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

August 10, 2026

[redacted]
GAHC3 BOYERTOWN PA ALF TRS SUB LLC
[redacted]

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 06/30/2026 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: *CHESTNUT KNOLL* **License #**: *22613* **License Expiration**: *06/30/2027*

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *156* **Waking Staff**: *117*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/30/2026*

Inspection Dates and Department Representative

06/30/2026 - 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**: *Memory Care* **Capacity**: *52* **Residents Served**: *50*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *101*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *54*

Have Physical Disability: *0*

Inspections / Reviews

06/30/2026 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**: *08/07/2026*

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

Inspections / Reviews *(continued)*

08/10/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/07/2026*

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

65g Annual Training Content

1. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff person A hired on [redacted] did not receive the Fire Safety training completed by a fire safety expert or by a staff person trained by a fire safety expert, during the training year 2025.

Repeated Violation: 06/12/2025

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

Immediate Corrective Actions: Staff Person A did complete Chestnut Knoll specific fire safety training on 12/31/2025 and a basic fire training on 5/6/2025 on video learning center. (training log will be provided) Chestnut Knoll had two onsite staff persons trained by a fire safety expert during those times. (certificates will be provided)

On 7/9/2026, Staff Person A completed [redacted] in person fire training with the Environmental Services Director, who is a trained fire safety expert. (training sign in sheet will be provided along with fire safety expert certificate)

Additional Corrective Actions: On 7/9/2026, Fire Safety Training of all employees was audited by Executive Director to ensure all staff have had required annual training.

Ongoing Quality Assurance Actions: Beginning 8/1/2026, the Business Office Director will review a 5% sample of employee records each month, including a review of training, to ensure Fire Safety Training is completed. Ongoing compliance will will be reviewed at Quarterly QA Meetings, beginning with the Q3 (July, August, September) Review to be held in October 2026.

Licensee's Proposed Overall Completion Date: *07/26/2026*

Implemented ([redacted] - 08/10/2026)

183e Storing Medications

2. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 6/30/26, at approximately 3:26 p.m., resident #1's Lispro 100 Unit/ ML Kwikpen stored in the 300-level medication cart was dated as opened and used on 5/25/26. According to the manufacturer's instructions, the medication must be discarded 28 days after the first use.

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

Immediate Corrective Actions: On 6/30/2026, the Kwikpen was removed from the cart by the Resident Care Director, having remained there while the resident was hospitalized since 5/26/2025 (the med expired on 6/22/2026 during the time the resident was out at the hospital) and had not yet returned on the date of inspection.

183e - Storing Medications (continued)

Additional Corrective Actions: On 7/15/2026, Med Techs were educated by Medication Train the Trainer, regarding regulatory requirements for expired medications and following manufacturer's instructions. During the week of 7/20/2026 all medication carts were audited by the med techs to ensure all other medications were appropriately stored.

Ongoing Quality Assurance Actions: Beginning 8/1/2026, medication carts will be audited weekly by the med techs to ensure proper storage.

Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with the Q3 (July, August, September) Review to be held in October 2026.

Licensee's Proposed Overall Completion Date: *08/01/2026*

Implemented ([redacted] - 08/10/2026)

187a - Medication Record

3. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
10. Duration of therapy, if applicable.

Description of Violation

Resident #2's prescription for Furosemide 40 mg tablet once daily was discontinued on 6/24/26 for seven days by the provider but at 3:15 p.m. on 6/30/26, the prescription remained active on the resident's Medication Administration Record.

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

Immediate Corrective Actions: On 6/30/2026 the Resident Care Director coordinated services with the pharmacy to update the EMAR. On 7/1/2026, the Resident Care Director reported the error to BHSL, the physician, and the family.

Additional Corrective Actions: On 7/1/2026 the med tech who made the approval error was re-educated on the proper procedure. On 7/15/2026 Medication Train the Trainer, provided education to Med Techs to implement proper medication administration procedures specific to order approval and compare labels, orders, and EMARs prior to medication administration.

Ongoing Quality Assurance Actions: Beginning 7/27/2026, the RCD will complete a daily review of the SMART Dashboard to monitor for changes in prescriptions and instructions.

Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with the Q3 (July, August, September) Review to be held in October 2026.

Licensee's Proposed Overall Completion Date: *07/27/2026*

Implemented ([redacted] - 08/10/2026)

225c - Additional Assessment

4. Requirements

225c Additional Assessment *(continued)*

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #3's assessment was completed on [redacted] As per interviews with staff, and a review of the resident's record, the resident began receiving hospice services through Caring Hospice on [redacted]. The resident's assessment was not updated regarding the resident receiving hospice services.

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

Immediate Corrective Actions: Resident #3's RASP reflected hospice care and private duty on a RASP update dated 6/23/2026. On 7/17/2026, Resident #3's RASP was updated by Executive Director to include the specific care and services provided by Caring Hospice and Chestnut Knoll at Home.

Additional Corrective Actions: On 7/24/2026, care management staff (RCD, MCD, RCC, ED) were educated by the Regional Director of Operations regarding the need to include in the RASP the specific care and services to be provided by supportive services such as hospice care providers.

RASPs for residents receiving hospice care will be reviewed by Executive Director, Resident Care Director, and Memory Care Director by 8/1/2026 to ensure they include the specific care and services provide by each hospice care provider.

Ongoing Quality Assurance Actions: Beginning 8/1/2026, a 5% sample of RASPs will be reviewed each month by Executive Director to ensure they include the specific care and services provide by each hospice care provider. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with the Q3 (July, August, September) Review to be held in October 2026.

Licensee's Proposed Overall Completion Date: *08/01/2026*

Implemented ([redacted] - 08/10/2026)