



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [REDACTED]
MAILING DATE: August 31, 2015

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 Human Services' licensing inspection on April 7, 2015 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,

Michele Moskalczyk
Michele Moskalczyk
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

Violation Report: 21663 - 04/07/2015 - OHaire, Anne
 PCH 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

On 03-31-15, Resident #1 struck Resident #2 while both residents were in the home's dining room eating supper. Resident #2 received a bloody lip as a result of this resident to resident altercation. Resident #1 was transported and admitted for a psychiatric hospitalization due to his aggressive behavior. Resident #1 has a history of abusive behaviors.

On 03-10-15, Resident #3 struck Resident #4 in the mouth during a resident to staff altercation. Resident #4 stepped in to assist a staff person and was struck during this incident. Resident #3 has a history a abusive behaviors

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 (2 pages)

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/09/2014
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Toby Tarquin*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Toby Tarquin-Stackhouse-Admin</i>	Date <i>8/12/15</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8/31/15
 (Date)

The above plan of correction was approved by *[Signature]*
 (Initials)

Plan of correction implementation status as of 8/31/15
 (Date)

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

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cont.

Incident on 3-10-15

Resident #3 had been declining his psychiatric medications and began to utilize illicit substances. On 3/10/15, Resident # 3 appeared under the influence of alcohol. Resident #3 (who does not have a history of physical aggression) was asked to complete a breathalyzer (as ordered by his attending medical professional) to determine the presence of alcohol. The individual declined. When staff turned to walk away, resident #3 pushed the staff member into a door knocking her to the floor. Resident #4 witnessed the behavior of resident #3 and attempted to intervene resulting in resident #4 being struck. Resident #3 independently disengaged from the staff and other resident. Staff suggested that Resident #3 go to the local ER for a psychiatric evaluation and Resident #3 agreed. During the hospital's assessment, it was determined that Resident #3 was under the influence of alcohol but did not meet criteria for inpatient admission. He left hospital grounds on the morning of 3/11/15 and was immediately transported to the resident's behavioral health center for an emergency psychiatric evaluation. During that appointment, it was determined Resident #3 would need psychiatric inpatient care. He was admitted to Brooke Glen Hospital and did not return to live at Mount Trexler Manor.

Incident on 3-31-15

Several safety procedures were set in motion prior to the date of the incident. Clinical, residential, and Lehigh County Crisis teams had been in communication to discuss Resident #1's inconsistent use of medications and share observations about Resident #1's recent behaviors. Lehigh County Crisis workers indicated the individual did not meet criteria for an involuntary psychiatric admission, but notified Mount Trexler Manor staff that Resident #1's case would be monitored closely.

Resident #2, who was admitted earlier in the day on 3/31/15, was engaged in communication with a peer to determine the name of another person. Resident #1 was experiencing an increase in symptoms of paranoia, but did not yet meet criteria for psychiatric admission. Resident #1 believed resident #2 was talking about him, and struck resident #2. Resident #2 had a bloody lip as a result and was immediately assessed by staff proficient in First Aid techniques; no other injuries were present. Lehigh County Crisis was called to assist in a 302 petition to engage Resident #1 in inpatient care. Resident #1 was assessed and certified to need psychiatric inpatient care and was transported to the ER. The 302 was upheld and Resident # 1 was transferred to Friend's Hospital for an involuntary psychiatric inpatient admission. The individual did not return to Mount Trexler Manor.

Corrective Action for Both Incidents

Maintaining a safe environment is one of the paramount concerns of staff at Mount Trexler Manor. Our staff members routinely engage in trainings to ensure safety, including Safe Crisis Management skill building and medication education trainings to facilitate a positive, supportive environment for residents and staff. In response to the two incidents above, our team will continue to collaborate with Lehigh County Crisis and other community supports to encourage a safe and welcoming environment for residents, families, and allies.

At times, individuals may decline to utilize their prescription medications as a means to recovery. Mount Trexler Manor staff members are sensitive to the preferences of each resident, but will continue to coach, counsel, and educate all residents about the importance of working with their team of medical professionals when thinking about reducing or discontinuing prescription medications. It is hoped that continued medication education will assist individuals in making healthy choices regarding their medication options and in turn, promote a safe and welcoming community where each resident feels supported in decision making.

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Mount Trexler Manor staff will also continue to utilize effective communication methods to ensure that staff members are aware of residents who are actively experiencing behavioral health concerns. Shift-to-shift reports with clear behavioral observations and expectations will continue to be utilized to assist with sessions of increased monitoring. Strategies to assist the individual with current symptoms will include personalized wellness/coping skills to assist with managing strong emotions.

Staff members will continue to utilize the expertise of residents' treatment teams to assist with individualized safety planning. Collaboration with psychiatrists, nurses, individual therapists, and other supports, including families and allies, will continue to be the norm. Staff members will work to prevent future behavioral challenges through effective communication techniques that emphasize person-first, trauma-informed approaches. Staff members and residents will participate whenever possible in debriefing exercises to learn from each experience and adopt evidence-based practices to manage challenging situations. As needed, Lehigh County Crisis will be contacted in order to facilitate a higher level of care for those residents who may experience heightened behavioral health symptoms. Our goal is proactive prevention and ensuring personal wellness.


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