

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

April 17, 2025

[REDACTED]
ASBURY LIVING INC.
[REDACTED]
[REDACTED]

RE: ASBURY GRACE PARK
1170 WEST MAIN STREET
STROUDSBURG, PA, 18360
LICENSE/COC#: 23197

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/19/2025, 02/20/2025 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: ASBURY GRACE PARK License #: 23197 License Expiration: 12/28/2025
 Address: 1170 WEST MAIN STREET, STROUDSBURG, PA 18360
 County: MONROE Region: NORTHEAST

Administrator

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

Legal Entity

Name: ASBURY LIVING INC.
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 11/08/2008 Issued By: PA Dept L&I
 Type: I-1 Date: 11/03/2011 Issued By: Borough of Stroudsburg

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 100 Waking Staff: 75

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 02/20/2025

Inspection Dates and Department Representative

02/19/2025 - On-Site: [REDACTED]
 02/20/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 92 Residents Served: 78

Secured Dementia Care Unit
 In Home: Yes Area: Memory Care Capacity: 22 Residents Served: 16

Hospice
 Current Residents: 8

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 78
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 22 Have Physical Disability: 0

Inspections / Reviews

02/19/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/22/2025

Inspections / Reviews (*continued*)

04/09/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/17/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 04/11/2025

04/17/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/17/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On 2/19/25 at 9:30 a.m., a list of the home's current staff was requested by the Department Representative during the entrance conference. The list was not received until 12:45 p.m., at which time the staff records were selected for review. The Department Representative did not begin reviewing the selected staff records until 1:45 p.m. when the records were finally provided. (Day 1 - 2/19/25)

Plan of Correction

Accept (Y - 04/09/2025)

- 1. Effective immediately as of 02/20/2025 HR implemented a new system to expedite getting records to us that DHS request.
- 2. At the time surveyors arrive at campus the ED or Designee will place a phone call to our HR specialist notifying them of DHS arrival.
- 3. The HR generalist will automatically generate 2 associate listings, 1 will be all associates and 1 will be associates hired in the last year. This will be completed prior to DHS asking so it is ready on request.
- 4. The ED or designees will confirm receipt of these lists and let the HR generalist know it was received.

Licensee's Proposed Overall Completion Date: 03/21/2025

Implemented (Y - 04/17/2025)

25b - Contract Signatures

2. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1's contract dated [redacted] is signed by the POA but not the resident. There is no indication as to why the resident did not sign the contract. (Day 1 - 2/19/25)

Plan of Correction

Accept (Y - 04/09/2025)

- 1. On 02/19/2025 our Sales Director and The Executive Director revisited resident #1 to see if [redacted] would or could sign [redacted] contract from 12/26/2025. Resident still could not sign [redacted] contract. The sales Director and Executive Director both signed the contract on 02/19/2025 that [redacted] was unable to sign. See attached document of the signed contract page.
- 2. The Sales Director will continue to obtain signatures on admission with our residents and families.
- 3. The Sales Director will notify [redacted] immediate Supervisor or another facility Director if a resident is unable to sign for a witness and a second signature on the day of admission.
- 4. The Executive Director will monitor for on-going compliance by asking for all contracts to be reviewed by myself before uploading into the computer.

Licensee's Proposed Overall Completion Date: 03/22/2025

Implemented (Y - 04/17/2025)

82c - Locking Poisonous Materials

3. 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

Room #211 in the Secured Dementia Care Unit (SDCU) is shared by 2 residents. Several containers of hygiene products under the bathroom sink were noted. The lock on the cabinet is broken making the contents accessible to the residents. (Day 2 - 2/20/25)

Plan of Correction

Accept (Y - 04/09/2025)

1. On the day of inspection, room 211 cabinet lock was fixed by our maintenance department. See attached picture.
2. Wellness supervisor and Director of Wellness educating wellness, Hospice and Home health Aides on reporting broken locks to us and to review regulation 82C. by 04/01/2025
3. Wellness is in these cabinets' multiple times a day and are instructed to report a broken lock immediately. Wellness with document that they checked these locks on the form attached and will report the broken lock immediately.
4. The log sheets will be handed into the Director of wellness monthly for compliance.
4. The Director of Wellness to do weekly checks on all locked cabinets and doors in our secured unit. See attached sheet.
5. The Executive Director will collect these sheets monthly to monitor for on-going compliance along with doing random cabinet checks that poisonous materials are locked up.

Licensee's Proposed Overall Completion Date: 04/01/2025

Implemented (Y - 04/17/2025)

105g - Lint Removal and Duct Cleaning

4. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

A very large amount of lint was noted in the bottom of the industrial size clothes dryer located in the home's basement laundry room. (Day 1 - 2/19/25)

Plan of Correction

Accept (Y - 04/09/2025)

1. On the day of inspection, 02/19/2025, the Housekeeping Manager rechecked all dryers for compliance.
2. Forms are on each dryer for associates to sign that they check lint and remove regularly. See attached sheets.
3. The housekeeping Director will do weekly checks on the dryers that her staff are maintaining compliance.
4. The Maintenance team will check lint traps on their dryer blow outs every 3 months to oversee compliance.
5. The Executive Director will maintain on-going compliance.

Licensee's Proposed Overall Completion Date: 03/21/2025

Implemented (Y - 04/17/2025)

141a - Medical Evaluation

5. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #2 was admitted to the home on [REDACTED] The Medical Evaluation was completed [REDACTED]. (Day 1 - 2/19/25)

Plan of Correction

Accept (Y - 04/09/2025)

1. Resident #2 was evaluated by [REDACTED] Nurse Practioner on [REDACTED]. It was discovered [REDACTED] did not complete the Med Eval on the day of inspection of 02/19/2025. The nurse Practioner completed the Med Eval on 02/25/2025. See attached.
2. The sales Director will double check that [REDACTED] admits someone within 60 days of a Med Eval and if not, [REDACTED] is to let the Wellness managers know they have the 30-day window to obtain the Med Eval per regulation.
3. The Wellness manager will double check all incoming med evals and assure on-going compliance with meeting the dates of this regulation.
Our Director of Wellness will double check these dates are complete and correct before uploading onto our e files.
4. The Executive Director will monitor for on-going compliance.

Licensee's Proposed Overall Completion Date: 03/21/2025

Implemented (Y - 04/17/2025)

141a 1-10 Medical Evaluation Information

6. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #3's Medical Evaluation dated [REDACTED] does not address the resident’s body positioning needs, if any. (Day 1 - 2/19/25)

Resident # 1's Medical Evaluation dated [REDACTED] does not address the resident’s body positioning needs, if any. (Day 1 - 2/19/25)

141a 1-10 Medical Evaluation Information (continued)

Plan of Correction

Accept (Y - 04/09/2025)

1. Resident #3 and #1 Med eval was updated on the day of inspection. See attached pages of the med eval.
2. All medical evaluations received will be reviewed by The Wellness Supervisor and double checked by our Director of Wellness prior to uploading on to the computer.
3. The Executive Director will monitor for on-going compliance.

Licensee's Proposed Overall Completion Date: 03/22/2025

Implemented (Y - 04/17/2025)

141b1 - Annual Medical Evaluation

7. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident # 4's Medical Evaluation dated [REDACTED] does not indicate any information on the resident's immunization status. (Day 1 - 2/19/25)

Plan of Correction

Accept (Y - 04/09/2025)

1. Resident #4 Med Eval was corrected on the day of inspection on 02/19/2025. See attached. See violation number 6 for POC for missing information on a Med Eval

Licensee's Proposed Overall Completion Date: 03/21/2025

Implemented (Y - 04/17/2025)

183f - Discontinued Medications

8. Requirements

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Approximately 20 packs of Acetaminophen 325 mg. tablets were noted inside of an empty Lidocaine Patch box in the Garden House medication cart. Staff confirmed the medication is not prescribed to any resident and was meant to be destroyed. (Day 2 - 2/20/25)

Plan of Correction

Accept (Y - 04/09/2025)

1. The packs of Acetaminophen were destroyed on the day of inspection via a drug buster on 02/19/2025
2. All med techs retrained on disposal of discontinued medications by 04/01/2025.
3. The Wellness Manager will do weekly med cart and med room audits for on-going compliance.
4. The Executive Director will assure on-going compliance with regular check ins with the wellness manager and random cart and med room checks.

Licensee's Proposed Overall Completion Date: 04/01/2025

Implemented (Y - 04/17/2025)

185a - Implement Storage Procedures

9. 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

The home has several residents receiving hospice services and are prescribed "comfort packs" which contain narcotics and are kept in locked cabinets in the medication rooms. However, when staff complete the narcotic count at the change of every shift per the homes policy, they are not including the narcotics in the comfort packs. (Day 2 - 2/20/25)

Plan of Correction

Accept (Y - 04/09/2025)

1. These comfort packs that were found on the day of inspection, 02/19/2025 were opened and all scheduled narcotics that are countable were removed, double locked and started being counted individually on 02/19/2025.
2. All comfort packs received will be opened by the Wellness supervisor and The Director of wellness to open and remove all countable narcotics.
3. These narcotics will be placed in the double lock system of the med cart and be counted every shift by the oncoming and out-going med techs.
4. The DOW will assure this on-going compliance of our controlled medications.

Licensee's Proposed Overall Completion Date: 03/21/2025

Implemented (Y - 04/17/2025)

227e - Self Administer Medication

10. Requirements

2600.

227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident # 1's Resident Assessment and Support Plan (RASP) dated 1-9-25 includes contradictory information about the resident's ability to self-administer medication. In one place it states the resident can self-administer medications without assistance, and in another it indicates the resident is unable to self-administer medication. (Day 1 - 2/19/25)

Plan of Correction

Accept (Y - 04/09/2025)

1. RASP for resident #1 was updated with the proper information. This resident was not able to self-administer medication. See attached correction.
2. The wellness supervisor reviewed all RASP for compliance.
3. The Wellness supervisor will complete RASP and all its content.
4. The Director of wellness will double check all RASP before uploading RASP onto the computer.
5. The Executive Director will maintain on-going compliance with monthly check ins and random e chart checks.

Licensee's Proposed Overall Completion Date: 03/22/2025

Implemented (Y - 04/17/2025)

227e - Self Administer Medication (*continued*)

227g - Support Plan Signatures

11. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3's RASP dated [REDACTED] is not signed by the resident, and there is no indication as to why the resident did not sign the RASP. (Day 1 - 2/19/25)

Plan of Correction**Accept [REDACTED] Y - 04/09/2025)**

1. Resident # 3 signed their RASP on the day of inspection of 02/19/2025. See attached signature sheet.
2. The Wellness Supervisor will continue to meet with residents and their families to review and sign RASP.
3. The Director of Wellness will double check all information and signatures before uploading to the computer.
4. The Executive Director will monitor for on-going compliance.

Licensee's Proposed Overall Completion Date: 03/22/2025**Implemented [REDACTED] Y - 04/17/2025)**