



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [REDACTED]
MAILING DATE: September 18, 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 July 2, 2015 and July 13, 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,

Anne Graziano
Anne Graziano
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

Violation Report: 21669 - 07/02/2015 - Hummel, Jesse
 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 8/30/15 at approximately 12:00pm resident #1 was admitted to the facility. Resident #1 was very reluctant to be admitted to the facility. The resident ate lunch at the facility, however was reluctant to stay inside the facility. At approximately 3:00pm the resident sat on a bench outside of the facility near the parking lot. The resident stated "This isn't my home, I'm not staying here." The resident also indicated they were waiting for a ride. On the day of the incident there were heavy thunderstorms and also a tornado warning. The facility allowed the resident to stay outside from 3:00pm on 8/30/15 through the night until the following morning. The resident sat on the bench outside of the facility with no protection from the elements. The facility placed the resident on 1:1 observations. Staff stood underneath the awning and observed the resident on the bench. The resident sat on the bench in the resident's wet clothing until the following morning. On 7/1/15 at 7:55am the facility contacted Lehigh County Crisis and petitioned for a 302 commitment. The resident was transported to the Hospital at 11:00am and was diagnosed with Hypothermia as a result of sitting outside in the rain all night.

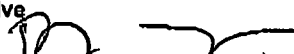
The facility failed to immediately contact the proper agencies in order to keep the resident safe and meet the resident's needs. As a result the resident's health was adversely affected.

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


Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) Tony Tarquin-Shuckhouse - Admin Date 8/12/15

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

The above plan of correction is approved as of 9-18-15
 (Date)

The above plan of correction was approved by 
 (Initials)

Plan of correction implementation status as of 9-18-15
 (Date)

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

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Mount Trexler Manor takes pride in ensuring a smooth transition when a new community member moves to one of our sites. A tour and site visit is routinely a part of our admissions process. Unfortunately, Resident # 1 was admitted to Mount Trexler Manor without having the opportunity to tour the building due to her continued stay at a local hospital. During her admission on 6/30/15, she became homesick and was reluctant to move her items to her room. Although she was willing to share lunch that day, she was hesitant to engage in conversation with staff. Subsequent attempts to engage the Resident #1 resulted in responses including, "This is not my home...I am waiting for a ride." Resident #1 exited the residence and remained on the porch despite staff's encouragement to help her feel more comfortable inside. Resident #1's family member (a sister) was contacted for assistance, but family was not able to provide additional suggestions to assist Resident #1. Staff members continued to monitor her and tried to engage her in conversation about every 15 minutes from the time of her admission until 9:00 PM when she was placed on 1:1 supervision. Staff remained approximately 5 to 10 feet away from the individual being monitored to ensure Resident #1's personal safety and space. During most interactions, Resident #1 declined to respond verbally to staff. One to one staff supervision remained in place throughout the night and into the next morning. Throughout the night, Resident #1 was offered a variety of food and drinks, the comfort of her bed, blankets, towels, and warmer clothing due to weather changes, and to come into the home. Resident #1 was also reminded about her medications; however, she declined all of staff's suggestions and offers. When staff asked to place a jacket or blankets around her shoulders she declined, stating, "Do not come near me." Lehigh Valley Crisis was called at approximately 7:55 AM on 7/1/15 and assisted with completing a petition for hospitalization. Resident #1 was admitted to the hospital for a higher level of care. Additionally, verbal reports from the hospital indicate resident #1 was not treated for hypothermia despite receiving the diagnosis. Medical records were unable to be obtained from the hospital to verify the statements from the hospital. Resident #1 was medically cleared and transferred to the hospital's Behavioral Health Unit.

Corrective Actions

Throughout Resident #1's stay at Mount Trexler Manor, staff members continually attempted to develop rapport and ensure her safety through direct monitoring, encouraging activities, and working to engage Resident #1 in the routines of the house. Staff members remained in direct contact throughout the event, including debriefings and regular updates regarding progress and responses from Resident #1. Staff members were concerned about the changes in weather and attempted to assist Resident #1 with weather-appropriate clothing; however, she declined despite multiple efforts to ensure her safety. Several staff members were utilized in an attempt to provide for Resident #1's personal needs; however, various attempts to engage Resident #1 were not successful.

As a result of this event, staff members participated in updated education opportunities that reviewed ways to protect residents from weather-related illness; specifically "Hypothermia in the Summer." Debriefing and brainstorming occurred following the date in question to identify new strategies to assist in potential scenarios in the future. Additionally, a full review of house policies, including on-call procedures, psychiatric and medical emergencies protocols, and house management procedures was completed. Staff members were also counseled regarding "closing the loop" for situations requiring further intervention.

In order to prevent similar events in the future, Mount Trexler Manor will continue to request all potential residents visit and tour the home to support a positive transition to our community. Additionally, administrators will continue to provide coaching and education to staff members to ensure the safety and wellbeing of all residents. Staff members will continue to partner with behavioral health supports and allies in order to address similar situations.

A. RLA
9-18-15J
8/12/15

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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.

ack. RLA
9-18-15

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