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

December 12, 2024

[redacted]
KEYSTONE SERVICE SYSTEMS INC
[redacted]

RE: KHS MENTAL HEALTH SERVICES-
GARDNERS SCR
221 OLD STATE ROAD
GARDNERS, PA, 17324
LICENSE/COC#: 31507

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/19/2024 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-GARDNERS SCR* **License #**: *31507* **License Expiration**: *06/07/2025*

Address: *221 OLD STATE ROAD, GARDNERS, PA 17324*

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

Administrator

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

Legal Entity

Name: *KEYSTONE SERVICE SYSTEMS INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-3 SP* **Date**: *09/18/2002* **Issued By**: *L&I*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/19/2024*

Inspection Dates and Department Representative

09/19/2024 - 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: *6* **Are 60 Years of Age or Older**: *5*

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

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

Inspections / Reviews

09/19/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/07/2024*

10/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/13/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/12/2024*

Inspections / Reviews *(continued)*

12/12/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/13/2024*

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

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident [redacted] has a hospital type bed which is in disrepair as the bed is collapsing with middle of the bed sagging towards the floor and the side towards the door is leaning to the floor. The legs at the foot end of the bed are splayed out away from the bed. It appears that the frame of the bed has broken causing the condition of the bed to be hazardous and in danger of complete collapse to the floor. The bed is equipped with half rails, one of which on the side of the bed towards the door, is leaning away from the bed approximately 12 inches which is an entrapment hazard.

Plan of Correction ***Accept ([redacted] 10/08/2024)***

On [redacted], Resident [redacted] primary care physician (PCP) was contacted by the Program Administrator as the script for the hospital bed was expired. Once the PCP confirms the type of bed needed for Resident [redacted], the Program Administrator will either obtain an updated script and procure a hospital bed or will purchase a regular bed for Resident [redacted] complete with a mattress and boxspring. 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 wheelchairs, walkers, prosthetic devices and other apparatus used by residents are clean, free of hazard and in good repair. 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 10/3/2024, the Director re-trained the Program Administrator on regulation 2600. 81(b) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #1. Effective, 11/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 10/3/2024, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director.

Proposed Overall Completion Date: 11/01/2024

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

Implemented [redacted] - 12/12/2024)

88a - Surfaces

2. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The following conditions were observed during the initial walk through of the home:
The exit door from the living room to the rear patio was difficult to open, requiring a great deal of pushing force to open it.
The floor of the interior fire exit stairwell from the second floor to the rear of the home was dirty with an accumulation of dead insects and dirt.

88a - Surfaces (continued)

Plan of Correction ***Accept [redacted] - 10/08/2024)***

On [redacted], a work order was submitted for the exit door from the living room to the rear patio to open more freely. Proof of this submitted work order is found in Attachment #2. On 9/19/2024, the Direct Support Professional cleaned the floor of the interior fire exit stairwell from the second floor to the rear of the home. Proof of this cleaning is found in Attachment #3. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazard. 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 10/3/2024, the Director re-trained the Program Administrator on regulation 2600. 88(a) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #1. Effective, 11/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 10/3/2024, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director.

Proposed Overall Completion Date: 11/01/2024

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

Implemented [redacted] - 12/12/2024)

96a - First Aid Kit

3. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the office/medication room does not include a thermometer, breathing shield and eye coverings.

Plan of Correction ***Accept [redacted] - 10/08/2024)***

On [redacted] a thermometer, breathing shield and eye covering were purchased by the Program Administrator and LPN and placed in the safety kit located in the office/medication room. 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 the first aid kit includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. 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 10/3/2024, the Director re-trained the Program Administrator on regulation 2600. 96(a) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #1. Effective, 11/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 10/3/2024, the Program

96a - First Aid Kit (continued)

Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director.

Proposed Overall Completion Date: 11/01/2024

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

Implemented [redacted] 12/12/2024)

101j3 - Bed/Linens/Pillows/Blankets

4. 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

The sheets and pillowcases on the bed for Resident [redacted] had multiple stains and soiled areas.

Plan of Correction ***Accept [redacted] - 10/08/2024)***

On [redacted], a new set of pillow cases and sheets were purchased by the DSP. for Resident [redacted] The new pillow cases and sheets were washed and placed on Resident [redacted] bed. Proof of the purchase and new sheets placed on the bed is found in Attachment #5. 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 10/3/2024 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 #1. Effective, 11/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 10/3/2024, 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 10/4/2024, 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. Proof of this inspection can be found in Attachment #6.

Proposed Overall Completion Date: 11/01/2024

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

Implemented [redacted] - 12/12/2024)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 Lighting/Operable Lamp *(continued)*

Description of Violation

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 10/08/2024)***

On 9/27/2024, the bedside lamp was placed back in Resident [redacted] room. 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 each resident's bedroom has an operable lamp or other source of lighting that can be turned on at bedside. 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 10/3/2024, the Director re trained the Program Administrator on regulation 2600. 101(j)(7) and completing the SCR Site Audit accurately; proof of this remediation is found in Attachment #1. Effective 10/3/2024, 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 10/4/2024, all other resident's rooms will be inspected by the Program Administrator to ensure that the resident's bedrooms have a light source that is functioning by their bedside. Proof of this inspection can be found in Attachment #6.

Proposed Overall Completion Date: 10/07/2024

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

Implemented [redacted] - 12/12/2024)

132c - Fire Drill Records

6. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the drills conducted on [redacted] at 9:45, [redacted] at 9:56 and [redacted] at 10:11 do not indicate if they were conducted in the AM or PM hours.

Plan of Correction ***Accept [redacted] 10/08/2024)***

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 selecting AM or PM for the time of 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

132c - Fire Drill Records (continued)

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 staff were utilizing a paper form instead of the electronic fire drill form. The AM/PM field on the electronic form is a mandatory field. Additionally, on 10/3/2024, the Associate Executive Director trained the Director and Program Administrator on regulation 2600.132(c), the electronic fire drill process and oversight of the fire drill process by the Director; proof of this training is found in Attachment #8. The Director will train all staff of this personal care home on the regulation 2600.132(c) and the fire drill process by 11/5/2024. 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. Finally, 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.

Proposed Overall Completion Date: 11/05/2024

Licensee's Proposed Overall Completion Date: *11/05/2024*

Implemented [redacted] - 12/12/2024)

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

The home exceeded the maximum evacuation time of 2 minutes 30 seconds during the fire drill conducted on 4/16/24 at 11:04 PM. The evacuation time for this drill was 11 minutes.

Plan of Correction ***Accept [redacted] 10/08/2024)***

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 entering the time of the fire drill in minutes and seconds. 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 first fire drill evacutaiton time exceeded the required time frame and a second fire drill was compleeted that met the required time frame. As a result, on/or before 10/3/2024 the Associate Executive Director will train the Director and Program Administrator on regulation 2600.132(d), the electronic fire drill process and oversight of the fire drill process by the Director. Proof of this

132d Evacuation (continued)

training is found in Attachment #8. On/or before 11/5/2024, 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. Finally, 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.

Proposed Overall Completion Date: 11/05/2024

Licensee's Proposed Overall Completion Date: *11/05/2024*

Implemented [redacted] - 12/12/2024)

141b1 - Annual Medical Evaluation

9. Requirements

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

Description of Violation

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

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

Repeated Violation 2/15/24 and 9/14/23

Plan of Correction ***Accept ([redacted] - 10/08/2024)***

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 at the time failed to ensure the medical evaluation was scheduled in the EHR. It should be noted that the Program Administrator from 2022 would have been responsible to schedule the placeholder appointment in the EHR; however, this person is no longer with the organization. As a result, on or before 10/3/2024 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 #8. The Program Administrator will audit all other resident records to ensure medical evaluation

141b1 - Annual Medical Evaluation (continued)

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: 10/07/2024

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

Implemented [redacted] - 12/12/2024)

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.

Description of Violation

The glucometer for Resident [redacted] has a [redacted] reading of [redacted] taken at 6:15 AM on [redacted] This reading does not appear on the resident's MAR (medication administration record).

The MAR for Resident [redacted] has a [redacted] reading of [redacted] recorded for 4 PM on [redacted] However, the glucometer reading is [redacted]

Repeated Violation - 9/14/23

Plan of Correction ***Accept [redacted] - 10/08/2024)***

The glucometers for Residents [redacted] was recalibrated on by the agency nurse. Keystone Service Systems, Inc. (Keystone) maintains a process wherein the glucometer is checked prior to use to ensure the correct date/time is showing on the glucometer. If the date/time is incorrect, the glucometer would be recalibrated prior to use. A staff would assist the resident in completing a blood glucose reading through the use of a calibrated glucometer. The glucometer reading is then transcribed onto the electronic medication administration record (eMAR) by the rendering staff and the medications are provided based upon the physician protocol. In review of this citation, it was found that staff are following the steps as outlined above for this business process. As a result, on 11/4/2024, the Licensed Practical Nurse (LPN) will train the Director, Program Administrator and all staff on how to calibrate the glucometer and accurately read/document for glucometer readings in accordance with regulation 2600.185(a); proof of this training will be forthcoming. In addition, effective 10/7/2024 the agency nurse will review the glucometer readings weekly and compare the readings to the eMAR to ensure accuracy in device calibration and transcription of blood glucose numbers. The nurse will complete the weekly glucometer and eMAR audits for 3 months in order to ensure continued compliance. In the event that the blood sugar readings and eMAR do not reconcile, then the specific staff responsible for the error will be re-educated by the nurse (or Program Administrator) on regulation 2600.185(a) and monitoring will continue for another 3 month time period by the nurse. If in the extended 3 month time monitoring period further errors are found in the documentation, the specific staff responsible for the error will be re-educated by the nurse (or Program Administrator) on regulation 2600.185(a) and disciplined (if applicable). If no errors are found in the 3 month monitoring period, then the nurse will review the glucometer and eMARs on a monthly basis to ensure ongoing compliance.

185a Implement Storage Procedures (continued)

Proposed Overall Completion Date: 11/04/2024

Licensee's Proposed Overall Completion Date: *11/04/2024*

Implemented [redacted] - 12/12/2024)