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

December 12, 2024

[redacted]
KEYSTONE HUMAN SERVICES
[redacted]

RE: KEYSTONE COMMUNITY MH
1009 OLD NOBLESTOWN ROAD
OAKDALE, PA, 15071
LICENSE/COC#: 43876

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/06/2024 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: *KEYSTONE COMMUNITY MH* **License #**: *43876* **License Expiration**: *04/29/2025*

Address: *1009 OLD NOBLESTOWN ROAD, OAKDALE, PA 15071*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *KEYSTONE HUMAN SERVICES*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *05/29/1981* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *6* **Waking Staff**: *5*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/06/2024*

Inspection Dates and Department Representative

11/06/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *6*

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**: *3*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

11/06/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/22/2024*

11/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/11/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/03/2024*

Inspections / Reviews *(continued)*

12/12/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/11/2024*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

At approximately 11:15 a.m., the carbon monoxide detector mounted to the wall in the second living room leading to the dining room had a nine-volt battery that was not dated. In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.

At approximately 11:55 a.m., the carbon monoxide detector mounted above the extra linen storage in the home's basement had two double-A batteries that were not dated. In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

On [redacted], the carbon monoxide alarm batteries on each floor were replaced and labeled by the Program Administrator with the date of current battery installation; proof of this remediation is found in Attachment #1. Keystone Service Systems, Inc. (Keystone) maintains a process in which program standards, including but not limited to, ensuring carbon monoxide detectors are present on each floor, functioning and all batteries are labeled with the date of recent change/changed annually. Any noncompliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was being completed. However, this issue was not identified by the Program Administrator or Program Coordinator. As a result, on 11/21/2024, the Director will retrained the Program Administrator on regulation 2600.18 (specifically the Care Facility Carbon Monoxide Alarm Standards Act), the updated SCR Site Audit and how to evaluate if all carbon monoxide detector batteries are labeled and compliant; proof of this remediationis found in Attachment #2. Additionally, on 11/20/2024, the Program Administrator trained all staff on regulation 2600.18 (specifically the Care Facility Carbon Monoxide Alarm Standards Act), the updated SCR Site Audit and how to evaluate if all carbon monoxide detector batteries are labeled and compliant; proof of this remediation is found in Attachment #3. Effective, 12/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 12/1/2024, 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: *12/02/2024*

Implemented [redacted] - 12/12/2024)

89b - Hot Water Temperature

2. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

89b - Hot Water Temperature *(continued)*

Description of Violation

At approximately 10:58 a.m. the hot water at the hand sink in the upper-floor bathroom measured one-hundred-and-thirty-two degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

On 11/8/2024, the hot water heater regulator was adjusted in by Program Administrator and all water temperatures were below 120 degrees. Proof of this remediation is found in Attachment #4. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards are assessed to ensure all faucets/water sources maintain a hot water temperature that does not exceed 120 degrees Fahrenheit. This standard is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was being completed. However, this issue was not identified by the Program Administrator or Program Coordinator. As a result, on 11/21/2024, the Director re-trained the Program Administrator on regulation 2600. 89(b), completing the SCR Site Audit accurately and ensuring when issues are non-compliant that they are marked as such and the Director is notified verbally for remediation instruction; proof of this remediation is found in Attachment #2. Effective, 12/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 12/1/2024, 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: *12/02/2024*

Implemented [redacted] 12/12/2024)

92 - Windows

3. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 10:58 a.m. the window in the upper-floor bathroom was missing a window screen.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

On 12/2/2024, the screen in the upper floor bathroom will be replaced by a contractor; proof of this remediation will be forthcoming. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards are assessed to ensure all windows and doors contain a screen that is in good repair. This standard is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was being completed. However, this issue was not identified by the Program Administrator or Program Coordinator. As a result, on 11/21/2024, the Director re-trained the Program Administrator on regulation 2600. 92, completing the SCR Site Audit accurately and ensuring when issues are non-compliant that they are marked as such and the Director is notified verbally for remediation instruction; proof of this remediation is found in Attachment #2. Effective, 12/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 12/1/2024, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this

92 Windows (continued)

standard with oversight from the Director.

Licensee's Proposed Overall Completion Date: *12/02/2024*

Implemented [redacted] - 12/12/2024)

103e - Left Overs

4. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 11:10 a.m. in the home's kitchen, the [redacted] side by side combination refrigerator and freezer had two square [redacted] bowls in the refrigerator section, one filled approximately one third of the way with what appeared to be baked beans that had a paper note that indicated "Extra" and was not dated or labeled. The second bowl was filled to the top with what appeared to be a garden salad and also had a paper note that indicated "Extra" and was not dated or labeled.

Plan of Correction ***Accept ([redacted] - 11/25/2024)***

On 11/6/2024 at the time of inspection, the two bowls in the refrigerator labeled extra that contained leftovers were discarded. Proof of this remediation is found in Attachment #5. Keystone Service Systems, Inc (Keystone) maintains a process in which program standards, including but not limited to ensuring leftovers are labeled and dated. This program standard is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was being completed. However, this issue was not identified by the Program Administrator or Program Coordinator. As a result, on 11/21/2024, the Director re trained the Program Administrator on regulation 2600. 103(e), completing the SCR Site Audit accurately and ensuring when issues are non compliant that they are marked as such and the Director is notified verbally for remediation instruction; proof of this remediation is found in Attachment #2. Additionally, on 11/20/2024, the Program Administrator trained all Personal Care Home staff on regulation 2600.103(e), labeling and dating of extra food from meals prepped and discarding of leftovers after one day. Proof of this training is found in Attachment #3. Effective, 12/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 12/1/2024, 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: *12/02/2024*

Implemented [redacted] - 12/12/2024)

105g - Lint Removal and Duct Cleaning

5. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

105g - Lint Removal and Duct Cleaning *(continued)*

Description of Violation

At approximately 11:30 a.m. the stackable General Electric washer and dryer in the home's bathroom #4 had a lint trap that was completely matted across the entire surface of the screen with grey lint that was approximately one-eighth-of-an-inch thick. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

On 11/6/2024 at the time of inspection, the lint trap was cleaned. 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 the lint trap is clean. This program standard is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic SCR Site Audit. Any non-compliance noted on the SCR Site Audit will be monitored through reporting by the Director and Program Administrator until full remediation is achieved. Through review of the process, in context to the citation, it was determined that the SCR Site Audit was being completed. However, this issue was not identified by the Program Administrator or Program Coordinator. As a result, on 11/21/2024, the Director re-trained the Program Administrator on regulation 2600. 105(g), completing the SCR Site Audit accurately and ensuring when issues are non-compliant that they are marked as such and the Director is notified verbally for remediation instruction; proof of this remediation is found in Attachment #2. Additionally, on 11/20/2024, the Program Administrator trained all Personal Care Home staff on regulation 2600.105(g), cleaning of all lint traps in all dryers after each use and at the end of each day. Proof of this training is found in Attachment #3. Effective, 12/1/2024, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 12/1/2024, 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: *12/02/2024*

Implemented [redacted] - 12/12/2024)

185a - Implement Storage Procedures

6. 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

On [redacted] at 7:00 a.m., resident [redacted] November 2024 medication administration record (MAR) documented a blood glucose reading of [redacted]. However, resident [redacted] indicated a blood glucose reading of [redacted] on [redacted] at 7:04 a.m.

On [redacted] at 7:00 a.m., resident [redacted] November 2024 medication administration record (MAR) documented a blood glucose reading of [redacted]. However, resident [redacted] indicated a blood glucose reading of [redacted] on [redacted] at 7:04 a.m.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

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. Through

185a - Implement Storage Procedures (continued)

review of this citation, it wa identified that the staff were incorrectly transcribing the glucometer reading. As a result of the citation, on or before 11/20/2024, the Licensed Practical Nurse (LPN) trained the 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 can be found in Attachment #7. In addition, effective 11/22/2024, the program 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.

Licensee's Proposed Overall Completion Date: *11/29/2024*

Implemented [redacted] - 12/12/2024)

190c - Record of Training

7. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The last record of the medication administration annual practicum being completed by direct care staff person A was on [redacted] and was not signed or dated by the student, direct care staff person A, and did not indicate requalified or failed to recertify on the Department's summary and requalification form.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

Staff Member A completed the annual practicum for the medication administration training on 9/8/2024 and successfully requalified. The certifying staff who completed Staff Member A's annual medication administration practicum completed an attestation statement to validate training was completed timely. Staff Member A signed and dated the annual practicum completed 9/8/2024 on 11/21/2024. Proof of this remediation can be found in Attachment #8. Keystone Service Systems, Inc. (Keystone) maintains a business process in which all annual medication administration practicums are completed by the certifying staff or designee. The certifying staff, typically the Program Administrator, will complete all Department issued recertification forms, including the recertification designation (if applicable) and have the trainee sign date. The documentation is maintained by the Program Administrator. Through review of this process, it was found that there was no review of the documentation outside of the Program Administrator. Therefore effective 12/1/2024, a new business process will be implemented in which the medication administration recertification documentation will be tracked and monitored by Keystone's Education Department. All documentation will be reviewed for technical compliance prior to being uploaded to the employee's electronic training record and noted for reporting purposes. In the interim, the Program Administrator will complete an audit of all current, active employees to ensure all annual medication administration recertification documentation is complete in its entirety including the designation of recertification, signing and dating of the document. This audit will be complete, including remediation actions taken on/or before 11/21/2024. Proof of this remediation is found in Attachment #9. Finally, on 11/21/2024, the Director trained the Program Administrator on

190c - Record of Training (continued)

regulation 2600.190(c), the documentation required to be completed and the signatures/dates required upon completion. Proof of this completed training is found in Attachment #2. Aditionally, on 11/20/2024, the Program Administrator trained all Personal Care Home staff on regulation 2600.190(c), the documentation required to be completed and the signatures/dates required upon completion. Proof of this completed training is found in Attachment #3. Effective 12/1/2024, Keystone's Education Department will notify all Program Administrators/Directors through reporting on a monthy basis of any upcoming, overdue or incomplete trainings.

Licensee's Proposed Overall Completion Date: *12/02/2024*

Implemented [redacted] - 12/12/2024)

224a - Preadmission Screen Form

8. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

The preadmission screen form for resident [redacted] dated [redacted] , did not indicate the resident's ability to self-administer medication, that area of the form was left incomplete.

Plan of Correction ***Accept [redacted] - 11/25/2024)***

On [redacted], the preadmission screening form dated [redacted] for Resident [redacted] was updated by the Program Administrator to include the resident's ability to self-administer. Proof of this remediation can be found in Attachment #10. It should be noted that upon intake of Resident [redacted] documentation was missing to allow for completion of the preadmission screening tool. Keystone Service Systems, Inc. (Keystone) maintains a business process in which the preadmission screening form is completed by the Program Administrator within 30 days prior to admission. The preadmission screening is reviewed by the Program Administrator for completion prior to uploading to the resident's electronic health record. In review of this citation in context to the business process it was found that the preadmission screening form was left blank as documentation was being gathered during the intake process. As a result, on 11/21/2024, the Director trained the Program Administrator on regulation 2600.224(a), the business process around maintaining compliant preadmission screenings and oversight of the process by the Director; proof of this training is found in Attachment #2. The Program Administrator will audit all other resident records to ensure preadmission screening form compliance with this standard on/or before 11/22/2024; proof of this can be found in Attachment #11. Effective 11/22/2024, the Program Administrator will monitor all preadmission screening form timeliness and content 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: *11/29/2024*

Implemented [redacted] - 12/12/2024)