Pennsylvania
Department of Human Services

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 5, 2026

[redacted]
Asbury Living INC.
[redacted]

RE: Asbury Grace Park
1170 West Main Street
Stroudsburg, Pennsylvania 18360
Certificate #: 23197

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on October 30, 2025, and November 4, 2025 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (231970) dated December 28, 2025, to December 28, 2026, to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, gross incompetence, negligence and misconduct in operating the facility, and failure to submit an acceptable plan to correct noncompliance items and is made pursuant to 62 P.S. § 1026 (b)(1);(4) and 55 Pa. Code § 20.71(a)(2);(3);(5);(6) (relating to conditions for denial, nonrenewal or revocation).

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

If you disagree with the decision to REVOKE your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Asbury Grace Park is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

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]

Legal Entity

Name: *ASBURY LIVING INC.*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *11/08/2011* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *96* **Waking Staff:** *72*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *11/04/2025*

Inspection Dates and Department Representative

10/30/2025 - On-Site: [redacted]
11/04/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served:** *81*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *2nd floor* **Capacity:** *22* **Residents Served:** *14*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *81*

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

Have Mobility Need: *15* **Have Physical Disability:** *0*

Inspections / Reviews

10/30/2025 - Partial

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

12/10/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *12/04/2025*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

12/12/2025 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *12/10/2025*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

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 10/2/25 resident #1 and resident #2 reported that money was missing from their rooms. On 10/2/25 Staff person A interviewed both residents and alerted police of the suspected thefts. The home did not report the incidents to the department's regional office until 10/6/25.

Plan of Correction ***Directed [redacted] - 12/08/2025)***

1. All managers/Directors were notified of the process on reporting reportable events and the steps involved on 11/16/2025 by [redacted]. See attached in-service sheet.
2. In the event The Executive Director is off, I will review reportable protocol with all Managers/Directors at that time as a refresher to assure on-going compliance.

Proposed Overall Completion Date: 11/28/2025

(Directed)
The Administrator will train all staff in reportable incidents and conditions, as well as the homes internal policy on who is responsible for reporting the incidents to the Department as required including weekends and holidays. Training shall be completed by 1-2-2026. All future incidents will be reported as required.

Directed Completion Date: *01/02/2026*

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]28/25 at approximately 10:45 a.m. resident #3 opened a window in a 2nd floor bedroom of the home's secure dementia unit and then fell from the window onto a concrete patio approximately 15 feet below. As a result of the fall resident #3 suffered spinal and rib fractures and was determined by medical evaluation to have lower extremity paraplegia. According to staff interviews, resident #3 had a history of daily exit seeking behaviors including: expressing a desire to get out of the unit, attempting to open multiple windows in residents' room, and opening alarmed delayed egress exits by holding the handles for 15 seconds. Approximately two weeks prior to the incident resident #3 had begun damaging blinds on other resident rooms' windows and removing the panels from the PTAC heating units installed under the windows. When asked by staff why the resident was removing the panels the resident responded that they were trying to "get out of here". The support plan dated [redacted]/25 was not updated to include these behaviors and did not include a plan to address these behaviors. Repeat Violation - 05/07/2025

Plan of Correction ***Directed [redacted] - 12/08/2025)***

1. We ordered a wander guard system in September for installation for extra security on our memory care unit.

42b - Abuse (continued)

Installation was completed on 11/24/2025. See attached pictures of new unit which is addition to present system.
2. We installed aluminum channels and torx with pin tamper proof screws for all windows on our memory care unit. See attached picture
3. The support plan addressed with violation 234D below. See attached in-service sheet.
4. The Executive Director was involved in both these processes to be sure the new systems were put in place for on-going safety compliance on our memory care unit.

Proposed Overall Completion Date: 12/04/2025

(Directed)
The home will review preadmission screening policy and procedures to include level of supervision needed prior to admission for all new residents. Update staff schedule accordingly to ensure new admission have proper supervision. Home shall schedule qualified and trained staff persons in the secured dementia care unit and non-secured dementia care unit capable of meeting or exceeding the supervision and service needs of the residents as defined by each resident's preadmission screening and/or assessment and support plan. The home will develop and implement elopement prevention policies and procedures to address alarms on doors and resident's ability to reenter the building after exiting, preadmission screening process and adequate supervision of new residents. Elopement prevention and elopement risk training will be provided at least every six months for all staff persons who work in the personal care home in both the secured dementia care unit and the non-secure section. Mock elopement drills will be conducted as part of the training. Mock elopement drills will be documented to include date, time, name of staff person conducting the drill, whether staff followed proper procedures and problems encountered. Mock elopement drill documentation will be immediately available to the Department upon request. Within 30 days, an elopement risk assessment will be completed for each resident who resides in the personal care home, both the secure dementia care unit and the non-secure care section. Direct care staff will be consulted during the elopement risk assessment process. This assessment will be completed at least every six (6) months and more frequently if a resident demonstrates evidence of exit-seeking behavior.

Directed Completion Date: *01/02/2026*

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1 has an enabler bar attached to their bed that has rectangular shaped opening approximately 12 inches across. On 11/4/25 at 11:45 p.m. the enabler bar did not have a cover over it as required for safety by FDA guidelines.

Resident #4 has an enabler bar attached to their bed. On 10/30/25 at 11:56 a.m. the enabler bar was not securely

81b - Resident Personal Equipment (continued)

attached to the bed frame and was observed to be resting at an angle against the mattress.

Plan of Correction ***Accept [redacted] - 12/08/2025)***

1. Resident #1 enabler bar was attached securely on the day of the inspection, 10/30/2025.
2. Resident #1 family was notified of the proper enabler bar needed.
3. Resident #1 was evaluated by PT and [redacted] Dr. to see if an enabler bar was needed. Resident able to safely get in and out of bed without the enabler bar per PT and her Dr.
4. Enabler bar removed from resident #1 bed on 11/26/2025
5. Notification sent out to families that we do need to be notified prior to families purchasing enabler bars so we can educate them on the correct enablers and process. See copy of email sent to families.
6. Our Wellness supervisor will do weekly rounds to check that enablers bars are not brought in without our knowledge.
7. The Executive Director meets weekly with the wellness supervisor and The Wellness Director to follow up and maintain compliance with enabler bars.

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

Not Implemented [redacted] - 12/10/2025)

92 - Windows

4. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 11/4/25 at 11:40 a.m. the glass paned door to the main entrance common area was left wide open with no screen in place.

Plan of Correction ***Accept [redacted] - 12/08/2025)***

1. The door was shut on 11/04/2025 once this was brought to our attention.
2. Activities associates were carrying things in and out of the building through that door for an activity and we met with them to close the door in-between carrying their items into or out of the building.
3. Signs were hung on all doors to close door behind them. See attached signs.
4. Staff meeting held to discuss watching that doors are closed when not immediately in use if they are a door with no screens. (see attached signature sheet)
5. The Executive Director will monitor doors on daily rounds to assure on-going compliance.

Licensee's Proposed Overall Completion Date: *12/04/2025*

Not Implemented [redacted] - 12/12/2025)

233c - Key-Locking Devices

5. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices *(continued)*

Description of Violation

At 12:42 p.m. the directions for operating the home's locking mechanism were not conspicuously posted near the exit door of the Secure Dementia Care Unit (SDCU) located near the staff bathroom.
At 12:45 p.m. the directions for operating the home's locking mechanism were not conspicuously posted near the exit door of the SDCU located at the South Tower.

Plan of Correction ***Accept [redacted] - 12/08/2025)***

1. We hung the directions to both areas this same day on 11/04/2025. See attached pictures.
2. Our Wellness supervisor rounds daily for on-going compliance.
3. We have placed an order for optical illusion pictures that have codes hidden within to hang as they will not be able to be easily removed like our present signs.
4. The Executive Director will check regularly for on-going compliance during rounds through the building.

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

Implemented [redacted] - 12/11/2025)

234d - Support Plan Revision

6. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #3 was admitted to the home's SDCU on [redacted]25. Resident #3 had frequent exit seeking behaviors including: verbally stating they wanted to get out of the unit and walk home, opening alarmed, delayed egress exit doors, and attempting to tear blinds off several different residents' windows. The support plan dated 8/1/25 was not updated to include these behaviors and did not include a plan to address the behaviors.

Plan of Correction ***Directed ([redacted] - 12/08/2025)***

1. Support plan not updated after DHS visit due to resident discharged on 11/1/2025
2. Our Wellness Directors and Supervisors updated on the proper way to do a RASP and discussed examples of when to do a status change and when to do an addendum to a RASP. See attached in-service signature list.
3. The Executive Director will review all initial RASP before finalizing and follow up when discussions are had that a resident is having changes to ensure on-going compliance with RASP are up to date and correct.

Proposed Overall Completion Date: 12/03/2025

(Directed)

The home will create an audit tool and review all SDCU resident assessment support plans and revised as the resident's condition changes to include a higher level of supervision. The home will document on the audit tool for each resident, and the home will maintain the documents. Update staff schedule accordingly to ensure residents have proper supervision. Home shall schedule qualified and trained staff persons in the secured dementia care unit capable of meeting or exceeding the supervision and service needs of the residents as defined by each resident's assessment and support plan. The home will develop and implement elopement prevention policies and procedures to address resident's exit seeking.