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

April 5, 2024

[redacted], MH DIRECTOR
KEYSTONE SERVICE SYSTEMS INC
[redacted]

RE: KHS MENTAL HEALTH SERVICES-
GREEN STREET SPECIALIZED PC
2900 GREEN STREET
HARRISBURG, PA, 17110
LICENSE/COC#: 32878

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/14/2024, 02/15/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *KHS MENTAL HEALTH SERVICES-GREEN STREET SPECIALIZED PC* **License #**: *32878* **License Expiration**: *06/21/2024*

Address: *2900 GREEN STREET, HARRISBURG, PA 17110*

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

Administrator

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

Legal Entity

Name: *KEYSTONE SERVICE SYSTEMS INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *R-4* **Date**: *04/11/2011* **Issued By**: *City of Harrisburg*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/15/2024*

Inspection Dates and Department Representative

02/14/2024 - On-Site: [redacted]

02/15/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older**: *3*

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

02/14/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/04/2024*

Inspections / Reviews *(continued)*

03/18/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/04/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/01/2024*

04/05/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/04/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], at [redacted], Resident 1 reported suspected abuse to Staff Person A. This incident was reported to Staff Person B on [redacted]. However, this allegation of abuse was not reported to the Local Area on Aging Agency until [redacted].

Plan of Correction ***Accept ([redacted] - 03/18/2024)***

Keystone Service Systems, Inc. (Keystone) maintains a process in that when an incident of abuse is observed or reported, the staff who observes or receives the abuse allegation must notify the Program Administrator (or on-call Program Administrator) immediately. The Program Administrator (or on-call Program Administrator) will then complete the incident report, notification to the area on agency, contact the resident's designated person (if applicable) and complete the internal incident notification process; all of these notifications are to be completed by the Program Administrator on the date of receiving the report. The Associate Executive Director is included on the internal incident notification process and would follow up to determine assigning of the incident investigation depending on the nature of the allegation. All staff are trained initially upon hire and annually on what the definition of an incident is and the business process for reporting incidents that is consistent with the business process outlined above. In review of the citation in context to the business process it was determined that the business process for reporting incidents was not followed by the staff on shift nor the Program Administrator. In order to remediate this immediate issue, the Director completed training on regulation 2600.15 and 2600.16 and all subcategories of these regulations in addition to the reporting process with the all direct staff and the Program Administrator of this personal care home; proof of this remediation is found in Attachment #2. Finally, in order to further clarify the incident notification responsibilities of the Program Administrator a new business process is being developed wherein a coversheet is going to be attached to the incident report form. The coversheet will outline what notifications need to occur, in designated timeframes by position. The coversheet and training on the incident management coversheet process will be implemented on/or before 4/1/2024; proof of this remediation will be maintained by the Director.

Licensee's Proposed Overall Completion Date: *04/01/2024*

Implemented [redacted] - 04/05/2024)

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 1 reported suspected abuse to Staff Person A. This incident was reported to Staff Person B on [redacted]. However, this allegation of abuse was not reported to The Department until [redacted].

16c - Written Incident Report *(continued)*

Plan of Correction ***Accept [redacted] - 03/18/2024)***

Keystone Service Systems, Inc. (Keystone) maintains a process in that when an incident of abuse is observed or reported, the staff who observes or receives the abuse allegation must notify the Program Administrator (or on-call Program Administrator) immediately. The Program Administrator (or on-call Program Administrator) will then complete the incident report, notification to the area on agency, contact the resident's designated person (if applicable) and complete the internal incident notification process; all of these notifications are to be completed by the Program Administrator on the date of receiving the report. The Associate Executive Director is included on the internal incident notification process and would follow up to determine assigning of the incident investigation depending on the nature of the allegation. All staff are trained initially upon hire and annually on what the definition of an incident is and the business process for reporting incidents that is consistent with the business process outlined above. In review of the citation in context to the business process it was determined that the business process for reporting incidents was not followed by the staff on shift nor the Program Administrator. In order to remediate this immediate issue, the Director completed training on regulation 2600.15 and 2600.16 and all subcategories of these regulations in addition to the reporting process with the all direct staff and the Program Administrator of this personal care home; proof of this remediation is found in Attachment #2. Finally, in order to further clarify the incident notification responsibilities of the Program Administrator a new business process is being developed wherein a coversheet is going to be attached to the incident report form. The coversheet will outline what notifications need to occur, in designated timeframes by position. The coversheet and training on the incident management coversheet process will be implemented on/or before 4/1/2024; proof of this remediation will be maintained by the Director.

Licensee's Proposed Overall Completion Date: *04/01/2024*

Implemented [redacted] - 04/05/2024)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.

Description of Violation

Direct care Staff Persons C and D did not receive training in the following areas during training year of 2023:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.

Plan of Correction ***Accept [redacted] - 03/18/2024)***

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 for both initial and annual trainings. This training plan includes annual training on meeting the needs of residents, the assessment tool, medication evaluation, support plan and personal care service needs of the resident. 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

65f - Training Topics (continued)

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 for new hires and within 7 days of an employee's annual training due date, 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. 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(f)(2)(5). The Education Consultant will complete an audit on all SCR employee training plans to ensure all staff have the required initial and annual trainings completed and will follow up with the Program Administrators/Directors on the audit findings and remediation needed on/or before 3/8/2024. On 2/29/2024, the Associate Executive Director trained the Director and Program Administrator on regulation 2600.65(f)(2)(5), the personal care home training plans and the monitoring and oversight of the employee past due reports. Proof of this training is found in Attachment #1.

Licensee's Proposed Overall Completion Date: *03/08/2024*

Implemented ([redacted] - 04/05/2024)

100b - Removal Snow/Obstructions

4. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 02/14/2024 at 10:50AM, there was an approximate 1/2-inch accumulation of snow and ice located on the patios of the 2nd and 3rd floor which are used in the event of emergency evacuation. Furthermore, there was an approximate 1/2-inch accumulation of snow and ice located on the stairs connecting the 2nd and 3rd floor patios.

Plan of Correction ***Accept [redacted] - 03/18/2024)***

On 2/14/2024, the snow and ice on the patio on the 2nd and 3rd floor and stairs connecting the floors was removed; proof of the removal is found in Attachment #4. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring emergency evacuation routes are free of hazards, 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 being completed; however, the staff were unclear on the responsibilities for clearing the emergency evacuation routes. This program uses a third party snow removal company and the snow removal company is contractually responsible to clear all external stairs and patios in the event of inclement weather. If the snow/ice isn't removed, the Program Administrator will contact the snow removal company immediately to complete this task. As a result, on 2/29/2024, the Assistant Executive Director trained the Director and the Program Administrator on regulation 2600.100(b), the SCR Site Audit and contacted the snow removal company to review clearing of all external patios/stairs during inclement weather. Proof of this training is contained in Attachment #1. The Program Administrator will provide this training to all PCH staff at the next staff meeting, scheduled to occur on 3/21/2024. Proof of this training will be maintained with the Program Administrator. The Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard.

100b - Removal Snow/Obstructions *(continued)*

Licensee's Proposed Overall Completion Date: *03/21/2024*

Implemented ([redacted] - 04/05/2024)

132b - Safety Inspection/Fire Drill

5. 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 home's most recent fire safety inspection and fire drill conducted by a fire safety expert was conducted on 10/23/2023. However, the prior fire safety inspection and fire drill conducted by a fire safety expert was conducted on 09/27/2022.

Plan of Correction ***Accept [redacted] - 03/18/2024)***

Effective 10/3/2023, Keystone Service Systems, Inc. (Keystone) developed a new process wherein the fire safety expert is scheduled by the Program Administrator to come out during the same month annually to complete the fire safety inspection and fire drill; the fire safety inspection is scheduled through a calendar appointment that is provided to all personal care home staff, the Program Administrator and the Director. The Program Administrator is then responsible to submit a copy of the fire safety inspection to a electronic central file upon completion. The Director is then able to monitor annual completion of the fire safety inspection by month for all personal care homes through the electronic centralized file. In review of this citation in context to the new process to monitor compliance with this standard it was found that this citations pre-dates the current business process. On 2/29/2024, the Associate Executive Director trained the Program Administrator and Director on regulation 2600.132(b) and reviewed the current business process established to maintain compliance with this standard. Proof of this training is found in Attachment #1.

Licensee's Proposed Overall Completion Date: *03/04/2024*

Implemented ([redacted] - 04/05/2024)

132d - Evacuation

6. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

From 09/27/2022 through 10/23/2023, the maximum safe evacuation time specified in writing by a fire safety expert was determined to be 3 minutes and 30 seconds. On the following dates, the drills exceed that time:
-04/05/2023 at 12:00AM 9 minutes and 30 seconds.
-04/13/2023 at 12:01AM 6 minutes and 30 seconds.
-09/09/2023 at 6:46PM 3 minutes and 40 seconds.

Plan of Correction ***Accept [redacted] - 03/18/2024)***

Keystone Services Systems, Inc. (Keystone) maintains a process in which all fire drills are completed monthly by the staff on shift during the fire drill through the use of an Electronic Fire Drill Form. The Electronic Fire Drill Form

132d - Evacuation (continued)

contains all regulatory required elements and can't be submitted until all fields are complete in their entirety, inclusive of any problems encountered during the fire drill. Once the Electronic Fire Drill Form is complete a copy is automatically submitted to Operational Leadership for a secondary review in order to improve overall monitoring of the monthly fire drill process. The Quality Manager will pull reports on the Electronic Fire Drill Forms completed weekly and will send this report to the Associate Executive Director, Director and Program Administrator. If a drill is not complete for any given month and/or any of the fields are incorrect and/or the fire drill was not completed within the regulatory requirements, including evacuating within the designated time of 2 minutes and 30 seconds, the Director will prompt the Program Administrator (or designee) to complete a fire drill or in some cases a secondary drill within the month in order to be in compliance with the regulatory requirements. Through review of the process, in context to the citation it was determined in the months of April 2023 and September 2023 the business process was followed and additional fire drills were completed until all residents successfully evacuated within the month in 2 minutes and 30 seconds. As a result, on 2/29/2024, the Associate Executive Director trained the Director and Program Administrator on regulation 2600.132(d), the electronic fire drill process and looked into reasons as to why the fire drills needed to be completed multiple times within the month so as to meet with specific residents and educate them on fire safety requirements; proof of this training is found in Attachment #1. The Program Administrator will continue to use the electronic Fire Drill Form and the Director will monitor regulatory compliance with fire drills using the reporting on the fire drill form to maintain compliance with this standard.

Licensee's Proposed Overall Completion Date: *03/04/2024*

Implemented [redacted] - 04/05/2024)

185a - Implement Storage Procedures

7. 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 2 is prescribed [redacted]. However, on [redacted], the medication was not available in the home.

Resident 1 is prescribed [redacted]. However, on [redacted], the medication was not available in the home.

Plan of Correction ***Accept [redacted] - 03/18/2024)***

On [redacted], Resident #2's primary care physician was contacted and the PRN [redacted] was discharged and removed from Resident #2's electronic medication administration record (eMAR); proof of this medication being discharged is found in Attachment #3. On [redacted], Resident #2's refill for [redacted] was received and administered as prescribed. Keystone Service Systems, Inc. (Keystone) maintains a process wherein medications are delivered to the program on an automated cycle. The medication for Resident #2 was due to be delivered on the date of inspection and this resident received the last dose of the medication available on-site earlier that morning. Additionally, the Program Administrator (or Nurse) will complete a medication cart audit bi-weekly to determine if medications that aren't on cycle fill need to be ordered due to usage or expiration and will contact the physician obtain a refill or will receive notice to discharge the medication. The Program Administrator would then remove the medication from the resident's eMAR. Through review of this citation in context to the business process it was determined that the business process was not followed by the Program Administrator. As a result, on 2/29/2024, the Associate Executive Director trained the Program Administrator and Director on regulation 2600.185(a), the

185a - Implement Storage Procedures (continued)

medication cart audit and oversight responsibilities of the medication audit; proof of this training is found in Attachment #1.

Licensee's Proposed Overall Completion Date: *03/04/2024*

Implemented [redacted] - 04/05/2024)