Department of Human Services
Bureau of Human Service Licensing

May 18, 2021

[redacted], ADMINISTRATOR
GAHC3 BOYERTOWN PA ALF TRS SUB LLC
18191 VON KARMAN AVE, SUITE 300
IRVINE, CA 92612

RE: CHESTNUT KNOLL
120 WEST FIFTH STREET
BOYERTOWN, PA, 19512
LICENSE/COC#: 22613

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/19/2021, 04/22/2021, 04/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Anne Graziano

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: *CHESTNUT KNOLL* **License #**: *22613* **License Expiration Date**: *06/30/2021*
Address: *120 WEST FIFTH STREET, BOYERTOWN, PA 19512*
County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *GAHC3 BOYERTOWN PA ALF TRS SUB LLC*
Address: *18191 VON KARMAN AVE, SUITE 300, IRVINE, CA, 92612*
Phone: *6104738066* **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/20/2000* **Issued By**: *Pa. L & I*

Staffing Hours

Resident Support Staff: *136* **Total Daily Staff**: *272* **Waking Staff**: *204*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Incident* **Exit Conference Date**: *04/30/2021*

Inspection Dates and Department Representative

04/19/2021 - Off-Site:
04/22/2021 - Off-Site:
04/26/2021 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *119* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *N/A* **Capacity**: *52* **Residents Served**: *43*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *88*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *48* **Have Physical Disability**: *0*

Inspections / Reviews

04/19/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/20/2021*

5/13/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/20/2021*

5/18/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Chestnut Knoll staff failed to contact resident # 1's Ophthalmologist, Dr. [redacted] upon receipt of a medication order dated 3/9/21. Doctor orders indicated Resident # 1 was to be given Prednisolone acetate 1 % eye drops, suspension Post Operation: instill 1 drop OS (left eye) QID (4 times daily) for two weeks then BID (2 times) as directed. [redacted] had cataract surgery on [redacted] afterward [redacted] Prednisolone acetate 1 % eye drops were administered starting Post Operation on 3/17/21. These eye drops were administered four times a day as prescribed for 14 days ending on 3/31/21. After this two- week period; the eye drops were to be administered twice a day as directed by [redacted] Chestnut Knoll staff did not administer Prednisolone acetate 1 % eye drops after 3/31/21 as prescribed.

Plan of Correction **Accept**

Since the time the medication was missed, the resident has been seen by the ordering physician multiple times and has no long term ill effects from the missed medication.

n this instance, the [redacted] was following up with the ordering physician to clarify the second part of the order due to 'as directed' orders not being clearly stated. Chestnut Knoll was not aware that the pharmacy was unsuccessful in reaching the ordering physician and therefore the second part of the order was never clarified nor given to the resident causing the error.

To avoid this type of error from happening again, the pharmacy has begun sending a weekly report to the nursing team at Chestnut Knoll that contains any outstanding orders such as orders needing clarification and orders that need new prescriptions for refills so that the Chestnut Knoll nursing team can be aware of and assist in getting what s needed. This process started the week of 5/3/2021 and is working well.

The Resident Care Director and Pharmacy Manager will monitor the reports weekly. The Executive Director will check with the Resident Care Director routinely to ensure the system remains in place and is effective.

Completion Date: *05/03/2021*

Update - 05/13/2021

Upon Resubmission of the Plan of Correction, the Home will submit a recent "Weekly Report" from the Pharmacy to the home, including any actions taken by the home, if warranted. This will satisfy the evidence of verification.

Please make submission via the Portal.

AG, 5-13-21

Document Submission **Implemented**

Two attachments are provided. first communication from the pharmacy manager to the facility regarding outstanding items needed (this is now sent weekly) and second the follow up note stating the system worked.

187d - Follow Prescriber's Orders *(continued)*

Update - 05/18/2021

attachments reviewed
AG, 5-18-21