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

March 30, 2026

[redacted]
GAHC3 YORK PA ALF TRS SUB LLC
[redacted]

RE: SENIOR COMMONS AT POWDER MILL
1775 POWDER MILL ROAD
YORK, PA, 17403
LICENSE/COC#: 33210

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/03/2026 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: *SENIOR COMMONS AT POWDER MILL* **License #**: *33210* **License Expiration**: *11/28/2025*

Address: *1775 POWDER MILL ROAD, YORK, PA 17403*

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

Administrator

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

Legal Entity

Name: *GAHC3 YORK PA ALF TRS SUB LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *160* **Waking Staff**: *120*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *03/03/2026*

Inspection Dates and Department Representative

03/03/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* **Residents Served**: *112*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *44* **Residents Served**: *38*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *112*

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

Have Mobility Need: *48* **Have Physical Disability**: *0*

Inspections / Reviews

03/03/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/20/2026*

03/20/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/27/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/27/2026*

Inspections / Reviews *(continued)*

03/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/27/2026*

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

On [redacted] at approximately 4:00 PM, Staff Members A and B heard Residents [redacted] and [redacted] yelling at each other in the hallway of the Secured Dementia Care Unit. Upon investigation, Staff Member A observed Resident [redacted] forcefully shove Resident [redacted] to the ground. As a result of the incident, Resident [redacted] was transported to the hospital and was diagnosed with a right [redacted]. Resident [redacted] was hospitalized for 6 days and was subsequently transferred to a skilled nursing facility.

Plan of Correction ***Accept[redacted] 03/20/2026)***

Immediate Corrective Actions:
On 1/19/26, both residents were redirected to separate areas to be assessed.
Resident 1 had no injuries nor was [redacted] in distress. [redacted] was contacted by the Memory Care Director on 1/19/26 about the incident, and [redacted] came to the community to spend time with [redacted] arrived at Senior Commons at approximately 5pm on 1/19/26 and remained with [redacted] until [redacted] went to bed, with no further concerns.
Following the initial assessment by community staff, 911 was called for Resident 2 to be transported to York Hospital for evaluation and [redacted] had surgery to repair a hip fracture at York Hospital on 1/20/26. [redacted] was medically stable on 1/25/26 and transferred to Normandie Ridge for rehabilitation services prior to returning to the community.
The Executive Director reported this incident to DHS and York Country Area Agency on Aging on 1/19/26.
Additional Corrective Actions:
On 1/20/26, the Memory Care Director and Resident 1's [redacted] discussed care needs and safety, and [redacted] agreed to private duty support for Resident 1 from 8:00am to 8:00pm daily. The Private Duty Nursing Addendum was signed by the appropriate parties and private duty support began on 1/20/26.
Resident 1's RASP was updated on 1/20/26 by the Memory Care Director to reflect the change in need and addition of private duty support.
Resident 2's RASP was updated by the Memory Care Director upon [redacted] return to the community on 3/7/26.
On 3/18/26 and 3/19/26, the Memory Care Director held training for memory care neighborhood staff, including Safe Management Techniques and Positive Approaches to Care. Topics included resident rights, structured activities, the Typical Day schedule, and de-escalating challenging moments.
Ongoing Corrective Actions:
Beginning on 2/20/26, daily huddle meetings are now held with the Resident Care Director, the Memory Care Director and the Executive Director to review incidents, changes in resident care needs, and behavioral concerns and assign each to be updated in residents' RASPs.
Beginning on 3/14/26, memory care activities are being conducted until later in the evening and wrapping up at approximately 7:00pm each day, to encourage more structured activities and less time for residents to become restless and/or wander into one another's personal space.
Staffing has increased to include an additional 24 hours per day beyond the state-required minimum, beginning on 3/14/26, to offer support for additional activities in smaller and more focused groups, as well as those later in the day, and aid in keeping residents engaged.
Additionally, the community policy regarding challenging resident interactions was sent to residents and their responsible parties on 3/1/26, to be effective 4/1/26. The policy includes, following an interaction of abusive behavior with another person, any resident exhibiting such behaviors will be required to have one-to-one private duty care

42b Abuse (continued)

as part of the updated RASP, to ensure the safety and well being of all residents. In the event of a second incident, a 30 day notice of discharge will be issued, as a different or higher level of care will be necessary if one to one care is not adequate to keep residents safe. As always, any time a 30 day notice is issued, the community will provide assistance in finding alternative residence in accordance with regulatory guidelines and community procedures. Ongoing compliance will be discussed at quarterly Quality Assurance meetings, beginning with the Q1 2026 (January, February, March) review on 4/9/26.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented ([redacted] - 03/30/2026)