pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **EC OPCO DILLSBURG LLC**
LEGAL ENTITY

To operate **CELEBRATION VILLA OF DILLSBURG**
NAME OF FACILITY OR AGENCY

Located at **153 LOGAN ROAD, DILLSBURG, PA 17019**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **80**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **January 30, 2026** until **July 30, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333792**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 13, 2026

[redacted]
EC OPCO DILLSBURG LLC
[redacted]

RE: Celebration Villa of Dillsburg
153 Logan Road
Dillsburg, Pennsylvania 17019
License/COC #: 333792

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on October 28, 2025, October 29, 2025, January 6, 2026, January 7, 2026 and January 8, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby refuses to renew your certificate of compliance License #333791 dated July 30, 2025 to January 30, 2026 and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (4); (5) and 55 Pa. Code §20.71(a)(2); (3) ;(4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from JANUARY 30, 2026 to JULY 30, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a SECOND PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted] Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *CELEBRATION VILLA OF DILLSBURG* **License #**: *33379* **License Expiration**: *01/30/2026*

Address: *153 LOGAN ROAD, DILLSBURG, PA 17019*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *EC OPCO DILLSBURG LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/05/1998* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *55* **Waking Staff**: *41*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *10/29/2025*

Inspection Dates and Department Representative

10/28/2025 On Site: [redacted]

10/29/2025 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *43*

Secured Dementia Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *12* **Have Physical Disability**: *0*

Inspections / Reviews

10/28/2025 - Full

Lead Inspector: *Annette Hutson* **Follow Up Type**: *POC Submission* **Follow Up Date**: *11/30/2025*

12/02/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/03/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *12/09/2025*

12/15/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/03/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/02/2026*

03/02/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/03/2026*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

19 - Review Waiver

1. Requirements

2600.
19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

On [redacted] the home received a waiver for non-medically licensed staff to be able to administer [redacted] medications. However, on [redacted] the home did not have the waiver posted in a conspicuous or public place in the home.

Plan of Correction ***Accept ([redacted] - 12/11/2025)***

On 10/30/2025, the waiver was posted in the front common area vestibule by the Executive Director. The Regional Director of Operations provided education to the Executive Director on this regulation. This was completed on 11/14/2025. Starting 11/1/2025, the Executive Director to monitor that the waiver is hanging weekly. Results will be documented and reviewed at Monthly Quality Assurance Meeting starting in December 2025. The December QA meeting will be December 17, 2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

52 - Hiring Staff

2. Requirements

2600.
52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons 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) and other applicable regulations.

Description of Violation

Staff Member B has not lived in Pennsylvania for the past 2 years. However, there was not a Federal Bureau Investigation background check completed.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

The FBI background check was completed by the Executive Director for Staff Member B and results were received 9/17/2025. Upon hiring, all associates are questioned about their residency status (see attached form that is completed by the associate). If they answer they have not lived in PA consecutively for the last 2 years, an FBI background check is initiated. The associate cannot work until the clearance letter is received. By 11/30/2025, Executive Director, Administrative Assistant and Director of Nursing will be provided education on this regulation by the Regional Director of Operations. An audit of all associate files will be completed by 12/10/2025 by the Executive Director and/or Administrative Assistant, to ensure the Residency Form is completed. On going, the Executive Director and/or Administrative Assistant will ensure that this form is completed prior to associate starting on the floor training. This will be tracked by using the attached New Hire Checklist form which will be reviewed by the Executive Director and/or Administrative Assistant for new associates prior to starting on the floor training for all new associates hired after 12/1/2025 moving forward.

Licensee's Proposed Overall Completion Date: *12/12/2025*

Not Implemented [redacted] - 03/02/2026)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff Member B does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeated Violation - [redacted], et al

Plan of Correction ***Accept [redacted] 12/11/2025)***

Upon discovery, the associate was asked by the Executive Director to provide an updated transcript however [redacted] resigned immediately. By 11/30/2025, Executive Director, Administrative Assistant and Director of Nursing will be provided education on this regulation by the Regional Director of Operations. By 12/10/2025, an audit of all current associate files will be completed to ensure a valid high school diploma, GED or active nurse aide registry is on file by the Executive Director and/or Administrative Assistant. On going, the Executive Director and/or Administrative Assistant will ensure that all new hire associates have a high school diploma, GED, or active registry status on the PA nurse aide registry. This will be monitored by using the attached New Hire Checklist form which will be reviewed by the Executive Director and/or Administrative Assistant for all new associates starting 12/1/2025 moving forward, prior to associates starting employment. Any diploma or credentials in question will be reviewed by the communities Regional Directors or HR department.

Licensee's Proposed Overall Completion Date: *12/12/2025*

Not Implemented [redacted] - 03/02/2026)

60a - Staff/Support Plan

4. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On the following dates and times, the home did not have a staff person who was certified to administer routine and PRN medications to residents, or a medically licensed staff on duty to administer medications:

- *[redacted] from 3:00 PM-3:00 AM on [redacted]*
- *[redacted] from 11:00 AM-7:00 AM on [redacted]*
- *[redacted] from 3:00 PM-11:00 PM*
- *[redacted] from 7:00 AM-7:00 AM on [redacted]*

Plan of Correction ***Accept [redacted] - 12/11/2025)***

Upon discovery, the medication technicians in question were re-enrolled in the PA Certified Med Tech online program by a certified train the trainer with a completion date to be 12/12/2025. The Executive Director and

60a - Staff/Support Plan (continued)

Director of Nursing were provided education on this regulation by the Regional Director of Operations on 11/13/2025. Additional clarification was received by the BHLS inspector to the Executive Director. The community has a binder to track the med tech qualifications, certifications and observations which will be kept in the Executive Director's office. The Director of Nursing and/or Executive Director will review this binder monthly starting December 1st, 2025 to ensure proper documents are obtained. This review will be reviewed monthly at the Quality Assurance Meeting starting December 2025 to ensure compliance. All documentation will be kept. The monthly QA meeting for December will the 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented ([redacted] 03/02/2026)

63a - First Aid/CPR Training

5. 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

43 residents were present in the home on the following dates and times, however, there were no staff persons present in the home who were certified in both CPR and First Aid:

- [redacted] *from 11:00 PM-7:00 AM*
- [redacted] *from 11:00 PM-3:00 AM*
- [redacted] *from 11:00 PM-3:00 AM*
- [redacted] *from 11:00 PM-7:00 AM*
- [redacted] *from 11:00 AM-3:00 PM*
- [redacted] *from 11:00 PM-7:00 AM*
- [redacted] *from 11:00 AM-3:00 PM*
- [redacted] *from 11:00 PM-7:00 AM*

Plan of Correction ***Accept [redacted] - 12/11/2025)***

On 11/4/2025 a first aid/CPR class was held at the community by an American Red Cross trainer. On 11/12/2025, Executive Director completed an audit of all employee files to check for first aid/cpr certifications. On 11/13/2025, Executive Director and Director of Nursing were provided education on this regulation by the Regional Director of Operations. On 11/20/2025, all staff were provided education on this regulation by the Executive Director. Beginning 11/14/2025, the Executive Director or Director of Nursing will audit upcoming schedules weekly to ensure this requirement is in compliance. Results of the audit will be reviewed at the monthly Quality Assurance meeting beginning December 2025. The monthly QA meeting for December is scheduled for 12/17/2025. Associate CPR/First aid information/binder will be reviewed monthly at QA meetings to ensure compliance and records will be kept in the Executive Director's office.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
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

Staff Member A did not receive training in safe-management techniques or training in caring for residents with mental illness or an intellectual disability during training year 2024. The home serves two residents with intellectual disabilities.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

On 11/20/2025, all staff were provided education by the Executive Director on this regulation and a training for safe management techniques and caring for residents with mental illness or an intellectual disability will be completed by 11/30/2025. The Executive Director and Director of Nursing were provided education this regulation by the Regional Director of Operations on 11/13/2025. By December 17, 2025, an audit will be completed by the Executive Director and/or Administrative Assistant on all current associate trainings to ensure these topics are included and training is up to date. Starting January 2026, the community's Annual Training Plan will be audited quarterly by the Executive Director to ensure these topics are included. Results will be reviewed quarterly during the Monthly QA meeting, starting December 2025. The monthly QA meeting for December is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On [redacted] at approximately 4:00 PM, Resident [redacted] glucometer was used to check Resident [redacted] blood sugar.

On [redacted] at 11:46 AM, there was trash to include soiled napkins, plates, cups and left over food on the ground surrounding both exterior dumpsters.

On [redacted] at 12:20 PM, the inside of the toilet in the bathroom of resident room [redacted] was covered in black spots.

On [redacted], at 12:05 PM, brown fecal matter was covering the raised toilet seat and regular toilet seat in the bathroom of resident room [redacted]

Plan of Correction ***Accept [redacted] - 12/11/2025)***

Daily glucometer audits, which were started in January 2025 will continue to be completed by the medication technicians which were used to discover the error which was self-reported on 10/4/2025 to BHLS. On 10/30/2025, the dumpster area was cleaned by the Maintenance Director. On 10/30/2025, the toilet in room 117 and 213 were

85a Sanitary Conditions (continued)

cleaned by a housekeeping associate. All staff were provided education on this regulation by the Executive Director on 11/20/2025. Starting 11/1/2025, the dumpster area will be monitored by Maintenance Director and/or Executive Director to ensure cleanliness daily for one month and then weekly thereafter. All members of management will check resident's toilet's daily x 30 days starting 11/20/2025, and then weekly x 4 weeks after that. Results will be documented and kept and reviewed at the Monthly QA meeting starting Dec 2025. The December QA meeting is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented (- 03/02/2026)

85d - Trash Receptacles

8. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On at 11:37 AM, the small trashcan in the kitchen located by the coffee station did not have a lid and was almost completely full of trash.

Plan of Correction ***Accept 12/11/2025)***

On 10/29/2025, a new trashcan with a closing lid was placed in the kitchen by the Executive Director. All staff and management were provided education on this regulation by the Executive Director on 11/20/2025. Starting 11/1/2025, the Dining Director or Cooks will complete daily checks to ensure all trashcans in the kitchen are kept covered while not in use. These checks will be documented and completed daily x 30 days and then weekly x 4 weeks. Documented results of these checks will be maintained and reviewed monthly at the Quality Assurance Meetings, starting December 2025. The December QA meeting is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented - 03/02/2026)

85e - Trash Outside Home

9. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On at 11:46 AM, the door of one of the outside dumpsters was open. There was trash inside the dumpster, and bees were flying around. The dumpsters were unattended.

Plan of Correction ***Accept - 12/11/2025)***

On 10/28/2025, the side door of the dumpster was closed by the Maintenance Director. All staff and management were provided education on this regulation by the Executive Director on 11/20/2025. Starting 11/1/2025, the Maintenance Director and/or Executive Director will complete daily checks to ensure the side dumpster doors are closed for 30 days. and then weekly thereafter. Results of these checks will be maintained and reviewed monthly at the Quality Assurance Meetings, starting December 2025. The December QA meeting is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

85e Trash Outside Home *(continued)*

Not Implemented (- 03/02/2026)

88a Surfaces

10. 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 at 9:51 AM, exposed electrical wires were accessible on the wall by the maintenance room.

Plan of Correction ***Accept 12/11/2025)***

On 10/29/2025, the hole in the wall wit covered wires exposed was covered completely (see attached photo) by the Maintenance Director. All staff and management were provided education on this regulation on 11/20/2025. Starting 11/20/2025, the Executive Director and/or Maintenance Director will complete daily checks to ensure the covering remains in place. Starting 12/8/2025, a community walk-though will be completed by any member of management daily to check for areas of concern. Documentation of these checks will be maintained and reviewed at the Monthly Quality Assurance Meetings, starting December 2025. The December QA meeting is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented (03/02/2026)

91 Telephone Numbers

11. 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.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department in the room of Resident , who has a cell phone.

Plan of Correction ***Accept - 12/11/2025)***

On 10/30/2025, the emergency telephone numbers were posted in the resident's room by the Executive Director. All staff and management were provided education on this regulation by the Executive Director on 11/20/2025. Beginning 11/20/2025 all members of management will complete daily audits for 30 days of resident rooms to check for emergency numbers. Results of these audits will be maintained and reviewed at the monthly Quality Assurance meetings, starting December 2025. The December QA meeting is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented - 03/02/2026)

103e Left Overs

13. Requirements

2600.
103.e. Food served and returned from an individual’s plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

103e - Left Overs *(continued)*

Description of Violation

On [redacted] at 9:50 AM, the following unlabeled and/or undated food was located in the resident refrigerator and freezer located in the kitchenette across from resident room [redacted]:

- *A pint of sherbert was not labeled or dated.*
- *An individual serving size of ice cream was not dated.*
- *Three boxes of Jimmy Deans's breakfast sandwiches were not labeled or dated.*
- *An open box of Eggo waffles was not labeled or dated.*
- *A takeout container of food labeled "Patsy" was not dated.*
- *A bottle of half-drank Hank's root beer was not labeled or dated.*

On [redacted] at 11:40 AM, the following unlabeled and/or undated food was located in the home's kitchen freezer, refrigerator and dry pantry storage:

- *Multiple bags of frozen fish fillets were not labeled or dated.*
- *A bag of frozen burgers was not labeled or dated.*
- *A bag of frozen hashbrowns and potatoes were not labeled or dated.*
- *A tray of cooked brownies was not dated.*
- *A bag of hot dogs was not labeled or dated.*
- *A container of cheese was not dated.*

Plan of Correction ***Accept [redacted] - 12/11/2025)***

Upon discovery, on 10/30/2025, the items in the resident pantries were labeled and/or discarded by the Executive Director. The items in the kitchen were labeled on 10/30/2025 by the Executive Director. All staff and managers were provided education on this regulation by the Executive Director on 11/20/2025. Starting 11/1/2025, the resident pantries will be monitored daily by the Direct Care staff and/or Executive Director and/or Maintenance Director to check for personal food items and ensure proper dates/labeling. Starting 11/1/2025, the Dining Director and/or Cooks will monitor food items in the kitchen daily times 4 weeks and then weekly to ensure compliance. Results of these audits will be maintained and reviewed monthly at the Quality Assurance Meetings, starting December 2025. The December QA meeting is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

132h - Designated Meeting Place

14. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

As confirmed by Resident #1 and staff interviews, Resident #1 has not participated in fire drills for at least the last six months.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

On 10/30/2025, the resident and family were provided education by the Executive Director on this regulation. The

132h - Designated Meeting Place (continued)

Director of Nursing and Executive Director were educated on the requirements for hospice residents to be exempt from participation by the Regional Director of Operations on 11/13/2025. All staff were provided education on this regulation by the Executive Director on 11/20/2025. Starting November 1, 2025, the Executive Director and/or Director of Nursing and/or Maintenance Director will ensure that all residents who are non-exempt will participate in monthly fire drills. This will be completed by the Exeuctie Director and/or Maintenance Director reviewing the fire drill records within 24 hours of completion to ensure compliance. Monthly fire drill records will also be reviewed monthly at the Quality Assurance Meetings starting December 2025. The December QA meeting is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented (- 03/02/2026)

162c - Menus Posted

15. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted] the menus posted conspicuously in the home were from [redacted] and did not include the next week's menu for [redacted] through [redacted].

Plan of Correction ***Accept [redacted] 12/11/2025)***

On 10/31/2025, the correct menu postings were made by the Executive Director to reflect the current weekly menu as well as the upcoming weekly menu. The Dining Director was provided education on this regulation by the Executive Director on 11/3/2025. Beginning 11/3/2025, the Dining Director and/or Cooks will complete a weekly audit of the menu postings to ensure that the current and future week's menus are posted. These audits will be reviewed at the Monthly Quality Assurance Meeting starting December 2025. The monthly QA meeting is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

171b5 - First Aid Kit

16. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On [redacted] the first aid kit in the home's 2020 Chevy 3500 used to transport residents did not include scissors, a thermometer, or a breathing shield.

Plan of Correction ***Accept [redacted] 12/11/2025)***

On 10/29/2025, when the Maintenance Director went to add the missing items, [redacted] found that they were already present the first aid kit. We kindly request that this violation be removed.
However, if not, Starting in Decmeber 2025, the Maintenance Director, Executive Director or other member of

171b5 - First Aid Kit (continued)

management will check the van first aid kit monthly to ensure all required items are present and in working order. All staff and management have been provided education on this regulation by the Executive Director on 11/20/2025. Results of these checks will be recorded and maintained and reviewed monthly at the community's Safety Meeting starting December 2025. The monthly QA meeting for December 2025 is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

182c - Medication Administration

17. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

Description of Violation

Staff Member E, who administered medications to Residents [redacted] and [redacted] during dinner on [redacted] did not ensure one of the residents ingested a white, thick, oblong pill. Staff Member C showed the partially disintegrated pill to Staff Member D on the morning of [redacted] and reported to Staff Member D they had found the partially disintegrated pill in a used single dose coffee creamer on the table when cleaning up dinner. During dinner on [redacted] Residents [redacted] and [redacted] were seated at the table that the pill was later found at.

On [redacted] at 12:18 PM, a clear medication cup which staff use to dispense medications was sitting on the bathroom sink of resident room [redacted] The medication cup contained a white cream which was untouched. Resident [redacted] and [redacted] live in resident room [redacted] Resident [redacted] is prescribed a medicated cream routinely, and Resident [redacted] is prescribed a medicated cream as needed.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

On 11/1/2025, all medication technicians were provided education on the "5 rights of medication administration" by the Executive Director. By 12/5/2025, all staff will be provided education by the Executive Director on what to do if medications are found: DCS or ancillary staff should notify the med tech on duty immediately and the med tech should notify the Director of Nursing and/or Executive Director immediately to investigate. Starting at the December 2025 the Director of Nursing will provide training on the "5 Rights of Medication Administration" at the monthly all staff meeting for 6 months. The attendance and meeting agenda of Monthly Staff Meetings will be maintained in the Executive Director's office.

Licensee's Proposed Overall Completion Date: *12/18/2025*

Not Implemented [redacted] - 03/02/2026)

183b - Meds and Syringes Locked

18. Requirements

2600.
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.

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

Description of Violation

On [redacted] a tube of Cortisone cream was unlocked, unattended and accessible in Resident [redacted] bathroom. Resident [redacted] has not been assessed as being able to self-administer medications.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

On 11/29/2025, the cortisone cream was removed from the resident's room. Re-education was provided to the resident that [redacted] may not have medications and/or medicated creams/lotions in [redacted] room without a prescriber's order to self-administer. On 11/13/2025, an email was sent to all Responsible Parties from the Executive Director reminding them not to bring in prescription or OTC items. On 11/20/2025, all staff and managers were educated on this regulation. Beginning 11/20/2025, all members of management will check occupied resident's rooms for prescription and OTC medications daily x 4 weeks and then weekly thereafter. The room check results will be documented and records kept. These checks will be reviewed monthly starting December 2025 at the Monthly Quality Assurance meeting. The December QA meeting is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

184b - Labeling OTC/CAM

19. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted], a tube of Cortisone cream belonging to Resident [redacted] was in Resident [redacted] bathroom and was not labeled with the resident's name.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

On 10/29/2025, the cortisone cream was removed from the resident's room by the Executive Director. On 11/20/2025, all staff and managers were educated on this regulation. Beginning 11/20/2025, all members of management will check occupied resident's rooms for prescription and OTC medications daily x 4 weeks and then weekly thereafter. The room check results will be documented and records kept. These checks will be reviewed monthly starting December 2025 at the Monthly Quality Assurance meeting. The December QA meeting is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

185a - Implement Storage Procedures

20. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 is prescribed blood sugar checks at 7:30 AM/8:00 AM and 4:30 PM. On 10/29/25, the following

185a - Implement Storage Procedures (continued)

discrepancies were observed between the blood sugar reading on the resident's glucometer and the documented blood sugar reading on the resident's Medication Administration Record (MAR):

- *On [redacted] at 8:00 AM, the blood sugar reading documented in the resident's MAR was [redacted]. However, this reading was not in the resident's glucometer.*
- *On [redacted] at 8:00 AM, the blood sugar reading documented in the resident's MAR was [redacted] However, this reading was not in the resident's glucometer.*

Resident [redacted] is prescribed [redacted] to be applied topically as needed for foley and catheter change. However, on [redacted] this gel was not available in the home.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

Upon discovery, the medication needed for the resident's foley catheter changes was ordered from the preferred pharmacy by the Director of Nursing. The medication technicians will continue to complete weekly medication audits (see attached). Starting 11/10/2025, these audits will be reviewed by the Director of Nursing and/or Executive Director weekly. The medication technicians will continue to complete glucometer checks for every shift. Starting 11/10/ 2025, these glucometer checks will be reviewed daily by the Director of Nursing and/or Executive Director. On 11/20/2025, all staff and managers were provided education on this regulation. The medication audits and glucometer check records will be kept in separate binders in the nursing office and reviewed monthly at the Quality Assurance meeting starting December 2025. The December QA meeting is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident [redacted] is prescribed the following medication:

- *[redacted] with orders to take 1 tablet by mouth twice daily.*
- *[redacted] with orders to take 2 by mouth twice daily*
- *[redacted] with orders to take 1 tablet by mouth once daily.*
- *[redacted] with orders to take 1 capsule once daily.*
- *[redacted] with orders to take 1 tablet by mouth at bedtime.*

On [redacted] at 8:00 PM, the resident's [redacted] and [redacted] were not administered to the resident due to the medication not being available in the home.

187d - Follow Prescriber's Orders (continued)

On [redacted] at 8:00 AM, the resident's [redacted] and [redacted] were not administered to the resident due to the medication not being available in the home.

On [redacted] at 8:00 PM, the resident's [redacted] and [redacted] were not administered to the resident due to the medication not being available in the home.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

This resident is no longer living at the community. The Executive Director provided education to all staff and managers regarding this regulation on 11/20/2025. Starting 11/20/2025, the Director of Nursing and/or Executive Director will run a "missed medication" report daily x 4 weeks and then weekly after that, from the electronic medication administration system (Point Click Care). This report will be reviewed daily by the Director of Nursing and/or Executive Director and any issues discovered will be addressed immediately. These reports will be kept in a separate binder in the nursing office. This binder will be reviewed monthly at the Quality Assurance meeting starting December 2025. The December QA meeting is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

190a - Completion Medication Course

22. 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 Member A, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

- *On [redacted] at 12:00 PM [redacted] of insulin to Resident #[redacted].*
- *On [redacted] and [redacted] at 8:00 AM, [redacted], [redacted] and [redacted] to Resident [redacted]*

Staff Member D, who has not successfully completed the Department-approved medication administration course, administered medications to residents to include the following;

- *On [redacted], and [redacted] at 12:00 PM [redacted] to Resident [redacted].*
- *On [redacted] and [redacted] at 9:00 AM [redacted], [redacted], and [redacted] to Resident [redacted]*

Staff Member E, who has not successfully completed the Department-approved medication administration course, administered medications to residents to include the following;

- *On [redacted] and [redacted] at 6:00 PM [redacted] and [redacted] to Resident [redacted].*
- *On [redacted] and [redacted] at 8:00 P [redacted] and [redacted] to Resident [redacted]*

Staff Member F, who has not successfully completed the Department-approved medication administration course, administered medications to residents to include the following:

190a - Completion Medication Course (continued)

- On [redacted] at 12:00 PM [redacted] to Resident [redacted]
- on [redacted] and [redacted] at 8:00 AM [redacted] to Resident [redacted]

Staff Member G, who has not successfully completed the Department-approved medication administration course, administered medications to residents to include the following:

- On [redacted], and [redacted] at 6:00 AM [redacted] to Resident [redacted].
- [redacted] and [redacted] at 8:00 PM [redacted], to Resident [redacted]
- On [redacted], and [redacted] at 8:00 PM [redacted] to Resident [redacted]

Staff Member H, who has not successfully completed the Department-approved medication administration course, administered medications to residents to include the following:

- On [redacted], and [redacted] at 8:00 PM [redacted] and [redacted] to Resident [redacted]
- On at [redacted], and [redacted] at 8:00 PM [redacted] to Resident [redacted]
- On [redacted], and [redacted] at 8:00 PM [redacted] to Resident [redacted]

Plan of Correction ***Accept [redacted] 12/11/2025)***

Upon discovery, the medication technicians in question were re enrolled in the PA Certified Med Tech online program by a certified train the trainer with the completion date of 12/12/2025 for these associates to complete the program. The Executive Director and Director of Nursing were provided education on this regulation by the Regional Director of Operations on 11/13/2025. Additional clarification was received by the BHLS inspector to the Executive Director. The community has a binder to track the med tech qualifications, certifications and observations; it is kept in the Executive Director's office. The Director of Nursing and/or Executive Director will review this binder monthly starting December 1st 2025 to ensure proper documents are obtained. This review will be reviewed monthly at the Quality Assurance Meeting starting December 2025 to ensure compliance. All documentation will be kept. The monthly QA meeting is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

190c - Record of Training

23. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for Staff Member A's 2025 medication administration practicum summary and qualification did not include documentation of the medication administration record review completed in August of 2025.

Staff Member E required additional attempts at the initial medication administration training. However, the date of

190c Record of Training (continued)

the attempts and the items completed to include all tests and practice activities documentation was not kept.

Plan of Correction ***Accept [redacted] - 12/11/2025)***

Upon discovery, the medication technicians in question were re enrolled in the PA Certified Med Tech online program by a certified train the trainer with the completion date to be 12/12/2025. The Executive Director and Director of Nursing were provided education on this regulation by the Regional Director of Operations on 11/13/2025. Additional clarification was received by the BHLS inspector to the Executive Director. The community has a binder to track the med tech qualifications, certifications and observations. The Director of Nursing and/or Executive Director will review this binder monthly starting December 1, 2025 to ensure proper documents are obtained. This review will be reviewed monthly at the Quality Assurance Meeting starting December 2025 to ensure compliance. All documentation will be kept. The monthly QA meeting for December is scheduled for 12/17/2025

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented [redacted] - 03/02/2026)

224a - Preadmission Screen Form

24. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [redacted] preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Repeated Violation [redacted] et al

Plan of Correction ***Accept ([redacted] 12/11/2025)***

The resident no longer lives at the community. By November 30, 2025, an audit of all current resident's pre screen documents will be completed by the Executive Director and/or Administrative Assistant to ensure that the correct documentation is present and that the needs of the residents can be met by the community. Starting December 1, 2025, when a new admission enters the community, the pre screen document will be reviewed by the Director of Nursing and/or Executive Director 24 48 hours prior to admission to ensure completion in its entirety.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented ([redacted] - 03/02/2026)

225c - Additional Assessment

25. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

225c - Additional Assessment *(continued)*

1. Annually.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted] current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted].

Resident [redacted] utilizes an air flow pressure relief mattress. However, the resident's current assessment, dated [redacted] does include the resident utilizes an air flow pressure relief mattress.

Plan of Correction ***Accept [redacted] 12/11/2025)***

The signed 2023 RASP for resident [redacted] was provided to the BHLS inspectors via email on 10/30/2025. It is attached again for your review.
On 10/30/2025, the RASP for resident [redacted] was updated to reflect that [redacted] uses an air flow pressure relief mattress. By 12/10/2025 Director of Nursing will conduct an audit of all resident RASPS for accuracy, to include durable medical equipment. Starting 12/1/2025, any durable medical equipment delivered to the community will be confirmed by the Director of Nursing and/or Executive Director for review/documentation.. All staff and managers have been provided education on this regulation on 11/20/2025. Ancillary providers (Home Health, therapy, hospice, etc) will be provided educated on this procedure by 12/1/2025 by the Executive Director. Documentation will be kept and reviewed monthly at the Quality Assurance meeting starting December 2025. The December QA meeting is scheduled for 12/17/2025.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented ([redacted] - 03/02/2026)

251b - Record Entries Legible

26. 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

Correction fluid was used to alter the number of residents in the home and number of residents evacuated during the [redacted] fire drill; both were altered to now read 40.

Correction tape was used to alter the amount of time of the evacuation for the fire drill held on [redacted]. The altered time now reads 9 minutes and 40 seconds.

251b Record Entries Legible (continued)

Plan of Correction ***Accept[redacted] - 12/11/2025)***

On 10/30/2025, the Executive Director was provided education by the Regional Director of Operations on the proper way to strike out errors and to not use correction fluid for documents. On 11/20/2025, all staff and managers were provided education on this regulation by the Executive Director. Starting December 1, 2025, monthly fire drill records will be updated by the Executive Director and reviewed by the Director of Nursing and/or Maintenance Director to ensure no improper alterations were made. The Medication Technician paperwork will be kept in a separate binder in the Executive Director's office. This binder is scheduled to be reviewed monthly starting December 1st, 2025, starting in December 2025 and the Director of Nursing and/or Executive Director will ensure that no correction fluid has been used, and any errors are properly marked out.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Not Implemented[redacted] 03/02/2026)

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

Facility Information

Name: *CELEBRATION VILLA OF DILLSBURG* **License #**: *33379* **License Expiration**: *01/30/2026*

Address: *153 LOGAN ROAD, DILLSBURG, PA 17019*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *EC OPCO DILLSBURG LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/05/1998* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date**: *01/08/2026*

Inspection Dates and Department Representative

01/06/2026 On Site: [redacted]
01/07/2026 On Site: [redacted]
01/08/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *45*

Secured Dementia Care Unit

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

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *45*

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

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

01/06/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/12/2026*

02/17/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/12/2026*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/24/2026*

03/02/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/24/2026*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

03/04/2026 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *03/02/2026*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

42b - Abuse

2. 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 9:00 AM, Staff Member B observed Staff Member A hit Resident [redacted] arm during breakfast. Staff Member B also observed Staff Member A say the following to Resident [redacted] during the altercation: "you are not a child", "you are not 5 years old", and "you are not going to act like that". As a result of the incident, Staff Member A was terminated.

Repeated Violation - [redacted] et al

Plan of Correction ***Accept ([redacted] - 02/13/2026)***

On 12/12/2025 staff Member A was terminated from their position in the home.
On 2/11/2026, the Executive Director provided members of management, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, with education on this regulation 2600.42b. By 2/27/26, all staff will be provided education on this regulation by the Executive Director. A record of these trainings will be kept in the Executive Directors office in accordance with 2600.65i. An in-service will be provided by the York Couty Area Agency on Aging on "Protective Services, Abuse and Neglect" to all staff on March 19, 2026.
Starting 2/12/26, the Executive Director and/or Director of Nursing will interview 5 residents per week for the next three months to ensure that residents feel safe, secure and know who to speak with if they have any concerns. Interviews will be documented and retained in the Executive Director's office. Any concerns will be addressed immediately. Resident interviews will be reviewed at the Monthly Quality Assurance meeting, starting in February. The February QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *03/19/2026*

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [redacted] at approximately 6:16 PM, Staff Member C took a picture of Resident [redacted] in the hallway. The resident was squatting in the corner with [redacted] pants down. Resident [redacted] was confused and was not aware of the photo being taken. Staff Member C confirmed in a written statement that they had taken a picture of the resident when they found the resident urinating in the corner of the hallway by resident room [redacted] to show other staff members. Staff Member E, F and G confirmed they had been sent the picture of the resident by Staff Member C. As result of the incident, Staff Member C was terminated.

Plan of Correction ***Accept [redacted] - 02/13/2026)***

On 11/24/2025 staff person C's employment at the home was terminated.
On 2/11/26 the Executive Director provided education to the management team, which includes the Director of

42s - Privacy (continued)

Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, on this regulation (2600.42s), this includes (management team). All staff will be provided education on this regulation by the Executive Director by 2/27/2026. A record of these trainings will be kept in accordance with 2600.65i in the Executive Directors office. An in-service will be provided by the York Couty Area Agency on Aging on "Protective Services, Abuse and Neglect" to all staff on March 19, 2026.
Starting 2/12/26, the Executive Director and/or Director of Nursing will interview 5 residents a week for the next three months to ensure that residents feel safe, secure and know who to speak with if they have any concerns. Interviews will be documented and retained in the Executive Director's office. Any resident concerns will be addressed immediately. Resident interviews will be reviewed at the monthly staff meeting, starting in February 2026. The February QA meeting is scheduled for 2/26/2026. Documentation will be kept in the Executive Directors office in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: *03/19/2026*

81a - Accomodation

4. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

Resident [redacted] current medical evaluation, dated [redacted], indicates the resident requires the use of a Hoyer lift for transfers. During an interview with the administrator, Staff Member I, they stated the policy of the legal entity does not allow for the use of Hoyer lifts in the home.

Plan of Correction ***Accept[redacted] - 02/17/2026)***

On 2/11/2026, an updated DME was obtained by the Director of Nursing. This new record has been placed in the resident's electronic and paper chart. The new DME certifies that the resident is a 2-person assist and there is no need or order for the resident needing a hoyer lift.
On 2/11/2026, the Executive Director has provided education to the Director of Nursing and Assistant Director of Nursing on this regulation. All staff will be provided education on this regulation by 2/27/206 by the Executive Director.
ONGOING: Starting 2/11/2026, new admission, annual or significant change medical evaluations will be reviewed by both the Director of Nursing and/or Assistant Director of Nursing and the Executive Director to ensure that the needs of the resident can be met at the community. By 2/26/2026, a review of all current residents' current medical evaluations will be reviewed by the Director of Nursing and/or the Executive Director to ensure compliance with this regulation. Records of this review will be kept in the Executive Director's office as well as reviewed at the February Quality Assurance Meeting which is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 03/04/2026)

82c - Locking Poisonous Materials

5. Requirements

82c Locking Poisonous Materials *(continued)*

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted] at 9:09 AM, there was an unlocked, unattended and accessible housekeeping cart located near the receptionist's desk that contained the following items:

- *A 23 fl oz bottle of Array Glass and Plastic Cleaner. The manufacturer's label read, "Keep out of reach of children. If eye or skin irritation persists, get medical attention."*
- *A 128 fl oz container of Array All-purpose Handwash. The manufacturer's label read, "Keep out of reach of children. If swallowed, consult a physician or poison control center."*

Not all the residents of the home, including Resident [redacted], have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 02/25/2026)***

On 2/10 and 2/11/2026, education was provided by the Executive Director to the housekeeping associates that their cleaning carts must be kept locked and/or cleaning materials should be kept in locked housekeeping rooms when not in use. On 1/8/2026, the Glass cleaner and Hand soap located on the cleaning cart was removed by the Executive Director and placed in the locked housekeeping closet.
Training: On 2/11/2026, Executive Director provided education to the members of management, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, on this regulation. By 2/27/2026, all staff will be provided education on this regulation by the Executive Director. Records of staff training on this regulation will be kept in the Executive Directors office in accordance with 2600.65i
Ongoing: Starting 2/11/2026, Executive Director and/or another member of management will conduct daily checks x 30 days to ensure housekeeping carts are locked and/or they do not contain any materials which would be considered poisonous. Any discrepancies found will be addressed and corrected immediately. A record of these checks will be kept in the Executive Directors office and reviewed at the Monthly Quality Assurance meeting in February 2026. The February QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] 03/04/2026)

103e Left Overs

6. Requirements

2600.
103.e. Food served and returned from an individual’s plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On [redacted] at 10:28 AM, there was an undated box of Banquet sausage patties stored in the freezer of the kitchenette located near room [redacted]

On [redacted] at approximately 11:00 AM, there was an undated 1/2 of a 4 lb. bag of broccoli florets in the standing freezer located in the kitchen. This bag was previously opened.

On [redacted] at approximately 11:00 AM, there was an undated bag of cinnamon raisin bread, an undated bag of

103e Left Overs (continued)

cinnamon raisin bagels, undated butter in a plastic container, undated sugar in a plastic container, and undated flour stored in a plastic container located in the kitchen. These items had been previously opened.

On [redacted] at approximately 11:00 AM, there was an undated gallon jug of Rutter's whole milk and an undated, unlabeled bag of sausage patties located in the walk in refrigerator. These items had been previously opened.

Plan of Correction ***Accept [redacted] - 02/17/2026)***

On 1/5/26 immediately upon discovery, the undated, unlabeled or opened food items identified were disposed of or labeled by the Executive Director. On 1/6/2026, an additional inspection for any additional items in violation of this regulation was conducted by the Director of Culinary Services.
On 2/11/2026, the Executive Director provided education to Management Team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, on this regulation. All Dietary Staff will be provided education on this regulation by the Executive Director by 2/27/2026. A record of this training will be kept in the Executive Director's office in accordance with regulation 2600.65i.
Starting 2/11/2026, The Director of Dining Services will conduct daily inspections for 30 days, then weekly x 4 weeks of opened and previously prepared food items in the kitchen, main dry storage areas, main service areas and kitchen refrigerators and freezers to ensure all opened items are properly labeled and dated. Any infractions will be corrected immediately by the Dining Director. A record of these inspections will be reviewed monthly at the Monthly Quality assurance meeting, starting February 2026. The February QA 2026 meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/04/2026)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted]s initial medical evaluation, dated [redacted] does not include the resident's weight.

Resident #[redacted]'s initial medical evaluation, dated [redacted] does not indicate if the resident's needs could be met safely in a personal care home.

Resident [redacted] initial medical evaluation, dated [redacted] does not include the following: type of the evaluation, height, weight, blood pressure, temperature and pulse rate.

Plan of Correction ***Accept [redacted] - 02/25/2026)***

By 2/13/2026, the DME for resident's #[redacted] and [redacted] will be updated with orders from their PCP (respectively) to correct the required information. Resident [redacted] no longer resides at the community.
On 2/12/2026, the Executive Director provided education to the Management Team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, on this regulation. All staff will be provided education on this regulation by the Executive Director by 2/27/2026. A record of these trainings will be kept in the Executive Directors office in accordance with regulation 2600.65i
By 2/20/2026, a review of all current residents' current medical evaluation will be completed by the Executive Director and/or Administrative Assistant to ensure compliance with this regulation. Any infractions will be sent to either the Director of Nursing and Assistant Director of Nursing for correction. A record of this review will be kept in the Executive Director's office and reviewed at the February Quality Assurance Meeting. This meeting is scheduled for 2/26/2026. Quarterly, starting April 1st, annual Medical Evaluations received from the previous quarter will be reviewed by the Director of Nursing or Assistant Director of Nursing to ensure correct information is provided by the provider. Any discrepancies will be addressed upon discovery.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented[redacted] - 03/04/2026)

183d - Prescription Current

9. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] prescribed for Resident [redacted] was in the home's medication cart; however, this medication was discontinued on [redacted].

Repeated Violation - [redacted], et al

Plan of Correction ***Accept [redacted] 02/17/2026)***

On 1/7/2026, the medication was immediately removed from the medication cart by the Director of Nursing. Education on this regulation was provided to members of Management team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, by the Executive Director on 2/11/2026. All licensed and medication technician staff will be provided education on this regulation by the Executive Director by 2/13/2026. A record of these educations will be kept in the Executive Directors office in accordant with regulation 2600.65i
From the electronic EMAR system, The Director of Nursing and/or Assistant Director of Nursing will check for discontinued items weekly x 8 weeks and complete a cart inspection to ensure that discontinued medications are removed from the cart immediately. This report and the subsequent action documentation will be kept in the Medication Room. This review will be reviewed at the Monthly Quality Assurance Meeting starting in February 2026. The February QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented[redacted] - 03/04/2026)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] is prescribed blood glucose checks twice daily at 8:00 AM and 8:00 PM. On [redacted] at 8:00 PM, the reading in the resident's glucometer was [redacted] However, the documented reading on the resident's January 2026 medication administration record was [redacted]

Plan of Correction ***Accept [redacted] - 02/17/2026)***

On 1/ 9/2026, the Executive Director provided education to medication technicians on duty staff, the Director of Nursing and Assistant Director of Nursing on this regulation, the initial possible violation and the importance of accurate data entry
On 2/11/2026, all members of management, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, have been provided education on this regulation by the Executive Director. By 2/13/2026, all licensed staff and certified medication technicians will be re-educated on this regulation. Licensed staff and med tech staff will also be provided education on the importance of entering the correct values when inputting resident information. A record of this training will be kept in the Executive Directors office in accordance with regulation 2600.65i
Starting 2/11/2026, the Director of Nursing or Assistant Director of Nursing will complete weekly reviews x 8 weeks

185a Implement Storage Procedures (continued)

of the "Blood Glucose Binder" which has been previously implemented at the community. Any discrepancies will be addressed immediately. This binder and the review audits will be kept in the Medication Room. Documentation of these weekly reviews will be reviewed at the Monthly Quality Assurance meeting starting February 2026. The February QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 03/04/2026)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [redacted] is prescribed [redacted] with orders to give 4 mg by mouth every 12 hours as needed for diarrhea and subsequent loose stools administer after each loose stool. However, Resident [redacted] January 2026 medication administration record does not include this medication.

Repeated Violation [redacted], et al

Plan of Correction ***Accept [redacted] - 02/17/2026)***

On 1/9/2026, the Director of Nursing reviewed the resident's medication orders against [redacted] electronic MAR to check for any discrepancies. No other issues were discovered.
On 2/11/2026, the Executive Director provided education to the Director of Nursing and Assistant Director of Nursing on this violation. Records of this education will be kept in the Executive Directors office in accordance with regulation 2600.65i
Beginning 2/16/2026, a review all current resident orders, 5 residents per week for 9 weeks, will be conducted by the Director of Nursing and/or Assistant Director of Nursing to ensure all prescribed medications are present on the MAR. Any discrepancies will be addressed immediately. A record of these reviews will be kept in the Medication Room in accordance with regulation 2600.65i. These reviews will be reviewed monthly at the monthly Quality Assurance meeting starting in February 2026. The February QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 03/04/2026)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident [redacted] is prescribed the following medication: [redacted] with orders to take 1 tablet by mouth at bedtime, [redacted] with orders to take 1 tablet by mouth every 12 hours, and [redacted] with orders to take 1 capsule by mouth at bedtime. These medications were documented as being held on [redacted] and [redacted]. However, there was no order for holding these medications. An order for holding these medications if the resident is sleeping was prescribed on [redacted]

Resident [redacted] is prescribed to have weight checked once a month. However, the resident's weight was not taken during the month of December 2025.

Plan of Correction ***Accept [redacted] - 02/17/2026)***

Resident [redacted] no longer resides in the community. The monthly weight for resident [redacted] was obtained and documented on 1/15/2026.
On 2/11/2026, the Executive Director provided education to the Management Team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, on this regulation. By 2/20/2026, education will be provided to the licensed staff and medication technicians on this regulation by the Executive Director. This training will also include specifically that medications cannot be held without a prescriber's order.
Starting 1/13/2026, The Director of Nursing and/or Assistant Director of Nursing run a report for the previous week, from the electronic medication administration system to check for missed medications. Starting 2/16/2026, in addition to the weekly missed medication report, the Director of Nursing and/or Assistant Director of Nursing will review resident's EMAR for medications there were held to ensure proper orders are in place. Any necessary corrective action will be taken immediately. Results of these findings will be kept in the Medication Room. These results will be reviewed at the Monthly Quality Assurance Meeting starting February 2026. The February QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 03/04/2026)

190a - Completion Medication Course

13. 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 Member H, who has not successfully completed the Department-approved medications administration course as evidenced by the course test total of 86.7/100, administered medications to residents including the following:

- *On [redacted], and [redacted] at 8:00 AM and 12:00 PM to Resident [redacted], including [redacted] and [redacted]*
- *On [redacted], and [redacted] at 8:00 AM and 12:00 PM, to Resident [redacted], including [redacted],*

190a - Completion Medication Course (continued)

[redacted] and [redacted].

Plan of Correction ***Accept[redacted] - 02/17/2026)***

The home respectfully requests to withdraw this violation from the report. Staff person H completed training and received an initial score of 88.21. The staff member was remediated and completed the required quizzes on 11/19/2025 and received a final score of 93.02. Staff person H successfully completed the course within the last 2 years. Staff person H's training was in compliance with 2600.190a. If not, below is the Proposed POC for this violation:
On 1/9/2026, the Executive Director reviewed the documents for all certified medication technicians, which is kept in a binder in the Executive Director's office, to ensure compliance with this regulation.
On 2/11/2025, the Regional Director of Operations provided education to the Executive Director on this regulation.
On 2/11/2026, the Executive Director provided education on this regulation to the Management Team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator on this regulation. A record of this education will be kept in the Executive Director's office in accordance with regulation 2600.65i.
Effective 2/16/2026, the Executive Director will review the documents for all current certified medication technicians monthly x 6 months to ensure that all documents and observations are current and accurate in accordance with this regulation. A record of this review will be kept in the Executive Directors office. This record will also be reviewed at the monthly Quality Assurance meeting starting February 2026. The February QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented[redacted] 03/04/2026)

190b - Insulin Injections

14. 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 Member H, who has not successfully completed the Department-approved medications administration course as evidenced by the course test total of 86.7/100, administered insulin to residents including the following:

- *On [redacted], and [redacted] to Resident [redacted]*
- *On [redacted] and [redacted] at 8:00 AM to Resident [redacted]*

Plan of Correction ***Accept[redacted] - 02/17/2026)***

The home respectfully requests to withdraw this violation from the report. Staff person H 's diabetic certification was provided to the inspectors and is current and valid until 2/25/26. Staff person H is scheduled to be re-certified on 2/16/26. If not, below is the proposed POC for this violation:

190b - Insulin Injections (continued)

On 2/10/2026, the Executive Director reviewed the diabetic certification for all current medication technicians to ensure compliance with this regulation. No discrepancies were discovered.
On 2/11/2026, The Executive Director provided education to the Management Team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator. A record of this education will be kept in the Executive Director's office in accordance with regulation 2600.65i.
Starting 2/16/2026, the Executive Director will review the records for all current medication technician associates to ensure their Diabetic Certifications are current and valid. Any discrepancies will be addressed immediately. a record of this review will be kept in the Executive Director's office and reviewed monthly at the Monthly Quality Assurance Meeting starting February 2026. The February 2026 QA meeting is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 03/04/2026)

190c - Record of Training

15. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for Staff Member I does not include the original qualification date on Staff Member I's 2024 Annual Practicum form. The completion date and date trainer signed the form was on [redacted]. There is only one medication administration record review and one medication administration observation listed on the form. However, additional pages show two medication administration record reviews and two medication administration observations were all completed on [redacted].

Plan of Correction ***Accept [redacted] - 02/25/2026)***

On 1/9/2026, the medication technician training records for all current medication technicians were reviewed by the Executive Director. No additional discrepancies were found.
On 2/11/2026, the Executive Director provided educated the Director of Nursing and Assistant Director of Nursing on regulation 2600.190a. A record of this education will be kept in the Executive Directors office in accordance with regulation 2600.65i
By 2/27/2026 a review will be completed by the Executive Director and/or Administrative Assistant to ensure valid, current medication administration training certifications are present. These records will also be reviewed monthly by the Executive Director and/or Administrative Assistant to ensure compliance with this regulation. These certifications are kept in a binder in the Executive Director's office. This review will be kept on file in the Executive Director's office and reviewed monthly at the monthly Quality Assurance meeting starting February 2026. The February QA meeting is scheduled for 2/26/2026. Starting in April 2026, the Medication Technician binder will be reviewed quarterly by the Executive Director and/or Administrative Assistant to ensure necessary observations are completed and documented properly. Any discrepancies will be addressed immediately.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] 03/04/2026)

224a - Preadmission Screen Form

16. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [redacted] preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident [redacted] preadmission screening form, dated [redacted], does not include the resident's date of birth.

Repeated Violation - [redacted], et al

Plan of Correction ***Accept [redacted] 02/17/2026)***

On 1/9/2026, the Executive Director reviewed both preadmission screenings and provided updated forms with tie-back tools for their charts.
On 2/11/2026, the Executive Director provided education to the Management Team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, on this regulation. All staff will be provided education on this regulation by the Executive Director by 2/27/2026. A record of these trainings will be kept in the Executive Director's office in accordance with regulation 2600.65i
By 2/26/2027, a review of all current resident's Preadmission screen forms will be conducted by the Executive Director and/or Administrative Assistant to ensure the resident's needs can be met by the services provided by the home and there is no missing required information on the department approved form. Starting 2/16/2026, new residents admitting to the home will have their Preadmission Screen Form reviewed by both the Executive Director and Director of Nursing/Assistant Director of Nursing to ensure compliance. Any discrepancies will be addressed immediately. A record of this review will be kept in the Executive Director's office and reviewed at the February monthly Quality Assurance Meeting which is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/04/2026)

225c - Additional Assessment

17. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident [redacted] current assessment, dated [redacted] does not include behavioral and cognitive needs.

Plan of Correction ***Accept [redacted] - 02/25/2026)***

Resident # [redacted] has been discharged from the community on 1/9/2026. By 1/31/2026, the Director of Nursing and/or Assistant Director of Nursing will review all current resident assessments to confirm compliance with 2600.225c. All current residents have completed assessments. Documentation of this review is kept in the Executive Director's office. The Director of Nursing and the Assistant Director of Nursing are responsible for ensuring the assessments are updated accurately and completely. On 2/11/2026, the Director of Nursing and Assistant Director of Nursing were

225c - Additional Assessment (continued)

provided educated on regulation 2600.225c by the Executive Director. A record of this training will be kept in accordance with regulation 2600.65i.
Beginning 2/16/2026, the Director of Nursing and/or Assistant Director of Nursing will monitor compliance by conducting monthly reviews on all new assessments completed for that month to ensure all sections are completed fully and accurately. On 2/10/2026, a new tracking system was implemented by the Director of Nursing and Assistant Director of Nursing to ensure timely completion of annual assessments. The Executive Director will monitor compliance by conducting 10 reviews monthly of resident assessments to ensure all sections are completed. These reviews will be documented and records will be kept in the Executive Directors office in accordance with regulation 2600.65i. The results of these inspections will be reviewed monthly at the monthly Quality Assurance meeting, starting in February 2026. The Monthly QA meeting for February is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented ([redacted] - 03/04/2026)

251b - Record Entries Legible

19. 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

Correction fluid was used on Resident [redacted] preadmission screening form, dated [redacted], on section I-E, the date the screening was completed.

Plan of Correction ***Accept [redacted] - 02/17/2026)***

On 1/9/2026, the Executive Director was provided education by the Regional Director of Operations on the proper procedure to make corrections or mark out information as needed.
On 2/11/2026, the Executive Director provided education to the Management Team, which includes the Director of Nursing, Assistant Director of Nursing, Dietary Director, Administrative Assistant, and Life Enrichment Coordinator, on regulation 2600.251b. All staff will be provided education on this regulation by the Executive Director by 2/27/2026. A record of these trainings will be kept in the Executive Directors office in accordance with regulation 2600.65i
By 2/26/2027, a review of all current resident's Preadmission screen forms will be conducted by the Executive Director and/or Administrative Assistant to ensure there is no correction fluid present. Starting 2/16/2026, new residents admitting to the home will have their Preadmission Screen Form reviewed by both the Executive Director and Director of Nursing/Assistant Director of Nursing to ensure compliance. Any discrepancies will be addressed immediately. A record of this review will be kept in the Executive Director's office and reviewed at the February monthly Quality Assurance Meeting which is scheduled for 2/26/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 03/04/2026)