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

April 15, 2025

[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 01/08/2025 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: *GAP VIEW PERSONAL CARE* **License #**: *23125* **License Expiration**: *11/10/2025*

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**: *19* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/08/2025*

Inspection Dates and Department Representative

01/08/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *18*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

01/08/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/20/2025*

02/03/2025 - POC Submission

Submitted By: **Date Submitted**: *03/04/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/07/2025*

Inspections / Reviews *(continued)*

03/04/2025 - POC Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *03/04/2025*

Follow-Up Type: *Bypass Document Submission*

04/15/2025 - Bypass Document Submission

Submitted By: [redacted]

Reviewer: [redacted]

Date Submitted: *03/04/2025*

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

Due to being out of the facility, Resident #1 missed the following medications on the following dates:
- Atorvastatin 80mg on
- Ferrous Sulfate 324mg on
- Humalog Kwikpen 100unit/ml on
- Lantus Solostar 100units/ml on
- Metoprolol 50mg on
- Ropinirole Hcl 0.5mg on

These missed medications were not reported to the Department.

Plan of Correction ***Accept (- 03/04/2025)***

How this happened?
The resident was out of the facility on the dates in question. The doses went uncharted in the MAR. The med tech left it as a missed dose instead of charting the resident was out of facility.

Plan of correction:
The missed doses were reported to the Department of Human services. A copy of the incident was reported to the resident PCP, . A copy of the incident was given to the residents POA. The med tech in question was retrained on proper documentation when a resident is out of facility. The retraining on the EMAR was conducted with the med tech in question on 01/08/2025. The remaining med techs were given a refresher course.

Moving forward: The administrator and med tech supervisor will do weekly audits on the MAR, to ensure there are no missed medications. If any missed medications are found the administrator and/or med tech supervisor will follow the protocol required by reg 2600.16C.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

26a - Quality Management Plan

2. Requirements

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

Description of Violation

The home conducts Quality Management meeting annually. The home did not conduct a Quality Management meeting in 2024.

Plan of Correction ***Accept (- 03/04/2025)***

How did this happen?
The administrator failed to have a Quality Management meeting as required by the 2600.26.a regulation.

26a - Quality Management Plan (continued)

Plan of Correction:
A Quality Management meeting was conducted immediately. The Quality Management Plan completed on 01/10/2025

Moving forward:
The Quality Management meeting is now on the general schedule to be held yearly in January. It is marked on the calendar. The calendar is reviewed daily for items of importance. This will prevent missing any important documents needed for future inspections. The Quality Management meeting documents will be kept in the DHS inspection binder with the rest of the documents needed.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

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

The home did not have documentation that Direct care staff person A, date of hire , had a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 03/04/2025)***

How did this happen?
Staff person A was hired on and trained as a med tech. It was an oversight on the administrator that the diploma requirement was missed in the file.

Plan of Correction:
Staff person A located high school diploma and submitted as proof that had graduated high school. A copy of high school diploma is attached.

Moving forward:
The administrator and med tech supervisor are conducting an audit of the personnel files to ensure all the required documents at intact in the file.
Audit of records/diplomas/GEDs was completed on 01/10/2025

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

65d - Initial Direct Care Training

4. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

The home did not have documentation that Direct care staff person A, date of hire [redacted], completed the Department-approved direct care training course and passed the competency test.

Plan of Correction ***Accept ([redacted] - 03/04/2025)***

How did this happen?
There was a misunderstanding between Staff person A and the Administrator. The administrator was under the assumption that the Direct Care Course was completed by staff person A.

Plan of correction:
Staff person A completed the online Direct Care Course. And promptly submitted the certificate to administrator. Date of completion of Direct Care Course is 01/20/2025, see attached.

Moving forward:
The administrator and med tech supervisor will conduct an audit of the personnel files and will keep an ongoing log of all the completed certificates for the direct care course.
Audit completed 01/10/2025
Moving forward all certificates are kept in the binder, and the binder is audited monthly for any expiration's and/or changes

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented ([redacted] - 04/15/2025)

81b - Resident Personal Equipment

5. 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

The enabler bar located in resident room A-7 was uncovered at time of inspection and was not securely fastened to the bed.

Plan of Correction ***Accept ([redacted] - 03/04/2025)***

How did this happen?
Resident room A 7 has an enabler bar. The bar is covered with a fitted pillow case, in which the resident does not like, so [redacted] removes it. The enabler bar also works itself loose from usage.

Plan of correction:
On 01/09/2025, the enabler bar was replaced with a new model and fastened tightly to the frame of the bed. The enabler bar has a cover installed. Staff was trained on 01/09/2025 assessment of the enabler bar to ensure it is properly fastened and covered.

Moving forward:

81b - Resident Personal Equipment (continued)

The administrator and supervisor will conduct weekly audits of the enabler bar to ensure it is covered and tightly fastened commencing on 01/09/2025.
Please note: The enabler bar was removed completely and resident is in a hospital bed.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

85a - Sanitary Conditions

6. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

There were 3 used bath towels in the shower in the common bathroom near bedroom A-5 at time of inspection.

Plan of Correction ***Accept (- 03/04/2025)***

How did this happen:
On the morning of the survey, a resident in the room next to the shower room had taken a shower. is independent and does not need an aide to shower. The resident had left dirty bath towels on the shower chair. The housekeeper had not had a chance to collect them before the surveyor had inspected the room.

Plan of correction:
The administrator was walking with the surveyor when the linens were found. The administrator immediately removed the dirty linens from the shower and asked the housekeeper to sanitize the shower for the next resident. On 01/08/2025, After the surveyor left the administrator had a discussion with the housekeeper regarding the cleanliness and importance of following after the resident to collect the dirty linens and sanitation.

Moving forward:
The administrator had a discussion with the housekeeper to please check the shower rooms as soon as clocks in for the day. was further directed to remove any dirty linen from the bathroom. On 01/08/2025 a sign-off sheet was posted for the med techs and the housekeeper to initial when they inspect the bathrooms daily.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

101j2 - Bedroom Chairs

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
 2. A chair for each resident that meets the resident's needs.

Description of Violation

Resident room B-12 currently has 2 residents residing in it. There was only 1 chair available in the bedroom at time of inspection.

Plan of Correction ***Accept (- 03/04/2025)***

How did this happen?

101j2 - Bedroom Chairs (continued)

Room B 12 has two residents occupying this room. They refused a second chair months ago due to space being an issue with the one resident and this was forgotten about.

Plan of correction:
The surveyor suggested folding chairs. The administrator purchased several folding chairs and one chair was placed under the beds for storage. This allows the resident the space ██ desires as well as the use of a chair when ██ has a visitor. The resident was assessed for competency of proper use on operating a folding chair on 01/10/2025. The residents RASP was update to reflect the resident is capable of operating a folding chair in the proper manner on 01/10/2025. The new folding chair was placed in use on 01/10/2025.

Moving forward:
The administrator will do an audit on all rooms to ensure each has a chair per bed for every resident. Audit commenced on 01/10/2025 and rooms will be audited monthly for the proper furnishing are in place as required per regulation 2600:101.j.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (██ - 04/15/2025)

132b - Safety Inspection/Fire Drill

8. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent annual fire safety inspection and supervised fire drill was conducted on 10/21/24. The previous inspection was conducted on 7/24/23, more than one year prior.

Plan of Correction ***Accept (██ - 02/03/2025)***

How this happened?
The fire drill inspection occurred on 10/21/2023. Gap View PCH uses the local fire company to complete our yearly fire inspection and supervised fire drill. The previous years drill was completed in July of 2024. It was an oversight on the administrator, that the supervised drill was scheduled later than previously.
Plan of correction:
The administrator had a conversation with the acting Fire Chief Dean Parsons to schedule a supervised fire drill twice a year with the first one commencing in May of 2025. The administrator has noted on the calendar to schedule a twice yearly drill one in the spring and one in the fall for our supervised drill. With the first one commencing in May of 2025.
Moving forward:
The administrator has spoken with the Fire Chief ██████ to schedule the supervised drill twice yearly. This commences in May of 2025 and September 2025. This benefits not just Gap View PCH but also the fire company as they are volunteer and it is good practice for their junior fire fighters and new members.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (██ - 04/15/2025)

132d - Evacuation

9. 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's most recent annual fire safety inspection was conducted 10/21/24. The previous inspection was conducted 7/24/23, more than one year prior. Therefore, the home's evacuation time from 7/24/23 through 10/21/24 reverted to the state minimum evacuation time of 2min 30sec. On the following dates, the home conducted fire drills and exceeded their evacuation time:

- *8/1/24, with an evacuation time of 3min*
- *9/10/24 with an evacuation time of 3min*

Plan of Correction ***Accept (█ - 02/03/2025)***

How did this happen?
The previous supervised fire drill was held on July 24, 2023. This years fire drill was completed on 10/21/2024. This was an oversight on the administrator. The administrator did not realize the difference would cause two drills to be affected in the evacuation time.
Plan of correction:
The administrator has noted on the calendar the next supervised drill in May 2025.
Moving forward:
The administrator has scheduled on the calendar the two supervised fire drill dates in May and September of 2025. This will ensure that no evacuation drills will be reverted back to the regulation time of 2 minutes, 30 sec.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Implemented (█ - 04/15/2025)

132e - Fire Drill Sleeping Hours

10. Requirements

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

Description of Violation

The home has not conducted a fire drill during sleeping hours in the past 12 months. The earliest time a fire drill was conducted in the past 12 months was 7am, and the latest time was 7pm.

Plan of Correction ***Accept (█ - 03/04/2025)***

How did this happen?
There no fire drill prior to 7 am and after 7pm. This was an error on behalf of the administrator, not paying attention to our scheduled time frames.

Plan of correction:
The administrator has implemented a new fire drill schedule to ensure that an over night fire drill will be conducted between the hours of 11 pm and 6 am. The over night drill was conducted 01/12/2025 at 11:30 pm.

Moving forward:

132e - Fire Drill Sleeping Hours (continued)

The administrator has implemented a fire rill record and it is posted on the calendar, to prevent a missed drill and ensure a fire drill is held within the over night hours between 11 pm and 6am

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

181c - Self-administration Assessment

11. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 self-administers a Fluticasone 50gm nasal spray. The resident is not currently assessed to self-administer medications.

Plan of Correction ***Accept (- 03/04/2025)***

How this happened?
Resident #1 was in possession of Fluticasone 50 gm nasal spray. It was an oversight that the facility did not have a script from Dr. that the resident was competent enough to administer own nasal spray.

Plan of correction:
On 01/09/2025, The administrator contacted the residents PCP. regarding whether the doctor felt the resident was cognitive to self administer Fluticasone? The doctor agreed the resident is capable of administering Fluticasone appropriately. The administrator provided a lock box to the resident and explained that medicine needs to be locked in box on 01/09/2025 when is not in room. On 01/09/2025, The administrator obtained a script from Dr stating the resident may have the Fluticasone in room.
Moving forward:
The administrator has placed the script in the residents file as well as in a general notebook. It was added to the EMAR, "self in room."
On 01/09/2025,The administrator commenced with auditing the med carts to ensure the prescribed medications are within the cart. The audit was conducted on 01/09/2025

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

185a - Implement Storage Procedures

12. 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 controlled substance policy includes the oncoming and the off-going Med Techs complete a complete count of the home's controlled substances inventory, and document that the count was completed by signing the home's Drug Count Sheet. On 1/7/25, the count was not completed in the 3rd shift. On 1/8/25, the count was not completed on

185a - Implement Storage Procedures (continued)

the 1st shift.

Plan of Correction ***Accept (- 03/04/2025)***

How this happened?
The drug count sheet is to be signed by the med tech who is arriving on shift and again when going off shift. This is to be completed when the med techs count the narcs at the change of shift. The count sheet was not signed on the third shift and the first shift the next day. Indicating the narc counts were not performed.

Plan of correction:
The administrator retrained the med tech staff in signing the narc count sheet. Training on the NARC count sign in/sign off sheet was completed on 01/08/2025 for the immediate staff involved, staff member B and staff member A.

Moving forward:
The administrator is exploring the use of accessing the narc count electronically with in the EMAR. The administrator will conduct an audit daily to ensure the narc sheet is signed accordingly. In the event the Administrator is unavailable to do the audit, it will be conducted by the Med Tech Supervisor. This audit has been implemented on 01/08/2025.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

187b - Date/Time of Medication Admin.

13. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1's medication administration record (MAR) was not documented to indicate whether or not the following medications were administered on the following dates/times:
- Aspirin 81mg on
- Atorvastatin 80mg on
- Ferrous Sulfate 324mg on
- Humalog Kwikpen 100 unit/ml on

Resident #1 was prescribed Lisinopril 5mg and Pantoprazole 40mg on 12/31/24. These medications were not added to the resident’s medication administration record (MAR). Staff person B confirmed that these medications are being administered. However, documentation of the medications being administered is not occurring due to them not being included in the MAR.

Resident #2 is prescribed Miralax 17gm every morning. This medication was not on-site at time of inspection. It was documented on the resident's MAR that the medication was administered on 1/8/25 at 8:00am by staff person B. Per interview with Staff person B, this medication was actually not administered on 1/8/25 at 8:00am.

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction ***Accept (- 03/04/2025)***

How this happened?
The med tech on duty had erroneously charted on Resident #2 that administered the Miralax that morning when the last dose was administered the previous day.
Resident #1 was prescribed the Lisinopril 5mg and Pantoprazole 40 mg. It was not profiled in the EMAR. There was a paper MAR, however the med tech didn't know where placed the paper MAR. It was the same med tech that failed to chart correctly on the following meds for Resident #1.
- Aspirin 81mg on
- Atorvastatin 80mg on
- Ferrous Sulfate 324mg on
- Humalog Kwikpen 100 unit/ml on 1

Plan of correction:
On 01/08/2025, When this error was discovered, the administrator called the pharmacy and requested copies of the scripts in question and requested these medication be profiled immediately. I questioned the refill for the Miralax for Resident #2 and it was being sent that day within the hour.

Moving forward:
The administrator is auditing the med carts on a weekly basis to ensure all medications are profiled, present and account for. Staff person #B was retrained in the proper documenting in the EMAR on 01/08/2025. The audits will be conducted weekly by the administrator and/or the med tech supervisor. It has been recorded on the office calendar as a reminder to audit the carts. These audit sheets will be kept in the binder with the documents needed for the DHS inspection book.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

187d - Follow Prescriber's Orders

14. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Due to being out of the facility, resident Resident #1 missed the following medications on the following dates:
- Atorvastatin 80mg on
- Ferrous Sulfate 324mg on
- Humalog Kwikpen 100unit/ml on
- Lantus Solostar 100units/ml on
- Metoprolol 50mg on
- Ropinirole Hcl 0.5mg on

Resident #2 is prescribed Miralax 17gm every morning. This medication was not on-site at time of inspection. It was documented on the resident's MAR that the medication was administered on 1/8/25 at 8:00am by staff person B. Per interview with Staff person B, this medication was actually not administered on 1/8/25 at 8:00am.

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept (- 03/04/2025)***

How this happened?
Resident #1 was out of the facility on the dates in question. The doses went uncharted in the MAR. The med tech left it as a missed dose instead of charting the resident was out of facility. Resident #2 was prescribed Miralax daily. The last dose was administered the day prior. The med tech on duty erroneously charted on the Miralax as though had administered the medication.

Plan of correction:
A phone call was made to Dr regarding the missed medications, this was then followed up by a hard copy of the incident report that was sent to DHS. The administrator then called the POA for resident #1 and informed the POA of the missed medications. This was also followed up with a hard copy of the incident report that was submitted to DHS. On 01/09/2025, the start of the shift, the med tech in question was retrained on proper documentation when a resident is out of facility and on proper documentation regarding charting on med that is out of stock or needs to be refilled. Further the med tech was also retrained on the procedures for ordering the missing med from the pharmacy.

Moving forward:
On 01/09/2025 the administrator and med tech supervisor will do weekly audits on the E MAR, to ensure there are no missed medications. If any missed medications are found the administrator and/or med tech supervisor will follow the protocol for "missed meds," required by the reg 2600.16C

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

188b - Medication Error Reporting

15. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident’s designated person and the prescriber.

Description of Violation

Due to being out of the facility, Resident #1 missed the following medications on the following dates:
- Atorvastatin 80mg on
- Ferrous Sulfate 324mg on
- Humalog Kwikpen 100unit/ml on
- Lantus Solostar 100units/ml on
- Metoprolol 50mg on
- Ropinirole Hcl 0.5mg on

These missed medications were not reported to the resident’s PCP or designated party.

Plan of Correction ***Accept (- 03/04/2025)***

How did this happen:
The resident was out of the facility on the dates in question. The doses went uncharted in the MAR. The med tech left it as a missed dose instead of charting the resident was out of facility.

188b - Medication Error Reporting (continued)

Plan of correction:
The administrator called the POA for resident #1 and informed the POA of the missed medications. This was also followed up with a hard copy of the incident report that was submitted to DHS. The resident was informed of missed medications. Resident explained was at and did think about medications. The med tech wasn't thinking of being out of facility to give medications to the residents It was the same med tech in question for these medications in question. On 01/09/2025 at the start of the med tech in question shift, was properly retrained on the proper documentation when a resident is out of facility as well as documentation regarding charting on med that is out of stock or needs to be refilled.

Moving forward:
On 01/09/2025, the administrator and med tech supervisor will do weekly audits on the MAR, to ensure there are no missed medications. If any missed medications are found, the administrator and/or med tech supervisor will follow the protocol required by the reg 2600.188.b outlining the med error protocol.

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (- 04/15/2025)

227d - Support Plan Medical/Dental

16. 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 #3 utilizes and enabler bar to assist with transfers in/out of bed. The resident's assessment and support plan dated 4/10/24 does not include the following required verbiage:

o The specific need for the device
o The intended use and any risks associated with the use
o The resident's ability to use the device safely for the purpose it was intended
o Identification of the specific device to be used and whether a cover is required to meet FDA guidelines

Plan of Correction ***Accept (- 03/04/2025)***

How did this happen?
Resident #3 has an enabler bar that accesses to pull up from the reclining position. It was not properly documented in the RASP per the regulation verbage.

Plan of correction:
On 01/15/2025 the med tech supervisor immediately pull resident # 3 RASP and corrected the documentation per the 2600.227.d regulation.

Moving forward:

227d - Support Plan Medical/Dental (continued)

The med tech supervisor will be doing monthly audits of the RASP for all the residents at Gap View PCH. This will ensure nothing is missed and new information is documented. The first audit will commence on 01/15/2025

Licensee's Proposed Overall Completion Date: *02/10/2025*

Implemented (█ - 04/15/2025)