

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

June 2, 2025

[REDACTED]
CSH EXTON LESSEE LLC
[REDACTED]

Second Floor
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/27/2025 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: ARBOR TERRACE EXTON

License #: 14793

License Expiration: 07/27/2025

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:

Total Daily Staff: 111

Waking Staff: 83

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint, Incident

Exit Conference Date: 03/27/2025

Inspection Dates and Department Representative

03/27/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 99

Residents Served: 84

Secured Dementia Care Unit

In Home: Yes

Area: Memory Care

Capacity: 32

Residents Served: 26

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 84

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 1

Have Mobility Need: 27

Have Physical Disability: 0

Inspections / Reviews

03/27/2025 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/26/2025

04/30/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/05/2025

Inspections / Reviews *(continued)*

05/05/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/14/2025

06/02/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

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

Resident ■, who has a diagnosis of ■, had a history of wandering away from home prior to admission to the Secured Dementia Care Unit (SDCU) on ■

On ■ between 2 am and 3 am, resident ■ started asking to leave and had attempted to elope from the SDCU multiple times throughout the evening. Each time the resident was redirected by staff. In one instance, resident ■ held the push bar for 15 seconds on the emergency exit door across from their room which led to an enclosed patio, and achieved opening the door. Staff person A, convinced the resident to come away from the door and brought resident ■ to the living room area, where the resident eventually fell asleep in a chair.

At approximately 5:00 am, staff person B who was located in the laundry room, saw resident ■ walk up to the main doors of the SDCU, stop, turn around, and begin walking back towards the living room area. As resident ■ was heading in the direction of the living room area of the unit, staff person B took this opportunity to switch over a load of laundry and put in another load. Once staff person B completed this task, the staff person exited the laundry room and looked toward the living room area where they expected to see resident ■ however the living room was empty. Staff person B located staff person A and let them know they could not locate resident ■. Staff persons A and B began a room-to-room search. It was during this search, at approximately 5:15 am, that the door to room ■ was found slightly opened. The bedroom window on the ■ side of the room was opened as far as it could go, with the window blockers broken and the screen fully pushed out. Room ■ is located on the right side, immediately next to the laundry room. Elopement protocol was initiated when the resident couldn't be found which included a complete search of the entire facility and an area search, by car, of a 1-mile radius of the home. The home's staff were unable to locate the resident during this search. The resident sleeping in room ■ was undisturbed.

Immediately outside of the window are grounds consisting of mulch beds, small bushes, grass and a pathway. The grounds surrounding the building do not have fencing or enclosures preventing or deterring residents from walking directly off the home's property onto Route 30, a 5-lane highway.

Resident ■ was found at a business a half mile away from the home. Staff at the business heard banging on the side door of the building at approximately 6 am, and opened the door and found resident ■ dressed in pajamas, with a shirt wrapped around their neck and wearing shoes. Resident ■ stated "Can I come in, I am freezing to death?" Staff let the resident in the building and contacted the on-site supervisor informing them of the situation. The supervisor saw the resident and talked to the resident, then contacted 9-1-1. The business staff and their supervisor reported that resident ■ was noticeably cold, upset and confused, and reported the resident stated "I'm late for my job". The business staff reported resident also indicated they "wanted to go to work", and "people were after [them]". Police and EMT's arrived and evaluated resident ■ at the location; resident ■ had no injuries. Resident ■ family member, who had been contacted and arrived at the location, declined resident ■ transport to the hospital, and drove resident ■ back to the home in their own vehicle.

42b - Abuse (continued)

The Department determined the resident would have walked a route which included crossing Oaklands Boulevard, a 4 lane road, walking in the road for a significant part of the walk due to lack of sidewalks available in that section of the industrial park. The resident crossed two road intersections in the dark and in 39 degree weather without appropriate clothing.

Plan of Correction

Accepted [REDACTED] - 05/05/2025)

Prior to this incident, the windows were constructed with a factory installed locking mechanism. Resident [REDACTED] pulled the window open breaking the mechanism. Effective 3/21/2025 all windows in the Memory Care Neighborhood had metal window brackets installed to only allow a window to open approximately 6". The window brackets are screwed into each window frame securely by 2 metal screws to reduce the ability to break the bracket. See picture attached. Effective 4/7/2025 Memory Care Neighborhood windows will be checked weekly for secured brackets for 4 weeks or until safety compliance is achieved and then monthly for continued compliance. Records of compliance will be maintained in the Maintenance Director's office.

All direct staff will be re-educated on wandering and elopement by 5/12/2025 by the Memory Care Director. The Memory Care Director will review all current support plans for changes in wandering and supervision needs by 5/12/2025.

Licensee's Proposed Overall Completion Date: 05/12/2025

Implemented [REDACTED] - 06/02/2025)

121a - Unobstructed Egress**2. Requirements**

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [REDACTED] the exit door located at Stairway 3 would not open after the delayed released bar was held for 30 seconds blocking egress from the Stairway 3 exit.

Plan of Correction

Accepted [REDACTED] - 04/30/2025)

On 3/28/2025 a technician from NEPPS (Parkesburg) repaired the delayed release bar on the exit door at Stairway 3. Effective 3/28/2025 delayed release bars located in the Memory Care Neighborhood will be audited weekly for 4 weeks or until compliance achieved then monthly for continued compliance. Records of compliance will be maintained in the Maintenance Director's office.

Licensee's Proposed Overall Completion Date: 04/25/2025

Implemented [REDACTED] - 06/02/2025)

121a - Unobstructed Egress (*continued*)

187b - Date/Time of Medication Admin.

3. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] tablet. Resident [REDACTED]'s March, 2025 medication administration record does not include the initials of the staff person who administered [REDACTED] tablet on [REDACTED] at 6 am.

Plan of Correction**Accept [REDACTED] - 04/30/2025)**

The community utilizes an electronic medication administration record. Effective immediately and ongoing, the RCD/MCD/designee will review daily the missed medication report to monitor and respond to any medications not documented as given or refused. All medication administration staff will be re-educated by the RCD and MCD on medication administration documentation by 5/1/2025. Beginning 4/24/2025, the ED will review the missed medication report weekly to ensure compliance.

Licensee's Proposed Overall Completion Date: 05/01/2025**Implemented [REDACTED] - 06/02/2025)**