

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

May 4, 2026

[REDACTED]
SHP V WILLISTOWN LLC
[REDACTED]
[REDACTED]

RE: ARBOR TERRACE WILLISTOWN
1713 WEST CHESTER PIKE
WEST CHESTER, PA, 19382
LICENSE/COC#: 14245

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/23/2026, 03/24/2026 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: ARBOR TERRACE WILLISTOWN **License #:** 14245 **License Expiration:** 07/19/2026
Address: 1713 WEST CHESTER PIKE, WEST CHESTER, PA 19382
County: CHESTER **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: SHP V WILLISTOWN LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 08/29/2013 **Issued By:** Willistown Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 122 **Waking Staff:** 92

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 03/24/2026

Inspection Dates and Department Representative

03/23/2026 - On-Site: [REDACTED]
 03/24/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 104 **Residents Served:** 83

Secured Dementia Care Unit

In Home: Yes **Area:** Evergreen **Capacity:** 35 **Residents Served:** 29

Hospice

Current Residents: 11

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 83
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 39 **Have Physical Disability:** 0

Inspections / Reviews

03/23/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/12/2026

04/13/2026 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 05/01/2026
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/18/2026

Inspections / Reviews *(continued)*

04/20/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/01/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/01/2026

05/04/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/01/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

162c - Menus Posted

1. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted] the home's menu for the week of [redacted] was posted. However, the one for the week of [redacted] was not posted. There was no weekly menu posted in the home's Secured Dementia Care Unit (SDCU).

Plan of Correction

Accepted [redacted] - 04/20/2026

On 3/23/2026, the Dining Director reviewed and posted current and the upcoming week's menu in a conspicuous public location to accurately reflect meals being served in the personal care and memory care neighborhoods. Effective 4/6/26, weekly verification of the 2- week menu posting will be completed by the Executive Director or designee. The Dining Director or Executive Director will re-educate dining staff on regulatory requirements by 4/30/26. The Dining Director or Executive Director will complete weekly audits for four weeks, with results reviewed by ED during Quality Improvement meetings. The next QI meeting is scheduled for 4/27/26. Evidence of Completion: Staff training sign-in sheets, audit tools, and Quality Improvement meeting agenda.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [redacted] - 05/04/2026

184a - Resident's Meds Labeled

2. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident [redacted] was torn, faded and illegible.

Repeat Violation: [redacted]

Plan of Correction

Accepted [redacted] - 04/13/2026

On 3/23/2026, the Memory Care Director replaced pharmacy labeling for Resident [redacted] to ensure legibility. Effective 4/6/26 the Care Director(s) or designee will conduct weekly medication cart audits for four weeks, followed by monthly audits to ensure continued compliance. Medication management policies will be reviewed and reinforced with all medication-trained staff, with re-education provided by Care Director(s) completed by 4/30/26. Ongoing collaboration with the pharmacy provider will ensure all medications are dispensed with complete and accurate labeling. Audit results will be reviewed during Quality Improvement meetings. Evidence of Completion: Evidence will include completed medication audit tools, staff education records, and Quality Improvement meeting agenda.

Licensee's Proposed Overall Completion Date: 04/30/2026

184a Resident's Meds Labeled (continued)

Implemented [REDACTED] - 05/04/2026)

185a Implement Storage Procedures

3. 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 [REDACTED]'s glucometer was not calibrated to correct date and time. The resident's glucometer reading for [REDACTED] at 8:06 PM read [REDACTED] at 2:31 AM on the meter.

Resident [REDACTED] is prescribed blood sugar readings via "accu-chek" 4 times a day. On [REDACTED] at 05:00 PM, a reading of [REDACTED] on the resident's glucometer was documented as [REDACTED] on the blood sugar log. The following numbers observed on the blood sugar log were not found on the glucometer:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Plan of Correction

Accept ([REDACTED] 04/20/2026)

On 3/23/2026, the Resident Care Director and Memory Care Director reviewed each resident with an order for blood glucose monitoring, ensuring each resident has their own device and calibrated the equipment with the correct date and time. Effective 4/6/26. Each LPN or Medication Technician responsible for blood glucose monitoring will receive training by the Care Director(s) on proper and safe use, storage, cleaning and calibration of devices by 4/30/26. A competency checklist will be used to document training and return demonstration.

A schedule will be established to routinely check calibration no less than once per week by the overnight shift Medication Technician or LPN. Results will be documented in an audit log and will be ongoing.

Medication Technicians or LPNs will report devices that are not reading the correct date and time to the nurse on duty to correct the calibration and reset the date.

Effective 4/6/26 the Care Director(s) or assigned medication technician or LPN will conduct weekly medication cart audits for four weeks, followed by monthly audits which will include review of medication storage, labeling, administration practices, and proper use of medical equipment. The monthly audits will be ongoing to maintain compliance.

Audit findings will be reviewed during Quality Improvement meetings by the Resident Care Director, Memory Care Director and Executive Director to ensure sustained compliance and to identify opportunities for continued improvement. The next QI meeting is scheduled for 4/27/26.

The Resident Care Director will monitor the glucometer calibration log weekly effective 4/15/26 to ensure all devices are properly calibrated. This will be ongoing to maintain compliance.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [REDACTED] 05/04/2026)

4. 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.

185a - Implement Storage Procedures (continued)

Description of Violation

Resident [redacted] is prescribed [redacted] as needed. On [redacted] this medication was not available in the home.

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] - 04/20/2026)

On 3/23/26 an audit of each resident's medication orders was completed to ensure the medication ordered was on the cart and available for administration. Resident [redacted] prescribed [redacted] is now available on the medication cart. Effective 4/6/26 the Care Director(s) or assigned medication technician or LPN will conduct weekly medication cart audits for four weeks, followed by monthly audits which will include review of medication storage, labeling, administration practices, and proper use of medical equipment. The monthly audits will be ongoing to maintain compliance.

Audit findings will be reviewed during Quality Improvement meetings by the Resident Care Director, Memory Care Director and Executive Director to ensure sustained compliance and to identify opportunities for continued improvement. The next QI meeting is scheduled for 4/27/26.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [redacted] 05/04/2026)

225c - Additional Assessment

5. Requirements

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted] utilizes a bedside mobility device for transferring in and out of and turning and positioning in bed & chair. However, the resident's status change assessment, dated [redacted] does not include any risks associated with such use, the resident's ability to use the device safely for its intended purpose, and an identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Resident [redacted] utilizes a bedside mobility device. However, the resident's annual assessment, dated [redacted], does not mention the device and does not include the specific need for the device, the intended use and any risks associated with such use, the resident's ability to use the device safely for its intended purpose, and an identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] - 04/13/2026)

On 3/24/2026, the Care Director(s) or designee conducted a focused audit of all residents utilizing bedside mobility devices to ensure assessments accurately reflect device use, associated risks, resident ability to safely use the device, and required safety measures, including identification of the specific device and whether a cover is required per FDA guidelines. The assessments for the identified residents [redacted] and [redacted] were immediately updated by 3/25/2026 to include all required elements, including risks, safe use evaluation, and device specifications.

The Executive Director will re-educate all clinical staff responsible for completing assessments by 3/31/26 on

225c - Additional Assessment (continued)

thorough detailed documentation of assistive devices and reassessment following any change in condition. Effective, 4/6/26 an audit process has been implemented to include weekly audits for four weeks completed by Care Director(s) or designee to ensure compliance with assessment requirements. Findings will be reviewed during Quality Improvement process to ensure sustained compliance.

Evidence will include updated resident assessments, staff training records, completed audit tools, and Quality Improvement meeting agenda.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented (████) - 05/04/2026)

227g -Support Plan Signatures**6. Requirements**

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident █████ participated in the development of █████ support plan on █████. However, the resident did not sign the support plan.

Plan of Correction

Accept █████ - 04/13/2026)

On 3/24/2026, resident █████ support plan was reviewed and signed by resident █████. Effective 4/6/26 all current support plans will be audited by Care Director(s) or designee to ensure required signatures and dates are present. Any missing signatures will be obtained by 4/30/26. Staff responsible for care planning will be re-educated by the Executive Director on documentation requirements by 3/31/2026. Monthly audits of randomly selected support plans will be conducted by the Care Director(s) or designee, with findings reviewed during Quality Improvement meetings.

Evidence will include completed audit tools, staff training records, and Quality Improvement meeting agenda.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented (████) 05/04/2026)

234a - Admission Support Plan**7. Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident █████ was admitted to the Secured Dementia Care Unit (SDCU) on █████. However, the resident's initial support plan was completed on █████.

Repeat Violation: █████

Plan of Correction

Accept █████ - 04/20/2026)

On 3/30/26, an audit of recent admissions was completed by the Memory Care Director to verify that support plans were developed within or prior to 72 hours of admission. Any missing or delayed support plans will be completed by 4/30/26 by Care Director(s).

234a - Admission Support Plan (continued)

Effective, 4/6/26 the Executive Director or Care Director(s) will review all new admissions weekly for four weeks to ensure support plan is developed prior or within 72 hours of admission. Care Director(s) will be re-educated by Executive Director on admission and support plan timelines by 3/31/2026. Compliance will be monitored through audits and reviewed by the Executive Director or Care Director(s) during Quality Improvement meetings. Our next QI meeting is scheduled for 4/27/26. Evidence will include audit logs, staff training documentation, and Quality Improvement meeting agenda.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [REDACTED] - 05/04/2026)