

Department of Human Services
Bureau of Human Service Licensing

July 6, 2022

[REDACTED] EXECUTIVE DIRECTOR
SHP V WILLISTOWN LLC
[REDACTED]

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

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/03/2022, 06/07/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: ARBOR TERRACE WILLISTOWN **License #:** 14245 **License Expiration:** 07/19/2023
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

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 108 **Waking Staff:** 81

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Incident **Exit Conference Date:** 06/07/2022

Inspection Dates and Department Representative

06/03/2022 - Off-Site: [REDACTED]
06/07/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 104 **Residents Served:** 70

Secured Dementia Care Unit

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

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 70
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 38 **Have Physical Disability:** 0

Inspections / Reviews

06/03/2022 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 07/04/2022

Inspections / Reviews *(continued)*

07/05/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/11/2022*

07/06/2022 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted]/22, at [redacted] pm, Staff person A entered Resident #1's bedroom, took a bag from their bedside table, removed money from resident's wallet, and replaced resident's bag on the bedside table, while the resident was sleeping in their room. This incident was reported to staff person B, on [redacted]/22 at [redacted] am. However, this allegation of abuse was not reported to the local area agency on aging via the written Act 13 form until [redacted]/22. The incident was caught on video by a nanny cam set up by the residents family.

Plan of Correction

Accept

Arbor Terrace Willistown ("Arbor") submits this Plan of Correction ("POC") to comply with PA 2600 et al. and all other applicable regulations and statues. The preparation and submission of this POC does not constitute an admission of fault or liability on the part of Arbor or an agreement by Arbor as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiencies issued.

On [redacted]/22, when the POA made us aware of the incident that took place the previous night on [redacted]/22, Staff Person B immediately notified Emergency Services, submitted the verbal and written to the Department of Human Services, and a verbal report was left with the local area agency on aging office. However, upon discovery on [redacted]/22 that the written Act 13 form was not submitted, it was completed and submitted immediately on [redacted]/22. Compliance with regulation 2600.15(a) is the responsibility of the Administrator or designee.

Completion Date: 06/03/2022

Document Submission

Implemented

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42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]/22 at [redacted] pm, staff person A stole [redacted] from resident #1's wallet. Staff person A entered resident

42b - Abuse (continued)

#1's room while resident was sleeping, removed resident's bag from resident's beside table, took the bag out of the resident's room and a few minutes later, returned the bag after having removed the money from resident's wallet. The incident was caught on video by a nanny cam set up by the residents family.

Plan of Correction**Accept**

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On [REDACTED]/22, when the POA made us aware of the incident that took place the previous night on [REDACTED]/22, Staff Person B began to investigate the incident immediately, and we were able to determine who staff Person A was from the camera. Staff Person A's employment was terminated effective immediately by the Home. A re-training was completed by the Administrator (please see attached evidence) on 6/8/22 with all staff on the importance of Resident Rights, specifically focusing on the contents of regulation 2600.42(b). Compliance with regulation 2600.42(b) is the responsibility of the Administrator or designee.

Completion Date: 06/08/2022

Document Submission**Implemented**

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42s - Privacy**1. Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [REDACTED]/22 at [REDACTED] pm, staff person A entered resident #1's room, however, Resident #1 was not scheduled for any care services or wellness checks during this time and resident's room did not require services. Staff person A had no reason to be in resident #1's room at this time. While in resident #1's room, staff person A removed resident's bag from their bedside table and left the resident's bedroom with the bag. Staff person A re-entered the resident's bedroom a few minutes later, returned the bag to the bedside table and left the room again. Staff person A removed [REDACTED] from resident's wallet before returning the bag to resident's room. The incident was caught on video by a nanny cam set up by the residents family.

42s - Privacy (continued)

Plan of Correction**Accept**

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Completion Date: 06/08/2022

Document Submission**Implemented**

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