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

September 16, 2024

[redacted] , PROGRAM ADMINSTRATOR
KEYSTONE SERVICE SYSTEMS INC
[redacted]

RE: KHS MENTAL HEALTH SERVICES - BEAVER CREEK SCR
676 BEAVER CREEK ROAD
HANOVER, PA, 17331
LICENSE/COC#: 33480

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/25/2024 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 - BEAVER CREEK SCR* **License #**: *33480* **License Expiration**: *06/11/2025*

Address: *676 BEAVER CREEK ROAD, HANOVER, PA 17331*

County: *ADAMS* **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: *R-3* **Date**: *12/24/2018* **Issued By**: *Berwick Township*

Staffing Hours

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

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal* **Exit Conference Date**: *07/25/2024*

Inspection Dates and Department Representative

07/25/2024 - 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: *0* **Are 60 Years of Age or Older**: *8*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *3*

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

Inspections / Reviews

07/25/2024 - Full

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

08/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/16/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/06/2024*

Inspections / Reviews *(continued)*

09/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/16/2024*

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

65f - Training Topics

1. 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.

Description of Violation

Direct care Staff Person A did not receive training on instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 2023 training year:

Plan of Correction ***Accept (- 08/19/2024)***

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 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 with 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 timely. In review of this citation in context to the business process, it was found that employee and Program Supervisor did not follow the business process surrounding overdue trainings and the follow-up process to ensure they are completed on time. 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 8/23/2024. On 8/9/2024, the Associate Executive Director trained the Director and Program Administrator on regulation 2600.65(f)(2), 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: *08/23/2024*

Implemented (- 09/16/2024)

85a - Sanitary Conditions

2. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

On 7/25/24, the carpeted steps leading to the basement were severely stained, appearing black.

On 7/25/24, the two refrigerators located in the lounge/common area contained various food and liquid stains as well as crumbs.

On 7/25/24, there were no hand drying options in the first and second floor bathrooms.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On 7/30/2024, the work order was submitted to replace the carpet steps leading to the basement. Proof of this submitted work order can be found in Attachment #2. The carpet will be replaced by 9/15/2024; proof of this remediation will be forthcoming. On 8/9/2024 the Program Administrator cleaned both the refrigerator in the lounge and in the common area; proof of this cleaning is found in Attachment #3. On 8/15/2024, work order was submitted to have hand dryers installed in the first floor and second floor bathrooms; proof of this submitted work order can be found in Attachment #4. The hand dryers will be install on or before 8/31/2024; proof of this remediation will be forthcoming. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring the home is clean and sanitary, 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 thoroughly or accurately by the Program Administrator. As a result on 8/12/2024, the Director re-trained the Program Administrator on regulation 2600. 85(a) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #5. Effective, 8/12/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 8/12/2024, 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: *09/16/2024*

Implemented ([redacted] - 09/16/2024)

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

On 7/25/24, the beds for Resident 1 and Resident 4 did not have sheets and the pillowcases were soiled and dirty.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On 07/31/2024, the bedsheets and pillow cases were washed and replaced for Resident #1's room and Resident

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

#4's room. 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 pillows, bed linens and blankets are clean and 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 not being completed thoroughly or accurately by the Program Administrator. As a result on 8/12/2024 the Director re-trained the Program Administrator on regulation 2600. 101(j)(3) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #5. Effective, 6/11/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 8/12/2024, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director. Finally, on/or before 8/16/2024, all other resident's rooms will be inspected by the Program Administrator to ensure that the room has a pillow, linens and blankets that are clean and in good condition.

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

Implemented ([redacted] - 09/16/2024)

103h - Thawing Food

4. Requirements

2600.
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 7/25/24, there were 2 packages of Hatfield-brand all-natural Texas smoked BBQ pork loin fillets being thawed in a container on the stove. They had been thawing there since the night before.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

The pork loin observed on the stove thawing at the time of inspection was discarded by the direct support staff. 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 8/23/2024; 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: *08/23/2024*

Implemented ([redacted] - 09/16/2024)

107d - Procedure Emergency Management Agency Submission

5. Requirements

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

Description of Violation

The home's written emergency procedures were not reviewed and submitted to the local emergency management agency in 2023.

Plan of Correction ***Accept (- 08/19/2024)***

The personal care home's written emergency procedures will be reviewed and updated by the Director on or before 8/23/2024. The home's updated written emergency procedures will be submitted to the local emergency management agency by the Program Administrator on or before 8/23/2024; 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 10/1/2024, wherein emergency management procedures for all personal care homes are maintained by an administrative staff in a central location and this staff will also monitor upcoming due dates for review/submission. 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 9/15/2024. Proof of this audit and any remediation will be maintained by the Associate Executive Director.

Licensee's Proposed Overall Completion Date: *10/01/2024*

Implemented (- 09/16/2024)

121a - Unobstructed Egress

6. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 7/25/24, the exit door located in the lounge area was blocked by an end table.

Plan of Correction ***Accept (- 08/19/2024)***

On 07/25/2024, the end table located in the lounge area blocking the exit was moved; 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 stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. 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 not being completed thoroughly or accurately by the Program Administrator. As a result on 8/12/2024, the Director re-trained the Program Administrator on regulation 2600. 121(a) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #5. Effective, 6/11/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 8/12/2024, 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 (- 09/16/2024)

121a - Unobstructed Egress *(continued)*

125a - Combustible Storage

7. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A full propane tank attached to the barbecue grill was stored near the designated smoking area.

Plan of Correction ***Accept (- 08/19/2024)***

On 07/25/2024, the barbecue grill with the propane tank was relocated away from the designated smoking area; 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. 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 not being completed thoroughly or accurately by the Program Administrator. As a result on 8/12/2024, the Director re-trained the Program Administrator on regulation 2600. 125(a) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #5. Effective, 6/11/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 8/12/2024, 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 (- 09/16/2024)

141b1 - Annual Medical Evaluation

8. Requirements

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

Description of Violation

Resident 1's most recent medical evaluation was completed on . The resident's previous medical evaluation was completed on

Resident 2's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on

Plan of Correction ***Accept (- 08/19/2024)***

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

141b1 - Annual Medical Evaluation (continued)

was found that these were not occurring timely due to staffing issues. As a result, on or before 8/9/2024, the Associate Executive Director trained the Director and Program Administrator on regulation 2600.141(b)(1) and the business process to maintain compliance with this standard regardless of staffing issues. Proof of this training is found in Attachment #1. Effective 8/9/2024, 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 8/23/2024; proof of this audit will be forthcoming.

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

Implemented ([redacted] - 09/16/2024)

144c1 - Smoking Area Guidelines

9. 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 at the back porch. On 7/25/24, there were multiple cigarette butts observed in the mulch/garden area and along the brick sidewalk at the rear of the home.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On 7/27/2024 the cigarette butts observed in the mulch/garden area were appropriately discarded; proof of this remediation is found in Attachment #9. On 8/15/2024, the Program Administrator provided education during the house meeting to all residents on the house rules and safe disposal of cigarettes; proof of this remediation is found in Attachment #10. Additionally, on or before 9/4/2024, the Program Administrator re-educated all staff of this personal care home on requirements to smoke in the designated smoking section, to place all cigarette butts in the smoking receptacles and to clean up cigarette butts found in the smoking area; proof of this remediation will be forthcoming. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to, ensuring smoking occurs at designated areas, cigarette butts are disposed of properly and cigarette disposal bins are regularly emptied. Theses program standards are 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 thoroughly or accurately by the Program Administrator. As a result on 8/12/2024, the Director re-trained the Program Administrator on regulation 2600. 144(c) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #5. The Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director. Effective, 6/11/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 8/12/2024, 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*

144c1 - Smoking Area Guidelines *(continued)*

Implemented ([redacted] - 09/16/2024)

171b5 - First Aid Kit

10. 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

The home's Toyota Sienna did not contain a first aid kit.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On 7/25/2024, an extra first aid kit was placed in the van for requirement 2600.96. The first aid kit was placed in the Toyota Sienna on 7/25/2024; proof of this remediation is found in Attachment #11. Keystone Service Systems, Inc. (Keystone) maintains a process wherein a digital vehicle safety checklist is completed monthly by the Program Administrator or Program Coordinator. Any non-compliances are monitored for completion through reporting by the Director and Associate Executive Director. Effective 9/15/2024, the data from the monthly vehicle safety checklist will be removed and monitored during management meetings to ensure all non-compliances are addressed in a timely manner. Finally, on/or before 8/23/2024, the Director will re-train the Program Administrator/Program Coordinator on regulation 2600.171(b)(5), completion of the vehicle safety checklist and ensuring that a first aid kit is present in the vehicle. Proof of this remediation is forthcoming.

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

Implemented ([redacted] - 09/16/2024)

183e - Storing Medications

11. 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

Resident 2 is prescribed [redacted] as needed. This medication expired on 6/4/24 and was observed in the home's medication cart on 7/25/24.

Resident 3 is prescribed [redacted]) as needed. This medication expired on 6/8/24 and was observed in the home's medication cart.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On 7/25/2024, the expired [redacted] for Resident #2 and the expired [redacted] for Resident #3 were appropriately discarded by the Program Administrator and MH Director. It should be noted that there are current medications ([redacted]) in the medication cart for Resident #2 and Resident #3. Effective 06/28/2024, roles and responsibilities were defined for the agency nurse by the Associate Executive Director and Director of Nursing which includes bi-weekly medication audits. Effective, 6/20/2024, as part of the medication audit, the nurse is to evaluate if all medications are within expiration. If issues are found with the medications not being within expiration, the nurse is responsible to contact the pharmacy and complete remediation as required. Effective,

183e - Storing Medications (continued)

7/5/2024 the Director of Nursing and Director of Residential Services will review the medical audits completed by the agency nurse bi-weekly to ensure accuracy in the review and follow up on findings occurs timely. On 8/12/2024, the Associate Executive Director trained the Director, Director of Nursing, Program Administrator and agency nurse on regulation 2600.183(e) and the agency nurse roles and responsibilities around medications being present, not expired and being administered as prescribed. The Associate Executive Director also trained all of these staff on the oversight responsibilities in the medication audit process; proof of this remediation is found in Attachment #12. On or before 9/4/2024, the Director trained all staff of this personal care home on ensuring all medications at the program are within expiration and notification to the agency nurse and Program Administrator if a medication is a week out from expiration. Proof of this remediation will be forthcoming.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 09/16/2024)

185a - Implement Storage Procedures

12. 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 4 is prescribed [redacted] as needed. On 7/25/24, this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On 8/6/2024, the [redacted] for Resident #4 was obtained through the pharmacy and placed in the medication cart. Proof of this remediation is found in Attachment #13. Effective 06/28/2024, roles and responsibilities were defined for the agency nurse by the Associate Executive Director and Director of Nursing which includes bi-weekly medication audits. Effective, 6/20/2024, as part of the medication audit, the nurse is to evaluate if all medications are present in the home as outlined in the electronic medication administration record (eMAR). If issues are found with the medications not being present within the home, the nurse is responsible to contact the pharmacy and/or physician and complete remediation as required. Effective, 7/5/2024 the Director of Nursing and Director of Residential Services will review the medical audits completed by the agency nurse bi-weekly to ensure accuracy in the review and follow up on findings occurs timely. On 8/12/2024, the Associate Executive Director trained the Director, Director of Nursing, Program Administrator and agency nurse on regulation 2600.185(a) and the agency nurse roles and responsibilities around medications being present, not expired and being administered as prescribed. The Associate Executive Director also trained all of these staff on the oversight responsibilities in the medication audit process; proof of this remediation is found in Attachment #12. On or before 9/4/2024, the Director trained all staff of this personal care home on ensuring all medications at the program are present for administration and notification to the agency nurse and Program Administrator if a medication has a week supply or less of a medication. Proof of this remediation will be forthcoming.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 09/16/2024)

221c - Post Activity Calendar

13. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The home does not have a current weekly activity calendar posted in a public and conspicuous place in the home. The activity calendar that is posted is dated June of 2024.

Plan of Correction ***Accept ([redacted] - 08/19/2024)***

On 7/26/2024, the currently weekly activity calendar was posted. Proof of current posted activity calendar is found in Attachment #14. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to, ensuring a current weekly calendar is posted 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 thoroughly or accurately by the Program Administrator. As a result on 8/12/2024, the Director re-trained the Program Administrator on regulation 2600. 221(c) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #5. Effective, 6/11/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 8/12/2024, 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] - 09/16/2024)