

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

November 15, 2023

[REDACTED]
RAK ASSISTED LIVING, INC
10543 STATE ROUTE 29
MONTROSE, PA, 18801

RE: GRACIOUS LIVING ESTATES
10543 STATE ROUTE 29
MONTROSE, PA, 18801
LICENSE/COC#: 23167

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/04/2023 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: GRACIOUS LIVING ESTATES License #: 23167 License Expiration: 07/17/2024
 Address: 10543 STATE ROUTE 29, MONTROSE, PA 18801
 County: SUSQUEHANNA Region: NORTHEAST

Administrator

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

Legal Entity

Name: RAK ASSISTED LIVING, INC
 Address: 10543 STATE ROUTE 29, MONTROSE, PA, 18801
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 06/08/1998 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 28 Waking Staff: 21

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint, Incident Exit Conference Date: 08/04/2023

Inspection Dates and Department Representative

08/04/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 65 Residents Served: 23
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 2
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 23
 Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 1
 Have Mobility Need: 5 Have Physical Disability: 0

Inspections / Reviews

08/04/2023 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/27/2023

11/08/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 10/26/2023
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 11/02/2023

Inspections / Reviews (*continued*)

11/15/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/14/2023

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home 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

Staff person A received a report that resident #1 was recorded with another staff person's cell phone while in a state of agitation about their walker. Staff person A notified staff person B. The incident of suspected abuse was not reported to the Area Agency on Aging as required.

Plan of Correction

Accept (████) - 10/27/2023)

We Disagree! The PCH Administrator, █████, thoroughly investigated the complaint of abuse filed by one of our staff members. I, █████, PCH Administrator, found no substantiation to any part of the complaint. No recording (photo) was found. Resident #1 did not substantiate any part of the complaint. █████ agitation was due to the fact that the staff member put █████ name on a walker resident #1 said was not █████. █████ described █████ as "that dumb █████." A number of staff members laugh because they thought it was funny. They were not laughing at Resident #1. Resident #1 is well liked and no-one on our staff would abuse, insult or hurt █████ feelings. A check determined that the walker did belong to resident #1. █████ has the habit of leaving it sitting all around the GLE facility. I, █████ did not report the complaint because there was nothing to report. The staff member who filed the complaint no longer works at GLE. Plan Correction: In the future, the GLE Administrator, █████ and the Assistant Administrator, █████ will file ALL complaints with the Area Aging and the Department regardless of the level of fact. Additionally, we █████ met with the two staff members who were supposedly involved to review how much negativity can result from a seemingly incidental moment when one is not paying attention to their responsibilities (08/07/23). Playing around on the job is never a productive endeavor. The Director of Health Services, █████, will be responsible to insure that all complaints or rumors of complaints are directed to the PCH administrators (██████████) who will investigate the complaint and forward, immediately, all information to the Area Agency on Aging and the Department (08/04/23). Every step possible will be taken to insure that this problem will not happen again (10/22/23)!

Licensee's Proposed Overall Completion Date:

Implemented (████) - 11/15/2023)

16c - Written Incident Report

2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Staff person A received a report that resident #1 was recorded with another staff person's cell phone while in a state of agitation about their walker. Staff person A notified staff person B. The incident of suspected abuse was not reported to the department's regional office.

Plan of Correction

Accept (████) 10/27/2023)

Agreed. Plan of Correction: We thoroughly investigated this incident and found no factual substantiation to the complaint. We could find no recording (photo), the agitation with Resident #1 was due to the fact that staff

16c - Written Incident Report (continued)

member M put a label with the resident's name on [REDACTED] walker. Resident #1 said it was not [REDACTED] walker and called staff M "a dumb [REDACTED]". Supposedly a picture was taken of the expression on Staff's M face - I, [REDACTED] could not find any recording (Photo). It turned out that the labeled walker did belong to Resident #1. We, [REDACTED] have talked to our staff (especially Staff M & E, who were involved) and stressed the importance of socializing with the Residents. It is best that staff not joke or kid around with the residents, since it can so easily be mistaken for something else (08/07/23). The PCH administrator, [REDACTED] and Assistant [REDACTED] are responsible to report ALL complaints to the Area Agency on Aging and the Department upon receipt of the complaint (08/04/11). Any pertinent information regarding the complaint is also to be forwarded. Involvement by any staff member(s) shall result in immediate suspension pending action by the Area Agency, Department and/or any law enforcement agency (08/04/23). The PCH Administrator is responsible for carrying out all aspects of this plan of correction (10/23/23).

Licensee's Proposed Overall Completion Date:

Implemented [REDACTED] - 11/15/2023)