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

June 9, 2026

[redacted], VP OF HEALTH CARE OPERATIONS
WILLOW VALLEY COMMUNITIES
675 WILLOW VALLEY SQUARE
LANCASTER, PA, 17602

RE: THE GLEN AT WILLOW VALLEY
675 WILLOW VALLEY SQUARE
3RD FLOOR
LANCASTER, PA, 17602
LICENSE/COC#: 32191

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/16/2026, 04/17/2026 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: *THE GLEN AT WILLOW VALLEY* **License #**: *32191* **License Expiration**: *02/19/2027*

Address: *675 WILLOW VALLEY SQUARE, 3RD FLOOR, LANCASTER, PA 17602*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *WILLOW VALLEY COMMUNITIES*

Address: *675 WILLOW VALLEY SQUARE, LANCASTER, PA, 17602*

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

Certificate(s) of Occupancy

Type: *I-1*	**Date**: *12/10/2019*	**Issued By**: *West Lampeter Township*
Type: *I-2*	**Date**: *12/10/2019*	**Issued By**: *West Lampeter Township*
Type: *C-1*	**Date**: *06/05/1995*	**Issued By**: *Department of Health*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *50* **Waking Staff**: *38*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/17/2026*

Inspection Dates and Department Representative

04/16/2026 - On-Site: [redacted]

04/17/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *76* **Residents Served**: *50*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *50*

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

Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

04/16/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/15/2026*

Inspections / Reviews *(continued)*

05/14/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/05/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *05/21/2026*

05/15/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/16/2026*

06/09/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/05/2026*

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

16c - Written Incident Report

1. 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] Resident #1 experienced a fall resulting in the diagnosis of [redacted] on [redacted] The home did not report the incident to the Department until [redacted]

On [redacted], Resident #2 experienced a fall resulting in [redacted] that required six staples. The home did not report the incident to the Department until [redacted]

Plan of Correction ***Accept ([redacted] - 05/15/2026)***

Licensing Violation
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).

Why did this happen?
On [redacted] Resident #1 experienced a fall resulting in the diagnosis [redacted]. The home did not report the incident to the Department until [redacted]
On [redacted], Resident #2 experienced a fall resulting in a [redacted] that required [redacted]. The home did not report the incident to the Department until [redacted].

What do we do right now to fix the problem?
Who – Administrator has and will complete verbal and written education with the Nursing Team.
What – Education detailed DHS reporting timeline requirements and review of regulation 2600.16.c. Specific examples provided.
When – Completed 5/13/2026 through June 3rd and 4th Personal Care Team Member Monthly Meeting. Will add specific DHS Survey Plan of Correction to Relias on June 5th for all Personal Care Team Members to review by 6/15/26.

How do we prevent this from happening again?
Who - Administrator will provide education verbally and in writing
What - DHS Reporting requirements and Reg 2600.16.c education will be reviewed via written DHS Survey Review Packet available 5/13/26 and ongoing for all PC Nursing Team Members, including
off-hours and on weekends. Education will be reviewed at the next PC Monthly Team Member Meeting. Education will also be added to Relias, which will be assigned to be reviewed.
When – Written education on the DHS Survey Plan of Correction provided 5/13/26. Review of the same information will be completed at Monthly PC Team Member Meetings June 3rd and 4th.
The same information will be added to Relias and PC Team Members will be assigned to review this information between June 5th -June 15th.

16c Written Incident Report (continued)

Timeframe/Work plan (Action, Owner, Completion Date)
Education on DHS Reporting requirements and Regulation 2600.16.c will be provided 5/12/26 to all Nursing Team Members by Administration, completion by June 15, 2026. DHS Survey results and full Plan of Correction education packet will the provided in writing to Personal Care Team Members 5/13/26 by Administrator. This information will be added to Relias on 6/5/26. Completion of review by June 15, 2026.
At Monthly PC Team Member Meetings on June 3rd and 4th , education on the DHS Survey Results and Plan of Correction will be reviewed verbally by the Administrator and in writing the form of meeting minutes.
Administrator will log completed DHS Reportables on a spreadsheet throughout the year as they are completed.
Education on reportable requirements will remain in the Wellness Suites to ensure Nurses have information at their fingertips should a situation arise that requires a reportable be completed. This will include the required timeframes for reporting as instructed in the DHS RCG.

For the Reportable Incident Log used by the Administrator, column for tracking was added for date of occurrence and date of notification to DHS. If noted that reporting is done outside the required timeframe of 24 hours, additional individual education will be completed with nurses that fail to report event to Administrator immediately or failure to report to DHS within 24 hours. The individual education would be done by the Administrator.

Licensee's Proposed Overall Completion Date: *06/15/2026*

Implemented ([redacted] - 06/09/2026)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The certificate of operation for the home's boiler with PA serial number 354572B expired on 10/13/2023.

Plan of Correction ***Accept ([redacted] - 05/14/2026)***

Licensing Violation
2600.18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Why did this happen?

18 - Compliance With Laws (continued)

The certificate of operation for the home's boiler with PA serial number 354572B expired on 10/13/2023.

What do we do right now to fix the problem?
Who – Maintenance Manager
What – Contacted Boiler Inspector and contacted PL&I and Boilers-[redacted] about the original inspection done 1/28/2026. The boiler passed inspection and L&I will send the cert in the mail.
When – Contact was made with the boiler Inspection Company on 4/28/26

How do we prevent this from happening again?
Who - Maintenance Manager and Maintenance Supervisor
What - Entered a request in the electronic work-order system to audit boiler certificates and inspection dates immediately and every 4 months
When – 5/12/26 electronic work-order was placed. Boiler certificates will be audited every 4 months to verify they are up to date and inspections of boilers are up to date. Audit was completed on 5/12/26 and new certificate that was issued after requested was dated for 4/30/2026 instead of for the inspection date 1/28/26.

Timeframe/Work plan (Action, Owner, Completion Date)
Boiler certificates and inspection dates will be audited by the Maintenance Manager and/or the Maintenance Supervisor every 4 months, starting on 5/12/26. There is an automatic work-order setup to prompt this audit. The said boiler for the citation was inspected on 1/28/26 and the missing certificate was obtained with an issued date of 4/30/26. Inspections and certificates are all up to date as of 4/30/26.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented ([redacted] - 06/09/2026)

121b - Locking Device Approval

3. Requirements

2600.
121.b. Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the home has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Description of Violation

The doors to the stairwells on the 3rd floor, which are used as an egress route from the hallways to the outer stairwells were equipped with an electronic fob-operated system, preventing immediately egress from resident hallways. The home does not have written approval or a variance from the Department of Labor and Industry, the Department of Health or the local building authority for use of the fob-operated system.

Plan of Correction ***Accept ([redacted] - 05/14/2026)***

3. Licensing Violation
2600.121.b. Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the

121b - Locking Device Approval (continued)

building, unless the home has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Why did this happen?
The doors to the stairwells on the 3rd floor, which are used as an egress route from the hallways to the outer stairwells were equipped with an electronic fob-operated system, preventing immediately egress from resident hallways. The home does not have written approval or a variance from the Department of Labor and Industry, the Department of Health or the local building authority for use of the fob-operated system.
Resident from a Skilled Care floor eloped in the past and was found in a stairwell of The Glen. The Skilled Care Administrator and DON asked Security to lock all stairwell doors to prevent further concerns. This was not communicated to the Personal Care Administrator. Audits were not in place to check the egress stairwell doors to ensure they remained unlocked.

What do we do right now to fix the problem?
Who – Security Coordinator and Administrator
What – Fob locking system for 3rd floor stairwell was checked electronically and they were found to all be locked and reprogrammed to be permanently unlocked as of 4/17/26. All egress stairwell doors were audited after reprogramming to be unlocked and they were all found to be unlocked.
When – 4/17/26 all stairwell egress doors were electronically reprogrammed to be unlocked at all times.

How do we prevent this from happening again?
Who - Security and Administrator
What - Egress stairwell doors on 3rd floor will regularly be audited by Security on rounds to ensure they remain unlocked. Security Manager meeting with the Security Coordinators to review the DHS regulation 121.b, the violation, and the plan of correction which includes Security physically auditing each 3rd floor stairwell door to ensure it is unlocked. Audit was completed on 4/17/26 and 5/13/26 and all egress stairwell doors remain unlocked.
When – Started audit on 4/17/26 and will continue regularly on Security Rounds in definitely.

Timeframe/Work plan (Action, Owner, Completion Date)
On 4/17/26 egress doors were electronically reprogrammed to be unlocked. Physical audit was completed the same day by Administrator and Security Coordinator to verify doors are unlocked. There will be ongoing physical door audits after 4/17/26 routinely by Security during routine rounds that will be indefinite to ensure doors remain unlocked. Education was provided to the Security Manager and Security Coordinator on DHS regulation 121.b. Administrator advised that any requests for locking devices to be active on 3rd floor need to be reviewed with the PC Administrator. No changes physically or with the electronic fob locking system are to be made for 3rd floor stairwell egress doors and they need to remain unlocked at all times.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented ([redacted] - 06/09/2026)

184a - Resident's Meds Labeled

4. Requirements

2600.

184a - Resident's Meds Labeled *(continued)*

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #4 was prescribed Diclofenac gel apply to left hip topically twice daily (0700 + 1300) for pain, may have evening dose whenever needed for pain. The pharmacy label for the resident's Diclofenac gel 1% indicated apply topically 4 grams to L hip three times daily.

Resident #5 was prescribed Geri-Tussin SYP DM give 10mL orally every 4 hours as needed for cough. The pharmacy label for the resident's Geri-Tussin SYP DM indicated 10ml by mouth four times daily as needed for cough.

Resident #6 was prescribed Famotidine tab 20MG give 20mg orally one time a day for GERD. The pharmacy label for the resident's Famotidine indicated 1 tab by mouth once daily as needed for indigestion.

Plan of Correction ***Accept ([redacted] - 05/15/2026)***

4. Licensing Violation
2600.184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following: 4. The prescribed dosage and instructions for administration.

Why did this happen?
Resident #4 was prescribed Diclofenac gel apply to left hip topically twice daily (0700 + 1300) for pain, may have evening dose whenever needed for pain. The pharmacy label for the resident's Diclofenac gel 1% indicated apply topically 4 grams to L hip three times daily.
Resident #5 was prescribed Geri-Tussin SYP DM give 10mL orally every 4 hours as needed for cough. The pharmacy label for the resident's Geri-Tussin SYP DM indicated 10ml by mouth four times daily as needed for cough.
Resident #6 was prescribed Famotidine tab 20MG give 20mg orally one time a day for GERD. The pharmacy label for the resident's Famotidine indicated 1 tab by mouth once daily as needed for indigestion.

Nursing that took off the doctor's order changes did not place a "change in directions" white sticker on the medication directions to show there was a change in direction and to "see new doctor orders". Nursing did not discard medication that was changed to routine dosing when new supply came in with correct directions. Medication was not reordered since change in directions which would have replaced the current supply with a new supply that would have had the current instructions on the packaging.

What do we do right now to fix the problem?
Who – Nursing
What – Change Direction Stickers were applied to Resident #4 Diclofenac Gel to indicate the nursing team to check the new orders before administering. Resident #5 Geri-Tussin had not been used in 60 days and medication was discontinued. Resident #6 Famotidine PRN Supply in blister packet was discarded due to no longer being ordered. Routine Famotidine given daily was present on the MAR and pills are in the routine daily pillow packs.
When – All changes were made on 4/17/26 immediately after the survey was completed.

How do we prevent this from happening again?
Who - Nurses and Pharmacy Nurse
What - Education provided to Nursing Team on the DHS Survey Results and Plan of Correction on 5/13/2026. All to review and sign acknowledgment between 5/13/26 and 6/15/26. Review of this education will be completed during

184a Resident's Meds Labeled (continued)

June monthly meetings on 6/3 and 6/4. Meeting minutes which will include this education will be posted to Relias 6/5/26 and assigned to all PC Team Members to complete review by 6/15/26. Quarterly Medication Car Audits will be completed by the Consulting Pharmacy Registered Nurse on 5/26/26 then quarterly to ensure carts and medications are in compliance with DHS regulations including all medications have correct directions on packaging to match MAR. PC Nurses education will include the step of adding the white direction change sticker to medication package directions when there are order changes. This is one step to be done when taking orders off.
When 5/13/26 written packet provided to nursing team to review and sign. Review at meeting on 6/3 and 6/4. Add to Relias on 6/5 with a completion date for review by 6/15/26.

Timeframe/Work plan (Action, Owner, Completion Date)
PC Administrator will provide written and verbal education to PC nursing team members through a written packet, verbal review at monthly meeting, and in the form of a module through Relias between 5/13/26 through 6/15/26 on the DHS Survey findings and the plan of correction. This will include education on the nurse's responsibility to use white change direction stickers when taking new doctor's orders off. Consulting Pharmacy RN will start quarterly audits on all PC medication carts and ordered medications on 5/26/26.

Licensee's Proposed Overall Completion Date: *06/15/2026*

Implemented ([redacted] - 06/09/2026)

185a - Implement Storage Procedures

5. 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 #3 was prescribed Novolog FlexPen 100unit/ml inject subcutaneously as needed for diabetes mellitus **for blood sugar greater than 350; no need to call oncall with blood sugar. On 4/16/2026 at approximately 3:20PM, this medication was not available in the home.*

Plan of Correction ***Accept ([redacted] - 05/15/2026)***

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.

Why did this happen?

185a Implement Storage Procedures (continued)

*Resident #3 was prescribed Novolog FlexPen 100unit/ml inject subcutaneously as needed for diabetes mellitus **for blood sugar greater than 350; no need to call on call with blood sugar. On 4/16/2026 at approximately 3:20PM, this medication was not available in the home.*
What do we do right now to fix the problem?
Who Nurse
What Order was discontinued on 4/16/26 for PRN Novolog for resident #3 due to non use for 60 days. No medication supply to destroy with the order change.
When 4/16/26

How do we prevent this from happening again?
Who Nurse
What Education provided on non use medications and the standing order to discontinue medications not used in 60 days. Education provided to nurses on the Cubex machines in the building and a current inventory list was provided which does include Novolog FlexPens. Resident #3 PRN FlexPen order was discontinued for non use on 4/16/26.
When 4/16/26 and education on the DHS Survey findings and plan of correction will be available for review in the form of a written packet, reviewed at the next monthly meeting, and will be on Relias to be reviewed by 6/15/26.

Timeframe/Work plan (Action, Owner, Completion Date)
On 4/16/26 order for Resident #3 Novolog PRN was discontinued. Education was provided to nursing team on 5/13/26 in the form of a written education on the DHS Survey findings and plan of correction. This includes information on the Cubex machines with a list of medications in the Cubex machines. This includes Novolog FlexPens. Education will be reviewed at the June 2026 monthly meeting on 6/3 and 6/4. All education will be added to Relias on 6/5, to be reviewed by all nursing team members by 6/15/26. Nursing will be made aware of the Consulting Pharmacy RN starting quarterly audits on 5/26/26 of the medications and medication carts.

Licensee's Proposed Overall Completion Date: *06/15/2026*

Implemented ([redacted] - 06/09/2026)