

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

October 27, 2025

[REDACTED], ADMINISTRATOR  
PINE VIEW PERSONAL CARE FACILITY, INC.  
[REDACTED]

RE: PINE VIEW PERSONAL CARE  
FACILITY  
1113 PINE VIEW LANE  
VANDERGRIFT, PA, 15690  
LICENSE/COC#: 42669

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/20/2025 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: *PINE VIEW PERSONAL CARE FACILITY* License #: *42669* License Expiration: *10/30/2025*  
 Address: *1113 PINE VIEW LANE, VANDERGRIFT, PA 15690*  
 County: *ARMSTRONG* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *PINE VIEW PERSONAL CARE FACILITY, INC.*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *07/02/1998* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *15* Waking Staff: *11*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *08/20/2025*

**Inspection Dates and Department Representative**

*08/20/2025 - On-Site:* [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: *28* Residents Served: *15*

**Secured Dementia Care Unit**  
 In Home: *No* Area: Capacity: Residents Served:

**Hospice**  
 Current Residents: *3*

**Number of Residents Who:**  
 Receive Supplemental Security Income: *2* Are 60 Years of Age or Older: *15*  
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*  
 Have Mobility Need: *0* Have Physical Disability: *0*

**Inspections / Reviews**

**08/20/2025 - Full**  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/15/2025*

**09/18/2025 - POC Submission**  
 Submitted By: [REDACTED] Date Submitted: *10/15/2025*  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/23/2025*

Inspections / Reviews *(continued)*

09/24/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/15/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/15/2025

10/27/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/15/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

64a - Admin Training

1. Requirements

2600.

64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

1. An orientation program approved and administered by the Department.
2. A 100-hour standardized Department-approved administrator training course.
3. A Department-approved competency-based training test with a passing score.

Description of Violation

Staff person [REDACTED] who is the home's administrator, has not successfully completed an orientation program approved and administered by the Department, a 100-hour standardized Department-approved administrator training course or the Department-approved competency-based training test with a passing score.

Plan of Correction

Accept ([REDACTED] - 09/17/2025)

The facility acknowledges there was a period of noncompliance when the administrator role was in transition. On August 7, Staff person [REDACTED] the designee, immediately notified the Department and followed regulatory manager guidance to prepare and submit a waiver. The waiver was accepted into the Department's review queue on August 19 and has since been approved, designating an acting administrator as attached.

Both the acting administrator and Staff person [REDACTED] (designee) are currently enrolled in the required 100-hour standardized administrator training course through Penn State Abington, with completion scheduled by December, 2025.

The owners will remain responsible for ensuring that at no time will the facility be without an approved administrator or designee in the future. The administrator will maintain records of training and competency completion and ensure all updates are provided to the Department.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented ([REDACTED] - 10/27/2025)

65e - 12 Hours Annual Training

2. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person C, hired [REDACTED], received 4 hours of annual training during the January 2024 through December 2024 training year.

Direct care staff person B, hired [REDACTED] received 8 hours of annual training during the January 2024 through December 2024 training year.

Plan of Correction

Accept ([REDACTED] - 09/18/2025)

The home reviewed the staff training files following inspection and located the missing documentation for staff persons B and C. Both had completed the required 12 hours of annual training for the January through December 2024 training year. Copies of the training certificates have been attached to verify compliance.

65e - 12 Hours Annual Training (continued)

The administrator will ensure that training documentation is filed promptly upon completion of each training session to prevent gaps in records. The administrator will also audit staff files and training logs monthly to verify all trainings are accurately recorded and that all documentation is properly maintained.

Moving forward, the location of all required documents will be documented by the administrator and conveyed to the owners to ensure that no documents location is unknown should there be a change of administrator again in the future.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented ( ) - 10/27/2025)

65f - Training Topics

3. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person C, hired ( ) did not receive training in the following required content areas during the January 2024 through December 2024 training year: medication self-administration, infection control.

Plan of Correction

Accept ( ) - 09/18/2025)

The home reviewed the staff training files following inspection and located the missing documentation for staff person C who had completed the required medication self-administration, infection control training. Copies of the training certificates have been attached to verify compliance.

The administrator will ensure that training documentation is filed promptly upon completion of each training session to prevent gaps in records. The administrator will also audit staff files and training logs monthly to verify all trainings are accurately recorded and that all documentation is properly maintained.

Moving forward, the location of all required documents will be documented by the administrator and conveyed to the owners to ensure that no documents location is unknown should there be a change of administrator again in the future.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented ( ) - 10/27/2025)

65g - Annual Training Content

4. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Direct care staff person B, hired [REDACTED] did not received training in the following required content areas during the January 2024 through December 2024 training year: fire safety, emergency preparedness and Older Adult Protective Services Act.

Direct care staff person C, hired [REDACTED], did not receive training in the following required content areas during the January 2024 through December 2024 training year: fire safety, emergency preparedness and Older Adult Protective Services Act.

Repeat Violation: 8/6/24

Plan of Correction

Accept ( [REDACTED] - 09/18/2025)

The home reviewed the staff training files following inspection and located the missing documentation for staff persons B and C who had completed the required fire safety, emergency preparedness and Older Adult Protective Services Act. training. Copies of the training certificates have been attached to verify compliance.

The administrator will ensure that training documentation is filed promptly upon completion of each training session to prevent gaps in records. The administrator will also audit staff files and training logs monthly to verify all trainings are accurately recorded and that all documentation is properly maintained.

Moving forward, the location of all required documents will be documented by the administrator and conveyed to the owners to ensure that no documents location is unknown should there be a change of administrator again in the future.

Licensee's Proposed Overall Completion Date: 09/11/2025

Implemented ( [REDACTED] - 10/27/2025)

65i - Training Record

5. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The records of training for multiple annual trainings did not include the training source/trainer to include:

65i - Training Record (continued)

- \*Understanding dementia, alzheimer's and cognitive impairments
- \*Caring for residents with mental illness and intellectual disabilities
- \*Importance of flu shot for healthcare workers
- \*Medication self administration

**Plan of Correction**

Accept ( ) - 09/18/2025

Training records for past sessions have been corrected to include the trainer/source, date, and content for each course. Updated certificates were obtained and filed on September 10, 2025.

Moving forward, the administrator will only accept training documentation that includes all required details. A checklist has been created to verify all required details are on hand. The administrator will maintain records and conduct monthly audits of staff files to ensure completeness.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented ( ) - 10/27/2025

85a - Sanitary Conditions

6. Requirements

- 2600.
- 85.a. Sanitary conditions shall be maintained.

**Description of Violation**

On 08/20/25 at 11:30 AM there were multiple crumbs and food particles on the stove's backsplash in the basement kitchen.

There was an unlabeled, used green bar of soap in the second floor bathroom next to resident #2's bedroom.

**Plan of Correction**

Accept ( ) - 09/17/2025

The basement kitchen stove backsplash was cleaned immediately on the day of inspection. The unlabeled soap bar was removed from the bathroom immediately on the day of inspection.

Staff were retrained by administrator on daily cleaning expectations and proper labeling/storage of personal care items on September 12, 2025.

The maintenance staff will complete weekly sanitation inspections of all kitchens, bathrooms, and common areas using a checklist that was developed by the Administrator on September 10, 2025.

The administrator will audit sanitation records monthly to verify completion and ensure deficiencies are corrected promptly. The administrator will walk the building daily to ensure compliance.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented ( ) - 10/27/2025

85b - Infestation

7. Requirements

- 2600.
- 85.b. There may be no evidence of infestation of insects or rodents in the home.

85b - Infestation (continued)

**Description of Violation**

*There were multiple black mouse droppings in multiple locations in the basement kitchen to include:*

- \*on the counter next to the toasters*
- \*In cabinets below the toasters and drawer next to the stove*
- \*on the shelves in the pantry*

**Plan of Correction**

**Accept (█) - 09/24/2025)**

*Pest control services were contacted immediately following the inspection. The company provided treatment, and follow-up visits are scheduled as monthly drop ins to insure the home never has any infestation of any kind.*

*In addition, all food service areas were thoroughly cleaned and sanitized, and staff received additional training on 9/8/25 from administrator on sanitation practices. Documentation of pest control visits and treatments will be maintained by the Administrator.*

*Maintenance staff will conduct weekly inspections of all kitchens and storage areas, with findings recorded on the administrator's inspection log. The administrator will review these logs monthly to verify that treatments, follow-up services, and preventive measures remain effective. The administrator will walk the building daily to ensure compliance.*

**Licensee's Proposed Overall Completion Date: 09/23/2025**

**Implemented (█) - 10/27/2025)**

**8. Requirements**

- 2600.
- 85.b. There may be no evidence of infestation of insects or rodents in the home.

**Description of Violation**

*On 8/20/25 at 12:21 PM there were 3 live bedbugs and multiple brown/black bedbug castings on the corner of the fitted sheet on resident #2's bed.*

**Plan of Correction**

**Accept (█) - 09/24/2025)**

*A licensed pest control company has been providing treatment for bedbugs. However, as the issue was not fully resolved, the facility has contracted with a new pest control provider with better expertise in bedbugs. Treatment has already begun, and services will continue as monthly drop ins until the home is fully cleared of any evidence of infestation. Afterward, we will treat preventatively.*

*The affected resident's room was treated immediately and the resident moved to a different room, bedding was replaced, and the room is being completely renovated. Staff have been retrained on 9/8/25 to identify and promptly report any signs of bedbugs to ensure early detection.*

*Direct care staff will conduct daily room inspections for evidence of pests. The administrator will review pest control and inspection records weekly to confirm effectiveness and verify that corrective measures remain in place.*

**Licensee's Proposed Overall Completion Date: 09/23/2025**

**Implemented (█) - 10/27/2025)**

88a - Surfaces

9. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 8/20/25 at 12:16PM there was a section of carpeting partially detached from the floor, measuring approximately 5 x 2 inches in area, at the doorway to resident #2's bedroom, creating a potential trip hazard.

Plan of Correction

Accept ( [redacted] - 09/18/2025)

This deficiency was corrected the day after inspection when maintenance staff re-secured the carpeting to ensure the area was safe and in good repair. To prevent recurrence, the Administrator has directed maintenance staff to conduct weekly review rounds to inspect floors, walls, ceilings, doors, and other surfaces for hazards or needed repairs. These rounds are documented on a maintenance inspection log, and any identified concerns are corrected immediately or scheduled for repair within 24 hours. The Administrator will review the log weekly to ensure all issues are resolved promptly.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented ( [redacted] - 10/27/2025)

89b - Hot Water Temperature

10. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 8/20/25 the hot water temperature in the first floor men's common bathroom measured 134.2 degrees Fahrenheit at 11:57 a.m. and 133.1 degrees Fahrenheit at 2:09 p.m.

On 8/20/25 the hot water temperature in the second floor common bathroom next to resident #2's bedroom measured 130.2 degrees Fahrenheit at 12:12 p.m. and 125.7 degrees Fahrenheit at 2:13 p.m.

Plan of Correction

Accept ( [redacted] - 09/18/2025)

To correct this deficiency, maintenance adjusted the hot water system on August 20, 2025, to ensure temperatures are maintained within the required safe range. The affected fixtures were re-checked and verified to be in compliance following the adjustment. To prevent recurrence, the Administrator has implemented a water temperature monitoring system requiring maintenance staff to test and log hot water temperatures at multiple resident-accessible locations once per week. If any reading exceeds 120°F, the maintenance staff is required to adjust the system immediately and document corrective action. The Administrator will review the temperature logs weekly to ensure compliance and timely follow-up.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented ( [redacted] - 10/27/2025)

103f - Refrigerator/Freezer Temps

11. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

103f - Refrigerator/Freezer Temps (continued)

**Description of Violation**

On 8/20/25 the temperature in the freezer section of the silver refrigerator/freezer in the 1st floor kitchen measured +25 degrees Fahrenheit at 10:00 a.m. and +4 degrees Fahrenheit at 2:07 p.m.

On 8/20/25 at 11:25 AM there was no thermometer in the small chest freezer in the basement.

Repeat Violation: 8/6/24

**Plan of Correction**

Accept ( ) - 09/24/2025

The silver refrigerator/freezer temperature was adjusted to proper freezing temperatures. A thermometer was placed in the basement chest freezer the same day. These corrections were made by the administrator.

Staff were retrained on 9/8/25 required daily temperature checks, with logs maintained and reviewed weekly by the administrator. Maintenance will keep a weekly log to verify that all thermometers are present, and the administrator will review regularly.

Preventive maintenance checks for all cooling units will be scheduled quarterly.

Licensee's Proposed Overall Completion Date: 09/23/2025

Implemented ( ) - 10/27/2025

121a - Unobstructed Egress

**12. Requirements**

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

**Description of Violation**

On 8/20/25 at 12:14 there was a dresser in the hallway blocking the egress to the second floor fire escape by resident #3's bedroom.

**Plan of Correction**

Accept ( ) - 09/24/2025

The dresser blocking the second-floor fire escape was removed immediately on August 20, 2025 by the administrator.

Staff were reminded on 9/8/25 that hallways and egress routes must remain clear at all times. The administrator implemented weekly safety rounds and checks completed by direct care staff and verified by the administrator. Any staff found placing objects in egress routes will be subject to disciplinary action.

Licensee's Proposed Overall Completion Date: 09/23/2025

Implemented ( ) - 10/27/2025

183b - Meds and Syringes Locked

**13. Requirements**

2600.

183b - Meds and Syringes Locked (*continued*)

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

**Description of Violation**

*There were multiple unlocked medications on the floor in the private bathroom in resident #1s bedroom to include:*

*\*two 6 patch boxes and one 20 patch box of Salonpas patches*

*\*a 0.9 ounce tube of Preparation H*

*\*a 0.5 ounce tube of Polysporin antibiotic*

*\*a 3 ounce container of Hempvana Pain Relief cream*

**Plan of Correction**

**Accept (█ - 09/24/2025)**

*Resident #1's medications were immediately removed from the bathroom floor and secured in the locked medication cart on the day of inspection by the administrator. Direct Care Staff were retrained by the Administrator on 9/8/25 on the requirement that all prescription and over-the-counter medications remain locked when not in use. Should any future residents need medications on hand, the administrator will verify procedure is followed to be in compliance with the code (locked, resident is assessed etc.).*

*The administrator will conduct weekly room checks to ensure no unsecured medications are present. Documentation of checks will be kept on file.*

**Licensee's Proposed Overall Completion Date: 09/23/2025**

**Implemented (█ - 10/27/2025)**