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

September 30, 2025

[redacted]
EC OPCO LEWISBURG LLC
[redacted]
ECLIPSE SR LIV ATTN LICENSING
[redacted]

RE: CELEBRATION VILLA OF LEWISBURG
2421 OLD TURNPIKE ROAD
LEWISBURG, PA, 17837
LICENSE/COC#: 22720

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/07/2025, 08/26/2025 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 LEWISBURG* **License #**: *22720* **License Expiration**: *12/18/2025*

Address: *2421 OLD TURNPIKE ROAD, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *EC OPCO LEWISBURG LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/13/1998* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *49* **Waking Staff**: *37*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/26/2025*

Inspection Dates and Department Representative

08/07/2025 - On-Site: [redacted]

08/26/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *73* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *17* **Residents Served**: *10*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *38*

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

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

08/07/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/19/2025*

09/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/29/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/29/2025*

Inspections / Reviews *(continued)*

09/30/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/29/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home 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 [redacted] an incident with staff person A verbally abusing resident [redacted] was not reported to the Area Agency on Aging until [redacted]

Plan of Correction ***Accept ([redacted] - 09/22/2025)***

Action: On 7/18/25, the staff did not follow the policy on reporting the abuse incident of resident [redacted] therefore, resulting in late reporting by the Executive Director. On 7/21/2025 the Executive Director was made aware of the allegation of verbal abuse incident and immediately suspended staff member A pending investigation and notified the Area Agency on Aging. The investigation was concluded on 7/21/2025 and staff member A was terminated.
Training: The Executive Director at the staff meeting on 7/25/25 completed 2600.115a training with all staff at the monthly staff meeting. The Executive Director and Director of Nursing will continue to train all staff on regulation 2600.15a during monthly staff meetings to begin on 9/25/25 and continue monthly for a period of 6 months. The Executive Director contacted the Area Agency on Aging on 8/7/25 to do a training which was scheduled for 8/26/25, but they had to reschedule the training for 9/25/25. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: Staff will be trained monthly at mandatory staff meetings that will begin 9/25/25 by the Director of Nursing and Executive Director to ensure understanding of abuse reporting. Monthly training will be done for 6 months. Training records will be kept in accordance with regulation 2600.65i. The Director of Nursing will complete 4 interviews a month for a period of an additional 6 months. This will include family interviews for Memory Care Residents. The Executive Director will complete monthly audits of Resident Interviews to ensure resident interviews are completed and reviewed. An overview of the questionnaires will be discussed by the leadership team at the monthly Quality Assurance Meetings starting on 9/25/25. Resident names will not be disclosed during the review. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented [redacted] - 09/30/2025)

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 [redacted] an incident with staff person A verbally abusing resident [redacted] was not reported to BHSL department until [redacted]

On [redacted] an incident of a power outage where the secured dementia unit door locking devices were not working and emergency preparedness measures were put in place by stationing staff at the unit's exits to prevent elopements was

16c Written Incident Report (continued)

not reported to BHSL department.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Action: On 7/18/25, the staff did not follow the policy on reporting the abuse incident of resident [redacted] therefore, resulting in late reporting by the Executive Director. On 7/21/2025 the Executive Director was made aware of the allegation of verbal abuse incident and immediately suspended staff member A pending investigation and notified the BHSL department. The investigation was concluded on 7/21/2025 and staff member A was terminated.
On 8/4/25 a power outage occurred in the town affecting the community. The power was out for less than 30 minutes, however, the Executive Director did not report the power outage to the Department of Human Services.
Training: On 8/27/25 the Executive Director was educated by the Regional Director of Operations on Regulation 2600.16c.
On 7/25/25, The Executive Director completed training on regulation 2600.15a training with all staff. On 7/25/25 the Executive Director trained all staff in the procedure of making the Executive Director aware of incidents that must be reported immediately. The Executive Director and Director of Nursing will train all staff on regulations 2600.15a and 2600.16c during monthly staff meetings to begin on 9/25/25 and continue monthly for a period of 6 months. The Executive Director contacted the Area Agency on Aging on 8/7/25 to do a training course which was scheduled for 8/26/25, but they had to reschedule the training for 9/25/25. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: Staff will be trained monthly at mandatory staff meetings to being 9/25/25 by Director of Nursing and Executive Director to ensure understanding of reporting of 2600.16c and continue training for a period of 6 months. Training records will be kept in accordance with regulation 2600.65i. An overview of the questionnaires will be reviewed by the leadership team at the monthly Quality Assurance Meetings starting 9/25/25. Resident names will not be disclosed during review. Quality Assurance meeting documentation will be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)

42c - Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Staff person A verbally abused resident [redacted] by repeatedly addressing resident 1 as a with derogatory slurs throughout the night.

Plan of Correction ***Accept ([redacted] - 09/22/2025)***

Action: On 7/21/2025 the Executive Director was made aware of the allegation of verbal abuse incident and immediately suspended staff member A pending investigation and notified the Area Agency on Aging. The investigation was concluded on 7/21/2025 and staff member A was terminated.
Training: Staff will be trained monthly at mandatory staff meetings to being 9/25/25 by Director of Nursing and Executive Director to ensure understanding regulation 42.c and continue training for a period of 6 months. Training records will be kept in accordance with regulation 2600.65i. Executive Director or Director of Nursing will continue

42c - Treatment of Residents (continued)

to complete the questionnaires by doing 4 interviews a month for a period of 6 additional months to include family interviews for Memory Care Residents to ensure residents' needs are being met, they are treated with dignity and respect and there are no resident concerns. The Executive Director and Director of Nursing will train all staff on regulation 42c. during the monthly staff meeting to begin on 9/25/25 and continue monthly for a period of 6 months. Area Agency on Aging was contacted for training and scheduled on 8/26/25, they rescheduled to 9/25/25. The training is scheduled for 9/25/25. Training records will be kept in accordance with regulation 2600.65i
Ongoing: The Director of Nursing or Executive Director will complete and monitor monthly audits to ensure resident interviews are completed and documentation will be kept. The Executive Director or Director of Nursing will review the interviews with the leadership team at the monthly Quality Assurance Meetings starting 9/25/25. Resident names will not be disclosed during review. Quality Assurance Meeting documentation will be kept in accordance with regulation 2600.65i .

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)

121a - Unobstructed Egress

4. 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

At 9:15 a.m., a chair was blocking the fire exit door in the dining room. At 9:17 a.m., a large trash can was blocking hallway 1's fire exit door in the front of the facility.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Action: On 8/7/25 the Executive Director immediately removed the chair in the dining room that was blocking the fire exit door. On 8/7/25 the large garbage can that was blocking the exit in front of the cleaning closet was removed by the Executive Director.
Training: At the staff meeting on 8/26/25 the Executive Director completed training on regulation 2600.121a. Training on 2600.121a will continue at Monthly Staff meetings quarterly for 12 months by Executive Director or Maintenace Director. Training documentation will be kept in accordance with regulation 2600.65i.
Ongoing: Executive Director started weekly emergency exit rounds and audits on 8/7/25 to be completed by the Executive Director or Maintenance Director for a period of 3 months. After the 3 months of weekly audits the Executive Director or Maintenance Director will complete monthly audits and monitoring for an additional 3 months to ensure no exits are blocked per regulation 2600.121a. An overview of the audits will be discussed with the leadership team at monthly Quality Assurance meetings beginning 9/25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented [redacted] - 09/30/2025)

144c1 - Smoking Area Guidelines

5. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c1 - Smoking Area Guidelines *(continued)*

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At 8:58a.m., a trash can at the facilities entrance contained cigarette butts and Styrofoam cups, napkins and other flammable materials.

Plan of Correction ***Accept [redacted] - 09/22/2025)***

Action: On 8/7/25 the trash can that was reported to have cigarette butts by DHS representative. On 8/7/2025, The Executive Director immediately removed the trash can and the contents.
Training: Regulation 2600.144c1 and Facility Smoking Policy will be reviewed at monthly staff meeting on 9/25/25 by the Executive Director or Director of Nursing. Training on 2600.144c1 and Facility smoking policy will be completed at the monthly staff meeting for a period of 3 months to begin on 9/25/25. All documentation will be kept in accordance with regulation 2600.65i. Regulation 2600.144c1 will be reviewed with residents at Resident council meeting on October 9, 2025, to ensure understanding of regulation and policy on smoking in the facility All documentation will be kept in accordance with regulation 2600.65i
Ongoing: Beginning 9/18/2025, Executive Director or Activities Director will complete weekly audits with internal and external building walk through to ensure that residents and staff are following regulation 2600.144c1 and safely disposing of cigarette butts in appropriate fireproof receptacle. Starting October 9, 2025, Regulation 2600.144c1 will be reviewed with residents at the resident council meeting by the Executive Director every month for 3 months. All documentation will be kept. Beginning 9/18/2025 an audit of all residents who smoke will be completed to ensure that they have a monthly Smoking Assessment by the Executive Director. The Director of Nursing will complete monthly smoking assessments on any residents who smoke. Beginning 9/18/2025, all residents who smoke will sign an agreement stating that they are aware of and will utilize the designated smoking area and the firesafe receptacle. The Executive Director will monitor that the smoking assessments are being completed. An overview of the audits and smoking agreements will be discussed with the leadership team at monthly Quality Assurance meetings beginning 9/19/25 for 6 months. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented [redacted] - 09/30/2025)

183b - Meds and Syringes Locked

6. 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 9:00 a.m., an unattended medication treatment cart was in the hallway by the dining room that was unlocked and accessible.

Repeat Violation: [redacted] *et al.*

Plan of Correction ***Accept ([redacted] 09/22/2025)***

Action: On 8/7/25 treatment cart was found to be unlocked near Hallway A in Personal Care Unit by Department of Human Services representative. This was unlocked due to a Med Tech being distracted by a resident and had walked away without locking it. On 8/7/25, The Executive Director immediately locked the treatment cart. Certified

183b - Meds and Syringes Locked (continued)

Medication Technician was educated by the Executive Director on 8/7/25 of regulation 183.b. Documentation of the education will be kept.
Training: The Executive Director and Director of Nursing will complete training with the Medication Technicians on 9/19/25 on regulation 2600.183b. This will be completed Quarterly for a period of 1 year. All documentation will be kept in accordance with regulation 2600.65i.
Ongoing: Director of Nursing will complete weekly audits for a period of 3 months to begin on 9/19/25 followed by monthly audits for 6 months to ensure all medication and treatment carts are locked per regulation 2600.183b. The findings will be reviewed by the Executive Director. Audit results will be discussed with the leadership team at monthly Quality Assurance meetings beginning 9/25/25 for 6 months. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (09/30/2025)

231e - No Objection Statement

7. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on . The home has no notation in the records that the resident has not objected to the admission.

Plan of Correction ***Accept (09/22/2025)***

Action: On 8/7/25 it was found by Department of Human Services auditor that Resident Contract did not have Resident 1 signature on documentation. On 8/7/25 Executive Director spoke with the family of Resident to discuss the missed signature and to inform them that Resident would be signing, family agreed. On 8/7/25 Resident did then sign the documentation stating that did not object to being in the Secure Dementia Care Unit.
Training: Regional Director of Operations completed training with the Executive Director on 9/05/25 on Regulation 2600.231e. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: On 9/18/2025 an audit will be initiated of all resident contracts that reside in the memory care unit to ensure that all admission and objection statements are signed by the resident. This audit will be conducted by the Executive Director and will conclude by 9/25/2025. Beginning 9/17/2025, the Executive Director or the Director of Nursing will review all Memory Care Admissions or transfers to ensure that the objection statement is signed by the resident prior to move in. Audit results will be discussed with the leadership team at monthly Quality Assurance meetings beginning 9/25/25 for 6 months. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented - 09/30/2025)