



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Sent via email to: [REDACTED]
MAILING DATE: July 21, 2014

Mr. Adam Devlin, President
Tri-County Respite, Inc.
5201 St. Joseph Road, PO Box 1001
Limeport, Pennsylvania 18060

RE: Mt. Trexler Manor
License # 216630

Dear Mr. Devlin:

As a result of the Department of Public Welfare's licensing inspection on June 9, 2014 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Michele Moskalczyk".

Michele Moskalczyk
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

Violation Report: 21668 - 06/09/2014 - O'Haire, Anne
PC # Name: MT TREXLER MANOR

1. REGULATION 55 Pa.Code §2600
2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION
Residents #1 and #2 had a verbal altercation that escalated into a physical altercation on 06-13-14 at 10:25 pm. Resident #1 struck and kicked Resident #2 resulting in injuries. Police were called and both residents were sent to different hospitals for evaluation.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Attached

The administrator shall monitor and assure that all residents may not be neglected, intimidated, physically or verbally abused, mistreated, subject to corporal punishment or disciplined in any way. The administrator shall be responsible for ongoing compliance

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Date 7/21/14

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 7/21/14 (Date)

Plan of correction implementation status as of 7/21/14 (Date)

- Fully Implemented
□ Partially Implemented - Adequate Progress
□ Partially Implemented - Inadequate Progress
□ Not Implemented

The above plan of correction was approved by (Initials)

Mount Trexler Manor
Plan of Correction for Violation Report on 6/9/14

42b

Summary of Incident

Resident #1 and Resident #2 became engaged in a physical altercation in which Resident #1 hit and kicked Resident #2. Both residents were immediately separated. Both residents were placed on immediate increased supervision and debriefed on the situation. As per MTM policy when a physical incident takes place, both residents were asked if they would like to receive medical attention. Both individuals indicated they would like to go to the hospital despite the absence of observed injuries. Both residents were transported by MTM staff to separate hospitals to receive medical evaluation as per their requests (no major injuries were found and residents were medically cleared to return to the Home).

Immediate Action Steps Taken:

- Residents were separated and received increased monitoring and supervision
- Residents requested and received follow-up at local emergency rooms, received medical clearance, and maintained increased monitoring and supervision upon return.
- Designated person(s) were contacted and informed of the incident
- Psychiatrists and therapists were contacted and follow-up appointments were made.
- Primary Care Physicians were contacted and follow-up appointments were made as needed.
- Individuals were debriefed on the incident, received counseling and coaching as to their part in the incident; and conflict resolution was offered.
- The Area Office of Aging contacted to report the incident. The Area Office on Aging determined that there was no abuse and therefore a report was not indicated.
- RASPs were reviewed and updated as needed.

Corrective Action Steps Taken:

- Resident #1 was working on a transition plan to leave Mount Trexler Manor and the plan was accelerated.
- Staff continued to receive training and information on proactive approaches for managing the milieu which included being aware of situations that require increased monitoring and supervision.
- Staff will continue to receive information regarding potential resident conflicts.

Steps Taken to Prevent Re-occurrence

- Residents will be encouraged to generate community by participating in house community meetings; house resident meetings; house social events; and monthly trainings for the house.
- Administration and staff will be aware of behaviors such as arguments; times of resident congestion such as waiting in line for meds or meals and higher risk

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resident behaviors such as declining medications. Staff will provide increased monitoring and supervision during these times or behaviors.

- Residents will be encouraged to develop a personal safety plan with their mental health provider and share this with the residence to assist during times of stress or when the individual is feeling their safety (physical, moral, emotional, social) is being challenged.
- Staff will receive training on the importance of proactive positive intervention to assist with the prevention of resident conflicts.

The administrator shall monitor and ensure ongoing compliance -

my
7/21/14