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

February 5, 2025

[redacted], ADMINISTRATOR
SUSAN DOWHOWER PERSONAL CARE HOME LLC
120 SOUTH 10TH STREET
LEBANON, PA, 17042

RE: SUSAN DOWHOWER PERSONAL CARE HOME
120 SOUTH 10TH STREET
LEBANON, PA, 17042
LICENSE/COC#: 33484

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/18/2024 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: *SUSAN DOWHOWER PERSONAL CARE HOME* **License #**: *33484* **License Expiration**: *10/11/2025*

Address: *120 SOUTH 10TH STREET, LEBANON, PA 17042*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *SUSAN DOWHOWER PERSONAL CARE HOME LLC*

Address: *120 SOUTH 10TH STREET, LEBANON, PA, 17042*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/28/2009* **Issued By**: *City of Lebanon*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *31* **Waking Staff**: *23*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *12/18/2024*

Inspection Dates and Department Representative

12/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *31*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *18* **Are 60 Years of Age or Older**: *19*

Diagnosed with Mental Illness: *31* **Diagnosed with Intellectual Disability**: *5*

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

Inspections / Reviews

12/18/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/10/2025*

01/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/03/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/15/2025*

Inspections / Reviews *(continued)*

01/15/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *02/03/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *02/07/2025*

02/05/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *02/03/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

42s - Privacy

1. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home has video recording in the staff office and the exterior areas of the home. However, there are no signs posted in these areas that that indicate images are being recorded.

Plan of Correction ***Accept (- 01/15/2025)***

On 12/18/2024 the Administrator was educated, by a representative of the Department while on-site, on the regulation requiring signs to be posted in areas with cameras indicating that there are video cameras and individuals are being recorded.
On 1/2/25 signs indicating that the area is being recorded under video surveillance were ordered by the Administrator and will be posted in all areas of the facility where cameras are being used. Signs will arrive on 1/13/25 and will be posted. See attached receipt for order.
Beginning 2/1/2025 the Administrator will do a monthly walk through to ensure the signs remain posted and repost if needed.

Proposed Overall Completion Date: 01/13/2025

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented (- 02/04/2025)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On 12/18/2024, at approximately 1:55PM, a puddle of urine was observed on the floor around the toilet and in front of the sink and feces was observed in the back of the toilet bowl in the 1st floor common area bathroom.

On 12/18/2024, at approximately 2:33PM, the overhead vent in the 1st floor entry hallway closest to the staff office had a thick accumulation of dust with the potential to prevent proper ventilation.

On 12/18/2024, at approximately 3:02PM, the 3rd floor hall bathroom did not contain any hand-drying methods.

Plan of Correction ***Accept (- 01/15/2025)***

On 12/18/2024 the bathroom was immediately cleaned by DCS.
On 12/18/24 the Administrator added an additional daily bathroom check to the daily bathroom check schedule that is completed by Housekeeping Staff. Bathrooms were previously being checked and cleaned three times daily and also cleaned as needed in between.
On 12/18/2024 Housekeeping Staff will begin checking all bathrooms at the additional time of 12PM daily and clean them in order to maintain sanitary conditions. Bathrooms will also continue to be cleaned as needed in between checks by Housekeeping Staff as done previously in accordance with the home's policy. See attached updated bathroom cleaning record.

85a - Sanitary Conditions (continued)

On 12/19/24 Staff cleaned and removed dust accumulation on the overhead vent in the bathroom on the first floor entry hallway to allow for proper ventilation.
On 12/19/24 Housekeeping staff was re-instructed by the Administrator on proper dust removal from bathroom exhaust fans and importance of maintaining proper ventilation.
Beginning 2/1/2024 all bathroom exhaust fans will be checked monthly by the facility's Designated Person or the Administrator to ensure they are being cleaned regularly by Housekeeping Staff. See attached monthly exhaust fan check record and staff training record.

On 12/18/2024 Staff fixed the inoperable hand dryer in the 3rd floor hall bathroom. On 12/18/2024 the Administrator added checking hand dryers to the daily bathroom check list used by Housekeeping Staff.
Beginning 12/19/2024 hand dryers will be checked daily by Staff to ensure proper working order. If a hand dryer is found to be inoperable, Staff will report to the Administrator. See attached bathroom check sheet.

On 1/10/2025 all Staff were trained by the Administrator on maintaining sanitary conditions. See attached training record.

Proposed Overall Completion Date: 01/10/2025

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented (█ - 02/05/2025)

86b - Bathroom

3. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 12/18/2024, at approximately 3:04PM, the overhead vent in the 3rd floor hall bathroom had a thick accumulation of dust, preventing proper ventilation. There is no window located in this bathroom.

Plan of Correction ***Directed (█ - 01/15/2025)***

On 12/18/24 dust accumulation was removed by Staff from the overhead exhaust fan in the 3rd floor hall bathroom to allow for proper ventilation.
On 12/18/24 housekeeping staff was re-instructed by the Administrator on dust removal from bathroom exhaust fans and importance of maintaining proper ventilation.
Beginning 2/1/2025 All bathroom exhaust fans will be checked monthly by the facility's designated person or the Administrator to ensure they are being cleaned regularly. See attached monthly exhaust fan check record and staff training record.

Proposed Overall Completion Date: 01/13/2025

Directed Completion Date: *02/01/2025*

Implemented (█ - 02/04/2025)

101r - Bedroom - shades/drapes/window covering

4. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 12/18/2024, at approximately 3:01PM, the right-side bedroom window in resident room #6 did not have drapes, shades, curtains, blinds, or shutters.

Plan of Correction ***Accept (- 01/15/2025)***

On 1/2/2025 a window shade was placed by Staff on the right side bedroom window in resident room #6.
On 1/2/2025 the Housekeeping daily checklist used by Housekeeping Staff was updated by the Administrator to include checking window coverings in resident rooms to make sure they are in good condition and cover the entire window when closed. Housekeeping staff is to notify the Administrator or Designated Person if window coverings need to be replaced.
On 1/9/2025 the Administrator educated Staff on the requirement of having clean window coverings in good repair that cover the entire window on all bedroom windows. See attached record of training.

Proposed Overall Completion Date: 01/13/2025

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented (- 02/04/2025)

141b1 - Annual Medical Evaluation

5. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 1's most recent medical evaluation was completed on However, the resident's prior medical evaluation occurred on

Plan of Correction ***Accept (- 01/15/2025)***

Resident 1 had repeated stays in the hospital since early and several scheduled appointments for the completion of the medical evaluation had to be canceled and rescheduled causing Resident 1's medical evaluation to be completed late. Staff had tried to have the medical evaluation completed by the hospital, but had difficulty because the resident had been moved to different facilities. The resident was also back in the facility for such short times that appointments had to be rescheduled. The DME had to be resent multiple times and was finally completed on 9/19/24 while It was documented according to facility policy why the DME was not done within the time frame. Staff will continue to make every attempt to have the DME completed within the time frame by sending it to the hospital if necessary and continue to document when circumstances beyond our control, such resident hospitalization force rescheduling of appointments.
On 1/5/25 staff was re-instructed by the Administrator on making every attempt to get medical evaluations completed within the time frame and proper documenting when unforeseen circumstances prevent it.
Office Staff currently maintains an ongoing list of DME due dates for the year. In accordance with the home's policy, Office Staff checks the list monthly and schedules appointments as needed, trying to stay three months or more ahead. Office Staff also checks the list monthly to ensure all DME's due in the current month have been completed or have been scheduled.

141b1 - Annual Medical Evaluation (continued)

On 1/10/2025 Staff performed an internal audit of all current DME's to ensure compliance and identify DME's coming due.
Beginning 3/1/2025 Staff will audit DME's quarterly to ensure compliance and identify DME's coming due.

Proposed Overall Completion Date: 01/13/2025

Licensee's Proposed Overall Completion Date: *01/13/2025*

Implemented (█ - 02/04/2025)

187d - Follow Prescriber's Orders

6. Requirements

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

Description of Violation

Resident 2 is prescribed Lispro Kwikpen 100 units with the following sliding scale orders sub-q before meals and at bedtime:
70-200=0 units
201-250=2 units
251-300=4 units
301-350=6 units
351-400=11 units
Over 400 call MD

On 12/17/2024 at 11:00AM, the resident had a blood sugar reading of 253 and was administered 2 units. However, there should have been 4 units administered per the resident's sliding scale orders

Resident 2 is prescribed Meloxicam 7.5mg tab with orders to take one tablet by mouth twice a day. However, on 12/18/2024 at 7:00AM, this medication was not administered because it was not available in the home.

Repeated Violation - 01/10/2024

Plan of Correction ***Accept (█ - 01/15/2025)***

On 12/30/24 upon investigating the administration of 2 units of insulin to resident 2, when 4 units should have been administered, the Administrator found that the error was made due to the Med Tech having difficulty reading the sliding scale chart the way it was written by the prescriber. The chart was written in a way where it could easily be misread and incorrect dose administered as it was written as a paragraph and not in a chart format.
On 12/30/2024 Medication Staff printed and posted a new sliding scale that more clearly shows the glucose reading and the prescribed dose to be administered. see attached previous chart and updated chart.
The administrator will audit MAR insulin administrations weekly for four weeks beginning 1/6/2025 to ensure correct insulin doses are being administered.

Resident 2's prescribed meloxicam was not on hand because it is not a routine medication and was to be taken for a limited time of two weeks and then stopped which was not indicated in the order.
On 12/16/2024 Med staff contacted the prescriber and left a message with the nurse to see if the medication was to be refilled and was told by the nurse that █ would check with the doctor and get back to █ Med staff was still

187d - Follow Prescriber's Orders (continued)

waiting to hear back from the provider as of 12/18/24 when the medication was found not to be on hand. On 12/19/2024 Med staff contacted the prescribing doctor again and was told that the medication was only to be taken for two weeks then stopped and re-ordered if needed but must be stopped for two weeks before it is re-ordered by the prescriber. Going forward the provider will specify on the order of the meloxicam or any other medication if it is to be given for a limited time and discontinued when finished.
On 12/30/2024 Med Staff was also re-instructed by the Administrator that if there are no refills left on a medication it is to be discontinued until a new order is obtained from the prescriber. see attached training record.
On 1/13/2025 Med staff audited all routine medications to ensure there is a current order and they are available in the home.
On 1/13/2025 the Administrator educated staff on following prescriber's orders. See attached training record.
Beginning 2/1/2025 Medication staff will audit all routine medications monthly to ensure there is a current order and the medication is available in the home.

Proposed Overall Completion Date: 01/14/2025

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented (█ - 02/04/2025)

225c - Additional Assessment

7. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 3 is diagnosed with bipolar, major depressive disorder with psychotic features, and anxiety. Resident 3's s current assessment and support plan, dated █ does not include the resident's struggle with judgement as a result of the resident's diagnoses or a plan for how this need will be met.

Plan of Correction ***Accept (█ - 01/15/2025)***

On 12/18/24, Resident 3's RASP was updated by staff to include the resident's struggle with judgement and a plan for meeting that need.
On 1/5/25, Staff was re-instructed by the Administrator on important information to be included in the RASP and when an update is needed.
In accordance with the home's policy, Med Staff currently audits RASPs monthly to ensure updates are being made as needed.
On 1//9/25 Med Staff will continue to audit RASP's monthly in accordance to the home's policy to ensure ongoing compliance.

Proposed Overall Completion Date: 01/14/2025

Licensee's Proposed Overall Completion Date: *02/01/2025*

225c - Additional Assessment *(continued)*

Implemented ([redacted] - 02/05/2025)