

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

May 5, 2026

[REDACTED]
HERITAGE CAMPUS GREEN HILLS OPCO LLC
[REDACTED]

RE: THE HERITAGE OF GREEN HILLS
CARE CENTER
400 TRANQUILITY LANE
READING, PA, 19067
LICENSE/COC#: 23113

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/26/2026, 04/06/2026 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: THE HERITAGE OF GREEN HILLS CARE CENTER License #: 23113 License Expiration: 08/18/2026
 Address: 400 TRANQUILITY LANE, READING, PA 19067
 County: BERKS Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: HERITAGE CAMPUS GREEN HILLS OPCO LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 08/06/2022 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 110 Waking Staff: 83

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Incident Exit Conference Date: 04/06/2026

Inspection Dates and Department Representative

03/26/2026 - On-Site: [REDACTED]
 04/06/2026 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 90 Residents Served: 71
 Secured Dementia Care Unit
 In Home: Yes Area: N/A Capacity: 23 Residents Served: 19
 Hospice
 Current Residents: 10
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 71
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 39 Have Physical Disability: 0

Inspections / Reviews

03/26/2026 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/01/2026
 04/29/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/30/2026
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 05/04/2026

Inspections / Reviews *(continued)*

05/05/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2026

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] at approximately 6:30P.M., resident [REDACTED] was walking through the secure dementia unit without using a walker, which the resident utilizes for stability. Staff member A loudly prompted the resident to sit in the common area of the unit. Once seated, multiple staff reported witnessing staff member A push resident [REDACTED] down in the chair when the resident attempted to stand up. The resident was heard to scream "ouch" and cry when sitting back down in the chair. Staff person A then used their foot to barricade the resident from standing. Approximately one minute later, staff person A grabbed the wrist of resident [REDACTED], standing the resident up and escorting to the resident's room.

Plan of Correction**Accept [REDACTED] - 04/29/2026)**

Management was notified of this incident on 3/16/26 at approximately 10 pm via email. On 3/17/26, we immediately began an investigation. There were 2 other staff members who were working and provided statements. We sat down with Staff Person A to discuss the situation, obtained their written statement of the event and Staff Person A was suspended pending our investigation. We also notified Resident #'s primary care physician and behavioral health specialist, who both saw the resident on 3/17/2026, to assess for any ill effects or bruising. Resident [REDACTED] did not show any signs of abuse, had no bruising or behavioral effects noted. Our investigation ended and we determined that the behavior of Staff Person A was not appropriate, was harsh, and violated the resident's rights, but was not abuse. Staff Person A acted out of concern for the resident's safety and frustration due to the resident's noncompliance with using their walker. We suspended Staff Person A through 3/19/2026; Berks County AAA was notified, the DHS Incident Report was submitted, and Resident [REDACTED]'s POA/Daughter was notified. Staff Person A took a PTO day on 3/20/2026 and returned to work on 3/23/2026. Upon return to work, Staff Person A was removed from providing care on the Memory Support unit. Staff Person A was provided with a First and Final Warning, see attached, and was provided with Resident Rights and Abuse Training, see attached. Staff Person A has been on a daily monitoring program since that time. This is a documented check-in process that occurs several times throughout the shift to ensure their behavior and frustration level remain appropriate. Staff Person A has been compliant and appropriate since their return to work. The check-in process will remain in place until 4/30/2026, and Staff Person A will remain off the memory care unit until 6/1/2026.

Licensee's Proposed Overall Completion Date: 04/30/2026**Implemented [REDACTED] - 05/05/2026)**