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

September 8, 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 08/05/2025 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**: *06/30/2026*

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**: *161* **Waking Staff**: *121*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date**: *08/05/2025*

Inspection Dates and Department Representative

08/05/2025 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *119* **Residents Served**: *107*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **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: *107*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *54*

Have Physical Disability: *0*

Inspections / Reviews

08/05/2025 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *09/01/2025*

Inspections / Reviews *(continued)*

09/02/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/08/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/08/2025*

09/08/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/08/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

In the Memory Care Resident Living Room/TV Common-Area, at 10:10 a.m., the laptop located on the medication cart was unlocked, unattended, and accessible to residents' records.

Plan of Correction ***Accept [redacted] - 09/02/2025)***

Immediate Corrective Action: Staff member that was working during the inspection on the laptop was educated during the inspection on 8/5/2025 by the Executive Director on how to appropriately lock the computer to prevent access when not immediately at the computer.

Ongoing Corrective Actions: Written reminders were attached to all Laptops stating "when not in attendance lock screen by pressing "windows" key and L together". Med Techs were educated on 8/6/2025 by the Resident Care Director and all care staff will be re-educated on 9/3/2025 by the Executive Director. Weekly Audits will replace the monthly audits and will now be completed by the Executive Director starting the week of 9/2/2025.

Ongoing Quality Assurance Actions: The weekly audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary Team starting in October 2025 for ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented ([redacted] - 09/08/2025)

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 approximately 8:15 p.m. staff noted a bruise on resident #[redacted] wrist. Resident [redacted] stated that staff person A provided care in a rushed manner earlier that day in the morning that caused the bruising.

On [redacted] at approximately 11:30 a.m. the home was informed that resident #[redacted] made statements during a hospital visit that they were afraid to return to the home due to concerns about staff person A's treatment of them. An investigation revealed that staff person A engaged in an argument with resident [redacted] as witnessed by their spouse, resident #[redacted]. Resident #[redacted] also stated that staff person A is frequently bossy with them during care. Resident [redacted] felt that staff person A was disrespectful to resident [redacted] when they checked resident [redacted]s brief with their hand instead of asking resident [redacted] if they needed to be changed.

42b - Abuse (continued)

Plan of Correction ***Accept [redacted] - 09/02/2025)***

Immediate Corrective Actions: Staff person A was suspended on 7/15/2025 by the Resident Care Director at 9:00 p.m. pending an investigation. Executive Director contacted Berks County Office of Aging to report the concern on 7/15/2025 and then sent an initial report to BHSL via email on 7/15/2025. Resident Care Director notified Resident #1's family and physician of the concern.

Additional Corrective Actions: An investigation was started by the Executive Director on 7/15/2025 into the concerns brought to our attention. Resident #1 was interviewed on 7/16/2025 by the Executive Director, Resident #3 was interviewed on 7/16/2025 by the Executive Director and Resident Care Director. Staff person A was interviewed on 7/16/2025 by the Executive Director and Business Office Director. Resident #2 and #3's family was made aware of the concern by the Executive Director on 7/16/2025. Resident #2 was interviewed by the Executive Director on 7/18/2025 when they returned from the hospital. Staff person A was terminated from employment on 7/18/2025.

Ongoing Quality Assurance Actions: All staff will be re-educated on Abuse and reporting by the Executive Director during the staff meeting scheduled on 9/3/2025. We will continue to report any concerns of abuse and educate staff annually on Abuse and reporting. Reportable incidents are reviewed as part of the Quarterly QA meetings, by the interdisciplinary team next one is scheduled for October 2025 and will continue quarterly for ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented [redacted] - 09/08/2025)

125a - Combustible Storage

3. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At 9:48 a.m. a large white blanket was observed behind the home's commercial dryer. The blanket was located directly underneath the external duct.

Plan of Correction ***Accept [redacted] - 09/02/2025)***

Immediate Corrective Action: Blanket was removed by the Laundry staff from behind the dryer immediately upon discovery on 8/5/2025.

Additional Corrective Actions: Laundry Staff were educated to check for and remove any items behind the dryer or located near the external duct by the Environmental Services Director between 8/5/2025 and 8/7/2025. A weekly audit will be completed by the Executive Director to verify that the area behind the dryer and/or near the external duct are free from any clutter or combustible materials starting the week of 9/2/2025.

Ongoing Quality Assurance Actions: The weekly audits will be reviewed at the Quarterly QA meetings starting in October 2025 by the Interdisciplinary Team for ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/05/2025*

125a Combustible Storage *(continued)*

Implemented ([redacted] - 09/08/2025)

185a Implement Storage Procedures

4. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] has an order for blood glucose checks three times daily at 8:00 a.m., 12:00 p.m., and 5:00 p.m. The resident uses a [redacted] continuous blood glucose monitoring device. Through interviews with staff it was noted that the only the residents physician can access the resident's blood glucose history. The home was unable to access the record of the resident's past blood glucose readings.

Resident [redacted] has a PRN order for [redacted]. On [redacted], the medication was not in the home's medication cart.

Plan of Correction ***Accept [redacted] - 09/02/2025)***

Immediate Corrective Action: Resident #5's [redacted] was ordered from the pharmacy immediately by the Clinical Care Coordinator and was received on 8/5/2025.

Additional Corrective Actions: During our investigation regarding the missing PRN medication, it was determined that the cream had expired on 7/31/2025, was discarded and the staff person did not request a refill at that time. Staff were re-educated by the Resident Care Director on 8/6/2025 that all PRN medications must be present and available for every resident. Staff will be educate on 9/3/2025 by the Executive Director that all expired medications are now to be given to the Resident Care Director so [redacted] can verify that refills have been requested. Monthly Med Cart audits completed by the Resident Care Director will continue and in addition a weekly review of all expired meds will be completed by the Resident Care Director and Executive Director starting the week of 9/2/2025. Resident #4 that has the Dexcom monitor has been educated on the concern of the CGM device that they are currently utilizing and not being able to review the history on demand. They have been reluctant to make a change but on 8/27/2025 they have agreed with the Executive Director to change to a different CGM device that will allow the staff at the community to review the Blood Glucose history on demand. Resident #4's niece and endocrinologist have been contacted on 8/27/2025 and are working to get a different CGM device to comply with state regulations. If the new CGM device is not received by the community by 9/22/2025, we will transition Resident #4's blood sugar checks to a manual blood sugar machine until an appropriate device can be obtained. The community also discovered that there is one other resident that has a Dexcom device and that resident is also agreeable to changing to a new CGM device but must make this change through the VA physician, again if we are unable to obtain a new CGM device by 9/22/2025 this resident will also transition to a manual blood sugar machine until a new device can be obtained. This process will be reviewed weekly by the Executive Director and Resident Care Director starting the week of 9/2/2025 until new CGM's are obtained or residents are transitioned to manual blood sugar machines. All new residents with CGM devices will be reviewed by the Resident Care Director upon move in to determine if the history can be obtained on-demand, if not, the Resident Care Director will work with the resident and their family to obtain the correct devices and will be required to utilize a manual blood sugar machine until an appropriate CGM can be obtained.

Ongoing Quality Assurance Actions: The weekly review of all expired medications and the monthly med cart

185a Implement Storage Procedures (continued)

audits will be reviewed at the Quarterly QA meeting by the Interdisciplinary Team starting in October 2025 to ensure ongoing compliance. All residents with CGM devices will be reviewed at the Quarterly QA meeting by the Interdisciplinary Team to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *09/23/2025*

Implemented (- 09/08/2025)

187d - Follow Prescriber's Orders

5. Requirements

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

Description of Violation

Resident receives on a sliding scale 3 times daily at 8:00 a.m. 12:00 p.m. and 5:00 p.m. and had a blood glucose reading of on at 5:00 p.m. The resident should have received 6 units of insulin for a blood glucose reading of however was administered 8 units.

Plan of Correction ***Accept - 09/02/2025)***

Immediate Corrective Action: Resident #4, their niece and their physician were made aware of the incorrect dose of insulin by the Resident Care Director on 8/5/2025 and no new orders were received.

Additional Corrective Actions: A reportable incident form was completed by the Executive Director on 9/6/2025 at 9:43 a.m. and sent to BHSL, per regulations. The med tech that was responsible for the medication error was verbally educated by the Executive Director and Resident Care Director of the error on 8/5/2025 via telephone. The med tech was observed by the Resident Care Director/Medication administration trainer on 8/7/2025 when completing all glucose checks on the evening medication pass to ensure that the proper steps are being followed and ensuring that all were documented correctly and residents all received the correct dose. Weekly audits of medications with parameters by the Resident Care Director will continue and will be monitored for any errors. Any errors discovered during the weekly audits will be reported by the Resident Care Director to BHSL per regulations.

Ongoing Quality Assurance Actions: The weekly audits will be reviewed at the Quarterly QA meetings by the interdisciplinary team to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/29/2025*

Implemented - 09/08/2025)