

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

July 1, 2026

[REDACTED], ADMINISTRATOR/OWNER
HILLVIEW HOME INC
615 CORNELL STREET
CORAOPOLIS, PA, 15108

RE: HILLVIEW HOME
615 CORNELL STREET
CORAOPOLIS, PA, 15108
LICENSE/COC#: 43023

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/14/2026 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: HILLVIEW HOME	License #: 43023	License Expiration: 07/06/2026
Address: 615 CORNELL STREET, CORAOPOLIS, PA 15108		
County: ALLEGHENY	Region: WESTERN	

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

Legal Entity	
Name: HILLVIEW HOME INC	
Address: 615 CORNELL STREET, CORAOPOLIS, PA, 15108	
Phone: [REDACTED]	Email: [REDACTED]

Certificate(s) of Occupancy		
Type: C-2 LP	Date: 12/21/1995	Issued By: Labor & Industry

Staffing Hours		
Resident Support Staff: 1	Total Daily Staff: 18	Waking Staff: 14

Inspection Information		
Type: Full	Notice: Unannounced	BHA Docket #:
Reason: Renewal	Exit Conference Date: 05/14/2026	

Inspection Dates and Department Representative	
05/14/2026 - On-Site:	[REDACTED]

Resident Demographic Data as of Inspection Dates			
General Information			
License Capacity: 20		Residents Served: 16	
Secured Dementia Care Unit			
In Home: No	Area:	Capacity:	Residents Served:
Hospice			
Current Residents: 2			
Number of Residents Who:			
Receive Supplemental Security Income: 4		Are 60 Years of Age or Older: 16	
Diagnosed with Mental Illness: 6		Diagnosed with Intellectual Disability: 1	
Have Mobility Need: 1		Have Physical Disability: 1	

Inspections / Reviews		
05/14/2026 Full		
Lead Inspector: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 06/22/2026
06/17/2026 - POC Submission		
Submitted By: [REDACTED]	Date Submitted: 06/30/2026	
Reviewer: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 06/22/2026

Inspections / Reviews *(continued)*

06/26/2026 POC Submission

Submitted By: [REDACTED] Date Submitted: 06/30/2026

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 07/01/2026

07/01/2026 Document Submission

Submitted By: [REDACTED] Date Submitted: 06/30/2026

Reviewer: [REDACTED] Follow Up Type: Not Required

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1's, resident home contract, dated [redacted] was not signed by resident #1.

Plan of Correction

Accept ([redacted] - 06/17/2026)

Resident #1 contract was signed by the POA on admission date. Resident signed contract on 5/18/2026 to comply with regulation.

Administrator checked all resident contracts on 5/15/26 for proper signatures , and will be sure to have POA and resident sign all contracts in the future.

Licensee's Proposed Overall Completion Date: 06/15/2026

Implemented ([redacted] - 07/01/2026)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Ancillary staff person A, hired on [redacted] and had a criminal background check done on [redacted] however, ancillary staff person A could not produce any documentation of [redacted] residency for the past two years in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. §§ 10225.101-10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Staff person C, hired on [redacted] could not produce any documentation that [redacted] had [redacted] fingerprints taken for the past two years in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. §§ 10225.101-10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Plan of Correction

Accept ([redacted] - 06/17/2026)

Staff person A had [redacted] FBI check completed 5/19/2026.

Staff person C has [redacted] appointment on 6/22/2026 for fingerprinting.

administrator checked all staff records immediately to monitor for compliance according to OAPSA and will follow through will all future hires.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented ([redacted] - 07/01/2026)

100a - Exterior - Free of Hazards

3. Requirements

100a - Exterior - Free of Hazards (continued)

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 5/14/26 at approximately 11:47 a.m., located behind the plastic smoking shed in the driveway against the cement block wall there was a wooden pallet, a brown metal bed frame, an empty blue and yellow colored bag of potato chips, 3 empty red colored plastic bags of round wheat top bread.

On 5/14/26 at approximately 11:50 a.m., located to the left of the smoking shed is a gray and white colored supply shed that is approximately 12' feet long by 8' wide that had a white colored electric washing machine along with a blue garbage can, a green colored metal chair, a blue colored milk crate basket, and approximately 8 cigarette butts strewn about the ground. Immediately behind the supply shed, was an empty white plastic bag, an empty black plastic bag and a pickaxe, with approximately 6 cigarette butts strewn about the ground.

On 5/14/26 at approximately 11:52 a.m., located on the brick exterior of the home beside the garage door mounted to the tan, red, and brown brick was a gray square plastic cover approximately 6" inches long by 6" wide that was broken and missing a piece of the cover which created a hazard.

Plan of Correction

Accept (█) - 06/26/2026

All outdoor areas were cleaned on 5/18/26 including picking up plastic bags, removal of the washer, metal chairs and crates.

plastic cover for the central vac exhaust was replaced on 5/19/26.

administrator will add these outside areas to the weekly inspection routine to keep the home in good repair and free of hazards immediately.

Staff was educated on this regulation on 6/19/26

Home policy was updated on 6/24/26.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented (█) - 07/01/2026

103i - Outdated Food

4. Requirements

2600.

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

Description of Violation

On 5/14/26 at approximately 11:25 a.m., in the dry goods closet #1 the following items were found to be expired:

* A 24oz plastic container of Members Mark brand of parmesan cheese with an expiration date of 5/23/25.

* An 8oz plastic container of Reggano brand of Parmesan cheese with an expiration date of 11/01/25.

Plan of Correction

Accept (█) - 06/26/2026

Outdated cheese was thrown out immediately.

All dry goods and canned goods were checked for dates on 5/15/26 no other expired food was found.

Ancillary staff will be responsible for checking all food on a weekly schedule for expiration dates as well as any dented cans and dispose of immediately.

Staff was educated on this requirement on 6/22/26

Kitchen policy was updated to include all food be checked for expiration dates weekly.

Licensee's Proposed Overall Completion Date: 06/24/2026

103i Outdated Food (continued)

Implemented () - 07/01/2026

132c Fire Drill Records

5. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record did not indicate the emergency exits used for the following fire drills conducted on:

- * 5/08/26 at 5:12 p.m.
- * 3/09/26 at 1:29 p.m.
- * 2/09/26 at 10:15 a.m.

Plan of Correction

Directed () - 06/26/2026

Fire Drill record had arrows indicating which exit was used in the drills.

Fire Drill record was changed to a key, noting which exit doors are being used as of 6/8/26

administrator will use the key for all future drills to specify exits used

Staff was educated on this regulation on 6/22/26

The administrator implemented the change on 6/8/26 fire drill

Proposed Overall Completion Date: 06/24/2026

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall audit the home's fire drill record monthly to ensure accuracy and completeness. 6/26/26

Directed Completion Date: 06/27/2026

Implemented () - 07/01/2026

132e Fire Drill Sleeping Hours

6. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The most recent fire drill conducted during sleeping hours was held on 10/08/25 at 11:12 p.m.

Plan of Correction

Directed () - 06/26/2026

Night time Fire Drill was conducted immediately on May 15, 2026.

Administrator or designee will run night time fire drills every 6 months per regulation without lapse per regulation, audits will begin June 2026 with an appointee and administrator to monitor the fire drill record monthly for accountability.

Staff was educated on this regulation on 6/19/26 and during the June 8th evening fire drill.

132e - Fire Drill Sleeping Hours (continued)

Proposed Overall Completion Date: 06/24/2026

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall audit the home's fire drill record monthly to ensure a sleeping hours fire drill is conducted at least every six months. [REDACTED] 6/26/26

Directed Completion Date: 06/27/2026

Implemented [REDACTED] - 07/01/2026

133.3 - Exit Signs Letter Size

7. Requirements

2600.

133.3. Exit Signs - The following requirements apply for a home serving nine or more residents: Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

Description of Violation

On 5/14/26 at approximately 10:58 a.m., there were two silver and black self-sticking exit signs posted on the wall in the hallway next to the 2nd floor bathroom, however, the lettering for the word "exit" measured approximately 1 1/2" inches high and 1/2" wide and not to the required size of 6".

Plan of Correction

Accept [REDACTED] - 06/17/2026

On 5/15/26 the old exit sign was removed and a new one put in its place with the correct size per regulation. The administrator checked all other exit signs for compliance on 5/15/26

Licensee's Proposed Overall Completion Date: 06/15/2026

Implemented [REDACTED] - 07/01/2026

141a - Medical Evaluation

8. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #2's, medical evaluation dated [REDACTED] was completed on the incorrect form utilized for assisted living residence's (2800) and not on the correct form utilized for personal care residence's (2600).

Plan of Correction

Accept [REDACTED] - 06/26/2026

Resident #2 had an incorrect DME form, the updated DME for PCH was completed on 5/19/26. Administrator checked all current residents' files to be sure all DME's were for PCH and will continue to be more observant in the future per regulation. Administrator designated a staff person with knowledge of this regulation to do a second check on all DME forms starting immediately.

141a - Medical Evaluation (continued)

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 07/01/2026

144c1 - Smoking Area Guidelines

9. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

- 1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 5/14/26 at approximately 11:47 a.m., in the plastic smoking shed located outside in the driveway of the home there were 6 metal chairs with wicker backs and wicker seats located inside the smoking shed. On the 6 chairs there were six assorted non-fire rated cushions placed on top of the wicker seats creating a potential fire hazard to the home and the residents.

Plan of Correction

Directed () - 06/26/2026

Cushions on the chairs in the smoking area were removed immediately and disposed of. Administrator educated residents and staff who use the smoking area to not purchase any cushions without approval according to regulation and for the safety of our residents and staff.

On June 19, 2026 staff meeting was held to discuss and educate staff.

Policy and procedure was updated on 6/24/26.

Administrator will be responsible for compliance during daily maintenance checks immediately.

Proposed Overall Completion Date: 06/24/2026

DIRECTED

Within one day of receipt of the plan of correction: The administrator or designated staff person shall audit the smoking area to ensure compliance with the regulation and the home's policy and procedures. 6/26/26

Directed Completion Date: 06/27/2026

Implemented () - 07/01/2026

181c - Self-administration Assessment

10. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2's, medical evaluations dated [redacted] indicated that the resident cannot self-administer [redacted] own medications. The resident's assessment dated [redacted] indicated the resident can self-administer medications;

181c - Self-administration Assessment (continued)

however, there was no supporting documentation from a physician indicating that the resident was assessed and can self-administer her own medication.

Plan of Correction

Directed (█ - 06/26/2026)

Resident #2's DME was updated on 5/19/26 to indicate self administration

Administrator checked all other resident's records on 5/15/26 for errors such as this and will be more vigilant reviewing doctors forms and making appropriate corrections in a timely manner.

A staff member with knowledge of this regulation has been appointed to monitor all forms along with the administrator checking for errors and making corrections.

Proposed Overall Completion Date: 06/24/2026

DIRECTED

Within five days of receipt of the plan of correction: The administrator shall have resident #2 assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders. The resident shall not be permitted to self-administer medications until the assessment is completed. █ 6/26/26

Within one day of receipt of the plan of correction: The administrator shall ensure all residents who wish to self-administer medications have been assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders and the documentation has been recorded in the resident's record. █ 6/26/26

Directed Completion Date: 07/01/2026

Implemented (█ - 07/01/2026)

190a - Completion Medication Course**11. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, hired on █ has not successfully completed a department-approved medication administration course that includes the passing of the Department's performance-based competency test within the past two years.

However, staff person B administered the following medications on the following dates and times to resident #3:

* Levetiracetam 750mg tabs, take one tablet by mouth twice a day for mental health on 5/4/26, 5/6/26 and 5/11/26 at 8:00 p.m.

* Trazodone HCL 50mg tabs, take 1 and ½ tablets (75mg) by mouth at bedtime for sleep on 5/4/26, 5/6/26 and 5/11/26 at 8:00 p.m.

* Divalproex 125mg Sprinkle, take one tab twice a day on 5/4/26, 5/6/26 and 5/11/26 at 8:00 p.m.

* Ondansetron HCL 4mg tab, take one tablet by mouth three times a day as needed for nausea on 4/29/26 and 5/6/26 at 8:00 p.m. and on 5/7/26 at 3:00 a.m.

190a Completion Medication Course (continued)

* Sumatriptan Succ 100mg, take 1 tablet by mouth daily as needed for migraine on 5/11/26 at 8:00 p.m.

Plan of Correction

Directed () - 06/26/2026

Staff person B became an LPN in () and was hired by me in () at which () license was current, I was not aware () did not re new () license while employed.

She has completed () direct care competency training as well as diabetic education in May 2026. The medication administration course will be completed as soon as possible, In the meantime () will not be administering medications until () passes the course per regulation.

Proposed Overall Completion Date: 07/30/2026

DRIECTED

Within one day of receipt of the plan of correction: The administrator shall complete an initial and six month audit of all current staff records to ensure all staff administering medications meet the requirements to administer medications and an audit to ensure these staff continue to meet the requirements to administer medications. ()

6/26/26

Directed Completion Date: 06/27/2026

Implemented () - 07/01/2026

190b - Insulin Injections

12. Requirements

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person B, has not successfully completed a department approved diabetic education course in the past two years, however staff person B administered 7 units of insulin from a Novolin 70/30 FlexPen to resident #4 on 5/11/26 at 4:30 p.m.

Plan of Correction

Directed () - 06/26/2026

Staff person B is an LPN who let their license lapse without knowledge to the administrator. () completed diabetic education on 5/29/26.

() will not administer any medications or insulin until () completes the medication administration course as soon as possible per regulation.

Administrator will monitor progress of the medication administration class before staff member is able to pass meds.

Proposed Overall Completion Date: 07/30/2026

Within one day of receipt of the plan of correction: The administrator shall complete an initial and six month audit of all current staff records to ensure all staff administering insulin medications meet the requirements to administer insulin medications and an audit to ensure these staff continue to meet the requirements to administer insulin

190b - Insulin Injections (continued)

medications. █ 6/26/26

Directed Completion Date: 06/27/2026

Implemented (█ - 07/01/2026)

251b - Record Entries Legible

13. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident #3's, resident contract dated █ had correction fluid used on the line of the contract indicating the resident or payer agrees to pay a charge of \$1500.00 per month for room and meals.

Plan of Correction

Directed (█ - 06/26/2026)

Resident #3 did have █ rate decreased due to lack of funds at which time white out was used.

Administrator is aware of entries being permanent and in the future will use an updated contract instead of white out to ensure compliance.

The administrator is solely responsible for contracts errors and has checked all other contracts for errors on 6/22/26

Proposed Overall Completion Date: 06/24/2026

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall complete a monthly audit of all newly completed resident records to ensure all records are permanent, legible, dated and signed by the staff person making the entry. █ 6/26/26

Within five days of receipt of the plan of correction: The administrator shall educate of the staff persons on the Regulation the home's policies and procedures to maintain compliance. █ 6/26/26

Directed Completion Date: 07/01/2026

Implemented (█ - 07/01/2026)

252 - Record Content

14. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

- 3. A photograph of the resident that is no more than 2 years old.

Description of Violation

The resident record for resident #3, did not contain a photograph of the resident that is no more than two years old.

252 - Record Content (continued)

Plan of Correction**Directed (█ - 06/26/2026)**

Resident #3 refused to have █ picture taken several times as this was documented, Asking █ repeatedly agitated █ and made █ more withdrawn. Administrator did ask family to bring in a current photo which they never did.

Administrator knows the regulation but feels this is a residents right to say no and ask for this violation to be removed.

Resident has since been discharged from our home.

In the future if any resident refuses a photo family will be asked to bring one in.

Proposed Overall Completion Date: 06/24/2026

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall obtain a photograph of resident #3 which is no more than 2 years old. █ 6/26/26

Within one day of receipt of the plan of correction: The administrator shall audit all resident records to ensure there is a photograph of the resident that is no more than 2 years old. █ 6/26/26

Directed Completion Date: 06/27/2026

Implemented (█ - 07/01/2026)