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

August 27, 2025

[redacted] PERSONAL CARE HOME ADMINISTRATOR
NEW HOPE GRACIOUS SENIOR COMMUNITY
300 UNION AVENUE
AVALON, PA, 15202

RE: NEW HOPE GRACIOUS PERSONAL CARE
300 UNION AVENUE
AVALON, PA, 15202
LICENSE/COC#: 43210

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/10/2025, 07/11/2025 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: *NEW HOPE GRACIOUS PERSONAL CARE* **License #**: *43210* **License Expiration**: *08/23/2025*

Address: *300 UNION AVENUE, AVALON, PA 15202*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *NEW HOPE GRACIOUS SENIOR COMMUNITY*

Address: *300 UNION AVENUE, AVALON, PA, 15202*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/07/2008* **Issued By**: *Avalon Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *07/11/2025*

Inspection Dates and Department Representative

07/10/2025 - On-Site: [redacted]

07/11/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *57*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *56*

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

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

Inspections / Reviews

07/10/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/31/2025*

08/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/15/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2025*

Inspections / Reviews *(continued)*

08/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/15/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/15/2025*

08/27/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/15/2025*

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

26a - Quality Management Plan

1. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home's quality management policy indicates that there will be at least 2 quality management meetings conducted annually; however, the home has not held a quality management meeting since 4/4/24.

Plan of Correction ***Accept (- 08/08/2025)***

A Quality Management meeting was scheduled and conducted on 7/21/2025 with the management staff of the facility. The minutes of the meeting are attached to this report of what was discussed. The facility has the next quality management meeting scheduled for 12/17/2025.

Long term steps to ensure QM meetings are conducted: The Home will schedule the next QM meeting at the conclusion of the previous meeting. Once the meeting is scheduled, it will be added to all department heads calendars so it is properly managed and done in the timeline outlined in the POC and homes procedures.

Licensee's Proposed Overall Completion Date: *08/07/2025*

Implemented (- 08/27/2025)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, hired on , does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry. Direct care staff person A regularly provides unsupervised ADL services to residents.

Plan of Correction ***Directed (- 08/08/2025)***

Staff Person A, hired completed the Pennsylvania GED program finishing did have a high school diploma form out of the country but completed the GED classes to meet state requirements. Management staff was re-educated on all requirements for Direct care Staff. (DIRECTED: Documentation of staff person A's successful completion of the GED shall be kept in staff person A's record. 8/8/25).

Staff persons A GED Paperwork was not presented at the time of he inspection. When the administrator talked to about getting transcripts from previous school stated did the GED program. paperwork was attached to the original.
All other staffing charts were reviewed to ensure they are in compliance with the state requirements for being a direct care worker by the administrator and administrative assistant. If someone had a GED the transcripts were requested by the facility to have on file.
Long term monitoring: once a new caregiver is hired, the chart will go to the administrator for review and a check list will be completed and signed by the administrator to ensure all documents are present in the chart.
management was re-educated on requirements and the signoff was attached. The training was completed 7/24/2025.

54a - Direct Care Staff (continued)

DIRECTED: By 8/15/25: The administrator shall develop and implement a new hire checklist to ensure documentation of qualifications specified in 2600.54a are obtained at the time of hire for each newly-hired direct care staff person. The completed checklists, as well as documentation of the qualifications shall be kept in each newly-hired direct care staff person's record. [redacted] *8/8/25*

Proposed Overall Completion Date: 08/07/2025

Directed Completion Date: *08/15/2025*

Implemented ([redacted] - 08/27/2025)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 6/22/25 from approximately 10:00pm through 6/23/25 at approximately 6:30am, there were no staff persons present in the home that are currently trained in first aid and certified in obstructed airway techniques and CPR. During this time, 55 residents were present in the home.

On 6/26/25 from approximately 10:00pm through 6/27/25 at approximately 6:30am, there was only 1 staff person present in the home that is currently trained in first aid and certified in obstructed airway techniques and CPR. During this time, 54 residents were present in the home.

On 6/30/25 from approximately 10:00pm through 7/1/25 at approximately 6:30am, there was only 1 staff person present in the home that is currently trained in first aid and certified in obstructed airway techniques and CPR. During this time, 55 residents were present in the home.

On 7/4/25 from approximately 10:00pm through 7/5/25 at approximately 6:30am, there was only 1 staff person present in the home that is currently trained in first aid and certified in obstructed airway techniques and CPR. During this time, 52 residents were present in the home.

REPEAT VIOLATION: 7/8/2024, et. al.

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

Schedules have been reviewed and revised to have 2 CPR Staff on at all hours of the day. A CPR Class was held on 7/30/2025 with the overnight staff to ensure we have the proper coverage of staff to residents in the home. Some staffing on the schedule, 7/4/2025 was agency staffing who had CPR. Requested CPR Cards for all agency who works in the building. All Staffing are being evaluated for updated CPR and scheduled a second CPR Training for the rest of the staffing 8/12/2025.

Plan to prevent:
The home has develop and implement a tracking system, which includes the names of all staff currently certified in

63a - First Aid/CPR Training (continued)

CPR/FA and their expiration dates. The tracking system shall be monitored monthly and when new hires are added to the schedule. by a designated staff person to ensure long-term compliance with this regulation. (DIRECTED: The monthly monitoring of the tracking system shall begin on 8/15/25. [redacted] 8/8/25).
The homes administrator will re-certify as a trainer to ensure CPR trainings are conducted in a timely manor. Administrator is registered to attend 9/25/2025. Until then, outside trainer will be utilized.

DIRECTED: Beginning on 8/10/25: The administrator/designee shall review the direct care staffing schedule daily to ensure compliance with 2600.63a. [redacted] 8/8/25

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: *08/15/2025*

Implemented ([redacted] - 08/27/2025)

91 - Telephone Numbers

5. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 7/11/25, there were no emergency telephone numbers posted on or by the 2 telephones present on resident #6's bedside table and dresser.

On 7/11/25, there were no emergency telephone numbers posted on or by the telephone on resident #8's bedside table.

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

Emergency numbers have been placed on the phones in Resident 6's room and resident 8's room. pictures are attached. Numbers have been placed on the cordless phone so they are always with the physical phone.

Housekeeping staff has been re-educated on all requirements for residents rooms including emergency numbers next to the telephones. They have been given extra stickers when they are doing their cleanings of the rooms to replace as needed or add if they are missing. It has been added to the job responsibilities to check for full compliancy on the days they clean rooms.
Numbers have been added to the phones that were cited in the violation report. They are stickered on the back of the phone.
Staff reeducation was completed on 7/25/2025.

Proposed Overall Completion Date: 08/07/2025

Licensee's Proposed Overall Completion Date: *08/07/2025*

Implemented ([redacted] - 08/27/2025)

101j7 - Lighting/Operable Lamp

6. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 7/11/25, no operable lamp or other source of lighting was present at resident #9's bedside.

Plan of Correction ***Accept (- 08/08/2025)***

Bed side lighting source has been placed next to resident 9's bed on 7/12/2025.
Housekeeping staff has been re-educated on all requirements for residents rooms including having operational source of light next to the bedside. This is including when residents transition to a hospital bed or on hospice. It has been added to the job responsibilities to check for full compliancy on the days they clean rooms.
Staff reeducation was completed on 7/25/2025.

Licensee's Proposed Overall Completion Date: *08/07/2025*

Implemented (- 08/27/2025)

103i - Outdated Food

7. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 7/10/25 at approximately 11:00am, there were 4 heads of cabbage, each 1/2 covered in unknown black/brown spots, present in the downstairs walk-in cooler.

Plan of Correction ***Directed (- 08/08/2025)***

The 4 heads of cabbage were removed immediately from the walk in cooler and disposed of. Kitchen director was re-educated on the regulations and why we can not keep the food to return it.
Staff had Re-education on the regulations on 7/24/2025.
Plan to prevent: The dietary Director is to check daily the rotation of produce in the facility and check for expired or spoiled foods. has been educated on not being able to keep expired produce for returns and is to dispose of any food items that are expired or spoiled. (DIRECTED: Beginning on 8/11/25: The Dietary Director shall inspect all food storage areas weekly to ensure compliance with 2600.103i. 8/8/25).

Proposed Overall Completion Date: 08/07/2025

Directed Completion Date: *08/07/2025*

Implemented (- 08/27/2025)

132e - Fire Drill Sleeping Hours

8. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home's most recent fire drill held during sleeping hours was conducted on 12/8/24 at 11:45pm.

REPEAT VIOLATION: 7/8/2024, et. al.

132e - Fire Drill Sleeping Hours (continued)

Plan of Correction ***Directed (- 08/08/2025)***

An sleeping hours fire drill was completed on 7/29/2025 and documented. A calendar reminder has been placed to complete the next sleeping hours fire drill in December. After each sleeping hours fire drill is completed, staff is to add the next reminder on the calendar to ensure it is completed within the 6 month time window.
the fire drill on 7/29 was conducted at 6:31am. The administrator and director of maintenance conducts the fire drills. Education was done with the administrator on reviewing the fire drill logs and checking for compliance. will track monthly the fire drills to ensure we are in compliance and sleeping hour fire drills are completed. the facility owner completed training with the administrator to prevent this. A tracker is in the Fire drill log box to ensure sleeping hour fire drills are being completed properly

DIRECTED: Beginning on 8/11/25: The administrator shall review all fire drill records monthly to ensure compliance with 2600.132e. 8/8/25

Proposed Overall Completion Date: 08/07/2025

Directed Completion Date: *08/11/2025*

Implemented (- 08/27/2025)

183b - Meds and Syringes Locked

9. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/11/25 at 10:55am, a 71 gram tube of Triad Wound Dressing Paste was unlocked, unattended and accessible in resident #8's private bathroom.

Plan of Correction ***Accept (- 08/08/2025)***

The 71 gram tube of Triad Wound Dressing Paste was removed from the room immediately. Staff checked all other resident rooms to ensure that any medications are properly locked up.

All med techs have been re-educated on the storage of cremes in the rooms before and after treatments and other medications locked up on the med cart. They are to monitor the rooms to the med carts they are assigned daily to ensure compliancy with this.
Staff checked all resident rooms on 7/12 for medications in the room and proper storage of creams and treatments. All med techs completing the re-education on 7/22/2025 about this issue.

Licensee's Proposed Overall Completion Date: *08/07/2025*

Implemented (- 08/27/2025)

190c - Record of Training

10. Requirements

2600.

190c - Record of Training *(continued)*

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The medication administration annual practicum training record for direct care staff person A, dated 6/28/25, is not signed by the train-the-trainer and does not indicate that direct care staff person A was requalified to administer medications.

The medication administration annual practicum training record for direct care staff person B, dated 4/16/25, is not signed by the train-the-trainer and does not indicate that direct care staff person B was requalified to administer medications.

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

Staff person A and Staff person B signed their observations and medication administrator trainer signed off the bottom of the sheet. They had observations updated to ensure they are still in compliancy. A tracking system was placed in the front of the medication administration training book to track when observations will need updated. All other trainings have been check to ensure compliancy.
The train-the-trainer signed staff persons A and B medication observations and completed additional observations on 7/22/2025.
Administrator shall review a sample of medication training records quarterly to ensure compliance with 2600.190c and all med techs are up to date with training and observations, as well as diabetic training. All trainings will be scheduled by the administrator as needed to ensure compliance. (DIRECTED: The quarterly reviews shall begin on 8/15/25 and include a review of all medication training documents during each review to ensure compliance with 2600.190c. [redacted] 8/8/25).

Proposed Overall Completion Date: 08/07/2025

Directed Completion Date: *08/15/2025*

Implemented ([redacted] - 08/27/2025)