

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

June 23, 2026

[REDACTED] CEO
GARDEN SPOT VILLAGE
[REDACTED]

RE: MEADOW VIEW AT GARDEN SPOT
VILLAGE
800 KRAYBILL AVENUE
NEW HOLLAND, PA, 17557
LICENSE/COC#: 33663

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/11/2026, 06/12/2026 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: MEADOW VIEW AT GARDEN SPOT VILLAGE License #: 33663 License Expiration: 08/26/2026
 Address: 800 KRAYBILL AVENUE, NEW HOLLAND, PA 17557
 County: LANCASTER Region: CENTRAL

Administrator

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

Legal Entity

Name: GARDEN SPOT VILLAGE
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 08/05/2020 Issued By: L&I
 Type: C-2 LP Date: 07/13/2020 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 78 Waking Staff: 59

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint Exit Conference Date: 06/12/2026

Inspection Dates and Department Representative

06/11/2026 - On-Site: [REDACTED]
 06/12/2026 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 50 Residents Served: 39
 Secured Dementia Care Unit
 In Home: Yes Area: Amber and Pearl Capacity: 50 Residents Served: 39
 Hospice
 Current Residents: 1
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 39
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 39 Have Physical Disability: 0

Inspections / Reviews

06/11/2026 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/27/2026

Inspections / Reviews *(continued)*

06/22/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/22/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/29/2026

06/23/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/22/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 5/27/26 at 9:16 PM, Resident #1 attempted to follow █████ family from the home when █████ family left after visiting the resident. Resident #1 grabbed Staff Member A's badge and used it to exit the home. Staff Member A pulled Resident #1 back into the home by the wrists, pinned Resident #1 against a wall, and then physically held Resident #1 on a bench in the vestibule of the main entrance, between the sliding doors. This incident was captured on video recording at the entrance of the home. The video showed Staff Member A holding Resident #1 against the wall to prevent █████ from leaving and pulled on the Resident #1's arm to get █████ back into the building. Upon entering the vestibule, Staff Member A had Resident #1 sit down between the sliding doors and began "bear hugging" the resident to keep █████ in the seat. Staff Member A described holding Resident #1 in a "bear hug" to prevent the resident from leaving the home. This allegation of abuse was not reported to the Local Area Office of Aging until 6/1/26.

Plan of Correction

Accept (████ - 06/22/2026)

1. Allegation of Abuse reported immediately to Local Area Office of Aging by Clinical Care Coordinator on 6/1/26 by telephone upon notification of event.
2. Allegation of Abuse written report submitted to Local Area Office of Aging by Clinical Care Coordinator on 6/2/26.
2. All facility staff provided education 6/2/26-6/17/26 on abuse types, abuse signs and symptoms, reporting abuse, de-escalation techniques, and regulatory requirements related to reporting by administrator
3. All staff complete Abuse training annually using Relias Platform.
4. Random Staff audits on procedures for reporting abuse weekly x1 months beginning 6/15/26, then monthly x3 months, if no concerns identified audits will be discontinued if continued concerns audits will continue until 3 months without issues.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented (████ - 06/23/2026)

16c - Written Incident Report

2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 5/27/26 at 9:16 PM, Resident #1 attempted to follow █████ family from the home when █████ family left after visiting the resident. Resident #1 grabbed Staff Member A's badge and used it to exit the home. Staff Member A pulled Resident #1 back into the home by the wrists, pinned Resident #1 against a wall, and then physically held Resident

16c Written Incident Report (continued)

#1 on a bench in the vestibule of the main entrance, between the sliding doors. This incident was captured on video recording at the entrance of the home. The video showed Staff Member A holding Resident #1 against the wall to prevent [REDACTED] from leaving and pulled on the Resident #1's arm to get [REDACTED] back into the building. Upon entering the vestibule, Staff Member A had Resident #1 sit down between the sliding doors and began "bear hugging" the resident to keep [REDACTED] in the seat. Staff Member A described holding Resident #1 in a "bear hug" to prevent the resident from leaving the home. However, this incident was not reported to the Department until 6/1/26.

Plan of Correction

Accept ([REDACTED]) - 06/22/2026)

1. Allegation of Abuse reported to Department's personal care home regional office on 6/2/26 by Clinical Care Coordinator within 24 hours of notification of the event.
2. All facility staff provided education on 6/2/26 6/17/26 on abuse types, abuse signs and symptoms, reporting abuse, de escalation techniques, and regulatory requirements related to reporting by administrator
3. All staff complete Abuse training annually using Relias Platform.
4. Random Staff audits on procedures for reporting abuse will be completed by administrator weekly x1 months beginning 6/15/26, then monthly x3 months, if no concerns identified audits will be discontinued if continued concerns audits will continue until 3 months without issues.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented ([REDACTED]) - 06/23/2026)

42b - Abuse

3. 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 5/27/26 at 9:16 PM, Resident #1 attempted to follow [REDACTED] family from the home when [REDACTED] family left after visiting the resident. Resident #1 grabbed Staff Member A's badge and used it to exit the home. Staff Member A pulled Resident #1 back into the home by the wrists, pinned Resident #1 against a wall, and then physically held Resident #1 on a bench in the vestibule of the main entrance, between the sliding doors. This incident was captured on video recording at the entrance of the home. The video showed Staff Member A holding Resident #1 against the wall to prevent [REDACTED] from leaving and pulled on the Resident #1's arm to get [REDACTED] back into the building. Upon entering the vestibule, Staff Member A had Resident #1 sit down between the sliding doors and began "bear hugging" the resident to keep [REDACTED] in the seat. Staff Member A described holding Resident #1 in a "bear hug" to prevent the resident from leaving the home. As a result of the incident, Staff Member A was terminated from employment on 6/3/26.

Plan of Correction

Accept ([REDACTED]) - 06/22/2026)

1. Staff member A was immediately suspended pending investigation and was terminated after investigation was completed on [REDACTED]

42b Abuse (continued)

- 2. All facility staff provided education on 6/2/26 6/17/26 on abuse types, abuse signs and symptoms, reporting abuse, de escalation techniques, and regulatory requirements related to reporting by administrator
- 3. All staff complete Abuse training annually using Relias Platform.
- 4. Random resident interviews will be completed by administrator to ensure residents feel safe in their home and have not experienced any neglect, intimidation, physical or verbal abuse, mistreatment, corporal punishment or discipline weekly x1 months beginning 6/15/26, then monthly x3 months, if no concerns identified audits will be discontinued if continued concerns audits will continue until 3 months without issues.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented () - 06/23/2026

65f - Training Topics

4. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 1. Medication self-administration training.
- 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- 5. Personal care service needs of the resident.

Description of Violation

Staff Member B, hired on (), did not receive the following training during the 2025 training year:

- 1. Medication self administration training.
- 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- 5. Personal care service needs of the resident.

Plan of Correction

Accept () - 06/22/2026

- 1. On 6/12/26 Administrator conducted an audit of direct care staff training in 2025 to ensure compliance.
- 2. Education covering items 1, 2, and 5 created by administrator and provided to Staff Member B on 6/18/26.
- 3. Education covering items 1, 2, and 5 added to 2026 Relias Training Plan by administrator for all direct care staff to ensure continued compliance.
- 4. Administrator will conduct quarterly staff training audits to ensure on going compliance as part of quality management plan beginning 7/2026.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented () - 06/23/2026

183d - Prescription Current

5. 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 6/11/26, Silver Alginate 2X2 patch prescribed for Resident #3, was in Resident #3's medication drawer; however, this medication was discontinued on 6/4/26.

183d - Prescription Current (continued)

Plan of Correction

Accept ([redacted] - 06/22/2026)

1. Silver Alginate 2X2 patch was immediately disposed of by LPN per facility protocol on 6/1/26 during inspection.
2. All LPNs and Med Techs educated on Regulation 2600.183d and 2600.185a on 6/18/26.
3. Audit of all resident medication storage conducted by night shift LPN on 6/15/26 to ensure no discontinued medications available.
4. Monthly medication storage audits will be completed by Clinical Care Coordinator or designee beginning 7/2026 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented ([redacted] - 06/23/2026)

185a - Implement Storage Procedures

6. 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 #3 is prescribed Bio Freeze 4% gel as needed. However, on 6/11/26, this medication was not available in the home.

Resident #4 is prescribed Nitroglycerine 0.4mg as needed. However, on 6/11/26, this medication was not available in the home.

Plan of Correction

Accept ([redacted] - 06/22/2026)

1. Bio Freeze 4% gel and Nitroglycerine 0.4mg was immediately reordered by LPN per facility protocol on 6/1/26 during inspection. Medications were delivered in the evening on 6/1/26.
2. All LPNs and Med Techs educated on Regulation 2600.183d and 2600.185a on 6/18/26.
3. Audit of all resident medication storage conducted by administrator on 6/19/26 to ensure all ordered medications are available.
4. Monthly medication storage audits will be completed by Clinical Care Coordinator or designee beginning 7/2026 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented ([redacted] - 06/23/2026)

202 - Prohibitions

7. Requirements

2600.

202. The following procedures are prohibited:

6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On 5/27/26 at 9:16 PM, Resident #1 attempted to follow [redacted] family from the home when [redacted] family left after

202 - Prohibitions (continued)

visiting the resident. Resident #1 grabbed Staff Member A's badge and used it to exit the home. Staff Member A pulled Resident #1 back into the home by the wrists, pinned Resident #1 against a wall, and then physically held Resident #1 on a bench in the vestibule of the main entrance, between the sliding doors. This incident was captured on video recording at the entrance of the home. The video showed Staff Member A holding Resident #1 against the wall to prevent [REDACTED] from leaving and pulled on the Resident #1's arm to get [REDACTED] back into the building. Upon entering the vestibule, Staff Member A had Resident #1 sit down between the sliding doors and began "bear hugging" the resident to keep [REDACTED] in the seat. Staff Member A described holding Resident #1 in a "bear hug" to prevent the resident from leaving the home.

Plan of Correction

Accept ([REDACTED] - 06/22/2026)

1. Staff member A was immediately suspended pending investigation and was terminated after investigation was completed on [REDACTED].
2. All facility staff provided education on 6/2/26-6/17/26 on abuse types, abuse signs and symptoms, reporting abuse, de-escalation techniques, and regulatory requirements related to reporting by administrator
3. All staff complete Abuse training annually using Relias Platform.
4. Random resident interviews will be completed by administrator to ensure residents feel safe in their home and have not experienced any neglect, intimidation, physical or verbal abuse, mistreatment, corporal punishment or discipline weekly x1 months beginning 6/15/26, then monthly x3 months, if no concerns identified audits will be discontinued if continued concerns audits will continue until 3 months without issues.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented ([REDACTED] - 06/23/2026)

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

The directions for operating the home's locking mechanism were not conspicuously posted near the courtyard gate in the Amer household and the main courtyard.

Plan of Correction

Accept ([REDACTED] - 06/22/2026)

1. Gate codes immediately replaced in the Amber Household and Main Courtyard on 6/11/26 during inspection by Program Coordinator.
2. Program Coordinator audited all gates and exits to ensure codes were conspicuously posted on 6/11/26.
3. All Gate codes were covered by weather-proof stickers on 6/12/26 by Administrator
- c. All staff educated on regulation 2600.233c at monthly staff meeting on 6/17/26 by Administrator
- d. Administrator or designee will complete weekly audits of all exits ensuring code is in place and legible x1 month

233c - Key-Locking Devices (continued)

beginning 6/15/26, then monthly audits x 3 beginning 7/10/26. If no issues are identified, audits will continue on a quarterly basis to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 06/22/2026

Implemented ([REDACTED] - 06/23/2026)