

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

March 13, 2026

[REDACTED]  
2725 4 MILE DRIVE OPERATING COMPANY LLC  
[REDACTED]  
[REDACTED]

RE: THE HILLSIDE SENIOR LIVING  
COMMUNITY  
2725 FOUR MILE DRIVE  
MONTOURSVILLE, PA, 17754  
LICENSE/COC#: 23095

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/21/2026, 01/30/2026 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: THE HILLSIDE SENIOR LIVING COMMUNITY License #: 23095 License Expiration: 11/21/2026  
 Address: 2725 FOUR MILE DRIVE, MONTOURSVILLE, PA 17754  
 County: LYCOMING Region: NORTHEAST

**Administrator**

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

**Legal Entity**

Name: 2725 4 MILE DRIVE OPERATING COMPANY LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 05/01/1998 Issued By: DLI  
 Type: I-2 Date: 04/22/2020 Issued By: Loyalsock Twp.

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 64 Waking Staff: 48

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Incident Exit Conference Date: 02/09/2026

**Inspection Dates and Department Representative**

01/21/2026 - On-Site: [REDACTED]  
 01/30/2026 - Off-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 60 Residents Served: 42  
 Secured Dementia Care Unit  
 In Home: Yes Area: NA Capacity: 27 Residents Served: 22  
 Hospice  
 Current Residents: 5  
 Number of Residents Who:  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 42  
 Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 22 Have Physical Disability: 2

**Inspections / Reviews**

01/21/2026 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/09/2026

Inspections / Reviews *(continued)*

## 03/11/2026 POC Submission

Submitted By: [REDACTED] Date Submitted: 03/13/2026

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 03/21/2026

## 03/13/2026 Document Submission

Submitted By: [REDACTED] Date Submitted: 03/13/2026

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 10:45p.m., Secure Dementia Care resident [redacted] was witnessed going through the trash can in the dining room by staff person B. Staff person B attempted to redirect the resident away from the trash can by jokingly taking a boxing stance. Resident [redacted] reacted by punching staff member B in the left side of the rib cage. Staff person B then reacted by grabbing the resident's wrists and verbally threatening the resident with physical aggression if they were to strike again. Other staff witnessing the event assisted to deescalate the situation and led the resident to another area of the home. Staff person B was suspended and then terminated from the home on [redacted].

Plan of Correction

Accept [redacted] - 03/11/2026)

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 10:45p.m., Secure Dementia Care resident [redacted] was witnessed going through the trash can in the dining room by staff person B. Staff person B attempted to redirect the resident away from the trash can by jokingly taking a boxing stance. Resident [redacted] reacted by punching staff member B in the left side of the rib cage. Staff person B then reacted by grabbing the resident's wrists and verbally threatening the resident with physical aggression if they were to strike again. Other staff witnessing the event assisted to deescalate the situation and led the resident to another area of the home. Staff person B was suspended and then terminated from the home on 1/19/26.

- 1. Staff person B was suspended immediately and then terminated on [redacted]. Resident [redacted] was assessed on date on January 16, 2026, with bruises identified to wrists. No further concerns noted.
- 2. Six like residents were identified in a sample set of questions on January 16, 2026 to identify any concerns related to abuse with none being identified
- 3. All staff were educated by the Personal Care Home Administrator on abuse between January 16, 2026, and January 21, 2026.
- 4. Random audits are being completed (prior citation for 42-B) weekly x4 and monthly x2 to ensure compliance. Audits will be reviewed at the quarterly Quality Assurance Meeting.
- 5. Date of compliance: April 20, 2026.

Licensee's Proposed Overall Completion Date: 03/26/2026

Implemented ([redacted] - 03/13/2026)

42c - Treatment of Residents

2. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

42c Treatment of Residents (continued)

**Description of Violation**

The home was having new flooring placed in the hallway outside of resident rooms at nighttime. It was reported that when resident [redacted] exited the bedroom staff person A pointed in their face and shouted "get in your room" at the resident to remain in their room and closed the door so the resident would remain in their room. Also, resident [redacted] exited the bedroom to walk the hallway. Staff person A shouted "Go" and pointed in the face of resident [redacted] and physically guided them away from the work being completed.

**Plan of Correction**

Accept [redacted] - 03/11/2026)

600.

42.c. A resident shall be treated with dignity and respect.

*Description of Violation*

The home was having new flooring placed in the hallway outside of resident rooms at nighttime. It was reported that when resident [redacted] exited the bedroom staff person A pointed in their face and shouted "get in your room" at the resident to remain in their room and closed the door so the resident would remain in their room. Also, resident [redacted] exited the bedroom to walk the hallway. Staff person A shouted "Go" and pointed in the face of resident [redacted] and physically guided them away from the work being completed.

1. Staff person A was immediately suspended pending investigation. Investigation was unsubstantiated based on factual witnesses. Staff member A was presented with an in person education with the Personal Care Home Administrator on January 23, 2026, on Dementia Redirection. Residents [redacted] and [redacted] had no concerns related to this unsubstantiated incident.
2. Staff member A was placed on a 5 day plan of supervision starting on January 23, 2026 through January 28, 2026, with no identified concerns.
3. All staff were educated by the Personal Care Home Administrator on abuse between January 16, 2026, and January 21, 2026.
4. Random audits will be completed weekly x2 and monthly x1 to ensure compliance. Audits will be reviewed at the quarterly Quality Assurance Meeting to ensure all residents are treated with dignity and respect.
5. Date of compliance: April 20, 2026.

Licensee's Proposed Overall Completion Date: 03/26/2026

Implemented [redacted] - 03/13/2026)