

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

November 19, 2024

[REDACTED], EXECUTIVE DIRECTOR OF KHS MENTAL HEALTH SERVICES
KEYSTONE SERVICE SYSTEMS INC
[REDACTED]

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

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/21/2024, 08/22/2024 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-REYNOLDS LANE SPECIALIZED PC
License #: 31658 **License Expiration:** 06/10/2025

Address: 5250 REYNOLDS LANE, HARRISBURG, PA 17111

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

Staffing Hours

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

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Incident **Exit Conference Date:** 08/22/2024

Inspection Dates and Department Representative

08/21/2024 - On-Site: [REDACTED]
 08/22/2024 - 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:** 4
Diagnosed with Mental Illness: 7 **Diagnosed with Intellectual Disability:** 2
Have Mobility Need: 0 **Have Physical Disability:** 0

Inspections / Reviews

08/21/2024 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/19/2024

Inspections / Reviews (*continued*)

09/26/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/18/2024

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 10/03/2024

09/30/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/18/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/18/2024

11/19/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/18/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On 08/21/2024, at approximately 10:30AM, resident files for Residents 1, 2, and 3 and staff files for Staff Persons B and C were requested. These records weren't received until 12:08PM. Furthermore, Staff Person B's 2023 annual training and Staff Person C's 1st day and 1st 40 hours of training weren't received until 2:36PM.

Plan of Correction

Accept ([REDACTED]) - 09/26/2024)

On 9/24/2024, the Program Administrator was educated by the Director on the licensing inspection notification process and timeliness response to the licensing request. Proof of this re-education completed by the Director on regulation 2600.5(a)(1) and timeliness of response with the Program Administrator is found in Attachment #1. Keystone Service Systems, Inc. (Keystone) does not have a licensing preparedness process. As a result on/or before 10/25/2024, the Associate Executive Director will work in tandem with the Compliance Department to develop a licensing preparedness process. This process will identify those items needed at the time of inspection, centralizing those documents in a centralized location for ease of access and having a crosswalk for those items that need to be requested. Additionally, on/or before 11/8/2024, the Associate Executive Director will train all Program Administrators on the new licensing preparedness process. Proof of this training will be forthcoming. The new licensing preparedness process will go into effect 11/9/2024.

Proposed Overall Completion Date: 11/09/2024

Licensee's Proposed Overall Completion Date: 11/09/2024

Implemented ([REDACTED]) - 11/19/2024)

15a - Resident Abuse Report

2. 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

The following allegations of abuse did not have a written report (Act 13) submitted to the Local Area Agency on Aging and/or Local Adult Protective Services:

- On [REDACTED] Resident 4 alleged staff was trying to stab him/her, and people were sexually assaulting him/her.
- On [REDACTED] Resident 4 alleged that male residents were coming into his/her room at night and sexually assaulting him/her.
- On [REDACTED], it was reported to staff that Resident 5 had funds stolen from his/her debit card.
- On [REDACTED], Resident 4 called 911 alleging that 3 men were shooting at him/her.
- On [REDACTED], Resident 4 accused Resident 2 of sexually assaulting him/her.

15a Resident Abuse Report (continued)

Plan of Correction

Accept () - 09/30/2024

On or before 9/24/2024, reports were made to Older Adult Protective Services for Resident 4 and Resident 5; proof of this reporting is found in Attachment #2. Keystone Service Systems, Inc. (Keystone) maintains a process in which all allegations of abuse are reported to the Department and subsequently to Adult Protective Services (APS)/Older Adult Protective Services (OAPS). In review of this citation, it was found that reports were not made to APS/OAPS for incidents involving individuals who are in active mental health crisis/ exhibiting clear delusions. As a result, on/or before 9/24/2024, the Associate Executive Director (AED) will train the Program Administrator and MH Director on regulation 2600.15(a) and the need to report all allegations of abuse regardless of verity to the Department and to APS/OAPS. Proof of this training is found in Attachment #3. Finally, to ensure ongoing compliance, effective 10/7/2024, during Director on site visits all incident reports submitted since the last on site visit will be audited by the Director to ensure all incident reports are present in the program, include both initial/final reports (if applicable) and proof of oral/written reports are present for reportable categories.

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented () - 11/19/2024

65f - Training Topics

3. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
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 Person B did not complete the following annual training topics for the 2023 staff training year:

Medication self administration.

Instructions on meeting the needs (DME and RASP).

Personal service care needs of the resident.

Plan of Correction

Accept () - 09/26/2024

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 as outlined in the preadmission screening form, assessment evaluation, support plan, medication self administration and personal care services needed by 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

65f - Training Topics (continued)

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 issue pre-dates the current business process to maintain compliance with standard 2600.65(f)(1)(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 10/4/2024 . On/or before 9/24/2024, the Associate Executive Director will train the Director and Program Administrator on regulation 2600.65(f)(1)(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 #3.

Licensee's Proposed Overall Completion Date: 10/04/2024

Implemented (█) - 11/19/2024)

107d - Procedure Emergency Management Agency Submission

4. 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 last reviewed and updated on 11/08/2023. However, the written emergency procedures have not been submitted to the local Emergency Management Agency (EMA) since 01/21/2021.

Plan of Correction

Accept (█) - 09/26/2024)

On 9/24/2024, The Program Administrator reviewed and updated the personal care home's written emergency procedures and submitted the updated emergency procedures to the local emergency management agency; proof of this submittal is found in Attachment #4 and Attachment #5. 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 10/4/2024. Proof of this audit and any remediation will be maintained by the Associate Executive Director. Finally, on 9/24/2024, the Associate Executive Director trained the MH Director and Program Administrator on regulation 2600.107(d); proof of this training is found in Attachment #X.

Licensee's Proposed Overall Completion Date: 10/04/2024

Implemented (█) - 11/19/2024)

132a - Monthly Fire Drill

5. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

132a Monthly Fire Drill (continued)

Description of Violation

An unannounced fire drill was not held during the month of February 2024.

Repeated Violation 09/07/2023

Plan of Correction

Accept () - 09/26/2024)

Keystone Services Systems, Inc. (Keystone) maintains a process in which all fire drills are scheduled by the Program Administrator for the entire year; this calendar is also shared with the Director overseeing the personal care home. The purpose of this scheduling is to ensure that fire drills occur each month, on different dates and times of the week and include fire drills that are scheduled at least every 6 months during sleeping hours. The completed monthly fire drill is instigated by the Program Administrator based upon the monthly schedule and notifies the staff on shift to conduct a fire drill. The staff on shift who conducted the fire drill will complete the Electronic Fire Drill Form. The Electronic Fire Drill Form 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. Effective 10/11/2023, 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 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 that follow up did not occur by the Director with the Program Administrator after the missed fire drill date and wasn't found to be out of compliance until the following month. In order to ensure ongoing compliance with this requirement, on 9/24/2024, the Associate Executive Director trained the Director and Program Administrator on regulation 2600.132(a), the electronic fire drill process and oversight of the fire drill process by the Director; proof of this training is found in Attachment #3. The Director will train all staff of this personal care home on the regulation 2600.132(a) and the fire drill process by 10/18/2024. 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: 10/18/2024

Implemented () - 11/19/2024)

132b - Safety Inspection/Fire Drill

6. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and fire drill observed by a fire safety expert was conducted on 10/20/2023. However, the prior fire safety inspection and conducted fire drill by a fire safety expert was completed on 09/23/2022.

Plan of Correction

Accept () - 09/26/2024)

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

132b - Safety Inspection/Fire Drill (continued)

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 citation pre-dates the current business process. To ensure ongoing compliance, on 9/24/2024, 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 #3. This personal care home has a fire safety inspection scheduled for 10/17/2024 with the fire safety expert.

Licensee's Proposed Overall Completion Date: 10/17/2024

Implemented (█) - 11/19/2024)

132d - Evacuation

7. 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

During the fire drill on 11/08/2023 at 1:46PM, it took a total of 6 minutes and 36 seconds to evacuate the residence. The home had a maximum safe evacuation time specified in writing within the past year by a fire safety expert of 5 minutes.

During the fire drill on 09/27/2023 at 2:30PM, it took a total of 6 minutes and 15 seconds to evacuate the residence. The home had a maximum safe evacuation time specified in writing within the past year by a fire safety expert of 2 minutes and 30 seconds.

Repeated Violation - 09/07/2023

Plan of Correction

Accept (█) - 09/26/2024)

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 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 that the Electronic Fire Drill Form was not being completed accurately and/or monitored to ensure compliance with fire safety standards. As a result, on/or before 9/24/2024, the Associate Executive Director will train the Director and Program Administrator on regulation 2600.132(d), the

132d - Evacuation (continued)

electronic fire drill process and oversight of the fire drill process by the Director. Proof of this training is found in Attachment #3. On/or before 10/18/2024, the Director will train all staff of this personal care home on the regulation 2600.132(d), the fire drill process and ensuring that drills are timely and recorded accurately. Proof of this training will be forthcoming. 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. Additionally, effective 11/1/2024, to improve oversight of the fire drill process, the Director will observe fire drills on a quarterly basis to ensure staff are completing the fire drills accurately.

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented (█) - 11/19/2024)

141a - Medical Evaluation**8. 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 3 was admitted to the home on █. However, the resident did not have an initial medical evaluation completed until █.

Plan of Correction

Accept (█) - 09/26/2024)

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. The Program Administrator will schedule the annual appointment at the time of uploading the initial medical evaluation. If an annual appointment can't be scheduled, then a placeholder appointment is scheduled for 3 months prior to the annual appointment date to schedule the annual appointment. Through review of this citation in context to the business process, it was found that the Program Administrator failed to ensure the medical evaluation was complete, accurate and met all regulatory requirements prior to uploading the supporting documentation and marking the appointment as complete. As a result, on or before 9/24/2024, 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 is found in Attachment #3. The Program Administrator will audit all other resident records to ensure medical evaluation compliance with this standard on/or before 10/4/2024; proof of this audit will be maintained by the Program Administrator. Effective 10/4/2024, the Program Administrator will monitor all medical evaluation timeliness by completing monthly resident record reviews. The Director will provide oversight for these reviews and will also audit records on a rotating basis to ensure accuracy in the Program Administrators reviewing and any identified remediation is completed by the Program Administrator (or designee).

Licensee's Proposed Overall Completion Date: 10/04/2024

141a Medical Evaluation (continued)

Implemented [REDACTED] - 11/19/2024)

141b1 Annual Medical Evaluation

9. Requirements

2600.

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

Description of Violation

Resident 2's most recent medical evaluation was completed on [REDACTED].

Plan of Correction

Accept [REDACTED] - 09/26/2024)

Resident #2 is scheduled for a medical evaluation on [REDACTED]; proof of the completed evaluation will be forthcoming. 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. The Program Administrator will schedule the annual appointment at the time of uploading the initial medical evaluation. If an annual appointment can't be scheduled, then a placeholder appointment is scheduled for 3 months prior to the annual appointment date to schedule the annual appointment. Through review of this citation in context to the business process, it was found that the Program Administrator failed to ensure the medical evaluation was scheduled in the EHR. As a result, on or before 9/24/2024, the Associate Executive Director will train the Director and Program Administrator on regulation 2600.141 (b)(1), the business process around maintaining compliant Medical Evaluations and oversight of the process by the Director; proof of this training is found in Attachment #3. The Program Administrator will audit all other resident records to ensure medical evaluation compliance with this standard on/or before 10/4/2024; proof of this audit will be maintained by the Program Administrator. Effective 10/4/2024, the Program Administrator will monitor all medical evaluation timeliness by completing monthly resident record reviews. The Director will provide oversight for these reviews and will also audit records on a rotating basis to ensure accuracy in the Program Administrators reviewing and any identified remediation is completed by the Program Administrator (or designee).

Proposed Overall Completion Date: 11/14/2024

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [REDACTED] - 11/19/2024)

183e Storing Medications

10. 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.

183e - Storing Medications (continued)

Description of Violation

Resident 3's [REDACTED] is currently open and in use. However, there is no date indicating when the insulin was opened.

Plan of Correction

Accept [REDACTED] - 09/26/2024)

The [REDACTED] found at the time of inspection for Resident #3 was discarded. A new [REDACTED] container was opened on [REDACTED] and dated accordingly; proof of this remediation is found in Attachment #6. Effective [REDACTED], 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 and are labeled upon opening (if applicable). If issues are found with the medications not being within expiration or labeled, the nurse is responsible to contact the pharmacy 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 9/24/2024 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, dated 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 #7. On/or before 10/18/2024, the Director trained all staff of this personal care home on ensuring all medications at the program are within expiration and specifically that the insulin is dated upon opening; proof of this remediation will be forthcoming.

Licensee's Proposed Overall Completion Date: 10/18/2024

Implemented [REDACTED] - 11/19/2024)

185a - Implement Storage Procedures

11. 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 3 has the following discrepancies between the blood sugar readings documented on the resident's MAR (medication administration record) and the readings in the resident's glucometer:

- On [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the resident's glucometer states [REDACTED].
- On [REDACTED] at [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the resident's glucometer states [REDACTED].
- On [REDACTED] at [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the resident's glucometer states [REDACTED].
- On [REDACTED] at [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the resident's glucometer states [REDACTED].
- On [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the resident's glucometer states [REDACTED].
- On [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the resident's glucometer states [REDACTED].
- On [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the

185a - Implement Storage Procedures (continued)

resident's glucometer states [REDACTED].

On [REDACTED], the resident's MAR has a documented reading of [REDACTED]. However, the reading in the resident's glucometer states [REDACTED].

Plan of Correction

Accept [REDACTED] - 09/26/2024)

On 9/4/2024, the glucometer was calibrated by the agency nurse. Keystone Service Systems, Inc. (Keystone) did not have a formalized process to audit all medical components of individuals supported, including medications. Therefore, effective 06/28/2024, roles and responsibilities were defined for the agency nurse by the Associate Executive Director and Director of Nursing which includes weekly medication audits. As part of the medication audit, effective 6/24/2024, the nurse is to evaluate if the staff are documenting Resident #3's blood sugar levels correctly and if the blood sugar levels match the glucometer readings. If issues are found with the readings, the nurse is responsible to correct the reading based upon the glucometer reading and to re-educate the staff. Effective 7/1/2024, 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/or before 9/24/2024, the Associate Executive Director will train 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, medication prescriptions/eMAR matching (including blood sugar levels), medications being administered as prescribed and in the original medication packaging. Proof of this training is found in Attachment #7. Finally, on/or before 9/4/2024, all staff will be trained by the agency nurse and Program Administrator on regulation 2600.185(a), the blood sugar reading and recording process and the glucometer reconciliation process. Proof of this training is found in Attachment #8.

Licensee's Proposed Overall Completion Date: 09/25/2024

Implemented [REDACTED] - 11/19/2024)

187a - Medication Record

12. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

Description of Violation

Resident 3 is prescribed the following:

- [REDACTED], with order to inject prior to meals according to blood sugars as follows:

[REDACTED]

- [REDACTED] with order to inject [REDACTED] units under the skin in the morning (Inject [REDACTED] units if not eating or ill or inject [REDACTED] if blood sugar less than [REDACTED]. Do not take any if sugar less than [REDACTED] or not eating.

187a - Medication Record (continued)

[REDACTED] with orders to inject [REDACTED] units under the skin in the evening [REDACTED]. Do not take if sugar less than [REDACTED] or not eating.

However, Resident 3's medication administration record (MAR) does not document how many units of insulin are administered to the resident for any of these medications.

Plan of Correction

Accept [REDACTED] - 09/26/2024

Effective 9/5/2024, staff are documenting the total insulin units given based upon Resident #3's blood sugar readings. Proof of this documentation is found in Attachment #9.

Keystone Service Systems, Inc. (Keystone) did not have a formalized process to audit all medical components of individuals supported, including medications. Therefore, effective 06/28/2024, roles and responsibilities were defined for the agency nurse by the Associate Executive Director and Director of Nursing which includes weekly medication audits. As part of the medication audit, effective 9/16/2024, the nurse is to evaluate if the medications, including insulin, are being administered as prescribed. If issues are found in that staff are not documenting for insulin units given, then the nurse will immediately follow up with the staff who didn't document for re-education and will notify the Program Administrator of the issue. Effective 9/16/2024, 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/or before 9/24/2024, the Associate Executive Director will train the Director, Director of Nursing, Program Administrator and agency nurse on regulation 2600.187(a) and the agency nurse roles and responsibilities around medications being present, medication prescriptions/eMAR matching, medications being administered and documented as prescribed and in the original medication packaging. Proof of this training is found in Attachment #7. Finally, on/or before 9/4/2024, all staff were trained by the agency nurse and Program Administrator on regulation 2600.187(a) and the process in place for documenting the individuals blood sugar levels consistent with the glucometer reading and then issuing the insulin and documenting the insulin given in accordance with the sliding scale instruction issued by Resident #3's physician. Proof of this training is found in Attachment #8.

Licensee's Proposed Overall Completion Date: 09/25/2024

Implemented [REDACTED] - 11/19/2024

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident 3 has an order that specifies the following:

**If blood sugar is above [REDACTED] call [REDACTED] endocrinologist @ (redacted phone number) and ask to speak to the nurse's line. It is a 24/7 line. **You should do this before giving [REDACTED] any insulin."

On the following dates and times, the resident's blood sugar was over [REDACTED], and the endocrinologist was not contacted:

- On [REDACTED], the resident had a documented blood sugar of [REDACTED].
- On [REDACTED], the resident had a documented blood sugar of [REDACTED].
- On [REDACTED], the resident had a documented blood sugar of [REDACTED].

Plan of Correction

Accept [REDACTED] - 09/26/2024

Resident #3's electronic health record (EHR) and electronic medication administration record (eMAR) were updated to reflect the physician issued guidance. Specifically, on the eMAR in the blood sugar reading vital, the protocol was

187d Follow Prescriber's Orders (continued)

listed and guidance was documented on where to document the conversation with the physician in the EHR. Proof of this remediation is found in Attachment #9. Keystone Service Systems, Inc. (Keystone) did not have a formalized process to audit all medical components of individuals supported, including medications. Therefore, effective 06/28/2024, roles and responsibilities were defined for the agency nurse by the Associate Executive Director and Director of Nursing which includes weekly medication audits. As part of the medication audit, effective 9/16/2024, the nurse is to evaluate if the medications, including insulin, are being administered as prescribed. If issues are found in that staff are not following the physician issued protocol, then the nurse will immediately follow up with the staff who didn't document for re education and will notify the Program Administrator of the issue. Effective 9/16/2024, 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/or before 9/24/2024, the Associate Executive Director will train the Director, Director of Nursing, Program Administrator and agency nurse on regulation 2600.187(d) and the agency nurse roles and responsibilities around medications being present, medication prescriptions/eMAR matching, medications being administered and documented as prescribed and specifically that proof of communication is being documented with the physician if Resident #3's blood sugar exceeds 401. Proof of this training is found in Attachment #7. Finally, on/or before 9/4/2024, all staff were trained by the agency nurse and Program Administrator on regulation 2600.187(d) and the process in place for documenting the individuals blood sugar levels consistent with the glucometer reading and then issuing the insulin and documenting the insulin given in accordance with the sliding scale instruction issued by Resident #3's physician. Additionally, staff will be trained on the blood sugar protocol for Resident #3, who to contact if the blood sugar reading is 401 or higher and how to document this in the EHR. Proof of this training is found in Attachment #8.

Licensee's Proposed Overall Completion Date: 09/25/2024

Implemented (█) - 11/19/2024)