Investigation ID: **242**
License #: **3187-14-010**
Organization Name: **STARS**

Date of Inspection: **11-25-2024**
Program Type/Facility Name: **14-010 Orion 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	Orion House This regulation was NOT MET as evidenced by: Please see the Office of Human Rights violations below.	PR) 01/09/2025 Staff completed verbal de-escalation training to be more therapeutic. Discussed ways to ensure safety when a concern come up whether it is between staff or residents. Staff will conduct random pop ups and camera reviews while Employee 2 is on shift to check on interactions and program compliance. This has been occurring and will continue for the next 2 months. OLR) Partially Accepted 01/13/2025 PR) 01/24/2025 Staff completed Youth Mental Health 1st Aid refresher on 1/10/25. OLR) Accepted 02/03/2025	1/10/2025
12VAC35-46-800. A. (1) - There shall be evidence of a structured program of care designed to: 1. Meet the residents' physical and emotional needs;	N	Orion House This regulation was NOT MET as evidenced by: The serious incident report dated 8/24/24 documents that Employee #2 engaged in a power struggle and cursed at Individual #1 causing Individual #1 to escalate into crisis. The provider failed to have in place a structured program of care to meets the resident's emotional needs.	PR) 01/09/2025 This staff completed verbal de-escalation training. OLR) Partially Accepted 01/13/2025 Please update the response to include actions all steps to develop a systemic plan to address Employee #2's behavior. When will be training be completed and how will the supervisor monitor that this training corrected the behavior. Please see the guidance document, specifically the bottom of page 2 **Providers should consider the following steps when writing a CAP.** extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs	1/10/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			\720\GDoc_DBHDS_6875_v2.pdf PR) 01/24/2025 Monthly supervision will be conducted. Within the supervisions, issues that any personnel have brought to an admin or the staff supervisor's attention will be discussed and documented. If any additional training or supports needed will be provided. During staff meetings it will be reiterated on how you talk to the residents. The said staff completed Youth Mental Health 1st Aid refresher on 1/10/25. OLR) Accepted 01/27/2025	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-800. A. (2) - There shall be evidence of a structured program of care designed to: 2. Provide protection, guidance, and supervision;	N	Orion House This regulation was NOT MET as evidenced by: The serious incident report dated 11/8//2 documents that Indivdiaul #1 and #2 were in the kitchen making sandwiches when Employee #1 heard commotion and entered the kitchen to find Individual #2 holding Individual #1 around the neck with their arm and holding a butter knife pointed at Indivdiaul #1. The serious incident report date d 11/9/24 documents that Employee #1 heard commotion and entered the shared bedroom of Indivdiaul #1 and #2 to find Individual #2 on top of Individual #1. Individual #1 was screaming and Indivdiaul #2 was slapping Individual #1 on the buttocks and back. When Indivdiaul #1 contacted their legal guardian, Individual #1 disclosed that Individual #2 digitally penetrated them. Individual #1 was taken to Entity #4 by their legal guardian to be evaluated and there was evidence of extensive injuries to Individual #1. The provider failed to have in place a structure program of care that provided protection and supervision.	PR) 01/09/2025 On unit staff will talk with other staff on unit, support staff, or on-call to discuss a safety plan for residents when issues arise. As well as inform other staff of what the plan is. OLR) Partially Accepted 01/13/2025 Please update the response to include actions all steps to develop a systemic plan to address when a safety plan is developed and how provider will monitor that communication between staff is occurring. Please see the guidance document specifically the bottom of page 2 **Providers should consider the following steps when writing a CAP.** extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6875_v2.pdf PR) 01/24/2025 The staff, on-call, support staff, and/or an admin will ensure that the safety plan will be passed on to the proceeding staff. It will be through verbal communication and/or a message/email sent to all house staff. OLR) Accepted 01/28/2025	1/10/2025
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be	N	Orion House This regulation was NOT MET as evidenced by: "Abuse" means any act or failure to act by an employee or	PR) 01/09/2025 While we don't agree with part of this finding, in an effort for reconciliation the provider provided verbal de-escalation training with the MANDT trainer for staff 1 and staff 2. The two staff will	1/10/2025

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protected from harm including abuse, neglect, and exploitation.		other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. 3. Use of language that demeans, threatens, intimidates, or humiliates the person. During records review for Individual 1, the advocate identified the following: • On a Serious Incident Report dated August 24, 2024, Employee 1 documented the following: ◦ Individual 1 was playing music loudly and Employee 2 yelled at Individual 1 to turn the music down. ◦ Individual 1 told Employee 1 that Individual 1 was mad at Employee 2 and asked to step outside to calm down. ◦ Employee 2 became upset with Employee 1 for allowing Individual 1 to go outside. ◦ Employee 1 went outside to talk with Individual 1, but Employee 2 followed and began to argue with Individual 1. ◦ Employee 1 documents that Employee 2 and Individual 1 were yelling "back and forth". • According to Employee 3, Employee 2 became so escalated that Employee 1 asked Employee 2 to leave the premises. • On a Staff Informative Plan dated August 25, 2024, Employee 2 was written up for cursing at Individual 1 stating, "Turn that shit off," and escalating a resident. "Neglect" means failure by a person, program, or	also be in training First Aid Mental Health Workshop on 1/10/25. Incidents will be discussed with the on-call/support staff to discuss a plan when residents need to be separated or if increased supervision will be needed. Staff will conduct random pop ups and camera reviews while Employee 2 is on shift to check on interactions and program compliance. This has been occurring and will continue for the next 2 months. OHR/OLR) Partially Accepted 01/10/2025 1/10/25 OHR Response - Partially Accepted. Additional employee supports need to be identified. How will employees be supervised and monitored to assure implementation of the training provided? PR) 01/24/2025 Monthly supervision will be conducted. Within the supervisions, issues that any personnel have brought to an admin or the staff supervisor's attention will be discussed and documented. If any additional training or supports needed will be provided. OHR/OLR) Accepted 02/03/2025	

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		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. During records review for Individual 1, the advocate identified the following: • On a Serious Incident Report dated November 8, 2024, Employee 1 documented that Individual 1 and a peer were in the kitchen and the peer had an arm around Individual 1's neck and had a butter knife pointed at Individual 1 with the other arm. • The peer and Individual 1 were separated through verbal redirection. The outcome and consequences of the incident was identified as, "Separate the kids. No consequence." • On November 9, 2024, Employee 4 found the same peer sitting on Individual 1 and hitting Individual 1 on the lower back/upper bottom region. • Individual 1 reported that the peer digitally penetrated Individual 1 during this assault. This is substantiated for neglect due to the provider failing to provide treatment or services		

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		necessary to the safety of Individual 1, such as taking the appropriate action steps to protect Individual 1 from the peer. This is evidenced by neither consequences issued as a result of the incident, nor increased supervision of the individuals to assure safety following the November 8, 2024, incident. The provider failed to identify the November 8, 2024, incident as a safety concern for Individual 1.		

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-115-60. B. (2) - The provider's duties. 2. Providers shall ensure that all services, including medical services and treatment, are at all times delivered in accordance with sound therapeutic practice. Providers may deny or limit an individual's access to services if sound therapeutic practice requires limiting the service to individuals of the same sex or similar age, disability, or legal status.	N	Orion House This regulation was NOT MET as evidenced by: During records review for Individual 1, the advocate identified the following: • On a Serious Incident Report dated August 24, 2024, Employee 1 documented that Employee 2 engaged in a power struggle and argument where Individual 1 and Employee 2 were both yelling at one another. • According to Employee 3, Employee 2 became so escalated that Employee 1 asked Employee 2 to leave the premises. • On a Staff Informative Plan dated August 25, 2024, Employee 2 incurred personnel action which noted the following: ◦ Cursing at a resident ◦ Escalating a resident ◦ Leaving work early during a crisis ◦ Sitting in the office while residents are awake ◦ Playing video games while on shift ◦ On phone numerous times ◦ Discussing resident's treatment with another resident	PR) 01/09/2025 For this staffs Staff Improvement Plan the Staff Supervisor met with this staff on these issues for them to work on the issues. The staff supervisor did not document it. Moving forward the staff will document any trainings or work that a staff does for their Staff Improvement Plan. Admin will be doing random pop ups or watch the camera while Employee 2 is on shift to see the interactions and program compliance. This has been occurring and will continue for the next 2 months. OHR/OLR) Partially Accepted 01/10/2025 1/10/25 OHR Response - Partially Accepted. Additional employee supports need to be identified. How will employees be supervised and monitored to assure implementation of the training provided? PR) 01/24/2025 During our weekly admin meetings when we discuss issues with staff for the previous week the admin team will remind the staff supervisor to document issues, trainings, or whatever is needed to show what was handled with that said staff member and put in the personnel file. This will be handled at the meeting to ensure it is completed. OHR/OLR) Accepted 02/03/2025	1/9/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
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	Orion House This regulation was NOT MET as evidenced by: During records review for Individual 1, the advocate identified the following: • On the daily progress note dated August 24, 2024, Employee 1 failed to document the incident which occurred between Individual 1 and Employee 2. • In answer to the question, "Did resident receive an SIR or behavior report?" Employee 1 circled the SIR box but checked the "None" box. • On the daily progress note dated November 8, 2024, in answer to the question, "Did resident receive an SIR or behavior report?" the "None" box is checked. • On the daily progress note dated November 9, 2024, in answer to the question, "Did resident receive an SIR or behavior report?" there is nothing marked. • On the daily progress note dated November 9, 2024, there is no narrative note for the 8:00am-4:00pm shift which is when Individual 1 was assaulted by a peer.	PR) 01/09/2025 Staff will make sure their paperwork is complete before the end of shift. The other staff on unit or support staff will check to ensure the paperwork/notes are complete. Case manager will be the ones to review documentation weekly to ensure that the residents plans/goals need to be updated or changed. OHR/OLR) Partially Accepted 01/10/2025 1/10/25 OHR Response - Partially Accepted. How often will documentation be reviewed clinically and for quality assurance? PR) 01/24/2025 Notes will be looked at, at the end of shift. The notes will be checked by the overnight staff daily for corrections. The staff will be informed of the corrections that needs to complete. The staff supervisor will be informed for corrections, and it will be addressed in the staff monthly supervision, along with ways to minimize corrections. of this matter. OHR/OLR) Accepted 02/03/2025	1/10/2025
12VAC35-115-80. A. (1) - Each individual is entitled to have all identifying information that a	N	Orion House This regulation was NOT MET as evidenced by:	PR) 01/09/2025 The staff supervisor discussed with the staff that if a resident is telling you something personal that the staff will inform the resident that this is	1/10/2025

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provider maintains or knows about him remain confidential. Each individual has a right to give his authorization before the provider shares identifying information about him or his care unless another state law or regulation, or these regulations specifically require or permit the provider to disclose certain specific information. 1. Providers shall maintain the confidentiality of any information that identifies an individual. If an individual's services record pertains in whole or in part to referral, diagnosis or treatment of substance use disorders, providers shall disclose information only according to applicable federal regulations (see 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient		Human Rights Regulation 12VAC35-115-80(A) During records review for Individual 1, the advocate identified the following: On a Staff Informative Plan dated August 25, 2024, Employee 2 incurred personnel action for discussing a resident's treatment with another resident.	something private would you like to move to a private area. If the resident refuses or says that they don't care if anyone else hears, still try but document that they tried talk privately. If the resident continues to talk about whatever the topic is. OHR/OLR) Accepted 01/10/2025	

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Records).				

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.

Ann Mays, Licensing Specialist	(Signature of Organization Representative)	Date

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