DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **295-14-011**
Organization Name: **Intercept Health**

Date of Inspection: **10-24-2023**
Program Type/Facility Name: **14-011 Intercept-Spring House**

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	Intercept-Spring House This regulation was NOT MET as evidenced by: See OHR citation.		

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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	Intercept-Spring House 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. Upon review of CHRIS entry, A-20230113 and A-20230114, the provider's investigation included a review of the provider's policy which revealed a performance issue demonstrated by Employee #1: • Employee #1 failed to follow the provider's policy: • Employee #1 admitted to not administering Individual #1's Medication #1 at the scheduled times. • Individual #1 did not receive their Medication #1 on 9/3/2023 at 12PM and 4PM as prescribed. • As a result, Employee #1 failed to provide a service necessary to the health, safety, and welfare of Individual #1, which meets the regulatory definition for neglect. Based on the provider's investigative finding, there is a preponderance of evidence to support the provider's substantiated finding of neglect.	PR) 11/15/2023 This incident occurred due to staff error in forgetting to administer the appropriate medication to the appropriate resident. The staff involved received a written corrective action plan on 9/5/23. The staff has been advised that she must remember to review the medication log and posted times for administration to ensure compliance. The staff is reminded that Intercept's policy states that three medication errors in a 12 month period will result in termination. The program manager will review medication compliance with staff monthly during staff meetings. OHR/OLR) Accepted 11/17/2023	9/5/2023

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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.

Andrea Milhouse, Human Rights	(Signature of Organization Representative)	Date

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