COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

AUGUST 20, 2021

[redacted] Allegheny County Manager
119 Courthouse
436 Grant Street
Pittsburgh, Pennsylvania 15219

[redacted] Allegheny County Manager
7150 Highland Drive
Pittsburgh, Pennsylvania 15206

RE: Shuman Juvenile Detention Center
7150 Highland Drive
Pittsburgh, Pennsylvania 15206
License Number: 414314

Dear [redacted]

As a result of the Pennsylvania Department of Human Services (department) inspections July 24, 2021 to August 4, 2021 of the above-named facility, the citations specified on the enclosed Emergency Removal Order and Attachment A – Findings issued on August 20, 2021 were found.

As a result of the violations of 55 Pa. Code Chapter 3800, the department is REVOKING your Fourth Provisional License to operate a child residential facility, License Number 414314. The department's decision to revoke your license is based upon the violations contained in the enclosed Emergency Removal Order and Attachment A – Findings, demonstrating failure to comply with department regulations; gross incompetence, negligence and misconduct in operating the facility; in the facility and is made pursuant to 62 P.S. §§ 1026(b)(1), (4); and 55 Pa Code §§ 20.71(a)(1), (2), (4), (6) (regarding conditions for denial, nonrenewal or revocation). The following violations are repeat violations: 55 Pa. Code §3800.148 (a) cited on August 24, 2018, October 1, 2019 and July 1, 2021; 55 Pa. Code §3800.53 (b) cited on July 1, 2021.

If you disagree with the decision to revoke your License Number 414314, 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the department's decision.

If you decide to appeal, a written request for an appeal must be received within ten (10) days of the mailing date of this letter.

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

This decision is final eleven (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,

Jonathan Rubin
Deputy Secretary

Enclosures:
Order for Emergency Relocation
Attachment A – Findings

c: [redacted]

ORDER

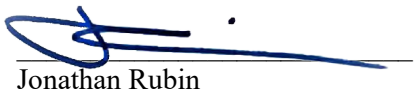
And now this **20th** day of August 2021, pursuant to 55 Pa. Code §20.37, the Commonwealth of Pennsylvania, Department of Human Services, hereby determines that the conditions existing at:

Shuman Juvenile Detention Center
7150 Highland Drive
Pittsburgh, Pennsylvania 15206

as described in Attachment A, constitute gross incompetence, negligence and misconduct in operating a facility likely to constitute immediate and serious danger to the life and health of the children in care.

Accordingly, it is hereby ordered that all children be removed from the facility in a safe, prompt, and orderly fashion by September 18, 2021.

Attachment:
Attachment A – Findings



Jonathan Rubin
Deputy Secretary

FINDINGS

FACILITY LOCATION: Shuman Juvenile Detention Center
7150 Highland Drive
Pittsburgh, Pennsylvania 15206

LEGAL ENTITY: Allegheny County Executive
7150 Highland Drive
Pittsburgh, Pennsylvania 15206

The Department of Human Services, Office of Children, Youth and Families (hereinafter "Department") opened a complaint investigation regarding systemic medication administration errors within the Shuman Juvenile Detention Center that is likely to constitute an immediate and serious danger to the life or health of the clients pursuant to 55 Pa. Code § 20.37.

Violations from July 24, 2021 and August 4, 2021 investigations:

On [redacted] 2021, the Department conducted an unannounced medication log review on [redacted] children placed at the facility as part of the ongoing provisional license technical assistance. The Department concluded that these [redacted] youth did not receive [redacted] doses of [redacted] prescribed medication. [redacted] youth was not administered [redacted] prescribed [redacted] youth did not receive [redacted] and [redacted] youth was not dispensed his Melatonin and Hydroxyzine on [redacted] 2021. [redacted] youth also did not receive [redacted] medication on [redacted] 2021.

The Shuman Juvenile Detention Center administration was contacted to further discuss the concerns that youth had not received [redacted] medication as prescribed.

The Department conducted a global assessment of the facility's medication administration records (MARs) on August 4, 2021 reviewing the MARs for all children placed at the facility between July 1, 2021 to August 4, 2021.

Based on this review, the Department confirmed that a total of [redacted] youth did not receive [redacted] medication on [redacted] 2021. On [redacted], 2021 [redacted] youth did not receive [redacted] dose of medication. [redacted] youth did not receive [redacted] dosage of medication on [redacted] 2021. These medications include, [redacted]

A total of 22 youth did not receive their prescribed medication on [redacted] 2021, because there was no nurse on the [redacted] shift to administer the medications. The only staff fully trained to provide the medication is the nursing staff assigned to the facility.

[redacted] youth prescribed [redacted] did not receive [redacted] medication on [redacted], 2021. [redacted] youth[redacted] prescription expired on [redacted], 2021 and was not refilled until [redacted], 2021. As a result, the facility was unable to provide [redacted] medication on [redacted], 2021 and [redacted] 2021.

Attachment A – Findings

[redacted] youth did not receive [redacted] assessment on [redacted] 2021. This assessment is to be provided over [redacted] to determine if an individual has [redacted] symptoms, which can be life threatening.

Upon review of nursing schedules from July 1, 2021 to August 4, 2021, the Department determined that on [redacted], 2021 and [redacted] 2021 no [redacted] nurses were scheduled to work to provide medication to the youth at the facility.

The medication administration records (MARs) were not completed as required as the missed medication dates were not circled and acknowledged by the medication administrator on the back of the document. This process is required to verify that the medication was not administered and not simply refused by the youth.

As a result of the ongoing investigations, Department representatives verified the following violations of the Department's regulations for child residential and day treatment facilities, pursuant to 55 Pa. Code Chapter 3800:

- 3800.53(b), regarding Director: The director shall be responsible for administration and management of the facility, including the safety and protection of the children, implementation of policies and procedures and compliance with this chapter.

- 3800.148(a)**,** regarding Health and behavioral health services: The facility shall identify acute and chronic conditions of a child and shall arrange for or provide appropriate medical treatment.

- 3800.185(a)**,** regarding Medication errors: Documentation of medication errors shall be kept in the medication log. Medication errors include the failure to administer medication, administering the incorrect medication, administering the correct medication in an incorrect dosage, or administrating the correct medication at the incorrect time.

The following violations are repeat violations: 55 Pa. Code §3800.148 (a) cited on August 24, 2018, October 1, 2019 and July 1, 2021; 55 Pa. Code §3800.53 (b) cited on July 1, 2021.

The amount and seriousness of the medication errors constitutes gross incompetence, negligence, and misconduct in operating the facility, that is likely to constitute an immediate and serious danger to the life or health of the clients pursuant to 55 Pa. Code § 20.37.