

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

April 18, 2025

[REDACTED]  
GAHC3 BOYERTOWN PA ALF TRS SUB LLC

[REDACTED]  
HERITAGE SENIOR LIVING  
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/06/2025 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,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: CHESTNUT KNOLL License #: 22613 License Expiration: 06/30/2025  
 Address: 120 WEST FIFTH STREET, BOYERTOWN, PA 19512  
 County: BERKS Region: NORTHEAST

**Administrator**

Name: [REDACTED] Phone: [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: 11/10/1999 Issued By: L & I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 153 Waking Staff: 115

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Incident Exit Conference Date: 03/06/2025

**Inspection Dates and Department Representative**

03/06/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 119 Residents Served: 102  
 Secured Dementia Care Unit  
 In Home: Yes Area: unit Capacity: 52 Residents Served: 48  
 Hospice  
 Current Residents: 12  
 Number of Residents Who:  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 102  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 51 Have Physical Disability: 0

**Inspections / Reviews**

03/06/2025 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/04/2025

04/10/2025 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 04/18/2025  
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 04/17/2025

Inspections / Reviews *(continued)*

04/18/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/18/2025

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**

On [REDACTED] Resident [REDACTED] was found by Staff Member A lying on top of Resident [REDACTED] in Resident [REDACTED] room. Resident [REDACTED] was visibly upset and crying. Both Resident [REDACTED] and Resident [REDACTED] pants were pulled down and Resident [REDACTED] top was pulled up over their undergarments. Resident [REDACTED] stated that Resident [REDACTED] "Asked them to do it", and Resident [REDACTED] was upset stating Resident [REDACTED], "Was lying".

**Plan of Correction****Accept [REDACTED] - 04/01/2025)**

*Immediate Corrective Actions: Staff member A immediately called for assistance from another staff member. Staff Member A and assistant separated Resident [REDACTED] and Resident [REDACTED]. Resident [REDACTED] was assisted with replacing their clothing and removed from the room. MCD arrived to the room and called for RCD to come in, ED was also called to the room. Staff member A assisted Resident [REDACTED] with replacing their clothing. Both residents were offered support as staff contacted 911 to report the incident and request EMT's and police report to the Community. Resident [REDACTED] was assessed for any physical injuries and none were found, EMT and police arrived at Community and were able to interview both residents involved as well as staff. Resident [REDACTED] was sent to a local hospital for evaluation. Resident [REDACTED] had no visible injuries but was also sent to a different local hospital for evaluation. Police did collect statements from both residents and staff. Families of Resident [REDACTED] and Resident [REDACTED] were contacted and staff made Resident [REDACTED] family aware of the need for private duty 1:1 for 24/7 until further notice. Resident [REDACTED] did return that afternoon with no new orders from the hospital and did have 1:1 private duty when they returned which continued until they were discharged on [REDACTED] to another community. Resident [REDACTED] also returned the same day in the evening and with no new orders from the hospital. Both residents are seen by Psychiatry and the psychiatrist for both residents was contacted and made medication changes for Resident [REDACTED] effective 3/5/2025. Berks County Office of Aging was contacted on 3/4/2025 and did come out on 3/5/2025 to interview both residents. PA Dept of Aging was contacted on 3/4/2025 and a representative did speak with the ED on 3/5/2025.*

*Additional Corrective Actions: Both Residents were seen by their PCP on 3/6/2025 and had no new orders from the PCP. They were both also seen on 3/10/2025 by the Psychiatrist and again [REDACTED] had no new orders for either resident. Resident [REDACTED] was also offered counseling with a social worker which they were agreeable to and was started on 3/12/2025. Staff involved were also offered support by the social worker and counseling was provided. Resident [REDACTED] family was made aware that private duty would be required indefinitely at this community and made the choice to seek other placement. Resident [REDACTED] did leave on 3/13/2025 to spend time at home with their spouse until 3/16/2025 and did return on 3/16/2025. Resident 1 discharged to another community on 3/19/2025, with no plans to return. Office of Aging did come out on 3/25/2025 to finalize their investigation of the incident. We are hosting at Trauma informed staff training on 4/11/2025 and 4/16/2025, staff education sign in sheets will be provided when completed.*

*Ongoing Quality Assurance Action: Memory Care Director and Resident Care Director will review incidents as part of our Quarterly QA meetings starting 4/10/2025.*

**Licensee's Proposed Overall Completion Date: 04/18/2025**

**Implemented [REDACTED] - 04/18/2025)**