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

April 1, 2025

MOUNT TREXLER MANOR CORPORATION

RE: MOUNT TREXLER MANOR
5201 ST. JOSEPH RD, PO BOX 1001
LIMEPORT, PA, 18060
LICENSE/COC#: 21663

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/13/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MOUNT TREXLER MANOR* **License #**: *21663* **License Expiration**: *07/02/2025*

Address: *5201 ST. JOSEPH RD, PO BOX 1001, LIMEPORT, PA 18060*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *MOUNT TREXLER MANOR CORPORATION*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/22/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *47* **Waking Staff**: *35*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *02/13/2025*

Inspection Dates and Department Representative

02/13/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *47*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *36* **Are 60 Years of Age or Older**: *13*

Diagnosed with Mental Illness: *47* **Diagnosed with Intellectual Disability**: *7*

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

Inspections / Reviews

02/13/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/14/2025*

03/18/2025 - POC Submission

Submitted By: **Date Submitted**: *03/30/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2025*

Inspections / Reviews *(continued)*

03/26/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/02/2025*

04/01/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2025*

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

Resident ██ was admitted to the home on ████. The Resident was placed on 15-minute checks due to being new to the home and presentation of paranoid thinking. On ████ resident could not be located by staff within the home for breakfast at 8:30am. Video Surveillance of the front door showed resident leaving the building at 5:40am. The residents 15-minute checks document ██ was seen in ██ bed until 7am. The video surveillance indicates that this was not accurate and that the checks were not being completed. The resident was located by staff about 1 mile from the home outside a hair saloon at 11:30am. The resident was unattended out of the home for approximately 6 hours before being located.

On ████ staff at the home noticed resident ██ had a bruised lower lip. Upon questioning, resident ██ admitted punching resident ██ in the face because resident ██ was invading their personal space and attempting to hug them.

Plan of Correction ***Accept (██ - 03/26/2025)***

Resident ██

The citation related to resident ██ while valid in some respects, is invalid as currently phrased. To be specific, the citation reports a violation of 55 Pa Code § 2600.42(b), which addresses both abuse and neglect. However, as currently written, the citation only refers to "abuse," which is inaccurate. The incident was not abuse and should not be characterized as such. Instead, the facts involved may support an event that fits the regulatory definition of "neglect," and the Provider does not contest this. In light of the facts and the law, the description of the incident should be changed to one of 'neglect," and all reference to "abuse" should be deleted.

The facts involved in this incident are as follows:
At approximately 8:30 a.m., staff became aware that a resident was unaccounted for and did not sign out of the facility per house rules. An immediate search of the premises and surrounding area was conducted. When the resident was not located, external authorities were notified, and additional internal resources were deployed to assist in the search. The resident was safely located near Mount Trexler by program staff a few hours later uninjured and in no apparent distress. The resident stated that ██ had not been sleeping well and wanted to go for a walk for fresh air. Immediately, the therapist and psychiatrist were notified. ██ was counseled and evaluated by a clinician from ██ outpatient program who determined ██ was not a danger to himself or others. Therapy scheduled; medication was adjusted.
To address the incident and to protect against repetition, the following corrective measures have been and others will be put in place:
-All staff received training on the importance of safety and shift change procedures, completed on 12/9/2024.
-The resident's living arrangements were adjusted to allow for closer monitoring on 11/26/2024.
-The resident was recommended to use a location monitoring device but declined.
-Leadership came in during shift transitions to ensure adherence to safety protocols starting 12/16/2024.
-Frequent safety checks remained in place.
-Additional technological supports are being explored/assessed to prevent/promote safety.
-Supervisory staff conduct periodic checks of documentation to confirm compliance.
-Leadership continues to perform unannounced check-ins during shift transitions.

42b Abuse (continued)

Documentation of safety checks are reviewed regularly, with additional spot checks as needed.
Person responsible: Administrator or designee

Completed: 12/16/2025

Resident [redacted] and Resident [redacted]
This citation is not properly cited as either "abuse" or "neglect."

Although one of the residents suffered a minor injury during this incident, the incident itself does not meet the regulatory definition of either abuse or neglect primarily because there was nothing in the background of either resident that suggested that any physical aggression was foreseeable and, therefore, preventable.
The definition section of the regulations defines "abuse" as including:
Abuse The occurrence of one or more of the following acts:
(i) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.
(ii) The willful deprivation by the personal care home or its staff persons of goods or services which are necessary to maintain physical or mental health.
(iii) Sexual harassment, rape or abuse, as defined in 23 Pa.C.S. Chapter 61 (relating to protection from abuse).
(iv) Exploitation by an act or a course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other benefit, gain or profit for the perpetrator, or monetary or personal loss to the resident.
(v) Neglect of the resident, which results in physical harm, pain or mental anguish.
(vi) Abandonment or desertion by the personal care home or its staff persons.
None of these applies here. Therefore the reference to abuse is improper.
The applicable regulations define "neglect" as including;
The failure of a personal care home or its staff persons to provide goods or services essential to avoid a clear and serious threat to the physical or mental health of a resident. The failure or omission to provide the care, supervision and services that the personal care home has voluntarily, or by contract, agreed to provide and that are necessary to maintain the resident's health, safety and well being, including personal care services, food, clothing, medicine, shelter, supervision and medical services. Neglect may be repeated conduct or a single incident.
Resident [redacted] Director of Social Services noticed a small bruise on the lower lip of Resident [redacted]. The Director of Social Services immediately investigated and found the following:
• Resident [redacted] moved toward Resident [redacted], initiating a hug.
• Resident [redacted] physically reacted, striking Resident [redacted]
• Resident [redacted] has limited expressive communication skills but acknowledged upon questioning that [redacted] struck Resident [redacted] and [redacted] was able to communicate that the actions of Resident [redacted] made [redacted] uncomfortable.
• A nurse assessed Resident [redacted] lip. [redacted] observed a small bruise and no swelling. Resident was in no distress, no mental anguish, and no pain.
Note: These two residents have known one for 14 years; there is no known history of Resident [redacted] attempting to hug or otherwise invade Resident [redacted] personal space in the past, nor are there any known previous incidents of physical aggression between them. This was an isolated incident with no antecedents (other than the attempted hug in the moment) for staff to be able to predict the incident.
To address the incident and to protect against repetition, the following corrective measures have been or will be

42b - Abuse (continued)

put in place:
• On [redacted], Resident [redacted] was educated to walk away when others are invading [redacted] space. Clinical staff have been made aware and will also review this with [redacted] during [redacted] visits.
• Staff educated to coach Resident [redacted] to walk away when others are invading [redacted] space on [redacted].
• Staff are to redirect Resident [redacted] when [redacted] approaches to hug others.
• Self-advocacy skills will be reviewed at the next Resident Council meeting on 3/25/2025
Staff training on Prevention of Abuse to be completed by March 31, 2025

Again, the facts in this case do not support a finding of neglect under this definition. Based on the long previous history of both residents, there was no clear or serious threat to either. Likewise, based on what was known about the interactions between the residents, there was no failure by the Provider to provide either services or supervision beyond what had been provided, successfully, in the past to keep both residents safe. For each resident, the Provider had agreed to provide the same level of service and supervision as it had provided in the past and, at all times previously, this level of service and supervision had been sufficient. There is nothing in the facts involved here that meets the regulatory definition of either abuse or neglect and the citation should be withdrawn; under the law, not every injury is abuse and not every injury is neglect.

Completion by: March 31, 2025

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] 04/01/2025)