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

May 4, 2026

[redacted], CEO
MOUNTAIN VIEW MEMORY CARE LLC
[redacted]

RE: MOUNTAIN VIEW MEMORY CARE
711 ROUTE 119
GREENSBURG, PA, 15601
LICENSE/COC#: 45377

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/05/2026, 02/06/2026 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: *MOUNTAIN VIEW MEMORY CARE* **License #**: *45377* **License Expiration**: *05/12/2026*

Address: *711 ROUTE 119, GREENSBURG, PA 15601*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *MOUNTAIN VIEW MEMORY CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/13/2006* **Issued By**: *Hempfield TWP*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *88* **Waking Staff**: *66*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/06/2026*

Inspection Dates and Department Representative

02/05/2026 - On-Site: [redacted]

02/06/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *facility* **Capacity**: *80* **Residents Served**: *44*

Hospice

Current Residents: *21*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *44*

Diagnosed with Mental Illness: *27* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *44* **Have Physical Disability**: *0*

Inspections / Reviews

02/05/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/09/2026*

03/23/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/30/2026*

Inspections / Reviews *(continued)*

03/31/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/01/2026*

05/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 2/5/26 at 9:10 am., a control count sheet for resident #1's Lorazepam Tab, 0.5mg. was unlocked, unattended, and accessible sitting on top of the medication cart in hallway #400.

Plan of Correction ***Accept ([redacted] - 03/23/2026)***

Immediate Action: This Administrator did a verbal education with the two med-techs on shift on 02/05/26 once the DHS surveyor notified me [redacted] had a completed control count sheet. This Administrator educated the med-techs working that they can't leave resident information on top of medication carts and walk away.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Med-techs to educate on Regulation 2600.17. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing Compliance: The Director of Wellness or the PCHA will do weekly checks to ensure Records are Confidential. Checks will be 1 x a week x 4 weeks starting on 03/16/26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented ([redacted] - 05/04/2026)

63a - First Aid/CPR Training

3. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 1/18/26 from 6:00am. to 6:00am. on 1/19/26, 44 residents were present in the home. During this time, no staff persons were present in the home who were trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept ([redacted] - 03/31/2026)***

Immediate Action: 02/06/26 the DHS surveyor educated the Director of Wellness and the PCHA to inform us that our CPR provider was not a valid provider. Our staff CPR training was not valid according to DHS regulation.
Action Plan: The Administrator set up CPR training with a Certified Health Care Provider that is recognized by the DHS on 03/16/26 at 10:00 am for Direct Care Staff to get CPR Certified. It will be the 1st class other dates to follow. All Direct Care staff to become CPR Certified by 04/10/26.

63a - First Aid/CPR Training (continued)

Ongoing Compliance: The PCHA will do a complete Audit of all Direct Care Staffs CPR Certification to ensure current Direct Care employees are CPR Certified by 4/10.26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 05/04/2026)

63b - Current First Aid Training

4. Requirements

2600.
63.b. Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

Description of Violation

Multiple staff persons, to include staff person A, staff person B, and staff person C were certified in CPR, AED, and First Aid by National CPR Foundation, an online training course. This training source is not certified as a trainer by a hospital or other recognized health care organization.

Plan of Correction ***Accept ([redacted] - 03/31/2026)***

Immediate Action: 02/06/26 the DHS surveyor educated the Director of Wellness and the PCHA to inform us that our CPR provider was not a valid provider. Our staff CPR training was not valid according to DHS regulation.
Action Plan: The Administrator set up CPR training with a Certified Health Care Provider that is recognized by the DHS on 03/16/26 at 10:00 am for Direct Care Staff to get CPR Certified. It will be the 1st class other dates to follow. All Direct Care staff to become CPR Certified by 04/10/26.
Ongoing Compliance: The PCHA will do a complete Audit of all Direct Care Staffs CPR Certification to ensure current employees are CPR Certified by 04/10/26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 05/04/2026)

65g - Annual Training Content

6. 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.
3. Resident rights.

Description of Violation

Staff persons C and staff person D did not receive training in Emergency Preparedness during training year 1/1/25 to 12/31/25.

Staff person E did not receive training in Fire Safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 1/1/25 to 12/31/25.

65g Annual Training Content *(continued)*

Plan of Correction ***Accept (- 03/31/2026)***

Immediate Action: On 02/06/26 The Administrator did a verbal education with the administrator assistant of the importance of mandatory Training Topics. That Emergency Preparedness has to be separate from Fire Safety Training unless documented on the specific training.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for all staff to educate on Regulation 2600.65 G. Emergency Preparedness and Resident Rights. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing Compliance: The Administrator will review the staff Training Plan for 2026 to ensure all topics are in compliance by 04/10/26

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented (- 05/04/2026)

65i - Training Record

7. 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 home's record of direct care staff training does not include the duration and dates of training for all trainings completed.

Plan of Correction ***Accept (- 03/31/2026)***

Immediate Action: On 02/06/26 Administrator did verbal education that moving forward is to use the DHS training form provided by the DHS.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for all staff to educate on Regulation 2600.65 i. Training Record The education will bed held on 03/10/26. The PCHA will ensure the new Form from the DHS site is used for compliance with regulation 2600.65i. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing compliance: The administrator or DOW will audit all staff training records moving forward after each training to ensure the record of training include the staff person trained, date, source, content, length of each course and copies of any certificates received are in the staff person's training file. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented (- 05/04/2026)

91 - Telephone Numbers

8. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

91 - Telephone Numbers *(continued)*

Description of Violation

On 2/5/26 at 10:00am, there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the laundry room.

Plan of Correction ***Accept ([redacted] - 03/23/2026)***

Immediate Action: On 02/05/26 The Maintenance Director placed emergency numbers by the telephone in the laundry room prior to the exit of the DHS Surveyor. [redacted] then showed the DHS surveyor that it was corrected.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Direct Care staff to educate on Regulation 2600.91. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing compliance: The Maintenance Director will do weekly checks to ensure emergency numbers are posted by all telephones. Checks will be 1 x a week x 4 weeks starting on 03/16/26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 05/04/2026)

103f - Refrigerator/Freezer Temps

9. 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.

Description of Violation

On 2/5/26, there was no thermometer in the refrigerator section of the white standup freezer/refrigerator in the activity kitchenette in the activity room.

Plan of Correction ***Accept ([redacted] - 03/23/2026)***

Immediate Action: The Maintenance Director placed a thermometer in the activities standup freezer/refrigerator area immediately on 02/05/26 upon notification from the DHS surveyor. The maintenance director showed the DHS surveyor the correction prior to end of day.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Direct Care staff to educate on Regulation 2600.103f. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing Compliance: The Maintenance Director will do weekly checks to ensure a thermometer is in the refrigerator/freezer per regulation. Checks will be 1 x a week x 4 weeks starting on 03/16/26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 05/04/2026)

103i - Outdated Food

10. Requirements

2600.

103i - Outdated Food *(continued)*

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 2/5/26 at 11:00 a.m., a 10 pound bag of spaghetti noodles and a 10 pound bag of mixed-colored pasta noodles were opened and undated on the second and third shelf in the dry food storage area.

Plan of Correction ***Accept (- 03/23/2026)***

Immediate Action: The Maintenance Director removed the 10 pound bag of spaghetti noodles and a 10 pound bag of mixed -colored pasta noodles from the dry food storage area on 02/05/26. The maintenance director showed the DHS corrective action prior to the end of day on 02/05/26.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Kitchen staff to educate on Regulation 2600.103i. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing Compliance: The Maintenance Director will do weekly checks to ensure Food is properly labeled once opened per regulation. Checks will be 1 x a week x 4 weeks starting on 03/16/26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented (- 05/04/2026)

131f - Fire Extinguisher Inspection

11. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 2/5/26 at 10:15a.m., the fire extinguisher in the sprinkler room did not have an inspection tag on the extinguisher indicating when it was last inspected.

Plan of Correction ***Accept (- 03/23/2026)***

Immediate Action: The Maintenance Director called Certicite Inspection company on 02/05/26 to replace our tag. The fire extinguisher in questions was inspected, however the tag must have came off.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Maintenance and Direct Care Staff to educate on Regulation 2600.131f. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing compliance: The Maintenance Director will do weekly checks to ensure all Fire extinguisher's are inspected with a tag per regulation. Checks will be 1 x a week x 4 weeks starting on 03/16/26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented (- 05/04/2026)

187c - Refusal of Medication

12. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 1/25/26 at 7:00a.m., 11:00a.m., 4:00p.m., 8:00p.m. and 1/26/26 at 7:00a.m. and 11:00.am., resident #2 refused to take the scheduled dose of Humalog Kwick Pen, 100ml.units per sliding scale; however, the provider was not notified, and documentation of response was not received until 1/26/26 at 4:58 p.m.

Plan of Correction ***Accept ([redacted] - 03/23/2026)***

Immediate Action: On 02/06/26 The DHS surveyor educated the Director of Wellness and the PCHA the regulation that there must be a note for each refusal of medication and times. The nurse only had one note due to it was the same medication. The Director of Wellness and The PCHA also was educated on there must be documentation of the physician response.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Med-techs on Regulation 2600.187C. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing Compliance: The Director of Wellness and or PCHA will do weekly checks to ensure all medication refusals are documented correctly. Checks will be 1 x a week x 4 weeks starting on 03/16/26. Documentation shall be kept

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 05/04/2026)

187d - Follow Prescriber's Orders

13. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed Humalog Kwik pen subcutaneous injections,100ml. unit per sliding scale before meals and at bedtime:
70-150= 0 units
151-200 = 3 units
201-250= 6 units
251-300 = 9 units
301-350 = 12 units
351-400 = 15 units
>400 = 18 units & notify MD

187d Follow Prescriber's Orders (continued)

On 2/2/26 at 11:00 am. resident #2's blood sugar reading was 179 and no Insulin was administered.

On 2/3/26 at 8:00 pm. resident #2's blood sugar reading was 260, however 6 units if Insulin was administered.

Repeat Violation: 2/14/25, et al

Plan of Correction ***Accept (- 03/31/2026)***

Immediate Action: On 02/06/26 The Administrator did verbal education to the Med tech's on staff to triple check their accuracy when it comes to recording and administering medications.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Med techs on Regulation 2600.187D. The education will bed held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing Compliance: The Director of Wellness and or PCHA will do weekly checks to ensure all resident #2 insulin is documented and administered correctly. Checks will be 1 x a week x 4 weeks starting on 03/16/26. Documentation shall be kept
The Director of Wellness and or PCHA will also do weekly ongoing audit to include all blood glucose readings for all residents who are prescribed Insulin per sliding scale, to ensure the blood glucose reading on the glucometer matches the blood glucose reading documented on the resident medication administration record, and the correct amount of Insulin is administered per sliding scale and correctly documented Checks be 1 x a week x 12 weeks. starting on 04/06/26 Documentation shall be kept

Proposed Overall Completion Date: 04/10/2026

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented (- 05/04/2026)

234b - Support Plan Needs Elements

14. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

On 2/5/26, the support plan, dated 1/7/26, for resident #3 did not address the services hospice would provide.

On 2/5/26, the support plan, dated 9/5/25, for resident #4 did not address how to meet the medical need for multiple diagnoses, to include A Fib, HTN, and Falls other than medications as per MD orders or therapy as per MD orders.

On 2/5/26, the support plan, dated 9/30/25, for resident #3 did not address the resident's multiple falls.

Repeat Violation: 5/30/25 et al

Plan of Correction ***Accept (- 03/31/2026)***

Immediate Action: On 02/05/26 The DHS surveyor educated the Director of Wellness and the Administrator on Regulation 2600.234 b. That the DHS would like to see more detail on the support plan when it comes to specific diagnoses to help navigate direct care workers in better understanding resident care needs.
Action Plan: The Director of Wellness and or the PCHA will conduct staff education for Direct Care Staff on

234b Support Plan Needs Elements (continued)

Regulation 2600. 234 b. The education will be held on 03/10/26. If staff is unable to attend they will have until 04/10/26 to complete the education. Documentation shall be kept.
Ongoing compliance: The Director of Wellness and the PCHA will conduct an audit of all active residents by 04/30/26 and update diagnosis and any therapies that need to be updated on the RASPs. The Administrator or Director of Wellness will audit all new resident assessment and support plans monthly x 12 months to ensure they identify the resident's physical, medical, social, cognitive and safety needs starting on 04/06/26 Documentation will be kept.

Licensee's Proposed Overall Completion Date: *04/10/2026*

Implemented ([redacted] - 05/04/2026)