

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

September 3, 2026

[REDACTED]
GAP VIEW PERSONAL CARE, INC
[REDACTED]
[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 07/14/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: GAP VIEW PERSONAL CARE

License #: 23125

License Expiration: 11/10/2026

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:

Phone:

Email:

Certificate(s) of Occupancy

Type: I-1

Date: 08/18/2022

Issued By: Dept of L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 19

Waking Staff: 14

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint

Exit Conference Date: 07/14/2026

Inspection Dates and Department Representative

07/14/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 25

Residents Served: 19

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 3

Are 60 Years of Age or Older: 18

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 0

Have Physical Disability: 0

Inspections / Reviews

07/14/2026 Partial

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 08/13/2026

08/19/2026 - POC Submission

Submitted By:

Date Submitted: 08/30/2026

Reviewer:

Follow-Up Type: POC Submission

Follow-Up Date: 08/26/2026

Inspections / Reviews (*continued*)

08/27/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/30/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/03/2026

09/03/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/30/2026

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 policy/plan for Quality Management is to hold meetings yearly during the first week of January. The home's most recent Quality Management meeting was held on [REDACTED]

Plan of Correction

Accept [REDACTED] - 08/19/2026)

Plan of correction:

On July 18th, the Administrator reviewed the minutes and data from the Quality Management meeting held on January 10, 2025. The review confirmed that all required regulatory components under § 2600.26(b) were fully evaluated. The Quality Management Plan was immediately held to discuss this year's meeting.

Moving forward:

The Quality Management Meeting will resume on the original date in January 2027.

On 07/15/2026, a formal administrative memorandum was placed in the Quality Management binder. This memo explicitly notes the 2025 schedule variance and confirms that the meeting met all state evaluation standards despite the delayed date. The next meeting will resume in January 2027. A memo and/or appointment was set on the Administrator's electronic Google Calendar.

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

82c - Locking Poisonous Materials

2. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 9:12 a.m., Lysol Advanced Power Clinging Gel with a manufacture's label indicating, "If swallowed, call a Poinson Control Center or Doctor immediately for treatment advice", was unlocked, unattended, and accessible in the first floor side room partitioned by a curtain. Not all the residents of the home, including Resident [REDACTED], have been assessed capable of recognizing and using poisons safely.

At approximately 11:56 a.m., Crest toothpaste with a manufacture's label indicating "If more than used for brushing is accidentally swallowed, get medical help or Contact a Poison Control Center", was unlocked, unattended, and accessible in the second floor shared bathroom near the main stairwell. Not all the residents of the home, including Resident [REDACTED], have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [REDACTED] - 08/14/2026)

Plan of Correction:

Immediately on July 14th, 2026, in the First Floor Side Room, the Administrator removed the Lysol Advanced Power Clinging Gel from the room on the day of inspection. Since the first floor side room does not have a locking door, the Administrator placed all products in a designated, locked housekeeping storage cabinet in the basement.

82c Locking Poisonous Materials (continued)

Second Floor Shared Bathroom: The Crest toothpaste was immediately secured. Because Resident #1 and other communal residents lack the cognitive assessment to safely manage products with poison labels, all personal care items with warning labels were removed and placed in a secure, locked medication cart in the med room. Further, those residents who are cognizant have been advised that upon finishing in the bathroom, are instructed to take their belongings, shampoos, conditioners, tooth pastes, hair care products, and any other such products back to their room.

Moving forward:

07/15/2025: All staff were trained in regulation 2600.82.c regarding poisonous materials. Further, the administrator will continue to do daily walk through to ensure there are no cleaning products and/or poisonous materials left out and accessible to residents.

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

88a - Surfaces**3. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

At approximately 9:23 a.m., a floor tile near the center of the Dining Room was observed having black tape on the upper right sides to secure the tile to the floor creating a tripping hazard.

Plan of Correction

Accept [REDACTED] 08/27/2026)

Plan of Correction:

Immediately, the Administrator notified the owner and General Manager of the deficiencies. The General Manager then called the contractor, 5 Stone Construction, to schedule work to begin. [REDACTED] at 5 Stone came out and replaced the piece of floor in question. and is working on completing other areas of concern at this time.

Moving forward:

The administrator will conduct building rounds every 5 days to investigate any areas of concern. The administrator will continue to report any areas of concern to the owner, [REDACTED] and the General Manager, [REDACTED]. The administrator has asked all staff to bring any areas of concern for repair to the administrator's attention. The administrator drafted a work order for staff to fill out when an area of concern is found; maintenance is to come fix, investigate, and correct.

Licensee's Proposed Overall Completion Date: 08/26/2026

Implemented [REDACTED] 08/31/2026)

93a - Handrails**4. Requirements**

93a - Handrails (continued)

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

At approximately 10:56 a.m., the handrail in the main stairwell to the second floor was not securely fastened to the wall.

Plan of Correction

Accept [REDACTED] - 08/14/2026)

Plan of Correction:

On 07/14/2026, the administrator inspected the handrail and noted that the bolt was loose. The administrator brought the concern to the General Manager, [REDACTED] and the owner, [REDACTED] for repair. The General Manager then notified the contractor, 5-Stone Construction, to schedule a date for 5-Stone to come out and repair the deficiencies at Gap View. [REDACTED] a representative of 5-Stone, came out this week, on 08/07/26, to repair railing.

Moving forward:

07/15/2026: The administrator will continue to conduct daily audits, inspecting any questionable issues that may require repair or become problems at a later date.

Proposed Overall Completion Date: 08/13/2026

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

100a - Exterior - Free of Hazards**5. Requirements**

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

At approximately 9:15 a.m., during the inspection, the exit ramp located on the west side of the Personal Care home, which is used by residents and emergency medical services as a means of egress, exhibited signs of structural deterioration. The concrete ramp had areas of exposed, corroded reinforcing steel. The ramp surface also displayed deep spalling, delamination, and erosive cracking. The deteriorated areas measured approximately ¾ inch in depth with 5-6 inches in diameter. Additionally, 3 holes were observed in the ramp surface measuring approximately 1-2 inches in depth and at least 8 inches in diameter. The exit ramp was not maintained in good repair and presented a potential safety hazard for residents with mobility devices using the ramp for ingress, egress, and transport.

Repeated Violation: [REDACTED].

Plan of Correction

Accept [REDACTED] - 08/14/2026)

Plan of Correction:

07/14/2026, during a recent complaint inspection, it was discovered that the concrete ramp at the West end of the building is severely deteriorated. It was repaired last winter, but the winter was harsh, and the ramp did not withstand the weather. The administrator notified the GM, [REDACTED] and the owner, [REDACTED] of the seriousness of this situation. The GM, [REDACTED], notified 5-Stone Construction to schedule a day to come out and assess the best way to address the decay. It is poorly constructed and crumbling. [REDACTED] the contractor, came out

100a Exterior Free of Hazards (continued)

last week and began rebuilding the ramp in accordance with the Department of Human Services Regulations. [REDACTED] and [REDACTED] crew have been working diligently on building the ramp to make it safe for our residents, staff, EMS and Fire personnel, and the occasional funeral home. At this time, it will need another week to complete, as it takes concrete/cement at least 28 days to reach its full structural strength. It reaches approximately 70% strength at 7 days, allowing safe foot traffic after 48 hours. At this time, Gap View PCH will continue to restrict activity on the ramp and redirect all residents to use the other entrances. We still have a bit more repair to complete. It is expected to be completed by the end of next week.

Moving forward:

The administrator will continue daily audits of the ramp and other deficiencies found in the building and will continue to report to the owner, [REDACTED] and GM [REDACTED] on areas of concern that require immediate attention and repair.

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

101o - Walls, Floors, Ceilings**6. Requirements**

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

At approximately 10:58 a.m., brown stains that appeared to be water damaged were observed covering approximately 50 % of two ceiling tiles near the middle of the rear ceiling in Resident [REDACTED] room. Another ceiling tile was not securely fastened to the ceiling.

At approximately 10:58 a.m., a 1 ½ ft. x 3 ft. area of raised cracked plaster was observed on the rear upper middle wall in Resident [REDACTED] room.

Plan of Correction

Accept [REDACTED] - 08/19/2026)

Plan of Correction:

07/15/2026, the Administrator immediately notified the owner and General Manager of the deficiencies. The General Manager then called the contractor, 5 Stone Construction, to schedule work to begin. [REDACTED] at 5 Stone came out, began the plaster work on the wall, and removed the loose ceiling tiles. [REDACTED] is working on completing other areas of concern at this time. The plaster on the wall directly below this area was spackled, sealed with an oil based sealer, painted, and finished.

Moving forward:

The administrator will continue to conduct daily audits of resident rooms, looking for deficiencies such as leaks, holes in plaster, loose door railings, etc. For any deficiencies found, the administrator will continue to report them to the owner, [REDACTED] and GM [REDACTED] on areas of concern that require immediate attention and repair.

101o - Walls, Floors, Ceilings (continued)

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

102k - No Common Towel

7. Requirements

2600.

102.k. Use of a common towel is prohibited.

Description of Violation

At approximately 11:56 a.m., there were used, unlabeled bath towels and washcloths hanging in the second-floor shared bathroom near the main stairwell.

Repeated Violation: [REDACTED]

Plan of Correction

Accepted [REDACTED] 08/19/2026)

Plan of Correction:

All personal towels were removed, and the best way to address this was discussed. The residents were asked immediately to please remove their personal property such as towels wash cloths, to please take them back to their room or to place in the dirty linen hamper that is located within the bathroom. The residents that use that rest room are in good cognizant health and fully understand. Housekeeping and the overnight staff have been instructed to please remove and dispose of dirty linens from the restroom immediately if found.

Moving forward:

07/15/2026, the administrator will continue the daily walk-through of all areas of Gap View, including the public restroom and shower/bath areas. Staff were trained in Regulation 2600.102.k Use of a common towel is prohibited.

Proposed Overall Completion Date: 08/13/2026

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

121a - Unobstructed Egress

8. 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

At approximately 9:17 a.m., a detached outside gutter waterspout was observed protruding through the middle of the upper fourth and fifth step of the fire escape blocking the egress.

At approximately 9:17 a.m., a leaf blower was observed laying on the patio at the bottom of the fire escape blocking the egress.

Plan of Correction

Accepted [REDACTED] - 08/19/2026)

Plan of Correction:

121a - Unobstructed Egress (continued)

On 07/14/2026, the day of the complaint inspection, a downed downspout lay between the steps of the exterior fire escape. The administrator immediately went outside and removed the downspout from the area of the steps. The leaf blower was already removed by the cook that day. It was [REDACTED] personal blower, and [REDACTED] left it there till [REDACTED] could take it out to [REDACTED] vehicle. It was already removed by the time the administrator checked.

Moving forward:

On 07/15/2026, the administrator retrained the staff on Regulation 2600.121. A "Stairway, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. This is a concern for the administrator, as the building is small. The administrator will continue to conduct audits of daily areas of concern. That also goes with egress routes.

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

127a - Portable Space Heaters**9. Requirements**

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

At approximately 10:53 a.m., Resident [REDACTED] had a small portable space heater that was in use in their bedroom.

Plan of Correction

Accept [REDACTED] - 08/27/2026)

Plan of Correction:

On 07/14/2026, the administrator met with resident [REDACTED] and explained that space heaters are not allowed per regulation 2600.127.a. [REDACTED] became belligerent and stated, "We cannot take away [REDACTED] heater; [REDACTED] has rights." I gave [REDACTED] a copy of the "house rules" and [REDACTED] "resident rights." At this time, [REDACTED] is not very happy and has stated [REDACTED] will continue to complain to the authorities. I have offered [REDACTED] extra blankets and throws.

Moving forward:

07/15/2026, the administrator retrained the staff on regulation 2600.127.a: "Portable space heaters are prohibited." The administrator will continue to re-educate the staff and residents on the dangers of portable heaters in a facility. The administrator has added portable space heaters to the list of concerns when doing audits.

As of 07/14/2026, the portable space heater has been removed from the resident's room and locked in the basement closet. On 07/15/2026, a letter was sent, followed by a phone call to the resident's son on 07/20/2026, requesting that [REDACTED] please stop by to pick up the portable space heater as soon as possible. To date, there has been no reply.

As of 08/01/2026, the portable space heater in question has been removed from the building and locked in an outside storage shed.

08/24/2026, the space heater in question was removed and given to family.

Licensee's Proposed Overall Completion Date: 08/19/2026

Implemented [REDACTED] - 08/31/2026)

141b1 - Annual Medical Evaluation**10. Requirements**

141b1 Annual Medical Evaluation (continued)

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation*Resident [REDACTED]'s most recent annual medical evaluation was completed on [REDACTED].**Resident [REDACTED]'s most recent medical evaluation was completed on [REDACTED].**Repeated Violation:* [REDACTED]**Plan of Correction****Accept [REDACTED] - 08/19/2026)***Plan of Correction:*

On 07/15/2026, for Resident [REDACTED]: An urgent medical evaluation has been scheduled with the resident's primary care physician for 07/20/2026 - The facility will ensure the DME medical evaluation form is fully completed, signed, and placed in the resident's chart immediately following the appointment. Resident [REDACTED]: A medical evaluation has been scheduled with the resident's primary care physician for 07/21/2026. The completed and signed medical evaluation form will be obtained and filed in the resident's chart immediately following the appointment.

Moving forward:

On 07/15/2026, the Designated Administrator/Resident Care Coordinator (RCC) will conduct a 100% audit of all current resident files by 07/21/2026. This audit will verify that every resident has a valid, completed medical evaluation dated within the past 12 months. Any additional residents found to be out of compliance will have appointments scheduled immediately. The Administrator conducted a documented training session for all administrative and nursing staff on 07/26/2026 regarding the requirements of Regulation 2600.141(b)(1) and the use of the new tracking log.

Licensee's Proposed Overall Completion Date: 08/13/2026**Implemented [REDACTED] - 08/31/2026)****162c Menus Posted****11. 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

At approximately 9:15 a.m., the menu for the month of May was posted. However, the current menu for the week of [REDACTED] through [REDACTED] and the following week of [REDACTED] through [REDACTED] were not posted.

Repeated Violation: [REDACTED]**Plan of Correction****Accept [REDACTED] - 08/19/2026)***Plan of Correction:*

162c Menus Posted (continued)

On 07/15/2026, the menus for the next two weeks were completed and posted. Responsibility for creating menus, ordering, and posting menus was transferred to the assistant, [REDACTED]. Menus are now posted by the front entryway and in the kitchen area. Meals are currently planned for two weeks at a time; however, the plan is to plan out a full month of meals.

Moving forward:

The goal is to have a rotating menu system. The Administrator, assistant, and cook are working on planning this out. The administrator has added the menu board to the monthly audit list. Currently, we are at a full month of menus.

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

221c - Post Activity Calendar**12. Requirements**

2600.

221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

At approximately 9:15 a.m., the Activities calendar for the month of April was posted. However, the current Activities calendar for the week of [REDACTED] through [REDACTED] was not posted.

Plan of Correction

Accept [REDACTED] - 08/19/2026)

Plan of Correction:

On 07/14/2026, it was noted that the activities calendar had not been updated. On 07/15/2026, it was immediately erased and updated with residents' choices. Currently, we do not have a designated activities director. We are working on bringing in volunteers to assist Gap View with activities. Presently, it falls on the Med Tech and the Housekeeper.

Moving forward:

The administrator will continue to monitor the activities calendar. It will become another part of the weekly audit to ensure variety is available for the residents. The staff has been educated on Regulation 2600.221.c, which states, "A current weekly activity calendar shall be posted in a conspicuous and public place in the home."

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)

225a - Assessment 15 Days**13. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident [REDACTED]'s initial assessment dated [REDACTED] documents no problems with resident's ability to use and avoid poisonous materials; however, the medical evaluation dated [REDACTED] documents the resident can not safely use or

225a Assessment 15 Days (continued)

avoid poisonous materials.

Plan of Correction**Accept** [REDACTED] - 08/19/2026)*Plan of Correction:*

On 07/15/2026: The Administrator and the assistant, [REDACTED] a designated staff member, immediately reviewed and revised Resident [REDACTED]'s initial assessment and subsequent support plan. The updated assessment accurately reflects the medical evaluation dated 4/10/26 and notes that the resident cannot safely use or avoid poisonous materials.

Safety Measures: All hazardous materials, household cleaners, and chemicals in the resident's immediate living environment have been removed and locked in the housekeeping closet and/or the locked med cart.

Moving forward, any cleaning products needed by the resident will be handled by the housekeeping staff, and the resident will not be allowed to have any contact with said cleaning products. The admission and assessment process has been updated. The designee completing initial assessments must physically review the signed DME form before or simultaneously with completing the initial assessment form. Staff will utilize a formal reconciliation checklist to cross reference medical restrictions (such as safety awareness, cognitive deficits, and mobility) directly with the corresponding sections of the assessment tool.

On 07/23/2026, the Administrator conducted a mandatory training session for all staff members designated to complete assessments. Training will focus on cross referencing medical evaluations with assessments to ensure absolute document alignment.

The Administrator will conduct a 100% audit of all new resident admissions over the next 90 days.

The Audits will explicitly verify that the medical evaluation dates precede or match the initial assessment dates, and that all clinical limitations regarding toxic materials and daily living skills exactly match.

If 100% compliance is met after 90 days, auditing will transition to a random monthly check of 10% of active resident records during quarterly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] 09/03/2026)**225c - Additional Assessment****14. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

Description of Violation

Resident [REDACTED]'s most recent assessment was completed on [REDACTED].

Plan of Correction**Accept** [REDACTED] - 08/19/2026)*Plan of Correction:*

On 07/15/2025, the Administrator outlined the immediate completion of Resident [REDACTED]'s overdue assessment.

Administrator coordinated with [REDACTED] to redo the DME for Resident [REDACTED], as the original was lost.

The Administrator and Assistant have committed to a 100% audit of all current resident files by 07/24/2026, to

225c Additional Assessment (continued)

catch any other missed or expiring assessment deadlines.

Moving forward:

The fix that the administrator has developed is the implementation of a color coded Master Assessment Tracking Log that flags resident timelines 45 days before they are due, alongside staff retraining by July 30, 2026. Furthermore, the Administrator will continue a monthly audit of the tracking log for a minimum of six consecutive months to ensure sustained compliance.

Licensee's Proposed Overall Completion Date: 08/13/2026

Implemented [REDACTED] - 08/31/2026)