DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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

Date of Inspection: **03-22-2022**
Program Type/Facility Name: **14-001**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. E. - Training provided shall be comprehensive and based on the needs of the population served to ensure that staff have the competencies to perform their jobs.	N	This regulation was NOT MET as evidenced by: Review of Employee #3's personnel file revealed that the employee's training was not adequate to ensure that the employee was competent to perform their job. Employee #3 had a documented disciplinary note on 2/10/22 where the supervisor evaluated the employee's performance during a serious incident and determined that he needed additional "Suicide Prevention" retraining. There was no documented evidence that the employee had received this retraining and that the provider had followed up on this need.	PR) 04/14/2022 Employee #3 received Suicide Prevention re-training on 3/25/22 (see documents attached). Going forward, the RSS will be responsible for making sure that RCs receive re-trainings within appropriate timeframes. OLR) Accepted 04/15/2022	3/25/2022
12VAC35-46-450. C. - Precautions shall be taken to prevent scalding from running water. Water temperatures shall be maintained between 100°F and 120°F.	N	This regulation was NOT MET as evidenced by: During an inspection on 3/22/22, the water temperature in a couple of the cottages was not within the regulation parameters. The water temperature in the Marshall cottage was reading at 136 degrees Fahrenheit, and the water temperature in the Gwaltney cottage was reading at 129 degrees Fahrenheit.	PR) 04/13/2022 The water temperature was adjusted by Maintenance to fall within the required temperature range of 100-120 degrees Fahrenheit. The water temperature will be checked monthly by Maintenance to ensure the temperature is maintained within the required range. OLR) Accepted 04/15/2022	3/22/2022

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12VAC35-46-480. F. - Each child shall have a separate, clean, comfortable bed equipped with a clean mattress, clean pillow, clean blankets, clean bed linens, and, if needed, a clean waterproof mattress cover.	N	This regulation was NOT MET as evidenced by: During an inspection on 3/22/22 at the Darden cottage, it was discovered that when reviewing Individual #2's bedroom his mattress was on the ground and there was no evidence that the individual had clean blankets and bed linens. The individual's bed only had a sheet on it, with no evidence of any blankets or pillowcases.	PR) 04/13/2022 Due to occasional seizure activity, Individual #2 was physician ordered to sleep on mattress only to minimize bodily injury from falling off the bed during seizure. Per the RSS, Individual #2 had removed some of his bed linens to be washed. It was decided that a special paneled base bed (lower to the floor to prevent serious injury if individual falls from bed) will be ordered for future use. RSS will be responsible for ensuring that residents place proper bed linens on their mattresses. OLR) Accepted 04/15/2022	5/18/2022
12VAC35-46-500. C. - Every sleeping area shall have a door that may be closed for privacy or quiet and this door shall be readily opened in case of fire or other emergency.	N	This regulation was NOT MET as evidenced by: During an inspection on 3/22/22 at the Darden cottage, it was discovered that every sleeping area did not have a door that may be closed for privacy or quiet. Bedroom #20 did not have a door attached at the time of the inspection, and while Employee #7 reported that the door had been damaged and the provider was waiting on a new one there were no temporary arrangements made to allow the individual to have privacy in the meantime.	PR) 04/13/2022 The original door was destroyed by a resident. No alternate covering was provided, at the time, due to resident's self-injurious and suicidal ideation behaviors. The new door was replaced by Maintenance on 4/11/22. Going forward, when possible, a room change may be implemented as a temporary alternative to ensure resident's privacy. An extra door will also be kept in stock so a replacement can be installed quickly by Maintenance, when necessary. OLR) Accepted 04/15/2022	4/11/2022

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12VAC35-46-590. B. - The interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. This includes, but is not limited to, required locks, mechanical devices, indoor and outdoor equipment, and furnishings.	N	This regulation was NOT MET as evidenced by: During an inspection on 3/22/22, the following issues were discovered with the interior of the buildings that did not promote safety, proper maintenance, cleanliness, and some items were not in good working order: Rogers Cottage: • Bedroom #4 had foul language written on the wall above the bed where the individual sleeps Darden Cottage: • Bathroom #18 had a broken sink faucet and the toilet seat was too small and did not fit properly • Bathroom #19 had a shower curtain that was dirty and had mildew collected at the bottom. The bathroom also had a dirty toilet. • Bathroom #20 had a sink that was very dirty with debris	PR) 04/13/2022 In Rodgers Cottage, Maintenance completed a paint touch-up in Bedroom #4, painting over the foul language that was written on the wall. In Darden Cottage, Maintenance repaired the broken sink faucet and installed the correct sized toilet seat in Bathroom #18. New shower curtains were installed and toilet was cleaned in Bathroom #19. The sink in Bathroom #20 was also cleaned. All repairs were completed on 3/23/22. Going forward, after the weekly cottage clean-up, the RSS will be responsible for contacting Maintenance to complete any repairs needed. OLR) Accepted 04/15/2022	3/23/2022
12VAC35-46-710. C. - The resident's record shall contain a completed assessment at the time of a routine admission or within 30 days after an emergency admission.	N	This regulation was NOT MET as evidenced by: Review of Individual #2's service record revealed that the resident's record did not contain a completed assessment at the time of a routine admission. Individual #2's biopsychosocial assessment and admission intake assessment that was completed on 5/14/21 was very minimal and multiple sections were left blank so the assessments were not reviewed for completeness.	PR) 04/13/2022 Individual #2's intake assessment and biopsychosocial assessment will be reviewed and completed by Case Manager. Going forward, the Therapist and/or Case Manager will be responsible for completing the intake assessment within seven days of admission; and, completing the biopsychosocial assessment within 30 days of admission. The CSC/UR Specialist will be responsible for reviewing the resident chart to ensure both assessments are completed within the given timeframe. OLR) Accepted 04/15/2022	4/15/2022

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12VAC35-46-800. A. (1) - There shall be evidence of a structured program of care designed to: 1. Meet the residents' physical and emotional needs;	N	This regulation was NOT MET as evidenced by: Review of Individual #2's service record revealed that there was no evidence that the provider had implemented a structured program of care designed to meet the individual's physical needs as it relates to his seizure disorder. According to Individual #2's intake paperwork and ISP he has seizures, but there was no evidence of a written seizure protocol for staff to follow if Individual #2 was exhibiting a seizure. There was a physician's order on 5/29/21 that stated staff needed to administer a medication if Individual #2 had a seizure that lasted longer than 5 minutes, but it was not clear how current and new staff were made aware of this protocol. There was evidence that staff were trained by Employee #8 on 10/6/21, but the individual was admitted in May 2021 and it was unclear how new staff would be knowledgeable and aware of the individual's protocol after the training without a written protocol put in place.	PR) 04/14/2022 From the date of Individual #2's admission, 5/13/21, there was 24-hour nursing services and the nurse on shift responded immediately to all reported seizure activity. Staff were coached and assisted with interventions and documentation of seizures by the RN on night shift at the time of seizures. There was not a formal documented training held with staff of Rodgers Cottage related to seizures. All incidents of seizure activity were reported to the resident's Neurologist. The last day of overnight nursing services was 10/3/21 and the documented training was conducted on 10/6/21. The resident was moved from Rodgers Cottage to Darden Cottage which is where the training was conducted on 10/6/21. Going forward, a formal training will be conducted within five days of admission with established protocol when a resident is admitted with a documented physical need. The specific physical need will be documented on the Special Needs Roster for the cottage which the resident resides. A copy of the Special Needs Roster is attached. The Director of Nursing will have oversight by reviewing the Special Needs Roster as needed. OLR) Accepted 04/15/2022	4/13/2022
12VAC35-46-850. G. (6) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 6. Identity of the individual who administered the medication;	N	This regulation was NOT MET as evidenced by: Review of the medication administration records (MAR) for several individuals during an inspection on 3/22/22 revealed that several medications had not been documented appropriately as administered or refused on multiple dates, and the identity of the person who	PR) 04/14/2022 On the day of review, there were residents for whom medications were documented as given for 8pm that day though medications had not yet been given. In addition, there were missing signatures for medications for a period of three days on the day of the review. Medication Administration Records for all residents are checked on a daily basis for missing signatures.	4/13/2022

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		administered the medication was not documented. The following medications were not documented properly as administered or refused on the MAR for the month of March 2022: Individual #2 • Medication #1 was documented as administered on 3/22/22 at 8pm, but the time of the inspection was around noon so the employee had not administered the medication to the individual yet but already documented it on the MAR Individual #5 • Medication #2 and Medication #3 was documented as administered on 3/22/22 at 8pm, but the time of the inspection was around noon so the employee had not administered the medication to the individual yet but already documented it on the MAR Individual #6 • Medication #4 and Medication #5 was documented as administered on 3/22/22 at 8pm, but the time of the inspection was around noon so the employee had not administered the medication to the individual yet but already documented it on the MAR Individual #7 • Medication #6 was missing documentation for the 8am shift on 3/21/22 and 3/22/22 • Medication #7 was missing documentation for the 8am shift on 3/21/22 and 3/22/22. Medication #7 was also missing documentation on 3/21/22 for the 3pm shift. • Medication #8 was missing documentation for the 8pm shift on 3/21/22	If missing signatures are found, the nurse responsible is notified and directed to sign immediately by the Director of Nursing. All shift duties are signed as completed with initials each shift. Nursing staff are signing for all medications at the time of administration only. This duty is signed for each shift by the nurse administering medications. A copy of the Daily Shift Duties form is attached. An additional LPN has been hired and is currently being trained to assist with the nursing shift duties with a priority being assisting with medication administration and documentation. An ad was placed with the goal of hiring additional part-time LPN assistance. OLR) Accepted 04/15/2022	

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		• Medication #9 was missing documentation for the 8pm shift on 3/21/22 Individual #8 • Medication #10 was missing documentation for the 8am shift on 3/20/22, 3/21/22, and 3/22/22 • Medication #11 was missing documentation for the 8am shift on 3/20/22, 3/21/22, and 3/22/22 • Medication #12 was missing documentation for the 8am shift on 3/20/22, 3/21/22, and 3/22/22 • Medication #13 was missing documentation for the 8pm shift on 3/20/22 and 3/21/22 • Medication #14 was missing documentation for the 8am shift on 3/20/22, 3/21/22, and 3/22/22 • Medication #15 was missing documentation for the 8pm shift on 3/20/22 and 3/21/22 • Medication #16 was missing documentation for the 8am shift on 3/20/22, 3/21/22, and 3/22/22		

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General Comments / Recommendations:

1. Please ensure that you encourage individuals who are completing an application for admission to answer all of the questions on the packet as the questions are all really important and relevant for intake (Individual #1's application was left blank in some sections by the referral source)

2. Please ensure that all group note documentation is uploaded into the electronic record in a timely manner

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.

Lauren Allen, Investigator	(Signature of Organization Representative)	Date

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