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

May 1, 2025

[redacted], EXECUTIVE DIRECTOR
EC OPCO YORK LLC
[redacted]

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/25/2025, 02/26/2025 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**: *06/09/2025*

**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**: *47* **Waking Staff**: *35*

## Inspection Information

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

**Reason**: *Renewal* **Exit Conference Date**: *02/26/2025*

## Inspection Dates and Department Representative

*02/25/2025 - On-Site*: [redacted]

*02/26/2025 - On-Site*: [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *75* **Residents Served**: *43*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents**: *3*

### 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**: *0*

**Have Mobility Need**: *4* **Have Physical Disability**: *1*

# Inspections / Reviews

### 02/25/2025 - Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2025*

### 03/24/2025 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *04/24/2025*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/31/2025*

## Inspections / Reviews *(continued)*

**04/02/2025 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *04/24/2025*

**Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/25/2025*

**05/01/2025 - Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *04/24/2025*

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

## 3c - Post Current License

**1. Requirements**

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

**Description of Violation**

*On 02/25/2025, the home did not have a copy of the Licensing Inspection Summary from 10/01/2024 posted in a conspicuous and public place in the home.*

**Plan of Correction** ***Accept ( - 03/24/2025)***

*Action: Executive Director immediately placed the Inspection Summary in State Binder located at the front desk on 2/25/2025.*
*Training: RDO trained the Executive Director on Regulation 2600.3-C on 2/25/2025.*
*Ongoing: Executive Director will audit the State Binder monthly to ensure all Inspection Summaries are posted for 6 months and then quarterly. Audit form to be kept.*

**Licensee's Proposed Overall Completion Date:** *03/21/2025*

***Implemented ( - 05/01/2025)***

## 63a - First Aid/CPR Training

**2. Requirements**

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

**Description of Violation**

*On 02/25/2025, from 11:00PM-7:00AM, 43 residents were present in the home. During this time, there were no staff present who were certified in CPR and First Aid.*

**Plan of Correction** ***Accept ( - 03/24/2025)***

*Action: Staff member on 11-7a completed CPR and First Aid training on February 28,2025.*
*Training: Executive Director was trained by the Regional Director of Operations on Regulation 63-A on 2/27/2025. All managers and staff were trained on Regulation 63-A on 2/28/2025 by the Executive Director.*
*Ongoing: An audit of CPR/1st Aid will be completed by 3/31/2025 by the ED/DON/RCC. If a class is required, it will be scheduled by the ED/RCC/DON. The DON/RCC/ED will complete a monthly Audit of CPR/1st aid to ensure all Medication Technicians and Caregivers are current. Classes for CPR/1st aid will be scheduled as needed by the DON/RCC/ED.*

**Licensee's Proposed Overall Completion Date:** *03/31/2025*

***Implemented ( - 05/01/2025)***

## 103f - Refrigerator/Freezer Temps

**3. Requirements**

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

**Description of Violation**

*On 02/25/2025, at 2:30PM, the temperature in the kitchen's freezer labeled "2" was 10 degrees Fahrenheit, and on*

## 103f - Refrigerator/Freezer Temps (continued)

*02/26/2025, at 10:35AM, it was 8 degrees Fahrenheit.*

**Plan of Correction** ***Accept ( - 03/24/2025)***

*Action: On, 2/27/25 , Dining Director called to schedule repair for the freezer not holding temperature. On 3/3/2035, came to look at the freezer and give quote. Repair is scheduled for the week of 3/24/2025.*

*Training: The Dining Director and all dining staff were trained in Regulation 103-f and the procedure of refrigerator/freezer temps on 3/3/25 by the Executive Director.*

*Ongoing: Dining Director will review temperature logs weekly to ensure that all temps are within limit. This will be reviewed at QA monthly with the ED. Temp logs to be kept for a year.*

**Licensee's Proposed Overall Completion Date:** *03/31/2025*

***Implemented ( - 05/01/2025)***

## 132c - Fire Drill Records

**4. Requirements**

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

**Description of Violation**

*The fire drill record for the fire drill conducted on 11/21/2024, at 2:10PM, does not include the number of residents in the home and the exits that were used during the drill.*

**Plan of Correction** ***Accept ( - 03/24/2025)***

*Training: Maintenance Director and Executive Director trained on regulation 132-c and the proper form to be used to track fire drills by the RDO on 2/27/25.*

*Ongoing: Executive Director will review the fire drill record every month to ensure all parts are completed and sign off on it. This will be reviewed at QA monthly.*

**Licensee's Proposed Overall Completion Date:** *03/21/2025*

***Implemented ( - 05/01/2025)***

## 144c1 - Smoking Area Guidelines

**5. Requirements**

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

**Description of Violation**

*The home's designated smoking area is located on the right side of the building, near the dumpsters. However, on 02/25/2025, at approximately 3:00PM, 7 cigarette butts were observed in the grass partition of the parking lot, located near the benches of the main entrance.*

## 144c1 - Smoking Area Guidelines *(continued)*

**Plan of Correction** ***Accept ( - 03/24/2025)***

*Action: Maintenance Director immediately removed cigarette butts on 2/25/2025. The Maintenance Director placed No Smoking signs on the benches on 2/26/2025.*
*Training: Executive Director was trained on Regulation 144c-1 and smoking policy and procedures for staff and residents by RDO on 2/25/2025. All staff and managers were trained on Regulation 144-c1 and the smoking policy and procedures for staff and residents on 3/4/2025.*
*Ongoing: Maintenance Director / Executive Director will check the area near the benches weekly to ensure no cigarette butts are located. This will be documented, and documentation will be kept.*

**Licensee's Proposed Overall Completion Date:** *03/21/2025*

***Implemented ( - 05/01/2025)***

## 181c - Self-administration Assessment

**6. Requirements**

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

**Description of Violation**

*Resident 2 self-administers Biotene; however, Resident 2 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.*

**Plan of Correction** ***Accept ( - 03/24/2025)***

*Action: Resident Care Coordinator removed the Biotene from resident 2 room. On 2/26/25 ED contacted physician via phone who confirmed resident is not to self-administer medication or treatments per current DME.*
*Training: Executive Director trained all medication technicians at staff meeting on 3/4/2025 on regulation 2600.181c, ED also instructed the med techs to remove any ordered medication or treatments from rooms where the resident is deemed unable to self -administer.*
*Ongoing: Medication Technicians will remove any medication or treatment items from the room when/if they see them. Med Techs have been instructed to contact the on-call manager to alert them of their findings. Residents who wish to self-administer must be assessed by a physician and have an order to self-administer, resident is also required to have an assessment completed upon admission by the community per protocol to ensure they meet all requirements to self-administer in our community.*

**Licensee's Proposed Overall Completion Date:** *03/21/2025*

***Implemented ( - 04/28/2025)***

## 183d - Prescription Current

**7. 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 02/26/2025, at 9:22AM, Hydralazine prescribed for Resident 2, was in the home's "P1" medication cart; however, this medication is discontinued.*

## 183d - Prescription Current *(continued)*

**Plan of Correction** ***Accept ([redacted] - 03/24/2025)***

*Action: Resident Care Coordinator removed Hydralazine from medication cart on 2/26/25.*
*Training: Executive Director re-trained medication technicians on 3/4/2025 on removing discontinued medication and treatments from the cart immediately upon discontinuation.*
*Ongoing: Medication carts will be audited by Wellness Department weekly and documented to ensure no discontinued medication or treatments are present in carts.*

**Licensee's Proposed Overall Completion Date:** *03/21/2025*

***Implemented ([redacted] - 04/28/2025)***

## 183e - Storing Medications

**8. Requirements**

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

**Description of Violation**

*On 02/26/2025, at 10:02AM, there were two loose half salmon-colored pills located in the "B1" medication cart*

**Plan of Correction** ***Accept ([redacted] - 03/24/2025)***

*Action: Executive Director immediately removed and destroyed pills that were in "B1" Med Cart 2/26/25.*
*Training: Executive Director reviewed Regulation 2600.183e with medication technicians on 3/4/2025.*
*Ongoing: At time of shift change the oncoming medication tech will check all drawers on each medication cart for any loose pills. If medication is found it will be documented and destroyed on shift change over form by oncoming medication technician.*

**Licensee's Proposed Overall Completion Date:** *03/21/2025*

***Implemented ([redacted] - 04/28/2025)***

## 185a - Implement Storage Procedures

**9. 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 Guaifenesin Liq 100/5ml as needed and Albuterol Neb 0.63mg/3 as needed. However, on 02/26/2025, these medications were not available in the home.*

**Plan of Correction** ***Accept ([redacted] - 03/24/2025)***

*Action: Medication listed under violation 2600.185a was ordered immediately, arrived from pharmacy on 2/26/2025 and was placed in cart.*
*Training: Executive Director reviewed regulation 2600.185a with medication technicians on 3/4/2025.*
*Ongoing: Medication carts will be audited by Wellness Department weekly and documented. Every night the scheduled medication technician from 11PM-7AM is responsible for completing an audit of all medication carts to*

## 185a - Implement Storage Procedures (continued)

*ensure refills are not needed.*

**Licensee's Proposed Overall Completion Date:** *03/21/2025*

***Implemented ( - 04/28/2025)***

## 187c - Refusal of Medication

**10. Requirements**

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

**Description of Violation**

*Resident 1 refused the following medications on the following dates:*

- *Blood Glucose check on 02/09/2025 at 5:00PM*
- *Humalog Kwik inj 100/ml on 02/09/2025 at 5:00PM*
- *Humalog Kwik inj 100/ml on 02/17/2025 at 7:00PM*
- *Humulin inj 70/30 KWP on 02/17/2025 at 7:00PM*

*However, these refusals were not reported to the prescriber within 24 hours:*

*On 02/01/2025, 02/02/2025, 02/04/2025 through 02/07/2025, 02/12/2025, 02/13/2025, 02/15/2025, 02/16/2025, 02/18/2025 through 02/22/2025 and 02/25/2025, Resident 3 refused Triamcinolone Cre 0.025%. However, these refusals were not reported to the prescriber within 24 hours.*

*Repeated Violation - 11/05/2024*

**Plan of Correction** ***Accept ( - 04/02/2025)***

*Resident #1 refused BG check & Humalog Kwik 100/ml Injection on 2/9/25 @ 5PM. Humalog Kwik Inj. 100ml on 2/17/25 @ 7PM, Humulin 70/30 KWP on 2/17/25 @ 7PM.*
*Resident #3 refused Triamcinolone Cream 0.025% on the following dates 2/1/25, 2/2/25, 2/4/25, 2/7/25, 2/12/25, 2/13/25, 2/15/25, 2/16/25, 2/18/25 through 2/22/25 and 2/25/25.*
*Training: ED provided training to Med Techs regarding regulation 2600.187c at staff meeting on 3/4/25.*
*Ongoing: Daily Medication report will be pulled daily by the DON or RCC to determine if any medication has been refused or missed. The physician's office will be alerted of any refused or missed medication within the regulatory 24-hour timeframe. Documentation of the communication will be via phone and documented in PCC or via fax/email and stored in resident's record.*

**Licensee's Proposed Overall Completion Date:** *03/31/2025*

***Implemented ( - 04/28/2025)***

## 187d - Follow Prescriber's Orders

**11. Requirements**

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

## 187d - Follow Prescriber's Orders *(continued)*

**Description of Violation**

*Resident 4 is prescribed Austedo tab 12mg with orders to take 1 tablet by mouth once daily. However, on 02/10/2025, at 7:00PM, this medication was not administered because it was not available in the home.*

*Resident 1 is prescribed Humalog Kwik Inj 100/ML with orders to inject subcutaneously as directed per the following sliding scale before meals and at bedtime:*

- *70-150 = 0 units*
- *151-200 = 2 units*
- *201-250 = 4 units*
- *251-300 = 6 units*
- *301-350 = 8 units*
- *350-400 = 10 units, call MD for blood sugar below 60 or above 400.*

*On 02/10/2025, at 7:00PM, the resident had a blood sugar of 201 and was only administered 2 units.*
*On 02/21/2025, at 7:00PM, the resident had a blood sugar of 236 and was only administered 2 units.*

*Resident 2 is prescribed Tramadol HCL Tab 50mg with orders to take one tablet by mouth twice daily. However, on the following dates and times, this medication was not administered because it was not available in the home:*

- *02/10/2025 at 8:00PM*
- *02/11/2025 at 8:00PM*
- *02/18/2025 at 8:00AM and 8:00PM*
- *02/19/2025 at 8:00AM and 8:00PM*
- *02/20/2025 at 8:00AM and 8:00PM*

*Repeated Violation-10/01/2024 and 04/23/2024, et al*

**Plan of Correction** ***Accept ([redacted] - 04/02/2025)***

*Action: Executive director contacted PCP office via phone on 2/26/25 to alert physician that the following occurred for resident #1: Wrong dose of Humalog Kwik Inj. 100/ml was administered on 2/10/25 & 2/21/25; BG reading on 2/10/25 was 20, resident should have received 4 units however only received 2 units. 2/21/25 was 236, resident should have received 4 units however only received 2 units.*
*Executive Director contacted PCP office via phone on 2/26/25 to alert physician that the following occurred for resident #2: Missed dose at 8PM on 2/10 & 2/11, Missed dose at 8AM & 8PM on 2/18, 2/19, 2/20. Resident #2 was already discharged from facility at time of inspection, Tramadol was not re-ordered due to resident discharge.*
*Training: Executive Director re-educated medication technicians of regulation 2600.187d on 3/4/2025 at staff meeting.*
*Ongoing: Daily Medication report will be pulled daily to determine if any medication has been refused or missed. The physician's office will be alerted of any refused or missed medication within the regulatory 24-hour timeframe. Documentation of the communication will be via phone and documented in PCC or via fax/email and stored in resident's record.*
*Weekly medication cart audits will be completed every Thursday by RCC to ensure all ordered medication is available for administration.*

**Licensee's Proposed Overall Completion Date:** *03/31/2025*

***Implemented ([redacted] - 04/28/2025)***

## 224a - Preadmission Screen Form

**12. 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 1 was admitted to the home on [redacted]. However, as of 02/25/2025, the resident has not had a preadmission screening completed.*

*Resident 2 was admitted to the home on [redacted]. However, as of 02/25/2025, the resident has not had a preadmission screening completed.*

**Plan of Correction** ***Accept ([redacted] - 04/02/2025)***

*Action: Executive Director was able to locate Pre-Admission Screening in the DON office on 2/26/2025 dated [redacted] for Resident 1. Pre-Admission screening for Resident 2 was also found in DON office on 3/3/2025 dated [redacted] Pre-Admission Screenings were added to residents' chart immediately. Audit of all current resident record was completed on 3/31/25 to ensure all charts have initial pre-admission screening located in them.*
*Training: Executive Director provided training to the DON, Resident Care Coordinator and Marketing Director on 3/2/25. Regarding regulation 2600.224a and the importance that the pre-admission screening must remain in the chart for the lifetime of the resident chart.*
*Ongoing: Executive Director will review all admission documents prior to admission to community to ensure they are all complete to the expectation of the department. Quarterly audits will be completed and documented on the audit sheet to ensure the resident charts have all the required documents.*

**Licensee's Proposed Overall Completion Date:** *03/31/2025*

***Implemented ([redacted] - 05/01/2025)***

## 225a - Assessment 15 Days

**13. Requirements**

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

**Description of Violation**

*Resident 1 was admitted to the home on [redacted]. However, as of 02/25/2025, an initial assessment has not been completed.*

*Resident 2 was admitted to the home on [redacted] However, as of 02/25/2025, an initial assessment has not been completed.*

**Plan of Correction** ***Accept ([redacted] - 04/02/2025)***

*Action: Executive Director completed RASP for both residents 1 & 2 dated 2/28/2025. Initial audit was completed on 3/4/25 ensuring that all current residents have both initial assessments and support plans.*
*Training: Executive Director provided training to the DON & Resident Care Coordinator of regulation 2600.225 on 2/27/25.*
*Ongoing: Quarterly audits will be completed and documented on the audit sheet to ensure the resident charts have all the required documents completed within their regulated timeframes.*

## 225a - Assessment 15 Days *(continued)*

**Licensee's Proposed Overall Completion Date:** *03/31/2025*

***Implemented ( - 05/01/2025)***

## 227c - Support Plan Revision

**14. Requirements**

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

**Description of Violation**

*Resident 3's annual assessment was completed on . However, the resident's annual support plan was not completed until*

*Resident 4's annual assessment was completed on However, the resident's annual support plan was not completed until*

*Repeated Violation - 04/23/2024, et al*

**Plan of Correction** ***Accept ( - 04/02/2025)***

*Training: Executive Director provided training to the DON & Resident Care Coordinator of regulation 2600.227c on 2/27/25. Initial audit was completed on 3/4/25 ensuring that all current residents have both current assessments and support plans.*
*Ongoing: Quarterly audits will be completed and documented on the audit sheet to ensure the resident charts have all the required documents completed within their regulated timeframes.*

**Licensee's Proposed Overall Completion Date:** *03/31/2025*

***Implemented ( - 05/01/2025)***

## 227d - Support Plan Medical/Dental

**15. 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**

*Resident 3 utilizes a bedside mobility device to assist with mobility. However, the resident's most recent support plan, dated , does not include the resident's need for a bedside mobility device and if resident can safely use a beside mobility device. Furthermore, Resident 3 was prescribed a pureed diet on However, the resident's most recent support plan, dated does not include the resident's special diet.*

*Resident 4 was admitted to hospice services on However, the resident's most recent support plan, dated , does not include these services or how the need will be met.*

**Plan of Correction** ***Directed ( - 04/02/2025)***

*Action: Executive Director completed an audit as of 3/24/25 of all residents' rooms to determine what assistive*

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

*devices are being utilized to ensure the most up to date information regarding resident care needs are listed on the RASP. The Dietary Director completed an audit of all residents ordered diets; this was completed by 3/19/25.*

*Training: Executive Director provided training to the DON, Resident Care Coordinator, Dietary Director of regulation 2600.227d on 2/27/25.*
*Ongoing: Quarterly Level of Care Assessments will be completed by DON/RCC, at that time an audit of the residents RASP will be completed by the DON/RCC to ensure that they are current and match the level of care assessment that is completed. Residents RASP will detail all services that the resident requires at time of completion, furthermore the Wellness team will ensure to update the RASP immediately when there is a significant change. Each RASP will have a blank Addendum form for any significant changes to be added throughout the year.*

*Proposed Overall Completion Date: 03/31/2025*

*[Directed]*

- *In addition to the above plan of correction, the administrator or designee will update Resident #3 and Resident #4's RASPs by 4/18/25.*

**Directed Completion Date:** *04/18/2025*

***Implemented ([redacted] - 05/01/2025)***