pennsylvania
DEPARTMENT OF HUMAN SERVICES

February 8, 2019

The Shuman Juvenile Detention Center
Mr. Richard Gordon, Director
7150 Highland Drive
Pittsburgh, Pennsylvania 15206

Re: Plan of Correction Acceptance

Dear Mr. Gordon,

Please be advised that the Shuman Juvenile Detention Center's Plan of Correction regarding the Child Protective Services (CPS) investigation involving James Washington has been reviewed and has been accepted. The actions you have taken do address the issues identified in the CPS Licensing Summary. I apologize for the delay in sending this letter to your attention, but I assure you the plan of correction was reviewed upon receipt.

To further support your agency's implementation of the Plan of Correction, we plan to make ourselves available to meet with you and your team to provide any additional technical assistance if necessary. If you should have any questions, please do not hesitate to contact Rebecca Lewandowski at rlewandows@pa.gov or her supervisor, Mary Lou Warchola, at mwarchola@pa.gov.

Sincerely,

Amber D. Kalp

Amber D. Kalp, Regional Director
Bureau of Children and Family Services

# LICENSING/APPROVAL/REGISTRATION INSPECTION SUMMARY



| NAME OF AGENCY/FACILITY<br>Shuman Juvenile Detention Center #414310 | | | | TELEPHONE<br>412.661.6806 | OCYF REGIONAL STAFF APPROVAL | DATE |
|---|---|---|---|---|---|---|
| ADDRESS<br>7150 Highland Avenue, Pittsburgh, Pennsylvania 15206 | | | | COUNTY<br>Allegheny | Rebecca Lewandowski | 2/7/19 |
| INSPECTED BY<br>Rebecca Lewandowski | | | | INSPECTION DATE<br>08/24/2018 | Mary Lou Wachola | 2/7/19 |
| INITIAL INSPECTION | RENEWAL INSPECTION | COMPLAINT | UNANNOUNCED INSPECTION | RANDOM SAMPLE | Amber D. Kalp | 2/7/19 |
| | | X | | | | |

During the course of a Child Protective Service (CPS) investigation at the facility the following issues of non-compliance were found.

| 1. 55 PA CODE CHAPTER | 2. NON-COMPLIANCE AREA | 3. CORRECTION REQUIRED | 4. REQUIRED CORRECTION DATE | 5. PROVIDERS PLAN OF CORRECTION OR RESPONSE | 6. STATUS OF CORRECTION |
|---|---|---|---|---|---|
| PA Chapter 3800.16(a)(4) | This regulation requires that a reportable incident be completed when a serious injury, or trauma of a child requiring outpatient treatment at a hospital, not to include minor injuries such as sprains or cuts. 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 contracting agency within 24 hours. An incident | The Agency must immediately submit a plan to the Department that outlines how they are going to ensure compliance with this regulation. | September 10, 2018 | Please see attached. rg 9/4/18 | PLAN ACCEPTED |

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| | where a resident was injured.<br><br>The recordable incident report that was completed by the facility did not accurately reflect the facts of how the resident received the injury nor did it reflect the seriousness of the injury therefore a reportable incident was not completed by the facility. | | | | |
| 3800.32 (k) | This regulation states that a child has a right to appropriate medical, behavioral health and dental treatment.<br><br>A resident was injured and there was a delay in the child receiving any medical attention. He was seen the following day by in house nursing and then was seen by the local hospital. The child sustained serious trauma to his eye and a broken nasal bone. | The Agency must immediately submit a plan to the Department that ensures they are complying with this regulation. | September 10, 2018 | Please see attached. rg 9/4/18 | PLAN ACCEPTED |
| 3800.17 (6) | Recordable incidents are required when injuries, trauma and illnesses of children that do not meet the definition of a reportable incident in 3800.16 which occur at the facility. The recordable incident report that was written by the facility did not accurately reflect the incident that | The Agency must immediately submit a plan to the Department that ensures that they are complying with this regulation. | September 10, 2018 | Please see attached. rg 9/4/18 | PLAN ACCEPTED |

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| | occurred or the injury to the child. | | | | |
| 3800.148 (a) | This regulation requires that the facility shall identify acute conditions of a child and shall arrange for or provide appropriate medical attention.<br><br>The resident was visibly injured and was not seen by a medical professional either at the facility or outside of the facility for almost 24 hours. The child was diagnosed with a nasal fracture and significant trauma to the eye. | The Agency must immediately submit a plan to the Department that ensures that they are complying with this regulation. | September 10, 2018 | Please See attached. rg 9/4/18 | **PLAN ACCEPTED** |

| THE LEGAL ENTITY REPRESENTATIVE MUST COMPLETE COLUMN 5, SIGN ON THE SIGNATURE LINE AT THE BOTTOM AND DATE ALL PAGES OF THIS DOCUMENT. RETURN THIS ENTIRE DOCUMENT TO YOUR REGIONAL OFFICE BY: SEPTEMBER 10, 2018 | |
|---|---|
| | DIRECTOR |
| SIGNATURE OF LEGAL ENTITY REPRESENTATIVE | TITLE |
| 9/4/18 | 412-665-4117 |
| DATE | TELEPHONE NUMBER |

# Shuman Center Plan of Corrections for Licensing Inspection Summary Regulatory Citations dated August 24, 2018

**#1. Non-Compliance Area: 3800.16(a)(4)** - This regulation requires that a reportable incident be completed when a serious injury, or trauma of a child requiring outpatient treatment at a hospital, not to include minor injuries such as sprains or cuts. 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 contracting agency within 24 hours. An incident occurred at the facility where a resident was injured. The recordable incident report that was completed by the facility did not accurately reflect the facts of how the resident received the injury nor did it reflect the seriousness of the injury therefore a reportable incident was not completed by the facility.

**Plan of Correction:** On [redacted] at approximately 3:15pm, an incident occurred which prompted facility staff to respond to a unit. Once on the unit with the situation settling, Supervisory team noticed that a more problematic resident was not involved in this incident. Knowing the resident well, feeling something was odd, Supervisors decided to look in on the resident and noticed the resident had a swollen black eye. The resident reported that the injury happened while playing basketball the night before and that they had refused treatment. To remedy the situation, the Supervisors took the resident without incident to be examined by Shuman Medical without resident approval or consent. Medical determined that the resident should be transported by Sheriffs to Children's Hospital for further examination. Only there was the resident diagnosed with a nasal fracture and treated for such. Supervisor Tamara Brumfield completed a timely and accurate reportable incident report on [redacted] at approximately 10pm, within 7 hours of the acute condition being identified by Supervisors, Management, and Medical. This prompted Shuman Administration to investigate the details of the injury on [redacted] It quickly became apparent through video surveillance, that two staff members failed to report the resident's acute condition timely and accurately. Shuman Center immediately ChildLined the situation and notified Allegheny County police to investigate the incident. Both staff members were immediately suspended and subsequently terminated for their actions and/or lack thereof. It is the stance of Shuman Center that the Facility followed all state regulations accurately and timely when the acute condition was identified and that the two-indicated staff acted separately and independently from standard operating procedures.

A reportable incident is important to ensure all involved parties are aware of situations that may impact resident(s) safety and welfare. It is facility policy to report all acute conditions to supervisors and medical department to determine the appropriate course of treatment and action. These protocols and procedures will be reviewed with all staff during August and September 2018 monthly conferences with Supervisors and during August and September Thursday trainings with the Training Manager and Deputy Director of Operations. Staff will also sign off acknowledging that they read, know, and will implement faithfully the policy, the procedures, and the regulations cited above by October 15, 2018.

Rich Gordon - Director

9/4/2018

**#2. Non-Compliance Area: 3800.32(k)** - This regulation states that a child has a right to appropriate medical, behavioral health and dental treatment. A resident was injured and there was a delay in the child receiving any medical attention. He was seen the following day by in house nursing and then was seen by the local hospital. The child sustained serious trauma to his eye and a broken nasal bone.

**Plan of Correction:** On [redacted] at approximately 3:15pm, an incident occurred which prompted facility staff to respond to a unit. Once on the unit with the situation settling, Supervisory team noticed that a more problematic resident was not involved in this incident. Knowing the resident well, feeling something was odd, Supervisors decided to look in on the resident and noticed the resident had a swollen black eye. The resident reported that the injury happened while playing basketball the night before and that they had refused treatment. To remedy the situation, the Supervisors took the resident without incident to be examined by Shuman Medical without resident approval or consent. Medical determined that the resident should be transported by Sheriffs to Children's Hospital for further examination. Only there was the resident diagnosed with a nasal fracture and treated for such. It is the stance of Shuman Center that the Facility followed all state regulations accurately and timely when the acute condition was identified. The resident was never not treated for injuries sustained, but treatment was delayed due to the two-indicated staff acting separately and independently from standard operating procedures. Shuman Center immediately ChildLined the situation and notified Allegheny County police to investigate the incident. Both staff members were immediately suspended and subsequently terminated for their actions and/or lack thereof.

Providing a child with appropriate medical, behavioral, and dental treatment is a fundamental right that Allegheny County and Shuman Center supports for each resident(s) safety and welfare. It is facility policy to report all acute conditions to supervisors and medical department to determine the appropriate course of treatment and action. These protocols and procedures will be reviewed with all staff during August and September 2018 monthly conferences with Supervisors and during August and September Thursday trainings with the Training Manager and Deputy Director of Operations. Staff will also sign off acknowledging that they read, know, and will implement faithfully the policy, the procedures, and the regulations cited above by October 15, 2018.

Rich Gordon - Director

9/4/2018

**#3. Non-Compliance Area: 3800.17(6)** - Recordable incidents are required when injuries, trauma and illnesses of children that do not meet the definition of a reportable incident in 3800.16 which occur at the facility. The recordable incident report that was written by the facility did not accurately reflect the incident that occurred or the injury to the child.

**Plan of Correction:** On [redacted] at approximately 3:15pm, an incident occurred which prompted facility staff to respond to a unit. Once on the unit with the situation settling, Supervisory team noticed that a more problematic resident was not involved in this incident. Knowing the resident well, feeling something was odd, Supervisors decided to look in on the resident and noticed the resident had a swollen black eye. The resident reported that the injury happened while playing basketball the night before and that they had refused treatment. At this time there was no documentation of this incident by staff of record and Supervisors of record were not notified or aware of said injury. Supervisory team then instructed the two staff of record to document the injury. This prompted Shuman Administration to investigate the nature of the injury. It quickly became apparent through video surveillance, that two staff members failed to complete a recordable incident report documenting a resident's acute condition timely and accurately. One staff submitted a report that proved to be completely inaccurate and false, and the second staff failed to provide a report at all. It is the stance of Shuman Center that the Facility followed all state regulations accurately and timely when the acute condition was identified and that the two-indicated staff acted separately and independently from standard operating procedures. Both staff members were immediately suspended and subsequently terminated for their actions or lack thereof.

Having a record of incidents from staff detailing incidents is key to providing a safe and secure environment. As in this case, it helps to establish accurate timeframes for resident and staff safety and welfare. It allows there to be transparency for the protection of all parties involved. These protocols and procedures will be reviewed with all staff during August and September 2018 monthly conferences with Supervisors and during August and September Thursday trainings with the Training Manager and Deputy Director of Operations. Staff will also sign off acknowledging that they read, know, and will implement faithfully the policy, the procedures, and the regulations cited above by October 15, 2018.

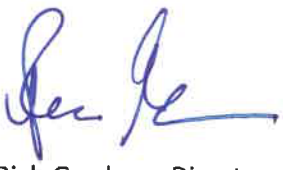
Rich Gordon – Director

9/4/2018

**#4. Non-Compliance Area: 3800.148(a)** - This regulation requires that the facility shall identify acute conditions of a child and shall arrange for or provide appropriate medical attention. The resident was visibly injured and was not seen by a medical professional either at the facility or outside of the facility for almost 24 hours. The child was diagnosed with a nasal fracture and significant trauma to the eye.

**Plan of Correction:** On [redacted] at approximately 3:15pm, an incident occurred which prompted facility staff to respond to a unit. Once on the unit with the situation settling, Supervisory team noticed that a more problematic resident was not involved in this incident. Knowing the resident well, feeling something was odd, Supervisors decided to look in on the resident and noticed the resident had a swollen black eye. The resident reported that the injury happened while playing basketball the night before and that they had refused treatment. To remedy the situation, the Supervisors took the resident without incident to be examined by Shuman Medical without resident approval or consent. Medical determined that the resident should be transported by Sheriffs to Children's Hospital for further examination. Only there was the resident diagnosed with a nasal fracture and treated for such. It is the stance of Shuman Center that the Facility followed all state regulations accurately and timely when the acute condition was identified. The resident was never not treated for injuries sustained, but treatment was delayed due to the two-indicated staff acting separately and independently from standard operating procedures.

Providing a child with appropriate medical, behavioral, and dental treatment is a fundamental right that Allegheny County and Shuman Center supports for each resident(s) safety and welfare. It is facility policy to report all acute conditions to supervisors and medical department to determine the appropriate course of treatment and action. These protocols and procedures will be reviewed with all staff during August and September 2018 monthly conferences with Supervisors and during August and September Thursday trainings with the Training Manager and Deputy Director of Operations. Staff will also sign off acknowledging that they read, know, and will implement faithfully the policy, the procedures, and the regulations cited above by October 15, 2018.



Rich Gordon – Director

9/4/2018