

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

March 6, 2023

[REDACTED], ADMINISTRATOR  
GAHC3 BOYERTOWN PA ALF TRS SUB LLC  
660 SENTRY PARKWAY, SUITE 220  
[REDACTED]

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 02/09/2023 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]  
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

**Name:** CHESTNUT KNOLL **License #:** 22613 **License Expiration:** 06/30/2023  
**Address:** 120 WEST FIFTH STREET, BOYERTOWN, PA 19512  
**County:** BERKS **Region:** NORTHEAST

**Administrator**

**Name:** Holly Heydt **Phone:** 610-473-8066 **Email:**  
 HHeydt@chestnutknoll.com/  
 Jjamison@chestnutknoll.com

**Legal Entity**

**Name:** GAHC3 BOYERTOWN PA ALF TRS SUB LLC  
**Address:** [REDACTED]  
**Phone:** [REDACTED] **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** C 2 LP **Date:** 08/20/2020 **Issued By:** PALI

**Staffing Hours**

**Resident Support Staff:** 0 **Total Daily Staff:** 163 **Waking Staff:** 122

**Inspection Information**

**Type:** Partial **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Complaint, Incident **Exit Conference Date:** 02/09/2023

**Inspection Dates and Department Representative**

02/09/2023 **On Site:** [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
**License Capacity:** 119 **Residents Served:** 110

**Secured Dementia Care Unit**  
**In Home:** Yes **Area:** 1st Floor **Capacity:** 52 **Residents Served:** 51

**Hospice**  
**Current Residents:** 12

**Number of Residents Who:**  
**Receive Supplemental Security Income:** 0 **Are 60 Years of Age or Older:** 110  
**Diagnosed with Mental Illness:** 0 **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 53 **Have Physical Disability:** 0

**Inspections / Reviews**

02/09/2023 - Partial  
**Lead Inspector:** [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 03/06/2023

Inspections / Reviews (*continued*)

## 03/01/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/05/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/08/2023

## 03/06/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/05/2023

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 1 grabbed Resident 2 after an argument over the TV. The 2 residents then pushed each other causing both to fall to the ground. As a result of the fall, Resident 2 fractured their hip and required hospitalization.

Plan of Correction

Accept ( [redacted] - 03/01/2023)

2600.42.b A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

What: [redacted] Resident 1 grabbed Resident 2 after an argument over the TV. The 2 residents then pushed each other causing both to fall to the ground. As a result of the fall, Resident 2 fractured their left hip and required hospitalization.

Who: 911 was called and Resident 2 was taken to the hospital. Resident 1 was checked for any injuries and when none were found, Resident 1 was assisted to their feet by the Executive Director and another staff member. The Executive Director did talk to Resident 1 to determine what happened. Then the Executive Director spoke with staff that had witnessed the argument and were in route to assist when both residents fell. Staff reported the incident to the families and physicians of both residents and also reported the incident to Office of Aging, Eastern Berks Regional Police and BHSL.

How: Resident 1 was seen on [redacted] by the psychiatrist in regards to the incident. Resident 2 was out of the facility for rehabilitation after [redacted] hospitalization and surgery and returned on [redacted].

On January 26 ,2023, upon Resident 2's return, both Resident 1 and Resident 2 were reminded by the Executive Director of the community rule that addresses resident behavior and asked to sign a form that makes them both aware that if there are any further incidents, with any residents, where the rule regarding behaviors was violated again, that it may result in being asked to leave the community. Both Residents expressed understanding and signed the agreements (attached). Resident 2 was also seen by the psychiatrist on [redacted]. Resident 2's seat was also moved in the dining room, upon their return to help avoid interactions between the two residents. Both support plans were updated. Resident 1 and Resident 2 have not had any further incidents of disagreement since Resident 2 returned from the hospital.

When: All staff are aware of the incident and continue to monitor both residents when they are in the common areas at the same time. Executive Director will continue to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 02/28/2023

Implemented ( [redacted] - 03/06/2023)