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

August 27, 2026

[redacted] ADMINISTRATOR
5485 PERKIOMEN AVENUE OPERATIONS LLC
5485 PERKIOMEN AVENUE
READING, PA, 19606

RE: BERKSHIRE COMMONS, GENESIS HEALTHCARE
5485 PERKIOMEN AVENUE
READING, PA, 19606
LICENSE/COC#: 22199

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/14/2026, 05/28/2026 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BERKSHIRE COMMONS, GENESIS HEALTHCARE* **License #**: *22199* **License Expiration**: *06/14/2026*

Address: *5485 PERKIOMEN AVENUE, READING, PA 19606*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *5485 PERKIOMEN AVENUE OPERATIONS LLC*

Address: *5485 PERKIOMEN AVENUE, READING, PA, 19606*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/04/1995* **Issued By**: *dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *63* **Waking Staff**: *47*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/28/2026*

Inspection Dates and Department Representative

05/14/2026 - On-Site: [redacted]

05/28/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *48*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Homestead* **Capacity**: *14* **Residents Served**: *14*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

Have Mobility Need: *15* **Have Physical Disability**: *1*

Inspections / Reviews

05/14/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/26/2026*

08/03/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/21/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/10/2026*

Inspections / Reviews *(continued)*

08/19/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/21/2026*

08/27/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's 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], at approximately 11:10 a.m., a staff member observed staff member A yelling at Resident #1 to sit down while holding both of the resident's arms trying to force the resident to sit down in a chair. The allegation of abuse was not reported to the local Area Agency on Aging in accordance with the Older Adult Protective Services Act until [redacted]

Plan of Correction ***Accept ([redacted] - 08/19/2026)***

Executive Director held an all staff meeting on 4/15/2026. Education provided regarding OAPSA. Abuse training. Mandatory Abuse Reporting. Resident Rights. De-escalation techniques for memory support residents. Executive Director held an all staff meeting on 7/15/2026. Education provided regarding OAPSA. Abuse training. Mandatory Abuse Reporting. Resident Rights. Dignity and Respect. Poisonous materials to be locked away in memory care when not in use. Ongoing annual training. Training to be reviewed during QAPI.

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented ([redacted] - 08/27/2026)

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 11:10 a.m., Staff person A was observed yelling at Resident #1 to sit down while holding both resident's arms trying to force them to sit down in a chair. Staff person A admitted to attempting to get the resident to sit and once the resident was sitting down, sat on the armrest of the chair to prevent the resident from standing up. Resident #1 reported to staff that Staff person A was mean to them and a quarter sized bruise was noted on the resident's left wrist after the incident.

Plan of Correction ***Accept ([redacted] - 08/19/2026)***

On [redacted] Employee was suspended pending investigation. Employee was terminated on [redacted] Executive Director held an all staff meeting on [redacted]. Education provided regarding OAPSA. Abuse training. Resident Rights. De-escalation techniques for memory support residents. Executive Director held an all staff meeting on 7/15/2026. Education provided regarding OAPSA. Abuse training. Resident Rights. Dignity and Respect. Poisonous materials to be locked away in memory care when not in use. Ongoing annual training. Training to be reviewed during QAPI.

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *08/05/2026*

Implemented ([redacted] - 08/27/2026)

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #2's bed enabler bar was observed to have approximately a 15 ½ x 14-inch opening and was not covered at the time of inspection.

Plan of Correction ***Accept ([redacted] - 08/03/2026)***

Bed enabler bar was removed from resident's bed on 5/14/2026. Bed enabler bar replaced by therapy on 5/14/26. Executive Director completed an audit on 5/15/26 for all residents utilizing a bed enabler bar. Bed enabler bar audits ongoing. Audits to be reviewed during QAPI.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/27/2026)

82c - Locking Poisonous Materials

4. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 9:49 a.m., REMEDY Zinc Oxide Paste and REMEDY Antifungal Powder with a manufacture's label indicating " If swallowed seek medical help or Call Poison Control ", was unlocked, unattended, and accessible in the bathroom of resident #3, who resides in the home's Secured Dementia Care Unit (SDCU) and has been assessed not capable of recognizing and using poisons safely.

At approximately 10:07 a.m., REMEDY Zinc Oxide Paste with a manufacture's label indicating " If swallowed seek medical help or Call Poison Control ", was unlocked, unattended, and accessible in the bathroom of resident #4, who resides in the home's Secured Dementia Care Unit (SDCU) and has been assessed not capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 08/19/2026)***

Housekeeping supervisor locked poisonous materials away for resident #3 and #4 during survey. Dementia Program Director or Designee began a daily audit on 5/15/2026 in memory support for poisonous materials being locked away. Daily audit was conducted 5/15/26 through 5/29/26. Weekly audits conducted 6/5/26 through 6/26/26. Executive Director provided education on 6/3/26 during the nursing staff meeting. Audits reviewed during QAPI.

Licensee's Proposed Overall Completion Date: *08/05/2026*

82c Locking Poisonous Materials *(continued)*

Implemented (- 08/27/2026)

85e Trash Outside Home

5. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 2:38 p.m., during the inspection, an outdoor trash receptacle located in the designated smoking area was observed containing waste materials and lacking a cover or lid.

Plan of Correction ***Accept (- 08/19/2026)***

Housekeeping Manager replaced the outside trash receptacle with a trash receptacle with a lid on 5/14/26. Executive Director provided education to housekeeping staff and maintenance staff in regards to outdoor trash receptacles requiring a cover or lid on 7/17/2026. Housekeeping Supervisor or Designee to audit outside receptacles weekly x 4 weeks. Audits to be reviewed during QAPI.

Licensee's Proposed Overall Completion Date: *08/28/2026*

Implemented (- 08/27/2026)

107d Procedure Emergency Management Agency Submission

6. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

A review of the home's emergency preparedness records revealed that the annual written emergency procedures were most recently submitted to the local emergency management agency on 12/8/25. However, the home was unable to provide documentation verifying the prior annual submission of the written emergency procedures to the local emergency management agency (EMA).

Plan of Correction ***Accept (- 08/03/2026)***

Executive Director provided education to managers and administrative assistant. Emergency preparedness plan binder at the front desk to include a minimum of two years proof (copy of email correspondence) that the emergency preparedness plan was sent to local emergency management officials.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented (- 08/27/2026)

185a Implement Storage Procedures

7. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

At approximately 9:50 a.m., one oxygen tank was stored directly on the closet floor in the room of resident # 3 and was not secured.

Resident #5's glucometer was observed to display an incorrect time. The glucometer read 11:44 a.m. on 5/14/2026, rather than the actual time of 3:11 p.m.

Resident #5's review of the glucometer readings and medication administration records (MAR) revealed discrepancies in documented blood glucose readings. On 5/10/2026, the glucometer recorded a blood glucose reading of 198 at 5:01 p.m., while the MAR documented a reading of 213 at 4:30 p.m. on 5/12/2026, the glucometer recorded a blood glucose reading of 172 at 7:49 a.m., while the MAR documented a reading of 179 at 7:20 a.m

Resident #5 is prescribed Acetaminophen tab 325mg as needed. At 3:18 p.m., on 5/14/2026 medication was not available in the home.

Repeat Violation 2/24/2026, 12/23/2025, 8/5/2025

Plan of Correction ***Accept ([redacted] - 08/03/2026)***

Oxygen tank was secured in an oxygen tank holder by Director of Health and Wellness on 5/14/26. DHW spoke with [redacted] Hospice nurse to ensure all oxygen tanks that are delivered to residents are being delivered with oxygen tank holders for safety.

Executive Director provided re-education 6/3/26 to all med techs and nurses regarding blood glucose monitoring, correct calibration of correct date, correct time, correct readings. Audits completed audits on all glucometers on 5/15/26. Audits completed weekly for four weeks 5/22/26-6/12/26.

Executive Director provided re-education 6/3/26 to all med techs and nurses that all medications on physician orders are to be available for resident use. Audits were completed weekly for four weeks 5/15/26-6/5/26.
Results of audits to be reviewed in QAPI.

Licensee's Proposed Overall Completion Date: *07/20/2026*

Implemented ([redacted] - 08/27/2026)

233c - Key-Locking Devices

8. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

At 10:03 a.m., the direction for operating the home's locking mechanism was not conspicuously posted near the door entering to the Secure Dementia Care Unit (SDCU) sensory area from the courtyard.

Plan of Correction ***Accept ([redacted] - 08/19/2026)***

Maintenance Director posted the code for the courtyard door entering from the sensory area in memory support on

233c - Key-Locking Devices (continued)

5/14/2026. Executive Director completed audits for codes posted by memory support neighborhood exits. Audits were completed weekly for two weeks, 5/15/26 and 5/22/26. Executive Director provided education during nursing staff meeting on 6/3/26 that code must be posted at all exits. Maintenance Director or Designee to complete audits weekly x 4 weeks. Audits to be reviewed during QAPI.

Licensee's Proposed Overall Completion Date: *08/28/2026*

Implemented ([redacted] - 08/27/2026)