License #: **3168-14-009**
Organization Name: **Clementine Twin Lakes, LLC**

Date of Inspection: **07-27-2023**
Program Type/Facility Name: **14-009 Clementine Fairfax**

| 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 | Clementine Fairfax<br><br>This regulation was NOT MET as evidenced by: See OHR citation below. | | |
| 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 | Clementine Fairfax<br><br>This regulation was NOT MET as evidenced by:<br><br>"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.<br><br>• Based on the preponderance of evidence including eyewitness statements, failure to follow policy and witness credibility, provider has substantiated A#20230006, A#20230007, A#20230008, and A#20230009.<br>• Employee #1 had not provided sufficient monitoring services to individuals #1, #2, #3, and #4. | PR) 08/16/2023<br>• **A statement of the issue that led to non-compliance:**<br><br>**#1: Supervision Procedural Break** – Clients were not in line of vision at all times by a staff member per policy and procedure.<br><br>**#2: Client Activity List** – Clients were allowed to participate in an activity that is not currently present on the Approved Activities List.<br><br>**#3: Staff Training** – Staff member did not have documentation of supervision protocol training. | 6/19/2023 |

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| | | • Provider failed to ensure Individual #1's right services necessary for health, safety and welfare. | • **A statement of how you corrected the issue:**<br><br>**#1:** The identified Recovery Coach who demonstrated non-compliance with the client supervision protocol will not be working any additional shifts at the program.<br><br>**#2:** The Clinical Director was re-trained on the Approved Activities List and will need to obtain Regional Director approval to allow for any activities not present on the list.<br><br>**#3:** All agency Recovery Coaches will sign the supervision protocol indicating their understanding of the protocol prior to their shift.<br><br>• **A plan of action to address systematic (process/protocols) that have been or will be implemented to ensure you remain in compliance of the regulation:**<br><br>**#2:** The Clinical Director will discuss client activities during monthly supervision with the Regional Director.<br><br>**#3:** All agency Recovery Coaches will sign the supervision protocol indicating their understanding of the protocol prior to their shift to help prevent future | |

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| | | | procedural breaks.<br>• **Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation:** Clinical Director, Regional Director<br>• **Indicate the frequency for monitoring the plan including how it will be monitored:** Monthly: Regional Director will check-in monthly with the Clinical Director on client activities to ensure on-going compliance. Quarterly: Clinical Director will report during the quarterly performance improvement reports on program compliance with ensuring agency Recovery Coaches have been signing off on protocols prior to their shifts.<br>OHR/OLR) Accepted 08/21/2023 | |

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



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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.

| Deborah Lochart, Human Rights | (Signature of Organization Representative) | Date |
|---|---|---|

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