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

August 12, 2026

[redacted], VICE PRESIDENT
CSH EXTON LESSEE LLC
[redacted]

RE: ARBOR TERRACE EXTON
100 OAKLANDS BOULEVARD
EXTON, PA, 19341
LICENSE/COC#: 14793

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/22/2026, 06/23/2026 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 EXTON* **License #**: *14793* **License Expiration**: *07/27/2026*

Address: *100 OAKLANDS BOULEVARD, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CSH EXTON LESSEE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/11/2021* **Issued By**: *West Whiteland Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *121* **Waking Staff**: *91*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *06/23/2026*

Inspection Dates and Department Representative

06/22/2026 - On-Site: [redacted]

06/23/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *99* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Evergreen* **Capacity**: *32* **Residents Served**: *29*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *NA* **Are 60 Years of Age or Older**: *88*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *33* **Have Physical Disability**: *NA*

Inspections / Reviews

06/22/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/25/2026*

08/04/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/07/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/07/2026*

Inspections / Reviews *(continued)*

08/12/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/07/2026*

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

65f - Training Topics

1. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care Staff Person A did not receive training in care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2025.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

Direct Staff Person A will receive training by 7/31/2026 by the Executive Director/designee on the topic of Care for Residents with Mental Illness or Intellectual Disability. See attachment A. All staff will be trained on Care for Residents with Mental Illness or Intellectual Disability by 8/5/2026 by the Executive Director/Designee. See Attachment B. The annual staff training plan has been updated to include Care for Residents with Mental Illness or Intellectual Disability, and training will be provided during the month of August 2026. See Attachment C.

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented ([redacted] - 08/12/2026)

95 - Furniture and Equipment

2. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 6/22/2026, a chair located in the corner of the private dining room was missing a wheel and unbalanced.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

The dining room chair was immediately taken out of service at the time of inspection. The dining room chair wheel was repaired and balanced on 6/24/2026 by the Maintenance Director and returned to the private dining room on 6/25/2026. Effective 6/25/2026 "Furniture and Equipment in good repair" has been added to the Environmental Audit sheet conducted at least weekly by the Executive Director/Designee. See Attachment D. Effective 6/25/2026 and ongoing, Items identified as repair needed will be removed and/or tagged out of service by the Maintenance Director/Designee until repairs or replacements are completed.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/12/2026)

101i - Access to Bedroom

3. Requirements

2600.
101.i. A resident shall have access to his bedroom at all times.

Description of Violation

On 6/23/2026, all rooms located in Evergreen/Memory Care were locked by staff and all, but four residents were unable to access to their bedrooms.

Plan of Correction ***Accept (- 08/04/2026)***

The memory care neighborhood apartment doors are controlled by electronic doorknobs and FOBs are utilized to unlock the exterior portion of the mechanism. On 6/24/2026 the ED/designee temporarily covered the latching area with tape to allow free access to all apartments. The community contacted the vendor to resolve disengagement to the locking mechanism to allow free access into the resident apartment. All apartments will be fully disengaged by 7/31/2026 due to the time frame necessary to individually reset each apartment door locking mechanism. Resident families/responsible parties were notified of the change on 7/20/2026. See attachment E.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented (- 08/12/2026)

101j3 - Bed/Linens/Pillows/Blankets

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bedsheets for Resident 1, were soiled with a substance that appeared to be urine.

Plan of Correction ***Accept (- 08/04/2026)***

At the time of inspection, Resident 1 was independent for ADLs and continence. Resident 1 was interviewed and stated that " spilled a beverage while in bed." The identified sheets in Resident #1's apartment were immediately changed. Resident 1's laundry and linens are changed and laundered on a weekly and as needed schedule. Resident 1 was immediately referred to Therapy and opened under OT for continued progress in ADL independence. An audit will be completed by 7/31/2026 by the RCD/designee for all residents on scheduled laundry/linen services to ensure that direct care staff completion is accurate and documented. See attachment F Effective 7/27/2026 Executive Director/Designee will complete random inspections of 5% of residents/week to ensure laundry/linen services were completed as scheduled. Compliance will be reported at the QI meeting by the Executive Director until compliance achieved x 3 months.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented (- 08/12/2026)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 Lighting/Operable Lamp *(continued)*

Description of Violation

Resident 2 and Resident 3 do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 08/04/2026)***

At the time of inspection, Resident 3's lamp had recently been relocated by family/hospice services to allow for bedside visits due to end of life decline. Resident 3's lamp was immediately relocated by the Maintenance Director to meet the regulation. Resident 3 has since passed away on hospice services.

Resident 2's push lamp had the battery replaced during inspection and is operational.

Effective 7/27/2026 the Executive Director/Designee will audit 10% of resident apartments weekly to ensure beside lighting compliance. Compliance will be reported at the QI meeting by the Executive Director until compliance achieved x 3 months.

Licensee's Proposed Overall Completion Date: *07/27/2026*

Implemented (- 08/12/2026)

103f - Refrigerator/Freezer Temps

6. 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 6/22/2026 at 11:44 am the temperature in the freezer was 10 degrees Fahrenheit and at 2:00 pm it was 8 degrees Fahrenheit.

Plan of Correction ***Accept (- 08/04/2026)***

The ice cream freezer temperature located in the main kitchen that was identified during inspection was corrected immediately as reflected in the repeat reading at 2pm. Effective 7/27/2026 the Dining Services Director/Designee will maintain a temp log for the ice cream freezer recording after each meal to ensure ice cream freezer remains compliant with temperature

Licensee's Proposed Overall Completion Date: *07/27/2026*

Implemented (- 08/12/2026)

103i - Outdated Food

7. Requirements

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

Description of Violation

There was unlabeled, undated cheese, fresh watermelon, fresh blueberries and thousand island dressing in the refrigerator located in Evergreen/Memory Care.

There was banana pudding with an expiration of date of 6/21/2026 and a gallon of milk dated 6/14/2026 that remained in the Evergreen/Memory Care refrigerator on 6/22/2026.

103i - Outdated Food (continued)

Plan of Correction ***Accept (- 08/04/2026)***

The undated/unlabeled items were immediately discarded at time of inspection. The Dining Services Director/designee will inspect the Evergreen refrigerator daily for undated/unlabeled items. All staff will be educated on labeling/dating food items by 8/5/2026 by the Dining Services Director/Designee. See attachment G

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented (- 08/12/2026)

105g - Lint Removal and Duct Cleaning

8. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 6/22/2026, there was an approximate 1 inch accumulation of lint in the lint trap of the commerical dryers. There were no clothes in the dryer at the time.

Plan of Correction ***Accept (- 08/04/2026)***

The commercial dryer was immediately cleaned of lint at the time of inspection. A sign has been placed on both commercial dryers indicating instructions on lint removal after each use. Effective 6/25/2026 a housekeeper has been assigned daily removal of lint. All care staff and housekeepers will be educated on how to remove lint after use on commercial dryers by the Maintenance Director/designee by 8/5/2026.

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented (- 08/12/2026)

181c - Self-administration Assessment

9. 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 4 self-administers medications to include Xylimelts 550mg" Take 1 tablet by mouth daily before bedtime"; however, Resident 4 has 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 (- 08/04/2026)***

Resident 4 was immediately assessed by the Resident Care Director to self-medicate the one medication available in room. The PCP was notified of Resident 4's ability and a new Medical Evaluation obtained noting self-medication administration. The RASP was immediately updated upon receipt of the new Medical Evaluation. See attachment

181c - Self-administration Assessment (continued)

H. The Resident Care Director will complete self-admin assessments on all residents identified with prescribed medications at bedside for ability to maintain administration by 8/5/26. Identified residents will have new Medical Evaluations and RASPs completed as needed to ensure medication administration matches the resident's physician certification. All new residents, The Resident Care Director will review all new admission DMEs to ensure that medication administration is accurate and documented accurately on the RASP. Self-med assessments are completed at least quarterly by the Resident Care Director.

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented ([redacted] - 08/12/2026)

183e - Storing Medications

10. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 6/23/2026, Resident 5's, Vitamin D3 2000U was punctured in slot 4 and the pill remained in place.

Resident 5's, Benztropine MES .5mg was punctured in slot 8 and the pill remained in place.

Resident 6's, Furosemide Tab 20mg was punctured in slot 6 and the pill remained in place.

Resident 7's, Tamsulosin HCL .4mg was punctured in slot 2 and the pill remained in place.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

Blister packs are provided by the authorized pharmacy with a sealed foil backing. Medications identified at time of inspection were immediately destroyed by the MedTech. Effective 7/27/2026, Med Techs will complete a weekly assessment of blister packs in their assigned medication carts and destroy any loose medications associated with a punctured blister pack. The Resident Care Director/MedTech/LPN will immediately notify pharmacy and request replacement medication upon destruction of medications.

Licensee's Proposed Overall Completion Date: *07/27/2026*

Implemented ([redacted] - 08/12/2026)

185a - Implement Storage Procedures

11. 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 6/23/2026, Resident 8's, Tylenol Oral tablet 325mg, " Take 2 tablets every 6 hours as needed" was not in the home.

The home's medication policy states that that all controlled substances must be securely stored and accurately

185a - Implement Storage Procedures (continued)

tracked. On 6/23/2026, the count for Resident 9's, Tramadol HCL 50mg tablet was inaccurate. 109 pills were documented on the control log, but 112 pills were counted in the medication cart.

Plan of Correction ***Accept (- 08/04/2026)***

The community immediately notified the pharmacy to obtain the Tylenol for Resident 8. The Tylenol was received on the evening of 6/23/2026 for use as a PRN for Resident 8. Education was provided to med admin staff by RCD on 6/24/2026 regarding process of PRN administration and notification of pharmacy/responsible party for medication replenishment. Medication Admin staff was re-educated on the process of documentation and accurate count for narcotic administration by the RCD on 6/24/2026. See Attachment I. Effective 7/27/2026 the RCD/Designee will conduct weekly cart and narcotic audits to ensure medication availability and accuracy.

Licensee's Proposed Overall Completion Date: *07/27/2026*

Implemented (- 08/12/2026)

225a - Assessment 15 Days

12. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 1 uses a beside mobility device to transfer in and out of bed. The resident's assessment, dated does not include a need for transferring in and out of bed.

Plan of Correction ***Accept (- 08/04/2026)***

Resident 1's family installed a non-approved bed mobility device without notifying community. Resident 1 is independent with ADLs at time of inspection. Upon discovery, the bedside mobility device was immediately removed by the Maintenance Director and an approved device (HALO) was installed. The resident's RASP was updated to reflect with the current use of the device. Effective 7/27/26 the RCD/designee will routinely verify residents without bedside mobility devices to monitor bedside mobility devices that have been installed without communication to the community. A notice to families/responsible parties was sent on 7/24/2026 by the Executive Director regarding notification to community, approval of devices prior to installation, and the community's responsibility to document device usage on the RASP. See Attachment M

Licensee's Proposed Overall Completion Date: *07/27/2026*

Implemented (- 08/12/2026)

225c - Additional Assessment

13. 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.
3. At the request of the Department upon cause to believe that an update is required.

225c - Additional Assessment *(continued)*

Description of Violation

Resident 10's most recent assessment was completed on [redacted]

The medical evaluation for Resident 11, dated [redacted], indicates the resident has a need for rolling walker to ambulate. The resident's assessment dated [redacted] does not document a needing for ambulating.

The medical evaluation for Resident 12, dated [redacted], indicates the resident has a need for walker and wheelchair to ambulate. The resident's assessment dated [redacted] does not document a needing for ambulating.

The medical evaluation for Resident 13, dated [redacted], indicates the resident has a need for rollator to ambulate. The resident's assessment dated [redacted] does not document a needing for ambulating.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

Resident 10 no longer resides in the community. Resident 11, 12, 13's RASP has been updated by the Resident Care Director on 6/24/2026 to include documentation of independent ambulation with the use of a device. By 8/5/2026 the Resident Care Director/designee will audit all residents with mobility devices and ensure accuracy of RASP/DME documentation. See attachment J. Effective 7/27/2026 the Resident Care Director will utilize a tracking system for annual and change of condition DME/RASPs to ensure timely documentation.

Licensee's Proposed Overall Completion Date: *07/27/2026*

Implemented ([redacted] - 08/12/2026)

231c - Preadmission Screening

14. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 10 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's written cognitive preadmission screening was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

Resident 10 no longer resides in the community. The Resident Care Director will audit by 8/5/2026 the current memory care residents prescreens to ensure compliance with the 72-hour documentation requirement. Variances during the audit will be noted and initialed on the prescreen by RCD/Designee. Effective 7/23/2026 the RCD/designee will audit each new memory care resident for pre-screen documentation within 72 hours of move in.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/12/2026)

236 - Staff Training

15. Requirements

2600.

236 - Staff Training *(continued)*

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care Staff Person A, who works in the Secure Dementia Care Unit (SDCU) had only 4.5 hours of training in dementia care during the January 2025 to December 2025 training year.

Plan of Correction ***Accept ([redacted] - 08/04/2026)***

The 2026 Staff training plan has been revised to include dementia training hours per this regulation. See attachment K. The online training system (Relias) has been reviewed and will be updated to include additional topics to meet the mandatory training hours for dementia. An audit will be completed by 8/5/2026 by the ED/designee for 1/1/2026 to 7/25/2026 to determine outstanding training hours for compliance with this regulation. See attachment L. A monthly review of all staff compliance will be completed by the ED/designee for 2026 training progress and compliance. Progress and compliance will be reported by the Executive Director/designee at the QI meeting at least quarterly.

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented ([redacted] - 08/12/2026)