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

October 6, 2026

[redacted]
EC OPCO MID VALLEY LLC
[redacted]
ECLIPSE SR LIV ATTN LICENSING
[redacted]

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

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/26/2026, 09/03/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CELEBRATION VILLA OF MID VALLEY* **License #**: *22718* **License Expiration**: *07/11/2027*

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**: *70* **Waking Staff**: *53*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/03/2026*

Inspection Dates and Department Representative

08/26/2026 - On-Site: [redacted]

09/03/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *35*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *50* **Residents Served**: *35*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *34*

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

Have Mobility Need: *35* **Have Physical Disability**: *0*

Inspections / Reviews

08/26/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/19/2026*

09/21/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/28/2026*

Inspections / Reviews *(continued)*

09/28/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/05/2026*

10/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/05/2026*

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

Resident [redacted] was admitted to the home on [redacted] with a diagnosis of [redacted] The entire facility is a secured dementia care unit. On [redacted], Resident [redacted] left the home with a family member, while staff were entering the unit. The resident's power of attorney called the resident, who said they were not going to return to the home. A missing person report was filed with the police. Later that day, the police returned the resident.
On [redacted] Staff person A administered medication to Resident [redacted] at 11:15a.m. in the resident's room. At 11:45a.m., staff person A went to the resident's room, resident [redacted] was not in the room, and the window was wide open with the screen missing. Staff person A immediately enacted a search, focusing on outside the building because of the missing screen. Once out in the courtyard, a chair from the patio was observed sitting close to the building up against the fence. Resident [redacted] is in good health and can climb on the chair and get over the fence. The police were immediately called. The police searched for the resident with the use of a K-9 and a drone. The resident was not located by the police. Staff of the home continued searching by looking at 3 properties the resident owns, and the resident was not located.
On [redacted], a family member of the resident called to state the resident was observed coming out of their camper on their property. Police were contacted and the resident was secured by police. Resident was taken to the hospital for further evaluation.

Plan of Correction ***Accept [redacted] - 09/28/2026)***

ACTION: Resident [redacted] was admitted to the home on 2/27/26 with a diagnosis of [redacted]. The entire facility is a secured dementia care unit. On 8/24/26 Resident [redacted] left the home with a family member while staff were entering the unit. The resident's power of attorney called the resident who said that they were not going to return to the home. A missing person report was filed with the police. Later that day the police returned the resident.
On 8/30/26 staff person A administered medication to Resident [redacted] at 11:15 am in the resident's room. At 11:45 am staff person A went to the resident
s room. Resident [redacted] was not in the room and the window was wide open with the screen missing. Staff person A immediately enacted a search focusing on outside the building because of the missing screen. Once out in the courtyard, a chair from the patio was observed sitting close to the building up against the fence. Resident [redacted] is in good health and can climb on the chair and get over the fence. The police were immediately called. The police searched for the resident with the use of a K-9 and drone. The resident was not located by the police. Staff of the home continued searching by looking at 3 properties the resident owns and the resident was not located.
On 8/31/26 a family member of the resident called to state that the resident was observed coming out of their camper on their property. Police were contacted and the resident was secured by police. Resident was taken to the hospital for further evaluation.
Resident [redacted] was transported to GCMC ER for further evaluation. While at the ER, [redacted] was admitted with the diagnosis of Delirium and observation. Resident [redacted] was assessed by the physiatrist and prescribed Seroquel. Resident [redacted] was discharged from our community back to the care of [redacted] POA, [redacted]

Training: By 9.30.26, the Executive Director educated all staff on regulation 2600.42b to include and maintaining the security of all entrances and exits to the secured unit, monitoring residents who demonstrate exit-seeking or elopement behaviors, following each residents'

42b Abuse (continued)

individualized support plan and supervision requirements, immediately reporting malfunctioning locks, alarms, doors, windows or any other security concerns, immediately notifying the appropriate staff when a resident is unaccounted for and following the community's elopement/wandering response procedure.

Ongoing: Beginning 9.30.26 the Executive Director or Director of Nursing will conduct daily audits of the secured unit, including verification that doors, windows and security systems are functioning properly x 2 weeks, weekly x 4 weeks then monthly x 2 months. Any identified deficiency will be corrected immediately and additional staff education will be provided as indicated. Audits will be reviewed monthly at the Quality Assurance meeting x 3 months. Documentation will be kept on file for review.

Licensee's Proposed Overall Completion Date: *10/01/2026*

Implemented [redacted] - 10/06/2026)