pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

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

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

Located at **2405 KNOB HILL ROAD, YORK, PA 17403**
(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 **75**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

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 28,** **2026** until **January 28,** **2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **334980**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

EMAILING DATE: JANUARY 28, 2026

Christian N. Cummings-President
EC OPCO York LLC
500 N. Hurstbourne Parkway, Suite 200
Louisville, Kentucky 40222

RE: Celebration Villa of York
2405 Knob Hill Road
York, Pennsylvania 17403
License #: 334980

Dear Mr. Cummings:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 29, 2025, of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-Term Living

Enclosure
<Licensing Inspection Summary>

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

January 23, 2026

[redacted]
EC OPCO YORK LLC
[redacted]
C/O ECLIPSE SR LIVING;LICENSING
[redacted]

RE: CELEBRATION VILLA OF YORK
2405 KNOB HILL ROAD
YORK, PA, 17403
LICENSE/COC#: 33498

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/29/2025, 10/29/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CELEBRATION VILLA OF YORK* **License #**: *33498* **License Expiration**: *01/18/2026*

Address: *2405 KNOB HILL ROAD, YORK, PA 17403*

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

Administrator

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

Legal Entity

Name: *EC OPCO YORK LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/16/2011* **Issued By**: *York Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/30/2025*

Inspection Dates and Department Representative

10/29/2025 - On-Site: [redacted]

10/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *52*

Secured Dementia Care Unit

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

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *52*

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

Have Mobility Need: *8* **Have Physical Disability**: *2*

Inspections / Reviews

10/29/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/28/2025*

12/09/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/22/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/19/2025*

Inspections / Reviews *(continued)*

01/23/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/22/2026*

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

The resident-home contract for resident [redacted] dated [redacted], was not signed by the resident until [redacted]

Plan of Correction ***Accept [redacted] - 12/09/2025)***

A Tieback audit finding tool was added to resident [redacted] contract and for those contracts not signed within 24 hours. From 11/4/2025 to 11/5/2025, a review of all current resident contracts was completed by the Operations Specialist to ensure each was signed and dated correctly by the residents. Any missing or improperly dated signatures were corrected immediately, with documentation kept.

On 10/31/2025, the Executive Director was trained on regulation 2600.25b by the Operations Specialist. Training record documentation will be kept in accordance with regulation 2600.65i.

Beginning 11/1/2025, new resident contracts will be reviewed by the Executive Director and a move in checklist form used to verify that all needed signatures are completed timely, with documentation kept. An overview of the checklist findings will be reviewed with the leadership team at monthly Quality Assurance meetings starting on 11/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented [redacted] - 01/23/2026)

54a - Direct Care Staff

2. 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

Direct care staff member B does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted] - 12/09/2025)***

Staff member B is no longer employed at the community and resigned on 10/27/2025. On 11/4/2025, the Operation Specialist completed an audit on training requirements for all caregivers to ensure they had High School Diploma's or active registry status on the PA nurse aid registry.

On 11/4/2025, the Operation Specialist provided training on 2600.54a to the Executive Director. Training record will be kept in accordance with regulation 2600.65i.

Beginning 11/1/2025, the Executive Director will use a new hire checklist for all new hires and placed in their employee files to ensure all documentation is present and compliant. No new hires will be allowed to start working in the community until all required documentation is received. An overview of the checklist will be reviewed with the leadership team at the monthly Quality Assurance meetings beginning on 11/25/25. Quality Assurance meeting documentation will be kept.

54a Direct Care Staff *(continued)*

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented [redacted] - 01/23/2026)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff member A, whose first day of work was [redacted], did not receive orientation on the following topics:

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.

4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

Plan of Correction ***Accept [redacted] 12/09/2025)***

On 10/31/2025, staff member A resigned from their position prior to signing off on [redacted] training requirements. On 11/4/2025, the Operation Specialist completed an audit on training requirements for all team members to ensure they had received their first 40 hour and first day required trainings with documentation kept. On 11/4/2025, the Operation Specialist provided training on regulation 2600.65a to the Executive Director. Training record will be kept in accordance with regulation 2600.65i. Beginning 11/1/2025, the Executive Director will use a new hire checklist for all new hires and place the new hire checklist in the employee files to ensure all required training within the first day and first 40 hours is met. Documentation will be kept. An overview of the findings will be reviewed with the leadership team at monthly Quality Assurance meetings starting 11/25/25. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/23/2026)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff member A, whose first day of work was [redacted], did not complete training in the following topics:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions

Plan of Correction ***Accept[redacted] 12/09/2025)***

On 10/31/2025, staff member A resigned from their position prior to signing off on [redacted] training requirements. On 11/4/2025, the Operation Specialist completed an audit on training requirements for all team members to ensure they had received their first 40 hour and first day required trainings with documentation kept. On 11/4/2025, the Operation Specialist provided training on regulation 2600.65b to the Executive Director. Training record will be kept in accordance with regulation 2600.65i. 11/1/2025, the Executive Director will use a new hire checklist for all new hires and place the new hire checklist in the employee files to ensure all required training within the first day and first 40 hours is met. Documentation will be kept. An overview of the findings will be reviewed with the leadership team at monthly Quality Assurance meetings starting 11/25/25. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented [redacted] - 01/23/2026)

125b - Combustible Restrictions

5. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On [redacted] a portable gas grill with 2 propane tanks attached under the grill in the cabinet base was observed in the home's courtyard unlocked, unattended, and accessible to resident(s).

Plan of Correction ***Accept ([redacted] - 12/09/2025)***

On 10/30/2025, the Executive Director removed the propane tank from the grill in the courtyard and placed it in a safe area. A gun lock was purchased on 10/31/2025 and placed on the propane tank when it arrived on 11/3/2025. The keys to the lock were provided to the Executive Director and Maintenance Director by the Operations Specialist

125b - Combustible Restrictions (continued)

On 11/4/2025, Operations Specialist provided training on 2600.125b to the Maintenance Director and Executive Director. Training records will be kept in accordance with regulation 2600.65i.
Beginning 11/1/2025, the maintenance director will complete safety rounds for combustible materials in community daily for 3 weeks and then monthly with documentation kept. The safety audits will be reviewed with the leadership team at the monthly Quality Assurance meetings starting on 11/25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented [redacted] - 01/23/2026)

141b1 - Annual Medical Evaluation

6. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]

Plan of Correction ***Accept [redacted] - 12/09/2025)***

After the inspection, on 10/31/2025 the ED located the most recent Annual Medical Evaluation in the electronic health record under the resident's profile which was signed by the physician and dated 9/11/25.
On 10/31/2025the Operations Specialist provided training on regulation 2600.141b1 to the Resident Care Coordinator and the Executive Director. Training record documentation will be kept in accordance with regulation 2600.65i. Beginning 11/1/2025, the Annual Medical Evaluation completion will be monitored monthly at the Quality Assurance meetings starting on 11/25/25 by the Executive Director and Director of Nursing to monitor trends, identify concerns, and ensure sustained compliance. Audit documentation will be kept. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented ([redacted] - 01/23/2026)

185a - Implement Storage Procedures

7. 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 [redacted] once daily:

- *On [redacted] this medication was not administered. The progress notes report "refill requested" as the reason for not administering this medication.*

Resident [redacted] is prescribed [redacted] 2 tablets daily, 3 times daily.

- *On [redacted] at 6:00 AM this medication was not administered and the Medication Administration Record (MAR) recorded "Not Available" as per the MAR chart codes.*

185a - Implement Storage Procedures (continued)

Resident [redacted] is prescribed blood sugar check once daily:

- *On [redacted] the glucometer was found to be incorrectly calibrated to the correct day and time.*
- *On the following dates the blood sugar measurements were not administered and the MAR recorded "Not Available" as per the MAR chart codes.*

-From [redacted] to [redacted] MAR reports "NA"
-On [redacted] MAR reports "NA"
-On [redacted] and [redacted] MAR reports "NA"
-From [redacted] to [redacted] MAR reports "NA"
-On [redacted] MAR reports "NA"

Resident [redacted] is prescribed [redacted] MG, 1 tablet 2 times daily.

- *On [redacted] at 6:00 AM this medication was not administered and the MAR recorded "Not Available" as per the MAR chart codes.*

Resident [redacted] is prescribed [redacted], 1 tablet daily.

- *On [redacted] at 6:00 AM this medication was not administered and the MAR recorded "Not Available" as per the MAR chart codes.*

Resident [redacted] is prescribed [redacted] apply 1 patch topically to affected area every morning, remove at bedtime. The following dates and times this medication was not administered and the MAR recorded "Not Available" as per the MAR chart codes.

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Resident [redacted] is presribed [redacted] 1 capsule daily at 6:00 AM

- *On [redacted] this medication was not administered and the MAR recorded "Not Available" as per the MAR chart codes.*

Resident [redacted] is prescribed [redacted] every 48 hours as needed.

- *On [redacted] this medication was not available at the home.*

Resident [redacted] is prescribed [redacted] 1 tab every 6 hours.

- *On [redacted] this medication was not administered and reported on the progress notes that this medication needs script".*

185a - Implement Storage Procedures (continued)

Repeated violation - [redacted], et all, [redacted], et al.

Plan of Correction ***Accept [redacted] - 12/09/2025)***

On 10/30/2025, the medication technician reordered resident [redacted] Milk of Magnesia from the community pharmacy, the medication was received on 10/31/2025. On 10/31/2025, the Operations Specialist calibrated Resident [redacted] glucometer. On 11/3/2025, Operations Specialist held a medication technician training to review regulation 2600.185a in specific regard to glucometer calibration and reordering of necessary medications. Training records will be kept in accordance with regulation 2600.65i. Beginning 11/1/2025, medication technicians will complete a refill list daily of needed medications and provide the documentation to the Director of Nursing and Resident Care Coordinator to ensure medications are being reordered. Beginning 11/1/2025, Resident Care Coordinator will complete monthly calibration on resident glucometers, with documentation kept. The executive director will review the glucometer calibration and audit findings with the leadership team at monthly Quality Assurance meetings starting on 11/ 25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented [redacted] - 01/23/2026)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident [redacted] is prescribed blood glucose check twice daily. The following measurements were not administered or recorded:

- *On [redacted] at 6:00 AM the blood sugar measurement was not recorded on the MAR*
- *On [redacted] at 5:04 PM the resident's glucometer recorded a measurement of [redacted] however the resident MAR did not record this measurement.*
- *During the month of October 2025, only the blood glucose measurement on [redacted] at 5:04 PM was recorded on resident [redacted] s glucometer. No other glucometer or measurements were found for the prescribed 4:00 PM blood sugar checks.*

Resident [redacted] is prescribed [redacted] once daily:

- *On [redacted] at 8:00 this medication was not administered. The MAR states to see progress notes. The progress notes do not give reasoning for the missed medication.*

Resident [redacted] was prescribed [redacted], 1 capsule 2 times daily for 7 days from [redacted] to [redacted].

187d - Follow Prescriber's Orders (continued)

- *On [redacted] the resident MAR was found to have recorded all of this medication as being administered during the prescribed time period of [redacted] through [redacted]. However, on [redacted], 2 capsules were observed in the blister pack cards which had not been administered.*

Resident [redacted] was prescribed [redacted] twice daily which began on [redacted]

- *On [redacted], the prescription was changed to 1 MG, one time daily for 5 days, then resume previous dose of 1 MG twice daily after 5 days.*
- *On [redacted], the home was found to be providing the standard dosage of 1 MG twice daily and also administering 1 MG one time daily.*
- *As recorded on the resident MAR, resident [redacted] had been given 1 MG twice and 1 MG once for a total of 3 MG on [redacted] and [redacted], instead of the prescribed 1 MG.*

Repeated violation - [redacted], et all, [redacted], et al.

Plan of Correction ***Accept [redacted] - 12/09/2025)***

On 11/3/2025, Operations Specialist completed training and education to Medication Technicians pertaining to regulation 2600.187d with documentation kept in accordance with regulation 2600.187d. Documentation kept. in accordance with regulation 2600.65i. Beginning 11/1/2025, Director of Nursing and Resident Care Coordinator will conduct MAR to Cart audits weekly to ensure there are no missed doses, and all medications are being administered as prescribed by the prescriber in accordance with 2600.187a.
The executive director will review the audit findings with the leadership team at monthly Quality Assurance meetings starting on 11/ 25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented ([redacted] - 01/23/2026)

227d - Support Plan Medical/Dental

9. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The medical evaluation for resident [redacted] dated [redacted], indicates that the resident has a need for [redacted] The resident's support plan dated [redacted] does not document how this need will be met.

Repeated violation - [redacted] et al.

227d - Support Plan Medical/Dental *(continued)*

Plan of Correction ***Accept [redacted] - 12/09/2025)***

On 10/31/2025, the Operation Specialist corrected resident [redacted] Rasp to include the diagnosis of [redacted]. On 11/4/2025, the Operation Specialist provided training on regulation 2600.227e to the Executive Director and Resident Care Coordinator. Training records will be kept in accordance with regulation 2600.65i
Beginning 11/1/2025, the Executive Director will review all newly completed RASPs for completion and sign each RASP in designated area when in agreement with all documented diagnoses on the support plan within 15 days of admission. Beginning 11/1/2025, RASP completion will be reviewed by the Executive Director and Director of Nursing with the leadership team at monthly Quality Assurance meetings starting on 11/25 /25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented [redacted] - 01/23/2026)

227e - Self Administer Medication

10. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident [redacted] assessment, dated [redacted] does not address the resident's ability to self-administer medications.

Plan of Correction ***Accept ([redacted] - 12/09/2025)***

On 10/31/2025, the Operations Specialist reviewed Resident [redacted]s RASP and added the resident's ability to self-administer medication to the resident's RASP.
On 11/4/2025, the Operation Specialist provided training to the Resident Care Coordinator and the Executive Director on regulation 2600.227e in regard to ensuring accurate and detailed information is included on resident support plans with documentation kept. Training records will be kept in accordance with regulation 2600. Beginning 11/1/2025, the Executive Director will review all newly completed RASPs within 72 hours of completion and sign each RASP in designated area when in agreement with all documented care on the support plan. Beginning 11/1/2025, RASP completion and compliance will be reviewed by the Executive Director and Director of Nursing with the leadership team at monthly Quality Assurance meetings starting on11/ 25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *01/05/2026*

Implemented [redacted] - 01/23/2026)

Department of Human Services
Bureau of Human Service Licensing
PRIVACY CODING

Facility Information

Name: *CELEBRATION VILLA OF YORK* **License #**: *33498* **License Expiration**: *01/18/2026*
Address: [redacted]

Inspection Information

Start Date: *10/29/2025* **Type**: *Full*

Staff Privacy Coding

Designation	Staff Members Name	Job Title	Date Hired
Staff Member A	[redacted]	*Director of Nursing*	*09/08/2025*
Staff Member B		*Aide*	*08/15/2025*

Resident Privacy Coding

Designation	Resident's Name
Resident 1	[redacted]
Resident 2	
Resident 3	
Resident 4	
Resident 5	
Resident 6	