

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

January 7, 2025

[REDACTED]
EC OPCO MID VALLEY LLC

[REDACTED]
ECLIPSE SR LIV ATTN LICENSING
[REDACTED]

RE: CELEBRATION VILLA OF MID VALLEY
67 STURGES ROAD
PECKVILLE, PA, 18452
LICENSE/COC#: 22718

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/29/2024, 11/06/2024, 11/08/2024 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 MID VALLEY License #: 22718 License Expiration: 07/11/2025
 Address: 67 STURGES ROAD, PECKVILLE, PA 18452
 County: LACKAWANNA Region: NORTHEAST

Administrator

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

Legal Entity

Name: EC OPCO MID VALLEY LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 12/27/2010 Issued By: L & I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 58 Waking Staff: 44

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint, Incident Exit Conference Date: 11/08/2024

Inspection Dates and Department Representative

10/29/2024 - On-Site: [REDACTED]
 11/06/2024 - Off-Site: [REDACTED]
 11/08/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 50 Residents Served: 29
 Secured Dementia Care Unit
 In Home: Yes Area: whole home Capacity: 50 Residents Served: 29
 Hospice
 Current Residents: 1
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 29
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 29 Have Physical Disability: 0

Inspections / Reviews

10/29/2024 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/13/2024

Inspections / Reviews *(continued)*

12/18/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/02/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 01/02/2025

01/07/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/02/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident [REDACTED], Resident [REDACTED], and Resident [REDACTED], all have a diagnosis of [REDACTED] and reside in a secure [REDACTED] care unit. Resident [REDACTED] was admitted to the home on [REDACTED]. Staff regularly documented the resident's aggressive behaviors and agitation. The resident often yelled and banged their hand on doors, walls, and windows. Staff Member A stated that, on a few occasions, Resident [REDACTED] had attempted to strike them with various objects. On the morning of [REDACTED], Resident [REDACTED] exhibited signs of aggression, leading to an altercation where they slapped Resident [REDACTED] across the face, who retaliated in kind. At approximately 7am, Resident [REDACTED] met Resident [REDACTED] and Resident [REDACTED] near the Activity Room, out of staff's sight. Staff heard commotion and loud thud, approached the residents, and witnessed Resident [REDACTED] on the floor. Resident [REDACTED] was standing over Resident [REDACTED] yelling. Resident [REDACTED] was sent to the hospital and determined to have a right femoral fracture, requiring surgery.

Repeat Violation [REDACTED]

Plan of Correction

Accept ([REDACTED] - 12/18/2024)

[REDACTED] Resident [REDACTED] was encouraged to a safe area by a caregiver while Resident [REDACTED] and [REDACTED] were cared for. Resident [REDACTED] was sent to ER for a change in mental status. Resident [REDACTED] was sent to ER due to a fall and Resident [REDACTED] was encouraged to an alternate area away from Resident [REDACTED] by Resident Assistant no injury to Resident [REDACTED]. Resident [REDACTED] was admitted to the hospital and did not return to the community as behaviors were not controllable. Staff will be trained by [REDACTED] to be aware of the resident's behaviors which may be an indicator of the start of aggressive behaviors. The DON will monitor for effectiveness of medication and behaviors of residents who display aggressive behaviors. Staff will be reminded to look for techniques to de-escalate residents with aggressive behaviors. Med Techs were trained on when to initiate 15-minute checks on residents who are displaying aggressive behaviors. Any resident who consistently exhibits aggressive behaviors will be referred to a physician for possible psych evaluation. Executive Director, Director of Nursing and Resident Care Coordinator will monitor this area. Resident behaviors/monitoring will be discussed with the Leadership Team in monthly Quality Assurance Meetings beginning in December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [REDACTED] 01/07/2025)

82c - Locking Poisonous Materials

2. Requirements

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

The home serves residents who are unsafe to be around poisonous materials. During 10/29/2024 onsite inspection, an unlocked public bathroom near the Cove, contained an unlocked housekeeping cart holding various chemicals, including Viking Pure Cleaner, Viking Pure Disinfectant, and Ecolab Bio-Enzymatic Odor Eliminator.

82c - Locking Poisonous Materials (continued)

Plan of Correction

Accept [REDACTED] - 12/18/2024)

On [REDACTED] Ecolab Bio-Enzymatic Odor Eliminator was removed from the housekeeping cart immediately by the Executive Director Housekeeping staff re-inserviced on 11/01/2024 regulation 2600.82c by the Executive Director and on the importance of ensuring all poisonous materials are safely stored at all times. Housekeeping cart Audits to be done by leadership team weekly to ensure compliance began 11/01/24. This area will be reviewed by the Leadership Team at monthly Quality Assurance meetings beginning in December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented ([REDACTED] 01/07/2025)

91 - Telephone Numbers

3. 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

The landline telephone in the kitchenette near the Cove did not have the required emergency phone numbers posted on or near the phone.

Repeat Violation 8/29/23

Plan of Correction

Accept [REDACTED] - 12/18/2024)

10/29/2024 the Emergency Telephone number list was replaced immediately by Executive Director to phone at Kitchenette.

All Staff will be educated on Regulation 2600.91 by Executive Director by 12/30/2024. A member of leadership will monitor daily for compliance by walking the community beginning 12/31/2024 Executive Director placed number list permanently to phones in 2 places to ensure if one was removed there would be an alternate available for viewing. This area will be reviewed with the leadership team monthly beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented ([REDACTED] - 01/07/2025)

92 - Windows

4. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

The first window screen located in the dining room of the home had a cracked frame and the screen was visibly broken.

Plan of Correction

Accept [REDACTED] - 12/18/2024)

11/1/24 screen was fixed and replaced by Maintenance Director. All Staff will be educated on regulation 2600.92 by 12/31/24. Maintenance Director to inspect the condition of screens on a monthly basis beginning December 2024.

92 Windows (continued)

This area will be discussed by leadership team at monthly Quality Assurance meetings beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [redacted] - 01/07/2025)

103f - Refrigerator/Freezer Temps

5. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The refrigerator and freezer in the kitchenette near the Cove, did not have a thermometer.

Plan of Correction

Accept [redacted] - 12/18/2024)

On 9/29/24 the Executive Director located the thermometer in a resident's room and immediately returned it to the refrigerator in kitchenette. On 9/29/24 the Executive Director used a zip tie to eliminate removal of the thermometer. All refrigerators and freezers were checked by Leadership team the to ensure each had a thermometer. 12/1/24 the Leadership team was educated by the on 2600.103f and will monitor the refrigerator daily to ensure thermometer is present. This area will be discussed by the leadership team at Quality Assurance meetings monthly beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [redacted] - 01/07/2025)

131f - Fire Extinguisher Inspection

6. Requirements

2600.

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

Description of Violation

The home's fire extinguisher located in the hallway near the kitchenette did not have a tag on it to note when it was inspected.

Plan of Correction

Accept [redacted] - 12/18/2024)

Resident Care Coordinator witnessed resident tearing the tag off on 9/28/24 and immediately placed call to Cintas Fire to replace the tag. Tag replaced 9/30/24 Cintas. Staff are trained in regulation 2600.131f by evidence of reporting tag removal to Executive Director. Extinguishers are inspected by a member of the leadership team weekly to ensure all are present and inspected. Findings will be discussed at Quality Assurance meetings with leadership team monthly beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [redacted] - 01/07/2025)

132c - Fire Drill Records

7. Requirements

2600.

132c - Fire Drill Records (continued)

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

Description of Violation

The home's fire drill log for the fire drill conducted on [REDACTED] does not list the fire drill time in minutes and seconds. The log notes the time of day the fire drill was conducted instead of the exact time it took to complete the fire drill. Supplementary documentation provide only lists the start and stop time for the fire drill in whole minute increments which does not reflect the actual time for the fire drill to be completed.

Plan of Correction

Accept [REDACTED] - 12/18/2024)

The Fire Drill log updated by the Executive Director to include Date, Time, Amount of time to evacuate, exit route, #residents in home, # residents evacuated, # of staff participating for 12/31/24. The Maintenance Director who completed the logs incorrectly is no longer employed. New Maintenance Director will be educated on regulation 2600.132c. Maintenance Director and Executive Director to monitor for compliance. This area will be reviewed with leadership team at monthly Quality Assurance meetings beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [REDACTED] - 01/07/2025)

132d - Evacuation

8. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home has a maximum evacuation time of 6 minutes as determined by a fire safety expert. The home conducted a fire drill on [REDACTED] that was noted as starting at 6:02am and ending at 6:15am which exceeded the predetermined evacuation time.

Plan of Correction

Accept [REDACTED] - 12/18/2024)

On 12/13/24 the Leadership team was in serviced on the evacuation time which is required by fire safety expert. 12/13/24 a new fire drill log was developed by Executive Director to monitor exact time of evacuation. If the time of a fire drill does not meet the 6 minute threshold it will be repeated at a different date to ensure compliance. Maintenance Director and Executive Director will monitor for compliance. The fire drill evacuation times will be discussed with the leadership team at monthly Quality Assurance meetings beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [REDACTED] - 01/07/2025)

133.1 - Exit Signs

9. Requirements

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

133.1 - Exit Signs (continued)

Description of Violation

The home has an exterior door at the end of short hallway, known as the Cove, that door leads outside to a secure courtyard. During 10/29/2024 onsite inspection, the door did not display any exit signage.

Plan of Correction

Accept (█) - 12/18/2024)

Executive Director located the sign in a residents room and immediately replaced the sign on 9/29/24. A permanently sign has been put in place Executive Director on 11/10/24. Leadership team will monitor monthly to ensure it is in place and discuss findings at monthly Quality Assurance meetings beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█) - 01/07/2025)

183d - Prescription Current

10. 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

Resident █ had an order █ tablets which was discontinued on █. The medication was still available in the medication cart on █.

Plan of Correction

Accept (█) - 12/18/2024)

10/29/2024 Director of Nursing (DON) removed Resident █ medications from the med cart, destroyed and, documented in the Medication Destruction binder. Medication cart audit was completed on 11/15/24 by Resident Care Coordinator and DON .An audit of all current resident's medication will be completed by DON/Med Tech by 11/30/24. Med Techs will be re-educated on regulation 2600.183d by DON by 12/30/2024. All discontinued medications will be removed from the med cart by med tech or DON/Resident Care Coordinator (RCC) when discontinued order is received. To be monitored by Director of Nursing/Resident Care Coordinator and reviewed during monthly Quality Assurance Meeting starting December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█) - 01/07/2025)

233c - Key-Locking Devices

11. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The home's dining area is a path of egress from the main hallway to the outdoors. Access to the dining area, from the hallway, is secured by locked doors and operated by a keypad. At the time of 10/29/2024 onsite inspection, directions for operation were not conspicuously posted near the keypad.

Repeat Violation 8/29/23

233c - Key-Locking Devices (continued)

Plan of Correction

Accept [REDACTED] - 12/18/2024)

10/29/24 Executive Director replaced the sign which had fallen down. On 11/1/24 the Executive Director placed an additional sticker to ensure if sign was removed there would be an alternative option for code posting. All staff will be reeducated on regulation 2600.233c by 12/31/24. Leadership team will monitor daily to ensure signs are present. Findings will be reviewed by leadership team at monthly Quality Assurance meetings beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [REDACTED] - 01/07/2025)

234d - Support Plan Revision

12. Requirements

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident [REDACTED], Resident [REDACTED] and Resident [REDACTED], all have a diagnosis of dementia and reside in a secure dementia care unit. On the morning of [REDACTED], Resident [REDACTED] exhibited signs of aggression, leading to an altercation where they slapped Resident [REDACTED] across the face, who retaliated in kind. Despite staff intervening, continuous supervision was not implemented. At approximately 7am, Resident [REDACTED] met Resident [REDACTED] and Resident [REDACTED] near the Activity Room, out of staff's sight. Staff heard commotion and loud thud, approached the residents, and witnessed Resident [REDACTED] on the floor. Resident [REDACTED] was standing over Resident [REDACTED], yelling. Resident [REDACTED] was sent to the hospital and determined to have a right femoral fracture, requiring surgery.

Prior to these events, Resident [REDACTED] had displayed a pattern of aggressive and agitated behavior since their admission on [REDACTED]. Staff had documented Resident [REDACTED] tendencies to yell and bang on surfaces. Staff Member A stated that Resident [REDACTED] had attempted to strike them with various objects. Staff noted that the resident's aggressive behaviors were often followed by the resident pacing the hallways. Staff report that Resident [REDACTED] was pacing the hallways prior to the physical altercations on [REDACTED]. Staff document resident behaviors on a 24-hour shift report log. The log is then reviewed by administration, who adjust supervision plans based on the information provided. However, interventions were frequently delayed. Logs were often reviewed hours after the resident was experiencing increased agitation. Furthermore, staff were not instructed to increase supervision until they received administrative direction, which is necessary to prevent a potential increase in violent behavior and ensure the safety of all residents.

Plan of Correction

Accept [REDACTED] - 12/18/2024)

Upon receipt of plan of correction from Pennsylvania Bureau of Human Service Licensing on [REDACTED] residents [REDACTED] had been discharged Resident [REDACTED] was discharged to skilled facility after hospital stay. Resident [REDACTED] family discharged her to location in Florida near family, Resident [REDACTED] discharged by family to skilled facility. Current residents exhibiting escalating behaviors will be placed on 15 minute checks immediately. DON/ED will be made aware to offer any further assistance. Current residents with escalating behaviors will have updated RASPs with interventions to manage and identify escalating behaviors before they increase to a higher level. All staff will be educated on the Behavior Management Policy which was implemented on 12/11/24 by DON/RCC/Executive Director by 12/31/24. DON/RCC/ Memory Care Coordinator will Train caregivers to recognize triggers and respond

234d Support Plan Revision (continued)

effectively and provide education about dementia progression and behavioral changes. by 12/31/24. This area will be discussed by Leadership team at monthly Quality Assurance meetings beginning December 2024.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented [REDACTED] - 01/07/2025)