Department of Human Services
Bureau of Human Service Licensing

October 3, 2022

[redacted], VP OF BUSINESS DEVELOPMENT, KHS
[redacted]

RE: KHS MENTAL HEALTH SERVICES-
REYNOLDS LANE SPECIALIZED PC
5250 REYNOLDS LANE
HARRISBURG, PA, 17111
LICENSE/COC#: 31658

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/10/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *KHS MENTAL HEALTH SERVICES-REYNOLDS LANE SPECIALIZED PC* **License #**: *31658* **License Expiration**: *06/10/2023*

Address: [redacted]

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *KEYSTONE SERVICE SYSTEMS INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-3 SP* **Date**: *06/04/2003* **Issued By**: *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *6* **Waking Staff**: *5*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *08/10/2022*

Inspection Dates and Department Representative

08/10/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *6*

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**: *3*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

08/10/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/29/2022*

Inspections / Reviews *(continued)*

09/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/09/2022*

09/06/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/09/2022*

09/09/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/30/2022*

10/03/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 8/10/2022, the home's licensing summaries issued by the Department, dated 1/11/2022 and 3/12/2020, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept***

The home's licensing summaries dated 1/11/2022 and 3/12/2020 were posted while the licensor was on-site on 8/10/2022 by the Program Administrator; proof of this posting is found in Attachment #1. Keystone Service Systems, Inc. (Keystone) has a process wherein the Program Administrator and/or designated person will post the updated license upon receival and will complete a daily check to ensure that the required postings outlined in 2600.3(c) are still present and in good condition. Upon review of this citation in context to the process, it was discovered that this process was not being followed. The Program Administrator was retrained on regulation 2600.3(c) and the operational process to maintain compliance with this regulation on 8/18/22. Proof of this training is contained in the attachment titled "PA Training Confirmation" provided on 9/6/22.

Completion Date: *09/09/2022*

Document Submission ***Implemented***

Validation documents attached

5a1 - DHS Access

1. Requirements

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 8/10/2022, at approximately 11:20 AM, an agent of the Department requested access to Staff Member A's record. This record was not available at the facility and not submitted to the agent of the Department.

Plan of Correction ***Accept***

Keystone Service Systems, Inc. (Keystone) maintains staff member records within the Human Resource department. Keystone has a process in which, upon request from an agent of the department, the Program Administrator, or the Program Coordinator, will make a formal request to the Human Resources department to obtain the staff members record for the Department within the same date of the request. Upon review of this citation, in context to the process, it was discovered that the Program Administrator did not request all of the documents needed. The Program Administrator was trained on this process, including what documents to request as part of licensing, on 8/25/22 and 8/31/22. Proof of this training is contained in the attachment titled "PA Training Confirmation" provided on 9/6/22.

Completion Date: *09/09/2022*

Document Submission ***Implemented***

Validation documents attached

17 - Record Confidentiality

1. Requirements

17 - Record Confidentiality *(continued)*

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 8/10/2022 at approximately 11:35 AM, an unmarked binder on the kitchen counter containing resident information was unlocked, unattended, and accessible. Documents in the binder included "About Me: What to know when providing me care," with descriptions on: means of communication, mobility skills, dietary needs, incontinence, addictions, social skills and other personal information for current and past residents in the home.

Plan of Correction ***Accept***

The unmarked binder on the kitchen counter containing confidential information was removed from the kitchen counter and locked in the Program Administrators office on the date of the inspection, 8/10/2022 by the Program Administrator. All staff are trained on an annual basis regarding the confidentiality of individual specific information and how to maintain the information consistent with regulatory requirement 2600.17. As a result of this citation, all program staff were re-trained on how the process for securing confidential information on 8/31/22 by the Program Administrator. Proof of this training can be found in the attachment titled "2600.17 - Staff Meeting 8.31.22" provided on 9/6/22. Additionally, the Program Administrator, or the Personal Care Specialist, will complete a daily check to ensure no records are unlocked on a daily basis.

Completion Date: *09/09/2022*

Document Submission ***Implemented***

Validation documents attached

26a - Quality Management Plan

1. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home conducts quality management reviews on an annual basis; however, the most recent quality management review was held on 7/19/2021.

Plan of Correction ***Accept***

Keystone Service Systems, Inc. (Keystone) has a process wherein the Quality Manager will prepare the Quality Management Review for the program approximately 2 weeks prior to the Quality Management Plan expiration and will forward to the Director and the Program Administrator. The data in the Annual Quality Management Review will be reviewed by the Program Administrator. Upon completion of this review, the Program Administrator will forward the signed/dated report to the Director for review and approval. When approved and signed by both parties, the Director will forward the executed report to the Quality Manager to maintain electronically. The Program Administrator will maintain a paper copy at the program. Upon review of the citation, in context to the process, it was founded that the Director nor the Program Administrator reviewed or signed the Quality Management Review. The Director and the Program Administrator were re-trained by the Quality Manager on this process on 9/8/22; proof of this training can be found in the attachment titled "2600.26a - Quality Management Rev Train 9.8.22." Additionally, the next Quality Management Review will take place on 9/23/22.

Completion Date: *09/23/2022*

26a - Quality Management Plan *(continued)*

Document Submission ***Implemented***

Validation documents attached

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Member A, whose first day of work was [redacted], did ~~not~~ receive orientation on general fire safety and emergency preparedness which includes the following topics:

- *Evacuation procedures*
- *Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable*
- *The designated meeting place outside the building or within the fire-safe area in the event of an actual fire*
- *Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable*
- *The location and use of fire extinguishers*
- *Smoke detectors and fire alarms*
- *Telephone use and notification of emergency services*

Plan of Correction ***Accept***

Staff Member A was removed from the scheduled on [redacted] by The Program Administrator due to Staff Member A not having completed all required trainings. Staff Member A was trained on the general fire safety and emergency preparedness on 8/23/22 by the Program Administrator. Keystone Service Systems, Inc. (Keystone) has a process in which prior to any staff working in the Personal Care Home (PCH), the Program Administrator (or the Program Coordinator) will use the SCR On-Site Orientation checklist to ensure all PCH training requirements are met, inclusive of but not limited to, general fire safety and emergency preparedness. Once the staff has been vetted, documentation of the completed trainings checklist will be uploaded to Keystone's electronic learning management system and monitored for completion by the Director. Through review of the process, it was determined that this process was not followed and training did not occur within the first 40 working hours with Staff Member A. As a result, the Program Administrator was retrained on the roles and responsibilities as it relates to using the SCR On-Site Orientation Checklist on 8/25/22 and 8/31/22 by the Director. Proof of this training can be found in the attachment labeled "PA Training Confirmation" provided on 9/6/22. An audit of all of the program staffs' training records will be conducted by the Director to ensure all required trainings have been completed by 9/30/22.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

65b - Rights/Abuse 40 Hours

1. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Member A did not complete training within 40 scheduled working hours in the following topics:

- *Resident rights*
- *Emergency medical plan*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102)*
- *Reporting of reportable incidents and conditions*

Plan of Correction ***Accept***

Staff Member A was removed from the scheduled on [redacted] by the Program Administrator due to not having completed all required trainings. Staff Member A was trained on the resident rights, emergency medical plan, mandatory reporting and OAPSA, as well as reporting of reportable incidents and conditions on 8/23/22 by the Program Administrator. Keystone Service Systems, Inc. (Keystone) has a process in which prior to any staff working in the Personal Care Home (PCH), the Program Administrator (or the Program Coordinator) will use the SCR On-Site Orientation checklist to ensure all PCH training requirements are met, inclusive of but not limited to, training on residents' rights, emergency medical plans, mandatory reporting and OAPSA, as well as reporting of reportable incidents and conditions. Once the staff has been vetted, documentation of the completed trainings checklist will be uploaded to Keystone's electronic learning management system and monitored for completion by the Director. Through review of the process, it was determined that this process was not followed and training did not occur within the first 40 working hours with Staff Member A. As a result, the Program Administrator was retrained on the roles and responsibilities as it relates to using the SCR On-Site Orientation Checklist on 8/25/22 and 8/31/22. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. An audit of all of the program staffs' training records will be conducted by the Director to ensure all required trainings have been completed by 9/30/22.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   vi. Implementation of the initial assessment, annual assessment and support plan.
   vii. Nutrition, food handling and sanitation.
   viii. Recreation, socialization, community resources, social services and activities in the community.
   ix. Gerontology.
   x. Staff person supervision, if applicable.
   xi. Care and needs of residents with special emphasis on the residents being served in the home.
   xii. Safety management and hazard prevention.
   xiii. Universal precautions.
   xiv. The requirements of this chapter.
   xv. Infection control.

Description of Violation

Direct Care Staff Member A, hired on [redacted], began providing unsupervised ADL services prior to completing the following initial direct care staff person training:

- *Safe management techniques*
- *ADLs and IADLs*
- *Personal hygiene*
- *Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities*
- *The normal aging-cognitive, psychological and functional abilities of individuals who are older*
- *Implementation of the initial assessment, annual assessment and support plan*
- *Nutrition, food handling and sanitation*
- *Recreation, socialization, community resources, social services and activities in the community*
- *Gerontology*
- *Staff person supervision, if applicable*
- *Care and needs of residents with special emphasis on the residents being served in the home*
- *Safety management and hazard prevention*
- *Universal precautions*
- *The requirements of this chapter*
- *Infection control*
- *Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition*

Direct Care Staff Member A, hired on [redacted], began providing unsupervised ADL services. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Direct Care Staff Member A, hired on [redacted] began providing unsupervised ADL services. However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice.

65d - Initial Direct Care Training (continued)

Plan of Correction ***Accept***

Staff Member A was removed from the scheduled on [redacted] by the Program Administrator due to not having completed all required trainings. Staff Member A completed and passed the Department-approved direct care training course and competency test, inclusive of required trainings and demonstration of job skills related to activities of daily living (ADL) services on [redacted] Proof of this completion can be found in the attachment titled "2600.65d - Staff Person A ODP Training" provided on [redacted]. Keystone Service Systems, Inc (Keystone) has a process in which prior to any staff working in the Personal Care Home (PCH), the Program Administrator (or the Program Coordinator) will use the SCR On-Site Orientation checklist to ensure all PCH training requirements are met, inclusive of Department- approved direct care training course and competency test. Once the staff has been vetted, documentation of the completed trainings checklist will be uploaded to Keystone's electronic learning management system and monitored for completion by the Director. Through review of the process, it was determined that this process was not followed and training did not occur with Staff Member A prior to providing unsupervised ADL services. As a result, the Program Administrator was retrained on the roles and responsibilities as it relates to using the SCR On-Site Orientation Checklist on 8/25/22 and 8/31/22 by the Director. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. An audit of all of the program staffs' training records will be conducted by the Director to ensure all required trainings have been completed by 9/30/22.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

65i - Training Record

1. Requirements

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

The home's record of direct care staff training does not include a training record for Staff Member A.

Plan of Correction ***Accept***

Keystone Service Systems, Inc. (Keystone) has a process wherein all training records are maintained in Keystone's electronic learning management system. During licensing, Program Administrators are able to print copies of all employees training transcripts and provide this information to the licensor upon request. In review of this citation, it was founded that Staff Member A had a profile in the electronic learning management system that was created on 12/7/2021. A copy of Staff Member A's training transcripts can be found in the attachment titled "2600.65i - Staff Person A Training Transcript" provided on 9/6/22. During the licensing visit on 8/10/2022, the Program Administrator did not provide this information to the licensor upon request. As a result, the Program Administrator was retrained on expectations about providing training records to the Department upon request, the training will include how to retrieve the training records from the electronic learning management system on 8/25/22 and 8/31/22 by the Director. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22.

Completion Date: *09/09/2022*

65i - Training Record *(continued)*

Document Submission ***Implemented***

Validation documents attached

66a - Staff Training Plan

1. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

On 8/10/2022, the home did not have a staff training plan for the training year 2021.

Plan of Correction ***Accept***

A copy of the 2021 Annual Training Plan is contained in Attachment #4. Keystone Service Systems, Inc. (Keystone) has a process wherein all Annual Training Plans are developed and maintained by Keystone's Education Department in conjunction with the Operational Leadership. During licensing, Program Administrators are able to gain copies of the Annual Training Plan from the Education Department. Upon review of this citation, it was founded that the Program Administrator did not provide this information to the licensor upon request. As a result, the Program Administrator will be retrained on expectations about providing annual training plans to the Department upon request; this training will occur by 9/2/2022 and proof of this training will be forthcoming.
Completion Date: *09/02/2022*

Document Submission ***Implemented***

Validation documents attached

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1's bed contains uncovered, bilateral half-length bed rails. The half rail furthest away from the wall was observed to be leaning away from the bed and wobbled loosely when handled, creating a potential safety hazard.

Plan of Correction ***Accept***

Resident #1 was provided a new bed without bed rails on 8/26/2022 by the Property Manager. Proof can be found in Attachment #1. Keystone Service Systems, Inc (Keystone) has a process in which program standards, including but not limited to ensuring wheelchairs, walkers, prosthetic devices and other apparatus used by residents are to be formally assessed and monitored weekly through the use of the SCR Weekly Site Audit. Through review of the process, it was determined that the SCR Weekly Site Audit was not being completed and/or monitored to ensure compliance with physical site standards. As a result, the Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director as it relates to the use of and monitoring of the SCR Weekly Site Audit. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Administrator resumed their responsibility to complete the SCR Weekly Site Audit on 9/1/22. The Director will be responsible to ensure accuracy and completion through oversight of the SCR Weekly Site Audit completed by the Program Administrator (or the Program Coordinator).
Completion Date: *09/09/2022*

81b - Resident Personal Equipment *(continued)*

Document Submission ***Implemented***

Validation documents attached

82c - Locking Poisonous Materials

1. 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

On 8/10/2022, at approximately 9:55 AM, Clorox Clean-Up Disinfectant Cleaner with Bleach and Clorox Toilet Bowl Cleaner Clinging Bleach Gel with manufacturer's labels indicating, "If Swallowed: call poison control center or doctor immediately," were unlocked, unattended and accessible to Resident #2 in the downstairs bathroom. Resident #2 has not been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept***

During the licensing visit on 8/10/2022, the Program Administrator locked all poisonous materials in a location that is inaccessible by residents. A doctor's appointment will be scheduled by [redacted] *in order for Resident #2 to be formally assessed for capability of recognizing and using poisons safely within the home. Keystone Service Systems, Inc (Keystone) has a process in which program standards, including but not limited to ensuring all poisonous materials are locked and inaccessible to residents is to be formally assessed and monitored weekly through the use of the SCR Weekly Site Audit. Through review of the process, it was determined that the SCR Weekly Site Audit was not being completed and/or monitored to ensure compliance with physical site standards. As a result, the Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director as it relates to the use of and monitoring of the SCR Weekly Site Audit. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Administrator resumed their responsibility to complete the SCR Weekly Site Audit on 9/1/22. The Director will be responsible to ensure accuracy and completion through oversight of the SCR Weekly Site Audit completed by the Program Administrator (or the Program Coordinator). The Director will conduct an audit of all residents' records to ensure they are assessed for capability of recognizing and using poisons safely by 9/30/22. If it is identified that a resident's assessment does not include their ability or lack thereof to be safe around poisons, all staff will be notified immediately to ensure poisons are locked up. The resident will be scheduled for an evaluation to determine their ability to recognize poisons.*

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

On 8/10/2022, at approximately 9:55 AM, the "Covid room"/lounge in the home's basement was observed to have dead bugs outlining the perimeter walls of the room.

85a - Sanitary Conditions (continued)

On 8/10/2022, at approximately 10:15 AM, Resident #1's bedroom smelled of a strong urine odor.

Plan of Correction ***Accept***

On 8/23/2022, the home's basement was cleaned and the dead bugs were disposed of by the Program Administrator and Direct Support Professional. Additionally, Resident #1's bedroom was cleaned while licensor was on site. Keystone Service Systems, Inc (Keystone) has a process in which program standards, including but not limited to ensuring sanitary conditions are to be formally assessed and monitored weekly through the use of the SCR Weekly Site Audit. Through review of the process, it was determined that the SCR Weekly Site Audit was not being completed and/or monitored to ensure compliance with physical site standards. As a result, the Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director as it relates to the use of and monitoring of the SCR Weekly Site Audit. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Administrator resumed their responsibility to complete the SCR Weekly Site Audit on 9/1/22. The Director will be responsible to ensure accuracy and completion through oversight of the SCR Weekly Site Audit completed by the Program Administrator (or the Program Coordinator). As an additional oversight to cleanliness of Individual #1's bedroom, a daily task will be initiated through Keystone's electronic task tracking software by 9/2/2022. This task will be maintained to ensure Individual #1's bedroom is cleaned on a daily basis by staff. Proof of this task tracking implementation can be found in the attachment titled "2600.85a - Resident #3 Task Tracking" provided on 9/6/22.

Completion Date: *09/09/2022*

Document Submission ***Implemented***

Validation documents attached

101j3 - Bed/Linens/Pillows/Blankets

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 8/10/2022, at approximately 3:50 PM, the bed for Resident #2 was without bed linens and pillow case which were not being laundered at the time. The pillow was observed to have red and brown stains.

Repeated Violation - 1/11/2022, et al

Plan of Correction ***Accept***

Resident #2 was provided new protective pillowcases and sheets on 8/26/2022 by the Program Administrator. Proof of this can be found in Attachment #2. Keystone Service Systems, Inc (Keystone) has a process in which program standards, including but not limited to ensuring all residents have clean pillows, bed linens and blankets are to be formally assessed and monitored weekly through the use of the SCR Weekly Site Audit. Through review of the process, it was determined that the SCR Weekly Site Audit was not being completed and/or monitored to ensure compliance with physical site standards. As a result, the Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director as it relates to the use of and monitoring of the SCR Weekly Site Audit. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Administrator resumed their responsibility to complete the SCR Weekly Site Audit on 9/1/22. The Director will be responsible to

101j3 - Bed/Linens/Pillows/Blankets (continued)

ensure accuracy and completion through oversight of the SCR Weekly Site Audit completed by the Program Administrator (or the Program Coordinator).

Completion Date: *09/09/2022*

Document Submission ***Implemented***

Validation documents attached

101j7 - Lighting/Operable Lamp

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 8/10/2022, Residents #2 and #3 did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept***

A wall mounted light that can be turned on/off from the residents' bedside was added to the residents' rooms by the Program Administrator. Proof of the light installation can be found in the attachment titled "2600.101j7 - Wall Mounted Lights" provided on 9/6/22. Keystone Service Systems, Inc (Keystone) has a process in which program standards, including but not limited to ensuring all residents have access to a light source that can be turned on/off at their bedside, are to be formally assessed and monitored weekly through the use of the SCR Weekly Site Audit. Through review of the process, it was determined that the SCR Weekly Site Audit was not being completed and/or monitored to ensure compliance with physical site standards. As a result, the Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director as it relates to the use of and monitoring of the SCR Weekly Site Audit. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Administrator resumed their responsibility to complete the SCR Weekly Site Audit on 9/1/22. The Director will be responsible to ensure accuracy and completion through oversight of the SCR Weekly Site Audit completed by the Program Administrator (or the Program Coordinator).

Completion Date: *09/09/2022*

Document Submission ***Implemented***

Validation documents attached

101r - Bedroom - shades/drapes/window covering

1. 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 8/10/2022 at approximately 4:00 PM, the window blinds in Resident #4's bedroom were observed to have broken slats.

Plan of Correction ***Accept***

The blinds in Resident #4's bedroom were replaced on 8/26/2022 by the Program Administrator. Proof can be found in Attachment #3. Keystone Service Systems, Inc (Keystone) has a process in which program standards, including but not limited to ensuring window coverings are clean and in good repair, are to be formally assessed and monitored weekly through the use of the SCR Weekly Site Audit. Through review of the process, it was determined that the

101r - Bedroom - shades/drapes/window covering (continued)

SCR Weekly Site Audit was not being completed and/or monitored to ensure compliance with physical site standards. As a result, the Program Administrator was trained on 8/25/22 and 8/31/22 by the Director as it relates to the use of and monitoring of the SCR Weekly Site Audit. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Administrator resumed their responsibility to complete the SCR Weekly Site Audit on 9/1/22. The Director will be responsible to ensure accuracy and completion through oversight of the SCR Weekly Site Audit completed by the Program Administrator (or the Program Coordinator).

Completion Date: *09/09/2022*

Document Submission ***Implemented***

Validation documents attached

107d - Procedure Emergency Management Agency Submission

1. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed, updated, or submitted to the local emergency management agency since 1/12/2021.

Plan of Correction ***Accept***

On 8/26/2022, the home's written emergency procedures were submitted to the local emergency management agency by the Program Administrator. Proof of this submittal can be found in the attachment titled "2600.107d - Emergency Management Letter". Through a review of this citation, it was determined that Keystone Service Systems, Inc. (Keystone) did not have a process in place to ensure compliance with regulation 2600.107(d). As a result, a process was put in place in which the Administrative Assistant will prompt the Director and Program Administrators on a monthly basis to identify any changes that would require sending updated information to the local emergency management agency. Should a new notification be needed, the Program Administrator will complete the notification within one week of identification and provide a copy of this notification to Administrative Assistant for documentation purposes. The Program Administrator and Administrative Assistant will be trained on this new process by 9/30/22 by the Director.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

124 - Notice to Fire Department

1. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept***

On 8/26/2022, written notification was sent to the local fire department containing the home's address, the

124 - Notice to Fire Department (continued)

location of the bedrooms, and assistance needed to evacuate in an emergency by the Program Administrator. Proof of this notification can be found in the attachment titled "2600.124 - Notification to Local FD". Through a review of this citation, it was determined that Keystone Service Systems, Inc. (Keystone) did not have a process in place to ensure compliance with regulation 2600.124. As a result, a process was put in place in which the Administrative Assistant will prompt the Director and Program Administrator 30 days prior to the emergency procedure needing to be reviewed, updated, and submitted to the local Fire Department. The Program Administrator and Administrative Assistant will be trained on this new process by 9/30/22 by the Director.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

130f - Testing Smoke Detectors

1. Requirements

2600.
130.f. Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

Description of Violation

The home's smoke detectors and fire alarms were not tested since 3/14/2022.

Plan of Correction ***Accept***

A fire drill was conducted by the Program Administrator on 9/8/22 where all smoke detectors and fire alarms in the home were tested. Proof of this completed fire drill can be found in the attachment titled "Fire Drill 9.8.22." Keystone Service Systems, Inc. (Keystone) has a process wherein the smoke detectors and fire alarms are tested during the monthly fire drill. Documentation of the fire drills and testing are maintained electronically. Completion of fire drills and testing of alarms are monitored monthly by administrative staff. Upon review of this citation, it was identified that program staff were not utilizing the electronic form, and were using a paper form that did not contain all the required fields, including testing smoke detectors and fire alarms. Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director on the fire drill and testing process. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. Additionally, program staff were trained on using the electronic fire drill form on 8/31/22 by the Program Administrator. Proof of this training can be found in the attachment titled "2600.130f - Staff Meeting 8.31.22" provided on 9/6/22. Administrative staff will continue to monitor completion monthly. The Director will complete quarterly checks to ensure ongoing compliance with process. The first quarterly check will occur on 10/15/22.

Completion Date: *10/15/2022*

Document Submission ***Implemented***

Validation documents attached

132a - Monthly Fire Drill

1. Requirements

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 months of December of 2021 and February, April, May, June and July of 2022.

132a - Monthly Fire Drill *(continued)*

Plan of Correction ***Accept***

An unannounced fire drill was conducted by the Program Administrator on 9/8/22. Proof of this completed fire drill can be found in the attachment titled "Fire Drill 9/8/22." Keystone Service Systems, Inc. (Keystone) has a process wherein the monthly fire drills are to be completed monthly. Documentation of the fire drills and testing are maintained electronically. Completion of fire drills and testing of alarms are monitored monthly by administrative staff, including keeping track of duration between fire drills conducted unannounced Upon review of this citation, it was identified that program staff were not utilizing the electronic form, and were using a paper form that did not contain all the required fields, and prevented reporting by administrative staff. Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director on the fire drill process. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. Additionally, program staff were retrained on the fire drill process on 8/31/22 by the Program Administrator. Proof of this training can be found in the attachment titled "2600.132a - Staff Meeting 8.31.22" provided on 9/6/22. Administrative staff will continue to monitor completion monthly. Director of SCR Services will complete quarterly checks to ensure ongoing compliance with process. The first quarterly check will occur on 10/15/22.

Completion Date: *10/15/2022*

Document Submission ***Implemented***

Validation documents attached

132b - Safety Inspection/Fire Drill

1. Requirements

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

The last fire safety inspection and fire drill observed by a fire safety expert was not conducted by December 31, 2021.

Plan of Correction ***Accept***

The Program Administrator contacted a local fire safety expert on 8/28/22 and is awaiting confirmation of a scheduled observed fire drill. Keystone Human Services, Inc (Keystone) has a process in which observed fire drills are scheduled with a fire safety expert three months prior to the yearly due date. This yearly inspection will include a supervised fire drill and verification of the amount of time it should take residents to get out of the house during a fire drill. Through review of the process, it was determined that the Program Administrator was not following this process. As a result, the process was reevaluated. Keystone's new process will require the Administrative Assistant to notify the Program Administrator and Director 30 days prior to the expiration of the annual observed fire drill by a safety expert. The Program Administrator will then schedule an observed fire drill by a safety expert within one week of this notification. The Director will follow up with the Program Administrator to ensure the scheduling of the fire drill. The Administrative Assistant and Program Administrator will be trained on this new process by 9/30/22. The first quarterly check will occur on 10/15/22. review of the process, it was determined that the Program Administrator was not following this process. As a result, the Program Administrator will be retrained by 9/2/2022 as it relates to the above process. Proof of this training will be forthcoming. The Director (or designee) will be responsible to ensure completion of these annual requirements.

Completion Date: *10/15/2022*

132b - Safety Inspection/Fire Drill *(continued)*

Document Submission ***Implemented***

Validation documents attached

132c - Fire Drill Records

1. Requirements

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 drill conducted on 1/18/2022 does not include the number of residents in the home at the time of the drill.

Plan of Correction ***Accept***

A fire drill was conducted by the Program Administrator on 9/8/22 where all smoke detectors and fire alarms in the home were tested. Proof of this completed fire drill can be found in the attachment titled "Fire Drill 9.8.22". Keystone Service Systems, Inc. (Keystone) has a process wherein the number of individuals present during the fire drill is included on the fire drill form during the monthly fire drill. Documentation of the fire drills and how many individuals are present are maintained electronically. Completion of fire drills is monitored monthly by administrative staff. Upon review of this citation, it was identified that program staff were not utilizing the electronic form, and were using a paper form that did not contain all the required fields. The Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director on the fire drill and testing process. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22.. Additionally, program staff were trained on using the electronic fire drill form on 8/31/22 by the Program Administrator. Proof of this training can be found in the attachment titled "2600.132a - Staff Meeting 8.31.22." Administrative staff will continue to monitor completion monthly. The Director will complete quarterly checks to ensure ongoing compliance with process. The first quarterly check will occur on 10/15/22.

Completion Date: *10/15/2022*

Document Submission ***Implemented***

Validation documents attached

132e - Fire Drill Sleeping Hours

1. Requirements

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 10/14/2021 at 11:10 PM.

Plan of Correction ***Accept***

A fire drill conducted during sleeping hours was conducted by the Program Administrator on 9/8/22. Proof of this completed fire drill can be found in the attachment titled "Fire Drill 9.8.22". Keystone Service Systems, Inc. (Keystone) has a process wherein the monthly fire drills are to be completed monthly. Documentation of the fire drills and testing are maintained electronically. Completion of fire drills and testing of alarms are monitored monthly by

132e - Fire Drill Sleeping Hours (continued)

administrative staff, including keeping track of duration between fire drills conducted during sleeping hours. Upon review of this citation, it was identified that program staff were not utilizing the electronic form, and were using a paper form that did not contain all the required fields, and prevented reporting by administrative staff. Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director on the fire drill process. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. Additionally, program staff were trained on using the electronic fire drill form on 8/31/22 by the Program Administrator. Proof of this training can be found in the attachment titled "2600.132e - Staff Meeting 8.31.22." Administrative staff will continue to monitor completion monthly. The Director will complete quarterly checks to ensure ongoing compliance with process. The first quarterly check will occur on 10/15/22.

Completion Date: *10/15/2022*

Document Submission ***Implemented***

Validation documents attached

141a 1-10 Medical Evaluation Information

1. Requirements

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 [redacted], did not include the use of bilateral half-rails on the resident's bed.

Resident #2's medical evaluation, dated [redacted], did not include body positioning and movement.

Resident # 3's medical evaluation, dated, [redacted], did not include a mobility needs assessment.

Resident #4's medication evaluation, dated [redacted], did not include the ability to self-administer medications.

Repeated Violation - 3/12/2020

Plan of Correction ***Accept***

Resident #1's evaluation was scheduled for [redacted]. Resident #2's evaluation is scheduled for [redacted]. Resident #3's evaluation is scheduled for [redacted]. Resident #4's evaluation was scheduled for [redacted] Proof of all scheduled evaluations can be found in the attachment titled "2600.141a&b - Res 1,2,3,&4 Eval Sched" provided 9/6/22. Keystone Service Systems, Inc. (Keystone) has a process wherein the Program Administrator, or the Program Coordinator, will complete a review of all required documentation for admission and annually thereafter, inclusive

141a 1-10 Medical Evaluation Information (continued)

of ensuring the medical exam was/is completed in its entirety and all information is correct prior to uploading into Keystone's electronic healthcare record. All annual documents will be housed in the residents electronic care record, including a scanned copy of the medical exam. Through review of this citation, it was identified that the Program Administrator was not reviewing and uploading these documents to the electronic care record. Keystone did not have a process to monitor the above process. As of 9/2/2022, the administrative assistant will complete a bi-monthly spot check to ensure documentation is uploaded and complete. The administrative assistant was trained on this new process on 8/29/22 by the Director; proof of this training can be found in the attachment titled "2600.141a&b - Admin Training on DME" provided on 9/6/22. The Program Administrator was trained on this new process on 8/25/22 and 8/31/22 by the Director; Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Coordinator will conduct an audit of all residents' records by 9/30/22 to ensure medical evaluations are completed in their entirety. Should a resident's evaluation be found to have missing information, the Program Coordinator will reach out to the resident's physician to complete the information. Copies of the contacts with the physician will be maintained as an attempted contact note, and any supporting documentation will be uploaded to the electronic care record. If needed, a new doctor's appointment will be scheduled to occur within 30 days of missing information being identified.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation document attached

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

On 8/10/2022, Resident #1's most recent medical evaluation was completed on [redacted]
Resident #2's most recent medical evaluation was completed on [redacted].
Resident #3's most recent medical evaluation was completed on [redacted]
Resident #4's most recent medical evaluation was completed on [redacted]

Plan of Correction ***Accept***

Resident #1's evaluation was scheduled for [redacted]. *Resident #2's evaluation is scheduled for* [redacted]. *Resident #3's evaluation is scheduled for* [redacted]. *Resident #4's evaluation was scheduled for* [redacted]. *Proof of all scheduled evaluations can be found in the attachment titled "2600.141a&b - Res 1,2,3,&4 Eval Sched" provided* [redacted]
Keystone Service Systems, Inc. (Keystone) has a process wherein the Program Administrator or the Program Coordinator will complete a review of all required documentation for admission and annually thereafter, inclusive of ensuring the medical exam was/is completed in its entirety and all information is correct prior to uploading into Keystone's electronic healthcare record. All annual documents will be housed in the residents electronic care record, including a scanned copy of the medical exam. Through review of this citation, it was identified that the Program Administrator was not reviewing and uploading these documents to the electronic care record. Keystone did not have a process to monitor the above process. As of 9/2/2022, the administrative assistant will complete a bi-monthly spot check to ensure documentation is uploaded and complete. The administrative assistant was trained on this new process on 8/29/22 by the Director; proof of this training can be found in the attachment titled "2600.141a&b - Admin Training on DME" provided on 9/6/22. The Program Administrator was trained on this new process on

141b1 - Annual Medical Evaluation (continued)

8/25/22 and 8/31/22 by the Director; Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Coordinator will conduct an audit of all residents' records by 9/30/22 to ensure medical evaluations are completed in their entirety. Should a resident's evaluation be found to have missing information, the Program Coordinator will reach out to the resident's physician to complete the information. Copies of the contacts with the physician will be maintained as an attempted contact note, and any supporting documentation will be uploaded to the electronic care record. If needed, a new doctor's appointment will be scheduled to occur within 30 days of missing information being identified.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

144c1 - Smoking Area Guidelines

1. Requirements

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

On 8/10/2022, at approximately 3:45 PM, the ground area under the back outside deck was covered in 50+ cigarette butts. The home permits smoking on the back outside deck, which is the designated smoking area.

Plan of Correction ***Accept***

All cigarette butts were cleaned up by the Program Administrator. Program Administrator will provide education to all residents at the next house meeting, to occur by 9/15/2022, on safe disposal of cigarette butts in the disposal bins on either end of the outside deck. Keystone Service Systems, Inc (Keystone) has a process in which program standards, including but not limited to ensuring sanitary conditions, are to be formally assessed and monitored weekly through the use of the SCR Weekly Site Audit. Through review of the process, it was determined that the SCR Weekly Site Audit was not being completed and/or monitored to ensure compliance with physical site standards. As a result, the Program Administrator was retrained on 8/25/22 and 8/31/22 by the Director as it relates to the use of and monitoring of the SCR Weekly Site Audit. Proof of this training can be found in the attachment titled "PA Training Confirmation" provided on 9/6/22. The Program Administrator resumed their responsibility to complete the SCR Weekly Site Audit on 9/1/22. The Director will be responsible to ensure accuracy and completion through oversight of the SCR Weekly Site Audit completed by the Program Administrator (or the Program Coordinator). Additionally, the Program Administrator will train all program staff by 9/30/22 on proper disposal of cigarette butts as well as daily checks of the outside of the program to ensure cigarette butts are cleaned up immediately.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

185a - Implement Storage Procedures

1. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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

Resident #1 is prescribed to have a [redacted] three times daily. The [redacted] did not match the numbers transcribed on the Medication Administration Record. The [redacted] on 8/9/2022 at 5:50 PM was [redacted]; the number documented on the blood glucose documentation form was [redacted]

On [redacted] 2022 at approximately [redacted] PM, Resident #1's [redacted] was not calibrated to the correct time.

Plan of Correction ***Accept***

Resident #1's [redacted] was calibrated on [redacted]/2022. Keystone Service Systems, Inc. (Keystone) has a process in that all individuals utilizing a [redacted] are monitored by Keystone staff. During use of the glucometer, the monitoring staff will review the [redacted] reading and document the blood sugar level, date and time within the electronic medication administration record (eMAR). Keystone did not have a standardized process to monitor oversight of the reconciliation between the entries made in the eMAR and the [redacted]. Therefore, a new process has been established in which the Program Administrator (or the Program Coordinator) will reconcile entries within the glucometer to the eMAR on a weekly basis. Documentation of this review will occur using the eMAR. If errors are identified, the staff completing the reconciliation will alert the Program Administrator and appropriate follow-up will occur, inclusive of documenting follow-up actions in the eMAR. The Program Administrator was trained on this process by the Director on 8/25/22 and 8/31/22. Proof of this training can be found in the attachment titled "PA Training Confirmation." Additionally all staff will be re-trained by 9/16/22 as it relates to the glucometer documentation and reconciliation with the eMAR by the Program Administrator. As of 8/29/2022, Keystone created and filled a new position, titled Health Services Manager. The Health Services Manager will begin quarterly site checks, including glucometer reconciliation, in November 2022.

Completion Date: *11/30/2022*

Document Submission ***Implemented***

Validation documents attached

191 - Resident Right to Refuse

1. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #3, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept***

Resident #3 was educated by the Program Administrator on their right to refuse medication on [redacted] Proof of this education can be found in the attachment titled "2600.191 - Resident #3 Education" provided on [redacted] Keystone Service Systems, Inc. (Keystone) has a process in that all individuals are educated on the right to refuse medication at intake. Documentation for this training is contained within the residential contract. Through review of this citation, it was found that staff were using an old version of the form, rather than using the new one built into the electronic

191 - Resident Right to Refuse (continued)

care record. This old version did not contain the resident's right to refuse medication. The Program Administrator was retrained on the use of the electronic version of the form to ensure individuals receive this education by the Director on 8/25/22 and 8/31/22. Proof of this training can be found in the attachment titled "PA Training Confirmation." The Program Administrator will begin to use the electronic intake form as of 9/1/22. Additionally, an audit of all residents' records will be conducted by the Director to ensure all residents have been educated on their right to refuse medication and that this has been documented in their electronic health care record. If this information is missing from any residents' records, the Director will send an email notification to the Program Administrator to have this issue rectified. Within 72 hours of receiving the email notification, the Program Administrator will provide education on the right to refuse medications to the identified resident and complete documentation in their electronic health record. This audit will be completed by 9/30/22.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

On 8/10/2022, Resident #1's most recent assessment was completed on [redacted].
Resident #2's most recent assessment was completed on [redacted].
Resident #3's most recent assessment was completed on [redacted].
Resident #4's most recent assessment was completed on [redacted]

Plan of Correction ***Accept***

All residents will have an updated assessment by [redacted]. *Keystone Service Systems, Inc. (Keystone) has a process wherein the Program Administrator (or the Program Coordinator) will run the Service Document Due Date report through the electronic health record on a monthly basis to ensure that annual assessments that are coming due are completed timely. The administrative assistant will complete a spot check bi-annually to ensure annual assessments are completed in accordance with the regulatory requirements. The Program Administrator was trained on the above process for monitoring annual assessment requirements by the Director on 8/25/22 and 8/31/22; proof of this training can be found in the attachment titled "PA Training Confirmation." Additionally, the Director will conduct an audit to ensure that all residents' assessments have been completed within 12 months of the previous assessment. This audit will be completed by 9/30/22.*

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

227c - Support Plan Revision

1. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

227c - Support Plan Revision *(continued)*

Description of Violation

On 8/10/2022, Resident #1's most recent support plan was completed on [redacted].
Resident #2's most recent support plan was completed on [redacted].
Resident #3's most recent support plan was completed on [redacted].
Resident #4's most recent support plan was completed on [redacted]

Plan of Correction ***Accept***

All residents will have an updated support plan by [redacted]. Keystone Service Systems, Inc. (Keystone) has a process wherein the Program Administrator (or the Program Coordinator) will run the Service Document Due Date report through the electronic health record on a monthly basis to ensure that annual assessments that are coming due are completed timely. The administrative assistant will complete a spot check bi-annually to ensure annual assessments are completed in accordance with the regulatory requirements. The Program Administrator was trained on the above process for monitoring annual assessment requirements by the director on 8/25/22 and 8/31/22; proof of this training can be found in the attachment titled "PA Training Confirmation." Additionally, the Director will conduct an audit to ensure that all residents' support plans have been completed within/by their annual due date. This audit will be completed by 9/30/22.

Completion Date: *09/30/2022*

Document Submission ***Implemented***

Validation documents attached

227d - Support Plan Medical/Dental

1. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The support plan for Resident #1 does not indicate a medical need for the use of the resident's [redacted].

Plan of Correction ***Accept***

Resident #1 was provided a new bed without [redacted] on 8/26/2022 by the Property Manager. Proof can be found in Attachment #1. Keystone Service Systems, Inc (Keystone) created and filled a new position, titled Health Services Manager. The Health Services Manager will complete quarterly site checks, inclusive of ensuring residents support plans document medical support services that a resident's physician, physician's assistant, or certified registered nurse practitioner have deemed necessary. The quarterly site checks will begin November 2022. Additionally, the Director and Health Services Manager will provide training to the Program Administrator by 9/30/22 on the process outlined above. The Health Services Manager will also provide training to the program staff on the use of bed rails by 10/15/22.

Completion Date: *10/15/2022*

227d - Support Plan Medical/Dental *(continued)*

Document Submission ***Implemented***

Validation documents attached