

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

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License #: **2172-14-001**

Organization Name: **Kempsville Center for Behavioral Health**

Date of Inspection: **07-05-2023**

Program Type/Facility Name: **14-001 The Kempsville Center for B.H.**

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-46-1070. C. - The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; 6. The name of the person to whom the report was made.	N	The Kempsville Center for B.H. This regulation was NOT MET as evidenced by: CHRIS Number: 20230020 Date/Time of Discover: 06/17/2023 12:00AM Enter Date/Time: 06/19/2023 11:10AM Reporting Delay: 35:10:00 Location Name: The Kempsville Center for B.H.	PR) 07/26/2023 PR) The Director of Risk Management will re-educate all nursing staff during shift change by 7/31/23, to complete an incident report immediately following an incident and if the incident is after regular business hours to notify the Administrator on Call or the Director of Risk Management to ensure timely reporting to the Office of Human Rights and Licensing. Once notification is made with all pertinent information the Director of Risk Management or designee will notify the Office of Licensing within 24 hours of any serious illness/injury and include the date and time the incident occurred, a brief description of the incident, any actions taken as a result of the incident, the name of the person who completed the report, the name of the person who made the report to the placing agency and to the parent an/or legal guardian, and the name of the person to whom the report was made. A signed attestation will be kept in each nurses training file as acknowledgement of the training. OLR) Partially Accepted 08/09/2023 In addition to the above, the provider response needs to include the following: 1. Staff by title responsible for monitoring process implemented to ensure timely data entry of Level II and Level III incidents into CHRIS. This role should be someone other than the person who is responsible for entering the data in CHRIS where possible. 2. Indicate the frequency for monitoring the plan including how it will be monitored	8/28/2023

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License #: 2172-14-001

Organization Name: Kempsville Center for Behavioral Health

Date of Inspection: 07-05-2023

Program Type/Facility Name: 14-001 The Kempsville Center for B.H.

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			(Ex: daily checks, monthly audits, weekly chart reviews, quarterly checklist). PR) 08/28/2023 PR) The Director of Nursing is responsible for ensuring incident reports are turned in timely to the Risk Management department and the Director of Risk Management/Performance Improvement is responsible for ensuring timely reporting into the CHRIS system. The Director of Risk Management/Performance Improvement will monitor 100% of incident reports for compliance with completion of the incident reports and turned into Risk Management within the appropriate timeframe as well as compliance with incident being entered into the CHRIS system within 24 hours of the incident occurring through daily checks and monthly audits. Compliance will be reported by the Director of Risk Management to Quality Council on a monthly basis. OLR) Accepted 08/28/2023	

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Date of Inspection: **07-05-2023**

Program Type/Facility Name: **14-001 The Kempsville Center for B.H.**

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
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				