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

September 2, 2025

COMPLIANCE DIRECTOR
KEYSTONE SERVICE SYSTEMS INC

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

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/16/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *KHS MENTAL HEALTH SERVICES - BEAVER CREEK SCR* **License #**: *33480* **License Expiration**: *06/11/2026*

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 Twp., Adams County*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/16/2025*

Inspection Dates and Department Representative

07/16/2025 - 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**: *4*
Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *5*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

07/16/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/31/2025*

07/28/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/28/2025*

Inspections / Reviews *(continued)*

09/02/2025 - Document Submission

Submitted By: [redacted]

Date Submitted: *08/28/2025*

Reviewer: [redacted]

Follow-Up Type: *Not Required*

64c - Annual Training

1. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

[redacted] the home's administrator, completed only 6 hours of Department-approved training in training year January 1, 2024 to December 31, 2024.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

The Program Administrator of this personal care home, [redacted], is expected to complete the remaining 18 training hours by 11/14/2025 for calendar year 2024. Through review of the process, in context to the citation, it was determined that Keystone Service Systems, Inc. (Keystone) did not have a business process in place to assign and track the 24 hours of annual Personal Care Home Administrator training. As a result, on/or before 8/6/2025, a new business process will be developed of which the 24 hour Personal Care Home Administrator training will be assigned and tracked in Keystone's electronic learning management system (LMS). All courses electronically assigned through the LMS will have an in person and on-line training allocation of hours. All Program Administrators will be assigned 12 hours of on-line training courses through the LMS and will be required to schedule and attend 12 hours of in person Program Administrator approved training. All completed in person trainings will require a certificate of completion and will then be added to the overall training plan hours for each Administrator to track the overall 24 hour training requirement. Additionally, effective 8/28/2025, the Director overseeing the Administrator will monitor training hour(s) completion monthly through reporting during routine supervision. During this supervision, the training plan for the remainder of the year will be reviewed to ensure the 24 hours are met within the calendar year and coverage is arranged for the program as needed for any extended training hours. On/or before 8/28/2025, the Education Consultant will complete an audit of all PCH Administrator annual training hours to ensure all Program Administrators have the 24 hours of annual training as required in 2600.64(c) and will follow up with the Directors on the audit findings and remediation needed. Finally, on 8/28/2025, the Associate Executive Director provided training to all Director and Program Administrators on regulation 2600.64(c), the newly developed annual training plan outlined in the Learning Management System and the responsibility of Program Administrators/Directors to adhere to this training plan; proof of this training will be forthcoming.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Implemented ([redacted] - 09/02/2025)

144c1 - Smoking Area Guidelines

2. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

A used plastic shopping bag filled with food wrappers, used paper cups and other paper trash was hanging from the stainless Ecopastar Cigarette Disposal Unit (ashtray-cigarette receptacle) that is affixed to the exterior brick wall of the home in the designated smoking patio.

144c1 - Smoking Area Guidelines (continued)

Repeated Violation - 7/25/24

Plan of Correction ***Accept (- 07/28/2025)***

On 7/16/2025, the plastic bag with trash was discarded; proof of this remediation is found in Attachment #1. On/before 7/24/2025, the Program Administrator will provide education to all residents on the house rules, safe disposal of cigarettes, and ensuring that flammable materials are kept out of the smoking area at the next house meeting; proof of this remediation is found in Attachment #2. Additionally, on/or before 7/28/2025, the Program Administrator will educate staff on regulation 2600.144(c)(1), the resident smoking policy and procedures and the need to remove any flammable materials found in the smoking area immediately. 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 smoking occurs in the designated smoking areas, that cigarette butts are disposed of properly in the cigarette disposal bins and that the cigarette disposal bins are regularly emptied. These program standards are to be formally assessed and monitored monthly by the Program Administrator or Program Coordinator through the use of the electronic Site Safety Inspection. Any non-compliance noted on the Site Safety Inspection 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 Site Safety Inspection was being completed, however, the plastic bag with trash was not identified as a safety concern in the smoking area by the Program Administrator. As a result on 7/21/2025 the Director trained the Program Administrator on regulation 2600. 144(c)(1), the need to identify and remove safety issues from the smoking area and completing the Site Safety Inspection accurately. Proof of this training is found in Attachment #3. Effective 7/21/2025, the Program Administrator will continue to use the SCR Site Audit to monitor compliance with this standard with oversight from the Director. Effective, 7/28/2025 the Director, or designee, will complete a site audit quarterly to check efficacy of the SCR Site Audits.

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented (- 08/29/2025)

183e - Storing Medications

3. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

A small round white pill and one half of a white oblong pill were loose in a drawer of the medication cart.

Plan of Correction ***Accept (- 07/28/2025)***

On 7/16/2025, at the time of the inspection, the small round white pill and half white oblong pill were appropriately discarded in the presence of the licensing inspector. Keystone Service Systems, Inc. (Keystone) maintains a process in which the agency nurse completes a medication cart audit bi-weekly. During the medication cart audit, the nurse ensures that all medications are stored in their pre-packaged blister packet directly from the pharmacy. If any loose medication is found, the agency nurse will dispose of the medication appropriately and will order new medication from the pharmacy as needed. In review of this citation, it was found that the small pill and half of an oblong pill were in a place that was overlooked by the agency nurse. As a result, on 7/28/2025, the Director trained the agency nurse, Program Administrator and all personal care home staff on regulation 2600.183(e) and proper disposal of loose medication if errantly popped. Proof of this training will be forthcoming. Finally, on/or before 8/1/2025, the

183e - Storing Medications (continued)

agency nurse will complete a medication cart audits ensure all medication is stored in its original packaging and is administered as prescribed.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented (█ - 09/02/2025)

185a - Implement Storage Procedures

4. 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 █ is not calibrated to the correct date. The recording dates on the medication administration record do not match with the dates on the glucometer as follows:

MAR date	***Glucometer date***
7/16/25	*1/3*
7/15/25	*1/2*
7/14/25	*1/1*

Plan of Correction ***Accept (█ - 07/28/2025)***

The glucometer for Resident █ was recalibrated on 7/17/2025 by the Director. 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 in context to the business process, it can be determined that the business process was not followed. As a result, on 7/28/2025, the Director will train the LPN, Program Administrator, and all staff of this personal care home on how to calibrate the glucometer and accurately read/document glucometer readings in accordance with regulation 2600.185(a); proof of this training will be forthcoming. In addition, effective 7/28/2025, the program nurse will review the glucometer readings weekly and will 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. Finally, on/or before 8/15/2025, the medication audit tool in the electronic health record will be modified to include fields for ensuring glucometers are calibrated to date and time. Proof of this remediation if forthcoming.

Licensee's Proposed Overall Completion Date: *08/15/2025*

Implemented (█ - 09/02/2025)