

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

May 10, 2023

[REDACTED], COO
GAHC3 BOYERTOWN PA ALF TRS SUB LLC

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 04/12/2023 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]

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: [REDACTED] **Email:** [REDACTED]

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:** 08/20/2000 **Issued By:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 145 **Waking Staff:** 109

Inspection Information

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

Reason: Complaint, Incident **Exit Conference Date:** 04/12/2023

Inspection Dates and Department Representative

04/12/2023 **On Site:** [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 119 **Residents Served:** 99

Secured Dementia Care Unit

In Home: Yes **Area:** 1st floor **Capacity:** 52 **Residents Served:** 44

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 99

Diagnosed with Mental Illness: 1 **Diagnosed with Intellectual Disability:** 0

Have Mobility Need: 46 **Have Physical Disability:** 0

Inspections / Reviews

04/12/2023 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 04/27/2023

Inspections / Reviews *(continued)*

05/05/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/05/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/11/2023

05/10/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/05/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home 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] Resident #1 was observed exposing themselves to resident #2, grabbing resident #2's hand and attempting to have resident #2 touch them. Both resident #1 and #2 reside in the home's secure dementia unit. The incident was not reported to the area agency on aging as required.

Plan of Correction

Accept [REDACTED] - 05/05/2023)

2600.15 a. The home shall immediately report suspected abuse of a resident served in the home 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.

What: On [REDACTED] Resident #1 was observed exposing themselves near Resident #2, and grabbing Resident #2's hand. Both Resident #1 and #2 reside in the home's secure dementia care unit. The incident was not reported to the Area Agency on Aging. We respectfully disagree with determination of an incident of an abuse, as noted below.

Who: Staff were nearby when this interaction occurred and immediately intervened, preventing any inappropriate touching from occurring. Staff educated Resident #1, who signed a statement agreeing to keep their body covered and not touch other residents. Resident #1 was seen by Psychiatrist on [REDACTED], with a recommendation for [REDACTED] to be sent out to the [REDACTED] Memorial Hospital psychiatric unit to evaluate and address any concerns necessary. The Resident did return on 12/17/22 with medication changes at that time. They were also seen on [REDACTED] by Psychologist as a follow up to the recent hospitalization. Resident#1 was placed on 1:1 with home care starting on [REDACTED]; the 1:1 supervision was discontinued on [REDACTED] due to no further episodes of inappropriate behavior, which was updated on the support plan (Attachment 6). Resident #2 did not suffer any ill effects from this incident and neither resident recalled this incident later the same day or any time after that.

How: We respectfully disagree that the incident on [REDACTED] was an episode of abuse since the interaction was witnessed and the resident was immediately redirected. Because no actual physical contact did occur, the incident was not reported to Aging at that time. Since the visit on 4/12/2023 when BHSL deemed it as abuse, an Act 13 report was completed (Attachment 1) and sent to Area Agency on Aging on 4/13/2023. All incidents going forward that could be perceived as potential abuse will be submitted verbally and in writing. Staff have been re-educated on the requirements of reporting abuse, each and every time that they occur. Resident #1 has home care in place during waking hours effective 4/21/2023 and will remain in place until deemed no longer needed.

When: Staff education on the reporting abuse will be completed by 4/27/2023 (Attachment 3). Resident # 1 did start with home care services for close supervision during waking hours on 4/21/2023 and will remain in place until deemed no longer needed. Resident #1's support plan has been updated to reflect this change (Attachment 4).

Ongoing: Staff will continue to monitor Resident #1 for any further behaviors and adjust the need for close supervision as required. All suspected abuse will be reported to Area Agency on Aging and BHSL as required, ongoing, with oversight provided by the Executive Director.

Licensee's Proposed Overall Completion Date: 04/27/2023

Implemented [REDACTED] - 05/10/2023)

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).

Description of Violation

On [REDACTED] Resident #1 was observed exposing themselves to resident #2, grabbing resident #2's hand and attempting to have resident #2 touch them. Both resident #1 and #2 reside in the home's secure dementia care. The incident was not reported to the department's regional office as required.

Plan of Correction

Accept [REDACTED] - 05/05/2023)

2600.16c. The home shall 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).

What: On [REDACTED] Resident #1 was observed exposing themselves near Resident #2, and grabbing Resident #2’s hand. Both Resident #1 and #2 reside in the home’s secure dementia care unit. The incident was not reported to the department’s regional office as required. We respectfully disagree with determination of an incident of an abuse, as noted below.

Who: Staff were nearby when this interaction occurred and immediately intervened, preventing any inappropriate touching from occurring. Staff educated Resident #1, who signed a statement agreeing to keep their body covered and not touch other residents. Resident #1 was seen by Psychiatrist on 12/5/2022, with a recommendation for [REDACTED] to be sent out to the [REDACTED] Memorial Hospital psychiatric unit to evaluate and address any concerns necessary. The Resident did return on 12/17/22 with medication changes at that time. They were also seen on 1 [REDACTED] by Psychologist as a follow up to the recent hospitalization. Resident#1 was placed on 1:1 with home care starting on 12/17/2022; the 1:1 supervision was discontinued on 12/24/2022 due to no further episodes of inappropriate behavior, which was updated on the support plan (Attachment 6). Resident #2 did not suffer any ill effects from this incident and neither resident recalled this incident later the same day or any time after that.

How: We respectfully disagree that the incident on [REDACTED] was an episode of abuse since the interaction was witnessed and the resident was immediately redirected. Because no actual physical contact did occur, the incident was not reported to the department at that time. Since the visit on 4/12/2023 when BHSL deemed it as abuse, an incident reporting form was completed (Attachment 2) and sent to the department’s regional office on 4/13/2023. All incidents going forward that could be perceived as potential abuse will be submitted in writing as required. Staff have been re-educated on the requirements of reporting abuse, each and every time that they occur. Resident #1 has home care in place during waking hours effective 4/21/2023 and will remain in place until deemed no longer needed.

When: Staff education on the reporting abuse will be completed by 4/27/2023 (Attachment 3). Resident # 1 did start with home care services for close supervision during waking hours on 4/21/2023 and will remain in place until deemed no longer needed. Resident #1’s support plan has been updated to reflect this change (Attachment 4).

Ongoing: Staff will continue to monitor Resident #1 for any further behaviors and adjust the need for close supervision as required. All suspected abuse will be reported to Area Agency on Aging and BHSL as required, ongoing, with oversight provided by the Executive Director.

Licensee's Proposed Overall Completion Date: 04/27/2023

Implemented [REDACTED] - 05/10/2023)

42b Abuse

3. Requirements

42b Abuse (continued)

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] resident #1 was observed exposing themselves to resident #2, grabbing resident #2's hand and attempting to have resident #2 touch them.

On [REDACTED] resident #3 was found in resident #1's bedroom performing oral sex on resident #1. All residents reside in the secure dementia unit and are unable to consent to sexual contact.

Plan of Correction

Accept [REDACTED] - 05/05/2023)

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

What: On [REDACTED] Resident #1 was observed exposing themselves near Resident #2 and grabbing Resident #2's hand. On [REDACTED] Resident #3 was found in Resident #1's bedroom performing oral sex on Resident #1. All residents reside in the secure dementia care unit. We respectfully disagree with the determination that this is an incident of abuse.

Who: Regarding [REDACTED], staff were nearby when this interaction occurred and immediately intervened, preventing any inappropriate touching from occurring. Staff educated Resident #1, who signed a statement agreeing to keep their body covered and not touch other residents. Resident #1 was seen by Psychiatrist on [REDACTED], with a recommendation for them to be sent out to the [REDACTED] Memorial Hospital psychiatric unit to evaluate and address any concerns necessary. The Resident did return on [REDACTED] with medication changes at that time. They were also seen on [REDACTED] by Psychologist as a follow up to the recent hospitalization. Resident #1 was placed on 1:1 with home care starting on [REDACTED]; the 1:1 supervision was discontinued on [REDACTED] due to no further episodes of inappropriate behavior, which was updated on the support plan (Attachment 4). Resident #2 did not suffer any ill effects from this incident and neither resident recalled this incident later the same day or any time after that.

Regarding [REDACTED] Resident #3 has a tendency to wander in the evenings and open/knock on other resident's apartment doors. It is believed Resident #3 let themselves into Resident #1's apartment and both residents willingly engaged in the oral sex act. Staff went to Resident #1's apartment to complete the Glucometer check and found Resident #3 in Resident #1's apartment performing oral sex on Resident #1. Staff intervened, and when staff attempted to separate them, both residents insisted that staff leave and return at another time, indicating that both residents were willing participants. Staff were successful in redirecting Resident #3 and Resident #1 and assisted Resident #3 back to their apartment. Neither resident suffered any ill effects from the interaction, both residents were assisted with preparing for bed and both stayed in their apartments the rest of the evening until morning, with staff doing frequent checks overnight. Both families and physicians were made aware of the interaction. Neither family expressed any concerns regarding the encounter. Resident #3 and Resident #1 were seen by the Psychiatrist on [REDACTED] during a routine visit, as follow up.

How: In regard to the [REDACTED] incident, we respectfully disagree that this interaction was an episode of abuse since the behavior was witnessed and resident was immediately redirected. Because no actual physical contact did occur, the incident was not reported to BHSL or aging at that time. Resident #1 has home care in place during waking hours effective 4/21/2023 and will remain in place until deemed no longer needed.

In regard to the [REDACTED] incident, we respectfully disagree that this interaction was an episode of abuse since both residents expressed their willingness and desire to continue with the sexual act when staff intervened. Neither resident has been adjudicated incapacitated by the courts. Therefore, we do not feel we are able to determine that they are not capable of consent, and want to ensure we protect their right to freely associate with others as well. This was also investigated by Protective Services and they did not indicate a need for services from this incident. Staff

42b - Abuse (continued)

education on abuse and reporting has been completed in March 2023 (Attachment 5). Any resident that has behaviors that may lead to sexual incidents will be monitored on an as needed basis, with appropriate documentation in the RASP, and the community will request increased supervision via home care as deemed necessary to help prevent any further episodes.

When: Staff education regarding preventing abuse was completed in March 2023 (Attachment 5). Dementia Education for all direct care staff that work in Memory care is ongoing.

Ongoing: Dementia Education for all direct care staff that work in Memory Care is ongoing, to include reporting of all concerns to be monitored and addressed. The Executive Director will provide oversight for all programming, and implementation of assessments and support plans in conjunction with the Memory Care Director.

Licensee's Proposed Overall Completion Date: 04/27/2023

Implemented () - 05/10/2023)

234d - Support Plan Revision**4. Requirements**

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #1 was admitted to the home's secure dementia unit on [REDACTED]. The support plan was completed on [REDACTED]. Resident #1's support plan was not updated to reflect that the resident exposed themselves to another resident on [REDACTED] and has had other inappropriate behaviors towards residents that required periodic 1:1 care and did not include a plan to address those behaviors.

Plan of Correction

Accept () - 05/05/2023)

2600.234d The support plan shall be revised at least annually and as the resident's condition changes.

What: Resident #1 was admitted to the home's secure dementia care unit on [REDACTED]. The support plan was completed on [REDACTED]. Resident #1's support plan was not updated to reflect that the resident had interactions with other residents that required periodic 1:1 care or a plan to address those interactions.

Who: Resident #1's support plan was updated on [REDACTED] to include the interaction on [REDACTED] and the 1:1 supervision in place from 12/17/2022-12/24/2022 (Attachment 4).

How: Support plans will be audited monthly starting in May 2023 to ensure that updates are completed when the resident's condition changes. Staff responsible for support plan changes including the Memory Care Director, Resident Care Director and Clinical Care Coordinator will have education regarding support plan updates completed by 4/27/2023.

When: Staff responsible for support plan changes will have education regarding support plan updates completed by 4/27/2023 (Attachment 6). Audits will be completed monthly by Resident Care Director and Memory Care Director, and the Executive Director will provide oversight.

Ongoing: Support plan education is completed annually as part of required training, with annual training will be completed ongoing. The QA Quarterly Review addresses the need to review and update the support plan and any other related documents in the resident record as changes occur. The QA Quarterly Review will continue indefinitely, in January, April, July, and October.

Licensee's Proposed Overall Completion Date: 04/27/2023

Implemented (JH - 05/10/2023)

234d - Support Plan Revision (*continued*)