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

September 20, 2024

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

RE: KHS MENTAL HEALTH SERVICES-
SILVER SPRING SPECIALIZED PC
427 HOGESTOWN ROAD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 30571

Dear Julie Rizzo,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/23/2024 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-SILVER SPRING SPECIALIZED PC* **License #**: *30571* **License Expiration**: *06/14/2025*

Address: *427 HOGESTOWN ROAD, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *KEYSTONE SERVICE SYSTEMS INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *R-3* **Date**: *11/07/2005* **Issued By**: *Silver Spring Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *9* **Waking Staff**: *7*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *07/23/2024*

Inspection Dates and Department Representative

07/23/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older**: *8*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *1*

Inspections / Reviews

07/23/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/10/2024*

08/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/19/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/20/2024*

Inspections / Reviews *(continued)*

09/20/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/19/2024*

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

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

Multiple poisonous materials, with manufacture's labels indicating "contact poison control center if ingested", were unlocked, unattended, and accessible to residents during the 7/24/24 inspection. Not all the residents of the home, including Resident #1, have been assessed capable of recognizing and using poisons safely. The following poisonous materials were witnessed:

- *4, Lysol laundry sanitizer bleach detergent bottles in the basement laundry room.*
- *2, Clorox germicidal bleach jugs in the basement laundry room.*
- *3, Arm and Hammer bags of laundry detergent pods in the basement laundry room.*
- *9, spray and wash stain remover bottles in the basement laundry room.*
- *2, Lysol wipe containers in the basement laundry room.*
- *1, All Day spray in the basement laundry room.*

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/26/2024, the Lysol sanitizer bleach, Clorox germicidal bleach, laundry detergent pods, spray and wash Lysol wipes and all day spray found in the laundry room during the inspection have been secured in a locked area by the Program Coordinator; proof of this remediation is found in Attachment #1. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to, ensuring all poisonous materials are locked and made inaccessible to residents who have not been assessed to safely use or avoid poisonous materials. This program standard 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 Program Administrator did not understand that due to the basement not being locked at all times that the chemicals found in the basement needed to be locked due to the assessed needs of the individuals in the residence. It should be noted effective, 7/18/2024, that the Program Administrator of this program is no longer with Keystone. As a result on 8/15/2024, the Director trained the Program Coordinator on regulation 2600. 82(c) and specifically measuring 82(c) for all areas of the residence; proof of this remediation is found in Attachment #2. Effective, 8/16/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator or Program Coordinator. Effective 8/16/2024, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 09/20/2024)

101j1 - Mattress Fire Retardant

2. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

101j1 Mattress Fire Retardant *(continued)*

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

At [redacted] on [redacted], Resident #5's mattress had many brown stains on the exposed part of the mattress.

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 8/16/2024, a new mattress was ordered by the Director for Resident #5 and it is scheduled to be at the residence on 8/23/2024; proof of this purchase is found in Attachment #3. Additionally a waterproof mattress cover was purchased by the Director for Resident #5's new mattress; proof of this remediation is found in Attachment #4. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring mattresses are in good repair. This standard 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 Program Administrator did not mark this standard are non compliant on the SCR Site Audit. It should be noted effective, 7/18/2024, that the Program Administrator of this program is no longer with Keystone. As a result on 8/15/2024, the Director trained the Program Coordinator on regulation 2600. 101(j)(1) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #2. Effective, 8/16/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator/Program Coordinator. Effective 8/16/2024, the Program Administrator/Program Coordinator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director. Finally, on 8/15/2024, all other resident's rooms will be inspected by the Program Coordinator and Director to ensure that each resident's room has mattress in good condition. If issues are found, new mattresses will be ordered and proof of the orders will be maintained by the Director.

Proposed Overall Completion Date: 08/23/2024

Licensee's Proposed Overall Completion Date: *08/23/2024*

Implemented [redacted] - 09/20/2024)

101j3 - Bed/Linens/Pillows/Blankets

3. 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

At 10:12 AM on 7/23/24, Resident #4's bed was not equipped with bedsheets and three pillows on their bed were not encased with pillowcases. The pillows had many large, brown stains over the surfaces of the pillows. The resident's bed had a grayish hue to the fabric, appearing to have been stained by sleeping directly on the mattress without a sheet. Bedsheets and pillowcases were not in the laundry room for the resident and staff were not currently washing bed sheets and pillowcases for Resident #4.

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 8/15/2024, sheets were placed on Resident #4's bed and the three pillows on Resident #4's bed were covered with pillowcases. 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 each resident has pillows, bed linens

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

and blankets that are in good condition. This standard 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 Program Administrator did not mark this standard as non compliant on the SCR Site Audit. It should be noted effective, 7/18/2024, that the Program Administrator of this program is no longer with Keystone. As a result on 8/15/2024 the Director trained the Program Coordinator on regulation 2600. 101(j)(3) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #2. Effective, 8/16/2024, the Director, or designee, will complete a site audits quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator/Program Coordinator. Effective 8/16/2024, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director. Additionally, on/or before 8/15/2024, all other resident's rooms will be inspected by the Program Coordinator and Director to ensure that each resident's room has pillows, bed linens and blankets present and that they're in good condition. If issues are found, new pillows, linens or blankets will be issued to the individual. If the individual has issues in keeping pillows, linens or blankets on their bed, then this documentation will also be maintained in the Resident Assessment and Service Plan. Finally, effective 8/16/2024, a daily task was added to the direct staff's schedule to check each resident's room for pillows, bed linens and blankets and to ensure they're clean and in good condition. On 8/5/2024, the Director trained all staff of this personal care home on regulation 2600.101(j)(3) and the newly added task to maintain compliance with this standard. Proof of this remediation is found in Attachment #6.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented ([redacted] - 09/20/2024)

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 10:10 AM on 7/23/24, there was an unlabeled, undated rotting plum in a bag in the refrigerator located in the front living room of the home, used by residents.

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 8/15/2024, the rotting plum found in the refrigerator located in the front living room was discarded by the Program Coordinator; 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 unlabeled, outdated or spoiled food is disposed of. This program standard 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 Program Administrator was not checking resident refrigerators. It should be noted effective, 7/18/2024, that the Program Administrator of this program is no longer with Keystone. As a result on 8/15/2024, the Director trained the Program Coordinator on regulation 2600. 103(i) and specifically looking in all refrigerators to ensure foods are stored properly and are not spoiled; proof of this remediation is found in

103i Outdated Food (continued)

Attachment #2. Effective, 8/16/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 8/16/2024, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented (- 09/20/2024)

141b1 - Annual Medical Evaluation

5. Requirements

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

Description of Violation

Resident #2's annual medical evaluation did not include a list of their medications or body positioning and movement stimulation for residents. The fields to indicate this were left blank and additional information was not attached to the evaluation.

Resident #1 received an updated medical evaluation on . The documented medical evaluation, did not include information that the resident's physician reviewed and documented the following at the time of the evaluation:

- *Medical diagnosis including physical or mental disabilities. The field to indicate this read, "see attached" but information attached was not printed until*
- *Medical information pertinent to diagnosis and treatment in case of an emergency. The field to indicate this read, "see attached" but information attached was not printed until .*
- *A complete order of the resident's dietary needs.*
- *Medication regimen. The field to indicate this read, "see attached" but information attached was not printed until 6/17/24.*
- *Body positioning and movement stimulation for residents. The field to indicate this read, "as tolerated." However, the resident requires the daily use of AFO leg braces, wheelchair, and walker for ambulation.*

Repeated Violation 5/16/2023

Plan of Correction ***Accept - 08/16/2024)***

On , Resident #2's annual physical dated was sent back to the doctor to review and sign off on the medications, body positioning and movement stimulation for residents. Proof of this remediation is forthcoming. On 8/14/2024, the Director of Nursing, who is a registered nurse, contacted the physician for Resident #1 to request permission to correct the body positioning and stimulation for residents section of the medical evaluation form. The Director of Nursing will correct the medical evaluation form dated 5/24/2024 to reflect the use of AFO leg braces daily, use of a wheelchair and walker for ambulation once approval is received by the physician. Proof of the phone call made by the Director of Nursing is found in Attachment #9. It should be noted that the medical evaluation dated was corrected by the physician on as a result of previous licensing citations for this personal care home. The physician for Resident #1 corrected the medical evaluation form on and attached the information for medical diagnosis, medical information pertinent to diagnosis and treatment, dietary needs and medication regimen. Resident #1 was not seen again by the physician, but a form update was completed by the physician on which is why the printed date of listed on the respective documents. On , the medical visit business process will be formalized and to include preparation of the medical

141b1 - Annual Medical Evaluation (continued)

evaluation form by the Program Administrator or Program Coordinator prior to the medical visit. A standard, formalized training was developed and recorded that reviewed scheduling of medical appointments in the electronic health record (EHR), completion of required documentation, how to upload completed documentation in the EHR and report monitoring of upcoming and completed medical appointments. All staff of this personal care home, including the Program Coordinator were enrolled and completed the recorded training between 7/2/2024 and 7/18/2024; proof of this remediation is found in Attachment #10. Finally, effective 8/2/2024, the Associate Executive Director (AED) holds bi-weekly Medical Visit Status (MVS) Leadership Meetings with all Program Administrators, Directors and Agency Nurses. The MVS meetings review all completed initial and annual medical evaluations for timeliness, completion and accuracy. If issues are identified during the MVS meeting, then guidance is given by the AED to the Program Administration on remediation actions required. All remediation actions issued are reviewed at the next bi-weekly meeting to ensure follow up occurs as directed. In addition, during the bi-weekly MVS meeting, any initial or annual medical evaluations scheduled for the upcoming week are reviewed to ensure the medical evaluation forms are prepped accurately by the Program Administrator or Program Coordinator prior to the appointment and include completion of all sections (with the exception of the Medical Professional Information section). Proof of the most recent bi-weekly MVS Meeting is found in Attachment #11.

Proposed Overall Completion Date: 09/16/2024

Licensee's Proposed Overall Completion Date: *09/16/2024*

Implemented ([redacted] - 09/20/2024)

161d - Dietary Needs

6. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On [redacted] Resident #1 was prescribed a nectar thick liquid diet for all liquids. However, on [redacted] the resident reported they were currently drinking iced tea without any thickening agent, and they have drunk water and iced tea without a thickening agent in their bedroom after the physician ordered a nectar thick liquid diet.

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 8/5/2024, all staff of this personal care home were trained by the Director on Resident #1's nectar thick liquid diet; proof of this remediation is found in Attachment #6. Additionally, all staff have been providing nectar thick liquids to Resident #1 during meals and as requested by Resident #1; proof of nectar think liquids being given to Resident #1 is found in Attachment #12. During the inspection, when it was found that Resident #1 had liquids in his room that he was consuming independently, the liquids were moved to the kitchen; proof of this remediation is found in Attachment #13. As per the Resident- Home Contract and House Rules, all residents are provided with meals, including beverages, at each scheduled meal time and as requested by the resident. All residents must store food and beverages in designated areas. On 8/15/2024, the Director educated Resident #1 on the need to keep all beverages in the kitchen or in the refrigerators. Additionally, Resident #1 was educated on the need to have liquids consumed in a manner prescribed by the physician for his safety. Proof of the education conducted with Resident #1 is found in Attachment #14. Effective 8/16/2024, the daily tasks for the personal care home was updated to include checking each resident's room for food/beverage. If food/beverages are found in the bedroom, they must be relocated to the kitchen so as to be monitored by staff. On 8/5/2024, the Director trained all staff of this personal

161d - Dietary Needs (continued)

care home on regulation 2600.161(d), the updated daily task list and need to monitor Resident #1 specifically for health, safety and welfare purposes. Proof of this remediation is found in Attachment #6.

Proposed Overall Completion Date: 08/16/2024

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented (- 09/20/2024)

183b - Meds and Syringes Locked

7. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/23/24 at 10:00 AM, the keys to open the medication area in the kitchen, were left sitting directly on top of the medication area lock unattended and accessible to anyone in the home. Additionally, at 1:04 PM the medication area and medication cart was left unlocked, unattended, and accessible.

Plan of Correction ***Accept (- 08/16/2024)***

On 8/5/2024, the keys to the medication area were placed on a wristlet and the wristlet is to be kept on the staff's person at all times. Additionally, all staff have been educated by the Director and put on notice to comply with regulation 2600.183(b) and keeping the wristlet on their person. Proof of this notice to staff is found in Attachment #6. In review of this citation, it was found that there was no formalized business process that evaluated this standard by supervisory staff. As a result on or before 9/2/2024, the Site Audit, was updated to include keeping medications locked and ensuring that keys are kept securely or on the staff's person. On 8/5/2024, the Director trained all staff again on regulation, 2600.183(b), the need to keep the medication key wristlet on their person and the updated Site Audit. Effective, 9/3/2024, the Program Administrator/Program Coordinator will use the updated Site Audit measure compliance with this regulatory requirement.

Licensee's Proposed Overall Completion Date: *09/03/2024*

Implemented (- 09/20/2024)

183d - Prescription Current

8. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] prescribed for Resident #1, was in the home's staff office; however, the medication was discontinued in [redacted].

Plan of Correction ***Accept (- 08/16/2024)***

The [redacted] that was discontinued in [redacted] for Resident #1 was appropriately discarded on [redacted]. Keystone Service Systems, Inc. (Keystone) maintains a process in which all medications that are discharged are destroyed by the Program Administrator, Program Coordinator or Agency Nurse only. The discharged medication is logged on the Medication Destruction Log. In review of this citation, it was found that the medication was removed

183d Prescription Current (continued)

as part of the medication cart audit; however, the medication was not destroyed in a timely manner by the Program Administrator. It was also found that the discharged medications, once pulled from the medication area were not locked. Therefore, effective 8/15/2024, a lock box was placed in the staff office to maintain all medications that have been discharged that are waiting for pharmacy pick up; proof of this remediation is found in Attachment #15. It should be noted that as of 7/18/2024, the Program Administrator is no longer employed by Keystone. As a result, on 8/15/2024, the Director trained the Program Coordinator on regulation 2600.183(e), the need to lock discharged medications in the staff office, timeframes for pharmacy pick up for a discharged medication and documentation required on the Destruction Log surrounding the pharmacy pick up. Proof of this education is found in Attachment #2.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented ([redacted] - 09/20/2024)

183e - Storing Medications

9. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 7/23/24 at 3 PM, ipratropium bromide and albuterol sulfate medication, expired in 2019 was in the home's medication cart.

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On [redacted], the expired [redacted] and [redacted] were removed from the medication area and destroyed. On [redacted] Keystone Service Systems, Inc. (Keystone) implemented a new process in which the agency nurse, or designee, would complete weekly medication audits. As part of the weekly, medication audit, if it is found that a medication has been discharged or expired, then the agency nurse, or designee, would be responsible to remove the discharged/expired medication from the medication area to a secure location in the staff office, log the medication on the Destruction Log and destroy the medication with a second staff present. A medication audit was completed by the Director of Nursing on 7/12/2024, prior to the inspection, however; the expired medications were not identified by the Director of Nursing. As a result, on 8/15/2024, the Director trained the Program Coordinator on regulation 2600.183(e), the weekly medication audit and specifically how to look for expired medications and the process for removing all expired/discharged medications. Proof of this remediation is found in Attachment #2. Finally, on 8/8/2024, the Director of Nursing completed a medication audit to ensure all medications in the medication area as of 8/8/2024 were not expired; proof of this audit is found in Attachment #16.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented ([redacted] - 09/20/2024)

185a - Implement Storage Procedures

10. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

At the time of the 7/23/24 inspection, the home was not implementing their Guidelines for Completing the Controlled Substance Record that included failure to:

- *initiate a new form when controlled medication is received/delivered*
- *maintain a separate form for each controlled substance blister pack*
- *have a 2-person count of each controlled medication with each changing of staff*
- *count the controlled substances at the time documented on the records.*

On [redacted] Resident #1's Controlled count sheet for [redacted] indicated there were 129 pills available. However, at the time of the inspection, there were only 128 pills available. Per interview with Staff Member A, the staff will complete the date and time they come on the shift on the controlled count log. At the end of the shift, staff will complete the controlled count log and document how many pills were administered that day and sign.

On [redacted], Staff Member A left the home at the end of his/her shift and a second staff member did not count the controlled medications or initial the log for Resident #1 with Staff Member A.

On [redacted] the controlled count sheet for Resident #1's [redacted] had one staff member sign for counting the controlled medication on [redacted].

On [redacted], additional medication for Resident #1's [redacted] was received. A new form was not initiated and the count went from 24 pills available on [redacted].

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 7/20/2024, all staff of this personal care home were enrolled in the medication refresher course through the Learning Management System (LMS). The medication refresher course reviews the controlled substance medication process and documentation to be completed as part of the process. All staff of this personal care home completed the medication refresher on 8/8/2024. Proof of the remediation, including the course outline/topics covered is found in Attachment #17 and Attachment #18. Additionally, all staff of this personal care home were observed between the dates of 7/30/2023 and 8/8/2023 by the Director and the Director of Nursing on the medication administration process and controlled medication substance process. Proof of the observations and follow up conducted with the staff of this personal care home is found in Attachment #17. Finally, effective 7/15/2024, either the Director, Director of Nursing or the Associate Executive Director are physically on-site 1-2 times per week at the personal care home to monitor shift change protocols, including controlled substance counts and medication administrations. If any issues are found during on-site inspections, then then the Director, Director of Nursing or Associate Executive Director would address the staff directly in real time, document the issue and work with Human Resources, as needed, to issue disciplinary action. Keystone Service Systems, Inc. (Keystone) will continue to utilize the Guidelines for Completing the Controlled Substance Record to maintain compliance with 2600.185(a).

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 09/20/2024)

187d - Follow Prescriber's Orders

11. Requirements

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

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

As of [redacted] Resident #5 is prescribed [redacted], inhale 2 puffs by mouth every 6 hours with 1 minute between all puffs. However, at the time of the [redacted] inspection, this medication has not been administered.

Resident #1 is to be administered the following medications at 8 AM: [redacted]. However, these medications were not administered until approximately [redacted].

Plan of Correction ***Accept [redacted] - 08/16/2024)***

On [redacted], medication errors were filed for Resident #5 and Resident #1; proof of this remediation is found in Attachment #19. On [redacted], all staff of this personal care home were enrolled in the medication refresher course through the Learning Management System (LMS). The medication refresher course reviews the medication administration process, including the timeframes for administration as per the prescriber's direction. All staff of this personal care home completed the medication refresher on 8/8/2024. Proof of the remediation, including the course outline/topics covered is found in Attachment #17 and Attachment #18. Additionally, all staff of this personal care home were observed between the dates of 7/30/2024 and 8/8/2024 by the Director and Director of Nursing on the medication administration process and controlled medication substance process. Proof of the observations and follow up conducted with the staff of this personal care home is found in Attachment #17. Finally, effective 7/15/2024, either the Director, Director of Nursing or the Associate Executive Director are physically on-site 1-2 times per week at the personal care home to monitor shift change protocols, including controlled substance counts and medication administrations. If any issues are found during on-site inspections, then then the Director, Director of Nursing or Associate Executive Director would address the staff directly in real time, document the issue and work with Human Resources, as needed, to issue disciplinary action. All personal care home staff will continue to receive medication administration training upon hire and annually through the medication refresher course.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 09/20/2024)

221b - Activity Types

12. Requirements

2600.
221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

The home's July 2024 activities program indicated outdoor games was the activity for 7/22/24. Per resident interview, the home did not have any activities for residents on 7/22/24. Additionally, the home was to provide miniature golf as the activity on 7/23/24. As of 6:30 PM on 7/23/24, the home had not provided miniature golf and did not have plans to provide the activity for the residents.

Plan of Correction ***Accept [redacted] - 08/16/2024)***

On 8/15/2024, the Program Coordinator re-issued the activity calendar that contains activities for residents that can be achieved. Proof of the updated activity calendar is found in Attachment #20. Keystone Service Systems, Inc.

221b Activity Types (continued)

(Keystone) did not have a good process in place to ensure residents activities are carried out as outlined on the activity calendar. As a result, beginning the week of 8/19/24,the Director or Associate Executive Director will observe the activities completed as outlined on the activity calendar during the weekly on site meetings. If issues are found in that the activity for the day isn't carried out as outlined on the calendar, the Director or Associate Executive Director will address with the staff on shift and Program Coordinator. Finally, on 8/5/2024, the Director trained all staff of this personal care home, including the Program Coordinator, on regulation 2600. 221(b), the activity calendar and the plan to have activities be executed as outlined on the calendar by the staff. Proof of this training is found in Attachment #6.

Licensee's Proposed Overall Completion Date: *08/19/2024*

Implemented ([redacted] - 09/20/2024)

252 - Record Content

13. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident #2's record does not include their eye color, identifying marks, religion, or race.

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On [redacted], Resident #2's record was updated by the Director to include their eye color, identifying marks, religion and race. Proof of this remediation is found in Attachment #21. Keystone Service Systems, Inc. (Keystone) maintains an electronic health record (EHR) for each individual wherein the fields listed in 2600.252 must be completed in the EHR for the resident by the Program Administrator at the time of admission, annually and when changes occur to the required information. On 7/31/2024, Keystone completed an optimization to the EHR in which the fields outlined in 2600.252 will be required for completion and will be prompted for review annually. In the interim, on 8/15/2024, the Director trained the Program Coordinator on regulation 2600.252 and will audit all individual's records to ensure the contents of record required in the regulations are complete and accurate. If issues are found, remediation actions will be taken to ensure the most up to date information is listed. Proof of the completed training is found in Attachment #2. Proof of the completed audit, including remediation actions taken, is found in Attachment #22.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented [redacted] - 09/20/2024)

254a - Records Discharge/Active

14. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On [redacted], Resident #2's blood pressure records, medication orders and parameters for administration, and medication administration records were unlocked, unattended, and accessible on top of the medication area in the kitchen.

254a - Records Discharge/Active *(continued)*

Plan of Correction ***Accept ([redacted] - 08/16/2024)***

On 8/9/2024, the blood pressure records, medication orders and parameters for administration, and medication administration record for Resident #2 was locked in the medication cart by the Director. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to, ensuring protected health information (PHI) is kept confidential and locked. This program standard 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 Program Administrator/Program Coordinator did not recognize this as an issue. It should be noted effective, 7/18/2024, that the Program Administrator of this program is no longer with Keystone. As a result on 8/15/2024, the Director trained the Program Coordinator on regulation 2600. 254(a) and specifically looking throughout the entire program to ensure PHI is stored appropriately; proof of this remediation is found in Attachment #2. Effective, 8/12/2024, the Director or Associate Executive Director will review the program during the weekly on-site visits to ensure all PHI is maintained locked in the staff office. Effective 8/16/2024, the Program Coordinator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director. Finally, on 8/5/2024, the Director trained all staff of this personal care home on regulation 2600.254(a), the need to maintain all PHI confidentially in the staff office and the staff office must remain locked. Proof of this training is found in Attachment #6.

Licensee's Proposed Overall Completion Date: *08/16/2024*

Implemented ([redacted] - 09/20/2024)