

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

February 19, 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 10/02/2025 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 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-1 **Date:** 11/01/2021 **Issued By:** West Whiteland Township

## Staffing Hours

**Resident Support Staff:** 0 **Total Daily Staff:** 126 **Waking Staff:** 95

## Inspection Information

**Type:** Partial **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Complaint, Incident **Exit Conference Date:** 10/02/2025

## Inspection Dates and Department Representative

10/02/2025 - On-Site: [REDACTED]

## Resident Demographic Data as of Inspection Dates

## General Information

**License Capacity:** 104 **Residents Served:** 80

## Secured Dementia Care Unit

**In Home:** Yes **Area:** Evergreen **Capacity:** 35 **Residents Served:** 30

## Hospice

**Current Residents:** 7

## Number of Residents Who:

**Receive Supplemental Security Income:** 0 **Are 60 Years of Age or Older:** 80  
**Diagnosed with Mental Illness:** 0 **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 46 **Have Physical Disability:** 0

## Inspections / Reviews

10/02/2025 Partial

**Lead Inspector:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/01/2025

11/04/2025 - POC Submission

**Submitted By:** [REDACTED] **Date Submitted:** 12/01/2025  
**Reviewer:** [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 12/01/2025

Inspections / Reviews *(continued)*

02/19/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/01/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [REDACTED], at 9:16 AM, resident records were unlocked, unattended, and accessible in the second-floor wellness center room.

At 9:27 AM, resident medication information was unlocked, unattended, and accessible in the Secure Dementia Care Unit (SDCU) resident services office.

At 9:48 AM an empty medication blister pack with resident's name and medical information was unlocked, unattended, and accessible on top of a medication cart in the SDCU.

Plan of Correction

Accept [REDACTED] - 11/04/2025)

Immediate Corrective Action:

All unattended resident records and medication materials were immediately secured in locked Wellness Center and medication carts on 10/2/2025 by the Care Director(s). The Executive Director and Care Director(s) conducted a full walkthrough to confirm all records were properly secured on 10/2/2025.

Quality Improvement and Ongoing Compliance:

Resident Protected Health Information Policy and Medication Management Policy will be reviewed by the Executive Director with all staff by 11/7/2025 to reinforce confidentiality, HIPAA compliance, and the requirement to keep records and medication information locked and inaccessible at all times. Signage reminding staff of these requirements was posted on 10/31/2025 in medication and wellness areas.

The Executive Director and Care Director(s) will conduct weekly audits starting on 11/3/2025 for 4 weeks, then monthly thereafter, to ensure compliance.

Evidence of Completion:

Training sign-in sheets, audit logs, and photo of signage will be uploaded following DHS approval.

Licensee's Proposed Overall Completion Date: 11/07/2025

Implemented [REDACTED] - 02/19/2026)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A's first day of work in the home was [REDACTED]. The background check on file in the home was completed on [REDACTED]

## 51 - Criminal Background Check (continued)

Staff person B's first day of work in the home was [REDACTED]. The background check on file in the home was completed on [REDACTED].

Plan of Correction

Accept [REDACTED] - 11/04/2025)

**Immediate Corrective Action:**

Ancillary staff persons A and B were immediately removed from the work schedule upon identification that their criminal background checks were not current within one year prior to hire. Updated background checks have been requested by the Executive Director on 10/31 and are in process. These staff will not be permitted to resume work duties until current clearances are received, reviewed, and verified by the Executive Director.

**Quality Improvement and Ongoing Compliance:**

The Executive Director will review the onboarding process with Agency group on 11/5/2025 to ensure background checks are dated within one year prior to hire. Starting immediately, the Business Office Director will verify current background checks before an agency employee's first workday.

The Executive Director will retrain all hiring managers and the Staffing Coordinator by 11/7/2025. Monthly agency file audits will verify compliance going forward completed by the Business Office Director.

**Evidence of Completion:**

Updated checklist documentation will be provided after POC approval.

Licensee's Proposed Overall Completion Date: 11/15/2025

Implemented [REDACTED] - 02/19/2026)

## 62 - Contact List

## 3. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

**Description of Violation**

Staff person C, the administrator, maintains a list of staff persons that does not include agency staff and substitute staff.

Plan of Correction

Accept [REDACTED] 11/04/2025)

**Immediate Corrective Action:**

The Executive Director will update staff contact list by 11/30/2025 to include all current agencies and substitute personnel with addresses and phone numbers.

**Quality Improvement and Ongoing Compliance:**

The Administrator will update the staff contact list weekly starting on 11/3/2025 and verify accuracy during leadership meetings. The list will be reviewed quarterly by the Executive Director starting in November 2025.

**Evidence of Completion:**

Updated staff contact list and verification logs will be available for DHS review.

Licensee's Proposed Overall Completion Date: 11/30/2025

Implemented [REDACTED] - 02/19/2026)

82c - Locking Poisonous Materials

4. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 9:30am, a bottle of Aloe hands sanitizer and a can of Home Bright Disinfectant Spray, both with a manufacture's label indicating "If swallowed contact poison control", were unlocked, unattended, and accessible to residents in the SDCU resident services office.

Two large bottles of Amaya home laundry detergent, with a manufacture's label indicating "If swallowed contact poison control", were unlocked, unattended, and accessible to residents in in the cabinet under the sink in resident 1's room.

Not all the residents of the home, including resident [REDACTED], have been assessed as capable of recognizing and using poisons safely.

Repeat violation: [REDACTED]

Plan of Correction

Accepted [REDACTED] - 11/04/2025)

Immediate Corrective Action:

All poisonous materials were secured immediately on 10/2/2025 by the Care Director. The Maintenance Director and Care Directors conducted an audit of all resident apartments and confirmed all poisonous materials were secured and inaccessible on 10/2/2025 an

Quality Improvement and Ongoing Compliance:

The policy on poisonous material storage will be reviewed by the Executive Director with all staff by 11/7/2025. Weekly audits of residents' rooms and service areas will be conducted on 11/3/2025 by the Maintenance Director/designee for one month and monthly thereafter.

Evidence of Completion:

Audit logs and staff training documentation will be uploaded.

Licensee's Proposed Overall Completion Date: 11/30/2025

Implemented [REDACTED] 02/19/2026)

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.

Description of Violation

Resident 1

**101j7 - Lighting/Operable Lamp (continued)**

does not have access to a source of light that can be turned on/off at bedside, because [REDACTED] beside lamp was not functioning.

**Plan of Correction**

Accept [REDACTED] - 11/04/2025)

**Immediate Corrective Action:**

A replacement light bulb was provided and installed on 10/2/2025 by the Maintenance Director. The Maintenance Director verified functionality.

**Quality Improvement and Ongoing Compliance:**

The Maintenance Director will inspect all resident rooms by 10/31/2025 to ensure operable bedside lighting. Lighting checks have been added to the monthly room safety inspection checklist starting in November 2025.

**Evidence of Completion:**

Inspection checklist and maintenance records will be submitted as documentation.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [REDACTED] - 02/19/2026)

**121a - Unobstructed Egress****6. 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] at 9:21 AM, a red stop sign shaped sticker was on the emergency exit door in stairwell 2 that lead to the SDCU's courtyard. This universal image of a stop sign presents an obstruction to the exit in an emergency as it may deter a person from using the exit upon seeing the image.

**Plan of Correction**

Accept [REDACTED] - 11/04/2025)

**Immediate Corrective Action:**

The sticker was removed immediately on 10/2/2025 by the Maintenance Director. The Maintenance Director confirmed that all egress signage complies with safety standards.

**Quality Improvement and Ongoing Compliance:**

On 10/13/2025, Maintenance Director will perform weekly rounds, and Executive Director will do random rounds of all stairways, hallways, doorways, passageways and egress routes to verify these are unlocked and unobstructed. Any issues identified will be addressed immediately, with documentation reviewed by leadership weekly. Staff will be re-educated by the Executive Director to maintain clear, unobstructed exits at all times by 11/7/2025.

**Evidence of Completion:**

Photo verification, audits, and training sign-in sheets will be uploaded.

Licensee's Proposed Overall Completion Date: 11/07/2025

Implemented [REDACTED] - 02/19/2026)

**141b1 - Annual Medical Evaluation****7. Requirements**

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

141b1 Annual Medical Evaluation (continued)

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Resident [redacted] most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Resident [redacted] most recent medical evaluation was completed on [redacted].

Plan of Correction

Accept [redacted] - 11/04/2025)

Description of Violation:

Residents had annual medical evaluations completed more than one year apart.

Immediate Corrective Action:

All affected residents received updated medical evaluations by 10/31/2025.

Quality Improvement and Ongoing Compliance:

The Care Director(s) updated the medical evaluation tracking log in the electronic health record to monitor evaluation due dates by 10/31/2025. Care Director(s) responsible for annual medical evaluation completion retrained on 10/10/2025.

Evidence of Completion:

Updated tracking log and updated evaluations will be uploaded.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [redacted] - 02/19/2026)

225c - Additional Assessment

8. 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.

Description of Violation

Resident [redacted] most recent assessment was completed on [redacted].

Resident [redacted] current assessment was completed on [redacted], however it was not signed by the assessor. The resident's previous assessment was not provided.

Plan of Correction

Accept [redacted] - 11/04/2025)

Immediate Corrective Action:

Resident [redacted]'s assessment was completed on 10/7/2025, and Resident [redacted] assessment was completed by a new assessor (Care Director) signed and filed on the same date. Previous assessor no longer employed at community as of 9/5/2025.

Quality Improvement and Ongoing Compliance:

## 225c Additional Assessment (continued)

The Executive Director reviewed the assessment completion process with Care Director(s) on 10/10/2025. Monthly assessment tracking reports will be reviewed in Quality Improvement meetings to ensure ongoing compliance starting November 2025.

**Evidence of Completion:**

Updated assessments, signature verification, and tracking logs will be maintained.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [REDACTED] 02/19/2026)

## 233c - Key-Locking Devices

## 9. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

**Description of Violation**

The directions for operating the home's locking mechanism are not conspicuously posted near the door in stairwell 2 that connects the SDCU to the SDCU courtyard. The code was missing a pound sign.

Repeat violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 11/04/2025)

**Immediate Corrective Action:**

The correct code signage was replaced by the Executive Director on 10/2/2025. The Executive Director verified visibility and accuracy.

**Quality Improvement and Ongoing Compliance:**

On 10/13/2025 The Maintenance Director will inspect all key locking devices weekly for 4 weeks and then monthly to ensure clear, legible instructions are posted. Any missing or worn signage will be replaced immediately.

**Evidence of Completion:**

Photo documentation of replaced signage and monthly inspection logs will be provided.

Licensee's Proposed Overall Completion Date: 11/30/2025

Implemented [REDACTED] - 02/19/2026)

## 234a - Admission Support Plan

## 10. 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 [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's initial support plan was completed on [REDACTED].

Plan of Correction

Accept [REDACTED] - 11/04/2025)

**Immediate Corrective Action:**

**234a Admission Support Plan (continued)**

All current resident files were audited by the Care Director(s) on 10/5/2025, and missing or late admission support plans were completed and signed.

**Quality Improvement and Ongoing Compliance:**

Effective immediately, all new admissions will have an admission support plan completed prior to 72 hours of move in. The Executive Director reviewed the process with leadership team on 10/10/2025. Weekly audits will be conducted by the Care Director(s) starting on 11/3/2025 for 4 weeks, then monthly thereafter.

**Evidence of Completion:**

Audit records, training sign ins, and completed support plans will be uploaded.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [REDACTED] 02/19/2026)