

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

April 25, 2025

[REDACTED]
KEYSTONE SERVICE SYSTEMS INC
[REDACTED]

RE: KHS MENTAL HEALTH SERVICES-
GREEN STREET SPECIALIZED PC
2900 GREEN STREET
HARRISBURG, PA, 17110
LICENSE/COC#: 32878

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/18/2025 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-GREEN STREET SPECIALIZED PC
License #: 32878 **License Expiration:** 06/21/2025
Address: 2900 GREEN STREET, HARRISBURG, PA 17110
County: DAUPHIN **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-4 **Date:** 04/11/2001 **Issued By:** city of harrisburg

Staffing Hours

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

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Interim **Exit Conference Date:** 03/18/2025

Inspection Dates and Department Representative

03/18/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 7 **Are 60 Years of Age or Older:** 3
Diagnosed with Mental Illness: 8 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 1 **Have Physical Disability:** 0

Inspections / Reviews

03/18/2025 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/12/2025

04/11/2025 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 04/25/2025
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/17/2025

Inspections / Reviews (*continued*)

04/15/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/25/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/01/2025

04/25/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/25/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

132d - Evacuation

1. 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 [REDACTED] at 5:33 PM, the home exceeded the maximum safe evacuation time of 5 minutes specified in writing by the Fire Safety expert; total evacuation time was 5 minutes and 34 seconds.

Repeated Violation - [REDACTED], et al.

Plan of Correction

Accept ([REDACTED] - 04/15/2025)

Keystone Services Systems, Inc. (Keystone) maintains a process in which all fire drills are prompted for completion monthly by the Program Administrator or designee. Upon completion of the monthly fire drill, the Administrator or staff on shift during the fire drill will complete 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. Effective 10/1/2023, the Quality Manager will pull reports on the Electronic Fire Drill Forms completed bi-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 maximum time or 2 minutes and 30 seconds, then 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 fire drill process was followed by the staff and Operational Leadership. A subsequent fire drill was completed successfully on 2/11/2025; proof of this fire drill is contained in Attachment #1. As a result, on 4/9/2025, the Director trained the Program Administrator and all staff of this program on regulation 2600.132(d), the electronic fire drill process and oversight of the fire drill process by the Director. Additionally, the Director provided guidance to the staff on the steps to evacuate the home given the current needs of some residents. The resident with the most need will be assisted by staff immediately at the start of the fire drill and all other residents will evacuate independently to the meeting location. Proof of this training is found in Attachment #2. On/or before 4/14/2025, the Program Administrator will hold a resident meeting to outline the need to participate in fire drills and to evacuate timely. Proof of the resident meeting conducted is found in Attachment #12. The Program Administrator will continue to use the electronic Fire Drill Form and the Director will monitor regulatory compliance with fire drills using reporting capabilities of the electronic Fire Drill Form. Additionally, effective 2/24/2025, 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: 04/15/2025

Implemented ([REDACTED] - 04/25/2025)

132h - Designated Meeting Place

2. Requirements

2600.

132h Designated Meeting Place (continued)

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on [REDACTED] at 5:33 PM, 8 residents were in the home, however only [REDACTED] residents evacuated.

Plan of Correction

Accept ([REDACTED] - 04/15/2025)

Keystone Services Systems, Inc. (Keystone) maintains a process in which all fire drills are prompted for completion monthly by the Program Administrator or designee. Upon completion of the monthly fire drill, the Administrator or staff on shift during the fire drill will complete 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. Effective 10/1/2023, the Quality Manager will pull reports on the Electronic Fire Drill Forms completed bi 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 maximum time or 2 minutes and 30 seconds, then 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 fire drill process was followed by the staff and Operational Leadership. A subsequent fire drill was completed successfully on 2/11/2025; proof of this fire drill is contained in Attachment #1. As a result, on 4/9/2025, the Director trained the Program Administrator and all staff of this program on regulation 2600.132(h), the electronic fire drill process and oversight of the fire drill process by the Director. Additionally, the Director provided guidance to the staff on the steps to evacuate the home given the current needs of some residents. The resident with the most need will be assisted by staff immediately at the start of the fire drill and all other residents will evacuate independently to the meeting location. Proof of this training is found in Attachment #2. On/or before 4/14/2025, the Program Administrator will hold a resident meeting to outline the need to participate in fire drills and to evacuate timely. Proof of the resident meeting conducted is found in Attachment #12. The Program Administrator will continue to use the electronic Fire Drill Form and the Director will monitor regulatory compliance with fire drills using reporting capabilities of the electronic Fire Drill Form. Additionally, effective 2/24/2025, 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: 04/15/2025

Implemented ([REDACTED] - 04/25/2025)

185a - Implement Storage Procedures

3. 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 [REDACTED] has a current order of [REDACTED] gum chew 1 piece of gum by mouth as needed for smoking cessation. On [REDACTED], the [REDACTED] was not available in the home and per Staff Member A, has never been available in the home.

185a Implement Storage Procedures (continued)

Repeated Violation [REDACTED], et al.

Plan of Correction

Accept [REDACTED] - 04/15/2025

On [REDACTED] the [REDACTED] gum for Resident [REDACTED] was discharged due to nonuse and continued smoking; proof of the requested discharge is found in Attachment #10. On [REDACTED], the [REDACTED] gum for Resident [REDACTED] was discharged on the electronic medication administration record (eMAR); proof of this remediation is found in Attachment #9. Keystone Service Systems, Inc. (Keystone) maintains a process in which the agency nurse, on a bi weekly basis, completes a Medication Cart Audit. As part of the Medication Cart Audit, the nurse ensures that all medications prescribed for the resident are present on site and the medication prescribed is on the electronic medication administration record (eMAR) for staff to document administrations. If there is an issue in which the medication is not on site the agency nurse would work with the pharmacy to determine the issue and obtain the medication. If there is an issue in which the medication has been discharged, the agency nurse will pull the medication from inventory, arrange for the medication to be picked up by the pharmacy and then will remove the medication from the eMAR. In review of this citation, it was found that that the Nicotine 2mg gum was not removed from the eMAR after discharge. As a result, on 4/9/2025, the Director trained the agency nurse and Program Administrator on regulation 2600.185(a), the Medication Cart Audit and oversight of the Medication Cart Audit. Proof of this training is found in Attachment #2. Finally, on/or before 4/8/2025, the agency nurse will complete a Medication Cart Audit for all residents of this personal care home to ensure all medication prescribed is on site and reconciles with the eMAR. Proof of this remediation is found in Attachment #4. Effective 4/9/2025, the agency nurse will continue to use the Medication Cart Audit and the Director will monitor completion and non compliance remediation actions identified through the use of the Medication Cart Audit. Additionally, effective 5/1/2025, to improve oversight of the Medication Cart Audit, the Director will observe the Medication Cart Audit on a quarterly basis to ensure the agency nurse is completing the audit accurately.

Licensee's Proposed Overall Completion Date: 05/01/2025

Implemented [REDACTED] - 04/25/2025

187a - Medication Record

4. Requirements

2600.

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

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [REDACTED] is prescribed [REDACTED]. However, Resident's [REDACTED] March 2025 medication administration record (MAR) does not indicate diagnosis or purpose for the medication. From [REDACTED] through [REDACTED], the MAR indicates "Diagnosis/Purpose: Mood". From [REDACTED] through [REDACTED], the MAR indicates "Diagnosis/Purpose: Decreased DOSAGE".

Plan of Correction

Accept [REDACTED] - 04/15/2025

On [REDACTED], the purpose and diagnosis for [REDACTED] was changed by the Program Administrator on the electronic medication administration record (eMAR) for Resident [REDACTED] to reflect a diagnosis of [REDACTED] of which is being administered for controlling manic and hypomanic episodes. Proof of this eMAR update is found in Attachment #11. Keystone Service Systems, Inc. (Keystone) maintains a process in which the agency nurse, on a bi weekly basis, completes a Medication Cart Audit. As part of the Medication Cart Audit, the nurse ensures that all

187a - Medication Record (continued)

medications prescribed are on the electronic medication administration record (eMAR) and that there is a documented purpose and diagnosis on the eMAR. If there is an issue in which the medication purpose and diagnoses are not listed and/or incorrect, then the nurse will update the eMAR to reflect the correct updated purpose and diagnosis. In review of this citation, it was found that the agency nurse was not reviewing the purpose and diagnosis for each medication thoroughly. As a result, on 4/9/2025, the Director trained the agency nurse and Program Administrator on regulation 2600.187(a)(12), the Medication Cart Audit and oversight of the Medication Cart Audit. Proof of this training is found in Attachment #2. Finally, on 4/8/2025, the agency nurse completed a Medication Cart Audit for all residents of this personal care home to ensure all medications prescribed contain a purpose and diagnosis. Proof of this remediation is found in Attachment #4. Effective 4/9/2025, the agency nurse will continue to use the Medication Cart Audit and the Director will monitor completion and non-compliance remediation actions identified through the use of the Medication Cart Audit. Additionally, effective 5/1/2025, to improve oversight of the Medication Cart Audit, the Director will observe the Medication Cart Audit on a quarterly basis to ensure the agency nurse is completing the audit accurately.

Licensee's Proposed Overall Completion Date: 05/01/2025

Implemented [REDACTED] - 04/25/2025)

187c - Refusal of Medication**5. Requirements**

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [REDACTED] and again on [REDACTED] at 4:00 PM, Resident [REDACTED] refused to take a scheduled dose of [REDACTED] Tablet. Per Staff Member A, the home did not report the refusal to the resident's doctor as required.

Plan of Correction

Accept [REDACTED] - 04/15/2025)

On [REDACTED], the physician for Resident [REDACTED] was notified by the Program Administrator of the refusals for [REDACTED] and [REDACTED]; proof of this communication is found in Attachment #5. Additionally a protocol was received from the Physician for Resident [REDACTED] to address medication refusals; proof of this protocol is found in Attachment #6. On 4/9/2025, the agency nurse and Program Administrator have implemented the physician directed protocol as it relates to refusals for Resident [REDACTED]. Keystone Service Systems, Inc. (Keystone) maintains a process in which the agency nurse or Program Administrator will notify the physician of any refusals within 24 hours of the refusal being documented in the electronic medication administration record (eMAR). The agency nurse or Program Administrator will document the refusal communication with the physician on a Health Services Note within the electronic health record (EHR). Additionally, the agency nurse, on a bi-weekly basis, completes a Medication Cart Audit. As part of the Medication Cart Audit, the nurse ensures that all refusals noted on the eMAR have a corresponding Health Services Note outlining communication with the physician. In review of this citation, it was found that the agency nurse nor the Program Administrator was documenting communication with the physician upon refusal. As a result, on 4/9/2025, the Director trained the agency nurse and Program Administrator on regulation 2600.187(c), the process for documenting refusals on the Health Services Note in the EHR, the Medication Cart Audit and oversight of the Medication Cart Audit. Proof of this training is found in Attachment #2. Finally, on 4/8/2025, the agency nurse completed a Medication Cart Audit for all residents of this personal care home to ensure all refusals have corresponding documentation with the physician. Proof of this remediation is found in Attachment #4. Effective

187c Refusal of Medication (continued)

4/9/2025, the agency nurse will continue to use the Medication Cart Audit and the Director will monitor completion and non compliance remediation actions identified through the use of the Medication Cart Audit. Additionally, effective 5/1/2025, to improve oversight of the Medication Cart Audit, the Director will observe the Medication Cart Audit on a quarterly basis to ensure the agency nurse is completing the audit accurately.

Licensee's Proposed Overall Completion Date: 05/01/2025

Implemented [REDACTED] - 04/25/2025)

187d - Follow Prescriber's Orders

6. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] starting [REDACTED]. However, this medication has never been administered to resident [REDACTED] because the medication has not been available in the home.

Plan of Correction

Accept [REDACTED] - 04/15/2025)

On [REDACTED], the [REDACTED] patches for Resident [REDACTED] was discharged due to nonuse and continued smoking; proof of the discharge is found in Attachment #7. On [REDACTED], the [REDACTED] patch for Resident [REDACTED] was discharged on the electronic medication administration record (eMAR); proof of this remediation is found in Attachment #3. Keystone Service Systems, Inc. (Keystone) maintains a process in which the agency nurse, on a bi weekly basis, completes a Medication Cart Audit. As part of the Medication Cart Audit, the nurse ensures that all medications prescribed for the resident are present on site and the medication prescribed is on the electronic medication administration record (eMAR) for staff to document administrations. If there is an issue in which the medication is not on site the agency nurse would work with the pharmacy to determine the issue and obtain the medication. If there is an issue in which the medication has been discharged, the agency nurse will pull the medication from inventory, arrange for the medication to be picked up by the pharmacy and then will remove the medication from the eMAR. In review of this citation, it was found that that the Nicotine 21mg patch was not removed from the eMAR after discharge. As a result, on 4/9/2025, the Director trained the agency nurse and Program Administrator on regulation 2600.187(d), the Medication Cart Audit and oversight of the Medication Cart Audit. Proof of this training is found in Attachment #2. Finally, on 4/8/2025, the agency nurse completed a Medication Cart Audit for all residents of this personal care home to ensure all medication prescribed is on site and reconciles with the eMAR. Proof of this remediation is found in Attachment #4. Effective 4/9/2025, the agency nurse will continue to use the Medication Cart Audit and the Director will monitor completion and non compliance remediation actions identified through the use of the Medication Cart Audit. Additionally, effective 5/1/2025, to improve oversight of the Medication Cart Audit, the Director will observe the Medication Cart Audit on a quarterly basis to ensure the agency nurse is completing the audit accurately.

Licensee's Proposed Overall Completion Date: 05/01/2025

Implemented [REDACTED] - 04/25/2025)

225a - Assessment 15 Days

7. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department’s assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident [REDACTED] receives medications daily for [REDACTED] and [REDACTED]. However, Resident [REDACTED] assessment, completed [REDACTED] does not include an assessment of need in these areas.

Plan of Correction

Accept [REDACTED] - 04/11/2025)

On [REDACTED], Resident [REDACTED] Resident Assessment and Support Plans (RASPs) was updated by the Program Administrator to include a diagnosis of depression and tremors. Additionally, how staff support the resident with these issues is detailed in section 2a and section 3a. Proof of the RASP updates is found in Attachment #8. On 4/9/2025, the Director trained all staff in this personal care home on the updated RASP for Resident [REDACTED]; proof of this training is found in Attachment #2. Keystone Service Systems, Inc. (Keystone) maintains the RASP in the electronic health record for each resident. The RASP is to be completed by the Program Administrator and must address all sections accurately based upon the individual's assessed need prior to reviewing with the individual and having all parties electronically sign the RASP. Effective 07/01/2024, Keystone has amended this business process to require a Director review and sign off on all RASPs. Additionally, all reporting on completed RASPs will be sent to all Directors and the Associate Executive Director in order to allow additional oversight and follow up with the Program Administrator to occur. Through review of this citation in context to the business process, it was found that this citation pre-dates the current business process to maintain compliance with 2600.225(a). As a result, on 4/9/2025, the Director trained the Program Administrator on regulation 2600.225(a), the RASP completion process, and oversight responsibilities of the business process. Proof of this training can be found in Attachment #2. Additionally, on/ or before 4/18/2025, the Director, or other designee, will audit all other resident records to ensure RASP accuracy including diagnosis, completion of all sections and that the second signature is that of the Director on all current RASPs. Proof of this completed audit will be forthcoming. Effective 4/10/2025, the Program Administrator will monitor all support plans by completing monthly resident record reviews. The Director will provide oversight of these reviews and ensure any identified remediation is completed by the Program Administrator (or designee).

Licensee's Proposed Overall Completion Date: 04/18/2025

Implemented [REDACTED] 04/25/2025)