October 30, 2019

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

RE: KHS Mental Health Services-Chambers St.
Specialized Personal Care
1025 Chambers Street
Harrisburg, Pennsylvania 17113
Certificate #: 304830

Dear Mr. Baker:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 17 and 18, 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,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *KHS MENTAL HEALTH SERVICES CHAMBERS ST SPECIALIZED PC* **License Number:** *30483*
Address: *1025 CHAMBERS STREET, HARRISBURG, PA 17113*
County: *DAUPHIN* **Region:** *CENTRAL*

Administrator

Name: *Natalie Moraa* **Phone:** *7179391979* **Email:** *nmoraa@keystonehumanservices.org*

Legal Entity

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

Certificate(s) of Occupancy

Type: *Other* **Date:** *09/26/2005* **Issued By:** *Swatara Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *7* **Waking Staff:** *5*

Inspection

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

Inspection Dates and Department Representative

07/17/2019 - On-Site: Hope O'Pake

07/18/2019 - On-Site: Hope O'Pake, Laura Heemer

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served:** *7*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older:** *2*
Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *0* **Have Physical Disability:** *0*

5a1 - DHS Access

Regulations

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On July 1, 2019 at 9:00 AM, Hope O'Pake, an agent of the Department, requested access to the home, residents, staff, and all records for the purpose of completing an annual renewal inspection. O'Pake was informed by Staff Member A an Administrator was not available and no staff were available with access to records and necessary information to complete an inspection. After contacting someone at an Administrative level in another Keystone office, Staff Member A confirmed no one would be able to assist O'Pake.

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 DHS visit was rescheduled as there was not a local Program Administrator (PA) available that day. The Regional Director (not PA certified) offered to come to the program but was informed by staff that a PA needed to be present. To address the issue, a process was developed and implemented on 8/7/19 (Attachment #1). The process identifies a backup PA for times that the program PA will be absent. Should DHS arrive to the program without a PA present again, on duty staff will immediately contact the back-up PA and the Regional Director (RD) to inform them that a DHS representative has arrived and will assist the DHS representative with accessing needed information until the back-up PA arrives. The Back-up PA Assignment List (Attachment #2) was created on 8/1/19 and reviewed with staff and implemented on 8/7/19. The list will kept at the program for immediate access of staff on shift

2. To prevent future occurrences of not having a PA on site, the Personal Care Specialist (PCS) will be registered for PA classes on 8/15/19 by the Regional Director and certified as a PA by 10/29/19 thus acting as a back-up for the PA in times of absence.

Legal Entity Representative

Signature: [signature]

Printed Name and Title: **Robert J. Baker, President/CEO**

Date: 8/22/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/25/19 (Date)

Plan of correction implementation status as of 9/25/19 (Date)

- [XX] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

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

16c - Written Incident Report

Regulations

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 July 2, 2019, medications were administered to Resident #1 and Resident #2 at the wrong time. The home did not report this incident to the department.

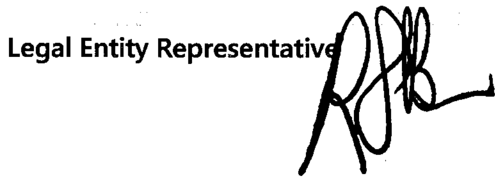
Plan of Correction (POC)

(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. All staff were re-educated on reporting procedures by the Program Administrator in a Training held on 8/7/19 (Attachment #3)
2. To prevent future occurrences, the Program Administrator will review the MARS monthly using the Medication Audit Form updated on 8/1/19 (Attachment #4) that was reviewed with staff and implemented on 8/7/19 (Attachment #5) to ensure that medication errors are reported to DHS. If they were not reported, the PA or LPN will do so immediately by forwarding the incident report.

Reportable incident and condition reporting procedures will be included in the home's next quality management review. - GE, 9/25/19

Legal Entity Representative



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65f - Training Topics

Regulations

2600.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care Staff Member A and Staff Member B did not receive training in medication self-administration or meeting residents' personal care needs using the DME and RASP 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. The Program Administrator, designee or Director of Education will track employee progress in Relias monthly beginning on 8/7/19 and ongoing, and schedule trainings by adding those trainings required by the Department into the Professional Development Plan (Attachment #6). The Program Administrator will follow up with employees to ensure that trainings have been completed.
2. The Program Administrator reviewed the Medication Instructions for residents that are self-administering and had staff sign the Training log on 8/7/2019. (Attachment #7)
3. The Program Administrator used the Pre-Admission Screening form, the RASP and the DME to educate staff on meeting the needs of the residents and had them sign a training log on 8/7/19. (Attachment #8)

Staff training needs will be included in the home's periodic quality management reviews. - GE, 9/25/19

Legal Entity Representative

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85a - Sanitary Conditions

Regulations

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

Description of Violation

The second drawer of the vanity located in the shower room, nearest the living room, contained 2 used tooth brushes with no identifying markings. The bottom drawer of the vanity contained one used, unlabeled tooth brush. These tooth brushes were not in containers and were laying on the bottom surfaces of the drawers. The bottoms of the drawers were marked with dried tooth paste residue.

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. On 7/18/19, the two unidentified toothbrushes were discarded and the drawers were cleaned by the Program Administrator.
2.To address the issue ongoing, the Regional Director updated the Staff Daily Task Sheet on 8/1/19 to include that each bathroom is checked to ensure that any hygiene products are sealed and labeled. The new form (Attachment #9) was reviewed with staff to begin use on 8/7/19 (Attachment #10)

Legal Entity Representative

[signature]

Signature	Printed Name and Title	Date
	Robert J. Baker, President/CEO	8/22/19

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88a - Surfaces

Regulations

2600.

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

Description of Violation

The air conditioner vent located in the ceiling of Resident #2's room has a black mold or mildew-like substance covering approximately 1/3 of its surface area.

The vent in the ceiling of the main bedroom hallway has a heavy accumulation of dust covering the entire surface.

The ceiling vent in the shower room, located in the short resident room hallway, has a heavy accumulation of dust covering its entire surface.

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. On 7/22/19, Personal Care Associates cleaned the air conditioning and ceiling vents.
2. To address the issue ongoing, the Program Administrator will complete the Weekly Physical Site Audits updated on 8/1/19 (Attachment #11) by the Regional Director to include cleaning of the air-conditioning vents and ceiling vents. The new form was reviewed with staff to begin use on 8/7/19 (Attachment #10).

Legal Entity Representative

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[signature]	**Robert J. Baker, President/CEO**	8/22/19

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105g - Lint Removal and Duct Cleaning

Regulations

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

The home does not have records of cleaning of the dryer vent duct and internal and external duct work, according to the manufacturer's instructions.

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. On 7/18/19, The Program Administrator cleaned the lint from the lint trap. The Regional Director will schedule professional duct cleaning by 8/25/19.
2. To prevent future occurrences, the Staff Daily Task sheet (Attachment #9) was updated by the Regional Director on 8/1/19 to include cleaning dryer lint traps after each use. The new form was reviewed with staff and implemented on 8/7/19 (Attachment #10).
3. The Weekly Physical Site Audit (Attachment #11) was updated on 8/1/19 by the Regional Director to include a review of lint traps cleanliness and vent ducts cleaning dates. The new form was reviewed with staff and implemented on 8/7/19 (Attachment #10).
4. The monthly Physical Site Audit will be completed by the PA or designee and if issues are noticed, they will be immediately cleaned by staff on duty.

Legal Entity Representative

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[signature]	**Robert J. Baker, President/CEO**	8/22/19

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126a - Furnace Inspection

Regulations

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home has a "Trane" brand electric heat pump system with a manufacturer's recommendation that the system should be inspected at least once a year by a properly trained service technician. The last inspection and service records the home has for this system were dated 2017.

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. Documentation was obtained by the Regional Director and maintenance was found to have been performed by Daflur on 10/24/18 (Attachment #12).
2. The Regional Director added the annual inspection to the Weekly Physical Site Audit (Attachment #11) on 8/1/19 to assure that the annual inspection is kept on file in the DHS binder located at the program ongoing. The new form was reviewed with staff for implementation on 8/7/19 (Attachment #10).
3. The next service will be scheduled by 11/31/19 by property management.

Legal Entity Representative

[signature]	**Robert J. Baker President/CEO**	8/22/19
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132a - Monthly Fire Drill

Regulations

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of February 2019.

Plan of Correction (POC)

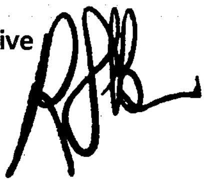
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

1. The Program Administrator will educate staff on the fire drill completion process by 8/31/19.

2. The Program Administrator will review the Fire Drills using the Fire Drill Log Form (Attachment #13) to ensure that fire drill are completed monthly. The updated form was reviewed with staff for implementation on 8/7/19 (Attachment #14).

The review of the logs will be included in the home's periodic quality management reviews. - GE, 9/25/19

Legal Entity Representative



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132b - Safety Inspection/Fire Drill

Regulations

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

No fire safety inspection was conducted in 2019. The last inspection was conducted on 6-6-18.

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 will schedule a fire safety training and inspection by 8/31/19.
2. The annual fire drill inspection and training date was added to the monthly Fire Drill Log Audit Form on 8/1/19 (Attachment #13) This update was reviewed with staff for implementation on 8/7/19 (Attachment #14). The Program Administrator will review this form monthly to ensure that this annual training and inspection scheduling is completed.

Documentation of the inspection and drill will be kept by the home. - GE, 9/25/19

Legal Entity Representative [signature]

Signature — **Robert J. Baker, President/CEO** Printed Name and Title — 8/22/19 Date

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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 allows smoking in a designated smoking area. The front entrance to the home and the rear entrance to the home do not have signs that state, "Smoking Permitted in Designated Smoking Areas Only." There were approximately 4 cigarette butts as evidence of smoking outside of the designated smoking area on the porch floor at the side entrance of the home. There was no sign designating the approved smoking area located at the front porch of the home.

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. On 7/18/19, the cigarette butts were removed from the area by the Personal Care Associate.
2. The Program Administrator will conduct audits using the Weekly Physical Site Audit Form (Attachment #11) which was updated by the Regional Director on 8/1/19 to include review of the outside area of the program for fire hazards. The new form was reviewed with staff for implementation on 8/7/19 (Attachment #10). If issues are found, they will be remedied immediate.
3. Designated smoking area signs will purchased by the Program Administrator and posted in the designated smoking area by 8/31/19.
4."Smoking Permitted in Designated Smoking Areas Only" signs will be purchased by the Program Administrator and posted at the front and rear entrance of the home by 8/31/19.
5. A house meeting will be held by the Program Administrator to review designated smoking areas with the residents by 8/31/19.

Legal Entity Representative

[signature]	**Robert J. Baker, President/CEO**	8/22/19
Signature	Printed Name and Title	Date

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187a - Medication Record

Regulations

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 is prescribed Venlafaxine , Calcium Antacid, Clozapine, Divalproex, and Acetaminophen. However, the medication administration record does not indicate the diagnosis or purpose of the medications.

Resident #2 is prescribed Glipizide and Diphenhydramine. However, the medication administration record does not include the diagnosis or purpose of the medications.

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. On 7/19/19, the LPN added the diagnosis and purpose of the medications to resident #1 and #2's MAR.
2. The LPN will assure that diagnosis and purpose is added to all Medication records ongoing using the Medication Audit Form updated by the Regional Director on 8/1/19 to include checking that diagnosis and purpose and listed on the MAR (Attachment #4). This form was reviewed with staff for implementation on 8/7/19 (Attachment #5).

Legal Entity Representative

[signature] | **Robert J. Baker, President/CEO** | 8/22/19
Signature | Printed Name and Title | Date

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188b - Medication Error Reporting

Regulations

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Residents #1 and #2 received 4:00 PM medications at 12:00 PM on July 2, 2019. The medication error was not reported.

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. Resident #1 was notified along with his designated person and prescriber by the Program Administrator on 8/21/19 (Attachment #15). Resident #2 had his designated person and prescriber notified on 8/21/19 by the Program Administrator (Attachment #16). Resident #2 will be notified by the Program Administrator upon his return to the program from inpatient hospitalization out of the area.
2. All staff were re-educated on reporting procedures by the Program Administrator in a training held on 8/19/19 (Attachment #17)
3. To prevent future occurrences, the Program Administrator will review the MARS monthly using the Medication Audit Form revised on 8/16/19 by the Regional Director (Attachment #4) and reviewed with staff and implemented on 8/19/19 (Attachment #17) to include that all medication errors are to be reported to the resident, the resident's person and the prescriber. If they were not reported, the PA or LPN will do so immediately.

Legal Entity Representative

Signature [signature] | **Robert J. Baker. President/CEO** Printed Name and Title | 8/22/19 Date

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