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

March 24, 2026

AL ONE PA INVESTMENTS OPCO LLC

ATTN LICENSING

RE: SUNRISE OF WESTTOWN
1045 WILMINGTON PIKE
WEST CHESTER, PA, 19382
LICENSE/COC#: 14494

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/09/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SUNRISE OF WESTTOWN* **License #**: *14494* **License Expiration**: *01/01/2026*

Address: *1045 WILMINGTON PIKE, WEST CHESTER, PA 19382*

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

Administrator

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

Legal Entity

Name: *AL ONE PA INVESTMENTS OPCO LLC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/29/1999* **Issued By**: *Westtown Township*

Staffing Hours

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

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *12/09/2025*

Inspection Dates and Department Representative

12/09/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *110* **Residents Served**: *77*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *25* **Residents Served**: *19*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *76*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

12/09/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/22/2026*

01/26/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/18/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/31/2026*

Inspections / Reviews *(continued)*

02/11/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *02/18/2026*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date:** *02/18/2026*

03/24/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *02/18/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's 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], at approximately 10:00 AM, staff person A threw a cup of water in resident [redacted]s face. This incident was observed by staff persons B and C. The incident was reported to staff person D on [redacted] at approximately 6:00 PM. However, this allegation of abuse was not reported to the local area agency on aging until [redacted] at 12:10 PM.

On [redacted], at approximately 9:00 PM, a family member of resident [redacted] reported alleged sexual abuse against the resident to staff person E. However, this allegation of abuse was not reported to the local area agency on aging until [redacted] at 6:15 PM, and a written report was not submitted to the local area agency on aging until [redacted] at 9:10 AM.

Plan of Correction ***Accept [redacted] - 01/26/2026)***

On 12/3/25 Executive Director re-educated the coordinator team, to include Staff Person D, on regulation 2600.15(a) to ensure the community immediately reports suspected abuse of a resident served in the community, in accordance with the Other Adult Protective Services Act.
Beginning on 11/11/25 and 12/2/25, following each allegation of suspected abuse, Executive Director interviewed staff members to ensure no additional incidents of suspected abuse were unreported. No additional concerns were noted.
On 12/4/25, the coordinator team began retraining all team members on 2600.15(a) to ensure the community immediately reports suspected abuse of a resident served in the community, in accordance with the Other Adult Protective Services Act.
On 12/18/25, at the monthly Town Hall, all team members were retrained on regulation 2600.15(a), 16(c), and 42b as it relates to mandated reporting of suspected or alleged abuse, and abuse prevention.
On 1/22/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented [redacted] 03/24/2026)

16c - Written Incident Report

2. 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).

16c Written Incident Report *(continued)*

Description of Violation

On ██████ at approximately 10:00 AM, staff person A threw a cup of water in resident ██ face. This incident was observed by staff persons B and C. This incident was reported to staff person D on ██████ at approximately 6:00 PM. However, The home did not report this incident to the department until ██████ at 5:57 PM.

On ██████ at approximately 9:00 PM, a family member of resident 2 reported alleged sexual abuse against the resident to staff person E. However, The home did not report this incident to the department until ██████ at 12:18 PM.

Plan of Correction ***Accept ██ - 01/26/2026)***

On 12/3/25 Executive Director re educated the coordinator team on regulation 2600.16(c), to ensure the community reports incidents or conditions to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours.
Beginning on 11/11/25 and 12/2/25, following each allegation of suspected abuse, Executive Director interviewed staff members to ensure no additional incidents of suspected abuse were unreported. No additional concerns were noted.
On 12/4/25, the coordinator team began retraining all team members on 2600.16(c) to ensure the community immediately reports suspected abuse of a resident served in the community, in accordance with the Other Adult Protective Services Act.
On 12/11/25, following inspection from Department of Human Services, Executive Director audited 2025 reportable incidents to ensure all written reports were sent timely. No additional concerns were noted
On 12/18/25, at the monthly Town Hall, all team members were retrained on regulation 2600.15(a), 16(c), and 42b as it relates to mandated reporting of suspected or alleged abuse, and abuse prevention.
On 1/22/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented ██ - 03/24/2026)

42b - Abuse

3. 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 ██████, at approximately 10:00 AM, staff person A was attempting to administer medication to resident █. Resident █ stated that they "did not want the medicine" and was pushing the water cup away. Staff persons B and C then witnessed staff person A throw the cup of water in resident ██ face.

Repeat violation: ████

42b - Abuse *(continued)*

Plan of Correction ***Accept - 01/26/2026)***

On 11/10/25, upon notification of the allegation of suspected abuse, Staff Person A was immediately placed on administrative leave, pending investigation.
On 11/10/25, Executive Director began interviewing staff members to ensure no additional incidents of suspected abuse occurred. No additional concerns were noted.
On 11/17/25, upon conclusion of the community's internal investigation, Staff Person A was terminated.
On 12/4/25, the coordinator team began retraining all team members on abuse and neglect prevention, to ensure understanding and compliance of regulation 2600.42(b), a resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal
punishment or disciplined in any way, in accordance with the Other Adult Protective Services Act.
On 1/22/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented - 03/24/2026)

187d - Follow Prescriber's Orders

4. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident is prescribed tablet, one tablet by mouth three times daily. However, resident was administered tablet only twice a day on and on both days the medication was not administered at 2:00 PM.

Plan of Correction ***Accept - 02/11/2026)***

Resident Care Director assessed resident for side effects and notified physician of missed dose on 12/10/25. No new orders written. Resident care director reviewed prescribers written order with medication manager on 12/11/25. Medication manager was trained on the importance of following prescribers written order while comparing it to the medication administration record on 12/11/25.
On 12/12/2025 an audit of prescriber written orders in comparison to the administration record was performed by Resident Care Director on all residents with no additional concerns noted. On 12/18/25 all medication managers and nurses were trained by Resident Care Director on the proper process and procedures of performing medication administration while following the prescribers written orders.
Resident Care Director will audit prescribers' written orders and medication records to ensure accuracy biweekly beginning 1/21/26 through next quarter.
On 1/22/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented - 03/24/2026)