



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [REDACTED]

MAILING DATE: September 10, 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 August 4, 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,

A handwritten signature in black ink, appearing to read "Bob Bisignani".

Bob Bisignani
Regional Licensing Director

Enclosure
Licensing Inspection Summary

Violation Report: 21663 - 08/04/2015 - Novak, Ryan
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

It has been determined through an interview with Resident #1 and other female residents that Resident #2 sexually harrasses female residents and intimidates them. Resident #2 has said the following things to female residents: "Do you like double penetration?", "Do you like gang bang rapes?", "Have you ever been raped?", "Don't worry, I wont rape you.", and "You are a bitch and a racist." The female residents interviewed reported they feel "uneasy and afraid" when Resident #2 is present in the facility.

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: Yes Date(s) of Previous Violation(s): 03/25/2015

Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tom Tarvin - Stackhouse Date 8/26/15

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

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

The above plan of correction was approved by B.B. (Initials)

Plan of correction implementation status as of 9/9/15 (Date)

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

Resident # 1 was on 1:1 staffing from her admission date on 7/15/15 until her discharge on 8/11/15 in order to assist her with feeling safe in the new environment of the residence. Our staff members continue to work to provide a welcoming environment where each resident is able to utilize supports in order to secure a personalized vision of recovery.

Unfortunately, Resident #2 was experiencing an increase in behavioral health symptoms, including hyper-sexual verbalizations and paranoia. These symptoms may have been the result of Resident #2's choice to use his medications inconsistently. Staff members responded immediately to put procedures into place to address these challenges including appointments with his psychiatrist for medication management; supportive counseling with his therapist; and increased monitoring as needed. More specifically; on 7/16/15, the Director of Wellness alerted Lehigh County Crisis to Resident #2's presentation. At that time, Lehigh County Crisis believed resident #2 did not meet criteria for admission to an inpatient psychiatric setting. Resident #2 was monitored consistently and placed on 15 minute checks. On 7/18, Resident #2 began using derogatory language toward female residents while waiting in line for medications. Resident #2 was counseled regarding his behavior and encouraged to utilize safe boundaries with others. Resident #2 was placed on 5 minute checks on 7/20 due to intensifying psychiatric symptoms, and a team meeting was set for 7/22/15. Unfortunately, Resident #2 declined to attend and participate in the meeting. Resident #2 participated in a medication management appointment on 7/24/15 to engage in conversation regarding his use of medications and possible adjustments to his medication list; however, Resident #2's symptoms did not subside. On 7/28/15, the Director of Wellness contacted Lehigh County Crisis to assist with a 302 petition to engage Resident #2 in inpatient care through a local hospital. Resident #2 was assessed to require inpatient psychiatric care and was transported to the ER. The 302 was upheld and Resident # 2 was transferred to a local hospital to address his psychiatric needs.

Corrective Action

New Vitae Wellness and Recovery Mount Trexler Manor takes the concerns of residents very seriously. Although 1:1 staffing was provided to Resident #1, she was upset by the presentation of Resident #2. Resident # 1 was not unattended with resident #2 at any point. While staff strives to maintain a safe environment for all residents, at times residents' behavioral health symptoms can wax and wane, especially in connection to routine use of medications. Mount Trexler Manor will continue to educate all staff with a focus on Safe Crisis Management and Trauma-Informed Care in order to facilitate our environment of community living. Additionally, staff will continue to work with residents in order to determine their most effective medication regimen. Additionally, staff will continue to be available to assist with medication administration and education for symptom reduction. Finally, Mount Trexler Manor's 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.

TBS
8/26/15