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**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller
(MAXIMUM CAPACITY)

Restrictions:

This certificate is granted in accordance with the Human Services 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 **September 11, 2019** until **March 11, 2020**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **414312**

Robert E. Robinson
ISSUING OFFICER

Amy Grippi
ACTING 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 – 5/19

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

OCT 29 2019

Mr. Richard Fitzgerald, County Executive
Allegheny County Executive
7150 Highland Drive
Pittsburgh, Pennsylvania 15206

RE: Shuman Juvenile Detention Center
7150 Highland Drive
Pittsburgh, Pennsylvania 15206
License Number: 414311

Dear Mr. Fitzgerald:

As a result of the Department of Human Services' (department) complaint investigation from August 2, 2019 to August 16, 2019 of the above-named facility, the areas of non-compliance listed on the enclosed Licensing Inspection Summary (LIS) were found.

Failure to comply with the applicable regulations as specified in detail in the enclosed LIS document is the basis for revocation of your first provisional license (#414311) dated March 11, 2019 to September 11, 2019, and the issuance of a second PROVISIONAL license (#414312) dated September 11, 2019 to March 11, 2020 (see 62 P.S. § 10058, 55 Pa. Code §§ 20.54 (a), and 20.71 (a)(2)). This second provisional license replaces all previously issued licenses and is effective for six months from the date of issuance. This decision is made pursuant to 62 P.S. 1026(b)(1) and 55 Pa. Code § 20.719(a)(2) (relating to conditions for denial, nonrenewal or revocation). Your second provisional license is enclosed.

If you disagree with the decision to issue a second provisional license, you have the right to appeal through a hearing before the department's Bureau of Hearings and Appeals, in accordance with 1 Pa. Code Part II, Chapters 31-35 (relating to General Rules of Administrative Practice and Procedures) by a petition which meets the requirements set forth at 1 Pa. Code § 35.17. If you decide to appeal your provisional license, a written request for an appeal must be received at the following address within ten (10) calendar days of the date of this letter:

Ms. Amber Kalp, Western Regional Director
Department of Human Services
Office of Children, Youth, and Families
11 Stanwix Street, Room 260
Pittsburgh, Pennsylvania 15222

This decision is final eleven (11) calendar 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,

Amy Grippi

Amy Grippi
Acting Deputy Secretary

Enclosures:
Licensing Inspection Summary
PROVISIONAL Certificate of Compliance

Department of Human Services
Office of Children, Youth and Families
LICENSING/APPROVAL/REGISTRATION INSPECTION SUMMARY
55 PA.CODE CHAPTER 3800

Agency/Facility Information

Name: *SHUMAN CENTER*
Address: *7150 HIGHLAND DRIVE,, PITTSBURGH, PA 15206*
Phone: *4126616806*

License #: *41431*
County: *ALLEGHENY*

Inspection Information

Start Date: *08/02/2019* **End Date:** *08/16/2019* **Type:** *Complaint* **Notice:** *Announced Visit*
Inspector(s): *Tiana Jordan*

Inspection Narrative

The Department conducted an investigation at the facility and found the following regulatory violations:

Signature

The legal entity representative must complete the "Provider's Plan of Correction or Response," sign on the signature line below and date all pages of this document. Return this entire document when completed to your Regional Office no later than 10/14/2019

Signature of Legal Entity Representative — Date: 10/8/19

Rich Gordon — Name of Legal Entity Representative
Director — Title
412-665-4117 — Telephone Number

OCYF Regional Staff Approval

Signature — Date: 10-21-19

Bonnie J. Shuda — Signature — Date: 10.21.19

Amber D. Kaup — Signature — Date: 10-22-19

Date:

16 Reportable Incidents

1. 55 PA Code Chapter 3800.

16.a. A reportable incident is the following:

2. A physical act by a child to commit suicide.

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.

Area of Non-Compliance

The Department determined the facility failed to notify the Department within 24 hours of the resident's suicide attempt.

Provider's Plan of Corrective Action or Response

* Please See Attached

Status of Correction:

32 Specific Rights

1. 55 PA Code Chapter 3800.

32.k. A child has the right to appropriate medical, behavioral health and dental treatment.

Area of Non-Compliance

It was determined the resident did not receive the appropriate behavioral health treatment, as recommended through the RESOLVE assessment; instead, the facility staff made the determination the resident should remain at the facility and be further evaluated the following day.

Provider's Plan of Corrective Action or Response

* Please See Attached

Status of Correction:

148 Health and Behavioral Health Services

1. 55 PA Code Chapter 3800.

148.a. The facility shall identify acute and chronic conditions of a child and shall arrange for or provide appropriate medical treatment.

Date:

148 Health and Behavioral Health Services *(continued)*

Area of Non-Compliance

The Department determined the facility staff member did not comply with the directive provided by the contracted mental health provider; instead, the resident remained at the facility for a second evaluation the following day.

Provider's Plan of Corrective Action or Response

* Please See Attached

Status of Correction:

Date:

Shuman Center Plan of Corrections for Licensing Inspection Summary Regulatory Citations dated October 1, 2019

Non-Compliance Areas:

3800.16(a)(2) & (c) – A reportable incident is the following: (2) A physical act by a child to commit suicide (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 contracting agency within 24 hours.

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

3800.148(a) – The facility shall identify acute and chronic conditions of a child and shall arrange for or provide appropriate medical treatment.

Plan of Correction:

We feel that it is important to understand the why and how the incident took place. On [redacted], an incident occurred where a resident mimicked a self-injurious behavior. This resident's behavior did not result in any injuries or marks, the child was never in chronic or acute distress, they never acted or attempted to harm themselves to complete self-destruction, and medical treatment was never needed. In fact, the resident immediately complied with a staff directive to stop the behavior. Even if the resident would have continued to mimic this self-injurious behavior for a long period of time, injury and self-destruction would and could not have been achieved. The mobile behavioral health team was contacted by the onsite supervisor and two mental health professionals arrived onsite to meet with the resident. According to the supervisor on site, one mental health professional stated to send the resident off site for mental health evaluation and the other mental health professional gave the supervisor the option to maintain the resident onsite under 1:1 supervision to be further evaluated the following day. The supervisor decided to follow the least restrictive option in part based on his relationship with the second mental health professional and knowledge of the incident and the resident. The resident remained at the facility overnight without any further incident or concern. The resident woke the following morning, attended his court hearing (which did not go well), and did have follow up with the facility's contracted behavioral health team upon his return. At that point, the facility's contracted behavioral health team decided to send the resident out for evaluation. At this time, the resident has still not suffered from acute, chronic, or self-injurious behaviors, but needs counseling to address their thoughts and ideations. The resident was then sent out for further behavioral health evaluation.

At the conclusion of their investigation, the Department has determined that: 1) The facility failed to notify the Department within 24 hours of the resident's suicide attempt, 2.) That the resident did not receive the appropriate behavioral health treatment as recommended, and 3.) That the facility staff did not comply with the directive provided by the contracted mental health provider. Shuman Center did not complete a reportable incident for a suicide attempt because there never was a suicide attempt. The facility did contact mobile behavioral health immediately who then provided two different treatment options. The supervisor followed the least restrictive option. The contracted behavioral health team met with the resident on the following day and decided to send the resident out for further evaluation, which the facility did do.

The Department does not define suicide gesture or suicide attempt in the 3800's. Thus, to clarify, a gesture is defined as body movement to express an idea or meaning. An attempt is defined as an action to try to accomplish or solve a task. There are many other examples that can be given to clearly demonstrate the difference. The Department does describe how each is to be documented, 3800.17(2) requires gestures to be recorded and 3800.16(a)(2) requires attempts to be Department reportable. Shuman Center did record the event since it was a gesture not an attempt based on the

10/31/19

definitions. These definitions along with the severity of the incident, would also affect documentation and treatment actions taken.

It is imperative that the residents and staff of Shuman Center are safe, cared for, and treated appropriately. Thus, to prevent this from happening again, Shuman Center will:

- Recommend to the Department that during their current 3800's Review Process, that they clearly define the terms suicidal gesture and suicidal attempt or eliminate a difference so as both actions are recordable or reportable based on the definition or direction of their choice
- Child Care Supervisors will contact mobile mental health team when a resident demonstrates either suicidal gestures and or attempts
- Child Care Supervisors will contact Shuman Administration to seek clarification of 3800.16(a)(2) & (c) and 3800.17(2) as needed
- Training Manager will provide all child care workers and child care supervisors with "Suicide Prevention and Awareness for Youth in Custody" training on October 3, 10, 17, 24, 2019
- Training Manager will provide and review the current Suicide Prevention and Intervention Policy during the October 3, 10, 17, 24, 2019 trainings with all child care workers and child care supervisors
- Immediately begin to utilize the Resident Special Supervision form to include all behavioral health team's treatment decisions or plan of treatment during regularly scheduled weekly treatment meetings by end of October 2019
- Coordinate improved protocols with the mobile crisis intervention team, the behavioral health treatment team, and Shuman Center Staff to include descriptions of services, definition clarification, protocols, and improved documentation of site visits by the end of October 2019

Rich Gordon - Director

10/8/19

To be completed by the Mental Health Team every day a resident is on Special Supervision.

Resident Special Supervision

Name _____ Date _____

This resident has been evaluated by the Mental Health Team and is hereby placed on:

☐ ***One-on-one Supervision***

Stage One:

1. Resident to be placed in: ***Room*** ***Unit*** ***Other*** _____
2. Items to be removed: _____
3. Special Instructions: _____

Stage Two:

1. Permissible Activities: None Cafeteria School
   Educational Programs
   All Activities
2. Special Instructions:

Yellow Card Status

Mental Health Professional: _____ *Date* _____ *Time:* _____