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

May 30, 2025

[redacted]
KEYSTONE SERVICE SYSTEMS INC
[redacted]

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

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/15/2025 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 - BEAVER CREEK SCR* **License #**: *33480* **License Expiration**: *06/11/2025*

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

County: *ADAMS* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *KEYSTONE SERVICE SYSTEMS INC*

Address: [redacted]

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

Certificate(s) of Occupancy

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

Staffing Hours

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

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *04/15/2025*

Inspection Dates and Department Representative

04/15/2025 - 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: *8* **Are 60 Years of Age or Older**: *3*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *2*

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

Inspections / Reviews

04/15/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/03/2025*

05/01/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/29/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/07/2025*

Inspections / Reviews *(continued)*

05/06/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/29/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/01/2025*

05/30/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/29/2025*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [redacted] the home's current violation report, dated [redacted] was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 05/01/2025)***

On 4/15/2025, the Program Administrator posted the Licensing Inspection Summary (LIS) dated 7/25/2024 and ensured all LIS from the current license period were available. 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 licensing inspection summaries are posted, is to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the 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 accurately by the Program Administrator however, the SCR Site Audit only questions if the most recent LIS is posted. As a result, on 4/30/2025, the SCR Site Audit will be updated to rephrase the language to ensure all LIS issued under the current license are posted in a conspicuous place for the past year. On 4/28/2025, the Director re-trained the Program Administrator on regulation 2600.3(c) and the business process to maintain compliance with this standard and specifically the updated language on the SCR Site Audit to address LIS postings. Proof of this re-training can be found in Attachment #2. Effective 4/29/2025, the Program Administrator will resume use of the SCR Site Audit on a monthly basis with oversight from the Director.

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

Implemented ([redacted] - 05/30/2025)

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

On [redacted] at 1:30 PM, resident [redacted] reported to staff member A that [redacted] was groped and asked repeatedly to perform sexual acts when resident [redacted] exposed [redacted]. This incident was not immediately reported to local Area Agency on Aging as an oral report was not made until [redacted] at 12:00 PM.

Plan of Correction ***Accept ([redacted] - 05/01/2025)***

Keystone Service Systems, Inc. (Keystone) maintains a process in that when an incident of abuse is observed or reported, the staff who observes or receives the abuse allegation must notify the Program Administrator (or on-call Program Administrator) immediately. The Program Administrator (or on-call Program Administrator) will then complete the incident report, notification to the area on agency, contact the resident's designated person (if applicable) and complete the internal incident notification process; all of these notifications are to be completed by the Program Administrator on the date of receiving the report. All staff are trained initially upon hire and annually on what the definition of an incident is and the business process for reporting incidents. In review of the citation in

15a Resident Abuse Report (continued)

context to the business process, it was determined that the business process for reporting incidents was not followed by the Program Administrator. As a result, on or before 5/7/2025, the Director re trained the Program Administrator and all staff of this personal care home on regulation 2600.15 and 2600.16 and all subcategories of these regulations in addition to the reporting process; proof of this remediation is forthcoming. Additionally, to prevent reoccurrence, on 4/28/2025, the SCR Notification Guide that outlines what external notifications need to occur, in designated timeframes by position was revised by the Quality Manager to ensure immediate reporting of all suspected abuse allegations. Training on the updated SCR Notification Guide will be provided by the Director to the Program Administrator and all staff of this personal care home on/or before 5/7/2025. Proof of this remediation is forthcoming.

Licensee's Proposed Overall Completion Date: *05/07/2025*

Implemented [redacted] 05/30/2025)

17 - Record Confidentiality

3. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted], the Resident Privacy Coding, for the violation summary dated [redacted] was posted publicly in the home's living room area. The Resident Privacy Coding included the names of resident [redacted] and [redacted]

Plan of Correction ***Accept [redacted] - 05/01/2025)***

On 4/15/2025, the privacy coding document was removed in the presence of the licensor. Keystone Service Systems, Inc. (Keystone) maintains a process in which program standards, including but not limited to, ensuring protected health information (PHI) is kept confidential and locked. 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, the Program Administrator did not recognize this as an issue. As a result on 4/28/2025, the Director re trained the Program Administrator on regulation 2600.17 specifically as it pertains to confidentiality with required postings; proof of this remediation is found in Attachment #2. Effective 4/29/2025, 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: *05/01/2025*

Implemented [redacted] - 05/30/2025)

42b - Abuse

4. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b Abuse *(continued)*

Description of Violation

Sometime between [redacted] and [redacted] resident [redacted] pulled [redacted] pants down, exposing [redacted] genitals to resident [redacted] Resident [redacted] kissed resident [redacted], grabbed resident [redacted] and asked resident [redacted] to "play with [redacted] or give [redacted] a [redacted] Resident [redacted] denied resident [redacted] requests multiple times by saying "no", however performed sexual acts to resident [redacted] when resident [redacted] persisted. Per resident [redacted] this interaction made resident [redacted] feel "bothered and uncomfortable".

Plan of Correction ***Accept [redacted] 05/06/2025)***

On 3/21/2025, following the disclosure made by Resident [redacted] an internal investigation into the sexual abuse allegations was initiated by Keystone's Certified Investigators. Immediately following the disclosure, staff implemented a safety plan requiring hourly supervision checks for both Resident [redacted] and Resident [redacted] Each hour, staff are prompted through Keystone's task tracking system to conduct the visual check. Documentation regarding both Resident [redacted] and Resident [redacted] whereabouts are required to be documented as a task. Proof of this documentation can be found in Attachment #3 and Attachment #4. Any interactions between Resident [redacted] and Resident [redacted] are to be supervised by staff for the duration of the interaction. Additionally, to ensure safety of all female resident's in the home, staff are to provide additional supervision in common areas and ensure Resident [redacted] does not go to the second floor of the home where female resident bedrooms are located without being escorted by staff. All staff were notified via email on 3/21/2025 and on 4/25/2025 of the process for ongoing safety checks. Proof of this communication can be found in Attachment #5. On 5/5/2025, all staff were formally trained on the procedure regarding the ongoing safety checks and documentation. Proof of this training is found in Attachment #8. On 4/3/2025, Keystone's Administrative Review team concluded the internal investigation with a confirmed finding for sexual abuse. Through the investigation, it was determined that Resident [redacted] and Resident [redacted] had been in an "on again, off again" relationship and previously shared a consensual intimate relationship however, the relationship was not active at the time of the incident. Treatment Team meetings have been held on a monthly basis between members of Keystone, the county and behavioral supports to discuss Resident [redacted] and [redacted] on going behavioral patterns. The Treatment Team has decided that on/or before 6/1/2025, Resident [redacted] will be transferred out of this personal care home due to the prior relationship with Resident [redacted] and [redacted] inability to conform to house rules and personal boundaries. Prior to Resident [redacted] move, Resident [redacted] Resident Assessment and Support Plan (RASP) will be updated to reflect this incident and the proclivity for Resident [redacted] to try and engage with female residents in appropriate or unwanted ways and how to address this behavior with both Resident [redacted] and any other female resident. On 5/5/2025, all staff were trained by the Program Administrator on Resident [redacted] updated RASP. Proof of this training can be found in Attachment #8. Additionally, on/or before 5/13/2025, the Program Administrator and Mental Health Professional will counsel Resident [redacted] on how to handle situations in real time if [redacted] feels coerced into participating in unwanted sexual acts. Proof of this counseling will be documented in Resident [redacted] electronic health record and will be forthcoming as validation. On/ or before 5/7/2025, all staff of this personal care home were retrained by the Director on Resident Rights in conjunction with reporting requirements in 2600.15(a). In response to this incident, an official policy to address resident relationships and assess consent is being developed by the Clinical Director of Mental Health Services. As of this time, law enforcement is no longer pursuing an investigation into the incident as Resident [redacted] declined to press charges.

Licensee's Proposed Overall Completion Date: *06/01/2025*

Implemented ([redacted] 05/30/2025)

88a - Surfaces

5. Requirements

88a - Surfaces *(continued)*

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

Description of Violation

On [redacted] the door to resident [redacted] bedroom was observed to be in disrepair. The top two hinges were not attached to the doorframe causing potential hazards from exposed screws as well as a risk of the door falling from the doorframe, entirely.

Plan of Correction ***Accept [redacted] - 05/01/2025)***

On 4/15/2025, a work order was submitted for Resident [redacted] bedroom door and the door was secured to the frame on 4/18/2025. Proof of the completed work is found in Attachment #6. 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 damage to the door was sustained a few days prior to the inspection, after the most recent SCR Site Audit was completed. On 4/28/2025, the Director re-trained the Program Administrator on regulation 2600.88(a) and the need to submit work orders if hazards are identified in between Monthly SCR Site Audits. Proof of this remediation is found in Attachment #2. Effective, 4/29/2025, the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits completed by the Program Administrator. Effective 4/29/2025, 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: *05/01/2025*

Implemented [redacted] - 05/30/2025)

225c - Additional Assessment

6. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted] assessment and support, dated [redacted], indicates resident [redacted] requires no supervision in the home or when in familiar surroundings. However, as of [redacted], safety checks are being implemented by staff every hour. Resident [redacted] requires visual supervision when in the common areas with another resident and resident [redacted] is not to go upstairs to the 2nd floor unsupervised.

Repeated Violation - [redacted]

Plan of Correction ***Accept ([redacted] - 05/06/2025)***

On 4/28/2025, Resident [redacted] Resident Assessment and Support Plan (RASP) was updated to reflect the increased need of supervision and hourly checks that were implemented as a result of this incident. Additionally, in consultation with the treatment team, the behavioral section of Resident [redacted] RASP was updated to address Resident [redacted] s behavior in regards to this incident and issues with boundaries and how to identify and manage these behaviors to ensure safety of all residents in the home. Proof of Resident [redacted] updated RASP can be found in Attachment #7.

225c - Additional Assessment (continued)

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. In review of the citation, it was determined that Keystone did not have a good process in place to address updating RASP's due to a change in condition or circumstance prior to the annual assessment. Therefore, on 4/28/2025, education was provided by the Director to the Program Administrator on regulation 2600.225(c) and the need to update the RASP following a significant change in condition including but not limited to an event requiring increased supervision. Proof of this training can be found in Attachment #2. On 5/5/2025, the Program Administrator trained all staff of this personal care home on the new supervision plan outlined in the RASP for Resident [redacted] Proof of this remediation is found in Attachment #8. Finally, on/or before 5/16/2025, the Director will complete an audit of all RASPs to ensure that each RASP accurately reflects the level of need and support of each resident; if amendments to the RASP are necessitated out of the audit, then the Director will work with the Program Administrator to update the RASP. Proof of this audit and remediation action(s) taken is forthcoming.

Licensee's Proposed Overall Completion Date: *05/16/2025*

Implemented [redacted] - 05/30/2025)