

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

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Investigation ID: 177

License #: 2917-14-001

Organization Name: Three Rivers Treatment Center, LLC

Date of Inspection: 04-05-2023

Program Type/Facility Name: 14-001 Three Rivers Treatment Center

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-46-750. A. - An individualized service plan shall be developed and placed in the resident's record within 30 days following admission and implemented immediately thereafter.	N	Three Rivers Treatment Center This regulation was NOT MET as evidenced by: The provider did not implement the service plans for Individuals #1,#2, #3, #4, #5 #6, and #7. Each individual's Service Plan require they each be within eyesight of staff personnel every 5 minute and were required to be supervised for possible elopement and self harm. The individuals were left alone for over 7 minutes per video camera review.	PR) 07/26/2023 PR1: On April 4, 2023 at or about 2200, Individuals 1 & 2 were encouraging and assisting Individuals 3-12 to assist in breaking one of the windows on Unit 2 and attempting to break down the fire exit. One pane of the triple paned security window was shattered; the door held. Staff on the unit were attempting redirection and de-escalation. Employee 3 had taken Individual 03 into the phone room to attempt further redirection when an unidentified individual punched a staff member, leading to Individuals 2 -9 and 11-12 led by Individual 1 to punch and kick at this staff member as well. Employee 3 left Individual 3 in the phone room to assist staff being attacked. Individual 3 called the police of her volition. Additional staff responded and eventually redirected Individuals 1-12. Following this incident Interviews with staff and residents, incident debrief, and video review indicate that this incident began at approximately 2100 hours with resident threats to staff and an attempt to break out a window in the rear dayroom. Despite threats of physical violence to staff, staff should have engaged to de-escalate the situation at that time and did not. Finding: Staff failed to engage aggressive residents in a timely manner in order to maintain safety in the milieu. Once physicality initiated between residents and staff, several staff were injured with one having several braids pulled from her head. However, video review does reveal that in attempting to defend themselves and restore order, staff did inadvertently utilize unauthorized holds during restraint.	8/31/2023

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			Finding: The use of unauthorized holds, regardless of reason, violates regulations and Three Rivers policy and is considered physically abusive. The incident and action taken as a result of this incident was not properly documented in either the incident reporting system or the clinical record. Finding: Failure to document is substantiated for neglect. Correction: Incident was thoroughly documented as a result of investigation into allegations of abuse/neglect. Clinical records were updated accordingly. PR2: Three Rivers uses Handle With Care as a behavior management program. Employee 3 is a certified instructor in HWC; however, Three Rivers has removed Employee 3 from the teaching roster for this program. Both Employees 2 and 3 & 3 will need to recertify in HWC. An incident debriefing was conduct for involved staff on April 12 where actions were critiqued. On-site training in our EMR has been provided to all staff, stressing the importance of timely incident documentation and clinical documentation. Incident reporting and restraint procedures continue to be reviewed. PR3: Incident reporting in general and for incidents of restrain/seclusion are reviewed daily by Risk Management, weekends and holidays excepted. Incidents that have occurred on a weekend or holiday are reviewed the next business day following the weekend or holiday. Incidents of reported restraint will include a	

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			clinical and video review to insure proper procedures were followed and documentation present. PR4: July 31, 2023 OLR) Not Accepted 07/31/2023 The provider did not address the description of the non-compliance within the citation. The citation is concerning the lack of supervision and not following Individuals #1, #2, #3, #4, #5, #6 and #7's ISPs. Please submit correction plan for addressing the training of staff concerning the requirements of each individuals ISP and supervision requirements and that staff understand the reasons for the supervision requirements. PR) 08/17/2023 A training module specifically addressing ISP review and implementation will be added to the EMR documentation training. This module will be presented to current staff and add to our orientation program for new staff. The program will focus on review of the ISP and those responsible for individual tasks. Supervision requirements will also be a focus and understanding of supervision requirements and documentation will be evaluated. OLR) Accepted 08/17/2023	
12VAC35-46-920. (5) - The following actions are prohibited: 5. Deprivation of	N	Three Rivers Treatment Center This regulation was NOT MET as evidenced by:	PR) 07/26/2023 PR1: On April 4, 2023 at or about 2200, Individuals 1 & 2 were encouraging and assisting Individuals 3-12 to assist in breaking one of the	7/31/2023

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appropriate services and treatment;		Individual #1, #2, #3, #4, #5, #6, and #7 were not provided appropriate treatment. The individual's were allowed to escalate in a group without staff supervision. When staff did interact with the individual's it appears via video recording that staff were engaging in loud vocal exchanges, based on the staffs body movements, including head and arm gestures. Per video recording staff also did not use approved behavioral management strategies. In one instance it appears Individual #2 was put in a hold where staff placed their arm around Individual #2's neck and held her there for over 45 seconds. Additional non-therapeutic restraints were also noted.	windows on Unit 2 and attempting to break down the fire exit. One pane of the triple paned security window was shattered; the door held. Staff on the unit were attempting redirection and de-escalation. Employee 3 had taken Individual 03 into the phone room to attempt further redirection when an unidentified individual punched a staff member, leading to Individuals 2 -9 and 11-12 led by Individual 1 to punch and kick at this staff member as well. Employee 3 left Individual 3 in the phone room to assist staff being attacked. Individual 3 called the police of her volition. Additional staff responded and eventually redirected Individuals 1-12. Following this incident Interviews with staff and residents, incident debrief, and video review indicate that this incident began at approximately 2100 hours with resident threats to staff and an attempt to break out a window in the rear dayroom. Despite threats of physical violence to staff, staff should have engaged to de-escalate the situation at that time and did not. Finding: Staff failed to engage aggressive residents in a timely manner in order to maintain safety in the milieu. Once physicality initiated between residents and staff, several staff were injured with one having several braids pulled from her head. However, video review does reveal that in attempting to defend themselves and restore order, staff did inadvertently utilize unauthorized holds during restraint. Finding: The use of unauthorized holds, regardless of reason, violates regulations and Three Rivers policy and is considered physically abusive.	

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			The incident and action taken as a result of this incident was not properly documented in either the incident reporting system or the clinical record. Finding: Failure to document is substantiated for neglect. Correction: Incident was thoroughly documented as a result of investigation into allegations of abuse/neglect. Clinical records were updated accordingly. PR2: Three Rivers uses Handle With Care as a behavior management program. Employee 3 is a certified instructor in HWC; however, Three Rivers has removed Employee 3 from the teaching roster for this program. Both Employees 2 and 3 & 3 will need to recertify in HWC. An incident debriefing was conduct for involved staff on April 12 where actions were critiqued. On-site training in our EMR has been provided to all staff, stressing the importance of timely incident documentation and clinical documentation. Incident reporting and restraint procedures continue to be reviewed. PR3: Incident reporting in general and for incidents of restrain/seclusion are reviewed daily by Risk Management, weekends and holidays excepted. Incidents that have occurred on a weekend or holiday are reviewed the next business day following the weekend or holiday. Incidents of reported restraint will include a clinical and video review to insure proper procedures were followed and documentation present. PR4: July 31, 2023	

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			OLR) Accepted 07/31/2023	
12VAC35-46-940. G. - Trained staff members may physically restrain a resident only after less restrictive interventions.	N	Three Rivers Treatment Center This regulation was NOT MET as evidenced by: Based on video review and interview with Employee #4, staff did not use less restrictive interventions before using physical restraints.	PR) 07/26/2023 PR1: On April 4, 2023 at or about 2200, Individuals 1 & 2 were encouraging and assisting Individuals 3-12 to assist in breaking one of the windows on Unit 2 and attempting to break down the fire exit. One pane of the triple paned security window was shattered; the door held. Staff on the unit were attempting redirection and de-escalation. Employee 3 had taken Individual 03 into the phone room to attempt further redirection when an unidentified individual punched a staff member, leading to Individuals 2 -9 and 11-12 led by Individual 1 to punch and kick at this staff member as well. Employee 3 left Individual 3 in the phone room to assist staff being attacked. Individual 3 called the police of her volition. Additional staff responded and eventually redirected Individuals 1-12. Following this incident Interviews with staff and residents, incident debrief, and video review indicate that this incident began at approximately 2100 hours with resident threats to staff and an attempt to break out a window in the rear dayroom. Despite threats of physical violence to staff, staff should have engaged to de-escalate the situation at that time and did not. Finding: Staff failed to engage aggressive residents in a timely manner in order to maintain safety in the milieu. Once physicality initiated between residents and staff, several staff were injured with one having several braids pulled from her head. However, video review does reveal that in attempting to defend themselves and restore order, staff did	7/31/2023

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			inadvertently utilize unauthorized holds during restraint. Finding: The use of unauthorized holds, regardless of reason, violates regulations and Three Rivers policy and is considered physically abusive. The incident and action taken as a result of this incident was not properly documented in either the incident reporting system or the clinical record. Finding: Failure to document is substantiated for neglect. Correction: Incident was thoroughly documented as a result of investigation into allegations of abuse/neglect. Clinical records were updated accordingly. PR2: Three Rivers uses Handle With Care as a behavior management program. Employee 3 is a certified instructor in HWC; however, Three Rivers has removed Employee 3 from the teaching roster for this program. Both Employees 2 and 3 & 3 will need to recertify in HWC. An incident debriefing was conduct for involved staff on April 12 where actions were critiqued. On-site training in our EMR has been provided to all staff, stressing the importance of timely incident documentation and clinical documentation. Incident reporting and restraint procedures continue to be reviewed. PR3: Incident reporting in general and for incidents of restrain/seclusion are reviewed daily by Risk Management, weekends and holidays excepted. Incidents that have occurred on a weekend or holiday are reviewed the next	

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			business day following the weekend or holiday. Incidents of reported restraint will include a clinical and video review to insure proper procedures were followed and documentation present. PR4: July 31, 2023 OLR) Accepted 07/31/2023	
12VAC35-46-940. L. - Any time children are present staff shall be present who have completed all trainings in behavior intervention.	N	Three Rivers Treatment Center This regulation was NOT MET as evidenced by: Per camera #3 file footage, five individuals walked into the back day room at 22:59:50 with no supervision. At 23:04:08 an additional individual walk into the back day room for a total of 6 unsupervised individuals. At 23:07:32 a staff member walks into the room. Individuals were left unattended for over 7 minutes without supervision.	PR) 07/26/2023 PR1: On April 4, 2023 at or about 2200, Individuals 1 & 2 were encouraging and assisting Individuals 3-12 to assist in breaking one of the windows on Unit 2 and attempting to break down the fire exit. One pane of the triple paned security window was shattered; the door held. Staff on the unit were attempting redirection and de-escalation. Employee 3 had taken Individual 03 into the phone room to attempt further redirection when an unidentified individual punched a staff member, leading to Individuals 2 -9 and 11-12 led by Individual 1 to punch and kick at this staff member as well. Employee 3 left Individual 3 in the phone room to assist staff being attacked. Individual 3 called the police of her volition. Additional staff responded and eventually redirected Individuals 1-12. Following this incident Interviews with staff and residents, incident debrief, and video review indicate that this incident began at approximately 2100 hours with resident threats to staff and an attempt to break out a window in the rear dayroom. Despite threats of physical violence to staff, staff should have engaged to de-escalate the situation at that time and did not. Finding: Staff failed to engage aggressive residents in a timely manner in order to maintain	7/31/2023

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			safety in the milieu. Once physicality initiated between residents and staff, several staff were injured with one having several braids pulled from her head. However, video review does reveal that in attempting to defend themselves and restore order, staff did inadvertently utilize unauthorized holds during restraint. Finding: The use of unauthorized holds, regardless of reason, violates regulations and Three Rivers policy and is considered physically abusive. The incident and action taken as a result of this incident was not properly documented in either the incident reporting system or the clinical record. Finding: Failure to document is substantiated for neglect. Correction: Incident was thoroughly documented as a result of investigation into allegations of abuse/neglect. Clinical records were updated accordingly. PR2: Three Rivers uses Handle With Care as a behavior management program. Employee 3 is a certified instructor in HWC; however, Three Rivers has removed Employee 3 from the teaching roster for this program. Both Employees 2 and 3 & 3 will need to recertify in HWC. An incident debriefing was conduct for involved staff on April 12 where actions were critiqued. On-site training in our EMR has been provided to all staff, stressing the importance of timely incident documentation and clinical documentation. Incident reporting and restraint	

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			procedures continue to be reviewed. PR3: Incident reporting in general and for incidents of restrain/seclusion are reviewed daily by Risk Management, weekends and holidays excepted. Incidents that have occurred on a weekend or holiday are reviewed the next business day following the weekend or holiday. Incidents of reported restraint will include a clinical and video review to insure proper procedures were followed and documentation present. PR4: July 31, 2023 OLR) Accepted 07/31/2023	
12VAC35-46-960. I. - All space in the seclusion room shall be visible through the locked door, either directly or by mirrors	N	Three Rivers Treatment Center This regulation was NOT MET as evidenced by: The The provider did not follow their own policies and procedure for use of a seclusion room. The providers policies state that when anyone is in a seclusion room they will be visually monitored at all times. Three staff pushed Individual #1 into the seclusion room, stayed at the door for two minutes, then all three staff walked away. No staff returned by the time the video surveillance clip ended that the LS was reviewing. Individual #1 was in the seclusion room for a minimum of two minutes without supervision.	PR) 07/26/2023 All space in the seclusion is visible. Staff were able to monitor Individual 1 through the door from the hall. If they had been in the room with the Individual, it would not have been a seclusion event. The hallway from which staff viewed Individual 1 is not captured by video cameras located in the seclusion room. OLR) Accepted 07/31/2023	7/26/2023

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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.				
_____ Cynthia Gwinn, Licensing Specialist		_____ (Signature of Organization Representative)		_____ Date
C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined				