DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **1376-14-001**
Organization Name: **Jackson-Feild Homes**

Date of Inspection: **12-15-2021**
Program Type/Facility Name: **14-001 Jackson Feild Homes**

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	Jackson Feild Homes This regulation was NOT MET as evidenced by: See OHR citations below.	PR) 01/11/2022 See PR response below. OLR) Accepted 01/11/2022	12/20/2021
12VAC35-115-110. A. - Each individual is entitled to be completely free from any unnecessary use of seclusion, restraint, or time out.	N	Jackson Feild Homes This regulation was NOT MET as evidenced by: • Upon review of CHRIS entry 20210038, the provider's investigation determined that abuse (seclusion) was found. • Upon review of the provider's internal investigation, according to the Incident Report dated 10/31/21 written by Employee #1, Employee #1 reported that Employee #1 did close the door to Individual #1's room with the Individual #1 inside. Employee #2 also reported in the Incident Report dated 11/01/21, that Employee #1 did close the door to Individual #1's room with the Individual #1 inside. Employee #2 reported in witness statement that Employee #1 was blocking the door to Individual #1's room as Individual #1 was trying to get out. Employee #3 reported in a witness statement that Employee #3	PR) 01/11/2022 Video cameras are not allowed in the residents' bedrooms, so there is no footage of Employee #1 closing the bedroom door or Employee #1's interaction with Individual #1 inside the bedroom; however, according to the IR dated 10/31/21, written by Employee #1, Employee #1 stated that he did close the door to Individual #1's room with the resident inside. Employee #2 also wrote in the IR dated 11/01/21 that Employee #1 did close the door to Individual #1's room with the resident inside. Employee #2 stated in his witness statement that Employee #1 was blocking the door to Individual #1's bedroom as Individual #1 tried to get out. Employee #3 stated they witnessed Employee #1 "holding" Individual #1 "back from coming out of his room." These written accounts support the definition of seclusion according to DBHDS 12VAC35-115-30 and 12VAC35-105-20:	12/15/2021

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		witnessed Employee #1 holding Individual #1 back from coming out of the room. These written accounts support the definition of seclusion. • Upon review of the provider's policy, #III-8.2 Behavior Support, Jackson Field Behavioral Health Services prohibits locked seclusion. • Per statement from Employee #4 on 12/9/21, the provider does not have a policy for the use of seclusion.	"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means, so that the individual cannot leave it. Employee #1 received remediation training for Human Rights and Child Abuse & Neglect - Recognizing, as well as supervision from Senior Residential Services Supervisor (see attached training documentation and supervision logs). Provider also added a separate policy regarding seclusion (see attached policy). This topic will be discussed further with all cottage staff during the weekly cottage staff meetings. The Residential Services Supervisor will continue to provide supervision to staff related to this topic on an as needed basis. OHR/OLR) Accepted 01/11/2022	
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	Jackson Feild Homes This regulation was NOT MET as evidenced by: "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse.	PR) 01/11/2022 Individual #1 alleged that Employee #1 restrained him by putting him in a choke hold and pushing him to the ground head first. Individual #1 also stated that Employee #1 threw him onto the hard part of Individual #1's bed and put Individual #1 in a headlock against the wall and started punching Individual #1. Individual #1 stated that Employee #1 walked out of Individual #1's bedroom and then re-entered the bedroom and hit Individual #1 twice more. After reviewing the safety video, it showed Individual #1 wrapping both of his legs around the right leg of Employee #1, causing Employee	12/15/2021

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		• Upon review of CHRIS entry 20210038, the provider's investigation determined that abuse (seclusion) was found. • Upon review of the provider's internal investigation, according to the Incident Report dated 10/31/21 written by Employee #1, Employee #1 reported that Employee #1 did close the door to Individual #1's room with the Individual #1 inside. Employee #2 also reported in the Incident Report dated 11/01/21, that Employee #1 did close the door to Individual #1's room with the Individual #1 inside. Employee #2 reported in witness statement that Employee #1 was blocking the door to Individual #1's room as Individual #1 was trying to get out. Employee #3 reported in a witness statement that Employee #3 witnessed Employee #1 holding Individual #1 back from coming out of the room. These written accounts support the definition of seclusion. • Upon review of the provider's policy, #III-8.2 Behavior Support, Jackson Field Behavioral Health Services prohibits locked seclusion. • Per statement from Employee #4 on 12/9/21, the provider does not have a policy for the use of seclusion.	#1 to stumble. It appeared that Employee #1 was unable to stop the fall and both Employee #1 and Individual #1 fell to the floor together. The allegation that Employee #1 threw Individual #1 to the ground headfirst was determined as unfounded. Individual #1's behavior plan includes the use of physical restraint according to MANDT; however, potential behavior escalation that may result in the use of physical restraint was added in more detail to Individual #1's ISP (see attached ISP - under Target 3 Interventions, #7, 8 & 9). Employee #1 received remediation training for Human Rights and Child Abuse & Neglect - Recognizing, as well as supervision from the Senior Residential Services Supervisor (see attached training documents and supervision logs). This topic will be discussed further with all cottage staff during the weekly cottage staff meetings. The Residential Services Supervisor will continue to provide supervision to staff related to this topic on an as needed basis. OHR/OLR) Accepted 01/11/2022	

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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