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

September 2, 2026

[redacted], ADMINISTRATOR
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 06/11/2026 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: *GRACIOUS LIVING ESTATES* **License #**: *23167* **License Expiration**: *07/17/2026*

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**: *38* **Waking Staff**: *29*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/11/2026*

Inspection Dates and Department Representative

06/11/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *34*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *34*

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

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

06/11/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/10/2026*

07/10/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/13/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/17/2026*

Inspections / Reviews *(continued)*

07/20/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/13/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/03/2026*

09/02/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/13/2026*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

At 10:05 a.m., the license inspection summary from 12/7/25 and the prior full license inspection summary from 11/5/25 were not posted in a conspicuous area of the home.

Plan of Correction ***Directed (- 07/20/2026)***

The Administration at GLE received its last completed inspection report it was posted up on the main public bulletin board. The old report was removed. and by accident the last year's annual was also taken down. The PCH Administrator) and Assistant PCH Administrator ( ) will guarantee that this will not happen again. The current annual inspection will always be posted as required. Exhibit 3c is a picture of this inspection report posted as required until the final inspection is complete and returned.

07/13/26 - CITATION: Last current inspection of GLE was not posted in a conspicuous area.
CORRECTION: The last current inspection of GLE was removed from our inspection file, a full copy was made and posted on the public Bulletin Board at 3:00 PM on June 11, 2026. , Assistant PCH Administrator made the copy and placed it on the bulletin board before the inspection team left our facility (June 11, 2026).
RESPONSIBILITY: , Assistant PCH Administrator fixed the problem) (3 PM, June 11, 2026). , PCH Administrator is responsible to insure that the current inspection summary is displayed as DHS regulations require. verified this on the morning of June 12, 2026 at 9AM.
SEE: Exhibit 3c, picture previously sent.

Proposed Overall Completion Date: 07/13/2026

Directed: In addition to the above plan of correction, the administrator or designee will complete weekly audits of postings in the home and verify that all required postings are available and posted conspicuously.

Directed Completion Date: *08/03/2026*

Implemented (- 08/05/2026)

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

On 5/27/26, the Department of Environmental Protection issued a Tier 1 PN boil water advisory to the home which should continue in place until receiving permission from DEP to lift it. The home did not notify the Department of the Tier 1 boil advisory.

Repeated Violation: 11/5/25

16c - Written Incident Report *(continued)*

Plan of Correction ***Directed ([redacted] - 07/20/2026)***

We apologize for the inconvenience. In the hustle and bustle of the boil advisory, we here at GLE were in a turmoil - even discussing the possibility of closing. We followed DEP advice, developed the Tier ! Public Notice, staff notified residents and I met with them at dinner time to discuss the situation. We purchased bottled water (purchased 192 bottles for the residents). Then we came back to reality, a water test was run to determine the extent of the contamination in the water. There was none! we tested the water every day, sometimes twice a day - still nothing. NO contaminates were ever found, either by us or the Kirby Labs in Wilkes Barre, GLE has tested its water every day for the last 28.3 years (10,330 days) and NEVER had a positive result from our tests or that of the State licensed labs we use. Exhibit 16c. and 16c. - 1 shows the testing results for May and June as submitted to the DEP. [redacted], PCH Administrator again apologizes for not sending in an incident report for the boil Advisory. It will not happen again.

07/13/26 - CITATION: Failure to submit an incident report.

Correction: Drinking water was purchased/provided to all residents/Tier 1 notice was posted (May 28,2026), drinking water tested twice a day starting May 27, 2026, Kirby Lab tested the samples on June 3 & June 4, 2026. DEP removed the boil advisory on June 11, 2026. Drinking water tested more than 40 times from May 27 through June 11 - no contaminates were ever found, To date (July 13, 2026) GLE has met all of the recommendations of the DEP. We are waiting for them to set a date and reinspect.

RESPONSIBILITY: [redacted], PCH Administrator is responsible to ensure that all reportable incidents are reported within 24 hours. 07/13/2026- 9 AM Every future incident will be reported to DHS as mandated, [redacted].

SEE: Exhibits 16c and 16c - 1 - Kirby Lab results (June 3 & 4, 2026

Proposed Overall Completion Date: 07/13/2026

Directed: In addition to the above plan of correction, all staff will be trained in reporting requirements and in the home's policy on reporting to BHSL.

Directed Completion Date: *08/03/2026*

Implemented ([redacted] - 08/05/2026)

18 - Compliance With Laws

3. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 5/27/26, the Department of Environmental Protection issued a Tier 1 PN boil water advisory to the home which should continue in place until receiving permission from DEP to lift it. The home indicated they have not been boiling their drinking water and no alternative water source has been used or found onsite.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

See 16c correction. All DEP requirements were followed - Tier ! notice posted, residents were notified and bottled water was made available to all resident on both floors. An advisory notice is a warning, suggestion of a possible or of an impending/potential danger, Our testing, day in and day out, showed the warning to be a pipe dream in the

18 - Compliance With Laws (continued)

mind of an overzealous individual who created havoc where NONE existed. This was proven by the water tests taken by us on a daily basis, and those taken on June 3 and June 4 and verified by Kirby Labs, in Wilkes Barre. The boil advisory was dropped on 6/11/26 after DEP received the official Lab reports. See Exhibits 16c and 16c - 1. Also see Exhibits 18 and 18 - 1 copies of the Kirby lab reports of 6/03 & 6/04.

07/13/26 - CITATION: Non-compliance with a State law: RE: Boil Water Advisory

CORRECTION: GLE was never not in compliance with the boil advisory. In fact our first step was the purchased of at least 3 Days of drinking water for residents/staff. May 27, 28 ,29 through June 11, 2026 we were in almost constant contact with the DEP (Scranton office - [redacted] and the Wilkes Barre, PA office). For the record, an advisory is a recommendation/suggestion, it is not a mandate. It generally is used when there is the possibility of a contaminant/microorganism in the water. That was never the problem at GLE, every water test taken from May 27 through June 11, 2026 failed to find any contaminants.

RESPONSIBILITY: [redacted], PCH Administrator was responsible to resolve the DEP inspection problem (May 27, 2026 - Present) here at GLE. All recommendations of the DEP here at GLE have now been resolved (July 13, 2026). We are waiting for the DEP inspectors to return for their follow up inspection - probably sometime in Late July/August. Their Deadline date is
September 24, 2026.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 08/05/2026)

65f - Training Topics

4. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff person A, hired on [redacted] did not receive training in medication self-administration, instructions on meeting the needs (DME & RASP), care of residents with dementia, infection control, personal care needs of the resident, and safe management techniques during training year 2025.

Plan of Correction ***Directed ([redacted] - 07/20/2026)***

Every new employee hired at GLE is required, before they are permitted on the floor, to have training in medication self-administration, instructions on meeting the needs (DME & RASP of residents etc. Staff member [redacted] and [redacted] both had their training but for some reason did not sign the back of their training sheets. [redacted], Assistant PCH administrator and [redacted], Director of Health Services are reviewing all staff training forms to ensure that they have been completed fully (01/01/2024 through 07/03/2026. Exhibit 65f Copy of Comprehensive State Exam & Exhibit 65f -1, copy of signed training form for [redacted] Exhibit 65f - 2, copy of Comprehensive Exam & 65f -3 copy of signed training form for [redacted]

07/14/26 - CITATION: Employee A. did not receive training in medication self-administration, instruction on meeting resident needs in DME and RASP, etc.

CORRECTION: Staff member A did receive all [redacted] required training before starting [redacted] employment here at GLE. [redacted]). Additionally, [redacted] received certificate as a State certified Med-Tech, State diabetic training, CPR etc.([redacted]. Additionally, staff member A was recertified as a med-tech on 2/10/25 and 07/13/25. To ensure that this citation is cleared properly, staff member A. will be totally recertified with [redacted] mandated training areas (12 Credit Hours) by July 31, 2026

65f - Training Topics (continued)

RESPONSIBILITY: [redacted], PCH Administrator and [redacted] will assume all responsibility for this training (07/31/2026). Every employee has an individual training plan (See Exhibit 66a previously submitted for the training plan 0709/2026). [redacted], PCH Administrator is responsible to ensuring that all staff training is completed by the end of the year (12/31/2026)

Proposed Overall Completion Date: 07/14/2026

Directed: In addition to the above plan of correction, Staff person A will receive training in medication self-administration, instructions on meeting the needs (DME & RASP), care of residents with dementia, infection control, personal care needs of the resident, and safe management techniques to be applied to the 2025 training year. This training will be in addition to any required trainings for the 2026 training year.
The administrator or designee will audit all staff trainings in the month that the training was provided. If any staff member missed the training, a makeup date will be immediately scheduled and completed prior to 1/1/2027.
All staff members that are involved in training or developing the staff training plan will be educated in the requirements of required annual training topics that are done in annually in addition to trainings provided in the first calendar year of hire.

Directed Completion Date: *08/03/2026*

Implemented ([redacted] - 09/02/2026)

65g - Annual Training Content

5. 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:

Description of Violation

Staff person A, hired on [redacted] did not receive training in fire safety by a fire safety expert, emergency preparedness, resident rights, OAPSA, and falls/accident prevention during training year 2025.

Plan of Correction ***Directed ([redacted] - 07/20/2026)***

Resident A. and all employees here at GLE will receive yearly training in all State mandated areas - Fire safety, emergency preparedness, resident rights, OAPSA, fall/accident prevention, etc. GLE does its training on a calendar year basis (01/01/2026 through 12/31/2026 - every effort is made to obtain their 12 credit hours even on employees hired after the start of the work year. See Exhibit 66a for a sample training plan.
07/14/26 - CITATIONS: Staff member A. did not receive training in fire safety by a fire safety expert, emergency preparedness, resident rights, , Etc. THIS citation is incorrect - Staff member A. did receive all [redacted] initial training the 1st week of employment [redacted] as required by the DHS regulations and [redacted] training continued over the next 3 weeks. See Exhibit 65g - 1, A copy of staff A. 's initial training sheet. The citation was really for Staff Member A. whose training sheet for 2025 lacked 6 hrs. of yearly training. In [redacted] member A. had almost 21 hours of training with the hours required for [redacted] Med-Teck training ([redacted]. I agree that that does not release [redacted] from her 12 hours of mandated training.

CORRECTION: Staff member A., will have her 12 hours of yearly mandated training during this calendar year (01/01/26 through 12/31/26). [redacted] is already scheduled for CPR on [redacted]. All staff members employed here at GLE will complete their 12 hours of mandated training before the end of this year (12/31/26).

RESPONSIBILITY: [redacted], PCH Administrator is responsible to ensure that every staff member

65g Annual Training Content (continued)

receives their 12 hours or more of mandated training (01/01/26 through 12/31/26). Staff member A. will receive additional training to compensate for the lost hours in 2025. This will be completed by 12/31/26. To ensure that their is no reoccurrence of this problem, [redacted], Assistant PCH Administrator will review all staff individual training sheets to ensure they meet State regulations (12/01/26).

Proposed Overall Completion Date: 07/14/2026

Directed: In addition to the above plan of correction, Staff person A will receive training in fire safety by a fire safety expert, emergency preparedness, resident rights, OAPSA, and falls/accident prevention to be applied to the 2025 training year. This training will be in addition to any required trainings for the 2026 training year.
The administrator or designee will audit all staff trainings in the month that the training was provided. If any staff member missed the training, a makeup date will be immediately scheduled and completed prior to 1/1/2027.
All staff members that are involved in training or developing the staff training plan will be educated in the requirements of required annual training topics that are done in annually in addition to trainings provided in the first calendar year of hire.

Directed Completion Date: *08/03/2026*

Implemented ([redacted] - 09/01/2026)

66a - Staff Training Plan

6. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a complete staff training plan for 2026. The staff training plan does not indicate to projected date of the trainings.

Plan of Correction ***Directed ([redacted] - 07/20/2026)***

All resident aides here at GLE are trained on a yearly calendar basis 01/01/2026 through 12/31/2026. [redacted], PCH Administrator, [redacted], Assistant PCH Administrator, [redacted], Director of Health Services and [redacted] Maintenance all are involved in ensuring that staff members have a quality training experience. The PCH Administrator shall be primarily responsible for all overall staff training. See Exhibit 66a for the 2026 Training Plan. 07/14/26 CITATION: Staff training Plan is not complete.

CORRECTION: Staff training plan has been revised to not only show the year of training, but also the period of training 01/01/26 through 12/31/26. See the top of the training plan Exhibit 66a previously attached. [redacted], PCH administrator revised this form on June 13, 2026.

RESPONSIBILITY: [redacted], PCH Administrator is responsible to ensure that all employees receive their required training in areas beneficial to them and GLE's residents (01/01/26 through 12/31/26. Each staff member has [redacted] individual training plan (06/13/26). This training manual is retained in the PCH Administrator's [redacted] office (07/14/26).

Proposed Overall Completion Date: 07/14/2026

66a - Staff Training Plan (continued)

Directed: In addition to the above plan of correction, all staff responsible for developing the training plan will be educated in the requirements of an annual training plan. All training plans must include the projected location, date and time of the training.
The administrator or designee will complete a 2026 training plan that includes all required information.

Directed Completion Date: *08/03/2026*

Implemented ([redacted] - 09/02/2026)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:45 a.m., there was an uncovered, unattended trash can in the 2nd floor west corridor shower/bathroom.

Plan of Correction ***Directed ([redacted] - 07/20/2026)***

This trash can has been removed and replaced with a trash bin with a lid as per regulation. [redacted], Maintenance Supervisor was directed to check all public facilities and resident rooms to ensure that no unlidded cans exist in any kitchen and/or bathroom in our facilities. [redacted], Assistant PCH is responsible to ensure that no unlidded trash cans exist in our facility. See Exhibit 85d - a picture of the trash can currently in the 2nd floor west corridor shower/bathroom.
07/15/26 - CITATION: Uncovered trash can - NO lid.
CORRECTION: [redacted] was directed to immediately replace the trash can with a lidded trash can (06/11/26. [redacted] was also [redacted] directed to theck the entire facility to ensure that no trash cans without lids are in any bathroom or kitchen areas. This [redacted] did on 06/12/26. No other cans were found. [redacted] will keep their eyes open for any future problems (06/12/26.
RESPONSIBILITY: [redacted] Maintenance Supervisor and [redacted], maintenance will be responsible to ensure that this trash can problem never reoccurs. (06/12/26).

Proposed Overall Completion Date: 07/15/2026

Directed: In addition to the above plan of correction, the administrator or designee will complete weekly checks on all kitchen and bathroom trash cans to verify that they are covered.

Directed Completion Date: *08/03/2026*

Implemented ([redacted] - 08/05/2026)

121a - Unobstructed Egress

8. 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

At 10:03 a.m., a chair was sitting on the outside patio in front of the emergency exit door located in the dining room,

121a - Unobstructed Egress (continued)

closest to the kitchen. It was preventing immediate egress in an emergency.

Repeated Violation: 11/5/25

Plan of Correction ***Directed (- 07/20/2026)***

This is correct. On 6/09/26, , Maintenance Supervisor decided to wash down the outside porch adjacent to this doorway. When turned on the outside spigot, water began to flow into the dining room. immediately turned off the spigot - there was a leak in the piping in the wall adjacent to the dining room. The next day 06/10/26, cut out the sheetrock in the dining room to reach and repair the water pipe. It had frozen and broke during the winter. disconnected the piping on the inside and outside of the panel next to the door in question. repaired the pipe. On 06/11/26, was in the process of replacing the pipe when the inspectors arrived. In fixing the problem, had to work both outside and inside the building - each time went outside, the door would swing shut and lock. , PCH Assistant Administrator moved an outside chair from a porch set to block and keep the door open. When completed the job, pushed the chair from the door, but not as far as should have moved it. The inspector came along and checked the door - when opened it, the door hit the chair resulting in this citation. It was justified! Our correction was to move the chair back across the porch to its rightful place in the porch chair set. Nothing now is close enough to impede the door from opening. is charged with the responsibility of checking this doorway and all exits to insure that nothing impedes the opening or closing of doorways or emergency exits. This doorway was involved in a previous citation - the citation was because the door was sticking and hard to open. The maintenance supervisor cleaned and oil all the hinges, removed the lower doorplate, chipped out some concrete and replaced the doorplate. The door now works perfectly and checks it the 1st of each month along with all the other doors. See Exhibit 121a for a picture of the wall repair process.

07/15/26 - CITATION: A chair was on the outside of an exit door, upon opening the door it hit the chair.

CORRECTION: The chair was moved back on the porch to its location as a part of a porch table set by Maintenance Supervisor 06/11/26. Reminder, this chair had been moved to prop the door open while was repairing a pipe in the wall beside the door, while the inspectors were here. Under regular conditions, the chair is never near the doorway.

RESPONSIBILITY: , PCH Administrator and , Maintenance Supervisor are responsible to ensure that nothing is blocking any doorway in this facility, including Emergency Exits (03/01/2024. In reality every member of our staff is aware of the importance of never blocking doorway and they are vigil about this responsibility 07/15/26. Additionally, checks every exit door the 1st of each month as is scheduled 07/01/26.

Proposed Overall Completion Date: 07/15/2026

Directed: In addition to the above plan of correction, all staff will be trained regarding regulation 121a. The administrator or designee will complete weekly checks on all exits. These checks will be documented with the date, person completing the check, and if any obstructions were identified. If any obstruction is identified it will be fixed immediately.

Directed Completion Date: *08/03/2026*

Implemented (- 08/05/2026)

184a - Resident's Meds Labeled

9. Requirements

184a - Resident's Meds Labeled *(continued)*

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident #1's Mupirocin was not legible. The label was worn and could not be read. Resident #1's medication administration record indicated a prescription for Zinc oxide.

Plan of Correction ***Accept (- 07/20/2026)***

Correct, But this was for two different citations. Citation 1 was for the label which was on the Mupirocin, it was worn and not very legible. The label needed to be replaced. To correct this, GLE contacted the Pharmacy and had a new label sent up for the Mupirocin cream which was for a rash on Resident 1. Mupirocin was prescribed for Resident 1 as a topical antibiotic used for a repeating infectious rash. See Exhibit184a picture of the new label. In the future, [redacted] Director of Health Services will insure that [redacted] Med-techs are more observant of worn or torn medication labels. Citation #2, the label on the MAR read for Zinc Oxide to be administered to Resident !, the med drawer contained Desitin (Although Desitin is made of Zinc Oxide), it should have been Zinc Oxide as the cream. The physician was contacted and the MAR was changed to Desitin. The MAR now reads, apply Desitin (See Exhibit 184a - 1, Exhibit 184a - 2, the Desitin Label and Exhibit 184a - 3 the Desitin, medication). The corrected Mupirocin Cream label is designated as Exhibit 184a - 4.. As previously indicated, [redacted] will assume responsibility to ensure that the MARs always match the medications.
07/16/26 - CITATION: The label for Resident #1 was not legible.
CORRECTION: The pharmacy was immediately called and a new label was sent up to GLE 06/11/26. Please see Exhibit 184a previously sent to you. It is dated 06/11/26.
RESPONSIBILITY: [redacted], Director of Health Services and [redacted], Med-Tech review every medication in our 3 med carts weekly to ensure proper labeling, etc (07/09/26). Additionally, all our med-techs are on the lookout daily for any med problems. 06/12/26.

Licensee's Proposed Overall Completion Date: *07/16/2026*

Implemented (- 08/14/2026)

221c - Post Activity Calendar

10. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

At 10:00 a.m., the home did not have a current weekly activity calendar posted in a public and conspicuous place in the home.

Plan of Correction ***Accept (- 07/20/2026)***

Every month here at Gracious Living we post an Activity Calendar on the main bulletin board adjacent to the upstairs Nurse station and a 2nd calendar in the elevator next to the monthly menu. Additionally, menus and activity calendars are sent out to a number of interested residents. I am not sure what happened to the bulletin board activity calendar, but it most certainly did not make it to the Public board. The July activity calendar/menu are both posted on the public bulletin board and in the elevator. [redacted], Assistant PCH Administrator is

221c Post Activity Calendar (continued)

responsible to ensure that an activity calendar/menu are posted the 1st of each month on their respective public bulletin boards. See Exhibit 221c and 221c 1 for the June and July Activity Calendars.

07/17/26 CITATION: An activity calendar was not posted on the upstairs bulletin board.

CORRECTION: A June Activity Calendar was immediately posted on the Bulletin Board by [redacted], Assistant PCH Administrator 06/11/26. The July Activity calendar and Menu was posted on July 5, the 1st day of the calendar by [redacted] 07/05/26. [redacted], PCH Administrator verified the posting that evening 07/05/26.

RESPONSIBILITY: [redacted], PCH Administrator and [redacted], Assistant PCH administrator will check the Bullet board the 1st of each month to ensure that there is no reoccurrence of this problem (07/17/26.

Licensee's Proposed Overall Completion Date: *07/17/2026*

Implemented ([redacted] - 08/05/2026)