Investigation ID: **147**
License #: **630-14-001**
Organization Name: **Hughes Center for Exceptional Children**

Date of Inspection: **03-16-2022**
Program Type/Facility Name: **14-001 The Hughes Center**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-1070. B. (2) - The provider shall document the following: 2. A brief description of the incident;	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of the Serious Event Report for Resident #1 from 3-5-2022 found the description of the incident included a description of events that did not match the video footage that was reviewed as part of the investigation. Additionally, what was inputted into the CHRIS system did not adequately portray a description of the events that occurred as the report was inputted based on reported information from the staff who created the internal Serious Event Report with inaccurate information.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Director of Risk Management reviewed policy Reporting and Investigating Resident Abuse, Neglect, and Exploitation. Chief Executive Officer provided retraining to leadership staff on policy and roles and responsibilities in the reporting process. • Director of Operations provided retraining to MHT staff on the process of reporting incidents including accuracy in reporting, description of events, actions taken as a result of the incident and notification process. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. • Leadership Rounding Tool was revised and is used to monitor staff engagement and milieu management techniques. Leadership Rounding Tool data is provided to Director of Risk Management and tracked on the comprehensive monitoring grid. • The Human Resources Manager monitors compliance and completion of re-education. Data is provided to Director of Risk management and tacked on the comprehensive monitoring grid.	6/30/2022

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			OLR) Accepted 06/09/2022 Please ensure proof of the type of re-training pertaining to serious incident reporting is maintained in the employee files and details about the training can be produced. Please ensure the comprehensive monitoring grid includes detail about how the accuracy of incident reporting has been implemented and addresses discrepancies, if found.	
12VAC35-46-1070. B. (3) - The provider shall document the following: 3. The action taken as a result of the incident;	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of the Serious Event Report from 3-5-2022 for Resident #1 reviewed during this investigation found the description of the action taken as a result of the incident did not align with the actual action taken during and after the incident as evidenced by video footage and interviews during the investigation process.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Director of Risk Management reviewed policy Reporting and Investigating Resident Abuse, Neglect, and Exploitation. Chief Executive Officer provided retraining to leadership staff on policy and roles and responsibilities in the reporting process. • Directors, Managers, and Coordinators completed Situational Awareness training via electronic learning platform. • Director of Operations provided retraining to MHT staff on the process of reporting incidents including accuracy in reporting, description of events, actions taken as a result of the incident and notification process. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid	6/30/2022

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			and presents results in monthly Quality Council. • Leadership Rounding Tool was revised and is used to monitor staff engagement and milieu management techniques. Leadership Rounding Tool data is provided to Director of Risk Management and tracked on the comprehensive monitoring grid. • The Human Resources Manager monitors compliance and completion of re-education. Data is provided to Director of Risk management and tacked on the comprehensive monitoring grid. OLR) Accepted 06/09/2022	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-280. A. (1) - There shall be a written job description for each position that, at a minimum, includes the: 1. Job title;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: As referenced in this section of code, there should be a written job description for each position to include a job description for Case Managers. Employee #8 had been identified by Hughes Center as the Case Manager for Resident #1. A review of Employee #8's Personnel File found Employee #8 does not have a Case Management job description. Additionally, the job description produced for Employee #8 is solely for another position with the agency, where 100% of their Standard Responsibilities are focused on another formal position title, which is also a required position for Children's Residential Services.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • The Director of Clinical Services reviewed and revised the job description for clinical staff to include required case management tasks. Title of therapist position changed to Therapist/Clinical Case Manager to provide clarification on role/responsibility of clinical staff members. • Specific case management tasks and documentation requirements were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services reviewed and revised annual competency checklist to include required case management duties. Checklist was reviewed with therapists to ensure understanding of case management requirements. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022 Please ensure the updated job descriptions have been filed in the staff charts for future review.	6/30/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-280. A. (2) - There shall be a written job description for each position that, at a minimum, includes the: 2. Duties and responsibilities of the incumbent;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: As referenced in this section of code, there should be a written job description for each position to include a job description for Case Managers including duties and responsibilities. Employee #8 had been identified by Hughes Center as the Case Manager for Resident #1. A review of Employee #8's Personnel File found Employee #8 does not have a Case Management job description. Additionally, the job description produced for Employee #8 is solely for another position with the agency, where 100% of their Standard Responsibilities are focused on another formal position title, which is also a required position for Children's Residential Services. There was no Case Management job description produced to include the Case Management duties and responsibilities.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • The Director of Clinical Services reviewed and revised the job description for clinical staff to include required case management tasks. Title of therapist position changed to Therapist/Clinical Case Manager to provide clarification on role/responsibility of clinical staff members. • Specific case management tasks and documentation requirements were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services reviewed and revised annual competency checklist to include required case management duties. Checklist was reviewed with therapists to ensure understanding of case management requirements. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	6/30/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-360. A. - Case managers shall have the responsibility for coordination of all services offered to each resident.	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of requested Case Management notes for Resident #1 found there were no documented Case Management Progress Notes for Resident #1 since their admission into services. There was no documented proof of Case Management coordination of services for Resident #1.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Specific case management tasks including coordination of services were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services developed and reviewed annual competency checklist to include required case management duties including coordination of services. Checklist was reviewed with therapists to ensure understanding of case management requirements. • Director of Clinical Services developed documentation standards to include monthly case management coordination of care notes for each patient. Documentation of care coordination and discharge planning is documented in both progress notes and in the treatment plan. • Director of Clinical Services or designee audits compliance with case management notes on a monthly basis and reports compliance in Quality Council. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	6/30/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-380. B. (3) - A child care worker and a relief child care worker shall: 3. Be a high school graduate or have a G.E.D. and have six months of experience working with children.	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of Employee #1's Personnel File found their chart did not show proof of the required six months of experience working with children as outlined in this section of code for a high school graduate. On the date of the incident, Employee #1 was working on a side of the cottage with Employee #2 who did not have documented experience greater than one or more years of professional experience working with children as outlined in section 380.C. of code.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • The Human Resources Manager identified direct care staff with greater than 1 year of experience and direct care staff with less than1 year of experience. Data was provided to Director of Operations to assist in scheduling employees. • Director of Operations reviewed employee list and developed schedule to ensure all staff with <1 year of experience are working with those tenured staff as defined by 12VAC35-46-380.B. • Director of Operations and Human Resources Manager review schedules weekly to ensure compliance. • Human Resources Manager audited direct care staff job descriptions and level of experience to ensure compliance with regulations. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022 Please ensure the comprehensive monitoring grid addresses the changes made for direct care staff scheduling.	6/30/2022
12VAC35-46-60. K. -	NS	**HEALTH AND SAFETY VIOLATION**	PR) 05/06/2022	6/30/2022

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Providers shall not engage in willful action or gross negligence that jeopardizes the care or protection of residents.		The Hughes Center This regulation was NOT MET as evidenced by: A review of video footage for this investigation into the incident on 3-5-2022 found Staff #1, Staff #2, and Staff #3 were negligent in their position duties, jeopardizing the safety of Resident #1 where Resident #1 required professional medical attention after the incident. Additionally, this incident under investigation on 3-5-2022 occurred a few hours after Staff #1, Staff #2, and Staff #3 programmed Resident #1 with other residents where they had been involved in an earlier peer on peer incident. It was self-reported by the provider that the residents had been separated to opposite parts of the cottage with historical knowledge that Resident #1 and the other residents on the separate side of the cottage should not be programmed together due to the concerns for peer on peer incidents. Despite this, they were programmed together, jeopardizing the residents care during the second incident on 3-5-22 referenced in this Licensing Report.	PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. • Leadership Rounding Tool was revised and is used to monitor staff engagement and milieu management techniques. Leadership Rounding Tool data is provided to Director of Risk Management and tracked on the comprehensive monitoring grid. • The Human Resources Manager monitors compliance and completion of re-education. Data is provided to Director of Risk management and tacked on the comprehensive monitoring grid. • Director of Clinical Services and Medical Director provided re-training to staff regarding patient rights, responding to abuse/neglect, mandated reporting and milieu management. • Chief Operating Officer and designee provided re-training to MHT staff regarding response to Code Yellow response and early identification of need for specific codes for additional staff assistance. • Directors, Managers, and Coordinators completed Situational Awareness training via electronic learning platform. • Risk manager developed internal	

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			investigation process to ensure all serious incidents are reviewed and investigated in a timely and through manner. Any incidents of staff deviation from standards of care and/or policy/procedures result in disciplinary action up to and including termination. • Director of Operations developed and executed structured staff-to-staff handoff process including report of specific at-risk behaviors to ensure potential risk events are identified early to prevent further incidents. • Director of Clinical Services and Director of Operations developed clinical supervision model for MHTs in conjunction with clinical staff to provided additional training on transference, counter transference, vicarious trauma, and trauma informed care principles. • Human Resources Manager revised orientation process to enhance new MHT experience with shadowing tenured staff and breaking training days into mix of didactic/hands on training. OLR) Accepted 06/09/2022 Please ensure the comprehensive monitoring grid has a means to capture the safety concerns related to this incident. Please ensure there is available documentation kept in staff records and proof of the content of the re-training that has been completed and for what population of staff regarding the patient rights, responding to abuse/neglect, mandated reporting, and milieu management as referenced in the response.	

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12VAC35-46-625. A. (7) - The provider shall have and implement written policies and procedures for the on-site provision of a structured program of care or treatment of residents with mental illness, mental retardation, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, mental retardation, substance abuse, or brain injury interventions shall be based on the assessed needs of the resident. These interventions, applicable to the population served, shall include, but are not limited to: 7. Providing positive behavior supports;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of video footage from 3-5-2022 found Staff #1, Staff #2, and Staff #3 did not provide appropriate positive behavior supports as outlined in Resident #1's Behavior Support Plan. All three staff did not follow the items listed under section "What can staff do to help:" of Resident #1's Behavior Support Plan.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Director of Program Operations provided retraining to staff on the use of Behavior Support Plans including where to find supportive interventions on rounding sheets and how to implement individualized behavior plans. • Director of Clinical Services and Medical Director provided re-training to staff regarding patient rights, responding to abuse/neglect, and milieu management. Training identified the use of Behavior Support Plans. • Director of Clinical Services and Director of Operations developed supervision model for MHTs in conjunction with clinical staff to provided additional support and processing on topics including Behavior Support Plans, transference, counter transference, vicarious trauma, and trauma informed care principles. • Human Resources Manager revised orientation process to increase training time emphasizing patient engagement, responding to prodromal signs/symptoms of escalation, and crisis management. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council.	6/30/2022

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			• Leadership Rounding Tool was revised and is used to monitor staff engagement and milieu management techniques. Leadership Rounding Tool data is provided to Director of Risk Management and tracked on the comprehensive monitoring grid. • The Human Resources Manager monitors compliance and completion of re-education. Data is provided to Director of Risk management and tacked on the comprehensive monitoring grid. OLR) Accepted 06/09/2022 Please ensure the content of the re-training is available for future review and it is clarified within staff charts for those staff who have received this updated re-training and re-education.	
12VAC35-46-780. A. (1) - The program of the facility shall be designed to provide case management services. At the time of the admission of any resident, the provider shall identify in writing the staff member responsible for providing case management services. Case management services shall address: 1. Helping the resident and the parents or legal guardian to understand the effects on the resident of separation	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Provider reported Staff #8 serves as Resident #1's Case Manager. A review of Resident #1's record found that there were no documented Case Management Progress Notes completed by Staff #8 or any other staff since Resident #1's admission. It was found that Staff #8 has another full-time position and nothing was produced in writing to identify Staff #8 as a Case Manager. Additionally, there was no documentation provided to identify a Case Manager for Resident #1. The Case Management services outlined in section 780.1-6 have not been documented for Resident #1.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Specific case management tasks including (1) coordination of services, (2) helping patient and guarding understand the impact if living away from family and in congregate setting, (3) discharge planning, (4) community linkages, (5) coordination of family contact and passes and (6) assisting patient in the development of interpersonal relationship were reviewed with all therapists by Director of Clinical Services • Director of Clinical Services developed and reviewed annual competency checklist to include required case	6/30/2022

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from the family and the effect of group living;			management duties including coordination of services. Checklist was reviewed with therapists to ensure understanding of case management requirements. • Director of Clinical Services developed documentation standards to include monthly case management coordination of care notes for each patient. Documentation of care coordination and discharge planning is documented in both progress notes and in the treatment plan. • Director of Clinical Services or designee audits compliance with case management notes and reports compliance in Quality Council. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022 Please ensure the comprehensive monitoring grid addresses the specific concerns that were related to Case Management and how this is being implemented and overseen moving forward.	
12VAC35-46-780. A. (2) - The program of the facility shall be designed to provide case management services. At the time of the admission of any resident, the provider	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Provider reported Staff #8 serves as Resident #1's Case Manager. A review of Resident #1's record found that there were no documented Case Management Progress Notes	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Specific case management tasks including (1) coordination of services, (2)	6/30/2022

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shall identify in writing the staff member responsible for providing case management services. Case management services shall address: 2. Assisting the resident and the family to maintain their relationships and prepare for the resident's future care;		completed by Staff #8 or any other staff since Resident #1's admission. It was found that Staff #8 has another full-time position and nothing was produced in writing to identify Staff #8 as a Case Manager. Additionally, there was no documentation provided to identify a Case Manager for Resident #1. The Case Management services outlined in section 780.1-6 have not been documented for Resident #1.	helping patient and guarding understand the impact if living away from family and in congregate setting, (3) discharge planning, (4) community linkages, (5) coordination of family contact and passes and (6) assisting patient in the development of interpersonal relationship were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services developed and reviewed annual competency checklist to include required case management duties including coordination of services. Checklist was reviewed with therapists to ensure understanding of case management requirements. • Director of Clinical Services developed documentation standards to include monthly case management coordination of care notes for each patient. Documentation of care coordination and discharge planning is documented in both progress notes and in the treatment plan. • Director of Clinical Services or designee audits compliance with case management notes and reports compliance in Quality Council. OLR) Accepted 06/09/2022 Please ensure the changes made to document Case Management tasks has been applied to all residents as of the submission of this action date.	
12VAC35-46-780. A. (3) - The program of the facility shall be designed to provide	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by:	PR) 05/06/2022 SPR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future:	6/30/2022

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case management services. At the time of the admission of any resident, the provider shall identify in writing the staff member responsible for providing case management services. Case management services shall address: 3. Utilizing appropriate community resources to provide services and maintain contacts with such resources;		Provider reported Staff #8 serves as Resident #1's Case Manager. A review of Resident #1's record found that there were no documented Case Management Progress Notes completed by Staff #8 or any other staff since Resident #1's admission. It was found that Staff #8 has another full-time position and nothing was produced in writing to identify Staff #8 as a Case Manager. Additionally, there was no documentation provided to identify a Case Manager for Resident #1. The Case Management services outlined in section 780.1-6 have not been documented for Resident #1.	• Specific case management tasks including (1) coordination of services, (2) helping patient and guarding understand the impact if living away from family and in congregate setting, (3) discharge planning, (4) community linkages, (5) coordination of family contact and passes and (6) assisting patient in the development of interpersonal relationship were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services developed and reviewed annual competency checklist to include required case management duties including coordination of services. Checklist was reviewed with therapists to ensure understanding of case management requirements. • Director of Clinical Services developed documentation standards to include monthly case management coordination of care notes for each patient. Documentation of care coordination and discharge planning is documented in both progress notes and in the treatment plan. • Director of Clinical Services or designee audits compliance with case management notes and reports compliance in Quality Council. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	

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12VAC35-46-780. A. (4) - The program of the facility shall be designed to provide case management services. At the time of the admission of any resident, the provider shall identify in writing the staff member responsible for providing case management services. Case management services shall address: 4. Helping the resident strengthen his capacity to function productively in interpersonal relationships;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Provider reported Staff #8 serves as Resident #1's Case Manager. A review of Resident #1's record found that there were no documented Case Management Progress Notes completed by Staff #8 or any other staff since Resident #1's admission. It was found that Staff #8 has another full-time position and nothing was produced in writing to identify Staff #8 as a Case Manager. Additionally, there was no documentation provided to identify a Case Manager for Resident #1. The Case Management services outlined in section 780.1-6 have not been documented for Resident #1.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Specific case management tasks including (1) coordination of services, (2) helping patient and guarding understand the impact of living away from family and in congregate setting, (3) discharge planning, (4) community linkages, (5) coordination of family contact and passes and (6) assisting patient in the development of interpersonal relationship were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services developed and reviewed annual competency checklist to include required case management duties including coordination of services. Checklist was reviewed with therapists to ensure understanding of case management requirements. • Director of Clinical Services developed documentation standards to include monthly case management coordination of care notes for each patient. Documentation of care coordination and discharge planning is documented in both progress notes and in the treatment plan. • Director of Clinical Services or designee audits compliance with case management notes and reports compliance in Quality Council. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility	6/30/2022

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			maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	
12VAC35-46-780. A. (5) - The program of the facility shall be designed to provide case management services. At the time of the admission of any resident, the provider shall identify in writing the staff member responsible for providing case management services. Case management services shall address: 5. Conferring with the child care staff to help them understand the resident's needs in order to promote adjustment to group living;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Provider reported Staff #8 serves as Resident #1's Case Manager. A review of Resident #1's record found that there were no documented Case Management Progress Notes completed by Staff #8 or any other staff since Resident #1's admission. It was found that Staff #8 has another full-time position and nothing was produced in writing to identify Staff #8 as a Case Manager. Additionally, there was no documentation provided to identify a Case Manager for Resident #1. The Case Management services outlined in section 780.1-6 have not been documented for Resident #1.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Specific case management tasks including (1) coordination of services, (2) helping patient and guarding understand the impact of living away from family and in congregate setting, (3) discharge planning, (4) community linkages, (5) coordination of family contact and passes and (6) assisting patient in the development of interpersonal relationship were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services developed and reviewed annual competency checklist to include required case management duties including coordination of services. Checklist was reviewed with therapists to ensure understanding of case management requirements. • Director of Clinical Services and Director of Operations developed supervision model for MHTs in conjunction with clinical staff to provided additional support and processing on topics including Behavior Support Plans, transference, counter transference, vicarious trauma, and trauma informed care principles. • A comprehensive monitoring grid has	6/30/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	
12VAC35-46-780. A. (6) - The program of the facility shall be designed to provide case management services. At the time of the admission of any resident, the provider shall identify in writing the staff member responsible for providing case management services. Case management services shall address: 6. Working with the resident and with the family or any placing agency that may be involved in planning for the resident's future and in preparing the resident for the return home or to another family for independent living or for other residential care.	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Provider reported Staff #8 serves as Resident #1's Case Manager. A review of Resident #1's record found that there were no documented Case Management Progress Notes completed by Staff #8 or any other staff since Resident #1's admission. It was found that Staff #8 has another full-time position and nothing was produced in writing to identify Staff #8 as a Case Manager. Additionally, there was no documentation provided to identify a Case Manager for Resident #1. The Case Management services outlined in section 780.1-6 have not been documented for Resident #1.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Specific case management tasks including (1) coordination of services, (2) helping patient and guarding understand the impact of living away from family and in congregate setting, (3) discharge planning, (4) community linkages, (5) coordination of family contact and passes and (6) assisting patient in the development of interpersonal relationship were reviewed with all therapists by Director of Clinical Services. • Director of Clinical Services developed and reviewed annual competency checklist to include required case management duties including coordination of services. Checklist was reviewed with therapists to ensure understanding of case management requirements. • Director of Clinical Services developed documentation standards to include monthly case management coordination of care notes for each patient. Documentation of care coordination and discharge planning is documented in both progress notes and in the treatment plan.	6/30/2022

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Organization Name: **Hughes Center for Exceptional Children**

Date of Inspection: **03-16-2022**
Program Type/Facility Name: **14-001 The Hughes Center**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			• Director of Clinical Services or designee audits compliance with case management notes and reports compliance in Quality Council. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	

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12VAC35-46-780. B. - The provision of case management services shall be documented in each resident's record.	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Provider reported Staff #8 serves as Resident #1's Case Manager. A review of Resident #1's record found that there were no documented Case Management Progress Notes completed by Staff #8 or any other staff since Resident #1's admission. It was found that Staff #8 has another full-time position and nothing was produced in writing to identify Staff #8 as a Case Manager. Additionally, there was no documentation provided to identify a Case Manager for Resident #1. The Case Management services outlined in section 780.1-6 have not been documented for Resident #1.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Director of Clinical Services developed documentation standards to include monthly case management coordination of care notes for each patient. Documentation of care coordination and discharge planning is documented in both progress notes and in the treatment plan. • Director of Clinical Services or designee audits compliance with case management notes and reports compliance in Quality Council. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	6/30/2022
12VAC35-46-810. A. (3) - The provider shall have and implement written procedures for promptly: 3. Providing emergency services for each resident;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: It was found that a code was called during an emergency situation on 3-5-2022 where Employee #4 and Employee #5 arrived to provide medical assistance to Resident #1. Upon review of video footage of the event, Employee #4 and Employee #5 completed other tasks that Employee #6	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Chief Operating Officer and Director of Nursing reviewed Disaster Emergency Codes Policy to clarify roles and responsibilities during emergency situations. (Provided re-education on	6/30/2022

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		and Employee #7 were already addressing prior to Employee #4 and Employee #5 tending to the emergent medical needs of Resident #1. Additionally, Resident #1 was not provided with adequate First Aid until a delayed timeframe had lapsed. Resident #1 needed First-Aid and medical attention; a non approved first-aid kit item was given to Resident #1 by Employee #2 in the interim and Resident #1 supported themselves before receiving any first aid attention from Employee #4 or Employee #5.	policy and practice • Director of Nursing reviewed and revised Medical Emergency Response Policy to clarify roles and responsibilities during emergency situations. • Director of Nursing provided re-training to all nurses regarding response to medical emergencies, assessment process of patients, and notification process to seek additional medical support. • Director of Nursing developed medical supplies checklist for weekly audit to ensure first aid and medical equipment are easily assessable and available to staff. • Medical supply audit tool will be presented in monthly Safety Meeting by Director of Nursing. • Internal investigation completed by Director of Risk Management, Chief Operating Officer, Human Resources Manager and Chief Executive Officer. Corrective action provided to employees who did not meet the standards of care set by facility policy and procedures. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022 Please ensure the weekly audit of medical supply tool is available for review as of the action date of this plan. Please ensure the medical supply audit tool is	

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			available for review as of the action date of this plan.	
12VAC35-46-840. K. - A well-stocked first aid kit shall be maintained and readily accessible for minor injuries and medical emergencies.	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of the First-Aid kit in the cottage where Resident #1 was residing found the first-aid kit was not fully stocked with the required items during the site inspection on 3-16-2022. Additionally, a review of the video footage from the incident on 3-5-22 found Resident #1 did not receive proper medical treatment with use of the first aid kit as a non-first-aid kit item was given to Resident #1 initially after the events were over. The first aid kit was verified on 3-16-2022 to have been readily available to all staff and should have been the first means of medical care when Staff #4 and Staff #5 arrived to provide medical attention to Resident #1.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Director of Nursing developed Supplies checklist for weekly audit to ensure all necessary first aide and medical equipment easily assessable and available to staff. • Supply audit tool will be presented in monthly Safety Meeting by Director of Nursing. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022	6/30/2022

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12VAC35-46-850. J. - The provider shall develop and implement written policies and procedures for documenting medication errors, reviewing medication errors and reactions and making any necessary improvements, the disposal of medication, the storage of controlled substances, and the distribution of medication off campus. The policy and procedures must be approved by a health care professional. The provider shall keep documentation of this approval.	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A site inspection at two cottages found two expired EpiPens for PRN use via medication order. The provider self-reported they conduct checks for expired medication to be disposed of and not longer available for use, but had not caught that both EpiPens at these two locations were expired and needed to be replaced with a medication that could be administered as prescribed prior to an expiration date. There was no medication checklist to keep track of the expiration dates for the EpiPens per self-report from the provider.	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Director of Nursing developed and implemented a weekly audit tool to review medication checks to ensure no medications are expired. • Director of Nursing reviews results of Medication Audit Tool in monthly Safety Meeting. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council. OLR) Accepted 06/09/2022 Please ensure the medication checks audit tool specifically includes a review of the EpiPen's in each of their designed locations. Please ensure a review of other EpiPen's found on the property has already taken place to ensure those that are available for use are not expired.	6/30/2022
12VAC35-46-900. A. (3) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Individual #1 has a developed Behavior Support Plan that was not implemented on 3-5-2022 by Staff #1, Staff #2, or	PR) 05/06/2022 PR: The facility has made the following systemic changes to our internal processes to ensure compliance to the regulation in the future: • Internal investigation completed by Director of Risk Management, Chief	6/30/2022

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behaviors. Each individualized behavior support plan shall include: 3. Identification of successful intervention strategies for problem behavior;		Staff #3. Additionally, as outlined in Policy #223, there is reference to "The least restrictive behavioral intervention feasible to safely and appropriately manage resident behavior will be employed in all circumstances." This policy and the agency's Handle with Care Behavioral Intervention Curriculum was not followed by Employee #1, Employee #2, and Employee #3 during the incident on 3-5-2022.	Operating Officer, Human Resources Manager and Chief Executive Officer. Corrective action up to an including termination provided to employees who did not meet the standards of care set by facility policy and procedures. • Director of Program Operations provided retraining to staff on the use of Behavior Support Plans including where to find supportive interventions on rounding sheets and how to implement individualized behavior plans. • Director of Clinical Services and Medical Director provided re-training to staff regarding patient rights, responding to abuse/neglect, and milieu management. Training identified the use of Behavior Support Plans. • Director of Clinical Services and Director of Operations developed supervision model for MHTs in conjunction with clinical staff to provided additional support and processing on topics including Behavior Support Plans, transference, counter transference, vicarious trauma, and trauma informed care principles. • Human Resources Manager revised orientation process to enhance new MHT experience with shadowing tenured staff and breaking training days into mix of didactic/hands on training. • A comprehensive monitoring grid has been developed to ensure practices are successfully implemented and facility maintains progress. Director of Risk Management maintains monitoring grid and presents results in monthly Quality Council.	

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			• Leadership Rounding Tool was revised and is used to monitor staff engagement and milieu management techniques. Leadership Rounding Tool data is provided to Director of Risk Management and tracked on the comprehensive monitoring grid. • The Human Resources Manager monitors compliance and completion of re-education. Data is provided to Director of Risk management and tacked on the comprehensive monitoring grid. OLR) Accepted 06/09/2022	

General Comments / Recommendations:
Please review and return on or before the due date via the CONNECT Provider Portal. Please include any pertinent supporting documentation with your responses.

Feel free to reach out to me with any questions or concerns.

Thank you,
Jordan Hyde

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.

Jordan Hyde	(Signature of Organization Representative)	Date

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