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

November 6, 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 09/16/2025 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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *20* **Waking Staff**: *15*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *09/16/2025*

Inspection Dates and Department Representative

09/16/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *20*

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**: *20*

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

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

Inspections / Reviews

09/16/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/17/2025*

10/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/05/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/28/2025*

Inspections / Reviews *(continued)*

11/06/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/05/2025*

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

On [redacted], Resident [redacted] did not receive dose of [redacted] at 8 am as prescribed. The home did not report this medication error t to the department until [redacted]

Plan of Correction ***Accept [redacted] - 10/23/2025)***

How this happened:
On 09/16/2025, the surveyor came to Gap to follow up on a complaint. While there, the surveyor conducted an audit of the med cart with the tech. It was discovered that Resident [redacted] missed [redacted] dose of [redacted]

Plan of correction:
09/16/2025 The Administrator went through the carts with the tech who was on the cart that day to address the missed med. The Administrator immediately filed the incident report and sent it to the DHS office. The Administrator then notified the resident and the resident's physician.

Moving forward:
On September 17, 2025, the Administrator will audit the medication carts at the start of every shift to ensure that no medications are missing. The administrator will audit the daily logs to verify that no incidents requiring reporting have been missed. These logs will be kept in the DHS book for future reference.
To date there have been no other incidents of missed meds.

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented [redacted] - 11/06/2025)

185a - Implement Storage Procedures

2. 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

During the month of September 2025, the Home Narcotic Log Sheet for resident [redacted] had a count of 20 [redacted] but the blister pack only contain 15 pills.

On [redacted] at 9:05 am, Staff person C did not initial the Narcotic Log Sheets for several resident's narcotics until after the Morning Med Pass was completed.

Plan of Correction ***Accept [redacted] - 10/23/2025)***

Note: this is in error. It is resident [redacted] who had 20 medications on the chart, but the card had 15. The medication is [redacted].

185a Implement Storage Procedures (continued)

Part 1: How this happened:
On 09/16/2025, the surveyor came to Gap to follow up on a complaint. While there, the surveyor conducted an audit of the med cart with the tech. Resident [redacted] had 15 doses of [redacted] in [redacted] blister pack. The logbook indicates 20 doses remaining. At first glance, it appears as though they are missing. However, the med tech on duty for those nights in particular had initialed the medication as [redacted] popped and administered the dose. It is Gap View's policy to initial the blister pack on the date the dose was popped from the card. After closer inspection, it appears the meds were initialed on the blister pack, but not logged in the narc log book.

Plan of Correction:
On September 17, 2025, the administrator retrained the staff on the medication policy for Gap View, and the staff signed and initialed the training document. The administrator will audit the narc logs daily to ensure that what is logged in the narc book is accurate in relation to the control count on the card. I interviewed the resident, who is cognizant and confirms [redacted] has been receiving [redacted] [redacted] as indicated. The administrator implemented the electronic count feature of Q Mar. Applying this system to the narcotic control counts ensures there is no room for error. The technician cannot proceed to the next chart without counting the narcotic and confirming the count in the electronic mar.

Moving forward:
The administrator will continue to audit the narcotic counts, both electronically and physically, within the cart. Furthermore, the administrator will check the counts at every shift to ensure that there are no missed counts and that everything is logged.

Part 2: How this happened:
On 09/16/2025 the surveyor conducted an audit of the med carts at Gap View. Upon inspecting the narcotic logbook, it is noted that Staff person A: did not initial the Narcotic log sheet for the residents [redacted] administered narcotics to until after [redacted] morning med pass.

Plan of correction:
09/17/2025 The medication administration policy was updated, and Staff Person A was retrained in the proper administration of the narcotic and the documentation of the narcotic in the logbook, both during administration and at shift change. All staff were retrained in the Gap View Medication Administration policy.

Moving forward:
As of 09/17/2025, the administrator and the assistant administrator conduct audits of the med techs when administering [redacted] narcotics during their shift and observe them recording the administration in the logbook. This audit is performed daily throughout the day, during the medication pass times.

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented [redacted] - 11/06/2025)

187d - Follow Prescriber's Orders

3. Requirements

2600.

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

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

Description of Violation

Resident [redacted] is prescribed [redacted] mg at 8 am daily. However, resident [redacted] was not administered this medication on [redacted] at 8 am.

Plan of Correction ***Accept [redacted] - 10/23/2025)***

How this happened:
Resident [redacted] was prescribed [redacted] mg at 8 am daily. The blister card still had the med for 09/13/2025 in the blister pack. The med tech missed the medication. Resulting in a medication error.

Plan of correction:
On 09/16/2025, the administrator retrained the medical technician on the medical error policy. The training was extended to the rest of the med tech staff on September 17, 2025. The electronic med count was installed on the E MAR and is active to catch all meds when administered. The program deducts the narc when administered, which helps keep the counts accurate. A second count sheet will be used to track the narcotics in the safe box within the cart. All techs must follow the corrective action, including recording the narc in the control book as well as in the E MAR.

Moving forward:
Starting September 17, 2025, the administrator will continue to conduct daily audits of the medication carts for any missed medications. In the event the administrator is not available, the assistant administrator will conduct the audit.

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented [redacted] - 11/06/2025)

188b - Medication Error Reporting

4. 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

Resident [redacted] is prescribed [redacted] at 8 am daily. However, resident [redacted] was not administered this medication on [redacted] at 8 am. The medication error was not reported to the resident, the responsible party or the prescriber until [redacted]

Plan of Correction ***Accept [redacted] - 10/23/2025)***

How this happened:
Resident #[redacted] is prescribed [redacted]. at 8 am daily. However, resident #[redacted] was not administered this medication on 9/13/2025 at 8 am. The medication error was not reported to the resident, the responsible party or the prescriber until 9/16/2025.

Plan of correction:
09/16/2025, the administrator immediately filed the incident report with the Department of Human Services, before the surveyor even left the facility. The administrator then went to the resident to inform the resident (the resident is [redacted] own responsible party) of the missed medication. The administrator then notified the prescriber, Dr. Pat

188b - Medication Error Reporting (continued)

Christianson, of the missed medication. The administrator will continue to do audits of the narc log book and the narc count, to ensure the counts are correct.

Moving forward:
09/17/2025 the administrator continues to conduct daily audits of the med cart and narcotic log book and daily checks to see if any incident reports need to be reported to the resident, the resident's designated person and the prescriber.

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented - 11/06/2025)