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

September 2, 2025

[redacted]
EC OPCO YORK LLC
[redacted]
C/O ECLIPSE SR LIVING;LICENSING
[redacted]

RE: CELEBRATION VILLA OF YORK
2405 KNOB HILL ROAD
YORK, PA, 17403
LICENSE/COC#: 33498

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/23/2025 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 YORK* **License #**: *33498* **License Expiration**: *01/18/2026*

Address: *2405 KNOB HILL ROAD, YORK, PA 17403*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *EC OPCO YORK LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/16/2011* **Issued By**: *York Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Fine* **Exit Conference Date**: *07/23/2025*

Inspection Dates and Department Representative

07/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *45*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *45*

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

Have Mobility Need: *11* **Have Physical Disability**: *1*

Inspections / Reviews

07/23/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/11/2025*

08/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/18/2025*

Inspections / Reviews *(continued)*

08/20/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/28/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/29/2025*

09/02/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/28/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted], at 9:07 AM and 9:12 AM, the following resident medical records to include medications, orders, and date of birth were unlocked, unattended, and accessible on top of the 4 medication carts in the main lobby of the home and inside the unlocked medication carts:

- *A sheet of paper with resident [redacted]s date of birth and an order to continue using [redacted] cane.*
- *Medication label for resident [redacted]s [redacted], take 1 tablet by mouth every 4 hours as needed for mild pain related to chronic pain syndrome.*
- *Medication instructions and diagnoses for:*
  - *resident [redacted].*
  - *resident [redacted].*
  - *resident [redacted]*

Repeated violation - [redacted]et al.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

On 7/23/2025, the 4 medication carts were locked by the medication technician on duty during inspection to ensure that residents [redacted] and #[redacted] confidential records were secured in the locked medication cart. On 7/25/2025, the medication technician was provided re-education and a counseling by the Director of Nursing, pertaining to regulation 2600.17 and the need to ensure no protected information is left accessible to anyone.
At the monthly staff meeting on 8/20/2025, the Executive Director will provide education to all staff on regulation 2600.17 along with providing a competency to all staff post training. Those found not competent in the training of this regulation will be educated further on this regulation by 8/28/2025. Training records will be kept in accordance with regulation 2600.65i.
Beginning 7/24/2025 daily walking rounds by the Executive Director or Director of Nursing or Resident Care Coordinator or the Manager on Duty will be done to ensure compliance with regulation 2600.17 and the medication carts will be observed to ensure they are locked, and confidential records are secured in each locked medication cart. Documentation of observations will be kept. The observation findings will be discussed with the leadership team at monthly Quality Assurance meetings beginning 8/20/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Implemented ([redacted] - 08/29/2025)

65d - Initial Direct Care Training

2. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

65d Initial Direct Care Training *(continued)*

Description of Violation

Staff member A, hired on [redacted] as an administrative assistant, began providing unsupervised ADL services on [redacted] from 7:00 AM 3:00 PM and 11:00 PM 7:00 AM. However, staff member A did not receive training that included a demonstration of direct care staff job duties, followed by supervised practice.

Plan of Correction ***Accept ([redacted] - 08/18/2025)***

Staff member A was trained and observed on ADL practice on 8/1/2025 by the Operations Specialist/Licensed Practical Nurse. Documentation will be kept. All direct care staff records will be checked by Executive Director, Director of Nursing or Resident Care Coordinator to ensure all training is completed, and a supervised practice will be completed by 8/25/25.
On 8/5/2025, Operations Specialist provided training to Executive Director, and Director of Nursing on regulation 2600.65d. Training records will be kept in accordance with regulation 2600.65i.
Beginning 8/5/2025, the Administrative Assistant or Executive Director will review each new direct care team member's initial direct care training record prior to filing to ensure compliance with regulation 2600.65d. Direct Care Staff will not be assigned to provide unsupervised care until competency training is completed. Audits will be done monthly for 3 months, then quarterly, by the Administrative Assistant or the Executive Director to monitor compliance beginning 8/11/2025. Audit findings will be kept. This area will be discussed by the leadership team at monthly Quality Assurance meetings beginning 8/20/2025. Quality Assurance meeting documentation will be kept. An audit of all employees will be completed by 8/25/25 by the Executive Director or Director of Nursing. A book with all competency checklists will be kept in the nursing office for use when completing schedules.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 08/29/2025)

85a - Sanitary Conditions

3. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at 10:14 AM, the bathroom in resident bedroom [redacted] had feces smeared on the toilet seat. At 11:58 AM, feces was on the toilet seat, on the floor next to the toilet, smeared on the trashcan lid next to the toilet, and on the inside of the resident's pants that were hanging over a lounge chair in the living room.

On [redacted] at 10:40 AM, a strong smell of urine was present upon entering resident bedroom [redacted]. Urine was in a plastic urinal sitting on a tv tray next to the resident's bed.

On [redacted] at 11:05 AM, a strong odor of feline urine was present in the bathroom of bedroom [redacted] which had a litter box present.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Directed [redacted] - 08/20/2025)***

On 7/23/25, the community housekeeper cleaned resident bedroom [redacted] The affected area was also sanitized using facility-approved cleaning solutions and soiled linens and waste were removed. The resident's support plan was updated to include bathroom assistance as of 8/11/2025, by the Director of Nursing. Care staff will clean urinal's daily. Director of Nursing or Resident Care Coordinator will check residents' rooms with urinal's two times a week for 3 months. Urinals will be replaced monthly or more often if needed to ensure there is no urine odor in resident bedroom [redacted] On 7/24/2025, resident in bedroom [redacted] cat litter box was cleaned and sanitized using facility-approved cleaning solutions and the resident room was ventilated until there were no odors. On 7/24/25 all rooms were checked for cleanliness and smell by the Executive Director. Documentation of audit will be kept.

At the community staff meeting on 8/20/2025, all staff will be trained in proper cleaning and disinfection procedures by the Executive Director. Documentation of training will be kept in accordance with regulation 2600.65i.

Beginning 8/5/2025, the Executive Director and/or Maintenance Director will monitor this area by conducting weekly walkthroughs for 3 months, then monthly to ensure the residence remains free from odors and that cleaning schedules are being followed. Documentation of the walkthroughs will be kept. Beginning 7/24/2025, resident in bedroom 128 will be provided with a new urinal monthly or more often if needed by the direct care staff or the Resident Care Coordinator. Documentation of findings will be reviewed with the leadership team at monthly Quality Assurance meetings beginning on 8/20/2025. Quality Assurance meeting documentation will be kept. The director of nursing or resident care coordinator will educate all residents on cleaning procedures of urinals and contact the staff via call bell after use of urinals by 8/25/25.

(Directed)
In addition to the above plan of correction:

- *Education will be provided to all direct care and housekeeping staff members that bedside urinals are to be emptied and sanitized after each use to maintain sanitary conditions. Staff will complete, at a minimum, 2 hour checks on residents with urinals in their bedroom to ensure they have been emptied and sanitized after each use. Education to be provided to all staff no later than 8/28/25.*

Directed Completion Date: *08/28/2025*

Implemented [redacted] - 09/02/2025)

125b - Combustible Restrictions

4. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On [redacted] at 9:25 AM, a can of [redacted] was unlocked, unattended, and accessible to all residents in the unlocked maintenance office.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

On 7/23/2025 combustible material was found in the Maintenance Director's office which was unlocked. The maintenance director's office door was immediately locked by the Executive Director. The Executive Director provided verbal training to the Maintenance Director pertaining to chemicals unlocked areas on 7/23/2025.
On 7/24/2025, Maintenance Director was provided education on 2600.125b by the Executive Director. All staff will

125b - Combustible Restrictions (continued)

be trained by the Executive Director at the all staff meeting scheduled on 8/20/2025 on the safe storage of hazardous materials. Documentation of the training will be kept in accordance with regulation 2600.65i.
Beginning on 8/4/2025, the Executive Director or Maintenance Director will audit and monitor this area two times a week for 1 month, then monthly to ensure hazardous materials are stored safely in compliance with regulation 2600.125b. Documentation of the audit findings will be kept. Audit findings will be discussed and reviewed with leadership team at the monthly Quality Assurance meetings beginning on 8/20/2025. Quality Assurance meeting minutes will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented (- 08/29/2025)

141a - Medical Evaluation

5. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident medical evaluation was not completed within 60 days prior to admission or within 30 days after admission; resident was admitted to the home on and the medical evaluation was completed on .

Plan of Correction ***Accept 08/12/2025)***

Resident was discharged from the community on 8/1/2025. On 7/23/2025 the Executive Director, Director of Nursing and Resident Care Coordinator were scheduled for training on regulation 2600.141a by the Operations Specialist to be completed by 8/8/2025.
On 8/5/2025, the Operations Specialist provided training to the Executive Director, Director of Nursing and Resident Care Coordinator on the requirement for a new resident to have the medical evaluation completed within 60 days prior to admission or within 30 days after the admission to ensure compliance with regulation 2600.141a. Training records will be kept in accordance with regulation 2600.65i.
Beginning 8/5/2025, the Executive Director will require all Medical Evaluations for new residents to be reviewed by the Director of Nursing or Resident Care Coordinator to comply with regulation 2600.141a. Beginning on 7/24/25 the Executive Director will monitor this with every new admission prior to filing the Medical Evaluation in the medical record. Beginning 7/24/25 the Executive Director will maintain an audit record of findings

Licensee's Proposed Overall Completion Date: *08/12/2025*

Implemented - 08/29/2025)

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

On at 9:07 AM, 4 medication carts were unlocked, unattended and accessible to residents in the main lobby.

183b Meds and Syringes Locked (continued)

Each medication cart contained medications for residents in the home including the following:

- *resident* [redacted].
- *resident* [redacted].
- *resident* [redacted].
- *resident* [redacted].
- *resident* [redacted].

On [redacted] *at 10:40 AM, the following medications were unlocked, unattended, and accessible in resident* [redacted] *bedroom:* [redacted]*, and* [redacted] *and* [redacted]*. Resident* [redacted] *is not assessed to self administer medications as indicated on the resident's medical evaluation, dated* [redacted].

On [redacted] *at 11:04 AM, the following medications were unlocked, unattended, and accessible in resident* [redacted] *bathroom: a bottle of* [redacted]*,* [redacted] *and* [redacted] *pain relief cream. Resident* [redacted] *is not assessed to self administer medications as indicated on the resident's medical evaluation, dated* [redacted].

On [redacted] *at 11:19 AM, the following medications were unlocked and accessible in resident* [redacted] *bedroom: refresh tears,* [redacted] *and* [redacted]*. Resident* [redacted] *is not assessed to self administer medications as indicated on the resident's medical evaluation, dated* [redacted]

Repeated Violation [redacted]*, et al.,* [redacted]

Plan of Correction ***Accept*** [redacted] ***- 08/12/2025)***

On [redacted] *residents* [redacted] *and* [redacted] *medication was removed from their rooms by the Executive Director and Director of Nursing. On 7/24/2025, certified letters were sent to residents POA by the Executive Director, which overviewed regulation 2600.183b. On 7/24/2025, Medication Technicians, Executive Director, and Resident Care Coordinator completed a room and bathroom inspection of all residents checking for medication. Beginning 7/24/25 an audit form with the findings will be documented and kept. On 7/24/2025, during audit of resident rooms, residents were educated on 2600.183b by the Executive Director and/or Operations Specialist. Resident education documentation will be kept. Regulation 2600.183b was reviewed at the monthly resident council meeting on 7/31/2025 by the Executive Director. Documentation of the monthly meeting will be kept.*

On 8/15/2025, the Executive Director will train all staff in role specific duties on reporting to the Director of Nursing, Resident Care Coordinator or the Executive Director if medications are observed in resident rooms. By 8/25/2025 all staff will complete a competency quiz on regulation 2600.183b with documentation kept. Training records will be kept in accordance with regulation 2600.65i.

Beginning 7/25/2025, Executive Director, Director of Nursing, Resident Care Coordinator, Maintenance Director and or Dining Director will conduct 10 resident room audits per week for 6 months, then will do 20 room audits per month with documentation of findings kept. The Executive Director will monitor weekly room audit completion with documentation kept, beginning 7/25/25. Beginning 8/5/2025 all new residents and POAs will be provided education by the Executive Director or Director of Nursing on 2600.183b prior to move in with documentation kept. The audit findings will be reviewed at Quality Assurance meetings with the leadership team beginning 7/25/2025. Quality Assurance meetings will be documented and kept.

183b - Meds and Syringes Locked *(continued)*

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 08/29/2025)

185a - Implement Storage Procedures

8. 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

On [redacted] an unlabeled, used glucometer was stored in resident [redacted] bedroom. Resident [redacted] reported the [redacted] did not belong to [redacted]

Plan of Correction ***Accept [redacted] - 08/12/2025)***

On 7/23/2025, the glucometer in resident [redacted] bedroom was immediately removed by the Executive Director. The glucometer was discarded.
On 8/15/2025, the Director of Nursing will provide education to the medication technicians on regulation 2600.185a. and on labeling the glucometers with the resident's name. Training records will be kept in accordance with regulation 2600.65i.
Beginning 8/11/2025 weekly glucometer checks will be done to ensure each is labeled with the resident's name. Audit findings will be kept. The audits will be reviewed with the leadership team at monthly Quality Assurance meetings beginning 8/20/2025.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented [redacted] - 09/02/2025)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident [redacted] most recent assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 08/12/2025)***

On 8/4/2025, Operations Specialist completed the annual Resident Assessment and Support Plan for resident [redacted] By 8/25/25 all Resident Assessment and Support Plans will be audited to ensure that they are up to date and completed by the Executive Director, Director of Nursing, and/or Resident Care Coordinator.
On 8/5/2025, Executive Director provided training on regulation 2600.225c to Director of Nursing and Resident Care Coordinator to ensure compliance. Training records will be kept in accordance with regulation 2600.63i
Beginning 8/5/2025, the Executive Director will complete monthly audit of annual assessments that are due that month to monitor compliance. Documentation of findings will be kept. The audits will be reviewed with the leadership team at monthly Quality Assurance meetings beginning 8/20/2025. Quality Assurance meeting documentation will be kept.

Proposed Overall Completion Date: 09/25/2025

225c Additional Assessment *(continued)*

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] 08/29/2025)