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

October 21, 2025

[redacted]
KEYSTONE SERVICE SYSTEMS INC
[redacted]

RE: KHS MENTAL HEATLTH SERVICES
MARKET ST SPECIALIZED COMM
RES
1926 EAST MARKET STREET
YORK, PA, 17402
LICENSE/COC#: 31238

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/19/2025 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 HEATLTH SERVICES MARKET ST SPECIALIZED COMM RES* **License #**: *31238* **License Expiration**: *03/14/2026*

Address: *1926 EAST MARKET STREET, YORK, PA 17402*

County: *YORK* **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**: *03/07/2006* **Issued By**: *Springettsbury Township*

Staffing Hours

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

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *09/19/2025*

Inspection Dates and Department Representative

09/19/2025 - 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: *7* **Are 60 Years of Age or Older**: *3*

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

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

Inspections / Reviews

09/19/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/13/2025*

10/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/24/2025*

Inspections / Reviews *(continued)*

10/21/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2025*

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

16c Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident [redacted] was prescribed [redacted] tablets-take 1 tablet by mouth three times daily. On [redacted] this medication was decreased to [redacted]-take 1 tablet by mouth at bedtime. However, the home discontinued the medication on [redacted] and the resident did not receive the prescribed medication from [redacted] through [redacted]. This medication error was not reported to the Department.

Plan of Correction ***Accept[redacted] 10/14/2025)***

On 09/25/2025, an incident report for the medication error was filed with the Department for Resident [redacted] missed doses of Senna 8.6mg from 7/17/25 to 7/28/25. Proof of this incident report can be found in Attachment #1. Keystone Service Systems, Inc. (Keystone) maintains a process wherein all staff of the personal care home are trained by a certified medication trainer upon hire and annually thereafter on the medication administration process, including but not limited to the reporting of medication errors and/or omissions immediately upon the error or omission occurring to the Program Administrator, Acting Program Administrator or rotating On-Call Program Administrator. In review of this citation in context to the business process, it was found that staff did not identify the missed doses as a medication error as it was documented in the eMAR that Resident [redacted] was changed to PRN. As a result, on or before 10/13/2025, the Director will train the Program Administrator, Program Coordinator and agency nurse on regulation 2600.16(c), the definition of a medication error, the incident reporting process, including timeframes for reporting and on-call reporting procedures. The content and proof of this training can be found in Attachment #3. The Program Administrator will provide training on regulation 2600.16(c), the definition of medication error, the incident reporting process, including timeframes for reporting and on-call reporting procedures at the next staff meeting that is scheduled to occur 10/17/2025; proof of this training will be forthcoming. Additionally, effective 10/13/2025, the agency nurse will continue to complete medication audits on a bi-weekly basis. The medication audits will include a review of medications to ensure they're present in the program, given at the exact dosage, time and frequency as outlined by the prescriber and that the medication label matches the electronic medication administration record. Proof of the medication cart audit completed on 10/13/2025 can be found in Attachment #6. If issues are identified during the audit, the agency nurse would be responsible to report the medication error immediately to the Program Administrator. The Program Administrator, acting administrator or designee who receives the report from the agency nurse would be responsible to submit an incident report to the Department, if applicable.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented ([redacted] - 10/21/2025)

186c Change in Medications

2. Requirements

2600.
186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

186c Change in Medications *(continued)*

Description of Violation

On [redacted], the home discontinued the medication [redacted] prescribed for resident [redacted]. The home had not received a written order from an authorized prescriber for the change and did not have registered nurses present authorized to receive verbal orders.

Plan of Correction ***Accept ([redacted] - 10/14/2025)***

On 9/16/25, the medication, [redacted] prescribed to Resident [redacted] was discontinued. It was determined that Resident #1 returned from a hospitalization on 7/9/25 with the order for Senna 8.6mg to be administered three times daily for occasional constipation. On 7/17/25, during Resident #[redacted] medication management appointment, a medical consult form discontinuing [redacted] (take 1 tablet by mouth 3 times daily) was electronically signed by the physician. Per the discussion at the appointment, staff believed the medication was to be discontinued altogether and removed the medication from the eMAR and med cart. However, there was a delay in the order being transmitted to the home and once received, it was realized that only the frequency of the medication was changed. Resident [redacted] was again hospitalized from 7/29/25 8/13/25. Upon return to the PCH, Resident [redacted] received the [redacted] once daily at bedtime as prescribed until its discontinuation. 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 medication cart audits were being completed however, it was not identified that the order for [redacted] was removed from the eMAR and med cart in error. As a result, on 10/13/2025, the Director trained the agency nurse and Program Administrator on regulation 2600.186(c) as it pertains to what staff are allowed to accept verbal orders and verifying verbal orders, the Medication Cart Audit and oversight of the Medication Cart Audit. Proof of this training can be found in Attachment #4. Finally, on 10/13/2025, 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 in Attachment #6. Effective 10/13/2025, 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 10/13/2025, 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: *10/20/2025*

Implemented [redacted] - 10/21/2025)

187d - Follow Prescriber's Orders

3. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On [redacted], Resident [redacted] was prescribed [redacted] take 1 tablet by mouth at bedtime. However, the resident was not administered this medication from [redacted]

187d Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept [redacted] 10/14/2025)***

On 09/25/25, an incident report for the medication error was filed with the Department for Resident [redacted] missed doses of [redacted] from 7/17/25 to 7/28/25. Proof of this incident report can be found in Attachment #1. On 09/16/2025, the medication [redacted] was discharged; proof of the discharge is found in Attachment #2. 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 medication cart audits were being completed however, it was not identified that the order for [redacted] was errantly removed from the eMAR and med cart. As a result, on 10/13/2025, 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 can be found in Attachment #4. Finally, on 10/13/2025, 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 can be found in Attachment #6. Effective 10/13/2025, 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 10/13/2025, 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: *10/20/2025*

Implemented [redacted] 10/21/2025)

225c - Additional Assessment

4. 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] has a history of suicidal ideations and multiple staff interviews indicated the resident has hypersexual behaviors. Resident [redacted] assessment, dated [redacted] does not include the resident's behaviors or history of suicidal ideations.

Plan of Correction ***Accept [redacted] 10/14/2025)***

On 10/14/25, Resident [redacted] Resident Assessment and Support Plan (RASP) will be updated to reflect the resident's history of suicidal ideation and hospitalization. Additionally, in consultation with the treatment team, the behavioral section of Resident [redacted] RASP was updated to address Resident [redacted] hypersexual behavior. Proof of Resident [redacted] updated RASP will be forthcoming. 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

225c - Additional Assessment (continued)

assessment. Therefore, on 10/13/2025, 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 inpatient hospitalization. Proof of this training can be found in Attachment #5. On 10/17/2025, the Program Administrator is scheduled to train all staff of this personal care home on the updated RASP for Resident [redacted]. Proof of this remediation wll be forthcoming. Finally, on/or before 10/20/2025, 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: *10/20/2025*

Implemented ([redacted] 10/21/2025)