



October 16, 2019

Mr. Robert J. Baker
Chief Executive Officer
Keystone Service Systems, Inc.
4391 Sturbridge Drive
Harrisburg, Pennsylvania 17110

RE: KHS Mental Health Services –
Green St. Specialized PC
2900 Green Street
Harrisburg, Pennsylvania 17110
Certificate #: 328780

Dear Mr. Baker:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 6, 2019 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", is written over a light blue horizontal line.

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: GREEN STREET SPECIALIZED COMMUNITY RESIDENCE
Address: 2900 GREEN STREET, HARRISBURG, PA 17110
County: DAUPHIN Region: CENTRAL

License Number: 328780

Administrator

Name: Shannon Housman Phone: 7175588450 Email: shousman@KEYSTONEHUMANSERVICES.ORG

Legal Entity

Name: KEYSTONE SERVICE SYSTEMS INC
Address: 4391 STURBRIDGE DRIVE, PA, 17110

Certificate(s) of Occupancy

Type: R-4 Date: 04/11/2004 Issued By: City of Harrisburg

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 8 Waking Staff: 6

Inspection

Type: Full Reason: Renewal, Incident BHA Docket #: Notice: Unannounced

Inspection Dates and Department Representative

05/06/2019 - On-Site: Kellie Cargile

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 8 Residents Served: 8

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 8 Are 60 Years of Age or Older: 3
Diagnosed with Mental Illness: 8 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 Have Physical Disability: 0

Rec'd
7/2/19
GE

25c4 - Payment Responsibility

Regulations

2600.

25.c. At a minimum, the contract must specify the following:

- 4. The party responsible for payment.

Description of Violation

The resident-home contracts, dated 11/30/16, for Residents #1, #2, and #3, do not specify the party responsible for payment.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- 1. The Program Administrator immediately updated the party responsible on the contract for individuals #1, #2, and #3.
- 2. The Program Administrator, Personal Care Specialist or the SCR LPN, will ensure that payment contract includes who is responsible for payment and use the updated Case File Audit Form to ensure completion moving forward. (Attachment #1)

Legal Entity Representative

Signature 

Printed Name and Title Robert J Baker CEO

Date 7/1/19

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The above plan of correction is approved as of 9/11/19
(Date)

Plan of correction implementation status as of 9/11/19
(Date)

The above plan of correction was approved by GE
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct Care Staff Person A did not receive training in infection control during training year 2018.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- 1. Staff Member A was scheduled for and received training on medical evaluation, assessment and support plan; infection control; and personal care service on 5/13/2019. (Attachment #2)
- 2. The Program Administrator will track employee training progress monthly in Relias, and schedule trainings based on the Professional Development Plan (Attachment #3) and follow up with employees to ensure that trainings have been completed.

Staff training needs will be addressed at the home's periodic quality management reviews. - GE, 9/11/19

Legal Entity Representative


Signature

Robert J. Baker CEO
Printed Name and Title

9/1/19
Date

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65i - Training Record

Regulations

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff Member B, hired 3/4/19, did not have a record of training that included the training topics covered in regulations 65a and 65b.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator immediately added the new employees Initial Program training records to the 2019 Staff Training Binder. The Initial Program Training Log will be used and kept in this binder to ensure completion of training for new employees moving forward. (Attachment #4) Employee B separated employment on 4/19/2019 and therefore his training record was not able to be obtained.

Staff training needs will be addressed at the home's periodic quality management reviews. - GE, 9/11/19

Legal Entity Representative

Signature 

Robert J. Baker CEO 7/1/19
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85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/6/19, during the physical walk-through of the home, there were no paper towels in the first and second floor bathrooms for residents, staff or visitors to use to dry their hands.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator updated the Staff Daily Task Sheet, for each shift to include that each bathroom is to be checked to ensure that paper towels are placed in them. This form will be used daily to ensure completion moving forward. (Attachment #5)

Legal Entity Representative


Signature

Robert J. Baker CEO 7/1/19
Printed Name and Title Date

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103h - Thawing Food

Regulations

2600.

103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

On 5/6/19 at 10:15 am, a package of chicken was being thawed in water in the kitchen sink. It had been thawing in the sink since approximately 9:30 am.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator updated the Staff Daily Task Sheet, for each shift to include the instructions and times on properly thawing meat for the next day (in its original package in the refrigerator, or placed in a sealed container in water in the kitchen sink). This form will be used daily to ensure proper thawing procedures moving forward (Attachment #5)

Kitchen staff will receive training in the proper ways to thaw food upon receipt of this plan. Documentation of training will be kept. - GE, 9/11/19

Legal Entity Representative


Signature

Robert J. Baker CEO 7/1/19
Printed Name and Title Date

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132c - Fire Drill Records

Regulations

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 fire drill record for the drills conducted in January and February of 2019 does not include the date of the month that each of the drills were held.

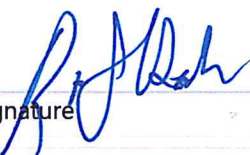
Plan of Correction (POC)

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1. The Program Administrator or Personal Care Specialist will review the Fire Drill log, once a month and use the Fire Drill Log Audit Form to ensure that all documentation is complete and accurate. If there are any errors found, they will be communicated with staff and resolved immediately. (Attachment #6)

The review of the logs will be included in the home's periodic quality management reviews. - GE, 9/11/19

Legal Entity Representative

Signature 

Printed Name and Title Robert J. Baker CEO Date 7/1/19

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132e - Fire Drill Sleeping Hours

Regulations

2600.

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

Description of Violation

The last fire drill conducted during sleeping hours was on 10/24/18 at 1:59 am.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator or the Personal Care Specialist will complete a Fire Drill Log Audit Form each month ongoing to ensure that and overnight fire drill is conducted at least every 6 months. (Attachment #6)

The monthly fire drills will be discussed at the home's periodic quality management reviews. GE, 9/11/19

Legal Entity Representative


Signature

Robert J. Baker CEO 7/1/19
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141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation, dated 10/31/18, does not include the resident's ability to self-administer medications, health status, cognitive functioning, body positioning and the mobility needs assessment.

Resident #2's medical evaluation, dated 1/18/19, does not include the resident's date of birth, temperature, or body positioning.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator or the Personal Care Specialist will review the Medical Evaluations on a monthly basis using the Case File Audit Form (Attachment #1). The information will be reviewed to ensure that it is complete and accurate. If there are any errors found, they will be communicated with staff and resolved immediately.

The administrator will ensure that physicians perform all of the required actions during medical evaluations and document the actions on the form. - GE, 9/11/19

Legal Entity Representative

Signature 

Printed Name and Title Robert J. Baker CEO

Date 7/1/19

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141b1 - Annual Medical Evaluation

Regulations

2600.

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

Description of Violation

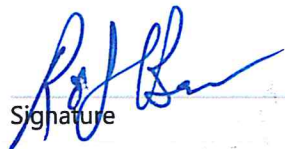
Resident #3's most recent medical evaluation was completed on 3/26/18.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- 1. The Program Administrator, Personal Care Specialist or the SCR LPN, will ensure that physical examinations are completed exactly 12 months apart. The Case File Audit Form will be used to ensure completion moving forward. (Attachment #1)
- 2. The Program Administrator, Personal Care Specialist or the SCR LPN, will ensure that physicals are kept up to date by using the Case File Audit form (Attachment #1) and utilizing monthly reports generated in Total Record to track upcoming due dates.

Legal Entity Representative


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Robert J. Baker CEO 7/1/19
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144c1 - Smoking Area Guidelines

Regulations

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is on the side patio and contains a fireproof receptacle for cigarette butts. At the time of the physical site inspection, 2 cigarette butts were found on the porch floor and approximately 9 butts were on the gravel outside of the smoking area.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator or Personal Care Specialist will conduct weekly audits using the Physical Site Audit Form, which include a review of the outside area of the program for being cigarette butt free. If issues are found, they will be remedied immediately.

The results of the staff's weekly audits of the smoking area will be included in the home's next quality management review. - GE, 9/11/19

Legal Entity Representative


Signature

Robert J. Baker CEO 9/11/19
Printed Name and Title Date

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| | | <input type="checkbox"/> Partially Implemented - Inadequate Progress | |
| | | <input type="checkbox"/> Not Implemented | |

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #2 is prescribed Wixela Inhub, an inhaler to be administered twice a day at 8 am and 8 pm. However, this medication was not administered to the resident from 5/2/19 at 8 pm to 5/6/19 at 8 am, because the medication was not available in the home.

Resident #3 receives blood sugar testing twice daily at 7 am and 4 pm. On 4/5/19, at 4 pm, his blood sugar was not checked as there was no reading recorded in the glucometer or on the medication administration record.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator educated staff on proper completion of medication logs on 5/10/2019. (Attachment #8)
2. The Program Administrator, Personal Care Specialist or the SCR LPN, will ensure that medication records and refills are kept up to date by using the Medication Audit form (Attachment #9). If there are any errors found, they will be communicated with staff and resolved immediately.

The results of the medication audits will be discussed at the home's periodic quality management reviews. GE-9/11/19

Legal Entity Representative


Signature

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Printed Name and Title

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