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

January 23, 2026

[redacted]
RAK ASSISTED LIVING, INC
[redacted]

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

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/05/2025 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *GRACIOUS LIVING ESTATES* **License #**: *23167* **License Expiration**: *07/17/2025*

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: [redacted]

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**: *43* **Waking Staff**: *32*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/05/2025*

Inspection Dates and Department Representative

11/05/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *36*

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**: *36*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

11/05/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/05/2025*

12/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/16/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/08/2025*

Inspections / Reviews *(continued)*

12/10/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/16/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/17/2025*

01/23/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/16/2025*

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

16c - Written Incident Report

1. 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

On [redacted], Resident [redacted] went to the hospital for a fractured hip. The home did not report this incident to the department until [redacted]. On [redacted], Resident [redacted] fell in their room. The resident went to the hospital on [redacted] and home was notified that the resident [redacted] had a fractured ankle. The home did not report this incident to the department until [redacted]

Plan of Correction ***Accept [redacted] - 12/01/2025)***

11/26/2025 - Agreed. This was our neglect. It will not happen again. The incident computer file was retained on one computer and was completed by the Assistant Administrator ([redacted]) upon [redacted] return on Mondays. To correct the citation, the incident reporting system has been installed on the computer of the Director of Health Services, [redacted] and on the PCH Administrator's computer, [redacted] This mean that the incident report can be filed to the Department within minutes of the Incident. [redacted] PCH Administrator will insure that all future incident reports are filed to the Department in a timely manner in the future. 11/26/2025

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 12/17/2025)

43b - Resident Rights Rewarded

2. Requirements

2600.
43.b. A resident's rights may not be used as a reward or sanction.

Description of Violation

Resident [redacted] has a contract dated [redacted] that states on page 8 of 12, Section H, a resident will be responsible for paying any citation/fine levied due to there being materials (Rx, OTC, CAM) being found in the Resident's Room". A resident's finances or resources may not be used as a reward or sanction in the home.

Plan of Correction ***Accept [redacted] - 12/01/2025)***

11/26/2025. Agreed. [redacted] PCH Administrator reviewed the Resident Contract and removed the section under discussion from the Contract. New contracts were developed, reviewed with each Resident/POA and resigned. As of 11/26/2025 every Resident has a new revised contract in [redacted] file corrected in line with this citation. [redacted] Assistant Administrator and [redacted] Directed of Health Services were responsible to ensure every resident had a new signed Contract. [redacted] PCH Administrator has attached Exhibit A., showing the new Page 8 of the contract.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 12/17/2025)

51 - Criminal Background Check

3. Requirements

2600.

51 Criminal Background Check *(continued)*

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [redacted] and their criminal background check was requested on [redacted]

Plan of Correction ***Accept ([redacted] 12/10/2025)***

11/26/2025. Agreed. We were under the impression that there was a time span allowed between the date of hire and the criminal background check. GLE , [redacted] PCH Administrator has setup a new program for hiring in line with the Department's regulation (2600 51). All new employees will follow this new hiring practice: Before starting employment, all new hires will complete all necessary paperwork including the criminal background check prior to their 1st starting day. There will be no exceptions this will ensure that all new employees have their background checks in their files prior to starting work. The PCH Administrator will be responsible to oversee this new hiring program. The last 4 new hires have been put through this program.

We are well into this new process. The PCH Administrator, [redacted] assures the Department that no future employee will ever be placed on payroll unless they have had their Criminal Background Check filed with the State Police. [redacted] Assistant PCH Administrator is responsible to handle all aspects of the hiring process. Attached is a copy of the New Hire Procedures. I'm sure we will make some adjustments over time as we use it. Exhibit R 1.

Proposed Overall Completion Date: 12/03/2025

Licensee's Proposed Overall Completion Date: *12/03/2025*

Implemented [redacted] - 12/17/2025)

121a - Unobstructed Egress

4. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The fire exit door in the home's dining room required excessive force to open on date of inspection.

Plan of Correction ***Accept [redacted] - 12/01/2025)***

11/26/2025. Agreed. This exit doorway is one of four exits from the dining room. It has never been used by Residents since it is in the far corner of the room and out of the normal flow of traffic. It is probably not opened once a year. But you are correct, it is and could be used as an exit in an emergency. On the day of the inspection 11/05/2025), maintenance man , [redacted] opened the door, cleaned and oil the hinges. The door was inspected by the PCH Administrator [redacted] It was in perfect working order without any sticking impediments. [redacted] has been directed to check the door and its operation the 1st of each month. [redacted] PCH Administrator, will ensure that this doorway continues to operate smoothly as a fire/emergency exit.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 12/23/2025)

132h - Designated Meeting Place

5. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill completed on [redacted] at 12:07p.m., Resident [redacted] did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept [redacted] - 12/01/2025)***

11/26/2025. Agreed. This was our fire drill in February. Resident [redacted] was under hospice care and had a large sore (2.3 inches deep) on [redacted] buttock. This sore could only heal from the inside out and had to be repacked twice a day. The hospice nurse was in the middle of the wound change when the fire drill sounded. The PCH administrator, [redacted] made the decision to continue the procedure and not go out for the fire drill. Yes it was a dumb decision, and we have NOT repeated it, nor will we make a decision like that again. All residents will be evacuated from the building during all fire drill or any other type of emergency. The PCH Administrator, [redacted] will assume all responsibility for ensuring that all residents exit the facility during fire drill.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 12/17/2025)

183e - Storing Medications

6. 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 [redacted] at 2:05 p.m. , Resident [redacted] s [redacted] was not labeled with an open date.

Plan of Correction ***Accept [redacted] - 12/01/2025)***

11/26/2025. Agreed. The Lantus pen was not labeled with the date it was opened. The PCH administrator, [redacted] specifically directed that [redacted] Director of Health Services and JF, med-tech review all meds in the three med carts to ensure that all items were properly marked. This was done on 11/06/2025. Additionally, a meeting was held with each med-tech (14) to review all citation relative to any negative incident with our medicine deliver system - labeling included. This critical area is forefront in our minds - there can be no mistakes. [redacted] Director of Health Services has been directed by the PCH Administrator to review all three med carts weekly to ensure that all items are properly marked and meds are in order. The PCH Administrator, [redacted] will monitor [redacted] to ensure that this procedure is followed.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 12/23/2025)

184b - Labeling OTC/CAM

7. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

184b - Labeling OTC/CAM *(continued)*

Description of Violation

A bottle of [redacted] and [redacted] belonging to Resident [redacted] and a bottle of [redacted] belonging to Resident [redacted] was in the 1ST floor medication cart and was not labeled with the resident's names.

Plan of Correction ***Accept [redacted] - 12/10/2025)***

11/27/2025. Agreed. These med bottles (Vitamins, biotin & aspirin) were brought in by Resident [redacted] and [redacted] families and were discovered by our staff. The names of the resident should have been added on each bottle when they were placed in resident 4 and 6's med section in the med cart. [redacted] Director of Health Services has talked to the residents' families who brought in the meds, reviewed this situation/incident with all our med-techs and reiterated to them the necessity/requirement of labeling each resident's meds. Additionally, Ann met with our staff and noted the importance of being visually aware of meds being brought in by family members. All staff members at GLE will continue to be observant, looking for meds in the rooms and following prescribed procedures for proper labeling of all medications. [redacted] Director of Health Services and the PCH Administrator, [redacted] will continue to ensure that all procedures are followed in proper labeling of meditations here at GLE.

meds. [redacted] met with approximately 16 members of our 1st & 2nd Shift at 3pm (Our regular daily meeting) and reviewed, in detail, all of our citations. The PCH Administrator, [redacted] was also present along with [redacted] Assistant PCH Admin. At the end of the meeting, [redacted] met with 6 med-techs (LT, RW, AA, , HD, Md & RL) To review the citation and the corrective measures necessary to provide a first class medication program for our residents.

11/07/25, Ann met with the additional 8 med-techs at 3 pm to review the citations. The group then audited the 3 med carts and checked med labels, med scripts that match the MARs, check names, dates, Etc. Med carts will be checked every Friday by the Med-tech on duty and under the supervision of [redacted], Director of Health Services. [redacted] PCH Administrator will continue to oversee this process.

11/10 through 11/14/25 [redacted] held staff meetings each day to insure all staff members were brought up to date on the citations and the steps necessary not only to resolve them but to ensure that we do not repeat them. We realize that this will be an ongoing process.

Licensee's Proposed Overall Completion Date: *12/03/2025*

Implemented [redacted] - 12/17/2025)

185a - Implement Storage Procedures

8. 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's narcotic count policy includes a required 2-person sign off of destroyed medications on the Controlled Substance Count Log. On [redacted] at 8:00a.m., Resident [redacted] had a [redacted] syringe that was found to have evaporated. Staff C destroyed the medication correctly but did not have a second person sign off on the disposal as required by the home's policy.

Repeat [redacted]

Plan of Correction ***Accept [redacted] - 12/10/2025)***

11/27/2025. Agreed. This incident cannot be justified. There were three certified Med-tech's present when this narcotic was destroyed - [redacted] Director of Health Services, LT, Med-tech and JF, Med-tech. All witnessed the

185a - Implement Storage Procedures (continued)

process of destroying the narcotic. It was an oversite on their part that only one signed for the procedure. As previously stated, [redacted] Director of Health Services and the PCH administrator, [redacted] reviewed every citation incident in the medication area with each of our med-techs. We will continue our policy of requiring 3 med-tech to be onsite anytime a narcotic is destroyed and that at least 2 MUST sign off on the process. Both [redacted] and [redacted] will ensure that all meds are properly disposed of in the manner directed by the Department. All GLE med-techs (14) have been educated on our above policy and each one understands the necessity of 2 signatures for each destroyed narcotic. [redacted] will be responsible to ensure that this policy is strictly adhered to by all the med-techs.

Licensee's Proposed Overall Completion Date: *12/03/2025*

Implemented [redacted] 12/17/2025)

187a - Medication Record

9. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
8. Frequency of administration.

Description of Violation

Resident [redacted] has an order for [redacted] to take one capsule per day. per pharmacy label. The medication administration record (MAR) indicated to take one capsule 3 times a week. The medication label does not match the directions on the MAR.

Plan of Correction ***Accept [redacted] - 12/01/2025)***

11/27/2025. Agreed. [redacted] was given as 1 capsule per day (As labeled). Resident's [redacted] physician changed the script to 3 times per week. The new script was sent to the pharmacy and a new MAR was made up. Resident 4 was receiving the correct dose of medicine. The pharmacy did not send a new label for the bottle and our med-techs did not catch the incorrect label. All med-techs were informed of the situation and questioned on how a med could be passed out with an incorrect label? [redacted] Director of Health Services has been instructed to review all meds in the carts once a week with a med-tech to ensure that the MAR and each medicine label correspond. The PCH Administrator will be responsible to ensure that this process is followed each week. A copy of the physicians medicine change to 3 times per week is attached for your review (Exhibit B.).

Licensee's Proposed Overall Completion Date: *11/27/2025*

Implemented [redacted] - 12/23/2025)