License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **03-27-2024**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-250. B. (1) - Tuberculosis evaluation: 1. At the time of hire or residency at the facility, each individual shall submit the results of a screening assessment documenting the absence of tuberculosis in a communicable form as evidenced by the completion of a form containing, at a minimum, the elements of a current screening form published by the Virginia Department of Health. The screening assessment shall be no older than 30 days.	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #2's personnel record, there failed to be documented evidence of the results of a screening assessment documenting the absence of tuberculosis in a communicable form.	PR) 04/19/2024 The correction action plan for tuberculosis screening is that every employee per policy will complete a tuberculosis screening or PPD skin test before working their first shift. Employee #2 who did not have the tuberculosis screening or PPD skin test completed the tuberculosis screening by the required due date per policy. According to the medical professional, employee #2 did not need to proceed with the PPD skin test. The appropriate document was placed in the employee's file per regulations. OLR) Not Accepted 04/29/2024 The provider is required to upload evidence of Employee #2's TB screening. PR) 05/14/2024 Employee document uploaded. OLR) Accepted 05/17/2024	4/12/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-290. B. - The provider shall develop and implement written policies and procedures to assure that persons employed in or designated to assume the responsibilities of each position possess the education, experience, knowledge, skills, and abilities specified in the job description for the position.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: There failed to be documented evidence that the provider implemented written policies and procedures to assure that persons employed in or designated to assume the responsibilities of each position possess the education, experience, knowledge, skills, and abilities specified in the job description for the position. The job description specifies an Associate's degree for minimum qualifications; however, Employee #1 and Employee #2 have a High School Diploma.	PR) 04/17/2024 The corrective action plan is moving forward regarding the job description. A correct job description will include the minimum qualifications according to regulations. Every employee per policy and procedure will have a minimum educational experience, knowledge, skills, abilities, and six months of experience working with children. Employee #1 is no longer employed at Lighthouse 1 LLC. An unsigned copy with the corrected job description will be placed in the file. Employee #2 will have a signed copy of the updated job description in the file. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure the job descriptions will include the minimum requirements according to regulations. OLR) Accepted 04/29/2024	4/17/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-300. B. (1) - The records of each employee shall include: 1. A completed employment application form or other written material providing the individual's name, address, phone number, and social security number or other unique identifier;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of a completed employment application form.	PR) 04/17/2024 The corrective action plan moving forward regarding an employment application. An employment application will be included in all employee files. Employee #1 is no longer employed at Lighthouse 1 LLC, but information submitted by the employee will be included in the file. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure employee records include employment applications. OLR) Accepted 04/29/2024	4/17/2024
12VAC35-46-300. B. (3) - The records of each employee shall include: 3. Written references or notations of oral references;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of written or notations of oral references.	PR) 04/17/2024 The corrective action plan moving forward regarding written references or notations of oral references. Written or oral references shall be included in each employee file according to regulations. Every employee will provide the recommended number of references. Employee #1 is no longer employed at Lighthouse 1 LLC. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that references are obtained and included in the files. OLR) Accepted 04/29/2024	4/17/2024
12VAC35-46-300. B.	N	**HEALTH AND SAFETY VIOLATION**	PR) 04/12/2024	5/22/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
(7) - The records of each employee shall include: 7. Documentation of compliance with requirements of Virginia laws regarding child protective services and criminal history background investigations;		Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of a child protective services check. In review of Employee #2's personnel record, there failed to be documented evidence of a child protective services check.	The correction action plan for the child protective services check is that every employee per policy will complete the background check. Regarding employee #2, the CPS form was submitted but eligibility has not been received. Employee #1 is no longer with us. Moving forward, the manager will ensure that all staff complete the child protective services check within 30 days of hiring. If the CPS check is not completed, the staff will not be scheduled to work until submitted. OLR) Not Accepted 04/29/2024 Please review 12VAC35-46-300.B.7. regarding background check requirements and update the response accordingly. PR) 05/15/2024 The child protective check for Employee #2 has been submitted through the new Central Registry Search. We will provide documented evidence upon receipt and include a copy in their personnel record. OLR) Accepted 05/17/2024	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. A. (2a) - Required initial training: 2. Within 14 days following an individual's begin date, and before an individual is alone supervising children, the provider shall conduct emergency preparedness and response training that shall include: 2a. Alerting emergency personnel and sounding alarms;	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of emergency preparedness and response training. In review of Employee #2's personnel record, there failed to be documented evidence of emergency preparedness and response training.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive training for emergency preparedness and response. The documentation for emergency preparedness and response training for employee #1 and #2 was accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 04/29/2024 The provider is required to upload evidence of emergency preparedness and response training for Employee #1 and Employee #2. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. A. (2b) - Required initial training: 2. Within 14 days following an individual's begin date, and before an individual is alone supervising children, the provider shall conduct emergency preparedness and response training that shall include: 2b. Implementing evacuation procedures, including evacuation of residents with special needs (i.e., deaf, blind, nonambulatory);	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of emergency preparedness and response training. In review of Employee #2's personnel record, there failed to be documented evidence of emergency preparedness and response training.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive training for emergency preparedness and response. The documentation for emergency preparedness and response training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of emergency preparedness and response training for Employee #1 and Employee #2. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. A. (2c) - Required initial training: 2. Within 14 days following an individual's begin date, and before an individual is alone supervising children, the provider shall conduct emergency preparedness and response training that shall include: 2c. Using, maintaining, and operating emergency equipment;	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of emergency preparedness and response training. In review of Employee #2's personnel record, there failed to be documented evidence of emergency preparedness and response training.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive training for emergency preparedness and response. The documentation for emergency preparedness and response training for employee #1 and #2 was accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of emergency preparedness and response training for Employee #1 and Employee #2. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. A. (2d) - Required initial training: 2. Within 14 days following an individual's begin date, and before an individual is alone supervising children, the provider shall conduct emergency preparedness and response training that shall include: 2d. Accessing emergency information for residents including medical information;	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of emergency preparedness and response training. In review of Employee #2's personnel record, there failed to be documented evidence of emergency preparedness and response training.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive training for emergency preparedness and response. The documentation for emergency preparedness and response training for employee #1 and #2 was accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of emergency preparedness and response training for Employee #1 and Employee #2. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. A. (2e) - Required initial training: 2. Within 14 days following an individual's begin date, and before an individual is alone supervising children, the provider shall conduct emergency preparedness and response training that shall include: 2e. Utilizing community support services.	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of emergency preparedness and response training. In review of Employee #2's personnel record, there failed to be documented evidence of emergency preparedness and response training.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive training for emergency preparedness and response. The documentation for emergency preparedness and response training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of emergency preparedness and response training for Employee #1 and Employee #2. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. A. (3a) - Required initial training: 3. Within 14 days following their begin date, new employees, employees transferring from other facilities operated by the same provider, relief staff, volunteers, and students/interns shall be given orientation and training regarding: 3a. The objectives of the facility;	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date. In review of Employee #2's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive orientation and training. The documentation for orientation and training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of orientation and training within 14 days following of begin date. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. A. (3b) - Required initial training: 3. Within 14 days following their begin date, new employees, employees transferring from other facilities operated by the same provider, relief staff, volunteers, and students/interns shall be given orientation and training regarding: 3b. Practices of confidentiality;	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date. In review of Employee #2's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive orientation and training. The documentation for orientation and training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of orientation and training within 14 days following of begin date. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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12VAC35-46-310. A. (3c) - Required initial training: 3. Within 14 days following their begin date, new employees, employees transferring from other facilities operated by the same provider, relief staff, volunteers, and students/interns shall be given orientation and training regarding: 3c. The decision-making plan;	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date. In review of Employee #2's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive orientation and training. The documentation for orientation and training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of orientation and training within 14 days following of begin date. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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12VAC35-46-310. A. (3d) - Required initial training: 3. Within 14 days following their begin date, new employees, employees transferring from other facilities operated by the same provider, relief staff, volunteers, and students/interns shall be given orientation and training regarding: 3d. These regulations including the prohibited actions as outlined in this regulation;	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date. In review of Employee #2's personnel record, there failed to be documented evidence of orientation and training within 14 days following of begin date.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive orientation and training. The documentation for orientation and training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of orientation and training within 14 days following of begin date. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024
12VAC35-46-310. A. (5) - Required initial training: 5. Within 30 days following their begin date, all staff working with residents	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed	PR) 04/12/2024 Upon hire employees #1 and #2 did receive child abuse and neglect, mandatory reporting,	4/12/2024

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shall be trained in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention.		to be documented evidence of training within 30 days in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention. In review of Employee #2's personnel record, there failed to be documented evidence of training within 30 days in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention.	maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention training. The documentation of the training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of training within 30 days in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	

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12VAC35-46-310. A. (6) - Required initial training: 6. Within 30 days following their begin date, all staff shall be trained on the facility's policies and procedures regarding standard precautions.	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence of training within 30 days in standard precautions. In review of Employee #2's personnel record, there failed to be documented evidence of training within 30 days in standard precautions.	PR) 04/12/2024 Upon hire employees #1 and #2 did receive training in standard precautions. The documentation of the training for employee #1 and #2 were accidentally omitted from their files. Moving forward, the Chief Administrative Officer will conduct monthly audits of all employee records to ensure that all documentation for new hire training is included per regulations. OLR) Partially Accepted 05/01/2024 The provider is required to upload evidence of training within 30 days in standard precautions. PR) 05/10/2024 The documentation of training attached. OLR) Accepted 05/17/2024	4/12/2024

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12VAC35-46-310. A. (8) - Required initial training: 8. Before administering medication, all staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications.	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence that the employee successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications.	PR) 04/12/2024 The corrective action plan moving forward regarding medication administration certificates. The certificate will be in employee files according to regulations, prior to having to administer any medication. An employee who does not have an active certification will not administer medications, as the policy states. Every employee per policy and procedure will complete a 32-hour medication management course and supply Lighthouse 1 LLC with their certificate following the successful completion of the class. Employee #1 is no longer employed at Lighthouse 1 LLC. Our attempts to contact employee #1 and obtain the certificate for the file have been unsuccessful. Moving forward upon hire, anyone who already has their medication administration certificate will supply that certificate to the Lighthouse 1 LLC, so that it can be in placed in their employee file upon hire. OLR) Accepted 05/01/2024	4/12/2024

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12VAC35-46-740. - Within three days following admission, individualized, measurable objectives and strategies for the first 30 days shall be developed, distributed to affected staff and the resident, and placed in the resident's record. The objectives and strategies shall be based on the reasons for admitting the resident.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider developed individualized, measurable objectives and strategies for the first 30 days of admission. In review of Individual #2's service record, there failed to be documented evidence that the provider developed individualized, measurable objectives and strategies for the first 30 days of admission. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/17/2024 The corrective action plan moving forward regarding individualized, measurable objectives and strategies for the first 30 days of admission. The initial assessment form should be completed to include the final Individualized service plan and/or exiting safety plan from the last place of residency. Initial assessment for Individual #1 and Individual #2 will be completed and included in the files within one week. Root Cause: (1) Completion of Initial Assessment was not done. (2) Admission training for children's residential facilities is needed. (3) The Admission Checklist needs updates. (4) Update policy and procedures needed. The corrective plan of action will include updating policies and procedures, admission forms, and conducting training for staff by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure that all documentation will be included. OLR) Accepted 05/01/2024	4/24/2024
12VAC35-46-750. A. - An individualized service plan shall be developed and placed	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by:	PR) 04/18/2024 The corrective action plan moving	4/24/2024

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in the resident's record within 30 days following admission and implemented immediately thereafter.		In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	forward regarding individualized service plan. The individualized service plan will be completed, distributed to the resident, the resident's family, if appropriate, legal guardian, or authorized representative, the placing agency, and appropriate facility staff, and included in all individual files. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. An Individualized service plan will be completed and included in Individual #1's files to meet regulations. The Individualized service plan will be scheduled with all necessary parties upon admission. An email will be sent with further information. Scheduling of appointment time will be included on the Admission Checklist. The checklist will be updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to	

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			ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	
12VAC35-46-750. B. (1) - Individualized service plans shall describe in measurable terms the: 1. Strengths and needs of the resident;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding individualized service plan describing measurable terms that include the strengths and needs of the resident. The individualized service plan will be completed, distributed to the resident, the resident's family, if appropriate, legal guardian, or authorized representative, the placing agency, and appropriate facility staff, and included in all individual files. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. An individualized service plan will be completed for Individual #1 and placed in the file to meet regulations. The Individualized service plan will be scheduled with all necessary parties upon admission. An email will be sent with further information. Scheduling of appointment time will be included on the Admission Checklist. The checklist will be	4/24/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	
12VAC35-46-750. B. (2) - Individualized service plans shall describe in measurable terms the: 2.Resident's current level of functioning;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding individualized service plan describing measurable terms that include resident's current level of functioning. The individualized service plan will be completed, distributed to the resident, the resident's family, if appropriate, legal guardian, or authorized representative, the placing agency, and appropriate facility staff, and included in all individual files. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. An individualized service plan will be completed for Individual #1 and placed in the file to meet regulations. The Individualized service plan will be scheduled	4/24/2024

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			with all necessary parties upon admission. An email will be sent with further information. The schedule with appointment times will be included on the Admission Checklist. The checklist will be updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	
12VAC35-46-750. B. (3) - Individualized service plans shall describe in measurable terms the: 3. Goals, objectives, and strategies established for the resident;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist).	PR) 04/18/2024 The corrective action plan moving forward regarding individualized service plan describing measurable terms that include resident's goals, objectives, and strategies established for the resident. The individualized service plan will be completed, distributed to the resident, the resident's family, if appropriate, legal guardian, or authorized representative, the placing agency, and appropriate facility staff, and included in all individual files. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks.	4/24/2024

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		4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	An individualized service plan will be completed for Individual #1 and placed in the file to meet regulations. The Individualized service plan will be scheduled with all necessary parties upon admission. An email will be sent with further information. Scheduling of appointment time will be included on the Admission Checklist. The checklist will be updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	
12VAC35-46-750. B. (4) - Individualized service plans shall describe in measurable terms the: 4. Projected family involvement;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will	PR) 04/18/2024 The corrective action plan moving forward regarding individualized service plan describing measurable terms that include projected family involvement. The individualized service plan will be completed, distributed to the resident, the resident's family, if appropriate, legal guardian, or authorized representative, the placing agency, and appropriate facility staff, and included in all individual files. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports.	4/24/2024

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		occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. An individualized service plan will be completed for Individual #1 and placed in the file to meet regulations. The Individualized service plan will be scheduled with all necessary parties upon admission. An email will be sent with further information. Scheduling of appointment time will be included on the Admission Checklist. The checklist will be updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	
12VAC35-46-750. B. (5) - Individualized service plans shall describe in measurable terms the: 5. Projected date for accomplishing each objective;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to	PR) 04/18/2024 The corrective action plan moving forward regarding individualized service plan describing measurable terms that include projected date for accomplishing each objective. The individualized service plan will be completed, distributed to the resident, the resident's family, if appropriate, legal guardian, or authorized representative, the placing agency, and appropriate facility staff, and included in all individual files. Root Cause: Lack of qualified mental health	4/24/2024

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		address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. An individualized service plan will be completed for Individual #1 and placed in the file to meet regulations. The Individualized service plan will be scheduled with all necessary parties upon admission. An email will be sent with further information. Scheduling of appointment time will be included on the Admission Checklist. The checklist will be updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	
12VAC35-46-750. B. (6) - Individualized service plans shall describe in measurable terms the: 6. Status of the projected discharge plan and estimated length of stay, except that this requirement shall not apply to a facility that discharges	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP:	PR) 04/18/2024 The corrective action plan moving forward regarding individualized service plan describing measurable terms that include the status of the projected discharge plan and estimated length of stay, except that this requirement shall not apply to a facility that discharges only upon receipt of the order of a court of competent jurisdiction. The individualized service plan will be completed, distributed to the resident, the resident's family, if	4/24/2024

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only upon receipt of the order of a court of competent jurisdiction.		1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	appropriate, legal guardian, or authorized representative, the placing agency, and appropriate facility staff, and included in all individual files. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. An individualized service plan will be completed for Individual #1 and placed in the file to meet regulations. The Individualized service plan will be scheduled with all necessary parties upon admission. An email will be sent with further information. Scheduling of appointment time will be included on the Admission Checklist. The checklist will be updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	

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12VAC35-46-750. C. - The initial individualized service plan shall be reviewed within 60 days of the initial plan and within each 90-day period thereafter and revised as necessary.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding individualized service plan shall be reviewed within 60 days of the initial plan and within each 90-day period thereafter and revised as necessary. The individualized service plan will be reviewed and revised as necessary. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. An individualized service plan will be completed for Individual #1 and placed in the file to meet regulations. The Individualized service plan will be scheduled with all necessary parties upon admission. An email will be sent with further information. Scheduling of appointment time will be included on the Admission Checklist. The checklist will be updated by April 24, 2024. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The initial individualized service plan shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. D. (1) - The provider shall develop and implement written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the: 1. Format;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. In review of Individual #2's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding development and implementation of written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the format. Progress notes will be completed according to individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be developed with the individualized service plan for Individual #1 and Individual #2 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. D. (2) - The provider shall develop and implement written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the: 2. Frequency;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. In review of Individual #2's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding development and implementation of written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the frequency. Progress notes will be completed according to the individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be developed with the individualized service plan for Individual #1 and Individual #2 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. D. (3) - The provider shall develop and implement written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the: 3. Person responsible.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. In review of Individual #2's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding development and implementation of written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the person responsible. Progress notes will be completed according to the individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be developed with the individualized service plan for Individual #1 and Individual #2 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. D. (3) - The provider shall develop and implement written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the: 3. Person responsible.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. In review of Individual #2's service record, there failed to be documented evidence that the provider developed and implemented written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding development and implementation of written policies and procedures to document progress of the resident towards meeting goals and objectives of the individualized service plan that shall include the person responsible. Progress notes will be completed according to the individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be developed with the individualized service plan for Individual #1 and Individual #2 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. E. (1) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 1. Resident's progress toward meeting the plan's objectives;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter that shall report the resident's progress toward meeting the plan's objectives Progress notes will be completed according to individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be reviewed and updated with the individualized service plan for Individual #1 and Individual #2 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. E. (2) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 2. Family's involvement;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter that shall report the family involvement. Progress notes will be completed according to individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be reviewed and updated with the individualized service plan for Individual #1 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. E. (3) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 3. Continuing needs of the resident;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter that shall report the continuing needs of the resident. Progress notes will be completed according to individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be reviewed and updated with the individualized service plan for Individual #1 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. E. (4) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 4. Resident's progress towards discharge;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter that shall report the resident's progress towards discharge. Progress notes will be completed according to individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be reviewed and updated with the individualized service plan for Individual #1 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. E. (5) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 5. Status of discharge planning.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter that shall report status of discharge planning. Progress notes will be completed according to individualized service plan with revisions. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be reviewed and updated with the individualized service plan for Individual #1 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/17/2024	4/24/2024

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12VAC35-46-750. F. - Each plan and quarterly progress report shall include the date it was developed and the signature of the person who developed it.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding each plan and quarterly progress report shall include the date it was developed and the signature of the person who developed it. Progress notes will be completed according to individualized service plan including the date and signature of the person who developed it. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. A progress report will be reviewed and updated with the individualized service plan for Individual #1 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. The progress notes shall be reviewed monthly and revised as necessary by the QMHP. Sessions will be scheduled to meet regulations. OLR) Accepted 05/17/2024	4/24/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-750. G. - Staff responsible for daily implementation of the resident's individualized service plan shall be able to describe the resident's behavior in terms of the objectives in the plan.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding staff responsible for daily implementation of the resident's individualized service plan shall be able to describe the resident's behavior in terms of the objectives in the plan. The direct care staff will be responsible for daily implementation of the resident's individualized service plan and describe the resident's behavior in terms of the objectives in the plan. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. Staff will complete behavior reports documenting the resident's behavior in terms of the objectives in the individualized service plan for Individual #1 and placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. OLR) Accepted 05/17/2024	4/24/2024

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12VAC35-46-750. H. (1) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 1. The resident;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report including the resident in the process. The resident shall be included in developing and updating the individualized service plan and in developing the quarterly progress report. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. Individual #1 will be included in developing and updating the individualized service plan and documentation will be placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. H. (2) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 2. The resident's family, if appropriate, and legal guardian;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report including the resident's family, if appropriate, and legal guardian. The resident's family, if appropriate, and legal guardian shall be included in developing and updating the individualized service plan and in developing the quarterly progress report. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. Individual #1 family, if appropriate, and legal guardian will be included in developing and updating the individualized service plan and documentation will be placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. H. (3) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 3. The placing agency;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report including the placing agency. The placing agency shall be included in developing and updating the individualized service plan and in developing the quarterly progress report. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. The placing agency for Individual #1 will be included in developing and updating the individualized service plan and documentation will be placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. H. (4) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 4. Facility staff.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report including the facility staff. The facility staff shall be included in developing and updating the individualized service plan and in developing the quarterly progress report. Root Cause: Lack of qualified mental health professionals to complete assessments and reports necessary for Individualized Service Plans, monthly, and quarterly reports. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. The facility staff will be included in developing and updating the individualized service plan for Individual #1 and documentation will be placed in the file to meet regulations. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-750. I. - The initial individualized service plan, each update, and all quarterly progress reports shall be distributed to the resident; the resident's family, if appropriate, legal guardian, or authorized representative; the placing agency; and appropriate facility staff.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence that an individualized service plan was distributed to the resident; the resident's family, if appropriate, legal guardian, or authorized representative; the placing agency; and appropriate facility staff. There failed to be documented evidence that the provider completed an individualized service plan. The provider is required to use the following to respond to the CAP: 1. Please identify the root cause(s) of the violation. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action.	PR) 04/18/2024 The corrective action plan moving forward regarding the initial individualized service plan, each update, and all quarterly progress reports shall be distributed to the resident; the resident's family, if appropriate, legal guardian, or authorized representative; the placing agency; and appropriate facility staff. The Individualized Service Plans, monthly, and quarterly reports shall be completed and distributed to the resident; the resident's family, if appropriate, legal guardian, or authorized representative; the placing agency; and appropriate facility staff. We will hire or contract the services of a QMHP to complete the individualized service plan. Completion within 1-2 weeks. Individual #1 will receive documentation of their completed Individualized service plan. Moving forward, the Chief Administrative Officer will conduct weekly file reviews to ensure the Individualized Service Plans and reports are included in all individual files. OLR) Accepted 05/01/2024	4/24/2024

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12VAC35-46-850. C. - All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer medication.	N	**HEALTH AND SAFETY VIOLATION** Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Employee #1's personnel record, there failed to be documented evidence that the employee successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications.	PR) 04/12/2024 The corrective action plan moving forward regarding medication administration certificates. The certificate will be in employee files according to regulations, prior to having to administer any medication. An employee who does not have an active certification will not administer medications, as the policy states. Every employee per policy and procedure will complete a 32-hour medication management course and supply Lighthouse 1 LLC with their certificate following the successful completion of the class. Employee #1 is no longer employed at Lighthouse 1 LLC. Our attempts to contact employee #1 and obtain the certificate for the file have been unsuccessful. Moving forward upon hire, anyone who already has their medication administration certificate will supply that certificate to the Lighthouse 1 LLC, so that it can be in placed in their employee file upon hire. OLR) Accepted 05/01/2024	4/12/2024
12VAC35-46-850. E. - A program of medication, including over-the-counter medication, shall be initiated for a resident only when prescribed in writing by a person authorized by law to prescribe medication.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's service record, there failed to be documented evidence of administration only when prescribed in writing by a person authorized by law to prescribe medication. The provider failed to have current medication orders for Individual #1. In review of Individual #2's service record, there failed to be documented evidence of administration only when prescribed in writing by a person authorized by law to prescribe medication. The provider failed to have current medication orders for Individual #2.	PR) 04/19/2024 A program of medication, including over-the-counter medication, shall be initiated for a resident only when prescribed in writing by a person authorized by law to prescribe medication. The corrective action plan regarding over the counter medications	4/19/2024

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			moving forward is that all individuals upon admission to the program will have a standing order from the current physician. In the event that a standing order is not provided at the time of admission, a doctor appointment will be made to obtain a standing order. No medication to include over the counter medications will be given without a valid medication order from the physician. Furthermore, an over the counter medication, that we have a physician order for, will only be administered by a staff member that has the appropriate credentials, when the client initiates a request for said medication. In compliance with regulation 12VAC35-46-850, Lighthouse 1 has revised the medication policy to reflect that all medications can only be given with a valid physician order	

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			to include over the counter medications. Over the counter medications can only be given when the individual specifically requests the medication. When all medications are administered by a trained staff, staff will document in the individual's medication administration record immediately following the administration of the prescribed medication. In compliance with regulation 12VAC35-46-850 the medication administration record shall include date the medication was prescribed, drug name, schedule for administration, strength, identity of the individual who administered the medication, and dates the medication was discontinued or changed. OLR) Accepted 05/01/2024	

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12VAC35-46-850. F. - Medication prescribed by a person authorized by law shall be administered as prescribed.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's Medication Administration Record, there failed to be documented evidence that medication was administered as prescribed. There failed to be documented evidence that Medication #1, Medication #4, Medication #5, and Medication #6 were administered as prescribed on 1/30/24 and 1/31/24. There failed to be documented evidence that Medication #2 was administered as prescribed on 3/18/24 and 3/19/24. There failed to be documented evidence that Medication #3 was administered as prescribed on 3/18/24, 3/23/24 and 3/24/24. The MAR indicated Medication #7 was administered on 2/30/24 when no such date exists. In review of Individual #1's Medication Administration Record, there failed to be documented evidence that medication was administered as prescribed. There were nine different medication bottles which were mixed with discontinued and current medications. There failed to be documented evidence that medications were administered after 3/12/24.	PR) 04/19/2024 Medication prescribed by a person authorized by law shall be administered as prescribed. The corrective action plan regarding authorized persons to prescribe and administer medication is as follows: All medications that are prescribed will have a physician order to accompany the medication and the medication administration record. In compliance with regulation 12VAC35-46-850 All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer medication. Per Lighthouse 1 policy and procedure all staff members who do not have a valid certification	4/19/2024

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			to administer medication will be trained. Staff persons who have a valid certificate will give Lighthouse 1 a copy of verification of successful completion of said training. In conjunction with Lighthouse 1 policy, only staff members who have completed medication training will be allowed to give individuals their medication. Each staff member administering medication will complete the 5 rights related to medication administration to ensure compliance and accuracy. Lighthouse 1 will also amend the current medication policy to indicate that only current prescribed medications will be stored together per individual. Medications that are awaiting to be disposed of will be stored independent of current medications. OLR) Accepted 05/01/2024	
12VAC35-46-850. G. (1) - A medication	N	Lighthouse 1, LLC	PR) 04/19/2024	4/19/2024

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administration record shall be maintained of all medicines received by each resident and shall include: 1. Date the medication was prescribed;		This regulation was NOT MET as evidenced by: In review of Individual #1's Medication Administration Record, there failed to be documented evidence of date the medications were prescribed. In review of Individual #2's Medication Administration Record, there failed to be documented evidence of date the medications were prescribed.	A medication administration record shall be maintained of all medicines received by each resident and shall include: 1. Date the medication was prescribed; The corrective action plan regarding medication administration records is as follows: All medications that are prescribed will have a physician order to accompany the medication and the medication administration record. In compliance with regulation 12VAC35-46-850 All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer medication. Per Lighthouse 1 policy and procedure all staff members	

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			who do not have a valid certification to administer medication will be trained. Staff persons who have a valid certificate will give Lighthouse 1 a copy of verification of successful completion of said training. In conjunction with Lighthouse 1 policy, only staff members who have completed medication training will be allowed to give individuals their medication. Each staff member administering medication will complete the 5 rights (the right patient, the right drug, the right time, the right dose, and the right route) related to medication administration to ensure compliance and accuracy. Lighthouse 1 will do an addendum to the current medication policy to include; each certified staff person that administers medication will ensure accuracy evident by completing the 5 rights to administer medication. Said staff person will identify themselves on medication administration records evident by initialing the front of the record as	

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			having given the prescribed medication, and printing and signing the back of the record for continuity related to documentation. When there is a change or discontinuation of a prescribed medication the date of the change and/or discontinuance will be documented on the record. Discontinued medication will be disposed of within 24 hours of the discontinuation. OLR) Accepted 05/01/2024	
12VAC35-46-850. G. (5) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 5. Route;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's Medication Administration Record, there failed to be documented evidence of route of medication administration. In review of Individual #2's Medication Administration Record, there failed to be documented evidence of route of medication administration.	PR) 04/19/2024 A medication administration record shall be maintained of all medicines received by each resident and shall include: 5. Route; The corrective action plan regarding medication administration records is as follows: All medications that are prescribed will have a physician order to	4/19/2024

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			accompany the medication and the medication administration record. In compliance with regulation 12VAC35-46-850 All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer medication. Per Lighthouse 1 policy and procedure all staff members who do not have a valid certification to administer medication will be trained. Staff persons who have a valid certificate will give Lighthouse 1 a copy of verification of successful completion of said training. In conjunction with Lighthouse 1 policy, only staff members who have completed medication training will be allowed to give individuals their medication. Each staff member administering medication will complete the 5 rights (the right patient, the right drug, the right	

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			time, the right dose, and the right route) related to medication administration to ensure compliance and accuracy. Lighthouse 1 will do an addendum to the current medication policy to include; each certified staff person that administers medication will ensure accuracy evident by completing the 5 rights to administer medication. Said staff person will identify themselves on medication administration records evident by initialing the front of the record as having given the prescribed medication, and printing and signing the back of the record for continuity related to documentation. When there is a change or discontinuation of a prescribed medication the date of the change and/or discontinuance will be documented on the record. Discontinued medication will be disposed of within 24 hours of the discontinuation. OLR) Accepted 05/01/2024	
12VAC35-46-850. G.	N	Lighthouse 1, LLC	PR) 04/19/2024	4/19/2024

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
(6) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 6. Identity of the individual who administered the medication;		This regulation was NOT MET as evidenced by: In review of Individual #1's Medication Administration Record, there failed to be documented evidence of identity of the individual who administered the medication. There failed to be employee signatures to identify initials listed on the MAR. In review of Individual #2's Medication Administration Record, there failed to be documented evidence of identity of the individual who administered the medication. There failed to be employee signatures to identify initials listed on the MAR.	A medication administration record shall be maintained of all medicines received by each resident and shall include: 6. Identity of the individual who administered the medication The corrective action plan regarding medication administration records is as follows: All medications that are prescribed will have a physician order to accompany the medication and the medication administration record. In compliance with regulation 12VAC35-46-850 All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer	

License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **03-27-2024**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			medication. Per Lighthouse 1 policy and procedure all staff members who do not have a valid certification to administer medication will be trained. Staff persons who have a valid certificate will give Lighthouse 1 a copy of verification of successful completion of said training. In conjunction with Lighthouse 1 policy, only staff members who have completed medication training will be allowed to give individuals their medication. Each staff member administering medication will complete the 5 rights (the right patient, the right drug, the right time, the right dose, and the right route) related to medication administration to ensure compliance and accuracy. Lighthouse 1 will do an addendum to the current medication policy to include; each certified staff person that administers medication will ensure accuracy evident by completing the 5 rights to administer medication. Said staff person will identify themselves on medication	

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Date of Inspection: **03-27-2024**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			administration records evident by initialing the front of the record as having given the prescribed medication, and printing and signing the back of the record for continuity related to documentation. When there is a change or discontinuation of a prescribed medication the date of the change and/or discontinuance will be documented on the record. Discontinued medication will be disposed of within 24 hours of the discontinuation. OLR) Accepted 05/01/2024	
12VAC35-46-850. G. (7) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 7. Dates the medication was discontinued or changed.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: In review of Individual #1's Medication Administration Record, there failed to be documented evidence of dates the medication was discontinued or changed. In review of Individual #2's Medication Administration Record, there failed to be documented evidence of dates the medication was discontinued or changed.	PR) 04/19/2024 A medication administration record shall be maintained of all medicines received by each resident and shall include: 7. Dates the medication was discontinued or changed. The corrective action plan regarding medication administration records is as follows:	4/19/2024

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Date of Inspection: **03-27-2024**
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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			All medications that are prescribed will have a physician order to accompany the medication and the medication administration record. In compliance with regulation 12VAC35-46-850 All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer medication. Per Lighthouse 1 policy and procedure all staff members who do not have a valid certification to administer medication will be trained. Staff persons who have a valid certificate will give Lighthouse 1 a copy of verification of successful completion of said training. In conjunction with Lighthouse 1 policy, only staff members who have completed medication training will be allowed to give individuals their medication. Each staff member	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			administering medication will complete the 5 rights (the right patient, the right drug, the right time, the right dose, and the right route) related to medication administration to ensure compliance and accuracy. Lighthouse 1 will do an addendum to the current medication policy to include; each certified staff person that administers medication will ensure accuracy evident by completing the 5 rights to administer medication. Said staff person will identify themselves on medication administration records evident by initialing the front of the record as having given the prescribed medication, and printing and signing the back of the record for continuity related to documentation. When there is a change or discontinuation of a prescribed medication the date of the change and/or discontinuance will be documented on the record. Discontinued medication will be disposed of within 24 hours of the discontinuation.	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			OLR) Accepted 05/01/2024	

General Comments / Recommendations:
The licensing specialist recommends the provider review regulations 12VAC35-46-250, 12VAC35-46-290, 12VAC35-46-300, 12VAC35-46-310, 12VAC35-46-740, 12VAC35-46-750, 12VAC35-46-850, and 12VAC35-46-250 for compliance.

The licensing specialist recommends the provider review regulations 12VAC35-520 A. The provider should reference the Crosswalk of DBHDS Approved Risk Management Training on the Office of Licensing webpage. The provider is responsible for submitting the completed DBHDS Risk Management Attestation to the Licensing Specialist along with the CAP. The providers CAP shall include a detailed description of corrective actions that will minimize the possibility of the violation occurring again. The provider MUST submit the completed attestation with the CAP.

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.

Melonie Beatty, Licensing Specialist | (Signature of Organization Representative) | Date

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