pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LANCASTER PCH LLC**
LEGAL ENTITY

To operate **LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER**
NAME OF FACILITY OR AGENCY

Located at **31 MILLERSVILLE ROAD, LANCASTER, PA 17603**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 **100**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

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

No: **333060**

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: MAY 28, 2026

[redacted]
Lancaster PCH LLC
31 Millersville Road
Lancaster, Pennsylvania 17603

RE: Legend Personal Care and Memory Care of Lancaster
License #: 33306

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 24, 2026 and March 25, 2026 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 Summaries>

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

May 18, 2026

[redacted]
LANCASTER PCH LLC
31 MILLERSVILLE ROAD
LANCASTER, PA, 17603

RE: LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER
31 MILLERSVILLE ROAD
LANCASTER, PA, 17603
LICENSE/COC#: 33306

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/24/2026, 03/25/2026 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: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *06/11/2026*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

Name: [redacted]

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA, 17603*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Type: *I-2* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *102* **Waking Staff**: *77*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *03/25/2026*

Inspection Dates and Department Representative

03/24/2026 - On-Site: [redacted]

03/25/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *40* **Residents Served**: *29*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

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

Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

03/24/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2026*

Inspections / Reviews *(continued)*

04/30/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/14/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/15/2026*

05/18/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/14/2026*

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

121a - Unobstructed Egress

1. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The exit door in the Secure Dementia Care Unit (SDCU) adjacent to resident room #311 is equipped with a code box for operating the locking mechanism on the door. On 3/24/26, at approximately 9:24 AM, the code box was not functioning, and the push bar did not open the door, preventing immediate egress.

Repeated Violation - 5/8/25

Plan of Correction ***Accept [redacted] - 04/30/2026)***

• On 3/24/2026, upon notification by the surveyor, the Maintenance Director immediately repaired the exit door and validated that the key pad was functioning.
• By 4/20/2026 current staff members were trained by the Residence Director, on the requirements of 2600.121a. Documentation shall be kept.
• Beginning 3/30/2026, the Administrator, or designee, shall conduct an audit to validate compliance with 2600.121a, daily for 2 weeks and then weekly for 4 weeks. Any issues found will be immediately addressed by the Maintenance Director or Designee. Documentation shall be kept
• On 4/28/2026, the above audit findings for 2600.121a will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)

125b - Combustible Restrictions

2. Requirements

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

Description of Violation

On 3/24/26 at 9:10AM, a propane tank was observed unlocked and accessible to residents under the grill, within the personal care courtyard.

Plan of Correction ***Accept[redacted] - 04/30/2026)***

• On 3/24/2026, upon notification by the surveyor, the Maintenance Director, immediately removed the identified combustible materials from the resident accessible area.
• On 3/26/2026, the Maintenance Director conducted comprehensive walk-through of resident accessible areas to identify and secure any other accessible combustible materials. No additional combustible materials were identified in resident accessible areas.
• Beginning 4/20/2026 the Maintenance Director, or designee, will conduct audits of resident accessible areas to

125b - Combustible Restrictions (continued)

validate compliance with 2600.125(b) weekly for 2 weeks and then monthly for 2 months. Documentation shall be kept.

• On 4/28/2026, the above audit findings for 2600.125b will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)

141a - Medical Evaluation

3. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1 was admitted [redacted]/24, a medical evaluation for this resident was not completed until 5/27/25.

Plan of Correction ***Accept [redacted] - 04/30/2026)***

• The community was unable to correct documentation for Resident #1 related to this violation due to the requirements of 2600.141a. The completed, signed medical evaluation (DME) form was received on 5/27/2025 and filed in Resident #1's record.

• By 4/20/2026, the Residence Director shall educate the Health Care director on the requirements of 2600.141a. Documentation shall be kept.

• On 4/6/2026, the Health Care Director Specialist conducted an audit of current resident medical evaluations for the requirements of 2600.141a. Any resident found missing a medical evaluation or having an incomplete evaluation will have a request submitted by the Health Care Director, or designee, to their physician. They will also have the following statement "Non-compliance identified during medical evaluation audit completed on XX/XX/XXXX by WHO as part of a plan of correction for survey on 3/24/2026" will be written on the bottom of the medical evaluation. Documentation shall be kept.

• Beginning 4/20/2026, the Administrator, or Designee, will audit all new admission records weekly for the next 2 weeks and monthly for the next 2 months to ensure compliance with 2600.225a. Identified assessments shall be completed upon identification. Documentation shall be kept.

• On 4/28/2026, the above audit findings for 2600.141a will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)

190a - Completion Medication Course

4. Requirements

2600.

190a - Completion Medication Course *(continued)*

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

The home's medication administration training record for Staff Member A did not include a completed Initial Summary and Qualification User Report. Additionally, the annual practicum was not completed within the expected time frame of 1 year. Staff Member A administered medications on the following dates to the following residents:

- *3/1/26 - 3/4/26, 3/6/26, 3/9/26-3/12/26, 3/14/26-3/18/26, 3/20/26, and 3/23/26 to Resident #2.*
- *3/1/26-3/4/26, 3/6/36, 3/9/36-3/12/26, 3/14/26-3/18/26, 3/20/26, and 3/23/26 to Resident #3.*

Plan of Correction ***Accept ([redacted] - 04/30/2026)***

• On 3/26/2026, the Health Care Director Specialist audited all current medication administration staff records to ensure compliance with 2600.190a. No other staff members were identified to be out of compliance with 2600.190a. Documentation shall be kept.
• By 4/20/2026, the Residence Director shall educate the Health Care Director on the requirements of 2600.190a. Documentation shall be kept.
• Beginning 4/6/2026, the Health Care Director or designee shall conduct monthly audits for 2 months of medication passers ensure all staff passing medications meet the requirements of 2600.190a. Associates not meeting the requirements of 2600.190a will not be permitted to pass medications. Documentation shall be kept.
• On 4/28/2026, the above audit findings for 2600.190a will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)

190c - Record of Training

5. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person A does not include a completed Initial Summary and Qualification User Report. Additionally, the Annual Practicum was not completed within the expected time frame of 1 year.

190c - Record of Training (continued)

Plan of Correction ***Accept [redacted] - 04/30/2026)***

• On 3/26/2026, the Health Care Director Specialist audited all current medication administration staff records to ensure compliance with 2600.190c. No other staff members were identified to be out of compliance with 2600.190c. Documentation shall be kept.
• By 4/20/2026, the Residence Director shall educate the Health Care Director on the requirements of 2600.190c. Documentation shall be kept.
• Beginning 4/6/2026, the Health Care Director or designee will conduct monthly audits for 2 months of medication passers ensure all staff passing medications meet the requirements of 2600.190a. Associates not meeting the requirements of 2600.190a will not be permitted to pass medications. Documentation shall be kept.
• On 4/28/2026, the above audit findings for 2600.190c will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)

225a - Assessment 15 Days

6. 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]/24. An assessment was not completed for Resident #1 until 6/10/25.

Plan of Correction ***Accept [redacted] - 04/30/2026)***

• The community was unable to correct documentation for Resident #1 related to this violation due to the requirements of 2600.225a. The assessment was completed on 6/10/25 by the Health Care Director and filed in the resident's record.
• On 4/6/2026, the Health Care Director Specialist, conducted and audit of current resident records to identify compliance with 2600.225a. Any assessments identified out of compliance will have "Non-compliance identified during medical evaluation audit completed on XX/XX/XXXX by WHO as part of a plan of correction for survey on 3/24/2026" will be written on the bottom of the medical evaluation. Documentation shall be kept.
• By 4/20/2026, the Residence Director shall educate the Health Care director on the requirements of 2600.225a. Documentation shall be kept.
• 4/20/2026, the Administrator, or Designee, will audit all new admission records weekly for the next 2 weeks and monthly for the next 2 months to ensure compliance with 2600.225a. Identified assessments shall be completed upon identification. Documentation shall be kept.
• On 4/28/2026, the above audit findings for 2600.225a will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

225a - Assessment 15 Days *(continued)*

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)

227a - Support Plan 30 Days

7. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on [redacted]/24; however, the resident's initial support plan was not completed until 6/10/25.

Plan of Correction ***Accept[redacted] - 04/30/2026)***

• The community was unable to correct documentation for Resident #1 related to this violation due to the requirements of 2600.227a. The assessment was completed on 6/10/25 by the Health Care Director and filed in the resident's record.
• On 4/6/2026, the Health Care Director Specialist, conducted and audit of current resident records to identify compliance with 2600.227a. Any assessments identified out of compliance will have "Non-compliance identified during medical evaluation audit completed on XX/XX/XXXX by WHO as part of a plan of correction for survey on 3/24/2026" will be written on the bottom of the medical evaluation. Documentation shall be kept.
• By 4/20/2026, the Residence Director shall educate the Health Care director on the requirements of 2600.227a. Documentation shall be kept.
• Beginning 4/20/2026, the Administrator, or Designee, will audit all new admission records weekly for the next 2 weeks and then monthly for the next 2 months to ensure compliance with 2600.227a. Identified assessments shall be completed upon identification. Documentation shall be kept.
• On 4/28/2026, the above audit findings for 2600.227a will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)

233c - Key-Locking Devices

8. 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

On 3/24/26, at approximately 9:24 AM, the directions for operating the home's locking mechanism were not conspicuously posted near the door adjacent to resident room #[redacted] in the Secure Dementia Care Unit.

Repeated Violation - 5/8/25

233c Key Locking Devices (continued)

Plan of Correction ***Accept[redacted] - 04/30/2026)***

• On 3/24/2026, upon notification by the surveyor the Maintenance Director immediately posted the directions in accordance with 2600.233c.
• By 4/24/2026, the Residence Director educated current associates on the requirements of 2600.233c. Documentation shall be kept.
• Starting 4/20/2026, the Maintenance Director, or designee, shall audit compliance of 2600.233c daily for 2 weeks and then weekly for 2 weeks. Any deficiency shall be corrected at the time of the audit. Documentation shall be kept.
• On 4/28/2026, the above audit findings for 2600.233c will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 05/18/2026)