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

September 9, 2026

[redacted]
SHP V WILLISTOWN LLC
[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 07/15/2026 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 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**: *132* **Waking Staff**: *99*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *07/15/2026*

Inspection Dates and Department Representative

07/15/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served**: *82*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st Floor* **Capacity**: *35* **Residents Served**: *30*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *82*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *50*

Have Physical Disability: *0*

Inspections / Reviews

07/15/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/14/2026*

08/13/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/07/2026*

Inspections / Reviews *(continued)*

09/09/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/05/2026*

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 10:45am, the home received a complaint alleging possible abuse or neglect of resident [redacted]. This allegation of abuse or neglect was not immediately reported to the local Area Agency on Aging. The home did not make an oral report to AAA until [redacted] at 9:27am.

On [redacted], at 4pm, the home received a complaint alleging abuse or neglect of resident [redacted] This allegation of abuse or neglect was not immediately reported to the local Area Agency on Aging. The home did not make an oral report to AAA until [redacted] at 10:53am.

Plan of Correction ***Accept [redacted] - 08/13/2026)***

On 7/15/26, the Executive Director reviewed the allegations involving Resident [redacted] and Resident [redacted] and confirmed all required reports had been submitted to the appropriate agencies.
All leadership staff responsible for receiving complaints, concerns, or allegations were re-educated by the Executive Director on 7/16/26 regarding mandatory reporting requirements under 55 Pa. Code §2600.15(a), including immediate oral reporting to the Area Agency on Aging, required documentation, and follow-up reporting obligations.
Beginning 8/10/26, the Executive Director or designee will audit all incident reports, complaints, grievances, and state reportables weekly for the next 4 weeks to verify allegations meeting reportable criteria were immediately reported to Area of Aging. Any identified concerns will be addressed immediately through retraining and corrective action.
The Executive Director is responsible for ensuring ongoing compliance.
Audit findings will be reviewed during Quality Improvement (QI) meetings to monitor compliance and prevent recurrence. The next QI Meeting is scheduled for 8/28/26.

Licensee's Proposed Overall Completion Date: *09/07/2026*

Implemented [redacted] - 09/09/2026)

42b - Abuse

2. 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] at 10:45am, Resident [redacted] reported to staff that they were physically abused over 3-4 days ago by a staff member. Resident [redacted] reported that a staff person slapped them on the back of the head, threw a wet towel in their face, and rolled a wheelchair into their lower legs causing pain, bruising, and minor cuts. Resident informed their family member of the incident on [redacted] but could not recall the name of the staff person. After the residence became aware of the allegation on [redacted] a full body assessment was conducted for the resident where it was found that the resident had bruising on their right wrist and back of left knee consistent with the resident's recollection of the injury from the wheelchair. Resident still had bruising and scabbing to their leg at the time of the Department's

42b Abuse (continued)

investigation. The residence conducted an internal investigation and determined that Staff Member A was providing care to the resident at the time in question and fit the resident's description of the staff member in question. Staff Member A was terminated on [redacted].

Plan of Correction ***Accept [redacted] 08/13/2026)***

Upon notification of the allegation, the identified employee was immediately removed from the schedule while an internal investigation was completed. The employee determined to have provided care during the identified timeframe was terminated from employment on 7/1/26 by the Executive Director. The resident received assessment and follow up evaluation and the allegation was reported and investigated in accordance with community policy.
All staff were re educated by the Executive Director on 7/16/26 regarding resident rights, abuse prevention, neglect prevention, mandatory reporting requirements, and Arbor's zero tolerance policy for abuse and mistreatment. This re education included our quarter 3 abuse drill scenario based training.
Beginning 8/10/26 the Care Director(s) or designee will conduct 3 random resident interviews weekly for the next 4 weeks to ensure residents are treated appropriately and free from abuse, neglect, mistreatment, intimidation, or corporal punishment. Beginning 8/10/26, the Resident Care Director, Memory Care Director, or designee will complete 3 random weekly observations of resident care delivery and staff resident interactions for 4 weeks. Any concerns identified will be addressed immediately through investigation, coaching, and corrective action. Arbor's Director of Dementia Training will be providing a 6 week Skill Initiative workshop onsite to improve staff competency during high risk care encounters and other ADL Care Experiences and Reduce Resident Distress and improve care team member experiences. The first week of the workshop is scheduled for 8/26 and 8/27.
The Executive Director and Resident Care Director are responsible for ensuring ongoing compliance.
Audit findings will be reviewed at Quality Improvement (QI) meetings to identify trends and ensure corrective measures remain effective. The next QI Meeting is scheduled for 8/28/26.

Licensee's Proposed Overall Completion Date: *09/07/2026*

Implemented [redacted] 09/09/2026)

42c - Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted] Staff Member B was observed on video to be verbally disrespecting Resident [redacted] by calling them "nasty" and demanding that they speak in English, which is not the resident's primary language. The video was captured by a resident owned device in the resident's room. The incident occurred after resident [redacted] experienced an episode of incontinence in a common area, after which Staff member B brought Resident [redacted] back to their room to provide incontinence care. After resident had been cleaned and changed, staff member B then placed the resident in their bed laying horizontally across the bed, without repositioning the resident to a comfortable position with their head at the top of the bed. Resident was left to sleep throughout the night in this awkward position as observed on the video.

Plan of Correction ***Accept [redacted] - 08/13/2026)***

Upon identification of the concern, the employee involved was removed from schedule, pending investigation and is no longer employed by the community as of 6/30/26. The residents' care plan and positioning needs were reviewed by the Executive Director on 7/16/26 to ensure services are provided with dignity, respect, and attention to resident comfort.

42c - Treatment of Residents (continued)

All staff were re-educated by the Executive Director on 7/16/26 regarding resident rights, dignity and respect, culturally sensitive communication, proper resident positioning after care, and person-centered care practices. All staff were provided with the resident rights handout and reminded were the resident rights are located in the community. Resident Rights were reviewed and discussed by the Executive Director at Resident Council on 7/27/26. Beginning 8/10/26, the Resident Care Director, Memory Care Director, or designee will complete 3 random weekly observations of resident care delivery and staff-resident interactions for 4 weeks. Any concerns identified will be addressed immediately through investigation, coaching, and corrective action.
The Executive Director and Care Directors are responsible for ensuring ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/07/2026*

Implemented [redacted] - 09/09/2026)

88a - Surfaces

4. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [redacted] at 9:58am, the Electrical room was partially open and accessible to residents in the Secured Dementia Care Unit. The room contained an operating electrical unit/motherboard and several monitors on the floor.

Plan of Correction ***Accept [redacted] - 08/13/2026)***

On 7/15/26, the electrical room within the secured dementia care neighborhood was immediately secured by the Maintenance Director upon identification, eliminating resident access to the area and its contents.
All staff were re-educated by the Executive Director on 7/16/26 regarding environmental safety requirements and ensuring all mechanical, electrical, and storage rooms containing hazardous equipment or materials remain secured and inaccessible to residents.
Beginning 8/10/26, the Maintenance Director or designee will conduct weekly environmental safety audits for 4 weeks to verify restricted-access areas remain secured. Any deficiencies identified will be corrected immediately.
The Executive Director and Maintenance Director are responsible for ensuring ongoing compliance.
Audit findings will be reviewed during Quality Improvement (QI) meetings to identify trends and ensure sustained compliance. The next QI Meeting is scheduled for 8/28/26.

Licensee's Proposed Overall Completion Date: *09/07/2026*

Implemented [redacted] - 09/09/2026)

227g -Support Plan Signatures

5. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

227g -Support Plan Signatures (continued)

Repeated Violation: [redacted] *et al.*

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

On 7/22/26, the Resident Assessment Support Plan (RASP) for Resident [redacted] was reviewed and corrected by the Executive Director to ensure required resident participation documentation was completed.
All staff responsible for RASP development and updates were re-educated by the Executive Director on 7/16/26 regarding requirements for support plan completion, resident participation, signatures, dates, and documentation of refusal when applicable.
The Operation Specialist had just completed an audit of all PC resident support plans by 7/31/26 to ensure regulatory requirements, including accuracy, signature and date completeness, and alignment with the current resident assessment. All deficiencies identified in the audit completed by 7/31/26 were corrected by the Executive Director on 7/31/26. The Resident Care Director or designee will conduct an audit of all recent resident admissions within the last 30 days and any new admissions by 8/14/26 to ensure required signatures, dates, and participation documentation are present and compliant. Any deficiencies identified will be corrected immediately.
The Executive Director and Resident Care Director are responsible for ensuring ongoing compliance.
Audit findings will be reviewed during Quality Improvement (QI) meetings to monitor compliance and prevent recurrence. The next QI Meeting is scheduled for 8/28/26.

Licensee's Proposed Overall Completion Date: *08/28/2026*

Implemented [redacted] - 09/09/2026)