Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY PUBLIC

February 5, 2024

[REDACTED], OWNER
GAP VIEW PERSONAL CARE, INC
306 WEST MAIN STREET
PEN ARGYL, PA, 18072

RE: GAP VIEW PERSONAL CARE
306 WEST MAIN STREET
PEN ARGYL, PA, 18072
LICENSE/COC#: 23125

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/12/2023 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]
Acting Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *GAP VIEW PERSONAL CARE* **License #**: *23125* **License Expiration**: *11/10/2024*

Address: *306 WEST MAIN STREET, PEN ARGYL, PA 18072*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *GAP VIEW PERSONAL CARE, INC*

Address: *306 WEST MAIN STREET, PEN ARGYL, PA, 18072*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *08/18/2022* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *12/12/2023*

Inspection Dates and Department Representative

12/12/2023 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *15*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

12/12/2023 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/08/2024*

01/16/2024 - POC Submission

Submitted By: **Date Submitted**: *01/14/2024*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/23/2024*

Inspections / Reviews *(continued)*

02/05/2024 Document Submission

Submitted By: [redacted]
Date Submitted: *02/02/2024*
Reviewer: [redacted]
Follow Up Type: *Not Required*

18 - Compliance With Laws

1. 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

The Pennsylvania care facility carbon monoxide alarm standard act indicated that carbon monoxide detector batteries are to be checked annually and dated when that occurs. The carbon monoxide detector located in the kitchen was dated 5/6/22.

Plan of Correction ***Accept (- 01/16/2024)***

POC:
On the day of the survey, it was checked and had not been updated. The cook immediately replaced the batteries and dated the detector with the current date.

Moving forward:
The Administrator and the Cook will conduct monthly checks on the carbon monoxide detector to ensure 1: they are functional and 2: the dates are correct.

See attached:

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/05/2024)

65e - 12 Hours Annual Training

2. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff training binder could not be located during the inspection. Unable to verify annual training hours for Staff member A hired on,

Plan of Correction ***Accept (C - 01/16/2024)***

Plan of Correction:
On the day of the inspection, the surveyor requested our training records for 2022. It was noted the previous Administrator had shredded documents before she terminated employment. The acting Administrator submitted the current training binder for 2023 on the day of the inspection to show the training records for staff person A.

Moving forward:
The 2022 binder was dismantled and will be kept in a secure location, and placed in the administrator's desk for future reference dated by the month and year. Upon an employee being hired, they are oriented initially to their job and duties, and the 12 hours of training sign-in sheets are kept in this binder with a copy placed in their personnel file. The Administrator will review the book every month to ensure it is kept up to date.

See attached:

65e - 12 Hours Annual Training *(continued)*

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/05/2024)

65f - Training Topics

3. Requirements

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

Description of Violation

Staff training binder could not be located during the inspection. Topics of training could not be measured for compliance for Staff A.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
On the day of the survey, the survey asked for the training book for 2022. It was discovered that the previous administrator shredded records before her termination. The training binder for 2023 was submitted in its place on the day of the survey.

Moving Forward:
The 2023 binder was dismantled and placed in a secure location at the current administrator's desk for review in our next survey. The Administrator will review the binder monthly for any updates/changes and to add any new training.

See attached:

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented - 02/05/2024)

65g - Annual Training Content

4. 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 training binder could not be located during the inspection. Content of trainings could not be measured for compliance for Staff A.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
It was discovered by staff that before the termination of the previous Administrator, the previous Administrator had shredded the staff training records. On the day of the inspection, the current Administrator submitted the current training binder of 2023 for review.

Moving forward:
The 2023 training binder was dismantled and the documents were placed in a secure location for the next survey. Copies were placed in all the staff files for future reference. A new training binder has been started and is placed within the administrator's office. The Administrator will review the binder monthly to ensure it is current with new

65g Annual Training Content (continued)

training available.

See attached:

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/05/2024)

65i - Training Record

5. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff training record was not maintained by the home for each staff person.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
It was discovered by staff that before the termination of the previous Administrator, the previous Administrator had shredded the staff training records. On the day of the inspection, the current Administrator submitted the current training binder of 2023 for review.

Moving Forward:
The 2023 training binder was dismantled and the documents were placed in a secure location for the next survey. Copies were placed in all the staff files for future reference. A new training binder has been started and is placed within the administrator's office. The Administrator will review the binder monthly to ensure it is current with new training available.

See attached.

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented - 02/05/2024)

81b - Resident Personal Equipment

6. 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 #4 bed enable was not securely fastened to the bed.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
The bed enabler bar was securely fastened by maintenance on the day of the survey.

Moving forward:
The Administrator will conduct weekly checks of the enabler bar to ensure it is sturdy and locked in place. The

81b - Resident Personal Equipment (continued)

weekly checklist will be hung within resident # 4's room for the staff to initial upon inspection. There is an additional checklist hanging in the med tech office to ensure compliance of the regulation.

See attached:

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/05/2024)

101j6 - Mirror

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
6. A mirror.

Description of Violation

Resident room #B11 did not have a mirror available to the residents in the room.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
During the survey, it was discovered that resident in B11 did not have a mirror in their room. I immediately notified the maintenance staff and they hung the mirror.

Moving forward:
The Administrator has conducted an inventory of all the rooms and noted any that have needs and is working towards remedying any issues. There will be monthly checks on all rooms for items required.

See attached:

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/05/2024)

101j7 - Lighting/Operable Lamp

8. 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

Residents in rooms C1A and B10 did not have an operable lamp or other source of lighting that could be turned on at bedside.

repeat violation 10/12/22

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
The surveyor visited several rooms and found two rooms did not have a lamp. C1A stated does not want a lamp. A compromise was made and we ordered push lights that stick on the wall above the bed. In the interim, has a lamp.

101j7 - Lighting/Operable Lamp (continued)

Moving forward:
The administrator ordered stick-on lights to be placed above the bed. The administrator and staff will do monthly checks to ensure everything required is in place in every room.

See Attached;
The document attached is put into effect 01/14/2024

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented (- 02/05/2024)

103g - Storing Food

9. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

In the kitchen freezer was a bag of meat, that appeared to be ground beef that was in a bag that was not securely closed.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
There was a bag of hamburger meat stored/thawing in the refrigerator. It was not properly sealed in the plastic bag, Immediately upon the discovery it was discarded.

Moving forward:
The chef will check all food storage products to ensure that all food is bagged, dated, stored, and thawed properly per the regulations of stored food. The administrator will follow the chef on the monthly surveys of the freezers/refrigerator to ensure the regulation is followed.

See attached:
Attached document is put into effect January 1, 2024

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented - 02/05/2024)

121a - Unobstructed Egress

10. 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 exit located in the front middle would not open without an excessive amount of force used, preventing immediate egress in the event of an emergency.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:

121a - Unobstructed Egress (continued)

At the end of the hall is an exit door that leads to the administrator's office in the basement. Prior to the survey, (the evening before) there were a string of burglaries in the area. The evening staff locked the exit door, to ensure the safety of the residents of Gap View PCH. Upon the arrival of the surveyor, I had forgotten we locked this door. Thus the surveyor found the door locked.
The administrator ran downstairs (there are currently three entry/exit doors to the basement. The administrator unlocked the door that enters the hallway.

Moving forward:
A special lock was ordered and will be installed on this particular exit door. This will ensure that all staff can access this exit/entryway can be accessed at any time of the day. The administrator and staff will conduct daily rounds of all exit/entryway doors that are unlocked and unobstructed.

See attached:

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented (█ - 02/05/2024)

132a - Monthly Fire Drill

11. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

Fire drill logs indicate that a fire drill is being completed on a monthly basis. However, a complaint was received that they were not being completed every month. Department rep interviewed staff and residents, and no one indicated that they were done on a monthly basis. A record from the alarm company was requested from Staff C but was not received.

Plan of Correction ***Accept (█ - 01/16/2024)***

Plan of Correction:
The alarm company submitted the record of all alarms recorded, including any time the alarm was placed on silence. The report is extensive and the administrator is trying to decipher the list. A monthly fire drill will be held and charted.

Moving forward:
The administrator (Staff C)and the staff will be conducting monthly fire drills. This will be logged on a monthly record of fire drills.

See attached: (a brief note: the administrator lost █r mother right before Christmas and I failed to follow through with submitting it to the surveyor)

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented (█ - 02/05/2024)

132d - Evacuation

12. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home has an evacuation time of 3 minutes and 7 seconds as indicated by a fire safety expert to safely evacuate the home. Fire drills that were conducted between 1/31/23 and 6/23/23 exceeded that maximum evacuation time allowed.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
The facility will continue to conduct monthly fire drills and improve upon the time of 3.7 seconds. The facility will repeat the fire drills to improve upon the time of evacuation.

Moving forward:
The administrator will conduct monthly fire drills and maintain the log required, with the help of the alarm company documenting when the alarm is put on test.

See attached:

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented - 02/05/2024)

141a - Medical Evaluation

13. 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 #1's most recent medical evaluation was completed on The medical evaluation did not contain resident's height and weight.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
an updated height and weight was conducted on resident #1, and charted immediately on the medical evaluation of resident #1.

Moving forward:
The administrator and the assistant have gone thru all the resident charts to ensure all the areas of information was charted appropriately on the evals. Each new updated DME the administrator will work with the assistant to catch any missed info.

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented (- 02/05/2024)

162c Menus Posted

14. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home did not have posted in a public and conspicuous area the home's menu for the current week and upcoming week's menu.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of correction:
The chef immediately finished her menus per the regulation 2600.162c.

Moving forward:
At the time of the survey, the chef had posted the duplicate menus for the same week. The chef had caught her error, and rectified the situation immediately. The administrator will follow up weekly to ensure this does not happen again.
See attached:

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented (- 02/05/2024)

183f Discontinued Medications

15. 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

Resident #4 is prescribed as needed for . The pharmacy label indicated the prescription expired on

Plan of Correction ***Accept (- 01/16/2024)***

Plan of correction:
On the day of the survey, the surveyor conducted a survey and med pass on the med cart with the Staff Member B, on duty. It was discovered thru this process that Resident #4 had a medication, as needed for constipation. The prescription had expired and the medication was never removed from the cart. It was removed and reordered that day.

Moving forward:
The administration and the assistant has put into place a monthly audit of the med carts to ensure all expired medications are removed and discarded and new medications are reordered in it's place.

See attached"

Licensee's Proposed Overall Completion Date: *01/14/2024*

183f - Discontinued Medications *(continued)*

Implemented (- 02/05/2024)

184b - Labeling OTC/CAM

16. Requirements

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

Description of Violation

Located in the medication cart is a . The pen did not have a name on it and was not in a pharmacy bag with a label. Staff B indicated this medication belongs to Resident #5.

Plan of Correction ***Accept - 01/16/2024)***

Plan of Correction:
The med cart was thoroughly searched to be sure that all medications are labeled and in their appropriate bag/box with the identifying label.

Moving forward:
At the start of every shift, the med tech on duty is to survey/inspect the cart after med count, to ensure that all medications are labeled and/or in their appropriate container/box or bag with the correct label. A report sheet was placed in the cart for the med tech to sign off on and to document any errors found. The administrator will review these reports daily.

See attached:

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented (- 02/05/2024)

185a - Implement Storage Procedures

17. 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 did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #2 – At on , the glucometer reading was and the Medical Administration Record, MAR, was incorrectly transcribed as

Plan of Correction ***Accept - 01/16/2024)***

Plan of Correction:
The med tech transposed the numbers and it resulted in a med error. The correct amount of medication was administered. All staff was educated and retrained in the proper administration and recording of glucose.

Moving forward:
All med tech staff was retrained in the reading and recording of the glucose test results, going from the glucometer to the MAR and the log sheet. The administrator and assistant will conduct weekly glucometer checks of both the MAR and the log sheets to ensure all numbers are recorded correctly.

185a Implement Storage Procedures (continued)

See attached:

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented - 02/05/2024)

227d - Support Plan Medical/Dental

18. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1 is receiving services. However, the assessment and support plan was not updated to reflect the care needs of the resident. Resident # 4 has a bed enabler on their bed. The Residents Assessment and support plan does not include any of the required elements when a resident has an enabled attached to their bed.

Plan of Correction ***Accept (- 01/16/2024)***

Plan of Correction:
The administrator and the assistant went through resident #1 assessment and support plan and corrected the error of the missing PT services. The administrator and assistant went through resident #4 assessment and support plan and corrected the missing error of the required elements regarding the enabler bar.

Moving forward:
The administrator and assistant are working together going through every RASP and chart to ensure there are no missing vital information such as PT/OT services, that may be required. This also includes assistive devices such as bed enablers.

See attached:

See attached:

Licensee's Proposed Overall Completion Date: *01/14/2024*

Implemented (02/05/2024)