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

April 17, 2026

[redacted]
KEYSTONE SERVICE SYSTEMS INC
[redacted]

RE: KHS MENTAL HEALTH SERVICES-
QUEEN ST SPECIALIZED PC
2033 SOUTH QUEEN STREET
YORK, PA, 17402
LICENSE/COC#: 32950

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/20/2026 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 HEALTH SERVICES-QUEEN ST SPECIALIZED PC* **License #**: *32950* **License Expiration**: *06/20/2026*

Address: *2033 SOUTH QUEEN 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-4* **Date**: *03/20/2012* **Issued By**: *York Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *6* **Waking Staff**: *5*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/19/2026*

Inspection Dates and Department Representative

03/20/2026 - 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: *5* **Are 60 Years of Age or Older**: *2*

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

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

Inspections / Reviews

03/20/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/17/2026*

04/15/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/16/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/21/2026*

Inspections / Reviews *(continued)*

04/15/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/16/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/17/2026*

04/17/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/16/2026*

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

42b - Abuse

1. 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.

Description of Violation

On [redacted], Resident [redacted] reported that Resident [redacted] had kissed [redacted] on the lips on [redacted] and [redacted] felt repulsed, uncomfortable and didn't like it. Resident [redacted] was found to be intentional in efforts to kiss Resident [redacted] on the cheek several times in the weeks prior and then on the lips when staff were not present and the two residents were alone. As per resident records and staff interviews, Resident [redacted] struggled with maintaining appropriate boundaries, inappropriate sexual behavior, and accepting "no" as an answer.

Plan of Correction ***Accept [redacted] 04/15/2026)***

On 10/21/2025, at the time of the disclosure made by Resident [redacted] the local Area Agency on Aging and Adult Protective Services were contacted and a Mandatory Abuse Report was filed. On the same date, an incident report was filed with the Department and 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 supervision checks every 15 minutes for both Resident [redacted] and Resident [redacted] Every 15 minutes, staff were prompted through Keystone's task tracking system to conduct the visual check. Any interactions between Resident [redacted] and Resident [redacted] were supervised by staff for the duration of the interaction. On 10/31/2025, Keystone's Administrative Review team concluded the internal investigation with a confirmed finding. Upon conclusion of the investigation, Resident [redacted] and Resident [redacted] received training on Individual Rights, Consent and Sexual Psychoeducation from Keystone's Clinical Director. Additionally, Treatment Team meetings were held on a monthly basis between members of Keystone, the county and behavioral supports for both residents to discuss health and safety. In early November 2025, Keystone initiated a transfer process for Resident [redacted] to another provider however, there was a lack of support from the county MH/ID. On 11/24/2025, Keystone issued Resident [redacted] a 30-day notice for conduct that jeopardized the health, safety, and welfare of other individuals in the home and on 12/16/2025, Resident [redacted] was discharged to the care of a relative. Resident [redacted] continues to participate in monthly treatment team meetings and regularly scheduled therapy appointments. To maintain compliance with this regulation, on 04/13/2026, the Director re-trained the Program Administrator and all staff of this personal care home on regulation 2600.42(b) and all Resident Rights. Proof of this remediation can be found in Attachment [redacted] Additionally, on 04/13/2026, the Program Administrator held a Resident Meeting in which all residents were re-educated on Resident Rights and how to report a violation of rights. Proof of the meeting and content covered can be found in Attachment [redacted]

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented ([redacted] - 04/17/2026)

42q - Compensation

2. Requirements

2600.
42.q. A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the home.

Description of Violation

On [redacted], Staff Member A required Resident [redacted] to clean [redacted] room before Staff Member A would provide a

42q Compensation (continued)

cigarette to the resident. When Resident [redacted] returned after completing the task, Staff Member A re checked the resident's bedroom and indicated it was still not clean, requiring the resident to complete further tasks. The home did not compensate the resident for this work.

Plan of Correction ***Accept ([redacted] - 04/15/2026)***

Resident [redacted] did not provide work for the home. Resident [redacted] struggles with maintaining a clean living space, resulting in [redacted] personal possessions being lost or damaged. As a result, in consultation with Resident [redacted]s treatment team, on July 5, 2024, daily task tracking was implemented for Resident [redacted] for maintaining a clean room. Daily, staff will prompt Resident [redacted] to clean [redacted] room starting at 8am. Staff will follow up with Resident [redacted] at 4pm to ensure that the task is completed. Staff will document the number of verbal and/or modeling prompts given, if applicable, and must visually check Resident [redacted]s room before marking the task as complete. If Resident [redacted] does not complete this daily task, staff will notate this in the task tracking system. On 10/26/2025, Staff Member A prompted Resident [redacted] to take a shower, change their clothes and tidy up their bedroom as part of Resident [redacted]s goals and daily task tracking. Resident [redacted] took a shower but did not tidy up [redacted] room. Staff Member A provided Resident [redacted] with an additional prompt to complete this task. Resident [redacted] refused and ultimately took [redacted] cigarettes and went outside to smoke. Staff Member A believed withholding cigarettes would motivate Resident [redacted] to complete the task as a method of positive reinforcement without realizing that this was a violation of Resident [redacted]s rights. Staff Member A also believed that limiting Resident [redacted]s nicotine use was acceptable per the physicians order regulating [redacted] daily intake. In November 2025, Staff Member A was informed by the Program Administrator that withholding Resident [redacted]s personal items such as cigarettes was not allowed and that all staff could do was re educate Resident [redacted] on the health risks associated with excessive nicotine use. On 04/13/2026, Resident [redacted]s Resident Assessment and Support Plan was updated to include staff expectations with prompting of tasks and what to do when Resident [redacted] refuses. Proof of this update can be found in Attachment #3. Per Resident [redacted]s updated RASP, staff will prompt [redacted] in the morning to clean [redacted] room. Staff will follow up in the afternoon to assess if the task was completed. If Resident [redacted] has not completed the task, staff will work with Resident [redacted] to identify any barriers preventing [redacted] from completing the task. If Resident [redacted] refuses to complete the task, staff will clean Resident [redacted]s room. Staff will review caring for personal possessions and cleanliness during treatment team meetings to discuss ways to support Resident [redacted] in maintaing a clean space to reduce the risk of personal items being lost or damaged. To prevent future recurrence, on 04/13/2026, the Director trained the Program Administrator and all staff of this personal care home on regulation 2600.42(q) and all resident rights with emphasis on ensuring that staff are allowing residents to make their own choices and Resident [redacted]s updated RASP; proof of this remediation can be found in Attachment [redacted] Additionally, on 04/13/2026, the Program Administrator held a Resident Meeting in which all residents were re educated on Resident Rights and how to report a violation of rights. Proof of the meeting and content covered can be found in Attachment [redacted]

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 04/17/2026)

43b - Resident Rights Rewarded

3. Requirements

2600.
43.b. A resident's rights may not be used as a reward or sanction.

Description of Violation

On [redacted] and [redacted], the home had possession of Resident [redacted]s cigarettes and withheld these items when the resident asked for them. On [redacted], Staff Member A told the resident [redacted] would not be allowed any more nicotine that day. On [redacted] Staff Member A required Resident [redacted] to clean [redacted] room before Staff Member A

43b - Resident Rights Rewarded *(continued)*

Plan of Correction ***Accept [redacted] - 04/15/2026)***

It should be noted that the first incident described took place on 10/12/2025, not 10/13/2025. On 10/11/2025, Resident [redacted] was hospitalized due to excessive caffeine use and newly recognized heart murmur at which time, the physician implemented a smoking and caffeine consumption plan to assist Resident [redacted] in regulating [redacted] daily intake. Per the plan, Resident [redacted] was to reduce cigarette use to 10 cigarettes or 6mg of zyn per day and would be offered with the option 10 times per day. On 10/12/2025, Staff Member A was attempting to encourage Resident [redacted] to make healthier choices due to the recent hospitalization and believed they were following the physicians' orders by limiting Resident [redacted]s nicotine use for the day. On 10/26/2025, Staff Member A prompted Resident [redacted] to take a shower, change their clothes and tidy up their bedroom as part of Resident [redacted]s goals and daily task tracking. Resident [redacted] took a shower but did not tidy up [redacted] room. Staff Member A provided Resident [redacted] with an additional prompt to complete this task. Resident [redacted] refused and ultimately took [redacted] cigarettes and went outside to smoke. Staff Member A believed withholding cigarettes would motivate Resident [redacted] to complete the task as a method of positive reinforcement without realizing that this was a violation of Resident [redacted]s rights. In November 2025, Staff Member A was informed by the Program Administrator that withholding Resident [redacted]s personal items such as cigarettes was not allowed and that all staff could do was re-educate Resident [redacted] on the health risks associated with excessive nicotine use. On 04/13/2026, Resident [redacted]s Resident Assessment and Support Plan was updated to include staff expectations with prompting of tasks and what to do when Resident [redacted] refuses. Proof of this update can be found in Attachment #3. To prevent future recurrence, on 04/13/2026, the Director trained the Program Administrator and all staff of this personal care home on regulation 2600.43(b) and all resident rights with emphasis on ensuring that staff are allowing residents to make their own choices and Resident [redacted]s updated RASP; proof of this remediation can be found in Attachment [redacted] Additionally, on 04/13/2026, the Program Administrator held a Resident Meeting in which all residents were re-educated on Resident Rights and how to report a violation of rights. Proof of the meeting and content covered can be found in Attachment [redacted]

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented [redacted] - 04/17/2026)