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

August 31, 2026

[redacted], ADMINISTRATOR
EC OPCO MID VALLEY LLC
[redacted]

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

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/09/2026 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: *CELEBRATION VILLA OF MID VALLEY* **License #**: *22718* **License Expiration**: *07/11/2026*

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**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *06/09/2026*

Inspection Dates and Department Representative

06/09/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *All* **Capacity**: *50* **Residents Served**: *36*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *35*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *36*

Have Physical Disability: *0*

Inspections / Reviews

06/09/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/16/2026*

07/30/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/05/2026*

Inspections / Reviews *(continued)*

08/31/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

At approximately 9:45 a.m. the batteries in the carbon monoxide detector in the home's dining room were last changed on 3/12/25, and were not maintained as per the Care Facility Carbon Monoxide Standards Act.

Plan of Correction ***Accept (- 07/16/2026)***

Action: On 6.9.26 the batteries in the carbon monoxide detector in the dining room were immediately removed and new batteries were placed into the carbon monoxide detector by the Director of Maintenance to ensure we stay in accordance with regulation 2600.18

Training: The Director of Maintenance was in-serviced by the Executive Director on regulation 2600.18 on 7.1.26 compliance with laws. The Director of Maintenance will change the carbon monoxide batteries twice yearly. The Director of Maintenance will change the carbon monoxide batteries every July and January to stay in compliance with regulation 2600.18. The Executive Director will complete checks on a monthly basis to ensure that all carbon monoxide batteries are in compliance. Training records will be kept in accordance with regulation 2600.18.

Ongoing: The Director of Maintenance and the Executive Director will track the documentation on an audit form to ensure that we stay in accordance with regulation 2600.18 for three months. This area will be reviewed by the Leadership Team at the monthly Quality Assurance meetings beginning on July 29, 2026 three months. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/31/2026)

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

At approximately 9:57 a.m. a tube of Diclofenac Sodium 1% topical gel with a manufacturer's label indicating "contact poison control if ingested", was unlocked, unattended, and accessible to residents on top of the fire panel outside the medication room . Not all the residents of the home, including resident #1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 07/16/2026)***

Action: On 6.9.26 resident #1 tube of Diclofenac Sodium 1% was on top of the fire panel outside ethe medication room. Med tech immediately removed the Diclofenac Sodium 1% and placed this medication in the secured locked med room to ensure that we stay in accordance with regulation 2600.82c.

Training: Starting on 7.1.26 all med techs were educated by the Executive Director on regulation 2600.82c. Training

82c - Locking Poisonous Materials (continued)

records will be kept.

Ongoing: On 7.16.26 the lead med tech and the Executive Director will monitor daily for 4 weeks and then monthly for three months to ensure that we stay in accordance with regulation 2600.82c. Documentation will be tracked on audit forms to ensure we remain in accordance with regulation 2600.82c. The Executive Director will review the documentation at the monthly quality assurance meeting starting in July 29,2026 for three months. quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/31/2026)

85d - Trash Receptacles

3. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 9:48 a.m. there was a half full, uncovered, unattended trash can in the shared bathroom located on the right side of the home's living room.

Plan of Correction ***Accept ([redacted] - 07/16/2026)***

Action: On 6.9.26 there weas a trash can without a lid located in the shared bathroom. The Directo of Maintenance immediately removed the trash can and replaced the trash can with a brand-new trash can with a lid in order to stay in accordance with regulation 2600.85d. Training records will be kept.

Training: On 7.1.26 the Director of Maintenance was educated by the Executive Director on regulation 2600.85d, trash shall be kept in a covered receptacle. All other employees will be trained by the Director of Maintenance, Lead Med Tech and the Executive Director by 7.20.26 to ensure compliance.

Ongoing: The housekeeping employees on a daily basis will ensure that al garbage cans have lids on the, if a garbage can does not have a lid the employee will immediately remove the garbage can and replace the garbage can with one that has a lid on it in order to stay in accordance with regulation 2600.85d. I would do an audit weekly x 4 weeks then monthly x 3 months. The Director of Maintenance will monitor twice weekly to ensure we are following regulation 2600.85d. The Executive Director will review the documentation at the monthly quality assurance meeting starting on July 29, 2026, for three months. Quality Assurance Meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/31/2026)

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

Resident #3 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 07/16/2026)***

Action: Resident #3 did not have access to [redacted] table lamp for [redacted] unplugs the lamp and puts it in [redacted] closet, but resident #3 does have access to a night light located on [redacted] wall next to [redacted] bed. Executive Director immediately took resident #3 lamp out of [redacted] closet and placed it on [redacted] end table in resident #3 room in order to stay in accordance with regulation 101j7.

Training: On 7.1.26 the Director of Maintenance was educated by the Executive Director on regulation 101j7. The Director of Maintenance will educate the housekeeping staff on 7.11.26 on regulation 101j7, each resident should have an operable light source within reach of the bedside.

Ongoing: The Director of Maintenance, lead med tech or Executive Director will monitor twice weekly x4 weeks then monthly x 3 months to ensure that all rooms have adequate light to stay in compliance with regulation 101j7. Documentation will be completed on audit forms to ensure compliance. The Executive Director will review the documentation at the monthly quality assurance meeting starting on July 29, 2026, for three months. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/31/2026)

103i - Outdated Food

5. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 9:50A.M., three 46 oz. cans of tomato juice and one 105 oz. can of marinara sauce were found dented in the kitchen pantry.

Plan of Correction ***Accept (- 07/16/2026)***

Action: On 6.9.26 the Dining Room Director immediately removed the three dented cans from the storage area and placed a storage container on the shelf marked for dented cans in order to stay incompliance with regulation 2600.103i.

Training: On 7.1.26 the Dining Room Director was educated on regulation 2600.103i, by the Executive Director in order to stay in accordance with regulation 103i. The Dining Room Director will train the Dining Room Employees by 7.20.26 on regulation 103i. Training records will be kept in accordance with regulation 2600.103i.

Ongoing: The Dietary employees will monitor and check for dented cans. If they find a dented can, they will place it in the storage container labeled dented can and document their findings on an audit form to stay in compliance with regulation 2600.103i. The Executive Director will review the documentation at the monthly quality assurance meeting starting on July 29, 2026 for three months. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/31/2026)

125a - Combustible Storage

6. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At approximately 9:38 a.m. a yellow sock was observed draped over the electrical cord of the home's dryer approximately 2 .5 inches from the dryer vent hose.
Repeated Violation 9/17/25 et al."

Plan of Correction ***Accept (- 07/16/2026)***

Action: Behind the first dryer in the laundry room there was a yellow sock observed draped over the electrical cord of the home's dryer approximately 2.5 inches from the dryer hose, The Executive Director immediately removed the sock from this area in order to stay in compliance with regulation 2600.125a.

Training: On 7.1.26 the Executive Director educated the Director of Maintenance on regulation 2600.125, combustible storage. On 7.9.26 the Director of Maintenance educated the housekeeping employees on regulation 2600.125a. By 7.20.26 all leadership and all other employees will be educated on regulation 2600.125a in order to stay in accordance with the regulation. Training records will be kept in accordance with this regulation.

Ongoing: The Maintenance Director will conduct a check two times a week for 4 weeks then monthly x 3 months to ensure that behind the dryer is clean and free from debris. The Executive Director will monitor to ensure we stay in compliance with regulation 2600.125a. The Executive Director will review the finding at the monthly quality Assurance meeting with the leadership team beginning on July 29. 2026. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/31/2026)

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation completed on 4/5/26 did not indicate the resident's height.

Plan of Correction ***Accept (- 07/16/2026)***

Action: Resident #2 medical evaluation did not indicate Residents #2 height. The Director of Nursing, was able to obtain resident #2 height and documented it to the medical evaluation in order to stay in accordance with regulation 2600.141b1.
Training: On 7.1.2026 the lead med tech along with the Executive Director was educated by the regional director of nursing, on regulation 2600.141b1 annual medical evaluations.
Ongoing: The executive director will conduct audits of the resident's medical evaluations weekly x4 weeks, then monthly x3 months to ensure we stay in compliance with regulation 2600 141b1. Audit sheets will be kept. The Executive Director will monitor to ensure we stay in compliance with regulation 2600 141B and review the findings at the monthly Quality Assurance meeting with the leadership team beginning on July 29, 2026 for three months. Quality Assurance meeting documentation will be kept.

141b1 - Annual Medical Evaluation *(continued)*

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/31/2026)

183b - Meds and Syringes Locked

8. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At approximately 9:57 a.m. a tube of Diclofenac Sodium 1% topical gel was observed to be unlocked and accessible on top of the home's fire panel located next to the medication room.

Plan of Correction ***Accept ([redacted] - 07/16/2026)***

Action: The Director of Maintenance immediately gave the medication to the med tech who locked it immediately in the medication room in the locked medication cart in order to stay in compliance with regulation 2600.183b.
Training: On 7.1.26 the lead med tech and the Executive Director were educated on regulation 2600183.b by the Regional Director of Nursing. The Executive Director/lead med tech educated all the med techs on 7.14.26 on regulation 2600 183.b in order to stay incompliance with regulation. All other employees will be educated by 7.20.26 on if the see a medication lying out that they should immediately bring the medication to the med tech in order to stay in compliance with regulation 2600.183b.
OnGoing: The Lead Med Tech and the Executive Director will monitor daily for 4 weeks and than monthly for 3 months to ensure we stay in compliance with regulation 2600183.b. Documentation will be tracked on audit forms to ensure we remain in accordance with regulation 2600.183.b Executive Director will review the documentation at the monthly quality assurance meeting starting in July 29, 2026 for three months. Quality assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/31/2026)

183e - Storing Medications

9. 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

At approximately 2:30 P.M., the home's medication cart contained a bottle of Timolol eye drops for resident #5 that documented a date of opening of 5/1/26. According to the manufacturer's instructions the drops should be used within 28 days of opening.

Plan of Correction ***Accept ([redacted] - 07/16/2026)***

Action: The med tech immediately removed the Timolol eyedrops from the cart and ordered a new Timolol from the pharmacy. The Timolol was delivered and a new open date sticker was put on the Timolol eyedrop in order to stay in compliance with regulation 2600 183 e.

Training On 7.1.2026 the Executive Director along with the Lead MEd tech were educated on regulation 2600 183e

183e - Storing Medications (continued)

by the Regional Director of Nursing. In order to stay in compliance with regulation. On 7.14.2026 all Med Techs were educated by the Executive Director on regulation 2600 183e in order to stay in compliance.

Ongoing: The Lead Med Tech will conduct weekly audits three months on the medications that require an open date sticker. The Med Techs will monitor daily and document their findings on an audit sheet. 5 days prior to the open date sticker expiring the Med Techs will re-order medication. The
Executive Director will monitor monthly for three months to stay in compliance with regulation 2600 183e. The Executive Director will review documentation starting on July 29, 2026, for three months at the Quality Assurance meeting for three months. Quality assurance documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/31/2026)

185a - Implement Storage Procedures

10. 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 #6 has an order for Robitussin CC CNG DM 5-100/5ml as needed. At 2:30p.m., the medication was not available in the home.

"Repeated Violation 9/17/25 et al."

Plan of Correction ***Accept ([redacted] - 07/16/2026)***

Action: Resident #6 order for Robitussin CC CNG DM 5-100/5ml was not available in the home. The Med Tech immediately ordered Resident #6 medication from the pharmacy. Resident #6 medication arrived at the community and was place in the medication cart in order to stay in compliance with regulation 2600 185a.
Training: On 7.1.2026 the Executive Director along with the lead med tech was educated by the Regional Nursing Director on regulation 2600.185a. On 7.14.26 the med techs were educated by the executive director on regulation 2600185a in order to stay in compliance with regulation.
OnGoing: The lead med tech will complete weekly audits for three months on the PRN mediations. The Executive Director will monitor monthly to stay in compliance with regulation 2600 185.a. The Executive Director will review documentation starting on July 29, 2026 at the Quality Assurance meeting for three months. Quality assurance documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 08/31/2026)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #1 has an order for blood testing and a sliding scale administration of ADMELOG SOLO 100u/ml at

187a Medication Record (continued)

7:30a.m., 12:30p.m., and 5:30p.m.. The order states if blood sugar is 150 to 199 1 unit , 200 to 249 2 units, 250 to 299 3 units, 300 to 349 4 units, 3 350 to 359 5 units, 400 to 449 6 units, 450 or greater 7 units. The resident's medication administration record documents the medication was administered but does not document the number of units administered after each testing.

Plan of Correction ***Accept (- 07/16/2026)***

Action: The Director of Nursing immediately went into ECP and added the question of how many units were given to Resident #1 medication administration record in order to stay in compliance with regulation 2600.187a. Med Techs were able to then document for Resident #1 number of units administered per the Dr. order and regulation.

Training: On 7.1.2026 the Lead Med Tech along with the Executive Director were educated by the regional nursing director on regulation 2600.187a, medication record. On 7.14.26 the Med Techs were trained by the Lead Med Tech on regulation 2600.187a in order to stay in compliance with regulation. Training documents will be kept.

Ongoing: The Lead Med Tech will complete weekly audits for three months to ensure that the documentation for Resident #1 insulin units is recorded in resident #1 medication record The Executive Director will review documentation at the Quality Assurance meeting starting July 29, 2026, for three months. Quality Assurance Meeting minutes will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/31/2026)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident #1 has an order for blood testing and a sliding scale administration of ADMELOG SOLO 100u/ml at 7:30a.m., 12:30p.m., and 5:30p.m.. The order states if blood sugar is 150 to 199 1 unit , 200 to 249 2 units, 250 to 299 3 units, 300 to 349 4 units, 3 350 to 359 5 units, 400 to 449 6 units, 450 or greater 7 units. The resident's medication administration record documents the medication was administered but does not document the number of units administered after each testing.
Repeated Violation 9/17/25 et al."

Plan of Correction ***Accept (- 07/16/2026)***

Action: The Director of Nursing immediately went into ECP and added the question of how many units were given, to residents #1 medication administration record in order to stay in compliance with regulation 2600.187d. Med Techs were able to than document for resident #1 number of units administered per the Dr. order and regulation.

Training: On 7.1.26 the lead med tech along with the Executive Director were educated by the regional nursing director on regulation 2600.187d following prescriber's orders. On 7.14.26 the med techs were trained the lead med tech on regulation 2600.187d in order to stay in compliance with regulation. Training documents will be kept.

Ongoing: the lead med tech will complete weekly audits for three months to ensure that the documentation for resident #1 insulin units are recorded in resident #1 medication record. The Executive Director will review documentation at the quality assurance meeting starting July 29, 2026 for three months. Quality Assurance

187d Follow Prescriber's Orders (continued)

Meeting minutes will be kept

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/31/2026)

233c - Key-Locking Devices

13. 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

At 10:00 a.m. the outdoor keypad inside the home's courtyard did not have power and could not be operated when pressing the code while standing in the courtyard. Interviews with staff confirmed there was a loose wire that rendered the outdoor keypad inoperable.

Plan of Correction ***Accept (- 07/16/2026)***

Action: The director of Maintenance immediately tightened the loose wire in order to stay in compliance with regulation 2600.233c.
Training: The director of Maintenance were educated on 7.1.26 by the Executive Director on regulation 2600.233c, key locking devices, in order to stay in accordance.
OnGoing: Starting on July 14 2026 the director of maintenance will complete a weekly monitoring of the court yard gate for three months, to ensure that the coding system is operable. An audit of weekly findings will be completed and the documentation will be kept for review. The Executive Director will review documentation monthly for three months to ensure we stay in compliance with regulation 2600.233c. Documentation will be reviewed starting on July 29, 2026 at the Quality Assurance meeting for three months. Documentation of the meeting will be kept.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented (- 08/31/2026)