DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **2240-14-009**
Organization Name: **Center for Discovery**

Date of Inspection: **11-29-2023**
Program Type/Facility Name: **14-009 Center for Discovery- Monterey**

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	Center for Discovery- Monterey This regulation was NOT MET as evidenced by: See OHR citation below.		
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	Center for Discovery- Monterey This regulation was NOT MET as evidenced by: "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. Due to a preponderance of evidence, including eyewitness statements, staff admissions, failure to follow behavior/ management plan, and failure to follow policy, the Provider has substantiated A#20230006. During the medication distribution, Employee #1 left Medication #1 within reach of Individual #1, allowing	PR) 12/10/2023 **Statement of the issue that led to non-compliance:** A patient expressed suicidal thoughts to a staff member. Per company policy, a suicide rescreening should have been completed, the staff member failed to do so. The staff member took that patient into the med room, took medication out of the locked medicine cabinet, and left the medication bottles on the desk. The patient reached over, grabbed the bottle, and attempted to swallow the contents. **Statement of how you corrected the issue:** *Physical changes made to the environment;* A visual barrier has been placed in the med room.	12/10/2023

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		Individual #1 to swallow more pills than prescribed. The Provider failed to protect Individual #1 from harm.	There is a long line red line indicating the barrier that a patient should never cross. A red X has been placed where the patient must stand to receive medication, and a red equal sign has been placed to indicate where staff should be standing while passing medication. *Changes in procedure;* The medication pass procedure has changed. Staff is to reference EMR medication administration and prepare medication before the patient comes into the med room. After confirming the right name, right medication, right time, and right dose no less than three times, the staff is to lock up the medication and then bring the patient into the med room. *Staff training;* An all-staff mandatory medication training occurred to educate staff on changes made to procedures and implement policy and procedures. An all-staff mandatory training occurred regarding suicide screenings and protocol. The material covered was as follows: Using multiple assessments to determine the risk of suicide (e.g., family BPS, BPS, Columbia Assessment)	

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			Scoring the suicide risk screen correctly and ensuring review prior to submission Understanding the mitigation strategies in DBH policy and how to implement them (flags, treatment plans, 1:1, rounds, etc.) Understanding the requirement to secure and upload documentation from other providers (e.g. ER, HLOC visit outcomes) Understanding scope of practice (what technicians can and should do vs. what a qualified mental health professional and nurses can and should do) Emphasizing the need to document any and all interactions with patients, parents, and other providers in coordination of care. *Disciplinary action;* A final written notice was presented to the staff who did not follow policy and procedure. **Ensurance of compliance:** The Program administrator is to ensure visual barriers remain intact during	

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			weekly walkthroughs of the facility. Med room procedures and suicide rescreening procedures will be reviewed during mandatory monthly staff meetings. Weekly chart audits are conducted by the Program Administrator and a Mental Health Compliance Administrator to ensure compliance with the policy on suicide rescreening timelines. OHR/OLR) Accepted 12/12/2023	

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.

Deborah Lochart, Human Rights | (Signature of Organization Representative) | Date

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