DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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

Date of Inspection: **04-16-2024**
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.		6/1/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
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. OHR Advocate received information relating to CHRIS entry A:20240011 including text messages which revealed: • Employee #1 admitted to Employee #2 via phone messages that Individual #1 had not received medications for 7 days. Based on the information provided there is a preponderance of evidence to support the OHR Advocates finding of neglect.	PR) 05/14/2024 This incident occurred due to a medication administration and reporting error from staff. Employee 1 reported to Employee 2 (Employee 1's previous Regional Supervisor that is no longer with Intercept Health) that the incident occurred. Employee 2 did not follow appropriate reporting guidelines and did not report the incident to CHRIS or her supervisor. Employee 2 is no longer with the agency; however, Employee 1 will be required to complete full Medication Administration Training again and it will be ensured that completed medication policy is understood from Employee 1. Director of Residential and Specialty Programs will ensure the medication training and comprehension is complete. Medication logs will be reviewed monthly by Utilization Review staff to ensure no errors occur. OHR/OLR) Accepted 06/24/2024	6/1/2024

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12VAC35-115-60. B. (8) - The provider's duties. 8. Providers shall ensure that the entries in an individual's services record are at all times authentic, accurate, complete, timely, and pertinent.	N	Journey House - Intercept "Providers shall ensure that the entries in an individual's services record are at all times authentic, accurate, complete, timely, and pertinent." This regulation was NOT MET as evidenced by: OHR Advocate received information relating to CHRIS entry A:20240011 including text messages which revealed: • Employee #1 admitted to Employee #2 via text message that they signed off on medications as given that were missed by Individual #1. Based on the information received, there is a preponderance of evidence to support the OHR Advocates violation of this regulation.	PR) 05/14/2024 This incident occurred due to a medication administration and reporting error from staff. Employee 1 reported to Employee 2 (Employee 1's previous Regional Supervisor that is no longer with Intercept Health) that the incident occurred. Employee 2 did not follow appropriate reporting guidelines and did not report the incident to CHRIS or her supervisor. Employee 2 is no longer with the agency; however, Employee 1 will be required to complete full Medication Administration Training again and it will be ensured that completed medication policy is understood from Employee 1. Director of Residential and Specialty Programs will ensure the medication training and comprehension is complete. Medication logs will be reviewed monthly by Utilization Review staff to ensure no errors occur. OHR/OLR) Accepted 06/24/2024	6/1/2024

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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