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

July 7, 2026

[redacted], EXECUTIVE DIRECTOR
KEYSTONE SERVICE SYSTEMS INC
[redacted]

RE: KHS MENTAL HEALTH SERVICES-
GREEN STREET SPECIALIZED PC
2900 GREEN STREET
HARRISBURG, PA, 17110
LICENSE/COC#: 32878

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/02/2026 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-GREEN STREET SPECIALIZED PC* **License #**: *32878* **License Expiration**: *06/21/2027*

Address: *2900 GREEN STREET, HARRISBURG, PA 17110*

County: *DAUPHIN* **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**: *04/11/2001* **Issued By**: *City of Harrisburg*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *06/02/2026*

Inspection Dates and Department Representative

06/02/2026 - 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**: *3*

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

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

Inspections / Reviews

06/02/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/19/2026*

06/17/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/06/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/23/2026*

Inspections / Reviews *(continued)*

06/18/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/06/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/06/2026*

07/07/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/06/2026*

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 #1 struck Resident #2 on the right side of their face with a closed fist. On [redacted] Resident #1 struck Resident #2 in the face with a closed fist causing injury to resident #2. Resident #2 was sent to [redacted] via ambulance. Resident #2 was diagnosed with [redacted]

Plan of Correction ***Accept ([redacted] - 06/17/2026)***

Following the incidents on [redacted], law enforcement was contacted and incident and mandatory abuse reports were immediately filed with the Department and the local Area Agency on Aging. Staff implemented safety plans requiring 15-minute safety checks for both Resident #1 and Resident #2 that occurred from [redacted]. Safety checks stopped on [redacted] at the direction of the Area Agency on Aging. Proof of safety checks can be found in Attachment #2. While with Keystone, Resident #1 actively participated in weekly sessions with the Mental Health Professional (MHP) and participated in monthly Treatment Team meetings with members of Keystone, the county, and behavioral supports to discuss needs, safety, and physical and behavioral health recommendations. Following the [redacted] incident, Resident #1 was referred for [redacted] Resident #1 was invovled in the second incident [redacted] Following the incidents, Resident #2 reports feeling safe and is doing well. The MHP has met with Resident #2 weekly and Keystone staff have continued to provide assistance [redacted]. On 6/12/2026, all staff of this personal care home were retrained by the Director on regulation 2600.42(b) and all Resident Rights; proof of this remediation can be found in Attachment #1. Additionally, on 6/15/2026, the Program Administrator held a resident meeting at which time all residents were informed of all resident rights and procedures for reporting a rights violation. Proof of attendance can be found in Attachment #3.

Licensee's Proposed Overall Completion Date: *06/17/2026*

Implemented ([redacted] - 07/07/2026)

132h - Designated Meeting Place

2. 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.

132h Designated Meeting Place *(continued)*

Description of Violation

During the fire drill on 2/25/26 at 9:18 PM, there were 8 residents present in the home; however, only 7 residents evacuated to a designated meeting place away from the building.

Repeated Violation 3/18/25

Plan of Correction ***Accept (- 06/18/2026)***

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 all residents 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 of the citation, it was determined that one resident refused to complete the evacuation on 2/25/2026 due to being tired. It should be noted that a successful fire drill was completed prior, on 2/17/2026 and that this resident has participated in all other fire drills within the past year. To prevent future recurrence, on 6/15/2026, 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 #4. In addition to the all resident meeting, on 06/16/2026, the Mental Health Professional (MHP) met one on one with the resident that refused to evacuate to reiterate that participation in fire drills is mandatory in accordance with program policy and regulations and for their safety. The resident acknowledged understanding and the MHP will continue to provide support to this resident to remain safe in the home. Going forward, if applicable, program staff and the MHP will meet after an unsuccessful fire drill to discuss a plan to help prevent any issues during during future fire drill evacuations. On 6/12/2026, 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. Additionally, the Director provided guidance to the staff on the steps to evacuate the home given the current needs of some residents. The resident with the most need will be assisted by staff immediately at the start of the fire drill and all other residents will evacuate independently to the meeting location. Proof of this training is found in Attachment #1. 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 7/1/2026 , 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: *07/01/2026*

Implemented (- 07/07/2026)

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 loose, one half, oblong, off white pill was found in the third drawer of the medication cart. Staff were unable to determine what the medication is or for whom it was prescribed.

Repeated Violation - 1/28/25, et al.

Plan of Correction ***Accept (- 06/17/2026)***

On 6/2/2026, at the time of the inspection, the loose single pill was appropriately discarded by the Program Administrator 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 order new medication from the pharmacy as needed. In review of this citation, it was found that the small pill became loose after the last medication cart audit. As a result, on 6/12/2026, 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 is found in Attachment #1. Finally, on 6/16/2026, the agency nurse completed a medication cart audit for all residents of the home to ensure all medication is stored in its original packaging and is administered as prescribed. Proof of this audit is found in Attachment #6.

Licensee's Proposed Overall Completion Date: *06/17/2026*

Implemented (- 07/07/2026)

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 #1's assessment, dated indicated Resident #1 requires no supervision in the home or when in familiar surroundings. However, 15-minute checks were implemented from as a result of physical aggression and violations towards another resident. Resident #1's assessment was not updated to reflect the resident's change in supervision needs.

Plan of Correction ***Accept (- 06/18/2026)***

On , Resident #1 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 6/12/2026, education was provided by the Director to the Program Administrator on regulation 2600.225(c)(2) 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

225c - Additional Assessment (continued)

training can be found in Attachment #1. Additionally, on/or before 6/26/2026, 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. Keystone Service Systems, Inc. (Keystone) implemented a process 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. 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. Effective 7/2/2026, all resident to resident incidents will be added to the MVS meeting agenda to review supervision needs in comparison to the residents RASP. If issues are identified during the MVS meeting, then guidance is given by the AED to the Program Administrator on remediation actions required. All remediation actions are reviewed at the next bi-weekly meeting to ensure follow up occurred as directed. Proof of the updated agenda and attendance at the 7/2/2026 meeting is forthcoming.

Licensee's Proposed Overall Completion Date: *07/02/2026*

Implemented ([redacted] - 07/07/2026)