

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

Page: 1 of 2

License #: 084-01-020

Organization Name: Western Tidewater Community Services Board

Date of Inspection: 09-05-2023

Program Type/Facility Name: 01-020 Bridges

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-105-160. D. (2) - The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or circumstances of the	N	Bridges This regulation was NOT MET as evidenced by: CHRIS Number: 20230084 Date/Time of Discover: 08/15/2023 11:35AM Enter Date/Time: 08/16/2023 6:15PM Reporting Delay: 6:40:00 Location Name: Bridges CHRIS Number: 20230085 Date/Time of Discover: 08/15/2023 11:35AM Enter Date/Time: 08/16/2023 6:43PM Reporting Delay: 7:8:00 Location Name: Bridges	PR) 09/21/2023 Provider #1 acknowledges the late reporting for the above referenced incident. Provider #1 acknowledges the need for continued training to ensure reports are entered correctly. In this instance, the report was entered timely under human rights (abuse), which OHR clarified the need for this to be entered under incident reporting, leading to the late report. Provider #1 will ensure the Crisis Stabilization Program Manager (s) and all staff members responsible for entering SIR into CHRIS complete an Agency wide refresher training. Upcoming opportunities for training include September 27th, October 25th, November 15th and December 13th. These trainings will be led by this Provider's Quality Assurance Director and will utilize the material directly from DBHDS. Provider #1's Crisis Stabilization Program Manager will review and update this programs specific written incident reporting procedure, detailing specifications for timely incident reporting and documenting incidents in CHRIS. It is the responsibility of the Crisis Stabilization Program Manager and Program Quality Assurance Manager to maintain and track serious incident reports for this program via auditing incidents on at least a monthly basis. Provider #1's Program Manager has reviewed and ensure the Programmatic Incident Reporting workflow is updated and accurate. This has been reviewed and will continue to be reviewed during Management meetings to ensure compliance. Evidence #1 attached.	10/20/2023

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death and any treatment received. For all other Level II and Level III serious incidents, the reported information shall also include the consequences that resulted from the serious incident. Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.			OLR) Accepted 09/29/2023	

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Lakesha Steele, Incident Management
Unit

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined