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

April 15, 2025

[redacted]
GAP VIEW PERSONAL CARE, INC
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/07/2025, 03/18/2025 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: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *GAP VIEW PERSONAL CARE, INC*

Address: [redacted]

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

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *16* **Waking Staff**: *12*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *03/07/2025*

Inspection Dates and Department Representative

03/07/2025 - On-Site: [redacted]

03/18/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *16*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *16*

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

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

Inspections / Reviews

03/07/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/29/2025*

04/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/04/2025*

Inspections / Reviews *(continued)*

04/07/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/14/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/14/2025*

04/15/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/14/2025*

Reviewer: [redacted] **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

The home did not report the following missed medications for resident [redacted] to the department's regional office as required:

On [redacted] Resident [redacted] was out of the home with a family member and missed the following 5:00p.m. prescribed orders:
[redacted], and [redacted]
On [redacted] at 5p.m.; Resident [redacted] was not administered their [redacted].
On [redacted] at 4:47p.m.; Resident [redacted] had a [redacted] reading of [redacted] requiring [redacted] of [redacted] per their sliding scale order but no units of [redacted] were administered.

Plan of Correction ***Accept [redacted] - 04/07/2025)***

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
The home did not report the following missed medications for resident [redacted] to the department's regional office as required:

How did this happen?
On [redacted] Resident [redacted] was out of the building with a family member and missed [redacted] medications at 5:00 pm: [redacted] and [redacted].
(The resident refuses to take the medications with [redacted] when [redacted] leaves. The medical technician charted that he was out of the facility with [redacted] family. it was an error in this charting. The resident or their family shall be given the medication to administer to the resident.)

On [redacted] at 5 p.m., Resident [redacted] was not administered their [redacted].
On [redacted] at 4:47 p.m., Resident [redacted] had a [redacted] reading of [redacted], requiring [redacted] of [redacted] according to their sliding scale order; however, no insulin was administered.
(The medication technician failed to document the administration of these medications.) It is not an excuse. IT was an error; for whatever reason, [redacted] was distracted and failed, with this resulting as a missed med. The administrator missed it, which resulted in this medication error not being reported as such.)

Plan of correction:
On 03/07/2025, a facsimile of the incident was forward to the department regarding 2600.16. c., to DHS on the missed meds and again on 03/29/2025 to be sure it was received. The plan of correction includes retraining of the med tech involved in the proper charting of missed meds. The administrator and the assistant will conduct daily audits on the MAR to ensure there are no more missed meds.

Moving forward:

16c Written Incident Report (continued)

The administrator will be more diligent in any future reporting of med errors to DHS per regulation 2600.16.c. The med techs have been retrained on 03/08/2025.
On 03/08/2025 The med techs were retrained on the proper documentation in the Q MAR. Moving forward the Administrator will continue to monitor the Mar and the carts to ensure no other errors occur.

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

Implemented [redacted] - 04/15/2025)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

At approximately 9:30 a.m., two wet towels were observed on the bench in the shower of the 1st floor bathroom.

Plan of Correction ***Accept [redacted] - 04/01/2025)***

Description of violation:
At approximately 9:30 a.m., two wet towels were observed on the bench in the shower of the 1st floor bathroom.

How this happened:
A resident had taken [redacted] shower that morning at approximately 9:00 after breakfast. There was no laundry hamper or basket in the shower room. The resident had left [redacted] wet towels on the shower seat that morning. As the surveyor and the administrator were doing the building survey, the med tech on duty had not had a chance to pick up those towels and place them in the hamper in the front storage room. The surveyor observed the towels just before the tech was able to pick them up.

Plan of correction:
On 03/07/2025, A laundry hamper was placed in the bathroom for residents to place their dirty linens in after showering

Moving forward:
The administrator will monitor the bathroom daily to ensure there are no linens on the floor or the bench. In the administrator's absence, it will be the responsibility of the med tech. This commences daily starting 03/08/2025

Licensee's Proposed Overall Completion Date: *03/29/2025*

Implemented [redacted] - 04/15/2025)

103d - Storing Food Off Floor

3. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

At around 10:00a.m. approximately 12 to 15 plastic bags of groceries were observed being stored outside the home's

103d Storing Food Off Floor (continued)

garage directly on the ground. The groceries had been delivered to the home around 9:00a.m.

Plan of Correction ***Accept [redacted] - 04/01/2025)***

Description of Violation
At around 10:00 a.m., approximately 12 to 15 plastic bags of groceries were observed being stored outside the home's garage directly on the ground. The groceries had been delivered to the home around 9:00 a.m.

How this happened:
An order was placed the evening before the delivery. The cook, housekeeper, and med tech were upstairs cleaning up after breakfast and didn't realize the order was so large. Since Gap View is a smaller facility, we haven't been lucky enough to procure a food vending company. This brings me to the delivery from Instacart. The driver delivered, and the staff was still upstairs, which resulted in the violation of 2600.103.d.

Plan of Correction:
On 03/10/2025, a pallet was put in place in the garage area where the freezers are for the Instacart deliveries to be unloaded and placed upon to get the product off the floor

Moving forward:
As the orders are delivered, the delivery instructions change for the Instacart delivery driver. Food is not to be placed on the floor; it is to be placed on top of the existing freezers and pallet.

Licensee's Proposed Overall Completion Date: *03/29/2025*

Implemented [redacted] - 04/15/2025)

132c - Fire Drill Records

4. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home conducted fire drills on [redacted] at 11:30 p.m. and [redacted] at 7:00 p.m. but did not record the evacuation times on the fire drill logs.

Plan of Correction ***Accept [redacted] 04/01/2025)***

Description of Violation
The home conducted fire drills on January 12, 2025, at 11:30 p.m., and February 28, 2025, at 7:00 p.m., but did not record the evacuation times in the fire drill logs.

How did this happen?
The administrator conducted the fire drills. The administrator used the stopwatch on the cell phone. The drill was written in, but when going back to look at the timer, it was erased when the timer was accessed to get the recording. It was a careless oversight on the administrator's part.

Plan of correction:
The administrator purchased an app that records the time and date and exports it into an Excel spreadsheet. This

132c - Fire Drill Records (continued)

will provide additional backup to time and date.

Moving forward:
03/10/2025 A stopwatch app was downloaded to the cell phone. This program tracks the time and date and exports the info to an Excel sheet. This sheet is then placed in the file book with the fire drill log. It will be replaced every month with each drill. The administrator will review the fire drill log monthly to ensure the log sheet is completed accurately; This is effective 03/18/2025

Licensee's Proposed Overall Completion Date: *03/29/2025*

Implemented [redacted] - 04/15/2025)

187d - Follow Prescriber's Orders

5. Requirements

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

Description of Violation

Resident [redacted] has an order for [redacted] to be administered four times daily on a sliding scale basis at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m.
On [redacted] at 5:00 p.m. the resident's blood sugar was not measured to determine amount of insulin that was needed due to the resident being out of the facility.
On [redacted] at 5:00 p.m., Resident [redacted] was also not administered their 5:00 p.m. doses of [redacted] and [redacted] due to being out of the facility. Staff indicated that the resident leaves the home with family and does not take prescribed medications while out of the facility with family.

Resident [redacted] has an order for [redacted], one capsule twice daily for 7 days. The medication was to be administered from [redacted] to [redacted] at 8:00 a.m. and 5:00 p.m. On [redacted] the home did not administer the medication at 5pm.

On [redacted], there was a reading of [redacted] at 4:47 p.m. found in resident [redacted] requiring [redacted] of [redacted] to be administered. The Medication Administration Record shows no units of [redacted] were administered for [redacted] at 5:00 p.m.

Plan of Correction ***Accept ([redacted] - 04/01/2025)***

Description of Violation
Resident [redacted] has an order for [redacted] to be administered four times daily on a sliding scale basis at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m.
On [redacted] at 5:00 p.m., the resident's [redacted] was not measured to determine the amount of [redacted] needed, as the resident was out of the facility.
On [redacted] at 5:00 p.m., Resident [redacted] was also not administered their 5:00 p.m. doses of [redacted] and [redacted] due to being out of the facility. Staff indicated that the resident leaves the home with family and does not take prescribed medications while out of the facility with family.
Resident [redacted] has an order for [redacted], one capsule twice daily for 7 days. The medication was to be administered from [redacted], to [redacted] at 8:00 a.m. and 5:00 p.m. On [redacted], the home did not administer the medication at 5:00 p.m.

187d - Follow Prescriber's Orders (continued)

On [redacted], a reading of [redacted] was recorded in resident [redacted] at 4:47 p.m., requiring four units of [redacted] to be administered. The Medication Administration Record indicates that no units of [redacted] were administered on [redacted] at 5:00 p.m.

How did this happen:
Resident [redacted] leaves the facility with [redacted] or [redacted] On [redacted] the resident was not in the facility to administer [redacted] or 5 pm meds, [redacted] and [redacted]. The med tech as trained in error that when a resident is out of the facility, it should be charted as such. In this case the resident and [redacted] family refuse to take [redacted] meds when [redacted] leaves the facility for the day. Resident [redacted] has an order for [redacted] medication taken at 8:00 am and 5:00 pm. At 5:00 pm the med tech failed to chart the med as being administered.
On [redacted] there was a reading of [redacted] on the resident's [redacted] However, the [redacted] reading and units of [redacted] is not recorded in the MAR. The med tech failed to record the administration of units and the glucometer reading.

Plan of correction:
The administrator has been checking the glucometer readings daily to ensure they have been charted properly and correctly with the units of insulin if it is required based upon the glucometer reading. The med techs are to fill out an additional log sheet with all the glucometer readings. This will help ensure none are missed.

Moving forward:
The administrator will continue to do daily audits on the MAR and the blood sugar reading sheet to ensure there are no missed readings or missed insulin'
On 03/08/2025 The med techs were retrained in the proper documentation of the glucometer checks.

Licensee's Proposed Overall Completion Date: *03/29/2025*

Implemented [redacted] - 04/15/2025)

188b - Medication Error Reporting

6. 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

The home did not notify resident [redacted] physician when the resident missed the following medication administrations:

On [redacted] at 5:00 p.m., [redacted] and [redacted].
On [redacted] at 5:00 p.m.; Resident [redacted] was not administered their [redacted].
On [redacted] at 4:47p.m.; Resident [redacted] had a [redacted] reading of [redacted] requiring [redacted] of [redacted] per their sliding scale order but no units of [redacted] were administered.

Plan of Correction ***Accept [redacted] - 04/01/2025)***

Description of Violation
The home did not notify resident [redacted] physician when the resident missed the following medication administrations:
On [redacted] at 5:00 p.m., [redacted] and [redacted].
On [redacted] at 5:00 p.m., Resident [redacted] was not administered their [redacted].

188b - Medication Error Reporting (continued)

On [redacted] at 4:47 p.m., Resident [redacted] had a [redacted] reading of [redacted] requiring [redacted] units of [redacted] per their sliding scale order, but no units of insulin were administered.

How did this happen?
The med tech failed to chart the medications as required by the doctors' orders and the DHS regulation 2600.188.b.

Plan of correction:
On [redacted] the administrator notified the [redacted], and the residents designated person immediately of the missed meds and any med refusals by the resident. The med tech was retrained in the proper medication administration according to the DHS regulations.

Moving forward:
On 03/08/2025 The administrator and the assistant will continually monitor the MAR to ensure all medications are charted accordingly to the doctors' instructions. This includes the glucometer check sheets and the MAR administration records.

Licensee's Proposed Overall Completion Date: *03/29/2025*

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