License #: **1266-14-008**
Organization Name: **Rest Assured, LLC**

Date of Inspection: **03-17-2022**
Program Type/Facility Name: **14-008 3830 Monza Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115).	N	Monza Drive This regulation was NOT MET as evidenced by: See OHR citation.	PR) 04/12/2022 **PR**: The provider entered the data into CHRIS on the day of the incident (2/26/2022). The incident was reported to the Office of Licensing as the adolescent involved was not abused nor neglected by the staff. The Provider was contacted by the Advocate for the Office of Human Rights on 3/10/2022 instructing the Provider to enter the case in CHRIS to OHR because after she had reviewed it, she determined the staff on duty had been negligent. However, the Provider fails to understand how the staff had been neglectful when every procedure had been followed, according to the Policies and Procedures at the time. **ROOT CAUSE OF ANALYSIS:** All vehicle keys were located in the top desk drawer in the office. This has been the procedure since 2015 when the facility opened at this location. Although a Dutch door is at the entrance of the office, it does not deter a youth who is determined and forcibly enters and assaults a staff member. **PLAN OF ACTION:** The Provider has instituted a new policy for the location and security of vehicle keys in order to alleviate the recurrence of the case. All keys are now locked in a Lock Box and then locked in the office closet. **RECOMMENDATION:** It is the request of the Provider that the case of Neglect be rescinded as staff neglect was not proven and the case had been officially entered into CHRIS within four hours after the incident. The Provider did not fail to enter the case within the allotted time frame and had only followed the directive of the	5/2/2022

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			Advocate of OHR. OLR) Partially Accepted 04/12/2022 OHR citation below reflects non-compliance with 12VAC35-115-230 (A)(2) for late reporting and not neglect as stated in provider response. Please see OHR guidance below and resubmit. PR) 04/26/2022 PR: The incident was entered into CHRIS within four (4) hours after the incident occurred on February 26th to OL as a Serious Incident. However, it was not entered into OHR until the OHR Advocate contacted the Provider on March 10th. ROOT CAUSE ANALYSIS: The Provider was under the misconception that because the incident was neither abuse. neglect nor was the individual injured in any form, the case only had to be entered into one entity, OL. PLAN OF ACTION: Staff (Executive Assistant, Case Manager, Quality Assurance Specialist) will continue to review CHRIS Navigation Training in order to clearly understand all aspects of what should be entered and how to enter the data into CHRIS. Staff entering data into CHRIS will also contact the Quality Assurance Specialist and OHR to ensure that the correct incident level is being entered and to all parties required. Also, the Quality Assurance Specialist will review records on a weekly basis to ensure that all links are contacted and that information is entered within the required timeframe.	

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			OLR) Accepted 04/27/2022	
12VAC35-115-230. A. (2) - Providers shall collect, maintain, and report the following information concerning abuse, neglect, and exploitation: 2. The director of a service licensed or funded by the department shall report each allegation of abuse or neglect via the department's web-based reporting application within 24 hours of receipt of the allegation (see 12VAC35-115-175).	N	Monza Drive This regulation was NOT MET as evidenced by: Upon review of CHRIS entry A-20220003, the provider became aware of the incident on 2/26/2022, and the date of entry into CHRIS is 3/10/2022. As a result, the provider failed to report the allegation to the department within 24 hours of receipt.	PR) 04/12/2022 **PR**: The provider entered the data into CHRIS on the day of the incident (2/26/2022). The incident was reported to the Office of Licensing as the adolescent involved was not abused nor neglected by the staff. The Provider was contacted by the Advocate for the Office of Human Rights on 3/10/2022 instructing the Provider to enter the case in CHRIS to OHR because after she had reviewed it, she determined the staff on duty had been negligent. However, the Provider fails to understand how the staff had been neglectful when every procedure had been followed, according to the Policies and Procedures at the time. **ROOT CAUSE OF ANALYSIS:** All vehicle keys were located in the top desk drawer in the office. This has been the procedure since 2015 when the facility opened at this location. Although a Dutch door is at the entrance of the office, it does not deter a youth who is determined and forcibly enters and assaults a staff member. **PLAN OF ACTION:** The Provider has instituted a new policy for the location and security of vehicle keys in order to alleviate the recurrence of the case. All keys are now locked in a Lock Box and then locked in the office closet. **RECOMMENDATION:** It is the request of the Provider that the case of Neglect be rescinded as staff neglect was not proven and the case had been officially entered into CHRIS within four hours after the incident. The Provider did not fail to enter the case within the allotted time frame	5/2/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			and had only followed the directive of the Advocate of OHR. OHR/OLR) Partially Accepted 04/12/2022 OHR response: The provider's pledged plan of action fails to include specific details of the plan of action to address systematic changes that have been or will be implemented to ensure the provider remains in compliance of the regulation **12VAC35-115-230 (A)(2) which is for late reporting**. The provider is requested to provide specific details of how the corrective action plan will be monitored, the frequency for monitoring, and who will be responsible for the monitoring. (Ex: monthly audits, weekly chart reviews, daily checklist). PR) 04/26/2022 **PLAN OF ACTION:** Staff (Executive Assistant, Case Manager, Quality Assurance Specialist) will continue to review CHRIS Navigation Training in order to clearly understand all aspects of what should be entered and how to enter the data into CHRIS. Staff entering data into CHRIS will also contact the Quality Assurance Specialist and OHR to ensure that the correct incident level is being entered and to all parties required. Also, the Quality Assurance Specialist will review records on a weekly basis to ensure that all links are contacted and that information is entered within the required timeframe. OHR/OLR) Accepted 04/27/2022	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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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.

Tonya Carr, Legal Operations Manager	(Signature of Organization Representative)	Date

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