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

April 23, 2026

[redacted] EXECUTIVE DIRECTOR
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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/11/2026 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**: *03/14/2027*

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**: *03/13/2006* **Issued By**: *Springetsbury Twp*

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**: *03/11/2026*

Inspection Dates and Department Representative

03/11/2026 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**: *4*

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

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

Inspections / Reviews

03/11/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/28/2026*

Inspections / Reviews *(continued)*

03/30/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *04/03/2026*

04/07/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/04/2026*

04/23/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2026*

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] *who is the home's administrator, only completed 5.5 hours of approved administrator training during the 2025 training year.*

Plan of Correction ***Accept ([redacted] - 04/07/2026)***

The Program Administrator of this personal care home, [redacted] is expected to complete the remaining 18.5 training hours by 5/1/2026 for calendar year 2025. These training hours will be in addition to the hours for needed for training year 2026. Proof of the completed training will be forthcoming. 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 4/6/20206, 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 4/7/2026, the Education Consultant in conjunction with the Director 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 on the audit findings and remediation needed. Proof of the completed audit will be forthcoming. Finally, on 3/26/2026, the Associate Executive Director provided training to all Directors 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 is in Attachment #9.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 04/23/2026)

85a - Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/11/26, there was a very strong urine odor in the second-floor bathroom, bedroom [redacted] and the sitting area. The strong urine odor was observed during the initial walk through at 9:15 AM and again during the physical site inspection at approx. 3:15 PM.

85a Sanitary Conditions *(continued)*

Plan of Correction ***Accept (- 03/30/2026)***

On 03/11/2026, the second floor bathroom, bedroom and the sitting area were cleaned. It should be noted that prior to licensing, the home hired a cleaning company specifically for this area of the home. The resident that resides in bedroom #8 is . Additionally, this residents treatment team has been working . Effective 03/24/2026, Keystone Service Systems, Inc (Keystone) will implement electronic daily task tracking for the resident residing in bedroom #8. The electronic task tracking will prompt staff at 3 intervals throughout the course of the day to check the resident . Staff will then be required to document what actions were taken to clean the resident room. If a prompt is missed by the staff on shift, then the Program Administrator will be notified and follow up can occur on the task in real time. On 03/23/2026, the Director trained the Program Administrator and all staff of this personal care home on regulation 2600.85(a), the newly implemented electronic task tracking for this resident and how to adequately document actions taken. Proof of this remediation is in Attachment #5 and Attachment #10. Finally, effective 4/6/2026, on bi weekly basis, the Director will be on site to review the personal hygiene tasks completed and cleanliness of the resident's room.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented (- 04/23/2026)

132d - Evacuation

3. 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

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the fire drill conducted on 4/18/25 with an evacuation time of 5 minutes.

Plan of Correction ***Accept (- 03/30/2026)***

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

132d - Evacuation (continued)

was not followed by the staff and Operational Leadership. As a result, on 03/23/2026, 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. Proof of this training is found in Attachment #10. On 3/23/2026, the Program Administrator held 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 #3. 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 4/6/2026, 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: *04/06/2026*

Implemented ([redacted] - 04/23/2026)

132h - Designated Meeting Place

4. Requirements

2600.
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 following fire drills, all residents did not evacuate to a designated meeting place away from the building.

Date & Time	*Number residents present*	*Number evacuated*
2/5/25 10:30 AM	*4*	*3*
10/2/25 12:00 AM	*6*	*5*

132h - Designated Meeting Place *(continued)*

Plan of Correction ***Accept (- 04/07/2026)***

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 not followed by the staff and Operational Leadership. As a result, on 03/23/2026, 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. Proof of this training is found in Attachment #10. On 3/23/2026, the Program Administrator held 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 #3. 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 4/6/2026, 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: *04/06/2026*

Implemented (- 04/23/2026)

141b1 - Annual Medical Evaluation

5. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The medical evaluation for resident #1 dated indicates:
Can self-administer - assistance in remembering schedule.
Can self-administer -assistance in offering medications at prescribed times.
Can self-administer some medications but not others - See Medication addendum on page 4.
The medication addendum on page 4 is marked "See attached" with no information as to what medications can be self-administered.

Plan of Correction ***Accept (- 03/30/2026)***

On or before 3/30/3026, Resident #1's physician will be contacted to update the DME to specify that Resident #1 can self-administer Proof of this update will be forthcoming. Keystone Service Systems, Inc. (Keystone) maintains a medical appointment business process that includes preparation of the medical evaluation form by the Program Administrator or Program Coordinator prior to the medical visit. A standard,

141b1 - Annual Medical Evaluation (continued)

formalized training was developed and recorded that reviewed scheduling of medical appointments in the electronic health record (EHR), completion of required medical evaluation documentation, how to upload completed documentation in the EHR and report monitoring of upcoming and completed medical appointments. In review of the citation, in context to the business process, it was found that the business process was followed, however, staff did not ensure the physician specified [redacted] for self-administration. To ensure ongoing compliance, on 3/25/2026, the Associate Executive Director trained the Director, Program Administrator and agency nurse on regulation 2600.141(b)(1), the medical visit process and the chart auditing process. Proof of this training is found in Attachment #8. Effective 8/2/2024, the Associate Executive Director (AED) holds bi-weekly Medical Visit Status (MVS) Leadership Meetings with all Program Administrators, Directors and agency nurses. During MVS meetings, all medical appointments and protocol changes are reviewed. In July 2025, review of completed initial and annual medical evaluations for timeliness, completion and accuracy was added to the MVS agenda. If issues are identified during the MVS meeting, then guidance is given by the AED to the Program Administration on remediation actions required. All remediation actions issued are reviewed at the next bi-weekly meeting to ensure follow up occurs as directed. In addition, during the bi-weekly MVS meeting, any initial or annual medical evaluations scheduled for the upcoming week are reviewed to ensure the medical evaluation forms are prepped accurately by the Program Administrator or Program Coordinator prior to the appointment and include completion of all sections (with the exception of the Medical Professional Information section). Proof of the most recent MVS meeting is included in Attachment #1.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented ([redacted] - 04/23/2026)

181c - Self-administration Assessment

6. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2 self-administers medications [redacted] however, per the resident's medical evaluation completed on [redacted] Resident #2 cannot self-administer medications.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On 03/24/2026, Resident #2 had a medical evaluation at which time the DME form was completed. This DME notes that Resident #2 can administer some medications but not others and specifies [redacted] can be self-administered. Proof of this completed medical evaluation can be found in Attachment #6. Keystone Service Systems, Inc. (Keystone) implemented a process on effective 8/2/2024 in which the Associate Executive Director (AED) holds bi-weekly Medical Visit Status (MVS) Leadership Meetings with all Program Administrators, Directors and agency nurses. The MVS meetings review all completed initial and annual medical evaluations for timeliness, completion and accuracy. If issues are identified during the MVS meeting, then guidance is given by the AED to the Program Administration on remediation actions required. All remediation actions issued are reviewed at the next bi-weekly meeting to ensure follow up occurs as directed. In addition, during the bi-weekly MVS meeting, any initial or annual medical evaluations scheduled for the upcoming week are reviewed to ensure the medical evaluation forms are prepped

181c - Self-administration Assessment (continued)

accurately by the Program Administrator or Program Coordinator prior to the appointment and include completion of all sections (with the exception of the Medical Professional Information section). Proof of the most recent bi-weekly MVS Meeting is found in Attachment #1. In review of this citation, in context to the business process, it was determined that there was confusion on the definition of self-administration [redacted]. As a result, on 3/13/26, the Director of Healthcare Services provided education to all Directors, Program Administrators and agency nurses on regulation 2600.181(c), residents who [redacted] the definition of self-administration and instructions for physician's on how to assess self-administration as it pertains [redacted] and how this should be documented on the DME and within the RASP. Proof of this training is in Attachment #2. Finally, a chart audit will be conducted by the Director by 3/26/2026 on all other resident records to ensure accuracy between the DME, RASP and how the individual is administered medications in the home. Proof of this chart audit can be found in Attachment #11.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented ([redacted] - 04/23/2026)

187a - Medication Record

7. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
13. Date and time of medication administration.

Description of Violation

Resident #1 is prescribed [redacted] which the resident self-administers [redacted] Resident #1 is also prescribed [redacted] which the resident self-administers. The remarks section of the MAR indicates that both [redacted] were omitted on 3/10/26 and 3/11/26 [redacted] Staff person B stated that the resident did self administer these medications however, the wrong remark was noted on the MAR by the staff person.

ResIdent #2 is prescribed [redacted] Resident #2 is also prescribed [redacted] The remarks section of the MAR indicates that both [redacted] were omitted on 3/10/26 and 3/11/26 [redacted] Staff person B stated that the resident did self administer these medications however, the wrong remark was noted on the MAR by the staff person.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

Keystone Service Systems, Inc. (Keystone) has a formalized process to audit all medical components of individuals supported, including medications and medication administration records (MAR) through weekly medication audits by the agency nurse. In review of the process, in context to the citation, it can be noted that the weekly medication audits were being completed as required. It was determined that the staff member responsible for documenting the administration [redacted] on 03/10/2026 and 03/11/2026 does not typically administer [redacted] medications and made a transcription error by writing "omitted [redacted]" instead of "administered [redacted]." To prevent future recurrence, on 3/23/2026, all staff including the staff that made the transcription error were trained by the Director and Program Administrator on regulation 2600.187(a) and ensuring administration of all medications is documented timely and accurately in the eMAR. Proof of this remediation can be found in Attachment #7. Effective, 3/23/2026, the agency nurse will continue to complete bi-weekly medication audits with oversight from the Director of Nursing to ensure accuracy and any follow up occurs timely. Proof of these audits will be forthcoming.

187a Medication Record *(continued)*

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented (- 04/23/2026)

225c - Additional Assessment

8. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #3's current assessment was completed on . However, the resident's previous assessment was completed on

Plan of Correction ***Accept (- 03/30/2026)***

Keystone Service Systems, Inc. (Keystone) maintains the RASP in the electronic health record (EHR) for each resident. The RASP is to be completed by the Program Administrator and must address all sections prior to reviewing with the individual and having all parties electronically sign the RASP. Effective 2/1/2023, the Quality Manager runs a report out of the EHR on a monthly basis that outlines those assessment and support plans that are coming due for annual completion and provides this report to all Program Administrators and Directors so that planning occurs for completion of these documents prior to the due date. Effective 10/13/2023, an optimization occurred in the EHR wherein all fields had to be complete on the RASP before it could be signed by the staff completing. Finally, effective 7/1/2024, the RASP requires a secondary signatory by the Director so that the RASP can be reviewed for accuracy and thoroughness. Through review of this citation in context to the business process, it was found that the RASP was not updated timely by the Program Administrator. It should be noted that this citation was identified through Keystone's internal pre licensing process prior to the annual inspection. To ensure continued compliance, on 03/23/2026, the Director trained the Program Administrator on regulation 2600.225(c) as well as RASP business process; proof of this training is found in Attachment #4. Additionally, the Program Administrator will audit all other resident records to ensure assessment and support plan compliance with this standard on/or before 4/3/2026; proof of this audit is will be forthcoming. The Director will provide oversight of this audit and will ensure any identified remediation is completed by the Program Administrator (or designee).

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented (- 04/23/2026)