pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALLEGHENY COUNTY EXECUTIVE**
LEGAL ENTITY

To operate **SHUMAN CENTER**
NAME OF FACILITY OR AGENCY

Located at **7150 HIGHLAND DRIVE, PITTSBURGH, PA 15206**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

To provide **Secure Detention**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **120**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 3800: Child Residential and Day Treatment Facilities
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 30, 2017** until **September 30, 2017**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **414313**

Robert E. Robinson
ISSUING OFFICER

Jay Bausch
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility

HS 628 – 12/14

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE JUN 0 9 2017

Mr. Richard Gordon,
Deputy Director of Operations
Allegheny County Executive
7150 Highland Drive
Pittsburgh, Pennsylvania 15206

RE: Shuman Center
License #: 414313

Dear Mr. Gordon:

As a result of the Department of Human Services' (Department) licensing inspections on October 6, 2016, October 7, 2016, October 13, 2016, November 2, 2016, January 6, 2017, January 13, 2017, January 16, 2017, February 23, 2017, March 15, 2017 and March 16, 2017 of the above facility, we found that violations specified for your previous PROVISIONAL license have not been corrected and we found new violations not found during our previous inspection.

A THIRD PROVISIONAL license is being issued based on substantial compliance with 55 Pa.Code Ch. 3800 (relating to Child Residential and Day Treatment Facilities). Your PROVISIONAL license is enclosed.

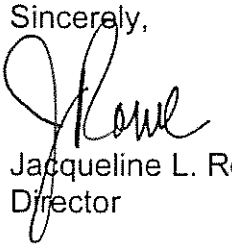
All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 3800 must be maintained.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa.Code Part II, Chs. 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Kevin Brumbach, Enforcement Manager
Bureau of Human Services Licensing
Department of Human Services
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Jacqueline L. Rowe
Director

Enclosures
License
License Inspection Summary

VIOLATION REPORT
CHILD RESIDENTIAL LICENSING - 55 Pa.Code Chapter 3800

Facility Name: SHUMAN CENTER	**License Number:** 41431
Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15206	**County:** Allegheny
Director: Earl Hill	**Region:** WEST
Legal Entity Name: ALLEGHENY COUNTY EXECUTIVE	
Legal Entity Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15206	
Certificate(s) of Occupancy	

Program Type:	**Licensed Capacity:**	**Number of Children Served:**
Secure Detention	120	49

Type of Inspection: Partial	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)
Complaint, Incident

On-Site Inspections Dates and Department Representatives On-Site
10/06/2016: Turby, Megan; Carr, David
10/07/2016: Turby, Megan; Alejandre, Carlos
10/13/2016: Turby, Megan; Lester, Marie
11/02/2016: Turby, Megan; Page, Page

Off-Site Inspection Dates and Inspectors, if Applicable
10/31/2016: Turby, Megan
11/02/2016: Turby, Megan
11/18/2016: Turby, Megan; Page, Page

Other Details

Partial or Full Triggers:	**Random Indicators:**

Child Demographic Data as of Inspection Dates

Age of Children:	Number of Children who:
0 to 5 years: 0	Are Adjudicated Delinquent: 49
6 to 13 years: 9	Are Dependent: 0
14 to 17 years: 25	Have Mental Illness: 25
18 to 21 years: 15	Have an Intellectual Disability: 0
	Have a Physical Disability: 1

Licensing Inspection Summary: 41431 - 10/06/2016 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.15(a) - The facility shall immediately report suspected abuse of a child in accordance with 23 Pa.C.S. § § 6301-6385 (relating to the Child Protective Services Law) and Chapter 3490 (relating to protective services).

2a. DESCRIPTION OF VIOLATION
On [redacted] Resident #10 attempted suicide while under the supervision of Staff Member A. Staff Member A neglected the supervision of Resident #10 from 10:28:23am to 10:58:44am, during which time Resident #10 was able to enter the unit office and attempt suicide by wrapping a cord around his/her neck. The "Supervisory Incident Summary" completed by Staff Member M asked the question "Did the incident require a ChildLine report to be completed?" which indicated "yes" but no ChildLine report was made.

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.

PLEASE SEE ATTACHED

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature] 12/14/16

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Rich Gordon - Dep. Director. Date 12/14/16

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

The above plan of correction is approved as of 1/17/17 (Date)

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

Plan of correction implementation status as of 1/17/17 (Date)

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

Licensing Inspection Summary: 41431 - 10/06/2016 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.32(b) - A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

2a. DESCRIPTION OF VIOLATION
On [redacted] Resident #6 reported that Staff Member A "bounced (his/her) head off of the floor and slammed (his/her) arm into the door in the room." Per footage obtained from the facility, at 08:36:20pm on [redacted] Staff Member A used his/her right hand to shove Resident #6's left shoulder with enough force that Resident #6 took two steps back. At 08:36:38pm Resident #6 threw a pink, plastic chair at Staff Member A which hit the floor and slid into him/her. At 08:36:42pm Staff Member A picked up the chair and charged at Resident #6 with the chair's legs pointing at Resident #6. At 08:40:15pm Resident #6 threw playing cards on Staff Member A. At 08:40:21pm Staff Member A began chasing Resident #6 into the bathroom and behind the staff office. At 08:40:24pm Staff Member A tackles Resident #6, face down, to the floor. At 08:40:34pm Staff Member A pulled Resident #6 from a face down position as Resident #6 was struggling, and began to drag Resident #6 across the floor. At 08:41:04pm Staff Member A dragged Resident #6 into the side of the large trash can against the right wall, head first, and the trash can fell over. At 08:41:09pm Staff Member A pulled on Resident #6 from inside of Resident #6's bedroom as Resident #6 laid horizontally against the outside of the door frame and pulled Resident #6 into the bedroom. At 08:41:20pm Resident #6 was outside of his/her room with his/her right hand on the outside wall, to the right of the door frame, resisting being pulled back into the bedroom by Staff Member A. At 08:41:24pm Resident #6 was pulled back into the bedroom by Staff Member A.

On [redacted] Resident #7 attacked Resident #8 at 08:00:34 am. Staff Member B stood up towards the youth at 8:00:34 am but did not attempt to pull Resident #8 off of Resident #7 until 8:00:40 am. Between 8:00:34 am and 8:00:40 am Resident #8 was able to punch Resident #7 approximately ten times. At 8:00:42 Staff Member B let go of Resident #8 and did not have hands on the youth again until 8:00:45 am when Staff Member C began assisting with separating the youth. Between 8:00:42 am and 8:00:45 am Resident #8 was able to punch Resident #7 approximately five times. As a result of the altercation, Resident #7 sustained multiple facial fractures including the right lamina papyracea and the medial wall of the right maxillary sinus nasal turbinate which required surgery to treat the injuries.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

PLEASE SEE ATTACHED

Repeat Violation: Yes	Date(s) of Previous Violation(s):	07/15/2015 et.al.	08/27/2015 et.al.	

Signature of Legal Entity Representative (Required on EVERY Page) [signature] [signature] 12/14/16

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) RichGordon - DEP.DIR.OPER. Date 12/14/16

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The above plan of correction is approved as of 1/17/17 (Date)

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

Plan of correction implementation status as of 1/17/17 (Date)

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

Licensing Inspection Summary: 41431 - 10/06/2016 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.32(k) - A child has the right to appropriate medical, behavioral health and dental treatment.

2a. DESCRIPTION OF VIOLATION
On [redacted] Resident #10 attempted suicide by wrapping a cord around his/her neck. Resident #10 was found by Staff Member A at 10:58:44 am. The facility's Injury Report dated [redacted] 11:15 am, related to Resident #10's suicide attempt indicated "Physical Examination: Resident awake, but unresponsive. Eyes rolling back into head. Slouching in chair. Unable to hold head up, and mouth and hands shaking and body rigid. Neck reddened all the way around" and "Glucose gel administered for low blood sugar." The Patient Record from the ambulance service indicated that the call for services was received at 11:16 am. 911 was not called for approximately18 minutes after finding Resident #10.

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.

PLEASE SEE ATTACHED +

The facility shall update the emergency procedures to include educating staff on the medical alert system and calling 911. 1/17/17

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature] Exec Dir 12/14/16

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) RICH GUNZON - DEP. DIR. OPER. Date 12/14/16

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Plan of correction implementation status as of 1/17/17 (Date)

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Licensing Inspection Summary: 41431 - 10/06/2016 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800

3800.141(c) - The assessment shall include the following:

(1) Medical information and health concerns such as allergies; medications; immunization history; hospitalizations; medical diagnoses; medical problems that run in the family; issues experienced by the child's mother during pregnancy; special dietary needs; illnesses; injuries; dental, mental or emotional problems; body positioning and movement stimulation for children with disabilities, if applicable; and ongoing medical care needs.

(2) Known or suspected suicide or self-injury attempts or gestures and emotional history which may indicate a predisposition for self-injury or suicide.

(3) Known incidents of aggressive or violent behavior.

(4) Substance abuse history.

(5) Sexual history or behavior patterns that may place the child or other children at a health or safety risk.

2a. DESCRIPTION OF VIOLATION

On [redacted] at 8:30pm Resident #'s 2, 3, and 4 attacked Resident #1 while he/she was sitting on two chairs. On Resident #2's health and safety assessment dated [redacted] the question "Have you been in a recent fight/acted out violently/any history of violence-describe?" was left blank and was not updated to include "known incidents of aggression or violent behavior." On Resident #3's most recent health and safety assessment dated [redacted] the question "Have you been in a recent fight/acted out violently/any history of violence-describe?" was checked "No" and therefore did not include "known incidents of aggression or violent behavior." On Resident #4's health and safety assessment dated [redacted] the question "Have you been in a recent fight/acted out violently/any history of violence-describe?" was checked "No" and was not updated to include "known incidents of aggression or violent behavior."

Resident #5's recent physical exam's dated [redacted] and [redacted] as well as recent health and safety assessments dated [redacted] and [redacted] an allergy to zucchini was indicated which was not reflected on Resident #5's most recent health and safety assessment dated [redacted].

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.

PLEASE SEE ATTACHED +

The facility will re-instruct staff on adding relevant, new occurrences of behaviors by next business day from the date of incident.

1/17/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	08/05/2015 et. al.		
Signature of Legal Entity Representative (Required on EVERY Page)				
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Rich Gordon - Dep. Director		Date 12/14/16	

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The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 1/17/17 (Date)

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

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DEC 14 2016
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Human Services Licensing

Licensing Inspection Summary: 41431 - 10/06/2016 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.142 - If the health and safety assessment in § 3800.141 (relating to health and safety assessment) identifies a health or safety risk, a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed.

2a. DESCRIPTION OF VIOLATION
Resident #10, DOA: [redacted], had a safety plan dated [redacted] that indicated safety instructions to "watch closely due to aggressive past behavior and history of depression and anxiety." Per footage obtained from the facility, on [redacted] Resident #10 was able to enter the unit office at 10:20:23 am and attempt suicide by wrapping a cord around his/her neck while under the supervision of Staff Member A. Staff Member A does not enter the office and find the resident until 10:58:44 am.

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.

PLEASE SEE ATTACHED +

The facility shall develop a monitoring system to ensure safety plans are implemented, including regular reviews of footage. Documentation of video review shall be kept and made available to the Department for review.

1/17/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	08/27/2015 et. al.		
Signature of Legal Entity Representative (Required on EVERY Page)		Exec. Dir.	12/14/16	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Regional Dep. Dir. Oper.		Date 12/14/16	

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Plan of correction implementation status as of 1/17/17 (Date)

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

Licensing Inspection Summary: 41431 - 10/06/2016 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.202(a) - A restrictive procedure may not be used in a punitive manner, for the convenience of staff persons or as a program substitution.

2a. DESCRIPTION OF VIOLATION
Per staff interviews, on [redacted] Resident #9 was put in a prone restraint by Staff Members D, E, B ,G, H, I, J, and K for refusing to go to his/her bedroom, being non-compliant, and verbally threatening staff while sitting in a chair to the left of the staff office.

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.

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

Signature of Legal Entity Representative (Required on EVERY Page) Exec Dir 12/14/16

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Rich Gordon - Dep. Dir. Oper. Date 12/14/16

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Plan of correction implementation status as of 1/17/17 (Date)

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Licensing Inspection Summary: 41431 - 10/06/2016 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.211(b) - Manual restraints that apply pressure or weight on the child's respiratory system are prohibited.

2a. DESCRIPTION OF VIOLATION
On [redacted] at 8:38:48 pm Staff Member I, D, B, H, and K began the hands-on restraint on Resident #9 while he/she was seated in a chair to the left of the staff office. At 8:38:54 Staff Members E and J also went hands-on with Resident #9. At 8:39:59 pm Staff Member J let go of Resident #9 and stepped away. At 8:39:04 pm Staff Member G began assisting the other six staff with the hands-on restraint. At approximately 8:39:22 pm Staff Member K let go of Resident #9 while the other five staff struggled with Resident #9, pulling his/her limbs in different directions. At 8:39:31 pm Staff Member E, G, I, B and D lifted Resident #9 up from the chair and on to the ground into a face down, prone position. At this time Staff Member E, G, I and D were on Resident #9's body while Staff Member B was lying on Resident #9's legs. At 8:39:38 pm Staff Member H had hands-on Resident #9 again, assisting the other 5 staff with pulling Resident #9's arms behind his/her back while in the prone position. At 8:39:38 pm Staff Member H let go of Resident #9 while the other five staff positioned themselves and continued to hold Resident #9's arms behind his/her back. Resident #9 was lying still at this time. At 8:39:49 pm Staff Member H approached Resident #9's feet and had hands-on Resident #9 again as Staff Member E was standing over Resident #9's head assisting in holding Resident #9's hands behind his/her back. At 8:39:57 Staff Member E let go and moved to the left side of Resident #9 between Staff Members D and I. At 8:40:06 pm Staff Member E put hands on Resident #9 again. All 7 staff was struggling with Resident #9 in the face down, prone position. At 8:40:13 pm the staff were still struggling with Resident #9 in the prone position as they began to lift him/her into the air with Resident #9 remaining in the prone position. At 8:40:22 pm all 7 staff were standing and Staff Member H let go as the other 6 staff began walking with Resident #9 in the air, in the prone position. 8:40:41pm all 6 staff carried Resident #9 into his/her bedroom in the prone position.

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.

PLEASE SEE ATTACHED

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature] Email Ltr 12/14/16

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Rich Gordon - Dep. Dir. Oper. Date 12/14/16

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

Plan of correction implementation status as of 1/17/17 (Date)

- ☐ Fully Implemented
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- ☒ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

rg 12/14/16
D.P.O.
pg 1

Page 2 of 9

Regulation – 3800.15(a) – The facility shall immediately report suspected abuse of a child in accordance with 23 PA CS 6301-6385 (relating to the Child Protective Services Law) and Chapter 3490

Plan of Correction:

Shuman Center agrees that it is important for the State to be notified of any and all suspected child abuse situations in accordance with Child Protective Service Law. On the day of [redacted] a resident attempted suicide while under the direct supervision of a Staff Member A. The Chief Supervisor on the shift completed all steps of the Shuman Suicide Policy with the exception of filing a ChildLine (online or by telephone). Chief Supervisor stated that [redacted] did not know [redacted] needed to ChildLine the situation because it was a mental health self-abusive incident. Chief Supervisor received a call from a female OCYF representative at an unknown time on [redacted] and instructed them to fax documentation to their office, which was done at [redacted] @ 6:12pm. The incident was ChildLined by an outside agency on Monday [redacted] at approximately 8:30am. A documented call to ChildLine from Chief Supervisor on [redacted] at approximately 9:15am was made, however Chief Supervisor denies that they made that call. Shuman Supervisors have a tendency to over report to error on the side of caution and we feel this was an anomaly of our process. Suicide Protocols and Procedures will be reviewed with all staff and supervisors immediately via email and during the January 2017 monthly conferences and weekly training. This Chief Supervisor and Staff Member A are no longer employed by Allegheny County Shuman Center. Shuman Center will continue to follow the extensive directed plans of correction that were previously accepted by the state on 9/30/16 relating to our provisional license.

Page 3 of 9

Regulation – 3800.32(b) – A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment

Plan of Correction:

Allegheny County and Facility Administration are committed to correcting and rectifying inappropriate mistreatment of youth in our care. On [redacted] Staff Member A fell victim to a classic power struggle and threatening behavior of the resident. This resulted in Staff Member A allowing [redacted] emotions to flood and fail to follow basic crisis intervention protocols. Staff Member A was re-trained and addressed through meetings and fact finding with Training Manager and Chief Supervisor regarding this incident. Staff Member A is no longer employed by Allegheny County Shuman Center. On [redacted] resident #7 attacked resident #8. Resident #8 then became the aggressor for six seconds before Staff Member B was able to attempt an intervention. Due to Resident #8 having approximately double the size of Staff Member B the intervention failed. At this time Staff Member C is calling for all available staff prior to also attempting to intervene. These are basic intervention protocols that were followed in six seconds. Licensing Regulatory Technicians feel that staff should have intervened faster than six seconds and not follow crisis intervention protocols in order to better protect resident #7 in response to the injuries he received. Shuman Center will continue to follow the extensive directed plans of correction that were previously accepted by the state on 9/30/16 relating to this regulation and our provisional license.

Page 4 of 9

Regulation - 3800.32(k) – A child has the right to appropriate medical, behavioral health, and dental treatment

Plan of Correction:

On [redacted] Resident #10 was given appropriate medical care from the time the first nurse responded to the unit until [redacted] left the building. Resident #10 was brought down to medical 10-15 minutes after the initial call for the nurse to

rg 12/14/16
DDO
pg2

come to the unit. When the resident arrived in medical from the unit, Dr. [redacted] along with two Medical Residents were still here in the building and examined Resident #10. Dr [redacted] assessed the resident and blood pressure respirations and pulse were within normal limits. No respiratory distress was noted. Residents #10's oxygen level was 98% on room air and blood sugar was a 76, also within normal limits. Dr. [redacted] then ordered Resident #10 to have the glucose any way. After Dr. [redacted] assessed the resident#10 and nothing significant was found wrong with [redacted]. Resident #10 was still not responding appropriately so a joint medical decision was made to send the resident to Children's Hospital for further evaluation and closer observation. 911 was called by the nurse to transport the resident to the ER.

All staff will be instructed in proper procedures is calling for emergency assistance with in the building and documentation of emergency incident more thoroughly with appropriate time frames included. Emergency procedures will be reviewed with all nurses and agency nurses working with Shuman Center. Discussion and review of incident will be held with supporting MD's from Children's hospital on how we respond to emergency's when a Doctor is present in the building. Shuman Center will continue to follow the extensive directed plans of correction that were previously accepted by the state on 9/30/16 relating to this regulation and our provisional license.

[redacted]

Regulation – 3800.141(c) – The assessment shall include the following etc...

Plan of Correction:

Shuman Center has continued to document and note assessment responses for each resident to ensure that all people within the facility are safe and secure. Much of the information provided to the staff to complete the assessment documentation is resident self-reported as accurately as possible. Staff is trained not to change resident responses and not all staff know every past detail of each resident. Thus, Shuman Center also created a Red Card system to denote violent/aggressive residents in our computer system and on our housing report sheets. Staff also denotes these residents by utilizing a "red card" on the unit to identify all Red Card residents. Staff is well aware that approximately 90+% of Shuman residents has a violent/aggressive background. Shuman Center will continue to be as accurate as possible when completing the self-reported assessment with Chief/Wing Supervisors and Residential Services Staff reviewing these for accuracy. As for the zucchini allergy being missed on a recent assessment, it was documented in the file on all previous exams and this failure to match is an error. Medical Manager and Shuman medical staff are aware that accuracy of these documents are vital for resident safety. These exams will be cross referenced by all medical staff

rg 12/14/16
D.D.O.
pg 3

at the time of admission. Shuman Center will continue to follow the extensive directed plans of correction that were previously accepted by the state on 9/30/16 relating to this regulation and our provisional license.

DEC 14 2016

WEST REGION FIELD OFFICE
Human Services Licensing

Page 7 of 9

Regulation – 3800.142 – If the health and safety assessment in 3800.141 identifies a health or safety risk a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed

Plan of Correction:

Shuman Center has made many efforts to improve its protocols and procedures to improve building wide safety and security. On [redacted] Staff Member A failed to provide basic unit management and appropriate supervision of a resident in their care which resulted in serious threat to resident security, health, and safety. Staff have been addressed to continue to enforce the yellow line rule, keep residents out of the staff office, maintain supervision of residents at all times, and to follow all emergency medical procedures during the November and December 2016 staff monthly conferences and weekly trainings conducted by Director, Deputy Director of Operations, Training Manager, and Chief/Wing Supervisors. Staff Member A is no longer employed by Allegheny County Shuman Center. Shuman Center will continue to follow the extensive directed plans of correction that were previously accepted by the state on 9/30/16 relating to our provisional license.

Page 8 of 9

Regulation 3800.202 (a) – A restrictive procedure may not be used in a punitive manner for the convenience of staff persons or as a program substitution

Plan of Correction:

This incident took place 8 months ago on [redacted] Shuman Center has been heavily scrutinized prior to for several months after this incident. It is safe to say that Shuman Center has dramatically improved its training curriculum and de-escalation techniques since this time. While we still have steps to take in order to improve our care and treatment of youth, utilizing restrictive procedure in this manner is no longer a concern. Due to this investigation, the November and December 2016 staff monthly conferences and weekly trainings conducted by Director, Deputy Director of Operations, Training Manager, and Chief/Wing Supervisors addressed this incident and that face down/prone physical interventions are strictly prohibited. During our Safe Crisis Management refresher trainings, supervisors and trainers described and trained the appropriate use of physical intervention and when to implement them. Shuman Center will continue to follow the extensive directed plans of correction that were previously accepted by the state on 9/30/16 relating to our provisional license.

Page 9 of 9

Regulation 3800.211(b) – Manual restraints that apply pressure or weight on the child's respiratory system are prohibited

Plan of Correction:

This incident took place 8 months ago on [redacted] Shuman Center has been heavily scrutinized prior to for several months after this incident. It is safe to say that Shuman Center has dramatically improved its training curriculum and de-escalation techniques since this time. While we still have steps to take in order to improve our care and treatment of youth, utilizing restrictive procedure in this manner is no longer a concern. Due to this investigation, the November and December 2016 staff monthly conferences and weekly trainings conducted by Director, Deputy Director of Operations,

12/14/16
DDO
PJ

Training Manager, and Chief/Wing Supervisors addressed this incident and that face down/prone physical interventions are strictly prohibited. During our Safe Crisis Management refresher trainings, supervisors and trainers described and trained the appropriate use of physical intervention and when to implement them. Shuman Center will continue to follow the extensive directed plans of correction that were previously accepted by the state on 9/30/16 relating to our provisional license.

Rich Gordon

Deputy Director of Operations

12/14/16

VIOLATION REPORT
CHILD RESIDENTIAL LICENSING - 55 Pa.Code Chapter 3800

Facility Name: SHUMAN CENTER	License Number: 41431
Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15208	County: Allegheny
Director: Earl Hill	Region: WEST
Legal Entity Name: ALLEGHENY COUNTY EXECUTIVE	
Legal Entity Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15208	
Certificate(s) of Occupancy	

Program Type:	Licensed Capacity:	Number of Children Served:
Secure Detention	120	49

Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)
Complaint, Incident

On-Site Inspections Dates and Department Representatives On-Site
01/06/2017: Turby, Megan; Alejandro, Carlos
01/13/2017: Turby, Megan
01/16/2017: Turby, Megan; Lester, Marie

Off-Site Inspection Dates and Inspectors, If Applicable
01/09/2017: Turby, Megan
01/12/2017: Turby, Megan

Other Details

Partial or Full Triggers:	Random Indicators:

Child Demographic Data as of Inspection Dates

Age of Children:	Number of Children who:
0 to 5 years: 0	Are Adjudicated Delinquent: 49
6 to 13 years: 0	Are Dependent: 0
14 to 17 years: 36	Have Mental Illness: 0
18 to 21 years: 13	Have an Intellectual Disability: 0
	Have a Physical Disability: 0

Licensing Inspection Summary: 41431 - 01/06/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.16(c) - The facility shall complete a written reportable incident report, on a form prescribed by the Department, and send it to the appropriate Departmental regional office and the contracting agency, within 24 hours.

2a. DESCRIPTION OF VIOLATION
Footage obtained from the facility showed that on [redacted] at approximately 7:07am, Resident #1 came out of his/her bedroom holding their bedding and belongings. Resident #1 set it on the ground then leaned against the right wall of the room with his/her hands at their sides. At approximately 7:08 am Resident #1 then took a few steps away from the wall, leaned down towards the ground, with their back facing Staff Member A when Staff Member A bear-hugged Resident #1 and pushed the child back approximately 4 steps. At 7:08:33 am Staff Member A grabbed Resident #1's hair and pulled the child down toward the blue chairs in the middle of the room. At 7:08:35 am Staff Member A was still pulling Resident #1's hair as the child was attempting to push Staff Member A off of him/herself. Staff Person D had their right hand on Staff Member A's back and their left hand on Resident #1's back. Staff Member E reached in towards the child. None of the staff members attempted to remove Staff Member A's grip on Resident #1's hair. At 7:08:37 am Resident #1 escaped Staff Member A's grip on his/her hair. From 7:08:39 am to 7:08:40 am Resident #1 was being pushed backwards towards the right side of the room by Staff Member's C and F while Staff Member D pulled Resident #1 back by gripping his/her sweatshirt to the left of Resident #1's neck. Staff Member A had a grip on Resident #1's head with their index and middle finger's near the child's ear and their thumb on the child's face. At 7:08:43 am Staff Member A grabbed Resident #1's hair again while Staff Members C and F pulled and pushed Resident #1 towards the right wall of the room. Resident #1 attempted to push Staff Member A away again. Staff Member's B, D, E and F did not attempt to remove Staff Member A's grip on Resident #1's hair. At 7:08:47 am Staff Member B placed his/her right arm under Resident #1's right armpit with their right hand under the child's chin against the child's neck, and his/her left arm under Resident #1's left arm pit with their left hand on the left side of the child's neck. Staff Member D was behind Resident #1 with both hands on the child's shoulders near the child's neck. Staff Member C also had hands on the child at that time. At 7:08:49 am Staff Members A, B, D and F had hands on Resident #1 from the waist area up while Staff Member E had their right hand on the child's leg and the child's foot was up in the air near Staff Member E's waist. At 7:08:52 am Resident #1's legs were in Staff Member E's hands, toes facing the floor as Staff Members A, B, and F put Resident #1 in a prone position on the floor. At 7:08:54 am Staff Member E let go of Resident #1's legs and Staff Member A and F were on top of the child. From 7:09:00 am to 7:09:20 am staff Members A, C, D, E, and F had hands on Resident #1 and were struggling with the child while holding him/her down in a prone position. At 7:09:20 am Staff Member D let go of the child and Staff Member A was over the child while the remaining staff continued to struggle. At 7:09:32 am Staff Member A stood up. At 7:09:39 am Staff Members A, E and F picked Resident #1 up from the floor by the back of the child's sweatshirt and his/her arms then Staff Member's A and F forcibly transported the child towards the unit door. At 7:09:49 am Staff Member A pushed Resident #1 face-first into a dark, closed door on the right side of the room. At 7:10:04 am Resident #1 was transported out of the unit. On [redacted] during an interview, Resident #1 stated that his/her neck hurt after the incident and was still hurting at the time of the interview, two days later. Resident #1 also stated that he/she could not breathe when the staff had him/her in the prone position and that he/she could not get a breath to tell the staff that he/she could not breathe. Resident #1 stated that Staff Member G, Deputy Director of Operations, interviewed him/her the day of the incident and that he/she disclosed what happened and that he/she could not breathe during the incident. On [redacted] Staff Member A was "suspended without pay until further notice" due to this incident. On [redacted] Staff Member G stated that he/she interviewed Resident #1 on [redacted] about the incident. Staff Member G was aware of this incident on [redacted] Staff Member G or the facility did not complete a written reportable incident report on a form prescribed by the Department.

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.

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature] Earl Hill

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Earl Hill, Director
Rich Gordon - Dep. Dir. Oper.

Date 2/24/17

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

The above plan of correction is approved as of 4/19/17 (Date)

Plan of correction implementation status as of 4/19/17 (Date)

Licensing Inspection Summary: 41431 - 01/06/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800

3800.16(c) - The facility shall complete a written reportable incident report, on a form prescribed by the Department, and send it to the appropriate Departmental regional office and the contracting agency, within 24 hours.

The above plan of correction was approved by (Initials)

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

Violation 3800.16(c) – The facility shall complete written reportable incident report, on a form prescribed by the Department, and send it to the appropriate Departmental regional office and the contracting agency, within 24 hours.

Plan of Correction:

Allegheny County Shuman Center recognizes that the prompt reporting of certain incidents is important for safety and security. This process allows for the facility and the State to manage, track, and hopefully prevent future reportable incidents. Furthermore, following all the prescribed timeframes for reportable incidents allows the State, the Department, and the facility to ensure that prompt attention to investigations, safety plans, and correctives actions are in place. On [redacted], an incident occurred in which a resident's rights were violated. All safety precautions, corrective action plans, and investigative process and notifications were followed to ensure resident safety. However, a state reportable incident was not completed. Shuman Center Training Manager will cover the 3800 resident rights and the reportable incident regulations, protocols, and procedures, that ensure compliance during the next training sessions with all staff. These will take place on March 2, 9, 16, and 23. The Deputy Director of Operations will also issue a memo by March 17, 2017, to all supervisors to sign off on, acknowledging that they have been given the child's rights and the reportable incident protocols. The Supervisors will also review and train all youth care workers of the resident rights during the February/March Mandated Monthly Conferences.

2/24/17

Rich Gordon – Deputy Director of Operations

Licensing Inspection Summary: 41431 - 01/06/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.32(b) - A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

2a. DESCRIPTION OF VIOLATION
Foolage obtained from the facility showed that on [redacted] at approximately 7:07am, Resident #1 came out of his/her bedroom holding their bedding and belongings. Resident #1 set it on the ground then leaned against the right wall of the room with his/her hands at their sides. At approximately 7:08 am Resident #1 then took a few steps away from the wall, leaned down towards the ground, with their back facing Staff Member A when Staff Member A bear-hugged Resident #1 and pushed the child back approximately 4 steps. At 7:08:33 am Staff Member A grabbed Resident #1's hair and pulled the child down toward the blue chairs in the middle of the room. At 7:08:35 am Staff Member A was still pulling Resident #1's hair as the child was attempting to push Staff Member A off of him/herself. Staff Person D had their right hand on Staff Member A's back and their left hand on Resident #1's back. Staff Member E reached in towards the child. None of the staff members attempted to remove Staff Member A's grip on Resident #1's hair. At 7:08:37 am Resident #1 escaped Staff Member A's grip on his/her hair. From 7:08:39 am to 7:08:40 am Resident #1 was being pushed backwards towards the right side of the room by Staff Member's C and F while Staff Member D pulled Resident #1 back by gripping his/her sweatshirt to the left of Resident #1's neck. Staff Member A had a grip on Resident #1's head with their index and middle finger's near the child's ear and their thumb on the child's face. At 7:08:43 am Staff Member A grabbed Resident #1's hair again while Staff Members C and F pulled and pushed Resident #1 towards the right wall of the room. Resident #1 attempted to push Staff Member A away again. Staff Member's B, D, E and F did not attempt to remove Staff Member A's grip on Resident #1's hair. At 7:08:47 am Staff Member B placed his/her right arm under Resident #1's right armpit with their right hand under the child's chin against the child's neck, and his/her left arm under Resident #1's left arm pit with their left hand on the left side of the child's neck. Staff Member D was behind Resident #1 with both hands on the child's shoulders near the child's neck. Staff Member C also had hands on the child at that time. At 7:08:49 am Staff Members A, B, D and F had hands on Resident #1 from the waist area up while Staff Member E had their right hand on the child's leg and the child's foot was up in the air near Staff Member E's waist. At 7:08:52 am Resident #1's legs were in Staff Member E's hands, toes facing the floor as Staff Members A, B, and F put Resident #1 in a prone position on the floor. At 7:08:54 am Staff Member E let go of Resident #1's legs and Staff Member A and F were on top of the child. From 7:09:00 am to 7:09:20 am staff Members A, C, D, E, and F had hands on Resident #1 and were struggling with the child while holding him/her down in a prone position. At 7:09:20 am Staff Member D let go of the child and Staff Member A was over the child while the remaining staff continued to struggle. At 7:09:32 am Staff Member A stood up. At 7:09:39 am Staff Members A, E and F picked Resident #1 up from the floor by the back of the child's sweatshirt and his/her arms then Staff Member's A and F forcibly transported the child towards the unit door. At 7:09:49 am Staff Member A pushed Resident #1 face-first into a dark, closed door on the right side of the room. At 7:10:04 am Resident #1 was transported out of the unit. On [redacted] during an interview, Resident #1 stated that his/her neck hurt after the incident and was still hurting at the time of the interview, two days later. Resident #1 also stated that he/she could not breathe when the staff had him/her in the prone position and that he/she could not get a breath to tell the staff that he/she could not breathe.

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.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/06/2016 et. al.		

Signature of Legal Entity Representative (Required on EVERY Page) [signature] 1/27/17

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Rich Gordon - Dep. Dir. Oper. / EARL HILL - Director

Date 1/27/17

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

The above plan of correction is approved as of 4/19/17 (Date)

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

Plan of correction implementation status as of 4/19/17 (Date)

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

Licensing Inspection Summary: 41431 - 01/06/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.32(b) - A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

Pg 3 of 8

Violation 3800.32(b) – A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

Plan of Correction:

It is important to all stakeholders that residents in residential care are appropriately cared for especially during times of crisis. Allegheny County Shuman Center is committed improving and developing consistent and competent staff that can demonstrate care for residents during a resident's time of crisis. Due to the incident review process for a previously implemented plan of correction, administrative staff was able to identify and take immediate corrective and safety actions with this situation. This regulation was violated by Shuman Staff who not only failed to follow crisis intervention curriculum and de-escalation graduated responses, but also failed to compose themselves and professionally intervene according to training, protocols, and procedures. According to the video staff member A appears to bear hug, push, and pull the hair of a resident without resident provocation creating a crisis situation. During this crisis situation, staff members involved attempted to gain physical containment or the resident, but did not attempt to separate staff member A and the resident for everyone's protection. As a result of this situation, staff member A has been indefinitely suspended and termination is pending, per the Allegheny County Shuman Center disciplinary process. In an attempt to correct and prevent future occurrences, on January 5, 12, 19, and 26, 2017, Deputy Director Gordon conducted Therapeutic Crisis Intervention (TCI) with all staff. Safe Crisis Management (SCM) will be refreshed and reviewed with all staff by our certified trainers on February 2, 9, 16, and 23, 2017. During both of these trainings discussion revolving around asphyxia and prone physical interventions was/will be discussed. All staff involved in this situation will be in attendance for both trainings. January mandated monthly conferences will include a review of appropriate use of physical intervention and "Professional Courage" discussion which includes "doing what is right, even when it is difficult." The de-escalation curriculum, crisis cycle, stress model of crisis, and self-awareness during a crisis was trained to all staff during the January TCI course. Allegheny County Shuman Center along with the County Managers Office continue to research an appropriate trauma informed care program, such as Sanctuary Model, to implement on site. Preliminary conversations are taking place with cultural change consultants RDP and possibly a request for proposal for others to assist Allegheny County Shuman Center with a six-month professional development evidence based leadership system for all staff.

1/27/17

Rich Gordon - Deputy Director of Operations - 1/27/17

IAP 10/4/16

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JAN 27 2017

Licensing Inspection Summary: 41431 - 01/06/2017 - Tuby, Megan

WEST REGION FIELD OFFICE
Human Services Licensing

Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800

3800.202(a) - A restrictive procedure may not be used in a punitive manner, for the convenience of staff persons or as a program substitution.

2a. DESCRIPTION OF VIOLATION

Footage obtained from the facility showed that on [redacted] at approximately 7:07am, Resident #1 came out of his/her bedroom holding their bedding and belongings. Resident #1 set it on the ground then leaned against the right wall of the room with his/her hands at their sides. At approximately 7:08 am Resident #1 then took a few steps away from the wall, leaned down towards the ground, with their back facing Staff Member A when Staff Member A bear-hugged Resident #1 and pushed the child back approximately 4 steps. At 7:08:33 am Staff Member A grabbed Resident #1's hair and pulled the child down toward the blue chairs in the middle of the room. At 7:08:35 am Staff Member A was still pulling Resident #1's hair as the child was attempting to push Staff Member A off of him/herself. Staff Person D had their right hand on Staff Member A's back and their left hand on Resident #1's back. Staff Member E reached in towards the child. None of the staff members attempted to remove Staff Member A's grip on Resident #1's hair. At 7:08:37 am Resident #1 escaped Staff Member A's grip on his/her hair. From 7:08:39 am to 7:08:40 am Resident #1 was being pushed backwards towards the right side of the room by Staff Member's C and F while Staff Member D pulled Resident #1 back by gripping his/her sweatshirt to the left of Resident #1's neck. Staff Member A had a grip on Resident #1's head with their index and middle finger's near the child's ear and their thumb on the child's face. At 7:08:43 am Staff Member A grabbed Resident #1's hair again while Staff Members C and F pulled and pushed Resident #1 towards the right wall of the room. Resident #1 attempted to push Staff Member A away again. Staff Member's B, D, E and F did not attempt to remove Staff Member A's grip on Resident #1's hair. At 7:08:47 am Staff Member B placed his/her right arm under Resident #1's right armpit with their right hand under the child's chin against the child's neck, and his/her left arm under Resident #1's left arm pit with their left hand on the left side of the child's neck. Staff Member D was behind Resident #1 with both hands on the child's shoulders near the child's neck. Staff Member C also had hands on the child at that time. At 7:08:49 am Staff Members A, B, D and F had hands on Resident #1 from the waist area up while Staff Member E had their right hand on the child's leg and the child's foot was up in the air near Staff Member E's waist. At 7:08:52 am Resident #1's legs were in Staff Member E's hands, toes facing the floor as Staff Members A, B, and F put Resident #1 in a prone position on the floor. At 7:08:54 am Staff Member E let go of Resident #1's legs and Staff Member A and F were on top of the child. From 7:09:00 am to 7:09:20 am staff Members A, C, D, E, and F had hands on Resident #1 and were struggling with the child while holding him/her down in a prone position. At 7:09:20 am Staff Member D let go of the child and Staff Member A was over the child while the remaining staff continued to struggle. At 7:09:32 am Staff Member A stood up. At 7:09:39 am Staff Members A, E and F picked Resident #1 up from the floor by the back of the child's sweatshirt and his/her arms then Staff Member's A and F forcibly transported the child towards the unit door. At 7:09:49 am Staff Member A pushed Resident #1 face-first into a dark, closed door on the right side of the room. At 7:10:04 am Resident #1 was transported out of the unit. On [redacted] during an interview, Resident #1 stated that his/her neck hurt after the incident and was still hurting at the time of the interview, two days later. Resident #1 also stated that he/she could not breathe when the staff had him/her in the prone position and that he/she could not get a breath to tell the staff that he/she could not breathe.

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.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/06/2016		
Signature of Legal Entity Representative (Required on EVERY Page)	[signature]	Earl Hill - Director		1/27/17
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Rick Gorecki - Dep Dep Oper.		Date	1/27/17

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

The above plan of correction is approved as of 4/14/17 (Date)

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

Plan of correction implementation status as of 4/19/17 (Date)

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

Licensing Inspection Summary: 41431 - 01/06/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.202(a) - A restrictive procedure may not be used in a punitive manner, for the convenience of staff persons or as a program substitution.

Violation 3800.202(a) – A restrictive procedure may not be used in a punitive manner, for the convenience of staff persons or as a program substitution.

Plan of Correction:

It is important to all stakeholders that residents in residential care are appropriately cared for especially during times of crisis. Allegheny County Shuman Center is committed improving and developing consistent and competent staff that can demonstrate care for residents during a resident's time of crisis. Due to the incident review process for a previously implemented plan of correction, administrative staff was able to identify and take immediate corrective and safety actions with this situation. This regulation was violated by Shuman Staff who not only failed to follow crisis intervention curriculum and de-escalation graduated responses, but also failed to compose themselves and professionally intervene according to training, protocols, and procedures. According to the video staff member A appears to bear hug, push, and pull the hair of a resident without resident provocation creating a crisis situation. During this crisis situation, staff members involved attempted to gain physical containment or the resident, but did not attempt to separate staff member A and the resident for everyone's protection. As a result of this situation, staff member A has been indefinitely suspended and termination is pending, per the Allegheny County Shuman Center disciplinary process. In an attempt to correct and prevent future occurrences, on January 5, 12, 19, and 26, 2017, Deputy Director Gordon conducted Therapeutic Crisis Intervention (TCI) with all staff. Safe Crisis Management (SCM) will be refreshed and reviewed with all staff by our certified trainers on February 2, 9, 16, and 23, 2017. During both of these trainings discussion revolving around asphyxia and prone physical interventions was/will be discussed. All staff involved in this situation will be in attendance for both trainings. January mandated monthly conferences will include a review of appropriate use of physical intervention and "Professional Courage" discussion which includes "doing what is right, even when it is difficult." The de-escalation curriculum, crisis cycle, stress model of crisis, and self-awareness during a crisis was trained to all staff during the January TCI course. Allegheny County Shuman Center along with the County Managers Office continue to research an appropriate trauma informed care program, such as Sanctuary Model, to implement on site. Preliminary conversations are taking place with cultural change consultants RDP and possibly a request for proposal for others to assist Allegheny County Shuman Center with a six-month professional development evidence based leadership system for all staff.

1/27/17

Rich Gordon – Deputy Director of Operations – 1/27/17

1AP 10/6/16 VR

RECEIVED

JAN 27 2017

Licensing Inspection Summary: 41431 - 01/06/2017 - Toby, Megan
Facility Name: SHUMAN CENTER

WESTERN REGION FIELD OFFICE
Human Services Department

1. REGULATION 55 Pa.Code §3800
3800.211(b) - Manual restraints that apply pressure or weight on the child's respiratory system are prohibited.

2a. DESCRIPTION OF VIOLATION
Footage obtained from the facility showed that on [redacted] at approximately 7:07am, Resident #1 came out of his/her bedroom holding their bedding and belongings. Resident #1 set it on the ground then leaned against the right wall of the room with his/her hands at their sides. At approximately 7:08 am Resident #1 then took a few steps away from the wall, leaned down towards the ground, with their back facing Staff Member A when Staff Member A bear-hugged Resident #1 and pushed the child back approximately 4 steps. At 7:08:33 am Staff Member A grabbed Resident #1's hair and pulled the child down toward the blue chairs in the middle of the room. At 7:08:36 am Staff Member A was still pulling Resident #1's hair as the child was attempting to push Staff Member A off of him/herself. Staff Person D had their right hand on Staff Member A's back and their left hand on Resident #1's back. Staff Member E reached in towards the child. None of the staff members attempted to remove Staff Member A's grip on Resident #1's hair. At 7:08:37 am Resident #1 escaped Staff Member A's grip on his/her hair. From 7:08:39 am to 7:08:40 am Resident #1 was being pushed backwards towards the right side of the room by Staff Member's C and F while Staff Member D pulled Resident #1 back by gripping his/her sweatshirt to the left of Resident #1's neck. Staff Member A had a grip on Resident #1's head with their index and middle finger's near the child's ear and their thumb on the child's face. At 7:08:43 am Staff Member A grabbed Resident #1's hair again while Staff Members C and F pulled and pushed Resident #1 towards the right wall of the room. Resident #1 attempted to push Staff Member A away again. Staff Member's B, D, E and F did not attempt to remove Staff Member A's grip on Resident #1's hair. At 7:08:47 am Staff Member B placed his/her right arm under Resident #1's right armpit with their right hand under the child's chin against the child's neck, and his/her left arm under Resident #1's left arm pit with their left hand on the left side of the child's neck. Staff Member D was behind Resident #1 with both hands on the child's shoulders near the child's neck. Staff Member C also had hands on the child at that time. At 7:08:49 am Staff Members A, B, D and F had hands on Resident #1 from the waist area up while Staff Member E had their right hand on the child's leg and the child's foot was up in the air near Staff Member E's waist. At 7:08:52 am Resident #1's legs were in Staff Member E's hands, toes facing the floor as Staff Members A, B, and F put Resident #1 in a prone position on the floor. At 7:08:54 am Staff Member E let go of Resident #1's legs and Staff Member A and F were on top of the child. From 7:09:00 am to 7:09:20 am staff Members A, C, D, E, and F had hands on Resident #1 and were struggling with the child while holding him/her down in a prone position. At 7:09:20 am Staff Member D let go of the child and Staff Member A was over the child while the remaining staff continued to struggle. At 7:09:32 am Staff Member A stood up. At 7:09:39 am Staff Members A, E and F picked Resident #1 up from the floor by the back of the child's sweatshirt and his/her arms then Staff Member's A and F forcibly transported the child towards the unit door. At 7:09:49 am Staff Member A pushed Resident #1 face-first into a dark, closed door on the right side of the room. At 7:10:04 am Resident #1 was transported out of the unit. On [redacted] during an interview, Resident #1 stated that his/her neck hurt after the incident and was still hurting at the time of the interview, two days later. Resident #1 also stated that he/she could not breathe when the staff had him/her in the prone position and that he/she could not get a breath to tell the staff that he/she could not breathe.

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.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/06/2016		

Signature of Legal Entity Representative (Required on EVERY Page) — Emil Hill - Director — 1/27/17

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) — Rich Gordon - Dep Dir. Oper. — Date 1/27/17

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

The above plan of correction is approved as of 4/19/17 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/19/17 (Date)

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

Licensing Inspection Summary: 41431 - 01/06/2017 - Tuby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.211(b) - Manual restraints that apply pressure or weight on the child's respiratory system are prohibited.

Pg 7 of 8

Violation 3800.211(b) – Manual restraints that apply pressure or weight on the child's respiratory system are prohibited.

Plan of Correction:

It is important to all stakeholders that residents in residential care are appropriately cared for especially during times of crisis. Allegheny County Shuman Center is committed improving and developing consistent and competent staff that can demonstrate care for residents during a resident's time of crisis. Due to the incident review process for a previously implemented plan of correction, administrative staff was able to identify and take immediate corrective and safety actions with this situation. This regulation was violated by Shuman Staff who not only failed to follow crisis intervention curriculum and de-escalation graduated responses, but also failed to compose themselves and professionally intervene according to training, protocols, and procedures. According to the video staff member A appears to bear hug, push, and pull the hair of a resident without resident provocation creating a crisis situation. During this crisis situation, staff members involved attempted to gain physical containment or the resident, but did not attempt to separate staff member A and the resident for everyone's protection. As a result of this situation, staff member A has been indefinitely suspended and termination is pending, per the Allegheny County Shuman Center disciplinary process. In an attempt to correct and prevent future occurrences, on January 5, 12, 19, and 26, 2017, Deputy Director Gordon conducted Therapeutic Crisis Intervention (TCI) with all staff. Safe Crisis Management (SCM) will be refreshed and reviewed with all staff by our certified trainers on February 2, 9, 16, and 23, 2017. During both of these trainings discussion revolving around asphyxia and prone physical interventions was/will be discussed. All staff involved in this situation will be in attendance for both trainings. January mandated monthly conferences will include a review of appropriate use of physical intervention and "Professional Courage" discussion which includes "doing what is right, even when it is difficult." The de-escalation curriculum, crisis cycle, stress model of crisis, and self-awareness during a crisis was trained to all staff during the January TCI course. Allegheny County Shuman Center along with the County Managers Office continue to research an appropriate trauma informed care program, such as Sanctuary Model, to implement on site. Preliminary conversations are taking place with cultural change consultants RDP and possibly a request for proposal for others to assist Allegheny County Shuman Center with a six-month professional development evidence based leadership system for all staff.

1/27/17

Rich Gordon – Deputy Director of Operations – 1/27/17

Licensing Inspection Summary: 41431 - 01/06/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.274(5) - There shall be one child care worker present with the children for every six children during awake hours.

2a. DESCRIPTION OF VIOLATION
On [redacted] Staff Member F worked alone from 7am - 3pm with 7 residents on Unit F.

On [redacted] Staff Member C worked alone from 7am to approximately 11am with 10 residents on Unit L.

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.

Violation 3800.274(5) – There shall be one child care worker present with the children for every six children during awake hours.

Plan of Correction:

Meeting staff to resident ratios is key to ensure adequate safety and care for residents and staff. During awake hours the staffing ratio is 1:6 and during sleep hours a ratio is 1:12 are the minimums. On [redacted] during the 7a-3p shift the ratio was 1:7 and on [redacted] the ratio was 1:10 from 7a-11am. During both of these situations, staff coverage was low due to too many vacant shifts, coupled with staff call offs, utilization of benefit time, and resident population fluctuation. Protocols and procedures to cover vacant shifts were followed and administrative staff was on site assisting. Unfortunately, the vacancies were greater than the support. In 2016, Allegheny County Shuman Center hired 24 total staff, 14 of which are childcare workers or supervisors. During this same time span Allegheny County Shuman Center has lost 25 staff, 13 of which were childcare workers or supervisors. As of 1/25/17, three new childcare workers have been hired and are going through orientation training, while additional candidates are continually being interviewed for childcare worker and supervisory positions. Chief Supervisors, Wing Supervisors, and Training Manager will continue to monitor the schedule, assign pre-scheduled overtime, mandate overtime, and adjust staff schedules and unit assignments when possible, in order to ensure staff to resident ratios. The Administrative team continues to cover scheduling gaps until sufficient staffing levels are reached.

1/27/17

Rich Gordon – Deputy Director of Operations – 1/27/17

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)		Ernie Hill 1/27/17		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Rich Gordon - Dep. Dir. Oper.	Ernie Hill - Director	Date	1/27/17

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

The above plan of correction is approved as of 4/19/17 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/19/17 (Date)

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

VIOLATION REPORT
CHILD RESIDENTIAL LICENSING - 55 Pa.Code Chapter 3800

Facility Name: SHUMAN CENTER	License Number: 41431
Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15206	County: Allegheny
Director: Earl Hill	Region: WEST
Legal Entity Name: ALLEGHENY COUNTY EXECUTIVE	
Legal Entity Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15206	

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MAR 14 2017
WEST Regional Office
Human Services Licensing

Certificate(s) of Occupancy

Program Type:	Licensed Capacity:	Number of Children Served:
Secure Detention	120	55

Type of Inspection: Partial | BHA Docket Number: | Notice: Unannounced

Reason(s) for Inspection(s)
Complaint, Incident, Monitoring

On-Site Inspections Dates and Department Representatives On-Site
02/23/2017: Turby, Megan; Black, Kim

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details
Partial or Full Triggers: | Random Indicators:

Child Demographic Data as of Inspection Dates

Age of Children:
- 0 to 5 years: 0
- 6 to 13 years: 2
- 14 to 17 years: 39
- 18 to 21 years: 14

Number of Children who:
- Are Adjudicated Delinquent: 55
- Are Dependent: 0
- Have Mental Illness: 18
- Have an Intellectual Disability: 0
- Have a Physical Disability: 0

Licensing Inspection Summary: 41431 - 02/23/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.32(b) - A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

2a. DESCRIPTION OF VIOLATION
Footage obtained from the facility shows that on [redacted] Staff Members A and B were sitting on the blue chairs with the residents in the middle area of Unit M. At approximately 2:47:52 pm Resident #1 chased Resident #2 to the back of the unit and the residents engaged in a physical altercation. Staff Members A and B remained seated and watched the residents fight until approximately 2:48:09 pm when they began to walk towards the residents. At approximately 2:48:18 pm the residents were still fighting and fell into the table then fell to the ground with Resident #2 on his/her back underneath Resident #1. Staff Member A did not attempt to separate the residents until approximately 2:48:25 pm while the residents are still fighting and started to stand up. At approximately 2:48:29 pm Staff Member B began to assist Staff Member A in separating the residents. Staff Member B was able to remove Resident #1 from the situation while Staff Member A continued to struggle with Resident #2. Resident #2 was surrounded by approximately 9 staff in the back right corner of the unit when he/she was placed in a prone position on the floor at approximately 2:51:28 pm. Staff pulled Resident #2 up from the floor at approximately 02:52:01 pm.

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.

PLEASE SEE ATTACHED

Repeat Violation: Yes	Date(s) of Previous Violation(s):	01/06/2017	10/06/2016	

Signature of Legal Entity Representative (Required on EVERY Page) Earl Hill 3/14/17

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Earl Hill - Director Rich Gordon - Dep. Director Date 3/14/17

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

The above plan of correction is approved as of 4/19/17 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4/19/17 (Date)

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

Violation 3800.32(b) – A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

Plan of Correction:

It is important to all stakeholders that residents in residential care are appropriately cared for especially during times of crisis. Allegheny County Shuman Center is committed improving and developing consistent and competent staff that can demonstrate a sense of urgency and care for residents during a resident's time of crisis. This violation was due to the staff not reacting fast enough or with a sense of urgency during a time of crisis. As described, staff physically intervened :33 seconds after physical altercation began. Timing of a physical intervention has been a point of focus and discussion for Shuman staff because we have received violations for staff intervening both too fast and too slow in the past. This has been discussed on more than one occasion with BHSL Representatives in order to fine tune the appropriate timing for an intervention safely for both residents and staff. A greater sense of urgency must be demonstrated once physical aggression is observed. In an attempt to correct and prevent future occurrences, on January 5, 12, 19, and 26, 2017, Deputy Director Gordon conducted Therapeutic Crisis Intervention (TCI) with all staff. Safe Crisis Management (SCM) was refreshed and reviewed with all staff by our certified trainers on February 2, 9, 16, and 23, 2017. Both staff involved in this situation were in attendance for both trainings. The Training Manager met with both staff involved to discuss the incident and the need for a greater sense of urgency during a crisis situation. During both of these trainings, discussion revolving around asphyxia and prone physical interventions prohibition was discussed. Allegheny County Shuman Center along with the County Managers Office continue to research an appropriate trauma informed care program and training, such as Sanctuary Model, Think Trauma, and Center for Victims Trauma Curriculum to implement with both residents and staff. On March 13, 2017, the Center for Victims and Shuman Center agreed to start coordinating and conducting training with residents and staff on Mediation & Conflict Resolution as well as Adversity & Stress. The future dates will be coordinated with our Training Manager, Residential Services Manager, and the Center for Victim Services. Shuman Center has moved forward with a six-month contract with RDP Consultants to implement cultural change, professional development, and an evidence based leadership system for all staff. Meetings with RDP have taken place on February 23 and March 8, with the next meeting scheduled March 23, 2017.

Rich Gordon - Deputy Director of Operations – 3/14/17

VIOLATION REPORT
CHILD RESIDENTIAL LICENSING - 55 Pa.Code Chapter 3800

Facility Name: SHUMAN CENTER	License Number: 41431
Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15206	County: Allegheny
Director: Earl Hill	Region: WEST
Legal Entity Name: ALLEGHENY COUNTY EXECUTIVE	RECEIVED
Legal Entity Address: 7150 HIGHLAND DRIVE, PITTSBURGH, PA 15206	APR 17 2017

Certificate(s) of Occupancy

I-2	Other	WEST REGION FIELD OFFICE
12/19/1874	08/01/2014	Human Services Licensing
City of Pittsburgh	Labor and Industry	

Program Type:	Licensed Capacity:	Number of Children Served:
Secure Detention	120	61

Type of Inspection: Full	BHA Docket Number:	Notice: Announced

Reason(s) for Inspection(s)
Renewal, Provisional, Incident

On-Site Inspections Dates and Department Representatives On-Site
03/15/2017: Turby, Megan; Black, Kim; Page, Page; White, Anthony
03/16/2017: Turby, Megan; Black, Kim

Off-Site Inspection Dates and Inspectors, if Applicable
03/24/2017: Turby, Megan

Other Details

Partial or Full Triggers:	Random Indicators:

Child Demographic Data as of Inspection Dates

Age of Children:	Number of Children who:
0 to 5 years: 0	Are Adjudicated Delinquent: 61
6 to 13 years: 3	Are Dependent: 0
14 to 17 years: 34	Have Mental Illness: 29
18 to 21 years: 24	Have an Intellectual Disability: 0
	Have a Physical Disability: 0

Licensing Inspection Summary: 41431 - 03/16/2017 - Tuby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3000
3800.32(b) - A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

2a. DESCRIPTION OF VIOLATION
Per footage obtained from the facility, on [redacted] at approximately 3:18pm Staff Member B struck Resident #2 on the left side of the face, then the right side of the face which knocked Resident #2 back approximately two steps. Resident #2 then stepped towards Staff Member B and Staff Member B struck Resident #2 on the right side of the face again. Staff Member C stepped between Staff Member B and Resident #2 and laid on Resident #2 on a blue chair to keep [redacted] from Staff Member B. While Resident #2 was being held down, Staff Member B continued to verbally confront Resident #2 until additional staff arrived on the unit at approximately 3:19:29pm.

Per footage obtained from the facility, on [redacted] at approximately 12:36:35pm Resident #4 pushed Resident #5 out of a chair and attacked him/her. At approximately 12:36:41pm Resident #4 lifted Resident #5 from the ground and slammed [redacted] to the floor, head first. Resident #4 held Resident #5 down on the floor and punched Resident #5 3 times. At approximately 12:36:44 Staff Member F pulled Resident #4 off of Resident #5. From approximately 12:36:45 until approximately 12:36:50pm Resident #5 was laying limp on the ground twitching. At 12:36:48pm Staff Member H looked down on Resident #5, then proceeded to step over Resident #5's twitching body. Resident #5 remained limp on the ground until approximately 12:36:56pm when he began to voluntarily move his/her head and get up off of the floor. At 12:36:59 pm Staff Member F began to walk towards Resident #5, but at 12:37:03pm Staff Member F turned away from Resident #5 and walked away. Staff Member F did not begin to assist Resident #5 until approximately 12:37:17pm.

Per footage obtained from the facility, on [redacted] at approximately 4:56:36pm Resident #6 pushed Resident #7 and they began fighting. At approximately 4:56:40pm Residents #8 and #9 began to also attack Resident #7. Staff Member F immediately ran to the residents and separated Resident #6 from the group. Staff Member F then went back to the residents and continued to attempt to break up the fight. Staff Member G walked over to the residents when he/she noticed the three residents attacking Resident #7 with little sense of urgency. Resident #7 was attacked from 3:56:36pm until 3:57:09pm. Resident #7 was transported to the hospital and diagnosed with a head injury.

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.

PLEASE SEE ATTACHED

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/06/2016		

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) RICH GULDEN - DIRECTOR. Date 4/13/17

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

The above plan of correction is approved as of 4/14/17 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4/14/17 (Date)

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

Regulation – 3800.32.(b) – A child must not be abused, mistreated, threatened, harassed or subjected to corporal punishment.

Plan of Correction:

It is important to all stakeholders that residents in residential care are appropriately cared for especially during times of crisis. Allegheny County Shuman Center is committed improving and developing consistent and competent staff that can demonstrate a sense of urgency and care for residents during a resident's time of crisis. Of the 1,700 residents admitted to Shuman Center yearly, approximately 85% have displayed violent and or aggressive behavior in the community and the facility. It is of our opinion that Shuman Center staff are also closely connected with the residents and appear to be desensitized to crisis, violence, and trauma. Shuman staff are need of trauma care training for not only the residents but also themselves. Shuman Center has moved forward with trauma informed care training from the Center for Victims of Violent Crime on April 13 and 20, as well as May 4 and 11, 2017. The training will include trauma informed care, mediation, conflict resolution, and coping with adversity and stress. Additional content will include trauma groups with residents, staff, and 1:1 sessions as needed and identified. Shuman Center has moved forward with a six-month contract with RDP Consultants to implement cultural change, professional development, and an evidence based leadership system for all staff. Meetings with RDP have taken place on February 23, March 8, 23, 31, and next scheduled training is April 25, 2017. Monthly supervisory conferences with mandated topics for child care workers will continue and cover topics such as unit management and supervision, de-escalation techniques, greater attention to 1:1 protocols, red and yellow card protocols, no contacts, and safety plans with a sense of urgency during times of crisis. Staff presence and proximity with residents, the use of TCI's self-awareness guidelines, seclusion/exclusion supervision. Topics will be generated from state licensing inspection summaries, video incident reviews, and the administrative team through department concerns, needs, as well as, trends and themes noticed. All child care workers detailed in this violation will receive this information and training except Staff Member B who is no longer employed by Allegheny County Shuman Center. Shuman Center will continue to address and discipline staff who fail to follow federal, state, county, and facility policy, procedure, and protocols per the county/bargaining unit discipline process.

(please see Monthly Conference topics, Crisis Intervention Curriculum, and first Trauma Informed Training sign in sheet attached)

Rich Gordon – Director

4/13/17

Licensing Inspection Summary: 41431 - 03/15/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.104(c) - Cold food shall be kept at or below 40°F. Hot food shall be kept at or above 140°F. Frozen food shall be kept at or below 0°F.

2a. DESCRIPTION OF VIOLATION
On [redacted] at approximately 3:20pm the milk refrigerator was measured at 46.5 degrees Fahrenheit.

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.

PLEASE SEE ATTACHED

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) RICH GORDON - DIRECTOR

Date 4/13/17

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

The above plan of correction is approved as of 4/19/17 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4/19/17 (Date)

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

Regulation – 3800.104(e) – Cold food shall be kept at or below 40° F. Hot food shall be kept at or above 140° F. Frozen food shall be kept at or below 0° F.

Plan of Correction:

Shuman Center agrees that it is important to maintain safe food temperatures for health and sanitary conditions of the facility. The temperature of the refrigerator on the day of the licensing audit was registering above 40°. Upon further inspection, the thermostat of the appliance was turned up to cool better and an internal thermometer was installed in case of faulty outside thermometer. The appliances are aging especially with high use. Kitchen staff will continue to monitor the temp daily and this will be supervised by the Utility Manager. If the temperature issue returns, a work order to inspect, diagnose, repair, and or replace the appliance will be issued.

(Please see temperature chart and photo of recent thermometer reading attached)

Rich Gordon – Director

4/13/17

POC Summary 3rb - LP -
drug related to 3rb

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APR 17 2017

WEST REGION FIELD OFFICE
Human Services Licensing

Licensing Inspection Summary: 61431 - 03/16/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3000
3800.142 - If the health and safety assessment in § 3800.141 (relating to health and safety assessment) identifies a health or safety risk, a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed.

2a. DESCRIPTION OF VIOLATION
Per footage obtained from the facility, on [redacted] at approximately 12:36:35pm Resident #4 pushed Resident #5 out of a chair and attacked him/her. At approximately 12:36:41pm Resident #4 lifted Resident #5 from the ground and slammed [redacted] to the floor, head first. Resident #4 held Resident #5 down on the floor and punched Resident #5 3 times. At approximately 12:36:44 Staff Member F pulled Resident #4 off of Resident #5. From approximately 12:36:45 until approximately 12:36:50pm Resident #5 was laying limp on the ground twitching. At 12:36:48pm Staff Member H looked down on Resident #5, then proceeded to step over Resident #5's twitching body. Resident #5 remained limp on the ground until approximately 12:36:58pm when [redacted] began to voluntarily move his/her head and got up off of the floor. At 12:36:59 pm Staff Member F began to walk towards Resident #5, but at 12:37:03pm Staff Member F turned away from Resident #5 and walked away. Staff Member F did not begin to assist Resident #5 until approximately 12:37:17pm.. At the time that Resident #4 attacked Resident #5, both Staff Member F and Staff Member H were in the unit office, and Staff Member H is looking away from both Resident #4 and Resident #5. On [redacted] Resident #4 was assessed as aggressive and identified as a "red card." On [redacted] Resident #5 was assessed as aggressive and identified as a "red card" with safety instructions to "monitor closely around other residents." Resident #5's safety plan was not implemented at the time of the attack.

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.

PLEASE SEE ATTACHED

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/06/2016	08/02/2016	04/04/2016

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Rich Gordon - DIRECTOR

Date: 4/13/17

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

The above plan of correction is approved as of 4/14/17 (Date).

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

Plan of correction implementation status as of 4/9/17 (Date)

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

Regulation – 3800.142 – If the health and safety assessment in 3800.141 identifies a health or safety risk, a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed.

Plan of Correction:

It is important to all stakeholders that residents in residential care are appropriately cared for especially during times of crisis. Allegheny County Shuman Center is committed improving and developing consistent and competent staff that can demonstrate a sense of urgency and care for residents during a resident's time of crisis. Of the 1,700 residents admitted to Shuman Center yearly, approximately 85% have displayed violent and or aggressive behavior in the community and the facility. It is of our opinion that Shuman Center staff are also closely connected with the residents and appear to be desensitized to crisis, violence, and trauma. Shuman staff are need of trauma care training for not only the residents but also themselves. Shuman Center has moved forward with trauma informed care training from the Center for Victims of Violent Crime on April 13 and 20, as well as May 4 and 11, 2017. The training will include trauma informed care, mediation, conflict resolution, and coping with adversity and stress. Additional content will include trauma groups with residents, staff, and 1:1 sessions as needed and identified. Shuman Center has moved forward with a six-month contract with RDP Consultants to implement cultural change, professional development, and an evidence based leadership system for all staff. Meetings with RDP have taken place on February 23, March 8, 23, 31, and next scheduled training is April 25, 2017. Monthly supervisory conferences with mandated topics for child care workers will continue and cover topics such as unit management and supervision, de-escalation techniques, greater attention to 1:1 protocols, red and yellow card protocols, no contacts, and safety plans with a sense of urgency during times of crisis. Staff presence and proximity with residents, the use of TCI's self-awareness guidelines, seclusion/exclusion supervision. Topics will be generated from state licensing inspection summaries, video incident reviews, and the administrative team through department concerns, needs, as well as, trends and themes noticed. All child care workers detailed in this violation will receive this information and training except Staff Member B who is no longer employed by Allegheny County Shuman Center. Shuman Center will continue to address and discipline staff who fail to follow federal, state, county, and facility policy, procedure, and protocols per the county/bargaining unit discipline process.

(please see Monthly Conference topics, Crisis Intervention Curriculum, and first Trauma Informed Training sign in sheet attached)

Rich Gordon – Director

4/13/17

Licensing Inspection Summary: 41431 - 03/15/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.184(c) - The information in subsection (b) shall be logged at the same time each dosage of medication is administered or self-administered.

2a. DESCRIPTION OF VIOLATION
Resident #1's Concerta given at 7am was not logged at the time of administration. Staff Member A logged the medication in front of our representatives at approximately 11:52am.

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.

PLEASE SEE ATTACHED

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) RICH GORDON - DIRECTOR

Date 4/13/17

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

The above plan of correction is approved as of 4/19/17 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4/19/17 (Date)

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

Regulation – 3800.184(c) – The information is subsection (b) shall be logged at the same time each dosage of medication is administered or self-administered.

Plan of Correction:

Administering and documenting medication for residents at the time dispensing, is a sound practice to ensure quality care. The medication in question was signed off on the resident's medication administration record (MAR) that morning at 8am correctly initialed by the nurse dispensing the medication. BHSL staff checked the Controlled Medication Flow Sheet and found a discrepancy in the count for the Concerta. This had to be corrected by Staff Member A. Staff Member A will receive progressive discipline following the County and Union progressive discipline process by May 1, 2017. The Health Services Manager will conduct random reviews for the MAR and the Controlled Medication Flow Sheets to ensure not only Staff A's compliance with Medication Administration procedures, but also all Registered Nurse staff. The Health Services Manager will also review the Medication Administration and the Controlled Medication policy and procedures with all Registered Nurse staff by May 31, 2017.

Rich Gordon – Director

4/13/17

IN - Serial Rec. 32B

RECEIVED
APR 17 2017
WEST REGION FIELD OFFICE
Human Services Licensing

Licensing Inspection Summary: 41431 - 03/16/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.202(c) - For each incident in which use of a restrictive procedure is considered:
(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

2a. DESCRIPTION OF VIOLATION
Per footage obtained from the facility, on [redacted] at approximately 7:30pm Resident #3 was instructed to go into his/her room and shut the door due to residents taking showers. Resident #3 was going in and out of his/her room when Staff Member D indicated that he/she would lock Resident #3's door if he/she did not stay in his/her room. Resident #3 stated that he/she had previously been locked in a room for hours and did not want that to happen again. At approximately 7:33pm Resident #3 was standing against the wall to the left of his/her doorway when Staff Member D grabbed Resident #3's arms near his/her elbows. Staff Member D physically pushed Resident #3 backwards into [redacted] room with the assistance of Staff Member E. In an interview, Staff Member D indicated that he/she had to "use force" to get Resident #3 into his/her room and that "that was when Resident #3 became combative".

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.

PLEASE SEE ATTACHED

Repeat Violation: Yes	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) Rich Gordon - Director

Date 4/13/17

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

The above plan of correction is approved as of 4/14/17 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 4/14/17 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Regulation – 3800.202(c) – For each incident in which use of a restrictive procedure is considered: (1) every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

Plan of Correction:

It is important to all stakeholders that residents in residential care are appropriately cared for especially during times of crisis. Allegheny County Shuman Center is committed improving and developing consistent and competent staff that can demonstrate a sense of urgency and care for residents during a resident's time of crisis. Of the 1,700 residents admitted to Shuman Center yearly, approximately 85% have displayed violent and or aggressive behavior in the community and the facility. It is of our opinion that Shuman Center staff are also closely connected with the residents and appear to be desensitized to crisis, violence, and trauma. Shuman staff are need of trauma care training for not only the residents but also themselves. Shuman Center has moved forward with trauma informed care training from the Center for Victims of Violent Crime on April 13 and 20, as well as May 4 and 11, 2017. The training will include trauma informed care, mediation, conflict resolution, and coping with adversity and stress. Additional content will include trauma groups with residents, staff, and 1:1 sessions as needed and identified. Shuman Center has moved forward with a six-month contract with RDP Consultants to implement cultural change, professional development, and an evidence based leadership system for all staff. Meetings with RDP have taken place on February 23, March 8, 23, 31, and next scheduled training is April 25, 2017. Monthly supervisory conferences with mandated topics for child care workers will continue and cover topics such as unit management and supervision, de-escalation techniques, greater attention to 1:1 protocols, red and yellow card protocols, no contacts, and safety plans with a sense of urgency during times of crisis. Staff presence and proximity with residents, the use of TCI's self-awareness guidelines, seclusion/exclusion supervision. Topics will be generated from state licensing inspection summaries, video incident reviews, and the administrative team through department concerns, needs, as well as, trends and themes noticed. All child care workers detailed in this violation will receive this information and training except Staff Member B who is no longer employed by Allegheny County Shuman Center. Shuman Center will continue to address and discipline staff who fail to follow federal, state, county, and facility policy, procedure, and protocols per the county/bargaining unit discipline process.

(please see Monthly Conference topics, Crisis Intervention Curriculum, and first Trauma Informed Training sign in sheet attached)

Rich Gordon – Director

4/13/17

Licensing Inspection Summary: 41431 - 03/15/2017 - Turby, Megan
Facility Name: SHUMAN CENTER

1. REGULATION 55 Pa.Code §3800
3800.274(17)(iii) - The following requirements apply to the use of seclusion: A staff person shall observe a child in seclusion at least every 5 minutes.

2a. DESCRIPTION OF VIOLATION
On [redacted] the following residents were secluded for the specified amount of time:
Resident #10 was secluded from 3:30pm – 5:36pm
Resident #9 was secluded from 3:30pm – 7:15pm
Resident #11 was secluded from 3:30pm – 7:15pm
Resident #3 was secluded from 3:30pm – 7:15pm

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Human Services Licensing

On [redacted] staff members performed checks on the residents at the following times: 3:33pm, 3:40pm, 3:51pm, 3:57pm, 4:01pm, 4:08pm, 4:20pm, 4:33pm, 4:53pm, 5:04pm, 5:11pm, 5:31pm, 5:35pm, 5:41pm, 5:46pm, 5:52pm, 5:58pm, 6:10pm, 6:16pm, 6:22pm, 6:26pm, 6:31pm, 6:45pm, 7:00pm.

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.

PLEASE SEE ATTACHED

Repeat Violation: No	Date(s) of Previous Violation(s):	06/02/2016		

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) RICH Gordon - DIRECTOR

Date 4/13/17

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

The above plan of correction is approved as of 4/19/17 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4/19/17 (Date)

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

Licensing Inspection Summary: 41431 - 03/15/2017 - Turby, Megan
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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.

PLEASE SEE ATTACHED

The Deputy Director of Operations will train all staff on proper seclusion protocol, including but not limited to the following:

- A staff person shall observe a resident in seclusion at least every 5 minutes.
- The physical needs of the resident shall be met promptly.
- A child in seclusion shall be checked and observed by a supervisory staff person who is not continually observing the child as required, at least every 2 hours the seclusion is used.

The training will occur at the Monthly Supervisory Conferences. 5/8/17

Repeat Violation: No	Date(s) of Previous Violation(s):	06/02/2016	

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Rich Gordon - Director

Date 4/13/17

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

The above plan of correction is approved as of 5/8/17 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/8/17 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
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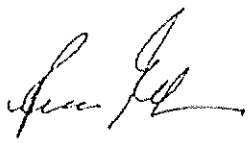

Rich Gordon – Director

4/13/17

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4/13/17