at approximately 10:15 p.m., staff member C heard someone yelling "help me" coming from the South hallway. When staff member C went down the hallway, [redacted] could tell it was coming from apartment [redacted] belonging to resident #[redacted] and resident [redacted]. As staff member C entered the apartment, [redacted] observed resident [redacted] sitting in a chair holding a metal object with wheels on it. Resident [redacted] was standing in front of resident [redacted] holding resident #[redacted] arm along with the metal object. Staff member C yelled "what are you doing" to both residents, both residents began to give their versions of what happened. Staff member C observed a bite mark on resident [redacted]'s right middle finger that was bleeding. Resident [redacted] had no noticeable injuries, marks, or bruises. The residents were separated for the night. The crisis center was contacted and consulted. The family hired a private sitter to assist with the residents and their outbursts. Due to the loud violent disruptions and complaints from other residents, the home has served resident [redacted] and resident [redacted] power of attorneys with a 30-day written notice to relocate the residents to another facility.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

After incident on 9/19/25, Administrator and social worker met with family of residents noted. Administrator discussed the incident with the POA's and the Residents separately. Educated all parties on the importance of safety. The [redacted] stated that [redacted] did not want to be separated from [redacted] [redacted] Mindcare consult completed by POA's for both Residents and MD notified. On 9/22/25, Team met with family and agreed that due to safety the two residents need to have separate rooms. PA was in to see the [redacted] and started [redacted] on Buspar 3x a day and agreed that they need separated but can see each other during the day. On 9/22/25, both Residents became upset when their rooms were separating, they will not be apart. They walked outside refusing to come in and trying to call for "A ride out of here". POA's were called and they attempted to get parents back inside and were unsuccessful. Crisis Center called. POA's did agree to get a night companion/sitter. Couple became tired and came in refusing to go to separate rooms. PSCN provided a sitter for safety. Crisis Center called 6 hours later to see if we still needed them, by this time both residents were sleeping. 9/23/25 Resident [redacted] was seen by Mindcare and given [redacted] orders 125mg 1x a day at dinner. 30 day noticed discussed with POA's on 9/23/25 and discussed possible rescinding if we can come up with a safe plan for both parents. Although, Residents have separate rooms they refuse to sleep apart. Sitter continued but the Residents become extremely agitated if they stay in the room. Arguing would continue but sitter was able to prevent any injuries and separate the two when needed. On 10/1- Resident [redacted] was again by MindCare and ordered trazadone routine and PRN and a urine culture order was obtained. On 10/6/25, PA ordered Resident [redacted] for a[redacted]. On 10/9- Resident [redacted] was throwing things at Resident #[redacted]. Nothing made contact. Resident [redacted] stated to team that [redacted] was scared of [redacted] Crisis hotline called to petition 302. 302 was denied due to witness not being present by the time they came out. Family called crisis intervention to petition a 302 as well. The evening of

42b Abuse (continued)

10/9 Residents went to separate rooms and resident [redacted] started screaming in the middle of the night for [redacted] demanding to see [redacted] now, waking up all residents. [redacted] children came in to speak with [redacted] and [redacted] picked up a fork from the table and threatened to stab [redacted] then put the fork to [redacted] neck to stab herself. 911 was called and resident was taken to Mercy Hospital. Resident [redacted] was admitted for a UTI and put on IV antibiotics then returned to Westminster Place on 10/15/25. Resident [redacted] and [redacted] continue to have two separate rooms and a sitter. Resident [redacted] on 10/15/25 started yelling at [redacted] again. On 10/16/25, POA toured Woodside Place, a secure dementia community on campus, due to a bed being available. Resident [redacted] will be moving into Woodside Place on 10/20/25 and Resident [redacted] will remain in Westminster Place.

Team resident right and abuse reporting will be facilitated by administrator and assistant administrator to all line team members by October 24th.

All shift leaders and administration class must complete the online Department of Aging abuse training and obtain certificate by October 24th.

Attached are completed certificates, sign in sheets, policy, and quizzes to date.

42b - Abuse (continued)

42b - Abuse (continued)

42b - Abuse (continued)

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented [redacted] - 10/28/2025)