

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

December 22, 2023

[REDACTED]  
KEYSTONE SERVICE SYSTEMS INC  
[REDACTED]

RE: KHS MENTAL HEALTH SERVICES-  
CHAMBERS ST. SPECIALIZED PC  
1025 CHAMBERS STREET  
HARRISBURG, PA, 17113  
LICENSE/COC#: 30483

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/11/2023, 10/12/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *KHS MENTAL HEALTH SERVICES-CHAMBERS ST. SPECIALIZED PC* License #: 30483 License Expiration: 06/17/2024

Address: 1025 CHAMBERS STREET, HARRISBURG, PA 17113

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: 06/26/2005 Issued By: *Department of Labor and Industry*

**Staffing Hours**

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

**Inspection Information**

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

Reason: *Renewal, Incident* Exit Conference Date: 10/12/2023

**Inspection Dates and Department Representative**

10/11/2023 - On-Site: [REDACTED]

10/12/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: [REDACTED] 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: [REDACTED] Are 60 Years of Age or Older: [REDACTED]

Diagnosed with Mental Illness: [REDACTED] Diagnosed with Intellectual Disability: 0

Have Mobility Need: 0 Have Physical Disability: 0

**Inspections / Reviews**

10/11/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: 10/27/2023

Inspections / Reviews (*continued*)

## 10/30/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 12/19/2023  
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/06/2023

## 11/03/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 12/19/2023  
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 12/18/2023

## 12/22/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: 12/19/2023  
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 [redacted] at approximately [redacted], the home's current violation report, dated [redacted], was not posted in a conspicuous and public place in the home.

Plan of Correction

Accepted [redacted] - 11/03/2023)

The personal care home's licensing inspection summary (LIS) dated [redacted] was posted while the licensor was on-site on [redacted] by the Program Administrator; proof of this posting is found in Attachment #1. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring licensing inspection summaries are posted, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.3(c ) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.3(c) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] - 12/22/2023)

16c - Written Incident Report

2. Requirements

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 [redacted], Resident [redacted] did not receive [redacted] medications. The home did not report this medication error to the Department until [redacted].

On [redacted], Resident [redacted] received [redacted] medication via the wrong route. The home did not report this medication error to the Department until [redacted].

Resident [redacted] has an order to receive [redacted] tablet by mouth in the morning. This medication was not administered from 10/1/2023 through 10/12/2023; the home did not report this medication error to the Department as of 10/12/2023.

**16c - Written Incident Report (continued)***Repeated Violation - 11/1/2022***Plan of Correction****Accepted** [REDACTED] **- 11/03/2023)**

On [REDACTED], the medication error incident report for Resident [REDACTED] was submitted for the medications that were not being administered from 10/1/2023 through 10/16/2023. Keystone Service Systems, Inc. (Keystone) maintains a process wherein all staff of the personal care home are trained by a certified medication trainer upon hire and annually thereafter on the medication administration process, including but not limited to the reporting of medication errors and/or omissions immediately upon the error or omission occurring to the Program Administrator, Acting Program Administrator or rotating On-Call Program Administrator. In review of these citations in context to the business process, it was found that the staff on shift who committed the error did not immediately report the issue due to the error occurring during a time when the Program Administrator was not physically present on site at the personal care home. As a result, on or before 11/3/2023, the Associate Executive Director will train the Director, Program Administrator and Program Coordinator on regulation 2600.16(c), the definition of a medication error, the incident reporting process, including timeframes for reporting and on-call reporting procedures. The content and proof of this training will be forthcoming. The Program Administrator will provide training on regulation 2600.16(c), the definition of medication error, the incident reporting process, including timeframes for reporting and on-call reporting procedures at the next staff meeting that is scheduled to occur 11/6/2023; proof of this training will be forthcoming. Additionally, effective 11/7/2023, an audit will be conducted by the Program Administrator daily. The Program Administrator will review the electronic medication administration records (eMARs) for each resident and confirm that medication errors are reported within that day (if applicable), re-educate the staff who committed the error and would contact the prescribing provider. Additionally, on a weekly basis, the program nurse (or Director in the absence of the nurse) will be responsible to review the eMAR and compare it to incidents reported within that week. If an incident was not reported, the program nurse (or Director) will report the incident, notify the Program Administrator immediately (or on call supervisor), immediately re-educate the staff who committed the error and would contact the prescribing provider. The Associate Executive Director will provide training on this business process to the Program Administrator, Program Nurse and Director on/or before 11/6/2023. Proof of this training will be maintained by the Associate Executive Director.

**Licensee's Proposed Overall Completion Date: 11/07/2023****Implemented** [REDACTED] **- 12/22/2023)****27a - SSI Benefits****3. Requirements**

2600.

27.a. If a home agrees to admit a resident eligible for SSI benefits, the home's charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance.

**Description of Violation**

The Home Rules state, "residents shall be responsible for any damage done to the house or property". Homes are not permitted to charge residents who receive SSI for damage-intentional or otherwise. Residents currently residing in the home receive SSI.

## 27a - SSI Benefits (continued)

**Plan of Correction****Accept** [REDACTED] - 10/30/2023)

On [REDACTED], the home rules that were posted at the time of inspection stating a resident is responsible for any damage done to the house or property have been removed from this personal care home. Keystone Services Systems, Inc. (Keystone) maintains a business process wherein the home rules are maintained digitally as a formal attachment to the resident home contract that is maintained in each individual resident's electronic health record (EHR). In review of the resident home contract, it was found that the following statement was present in the contract, the resident shall be responsible for any damage done to the house or property. As a result, the digital resident-home contract that contains the home rules will be updated on/or before 11/10/2023 in the EHR. All residents will be made aware of the upcoming changes in a home meeting that will take place on/or before 11/30/2023. All residents contracts will be updated with the new home rules language on/or before 12/31/2023. The Associate Executive Director will review the EHR resident-home contract changes in alignment with regulation 2600.27(a) at the next Director meeting that is scheduled to take place on 11/27/2023; proof of this training will be forthcoming.

Licensee's Proposed Overall Completion Date: 12/31/2023

**Implemented** [REDACTED] - 12/22/2023)

## 54a - Direct Care Staff

**4. Requirements**

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

**Description of Violation**

Staff Member A attended a non-U.S. educational institution and provides assistance with ADL's. The home does not have a Department-issued waiver for Staff Member's A employment.

**Plan of Correction****Accept** [REDACTED] - 11/03/2023)

Effective 10/26/2023, Staff Member A is not providing assistance with ADLs to residents at this personal care home. Keystone Service Systems, Inc. (Keystone) does not have a business process to evaluate those non U.S educated employees and the need for a waiver. Therefore, the Director of Compliance for Keystone will be submitting the waiver for regulation 2600.54(a)(2) for Staff Member A on/or before 11/3/2023. The Director of Compliance, the Director of Human Resources and Associate Executive Director will develop a business process around non U.S based education eligibility by position and the waiver process by 11/30/2023. As part of this meeting, the Director of Human Resources will also be auditing all current personal care home employee files to determine if any other current employees meet the criterion for a waiver; this audit will be completed on/or before 11/10/2023. Once the review is completed, the Director of Compliance or the Associate Executive Director will submit the waivers requested to the Department. Once the business process is drafted, the Director of Human Resources and the Associate Executive Director will train all Directors, Program Administrators and the Recruiting Department on regulation 2600.54(a)(2), the new business process for reviewing non U.S. educated employees and the waiver process on/or before 12/15/2023.

Licensee's Proposed Overall Completion Date: 12/15/2023

**Implemented** [REDACTED] - 12/19/2023)

## 63a - First Aid/CPR Training

**5. Requirements**

63a - First Aid/CPR Training (continued)

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

**Description of Violation**

On 10/1/2023, 10/2/2023 and 10/3/2023, from 11:00 PM to 7:00 AM, [REDACTED] residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

On 10/6/2023, 10/7/2023, 10/8/2023, 10/9/2023 and 10/10/2023, from 11:00 PM to 7:00 AM, 8 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

**Plan of Correction**

**Accept [REDACTED] - 11/03/2023)**

Effective, 10/26/2023, the staff member without a first aid certification is not permitted to work independently. This staff member is scheduled to complete the required first aid certification on/or before 11/30/2023. On 10/1/2022, Keystone Service Systems, Inc. (Keystone) implemented a new training plan for all Personal Care Homes (PCH) that contains all regulatory required trainings including first aid and CPR. The PCH training plan is assigned to each new employee through Keystone's Learning Management System by role with a determined due date based upon regulatory timeframe for completion. This training is completed by a certified instructor through Keystone that includes a combined First Aid and CPR certification. Effective 5/4/2023, completion of all required trainings are monitored by the Program Administrator and Keystone's Education Department through reporting functionality in Keystone's Learning Management System. Specifically, the Education Department will run coming due and past due reports at the beginning of each month to notify all Program Administrators and Directors of upcoming trainings so that staff and supervisors can schedule accordingly. If staff are on the past due reports, the Program Administrator may remove the staff from the schedule, issue discipline (as appropriate) and set up a time for training completion. It should be noted that it has been Keystone's practice to accept CPR and First Aid training from employees who held an external certification that was in good standing. The CPR and First Aid certification was approved by a member of Operations and noted as completed in Keystone's Learning Management System. Through review of this citation it was determined that Staff Member A presented an external CPR training that did not include a combined CPR and First Aid certification. As a result, effective 10/16/2023, all external CPR and first aid training certifications must be reviewed and approved by Keystone's Education Director or Keystone's Education Consultant. The Education Director or Consultant will be the only persons to approve and marked the required trainings as completed with the certification date. On 10/26/2023, the Associate Executive Director sent out notification to all Directors and Program Administrators on the external CPR and first aid certification process; proof of the communication in this business process change is found in Attachment #2. Finally, an audit of all current CPR and first aid certifications will be completed by the Education Consultant on/or before 11/3/2023. The Education Consultant will follow up with the Program Administrator, Director and Associate Executive Director on any staff who do not have a current, valid CPR first aid certification for remediation purposes. Any staff deemed non-compliant may be removed from the schedule or issued discipline (as appropriate) and a time for training completion will be established with the non-compliant employee. Proof of this audit will be maintained by the Education Consultant along with all follow up actions taken as it relates to remediation.

Licensee's Proposed Overall Completion Date: 11/03/2023

**Implemented [REDACTED] - 12/22/2023)**

65b - Rights/Abuse 40 Hours

**6. Requirements**

2600.

**65b - Rights/Abuse 40 Hours (continued)**

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.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

**Description of Violation**

Staff Member A completed [REDACTED] 40th scheduled work hour on [REDACTED]. However, this staff person did not complete training on resident rights until [REDACTED] or mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) until [REDACTED].

Repeated Violation - 11/1/2022

**Plan of Correction**

Accepted [REDACTED] - 10/30/2023)

On 10/1/2022, Keystone Service Systems, Inc. (Keystone) implemented a new training plan for all Personal Care Homes (PCH) that contains all regulatory required trainings as outlined in 2600.65 (a-i). The PCH training plan is assigned to each new employee through Keystone's Learning Management System by role with a determined due date based upon regulatory timeframe for completion. This training plan includes training on resident rights and the Older Adult Protective Services Act within 40 scheduled working hours for all direct care staff person(s). Effective 5/4/2023, completion of all required trainings is monitored by the Program Administrator and Keystone's Education Department through reporting in Keystone's Learning Management System. Specifically, the Education Department will run coming due and past due reports at the beginning of each month to notify all Program Administrators and Directors of upcoming trainings so that staff and supervisors can schedule accordingly. If staff are on the past due reports, the Program Administrator may remove the staff from the schedule, issue discipline (as appropriate) and set up a time for training completion. Additionally, on 6/1/2023, the business process was further optimized in that if any staff still had outstanding trainings at the 30th scheduled work hour a check in occurs with the staff who has the outstanding training, the hiring supervisor and the Education Consultant. The purpose of this is to review the outstanding trainings and ensure there is a scheduled plan to complete all required trainings within the first 40 scheduled worked hours. In review of this citation in context to the business process, it was found that this employee's training issues pre-dates the current business process to maintain compliance with standard 2600.65(b). The Education Consultant will complete an audit on all SCR employee training plans to ensure all staff have the required trainings initial and annual trainings completed and will follow up with the Program Administrators/Directors on the audit findings and remediation needed on/or before 11/3/2023. On or before 11/3/2023, the Associate Executive Director will train the Director and Program Administrator on regulation 2600.65(b), the personal care home training plans and the monitoring and oversight of the employee past due reports. Proof of this training will be forthcoming.

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented [REDACTED] - 12/22/2023)

**96a - First Aid Kit****7. Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

96a - First Aid Kit (continued)

Description of Violation

The home has two first aid kits. On 10/11/2023, neither of these kits included nonporous disposable gloves, thermometer, breathing shield, eye coverings or tweezers.

Plan of Correction

Accept [redacted] - 11/03/2023)

On 10/26/2023, nonporous disposable gloves, a thermometer, a breathing shield, eye coverings and tweezers were ordered; proof of this purchase is found in Attachment #3. Once receipt of these items, the Program Administrator will add these to the first aid kit. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring that the first aid kit is accessible and contains all regulatory required inventory, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.96(a) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.96(a) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] - 12/22/2023)

101j6 - Mirror

8. Requirements

- 2600.
- 101.j. Each resident shall have the following in the bedroom:
  - 6. A mirror.

Description of Violation

On 10/11/2023, there was no mirror in the bedroom of Resident [redacted] or in the bedroom of Resident [redacted]

Plan of Correction

Accept [redacted] - 11/03/2023)

On 10/18/2023, the Program Administrator purchased mirrors to place in the bedroom's for Resident [redacted] and Resident [redacted] proof of the mirrors placed in the bedroom's are found in Attachment #4. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring each resident's bedroom contains a mirror, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the

101j6 - Mirror (continued)

Director, Program Administrator and Program Coordinator on regulation 2600.101(j)(6) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.101(j)(6) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] - 12/22/2023)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 10/11/2023 at 9:21 AM, the temperature in the GE freezer located in the basement laundry room was 8 degrees Fahrenheit, and at 10:50 AM it was 8 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 11/03/2023)

The GE freezer located in the basement laundry room was emptied, the food was relocated to another freezer and unplugged. A new freezer was ordered on 10/26/2023 and will be delivered to this personal care home on 10/28/2023; proof of this remediation is found in Attachment #5. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring freezers are maintained with a thermometer that has a temperature of 0 degrees Fahrenheit, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.103(f) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.103(f) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] - 12/22/2023)

103h - Thawing Food

10. Requirements

2600.

103h - Thawing Food (continued)

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 10/11/2023 at 9:28 AM, a package of frozen chicken breasts was being thawed atop a white plastic container in the kitchen sink.

Plan of Correction

Accepted [redacted] - 11/03/2023)

The chicken observed in the sink thawing at the time of inspection was discarded. Keystone Service Systems, Inc. (Keystone) maintains a training plan for all personal care home staff that reviews the following content upon hire: nutrition, food handling and sanitation. Completion of this training by the personal care home staff is maintained in Keystone's learning management system by the Education Consultant. In review of this citation, it was found that all staff had completed this required training; however, as an additional step in remediation all staff of this personal care home have been assigned an additional training module in the learning management system that reviews specific safe food handling techniques that are consistent with regulation 2600.103(h). All direct staff, including the Program Administrator are scheduled to complete this training in Keystone's learning management system on/or before 11/10/2023; proof of this training will be forthcoming. All staff will continue to be trained upon hire as it relates to safe food handling techniques.

Licensee's Proposed Overall Completion Date: 11/10/2023

Implemented [redacted] - 12/19/2023)

107d - Procedure Emergency Management Agency Submission

11. 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 does not have documentation of the annual review or submission to local emergency management agency of the home's emergency procedures.

Plan of Correction

Accepted [redacted] - 10/30/2023)

The personal care home's written emergency procedures will be reviewed and updated by the Director on or before 11/3/2023; proof of the updated emergency procedures will be forthcoming. The home's updated written emergency procedures will be submitted to the local emergency management agency by the Program Administrator on or before 11/6/2023; proof of this submittal will be forthcoming. Through review of this citation, it was identified that Keystone Service Systems, Inc (Keystone) did not have a centralized process to ensure annual review of the emergency procedures and submission to the local emergency management agency. As such, Keystone will formalize a process on or before 11/17/2023, wherein emergency management procedures for all personal care homes are maintained by an administrative staff in a central location and monitor upcoming due dates for reviewing/submitting these procedures are tracked by administrative staff. In the interim, Directors will complete an audit of all personal care homes emergency management procedures to ensure that plans are up to date and have been submitted to the local emergency management agency by 11/30/2023. Proof of this audit and any remediation will be maintained by the Associate Executive Director.

Licensee's Proposed Overall Completion Date: 11/30/2023

107d - Procedure Emergency Management Agency Submission (continued)

Implemented [redacted] - 12/19/2023)

123b - Emergency Procedures Posted

12. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction

Accept [redacted] - 11/03/2023)

On 10/27/2023, the personal care home's emergency procedures were posted in a conspicuous and public place; proof of this remediation is found in Attachment #6. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring emergency procedures are posted, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.123(b) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.123(b) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] - 12/22/2023)

125a - Combustible Storage

13. Requirements

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 10/11/2023 at 9:19 AM, four white plastic trash bags were stored against the home's hot water heater in the basement.

Plan of Correction

Accept [redacted] - 11/03/2023)

On 10/11/2023, at the time of inspection, the four white plastic trash bags stored against the hot water heater were discarded; proof of this remediation is found in Attachment #7. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring combustible materials or flammable materials are safely stored away from heat sources, is to be formally assessed and monitored monthly by the

125a - Combustible Storage (continued)

Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. In addition to the formalized monthly SCR Site Audit, effective 11/7/2023, the daily checks for combustible or flammable materials near heat sources will be completed by staff on shift at the time of laundry tasks being completed. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.125(a) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.125(a) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] 12/22/2023)

125b - Combustible Restrictions

14. Requirements

2600.  
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 10/11/2023 at approximately 9:00 AM, a Blue Rhino propane tank was unlocked, unattended, and accessible to residents outside on the side porch of the home.

Plan of Correction

Accept [redacted] - 11/03/2023)

On 10/11/2023, the propane tanks left accessible to residents were removed; proof of this remediation is found in Attachment #8. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring combustible materials are kept inaccessible to residents, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.125(b) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.125(b) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] - 12/22/2023)

125b - Combustible Restrictions (continued)

141a - Medical Evaluation

15. 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.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. A medical evaluation has not been completed as of [redacted].

Plan of Correction

Accepted [redacted] 10/30/2023)

Resident [redacted] primary care physician completed the medical evaluation on [redacted]; proof of the completed medical evaluation is found in Attachment #9. Keystone Service Systems, Inc (Keystone) maintains an intake process wherein the medical evaluation is either reviewed or scheduled for completion by the Program Administrator (or designee). The Program Administrator (or designee) is responsible to review the medical evaluation form if it is completed prior to admission to ensure it is complete, compliant and does not exceed 60 days. Once reviewed, the Program Administrator (or designee) would then upload the completed medical evaluation form to the individual's electronic health record (EHR). The Program Administrator (or designee) would schedule the medical evaluation, if not completed for the individual prior to admission, within the EHR not to exceed 30 days post admission. Upon completion of the medical evaluation form, the Program Administrator (or designee) would then review the medical evaluation form to ensure it is complete and compliant prior to marking the appointment as complete in the individual's EHR and uploading the supporting documentation. Additionally through reporting functionality, the Program Administrator (or designee) will monitor timeliness of medical evaluations to ensure they are completed prior to and/or no later than 30 days post the date of admission. Through review of this citation in context to the business process, it was found that Resident [redacted] has a completed MA-51, but not a Medical Evaluation form approximately 30 days prior to admission. The Program Administrator did not differentiate the requirement between the MA-51 form and the Medical Evaluation form. As a result, on or before 11/3/2023, the Associate Executive Director will train the Director and Program Administrator on regulation 2600.141 (a), the business process around maintaining compliant Medical Evaluations and oversight of the process by the Director; proof of this training will be forthcoming. The Program Administrator will audit all other resident records to ensure medical evaluation compliance with this standard on/or before 11/14/2023; proof of this audit will be maintained by the Program Administrator. Effective 10/1/2023, the Program Administrator will monitor all medical evaluation timeliness by completing monthly resident record reviews. The Director will provide oversight for these reviews and ensure any identified remediation is completed by the Program Administrator (or designee).

Licensee's Proposed Overall Completion Date: 11/14/2023

Implemented [redacted] - 12/19/2023)

141b1 - Annual Medical Evaluation

16. Requirements

2600.

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

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

141b1 - Annual Medical Evaluation (continued)

Resident [REDACTED] most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Repeated Violation - 11/1/2022

Plan of Correction

Accept [REDACTED] - 10/30/2023)

Keystone Service Systems, Inc. (Keystone) maintains a process wherein all medical evaluations are scheduled by the Program Administrator (or designee) in the individual's electronic health record (EHR) for 365 days from the date of the last evaluation. Upon completion of the medical evaluation form, the Program Administrator (or designee) would then review the medical evaluation form to ensure it is complete and compliant prior to marking the appointment as complete in the individual's EHR and uploading the supporting documentation. Additionally through reporting functionality, the Program Administrator (or designee) will monitor timeliness of medical evaluations to ensure they are completed within the regulatory timeframe. Through review of this citation in context to the business process, it was found that Program Administrator was not trained on the annual medical evaluation process. As a result, on or before 11/3/2023, the Associate Executive Director will train the Director, Program Administrator and Program Coordinator on regulation 2600.141(b)(1) and the business process to maintain compliance with this standard regardless of staffing issues. Proof of this training will be forthcoming. Effective 10/1/2023, the Program Administrator will monitor all medical evaluations for timeliness by completing monthly resident record reviews. The Director will provide oversight for these reviews and ensure any identified remediation is completed by the Program Administrator (or designee). Additionally, the Program Administrator will audit all other resident records to ensure medical evaluation compliance with this standard on/or before 11/14/2023; proof of this audit will be maintained by the Program Administrator.

Licensee's Proposed Overall Completion Date: 11/14/2023

Implemented [REDACTED] - 12/19/2023)

144c1 - Smoking Area Guidelines

17. 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

The home's designated smoking area is located on the exterior side porch of the home. On [REDACTED] at approximately [REDACTED] a resident was observed smoking on the front porch steps of the home. Staff confirmed this was not a designated smoking area.

Plan of Correction

Accept [REDACTED] - 11/03/2023)

Keystone Service Systems, Inc. (Keystone) maintains a process wherein all residents of the personal care home are formally educated at the time of admission and annually thereafter during the resident-home contract process on the smoking policy. Each resident will acknowledge the terms of the smoking policy during this time. The personal

144c1 - Smoking Area Guidelines (continued)

care home smoking policy outlines that smoking is permitted in the designated area only by residents. Additionally, during resident house meeting the smoking policy is reviewed with all residents on an annual basis and includes the designated smoking area and where to appropriately discard cigarettes. On [REDACTED], the observed resident smoking in a non-designated smoking area was addressed by the Program Administrator directly; proof of the counseling and education conducted with this personal care home resident is found in Attachment #10. Additionally, at the house meeting on [REDACTED], the Program Administrator trained all residents on regulation 2600.144(c)(1) and the importance of abiding by the smoking policy; proof of this house meeting and the content reviewed around the smoking policy is contained in Attachment #11. Effective [REDACTED], the resident observed smoking in the non-designated area will be monitored by the staff on shift during smoking to ensure the resident is complying with the smoking policy.

Licensee's Proposed Overall Completion Date: 11/02/2023

Implemented [REDACTED] - 12/19/2023)

144c2 - Smoking Area Distance

18. 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:

- 2. 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: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

On [REDACTED] at approximately [REDACTED] a Blue Rhino propane tank was observed directly next to an ashtray in the home's designated smoking area. Additionally, propane tanks are stored in a locked bin directly behind the ashtray.

Plan of Correction

Accept [REDACTED] 11/03/2023)

On 10/11/2023, the propane tanks in the designated smoking area were removed; proof of this remediation is found in Attachment #8. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring combustible materials or flammable materials are safely stored away from heat sources, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was not being completed accurately by the Program Administrator or Program Coordinator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.144(c)(2) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator/Program Coordinator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.144(c)(2) and the SCR Weekly Site Audit to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [REDACTED] - 12/22/2023)

171b5 - First Aid Kit

19. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 10/11/2023, the first aid kit in the [redacted] van used to transport residents did not include a thermometer.

Plan of Correction

Accept [redacted] - 11/03/2023)

On 10/26/2023, a thermometer was ordered for the first aid kit used to transport residents at this personal care home; proof of this purchase is found in Attachment #3. Upon receipt, the Program Administrator will add the thermometer to the first aid kit in the vehicle used to transport residents. Keystone Service Systems, Inc. (Keystone) maintains a process referred to as the Bi-Weekly Vehicle Inspection. The Bi-Weekly Vehicle Inspection reviews vehicle safety standards, including but not limited to ensuring a complete first aid kit is present in the vehicle. The Program Administrator will complete Bi- Weekly Vehicle Inspection electronically. Any non-compliance noted on the Vehicle Inspection will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the Bi-Weekly Vehicle Inspection was not being completed accurately by the Program Administrator and was not being monitored consistently by the Director. As a result, on or before 11/3/2023, the Associate Executive Director will re-train the Director, Program Administrator and Program Coordinator on regulation 2600.171(b)(5) and the business process to maintain compliance with this standard that is to be completed by the Program Administrator and the expectations around monitoring and following up on non-compliances by the Director; proof of this re-training will be forthcoming. The Program Administrator will provide training on regulation 2600.171(b)(5) and the Bi-Weekly Vehicle Inspection to all personal care home staff at the next staff meeting that is scheduled to occur on 11/6/2023; proof of this training will be forthcoming. Effective 11/7/2023, the Program Administrator will continue to use the Bi-Weekly Vehicle Inspection to monitor compliance with this standard.

Licensee's Proposed Overall Completion Date: 11/07/2023

Implemented [redacted] - 12/22/2023)

185a - Implement Storage Procedures

20. Requirements

2600.

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 [redacted] is prescribed [redacted] tablets as needed for [redacted] and [redacted] caplets as needed for [redacted]. On 10/12/2023, these medications were not available in the home.

Resident [redacted] is prescribed [redacted] as needed for constipation. On 10/12/2023, this medication was not available in the home.

Resident [redacted] is prescribed [redacted] as needed for pain. On 10/12/2023, this medication was not available in the home.

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept [redacted] - 11/03/2023)

The [redacted], the generic brand for [redacted], for [redacted] was obtained for Resident [redacted] on [redacted]. Proof of this medication can be found in Attachment #12. Refills for the [redacted] tablets for [redacted] and the [redacted] caplets were requested for Resident [redacted] on [redacted]. A new script for [redacted] for pain was requested for Resident [redacted] on [redacted]. Proof of these requests can be found in Attachment #13 and Attachment #15. Keystone Service Systems, Inc. (Keystone) maintains a process wherein medications are reviewed by the Keystone nurse on a weekly basis referred to as a medication review. During this review, if any medications are going to expire or run out of refill prior to the next medication review, the nurse is responsible to contact the prescribers office at least 7 days prior to refill being needed. The nurse would document the refill request in the individual's electronic health record so that the rest of the team is aware of the refill request. If confirmation of the refill request is not received by the prescriber or pharmacy follow up will occur by the nurse daily until the medication is received. All attempts and contacts with the prescribers office and the pharmacy must be documented in the individual's record. Once the medications are received, the nurse (or designee) would review the received medication against the current medication and medication would be added to the electronic medication administration record (eMAR) in order for staff to document medication administrations. Through review of this citation in context to the citation, it was found that the nurse was not completing weekly medication reviews and/or following up with the prescribers/pharmacy consistently and documenting those attempts. As a result, on 10/16/2023, the Director completed an audit of all resident's eMARs and medications to ensure all prescribed medications were present for each resident based off of the current eMAR. If issues were noted, the nurse is required to follow up with the prescribing physician and update the eMAR on/or before 11/17/2023; proof of this audit and all communication will be maintained by the nurse with oversight by the Director and another lead nurse within the agency. On or before 11/17/2023, the Director and another lead Keystone nurse will train the nurse of this personal care home and the Program Administrator on regulation 2600.185(a) and the business process to maintain compliance with this standard, and responsibilities of all staff involved in the business process. Proof of this training will be forthcoming. Effective 10/1/2023, the Program Administrator will monitor all medications on the eMAR by completing monthly resident record reviews. The Director will provide oversight for these reviews as well as the weekly medication reviews completed by the nurse to ensure any identified remediation is completed by the Program Administrator, nurse (or designee).

Licensee's Proposed Overall Completion Date: 11/17/2023

Implemented [redacted] - 12/22/2023)

186b - Medication Used by Resident

21. Requirements

2600.

186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On [redacted] at [redacted], Resident [redacted] was administered [redacted] prescribed for and belonging to another resident in the home.

Plan of Correction

Accept [redacted] - 10/30/2023)

An incident report for this medication error was submitted to the Department on [redacted] Additionally, as of [redacted] the staff who committed the medication error is no longer administering medications until full

**186b - Medication Used by Resident (continued)**

training remediation is completed/passed and observed practicums are completed by the medication certified instructor. Keystone Service Systems, Inc. (Keystone) requires that all staff who administer medications complete the Department approved medication administration training prior to administering medications independently. This training consistent of a 15 step process when administering medications to an individual that includes identifying that the correct medication is being given to the correct resident for the correct dosage according to the medication label and the electronic medication administration record (eMAR). In review of this citation, it was found that the staff who committed the medication error did not follow the 15 step medication administration process. Therefore, in addition to doing individual specific remediation, on or before 11/17/2023, the Director and another lead Keystone nurse will re-train all staff including this personal care home's nurse and Program Administrator on regulation 2600.186(b), the 15 step medication administration process and what immediate steps to take should an error occur. Proof of this remediation will be forthcoming.

Licensee's Proposed Overall Completion Date: 11/17/2023

Implemented [REDACTED] - 12/19/2023)

**187d - Follow Prescriber's Orders****22. Requirements**

2600.

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

**Description of Violation**

On [REDACTED], Resident [REDACTED] did not receive the following scheduled medications:

- [REDACTED] tablet-take [REDACTED] tablet by mouth twice daily
- [REDACTED] tablet-take [REDACTED] tablet by mouth twice daily

Resident [REDACTED] is prescribed [REDACTED] take [REDACTED] tablet by mouth in the morning for [REDACTED]. However, this medication was not administered to resident from 10/1/2023 through 10/12/2023 because the medication was not available in the home.

Resident [REDACTED] has an order for [REDACTED]-instill 1 drop into [REDACTED] at [REDACTED]. On [REDACTED], this medication was not administered.

Medications are to be administered as ordered by the physician. If the physician has not discontinued an order, then the order remains current and should continue to be administered. Per Staff Member B, resident medications are removed from a Medication Administration Record (MAR) by pharmacy once a script has no more refills available. The home does not consult with the physician for a new script or a discontinued order for these medications. On 10/12/2023, the following medications were observed in the home's medication cart but not on the residents' MAR:

- Resident [REDACTED]
- Resident [REDACTED]
- Resident [REDACTED]

## 187d - Follow Prescriber's Orders (continued)

## Plan of Correction

Accept [REDACTED] - 11/03/2023)

On [REDACTED] a medication error was submitted to the Department for Resident [REDACTED] for the medications not given on [REDACTED]. On [REDACTED], a medication error was submitted to the Department for Resident #2 for the medications not given between [REDACTED]. On [REDACTED], a medication error was submitted to the Department for Resident [REDACTED] for the medications not given on [REDACTED]. On [REDACTED], Resident [REDACTED] and Resident [REDACTED] prescribing physicians were contacted to confirm the use of [REDACTED] solution (Resident [REDACTED]); [REDACTED] (Resident [REDACTED]; [REDACTED] (Resident [REDACTED])). Resident [REDACTED] is still prescribed [REDACTED] and the electronic medication administration record has been updated on [REDACTED] to reflect the correct medications. Proof of this remediation is found in Attachment #16. Proof of communication with prescriber for [REDACTED] (Resident [REDACTED]) and [REDACTED] Resident [REDACTED] is contained in Attachment #14 and Attachment #15. Once clarification is received from prescriber, the electronic medication administration records for both residents will be to reflect the correct medications. Keystone Service Systems, Inc. (Keystone) maintains a process wherein medications are reviewed by the Keystone nurse on a weekly basis referred to as a medication review. During this review, if any medications are going to expire or run out of refill prior to the next medication review, the nurse is responsible to contact the prescribers office at least 7 days prior to refill being needed. The nurse would document the refill request in the individual's electronic health record so that the rest of the team is aware of the refill request. If confirmation of the refill request is not received by the prescriber or pharmacy follow up will occur by the nurse daily until the medication is received. All attempts and contacts with the prescribers office and the pharmacy must be documented in the individual's record. Once the medications are received, the nurse (or designee) would review the received medication against the current medication and medication would be added to the electronic medication administration record (eMAR) in order for staff to document medication administrations. If any medications were discharged during this week from a prescriber, the nurse would remove the medications from the medication cart and remove the medication from the eMAR and contact the pharmacy for pick up. Through review of this citation in context to the citation, it was found that the nurse was not completing weekly medication reviews and/or following up with the prescribers/pharmacy consistently and documenting those attempts. As a result, on 10/16/2023, the Director completed an audit of all resident's eMARs and medications to ensure all prescribed medications were present for each resident based off of the current eMAR. If issues were noted, the nurse is required to follow up with the prescribing physician and update the eMAR on/or before 11/17/2023; proof of this audit and all communication will be maintained by the nurse with oversight by the Director and another lead nurse within the agency. On or before 11/17/2023, the Director and another lead Keystone nurse will train the nurse of this personal care home and the Program Administrator on regulation 2600.187(d) and the business process to maintain compliance with this standard, and responsibilities of all staff involved in the business process. Proof of this training will be forthcoming. Effective 10/1/2023, the Program Administrator will monitor all medications on the eMAR by completing monthly resident record reviews. The Director will provide oversight for these reviews as well as the weekly medication reviews completed by the nurse to ensure any identified remediation is completed by the Program Administrator, nurse (or designee).

Licensee's Proposed Overall Completion Date: 11/17/2023

Implemented [REDACTED] - 12/22/2023)

## 188b - Medication Error Reporting

## 23. Requirements

2600.

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

## 188b - Medication Error Reporting (continued)

**Description of Violation**

Resident [REDACTED] is prescribed [REDACTED]. On [REDACTED], the [REDACTED] were administered through the wrong route. The medication error was not reported to the prescriber until [REDACTED].

Resident [REDACTED] is prescribed [REDACTED] tablet by mouth in the morning for [REDACTED]. However, Resident [REDACTED] did not receive this medication [REDACTED]. The medication error was not reported to the prescriber.

**Plan of Correction**

Accept [REDACTED] - 11/03/2023)

On [REDACTED], a medication error was reported to the prescriber for Resident [REDACTED] the medications not given between [REDACTED]. Proof of this remediation is found in Attachment #17. Keystone Service Systems, Inc. (Keystone) maintains a process wherein medication errors are reported to the Program Administrator and the nurse upon discovery. The Program Administrator or the nurse completes the BHSL incident report, notifies the resident and notifies the prescriber of the medication error. Additionally, Keystone maintains a process wherein medications are reviewed by the Keystone nurse on a weekly basis referred to as a medication review. During this review, if any medications are going to expire or run out of refill prior to the next medication review, the nurse is responsible to contact the prescribers office at least 7 days prior to refill being needed. The nurse would document the refill request in the individual's electronic health record so that the rest of the team is aware of the refill request. If confirmation of the refill request is not received by the prescriber or pharmacy follow up will occur by the nurse daily until the medication is received. All attempts and contacts with the prescribers office and the pharmacy must be documented in the individual's record. Once the medications are received, the nurse (or designee) would review the received medication against the current medication and medication would be added to the electronic medication administration record (eMAR) in order for staff to document medication administrations. If any medications were discharged during this week from a prescriber, the nurse would remove the medications from the medication cart and remove the medication from the eMAR and contact the pharmacy for pick up. If any medication errors are identified during this review, including medication omissions, the nurse will notify the Program Administrator and complete the BHSL incident report, notify the resident, and notify the prescriber of the medication error. Through review of this citation in context to the citation, it was found that the direct support staff person administering the medication to resident #1 failed to notify the Program Administrator or nurse of the medication error, and the nurse was not completing weekly medication reviews and/or following up with the prescribers/pharmacy consistently and documenting those attempts. As a result, on 10/16/2023, the Director completed an audit of all resident's eMARs and medications to ensure all prescribed medications were present for each resident based off of the current eMAR. If issues were noted, the nurse is required to follow up with the prescribing physician and update the eMAR on/or before 11/17/2023; proof of this audit and all communication will be maintained by the nurse with oversight by the Director and another lead nurse within the agency. On or before 11/17/2023, the Director and another lead Keystone nurse will train the nurse of this personal care home, the Program Administrator and all personal care home staff on regulation 2600.188(b), the medication process, the process for reporting the medication issue, notifying the prescribing provider and the use of the management on-call during weekends/holidays. Proof of this training will be forthcoming. Effective 10/1/2023, the Program Administrator will monitor all medications on the eMAR by completing monthly resident record reviews. The Director will provide oversight for these reviews as well as the weekly medication reviews completed by the nurse to ensure any identified remediation is completed by the Program Administrator, nurse (or designee).

Licensee's Proposed Overall Completion Date: 11/17/2023

Implemented [REDACTED] - 12/22/2023)