

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

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License #: 142-04-005

Organization Name: Virginia Commonwealth University Health System Authority

Date of Inspection: 04-12-2022

Program Type/Facility Name: 04-005 VTCC Inpatient Unit

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-160. E. (2a) - A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises. 2. The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when: 2a. A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the Safety Event Reporting policy submitted by the provider for the root cause analysis policy does not include the thresholds for when a more detailed root cause analysis will be conducted. Please submit the root cause analysis policy that indicates the threshold number for when a more detailed root cause analysis will be conducted for similar Level II serious incidents that occur to the same individual or at the same location within a six-month period.	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct</u> the deficient practice in this specific violation. The Department of Psychiatry did not have a distinct Root Cause Analysis policy that outlined thresholds for when a more detailed RCA would be conducted. Historically, it relied on the Patient Safety Departments policy to conduct RCA's. The department has since created and implemented a new policy that remains in line with the system policy, and includes the required thresholds for level II serious incident RCA's stated in the above regulation. Include a plan of action to address <u>systematic changes</u> (process/protocols, etc) that have been or will be implemented to ensure you remain in compliance of the regulation. Nursing Directors from Adult Psychiatry and VTCC collaborated with the Patient Safety Department to create a Root Cause Analysis policy (attached) that aligns with the Patient Safety	6/15/2022

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served by the provider, of similar Level II serious incidents occur to the same individual or at the same location within a six-month period;			Department's system-wide policy. This policy was reviewed by departmental leadership, Patient Safety, and Regulatory Affairs. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the <u>frequency for monitoring the plan including how it will be monitored</u> (Ex: monthly audits, weekly chart reviews, daily checklist). The Department of Psychiatry Patient Liaison will notify the nursing director of any/all level II (or greater) serious incidents that require an RCA (either at the department level, or a more detailed version). The Patient Liaison will report all serious incidents by level at the quarterly Department of Psychiatry Quality Assurance and Process Improvement meeting as a standing agenda item. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented).	

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Program Type/Facility Name: 04-005 VTCC Inpatient Unit

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			The Departmental Root Cause Analysis Policy was approved by the Adult Psychiatry and VTCC Quality Assurance and Process Improvement. With this approval, the policy is now live. OLR) Partially Accepted 08/25/2022 Review of the provider policy identifies a threshold number of 4 for when a more detailed root cause analysis will be conducted for "Level II serious incidents involving the same individual during their inpatient stay." However, the citation indicated that the provider needs identify the threshold number for when a more detailed root cause analysis will be conducted for <u>similar Level II serious incidents that occur to the same individual or at the same location within a six-month period</u>. Please update the policy and resubmit. PR) 08/26/2022 Please see the attached Root Cause Analysis policy and Risk Management Assessment to include Level II incidents occurring to the same individual or at the same location within a 6 month period. OLR) Accepted 09/19/2022	
12VAC35-105-160. E. (2b) - A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the Safety Event Reporting policy submitted by	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct</u> the deficient practice in this specific violation.	7/7/2022

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises. 2. The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when: 2b. Two or more of the same Level III serious incidents occur to the same individual or at the same location within a six-month period;		the provider for the root cause analysis policy does not include the thresholds for when a more detailed root cause analysis will be conducted. Please submit the root cause analysis policy that indicates that a more detailed root cause analysis will be conducted for two or more of the same Level III serious incidents occur to the same individual or at the same location within a six-month period.	The Department of Psychiatry did not have a distinct Root Cause Analysis policy that outlined thresholds for when a more detailed RCA would be conducted. Historically, it relied on the Patient Safety Departments policy to conduct RCA's. The department has since created and implemented a new policy that remains in line with the system policy and includes the required thresholds for level II serious incident RCA's stated in the above regulation. Include a plan of action to address <u>systematic changes (process/protocols, etc)</u> that have been or will be implemented to ensure you remain in compliance of the regulation. Nursing Directors from Adult Psychiatry and VTCC collaborated with the Patient Safety Department to create a Root Cause Analysis policy (attached) that aligns with the Patient Safety Department's system-wide policy. This policy was reviewed by departmental leadership, Patient Safety, and Regulatory Affairs. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the <u>frequency for monitoring the plan including how it will be monitored</u> (Ex: monthly audits, weekly chart reviews, daily checklist). The Department of Psychiatry Patient Liaison will notify the nursing director of any/all level II (or greater) serious incidents that require an RCA (either at the department level, or a more	

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			detailed version). In addition, all level III serious incidents will require a detailed RCA facilitated by the Patient Safety Department. The Patient Liaison will report all serious incidents by level at the quarterly Department of Psychiatry Quality Assurance and Process Improvement meeting as a standing agenda item. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). The Departmental Root Cause Analysis Policy was approved by the Adult Psychiatry and VTCC Quality Assurance and Process Improvement committees. With this approval, the policy is now live. OLR) Accepted 08/25/2022	
12VAC35-105-160. E. (2c) - A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises. 2. The provider shall develop and implement a root cause analysis	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the Safety Event Reporting policy submitted by the provider for the root cause analysis policy does not include the thresholds for when a more detailed root cause analysis will be conducted. Please submit the root cause analysis policy that indicates the threshold number for when a more detailed root cause analysis will be conducted for similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period.	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. The Department of Psychiatry did not have a distinct Root Cause Analysis policy that outlined thresholds for when a more detailed RCA would be conducted. Historically, it relied on the Patient Safety Departments policy to conduct RCA's. The department has since created and implemented a new policy that remains in line with the system policy and includes the required	7/7/2022

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when: 2c. A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period;			thresholds for level II and level III serious incident RCA's stated in the above regulation. Include a plan of action to address systematic changes (process/protocols, etc) that have been or will be implemented to ensure you remain in compliance of the regulation. Nursing Directors from Adult Psychiatry and VTCC collaborated with the Patient Safety Department to create a Root Cause Analysis policy (attached) that aligns with the Patient Safety Department's system-wide policy. This policy was reviewed by departmental leadership, Patient Safety, and Regulatory Affairs. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist). The Department of Psychiatry Patient Liaison will notify the nursing director of any/all level II (or greater) serious incidents that require an RCA (either at the department level, or a more detailed version). The Patient Liaison will report all serious incidents by level at the quarterly Department of Psychiatry Quality Assurance and Process Improvement meeting as a standing agenda item.	

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			By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). The Departmental Root Cause Analysis Policy was approved by the VTCC and Adult Psychiatry Quality Assurance and Process Improvement committees. With this approval, the policy is now live. OLR) Accepted 08/25/2022	
12VAC35-105-160. E. (2d) - A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises. 2. The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the Safety Event Reporting policy submitted by the provider for the root cause analysis policy does not include the thresholds for when a more detailed root cause analysis will be conducted. Please submit the root cause analysis policy that indicates that a more detailed root cause analysis will be conducted for a death that occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. The Department of Psychiatry did not have a distinct Root Cause Analysis policy that outlined thresholds for when a more detailed RCA would be conducted. Historically, it relied on the Patient Safety Departments policy to conduct RCA's. The department has since created and implemented a new policy that remains in line with the system policy and includes the required thresholds for level II and level III serious incident RCA's stated in the above regulation. Include a plan of action to address systematic changes (process/protocols, etc) that have been or will be implemented to ensure you remain in compliance of the regulation. Nursing Directors from Adult Psychiatry and	7/7/2022

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provider to conduct a more detailed root cause analysis when: 2d. A death occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.			VTCC collaborated with the Patient Safety Department to create a Root Cause Analysis policy (attached) that aligns with the Patient Safety Department's system-wide policy. This policy was reviewed by departmental leadership, Patient Safety, and Regulatory Affairs. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist). The Department of Psychiatry Patient Liaison will notify the nursing director of any/all level II (or greater) serious incidents that require an RCA (either at the department level, or a more detailed version). The Patient Liaison will report all serious incidents by level at the quarterly Department of Psychiatry Quality Assurance and Process Improvement meeting as a standing agenda item. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). The Departmental Root Cause Analysis Policy was approved by the VTCC and Adult Psychiatry Quality Assurance and Process Improvement committees. With this approval, the policy is now live.	

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12VAC35-105-620. B. - B. The quality improvement program shall utilize standard quality improvement tools, including root cause analysis, and shall include a quality improvement plan.	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the provider's Quality Improvement Program submitted does not include Quality Improvement Tools. Please refer to page 3 of the OL website for Tools for Developing a Quality Improvement Program- https://dbhds.virginia.gov/wp-content/uploads/2022/02/Tools-for-Developing-a-Quality-Improvement-Program-02.2022.pdf	OLR) Accepted 08/25/2022 PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct</u> the deficient practice in this specific violation. The department of psychiatry quality improvement plan did not list quality improvement tools for both adult and pediatric inpatient services (VTCC). Include a plan of action to address <u>systematic changes (process/protocols, etc)</u> that have been or will be implemented to ensure you remain in compliance of the regulation. The Department of Psychiatry revised the quality improvement plan to include quality improvement tools for both adult and pediatric inpatient services (VTCC). Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the <u>frequency for monitoring the plan including how it will be monitored</u> (Ex: monthly audits, weekly chart reviews, daily checklist). The quality improvement plan will be evaluated at least annually by the Department of Psychiatry QAPI.	7/1/2022

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). The Department of Psychiatry quality improvement plan was updated on July 1st, 2022. OLR) Accepted 08/25/2022	
12VAC35-105-620. C. (4) - The quality improvement plan shall: 4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170;	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the provider's Quality Improvement Plan does not monitor implementation and effectiveness of approved corrective action plans. Please refer to information starting on the bottom of page 3 of the OL website Sample Quality Improvement Plan to update the Quality Improvement Plan- https://dbhds.virginia.gov/assets/doc/QMD/OL/sample-provider-quality-improvement-plan-6-2021.pdf	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct</u> the deficient practice in this specific violation. The department of psychiatry quality improvement plan did not include monitoring of implementation and effectiveness of approved corrective action plans for both adult and pediatric inpatient services (VTCC). Include a plan of action to address <u>systematic changes (process/protocols, etc)</u> that have been or will be implemented to ensure you remain in compliance of the regulation. The Department of Psychiatry revised the quality improvement plan to include monitoring of implementation and effectiveness of approved corrective action plans for both adult and pediatric inpatient services (VTCC). Include Staff by Title who will monitor the	7/1/2022

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			procedures implemented to ensure you stay in compliance with the regulation. Indicate the <u>frequency for monitoring the plan including how it will be monitored</u> (Ex: monthly audits, weekly chart reviews, daily checklist). The quality improvement plan will be evaluated at least annually by the Department of Psychiatry QAPI. Department of Psychiatry Nursing Directors will monitor the implementation and effectiveness of approved corrective actions plans at least quarterly with the Department of Psychiatry QAPI committee. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). The Department of Psychiatry quality improvement plan was updated on July 1st, 2022. OLR) Accepted 08/25/2022	
12VAC35-105-620. D. (1) - The provider's policies and procedures shall include the criteria the provider will use to: 1. Establish measurable goals and objectives;	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the Quality Improvement Program submitted does not include the criteria the provider will use to establish measurable goals and objectives. Please refer to criteria starting at the bottom of page 5 of the OL website to update the Quality Improvement Program and resubmit- https://dbhds.virginia.gov/wp-content/uploads/2022/02/Tools-for-Developing-a-Quality-Improvement-Program-02.2022.pdf	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct</u> the deficient practice in this specific violation. The department of psychiatry quality improvement plan did not include the criteria the provider will use to establish measurable goals and objectives for both adult and pediatric inpatient	7/1/2022

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			services (VTCC). Include a plan of action to address <u>systematic changes (process/protocols, etc)</u> that have been or will be implemented to ensure you remain in compliance of the regulation. The Department of Psychiatry revised the quality improvement plan to include the criteria the provider will use to establish measurable goals and objectives for both adult and pediatric inpatient services (VTCC). Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the <u>frequency for monitoring the plan including how it will be monitored</u> (Ex: monthly audits, weekly chart reviews, daily checklist). The quality improvement plan will be evaluated at least annually by the Department of Psychiatry QAPI and nursing directors. By what date you will have each planned	

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			corrective action completed (Ex. Date training completed or Date protocol implemented). The Department of Psychiatry quality improvement plan was updated on July 1st, 2022. OLR) Accepted 08/25/2022	
12VAC35-105-620. D. (2) - The provider's policies and procedures shall include the criteria the provider will use to: 2. Update the provider's quality improvement plan;	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the Quality Improvement Program submitted does not include the criteria the provider will use to update the provider's quality improvement plan. Please refer to criteria starting at the bottom of page 5 of the OL website to update the Quality Improvement Program and resubmit- https://dbhds.virginia.gov/wp-content/uploads/2022/02/Tools-for-Developing-a-Quality-Improvement-Program-02.2022.pdf	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct</u> the deficient practice in this specific violation. The department of psychiatry quality improvement plan did not include the criteria the provider will use to update the provider's quality improvement plan for both adult and pediatric inpatient services (VTCC). Include a plan of action to address <u>systematic changes (process/protocols, etc)</u> that have been or will be implemented to ensure you remain in compliance of the regulation. The Department of Psychiatry revised the quality improvement plan to include the criteria the provider will use to update the provider's quality improvement plan for both adult and pediatric inpatient services (VTCC). Include Staff by Title who will monitor the	7/1/2022

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			procedures implemented to ensure you stay in compliance with the regulation. Indicate the <u>frequency for monitoring the plan including how it will be monitored</u> (Ex: monthly audits, weekly chart reviews, daily checklist). The quality improvement plan will be evaluated at least annually by the Department of Psychiatry QAPI and nursing directors. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). The Department of Psychiatry quality improvement plan was updated on July 1st, 2022. OLR) Accepted 08/25/2022	
12VAC35-105-620. D. (3) - The provider's policies and procedures shall include the criteria the provider will use to: 3. Submit revised corrective action plans to the department for approval or continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies when reviews	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of the Quality Improvement Program submitted does not include the criteria the provider will use to submit revised corrective action plans to the department. Please refer to criteria starting at the bottom of page 5 of the OL website to update the Quality Improvement Program and resubmit- https://dbhds.virginia.gov/wp-content/uploads/2022/02/Tools-for-Developing-a-Quality-Improvement-Program-02.2022.pdf	PR) 07/07/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct the deficient practice in this specific violation.</u> The department of psychiatry quality improvement plan did not include the criteria the provider will use to update the provider's quality improvement plan for both adult and pediatric inpatient services (VTCC).	7/1/2022

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determine that a corrective action was fully implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to 12VAC35-105-170.			Include a plan of action to address <u>systematic changes</u> (<u>process/protocols, etc</u>) that have been or will be implemented to ensure you remain in compliance of the regulation. The Department of Psychiatry revised the quality improvement plan to include the criteria the provider will use to update the provider's quality improvement plan for both adult and pediatric inpatient services (VTCC). Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the <u>frequency for monitoring the plan including how it will be monitored</u> (Ex: monthly audits, weekly chart reviews, daily checklist). The quality improvement plan will be evaluated at least annually by the Department of Psychiatry QAPI and nursing directors. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented).	

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			The Department of Psychiatry quality improvement plan was updated on July 1st, 2022. OLR) Accepted 08/25/2022	
12VAC35-105-650. F. (6) - A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of developmental services. It shall address: 6. Financial resources and benefits;	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: Review of Individual #1's comprehensive assessment does not include financial resources and benefits. The provider's new EPIC system has several tabs related to financial resources, however it was not included as part of the comprehensive assessment. Please update the comprehensive assessment to include financial resources and benefits.	PR) 07/15/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will correct</u> the deficient practice in this specific violation. The VTCC Psychosocial assessment did not contain all the required elements of the Comprehensive Assessment. These elements exist in various parts of the electronic medical record, but not in a single document. Include a plan of action to address <u>systematic changes (process/protocols, etc)</u> that have been or will be implemented to ensure you remain in compliance of the regulation. The Director for Care Coordination met with the VTCC Social Sorkers to walk through the documentation process for the VTCC Psychosocial Admission Assessment and History. The Director for Care Coordination, Care Coordination Manager, Social Work Clinician for Care Coordination, and Regulatory Affairs manager met to update the Psychosocial Assessment (Comprehensive Assessment) document to contain the required elements of the Comprehensive Assessment (in conjunction with the medical assessment elements contained within the H&P). The Social Work Clinician for	7/18/2022

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			Care Coordinators educated VTCC Social Workers on the new template. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist). The Social Work Clinician for Care Coordination will monitor that the updated Psychosocial Assessment (Comprehensive Assessment) template is completed all VTCC social workers through monthly chart audits until 100% compliance has been met for 3 consecutive months. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). The education of VTCC social workers on the required financial resources documentation occurred on July 14, 2022. The updated Psychosocial Assessment (Comprehensive Assessment) template was completed on July 15, 2022. The goal implantation date for this template is July 18, 2022. OLR) Accepted 08/25/2022	
12VAC35-105-660. B. - The provider shall develop and implement an initial person-	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by:	PR) 07/14/2022 Provide a statement of the issue that led to non-compliance and state <u>how you corrected/will</u>	10/1/2022

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License #: 142-04-005

Organization Name: Virginia Commonwealth University Health System Authority

Date of Inspection: 04-12-2022

Program Type/Facility Name: 04-005 VTCC Inpatient Unit

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
centered ISP for the first 60 days for developmental services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first.		Review of Individual #1's ISP reveals that it was not signed within 24 hours of admission. The individual was admitted on 3/31/2022, and the individual and all staff signed the document on 4/4/2022.	<u>correct the deficient practice in this specific violation.</u> An individual patient's treatment plan was not signed by the provider within 24 hours of admission. Clarification was needed on who can sign the treatment plans, when each team member was responsible for signing the treatment plans. In addition, the process flow for providers signing treatment plans within Epic needed to be streamlined / corrected. <u>Include a plan of action to address <u>systematic changes (process/protocols, etc)</u> that have been or will be implemented to ensure you remain in compliance of the regulation.</u> On May 3, 2022, providers were educated on the importance of signing treatment plans within 24 hours of admission in the new EHR. A electronic medical record ticket was submitted to modify the current treatment plan process to include a BPA (best practice advisory) alerting providers that a treatment plan has not been signed before reaching the 24-hour admission mark. In addition, the process flow for providers signing treatment plans within Epic was streamlined. <u>Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist).</u> Clinical coordinators will complete monthly chart	

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Program Type/Facility Name: 04-005 VTCC Inpatient Unit

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			audits to monitor compliance with signing treatment plans within the 24 hours timeframe at admission. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). Education on treatment plans was complete on May 3, 2022. BPA (alert in Epic electronic medical record) for treatment plan signatures to be completed by October 1, 2022. OLR) Accepted 08/25/2022	

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Program Type/Facility Name: 04-005 VTCC Inpatient Unit

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
General Comments / Recommendations: Recommendations: 160 C.- The provider is completing the required elements of the quarterly review of serious incidents separately; however it is recommended that the provider consolidate all of the information into a single document. Please refer to the page 9 of the Guidance for Serious Incident Reporting- https://www.townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6415_v2.pdf 520. C- The provider is completing the required elements of the systemic risk assessment review separately; however, it is recommended that the provider consolidate all of the information into a single systemic risk assessment review document. Please refer to the Sample Systemic Risk Assessment Review found on the OL website- https://dbhds.virginia.gov/wp-content/uploads/2022/02/sample-provider-systemic-risk-assessment-revised-2-2022.pdf 440- The provider is completing objectives and philosophy and criteria within other training requirements, however it is recommended that the provider distinguish it separately. The provider also reviews person centeredness within the STAR service, and it is recommended that that provider distinguish it separately within a checklist of orientation. It is recommended that the provider develop an orientation checklist including all criteria specific to regulation. 620- The provider is doing 620 C 1, 2, 5 in various places, however they need to be consolidated. The provider demonstrated that they are implementing their pledged corrective action for a citation of late serious incident reporting, however the Quality Improvement Plan does not include details as to how the provider will monitor implementation and effectiveness of approved corrective action plans.				
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.				
Josie Russell, Investigator		(Signature of Organization Representative)		Date
C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined				