

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

July 31, 2025

[REDACTED], ADMINISTRATOR  
MAYBROOK-P DENVER OPCO LLC  
400 LANCASTER AVENUE  
STEVENS, PA, 17578

RE: THE GARDENS AT STEVENS  
400 LANCASTER AVENUE  
STEVENS, PA, 17578  
LICENSE/COC#: 33266

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/22/2025 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: *THE GARDENS AT STEVENS* License #: 33266 License Expiration: 08/15/2025  
 Address: 400 LANCASTER AVENUE, STEVENS, PA 17578  
 County: LANCASTER Region: CENTRAL

**Administrator**

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

**Legal Entity**

Name: *MAYBROOK-P DENVER OPCO LLC*  
 Address: 400 LANCASTER AVENUE, STEVENS, PA, 17578  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: 10/22/1990 Issued By: *Labor and Industry*

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 11 Waking Staff: 8

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: 05/22/2025

**Inspection Dates and Department Representative**

05/22/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: 26 Residents Served: 11

**Secured Dementia Care Unit**  
 In Home: No Area: Capacity: Residents Served:

**Hospice**  
 Current Residents: 0

**Number of Residents Who:**  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 11  
 Diagnosed with Mental Illness: 3 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 0 Have Physical Disability: 0

**Inspections / Reviews**

05/22/2025 - Full  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: 06/21/2025

06/23/2025 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 07/14/2025  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: 06/30/2025

Inspections / Reviews *(continued)*

07/03/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/14/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 07/11/2025

07/31/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/14/2025

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 5/22/25, the home's most recent annual license inspection summary, dated 5/30/24, was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept ( [redacted] - 07/01/2025)

Administrator has placed a copy of the current license inspection summary from 5/30/2024 on the facilities bulletin board, next to the current license.

Administrator was educated on May 22, 2025, by the licensing representatives.

Administrator will also ensure a copy of the renewal license along with the newest license inspection summary will be placed on the wall once received.

A monthly audit will be completed the first business day of every month by the administrator starting July 1, 2025, to ensure we are compliant with the regulations.

Proposed Overall Completion Date: 06/30/2025

Licensee's Proposed Overall Completion Date: 07/01/2025

Implemented ( [redacted] - 07/15/2025)

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 person B, whose first day of work was [redacted], did not receive orientation on the following topics until [redacted]

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.

## 65a - FS Orientation 1st Day (continued)

Repeated Violation - 5/30/24

**Plan of Correction**

Accept (█) - 07/03/2025

Administrator was educated on May 23, 2025, by the Regional Director of Personal Care.

Administrator has revised the orientation structure on May 26, 2025, to meet the guidelines for a PCH. This includes all materials to be covered in their first day of work.

An audit was conducted by the Administrator on May 26, 2025, to ensure all employees have had their first day training orientation completed. Which has been attached.

A quarterly audit will be completed by the Administrator starting September 1, 2025, to ensure we are compliant with the regulations.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (█) - 07/31/2025

## 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:

2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

**Description of Violation**

Staff person B, whose first day of work was █, did not complete training in the following topics:

2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

Repeated Violation - 5/30/24

**Plan of Correction**

Accept (█) - 07/03/2025

Administrator was educated on May 22, 2025, by the licensing representatives.

Administrator has revised the orientation structure on May 26, 2025, to meet the guidelines for a PCH. This includes all materials to be covered in their first day of work.

An audit was conducted by the Administrator on May 26, 2025, to ensure all employees meet the PC regulations.

Administrator has trained Staff Person B in Emergency Medical Plan and Reporting of reportable incidents and conditions on May 28, 2025.

A quarterly audit will be completed by the Administrator starting September 1, 2025, along with staff education, to ensure we are compliant with the regulations.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (█) - 07/31/2025

## 82b - Poisonous Material Storage

**5. Requirements**

2600.

82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

**Description of Violation**

*On 5/22/25, at 10:06 AM, a spray bottle containing "Santec Green" cleaning chemical was unlocked, unattended and located on the dining room's kitchenette counter which is used as a food preparation surface. The label affixed to the spray bottle has a universal sign for corrosive material and reads, "Store container away from food and drink. See Medical attention immediately if chemical is inhaled or comes into contact with eyes, skin or ingested."*

**Plan of Correction**

**Accept (████ - 07/03/2025)**

*Administrator was educated on May 22, 2025, by the licensing representatives. Administrator has secured all poisonous materials, including but not limited to "Santec Green" in a locked cabinet on May 22, 2025, and will ensure they remain inside when not used.*

*Administrator has conducted an annual training on Poisonous materials and storage on 5/29/2025, to all PCA's. The list has been attached.*

*A weekly audit will be completed by the Administrator starting June 30, 2025, to ensure we are compliant with the regulations.*

**Licensee's Proposed Overall Completion Date: 06/30/2025**

**Implemented (████ - 07/15/2025)**

**94b - Non-Skid Surface**

**6. Requirements**

2600.

94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

**Description of Violation**

*On 5/22/25, at 10:16 AM, the outside ramp connected to double door exit located at the entrance to the dining room had missing nonskid tape. The tape that was present was loose and did not adhere to the ramp when walked upon, causing a potential fall risk.*

**Plan of Correction**

**Accept (████ - 07/03/2025)**

*Maintenance Director was educated on May 23, 2025, by the Administrator.*

*An initial audit was completed by the Administrator and the Maintenance Director on May 23, 2025.*

*The Maintenance Director will be replacing the non-skid tape on the ramp to assure safety on June 23, 2025.*

*A monthly audit will be completed the first business day of every month by the administrator and Maintenance Director starting July 1, 2025, to ensure we are compliant with the regulations.*

**Proposed Overall Completion Date: 06/30/2025**

**Licensee's Proposed Overall Completion Date: 07/07/2025**

**Implemented (████ - 07/15/2025)**

**103f - Refrigerator/Freezer Temps**

**7. Requirements**

103f - Refrigerator/Freezer Temps (continued)

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 5/22/25, at 4:30 PM, the walk-in freezer temperature of the main kitchen was measured at 6 degrees Fahrenheit. As of 5/22/25, there were 44 temperature readings documented in May 2025. However, only 3 readings out of 44 were documented at 0 degrees Fahrenheit or below.

Plan of Correction

Accept (█ - 07/03/2025)

Maintenance Director was educated on May 23, 2025, by the Administrator.

Administrator has ensured that a process will be made in the kitchen starting May 26, 2025, for each shift to check the refrigerator temperature.

The Dietary Director will send these reports weekly to the administrator.

Administrator and Maintenance Director will call out the technician if refrigerator is still reading higher than 40°F and freezer not below 0°F.

A new thermometer will be placed in the walk-in freezer by the Maintenance Director on June 23, 2025.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (█ - 07/31/2025)

107d - Procedure Emergency Management Agency Submission

8. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed, updated and submitted to the local emergency management agency since 3/4/24.

Plan of Correction

Accept (█ - 07/03/2025)

Maintenance Director was educated on May 23, 2025, by the Administrator.

The Maintenance Director and Administrator will ensure that the emergency procedures are current, updated, and submitted to the local emergency management agency by June 25, 2025.

By June 1st of each year, the facilities written emergency procedures will be reviewed, updated, and submitted to EMA by the Maintenance Director. This will start on June 1, 2026.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented (█ - 07/31/2025)

123b - Emergency Procedures Posted

9. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 5/22/25, the home's emergency procedures were not posted in a conspicuous and public place in the home.

123b - Emergency Procedures Posted (continued)

**Plan of Correction**

Accept ( [REDACTED] ) - 07/03/2025)

Administrator was educated on May 22, 2025, by the licensing representatives.

Administrator made sure the emergency plan was documented and placed on the wall in visibility for residents and staff on May 23, 2025.

A monthly audit will be completed the first business day of every month by the Maintenance Director starting July 1, 2025, to ensure we are compliant with the regulations.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ( [REDACTED] ) - 07/31/2025)

123c - Evacuation Diagrams

**10. Requirements**

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

**Description of Violation**

The home currently serves 11 residents. However, there were no emergency evacuation diagrams posted in the home.

**Plan of Correction**

Accept ( [REDACTED] ) - 07/03/2025)

Maintenance Director was educated on May 23, 2025, by the Administrator.

The Maintenance Director and Administrator will ensure that the Emergency Evacuation Diagram of each floor are posted on the wall for residents and staff on June 23, 2025.

A monthly audit will be completed the first business day of every month by the Maintenance Director starting July 1, 2025, to ensure we are compliant with the regulations.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ( [REDACTED] ) - 07/31/2025)

127a - Portable Space Heaters

**11. Requirements**

2600.

127.a. Portable space heaters are prohibited.

**Description of Violation**

On 5/22/25, at 10:11 AM, there was a wooden encased portable electric space heater located in the dining room of the home. Within 60 seconds of turning on the space heater, the temperature of the vent in the front of the space heater rose to 149.6 degrees Fahrenheit and continued climbing.

**Plan of Correction**

Accept ( [REDACTED] ) - 07/03/2025)

Maintenance Director was educated on May 23, 2025, by the Administrator.

Administrator has removed the portable space heater in the dining room on May 23, 2025.

A monthly audit will be completed the first business day of every month by the Maintenance Director starting July 1, 2025, to ensure we are compliant with the regulations.

Licensee's Proposed Overall Completion Date: 06/30/2025

127a - Portable Space Heaters (continued)

Implemented ( ) - 07/31/2025)

225c - Additional Assessment

13. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #2's most recent assessment was completed on ( )

Plan of Correction

Accept ( ) - 07/03/2025)

Administrator conducted an audit on May 26, 2025, to ensure all residents annual assessment are current and up to date, which have been included.

Resident 2 Annual Assessment was completed on May 29, 2025.

Administrator has conducted an annual training on 5/29/2025, to all PCA's. The list has been attached.

A monthly audit will be completed the first business day of every month by the administrator starting July 1, 2025 to ensure we are compliant with the regulations of assessments and support plans.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ( ) - 07/31/2025)

227g -Support Plan Signatures

14. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1 participated in the development of ( ) support plan on ( ) However, the resident did not sign the support plan.

Plan of Correction

Accept ( ) - 07/03/2025)

Resident 1 has signed ( ) support plan that was conducted on ( ) No changes have been made.

Administrator has conducted an annual training Assessments and Support Plans on 5/29/2025. which have been attached. Administrator will ensure that all signatures are captured at the time of completion of ( ) support plan.

Administrator has conducted an initial audit on May 30, 2025, of all current residents to ensure all support plans have the proper signatures, which has been included.

A monthly audit will be completed the first business day of every month by the administrator starting July 1, 2025, to ensure we are compliant with the regulations of assessments and support plans.

Licensee's Proposed Overall Completion Date: 06/30/2025

Implemented ( ) - 07/31/2025)