

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

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Investigation ID: 179

License #: 2917-14-001

Organization Name: Three Rivers Treatment Center, LLC

Date of Inspection: 05-17-2023

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>
12VAC35-46-800. A. (2) - There shall be evidence of a structured program of care designed to: 2. Provide protection, guidance, and supervision;	N	Three Rivers Treatment Center This regulation was NOT MET as evidenced by: Based on a review of the treatment plans for Individual #1 and Individual #2 which required each individual to be within eyesight at every 5 minutes and via interview with Employee #, it was known among staff that these individuals were talking about how they were going "to get out" of the facility. The provider failed to provide protection, guidance and supervision, which resulted in Individual #1 and Individual #2 eloping from the facility on 5/1/2023 at approximately 6:30pm	PR) 07/06/2023 PR1: Facility staff's response to this incident was prompt and appropriate. Facility policies were followed, and all required external agencies were informed. Review of the incident found that the fence was not breeched, and the gates were secure; however, one external gate at the kitchen was not secured as tightly as it could have been. Gates are currently secured using a chain and a padlock. It is believed that the loose chain on the kitchen gate may have allowed Individuals 1 & 2 to have slipped through. Both Individuals were ordered to be on every 5-minute checks. Clinical records prior to the elopement document that these checks were maintained. Additionally, facility staff have conducted simulations – both Individuals could cross the courtyard from the main play area to any gate in the fence in well under 5 minutes. We do not believe that any failure of protection, guidance and supervision occurred during this incident except for the possibility the kitchen gate was loosely secured. The last to use this gate legitimately was the facility's pest control contractor. All contractors have been briefed on the requirement to secure all gates tightly. Additional checks of each gate are now made by maintenance staff to ensure they are secured as tightly as possible. PR2: Review of the incident found that the fence was not breeched, and the gates were secure; however, one external gate at the kitchen was not secured as tightly as it could have been. Gates are currently secured using a chain and a padlock. It is believed that the loose chain on the kitchen gate may have allowed Individuals 1	7/31/2023

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12VAC35-46-870. F. (1a) - Supervision policies: 1. The provider shall develop and implement written policies and procedures that address staff supervision of children including contingency plans for resident illnesses, emergencies, off-campus activities, and resident preferences. These policies and procedures shall be based on the: 1a. Needs of the population served;	N	Three Rivers Treatment Center This regulation was NOT MET as evidenced by: The provider did not follow their own policies and procedures NSG086, "Staff responsible for monitoring residents on elevated levels of precautions shall maintain the resident in a safe environment and take measures to protect the residents and others from harm." concerning supervision of residents as evidenced by the elopement of Individual #1 and #2.	OLR) Accepted 07/10/2023 PR) 07/06/2023 PR1: Facility staff's response to this incident was prompt and appropriate. Facility policies were followed, and all required external agencies were informed. Review of the incident found that the fence was not breeched, and the gates were secure; however, one external gate at the kitchen was not secured as tightly as it could have been. Gates are currently secured using a chain and a padlock. It is believed that the loose chain on the kitchen gate may have allowed Individuals 1 & 2 to have slipped through. Both Individuals were ordered to be on every 5-minute checks. Clinical records prior to the elopement document that these checks were maintained. Additionally, facility staff have conducted simulations – both Individuals could cross the courtyard from the main play area to any gate in the fence in well under 5 minutes. We do not believe that any failure of protection, guidance and supervision occurred during this incident except for the possibility the kitchen gate was loosely secured. The last to use this gate legitimately was the facility's pest control contractor. All contractors have been briefed on the requirement to secure all gates tightly. Additional checks of each gate are now made by maintenance staff to ensure they are secured as tightly as possible. PR2: Review of the incident found that the fence was not breeched, and the gates were secure; however, one external gate at the kitchen was not secured as tightly as it could have been. Gates are currently secured using a chain and a	7/31/2023

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			the fence before each courtyard activity. PR4: July 31, 2023 OLR) Accepted 07/10/2023	

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.

Cynthia Gwinn, Licensing Specialist

(Signature of Organization Representative)

Date

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