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

January 14, 2026

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

RE: CELEBRATION VILLA OF REEDSVILLE
55 CARRIAGE HOUSE LANE
REEDSVILLE, PA, 17084
LICENSE/COC#: 33378

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/18/2025, 11/19/2025 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 REEDSVILLE* **License #**: *33378* **License Expiration**: *08/01/2026*

Address: *55 CARRIAGE HOUSE LANE, REEDSVILLE, PA 17084*

County: *MIFFLIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *EC OPCO REEDSVILLE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/13/2018* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *61* **Waking Staff**: *46*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/19/2025*

Inspection Dates and Department Representative

11/18/2025 - On-Site: [redacted]

11/19/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *42*

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

Have Mobility Need: *19* **Have Physical Disability**: *1*

Inspections / Reviews

11/18/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/13/2025*

12/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/09/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/09/2026*

Inspections / Reviews *(continued)*

01/14/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/09/2026*

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

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On [redacted] and [redacted] from 10:00 PM to 6:00 AM, 42 residents were present in the home. During this time no staff persons were present and working in the home who were certified in obstructed airway techniques and CPR.

Repeated violation - [redacted] et al

Plan of Correction ***Accept [redacted] - 12/16/2025)***

INITIAL: On November 19, 2025, the Direct Care Schedule was reviewed by the Director of Nursing and the Assistant Director of Nursing to ensure compliance with Regulation 2600.63.a.
TRAINING: On November 19, 2025, the Executive Director was educated by the Regional Director of Operations on Regulation 2600.63.a. On November 19, 2025, the Executive Director educated the Director of Nursing and the Assistant Director of Nursing on Regulation 2600.63.a. A record of this training will be kept in accordance with Regulation 2600.65.i.
ONGOING: Effective December 1, 2025, the Director of Nursing or Assistant Director of Nursing will review the Direct Care Schedule to ensure compliance with Regulation 2600.63.a. Findings will be discussed by the Leadership Team weekly for four weeks, then monthly during the Quality Assurance meeting, starting at the December 2025 meeting. Quality Assurance meeting documentation will be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented [redacted] - 01/14/2026)

103f - Refrigerator/Freezer Temps

2. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On [redacted] at 11:15 AM the temperature in the freezer located by the ice cream chest was 6 degrees Fahrenheit and on [redacted] at 9:15 AM it was 4 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

INITIAL: On November 20, 2025, the Director of Maintenance replaced the thermometer in the freezer located next to the ice cream freezer to ensure compliance with Regulation 2600.103.f.
TRAINING: On November 19, 2025, the Executive Director was educated by the Regional Director of Operations on Regulation 2600.103.f. On November 19, 2025, the Executive Director educated the Director of Culinary Excellence on Regulation 2600.103.f. The Director of Culinary Excellence will educate the Dietary Staff on Regulation 2600.103.f during the December 2025 Staff Meeting. A record of this training will be kept in accordance with Regulation 2600.65.i.
ONGOING: Effective December 1, 2025, the Director of Culinary Excellence or a member of the Dietary Staff will complete daily temperature logs on all freezers and refrigerators to ensure compliance with Regulation 2600.103.f. Findings will be discussed by the Leadership Team weekly for four weeks, then monthly during the Quality

103f Refrigerator/Freezer Temps (continued)

Assurance meetings, starting with the December 2025 meeting. Quality Assurance meeting documentation will be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented (- 01/14/2026)

103i - Outdated Food

3. Requirements

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

Description of Violation

On there was a dented 6 lb. can of peaches in the dry food storage area.

Plan of Correction ***Accept - 12/16/2025)***

INITIAL: On November 18, 2025, a dented 6lb can of peaches located in the dry storage was removed by the Director of Culinary Excellence. On November 19, 2025, an audit was completed by the Director of Culinary Excellence on all canned goods to ensure compliance with Regulation 2600.103.i.
TRAINING: On November 19, 2025, the Executive Director was educated on Regulation 2600.103.i. by the Regional Director of Operations. On November 19, 2025, the Executive Director educated the Director of Culinary Excellence on Regulation 2600.103.i. The Director of Culinary Excellence will educate all Dietary Staff on Regulation 2600.103.i. during the December 2025 Staff Meeting. A record of this training will be kept in accordance with Regulation 2600.65.i.
ONGOING: Effective December 1, 2025, a weekly audit will be completed to ensure compliance with Regulation 2600.103.i. Findings will be discussed by the Leadership Team weekly for four weeks, then monthly during the Quality Assurance meeting, starting with the December 2025 meeting. Quality Assurance meeting documentation will be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented - 01/14/2026)

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:
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

The home's designated smoking area located in the rear of the building was observed having a chair cushion which did not have a label indicating the material was fire retardant.

Plan of Correction ***Accept - 12/16/2025)***

INITIAL: On November 18, 2025, the Director of Maintenance removed the chair cushion from the designated smoking area due to the label not specifying if the cushion was fire resistant or not to ensure compliance with

144c1 - Smoking Area Guidelines (continued)

Regulation 2600.141.c.1.
TRAINING: On November 19, 2025, the Executive Director was educated by the Regional Director of Operations on Regulation 2600.141.c.1. On November 19, 2025, the Executive Director educated the Director of Maintenance on Regulation 2600.141.c. The Director of Maintenance will educate all Staff during the December 2025 Staff Meeting on Regulation 2600.141.c.1. A record of this training will be kept in accordance with Regulation 2600.65.i.
ONGOING: Effective December 1,2025, the Director of Maintenance or a member of the Leasership Team will monitor the smoking area daily to ensure
compliance with Regulation 2600.141.c.1. Findings will be discussed by the Leadership Team weekly for four weeks, then monthly during the Quality Assurance Meetings, starting with the December 2025 meeting. Quality Assurance meeting documentation will be kept in the designated binder in the Executive Director's office.

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented [redacted] - 01/14/2026)

181c - Self-administration Assessment

6. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident [redacted] self-administers medications to include [redacted] and Resident [redacted] self-administers medications to include [redacted] and [redacted]; however, Residents [redacted] and [redacted] have not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

INITIAL: On November 19, 2025, the Assistant Director of Nursing removed Medications from Resident #[redacted] and Resident #[redacted] rooms due to them not being assessed to self□medicate. On November 20, 2025, the Director of Nursing and Assistant Director of Nursing completed an audit of all Resident rooms to ensure compliance with Regulation 2600.181.c.
TRAINING: On November 19, 2025, the Executive Director was educated on Regulation 2600.181.c. by the Regional Director of Clinical Operations. On November 19, 2025, the Executive Director educated the Director of Nursing and the Assistant Director of Nursing on Regulation 2600.181.c. The Director of Nursing and Assistant Director of Nursing will educate all Staff during the December 2025 Staff Meetings. The record of this training will be kept in accordance with Regulation 2600.65.i.
ONGOING: Effective December 1, 2025, The Director of Nursing and Assistant Director of Nursing will complete weekly audits to ensure compliance with Regulation 2600.181.c. Findings will be discussed by the Leadership Team weekly for four weeks, then monthly during the Quality Assurance meeting, starting with the December 2025 meeting. Quality Assurance meeting documentation will be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented [redacted] - 01/14/2026)

181c - Self-administration Assessment *(continued)*

183d - Prescription Current

7. 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 [redacted], [redacted] tabs prescribed for Resident [redacted], was in the home's medication cart; however, the medication was discontinued on [redacted]

Plan of Correction ***Accept [redacted] 12/16/2025)***

INITIAL: On November 19, 2025, the Assistant Director of Nursing removed the [redacted] for Resident #[redacted] from the Med Cart. On November 19, 2025, the Director of Nursing and Assistant Director of Nursing completed an audit on all Med Carts to ensure compliance with Regulation 2600.183.d.
TRAINING: On November 19, 2025, the Executive Director was educated by the Regional Director of Clinical Operations on Regulation 2600.183.d. On November 19, 2025, the Executive Director educated the Director of Nursing and the Assistant Director of Nursing on Regulation 2600.183.d. The Director of Nursing and Assistant Director of Nursing will educate all Med Techs on Regulation 2600.183.d. The record of this training will be kept in accordance with Regulation 2600.65.i.
ONGOING: Effective December 1, 2025, the Med Techs along with the Director of Nursing and / or Assistant Director of Nursing will review all Discontinued Medications weekly. to ensure compliance with Regulation 2600.183.d. Findings will be discussed with the Leadership Team weekly for four weeks, then monthly during the Quality Assurance meeting, starting with the December 2025 meeting. Quality Assurance meeting documentation will be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented ([redacted] - 01/14/2026)