DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **295-14-031**
Organization Name: **Intercept Health**

Date of Inspection: **12-13-2023**
Program Type/Facility Name: **14-031 Journey House - Intercept**

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	Journey House - Intercept 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	Journey House - Intercept 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-20230123 and A-20230124, the provider’s investigation was substantiated for neglect based on the following: • Employee #1 failed to adequately supervise Individual #1 and #2: • It was discovered that Employee #1 was unaware that both Individual #1 and #2 left the home. • Individual #1 and #2 were able to elope and allegedly robbed a vape store. • Employee #1 failed to provide services necessary to the health, safe, and welfare of Individual #1 and #2, 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) 12/28/2023 This incident occurred due to staff not following Intercept's sight and sound policies. Staff received a written corrective action on 10/5/23. Senior Regional Manager and Program Manager met with staff and staff was educated on the importance of sight and sound supervision. Room check procedures and accountability was reviewed with staff. Staff was informed that failure to comply with sight and sound supervision will lead to further corrective action, up to termination. Program Manager and Senior Regional Manager will continue to monitor staff daily to ensure procedures are being followed. OHR/OLR) Accepted 12/29/2023	10/5/2023

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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