Investigation ID: **154**
License #: **630-14-001**
Organization Name: **Hughes Center for Exceptional Children**

Date of Inspection: **07-25-2022**
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. A. - Any serious incident, accident, or injury to the resident; any overnight absence from the facility without permission; any runaway; and any other unexplained absence shall be reported within 24 hours (i) to the placing agency; (ii) to either the parent or legal guardian, or both as appropriate; and (iii) noted in the resident's record.	N	The Hughes Center This regulation was NOT MET as evidenced by: Guardian of Resident #1 was contacted per agency requirements and internal protocol to report any incidents involving the resident, but was not informed of Resident #1's injury or action taken for the injury incurred on 7-21-22. A note written by Employee #11 dated for 16:20 on 7-21-22 states that Resident #1's Guardian was notified of the incident and the resulting restraint and need for psychiatric evaluation. The Guardian reported they inquired about whether or not Resident #1 was alright, to which the Guardian was reassured that Resident #1 was alright/fine. There is no documentation of the report of the injury to Resident #1's Guardian and the treatment Resident #1 received prior to going to Entity #1. There is documentation that Resident #1's Guardian was later notified at 2230 by Employee #12 of the same information, but also did not tell the guardian about the symptoms that had been treated, also reporting Resident #1 was alright again. A review of documentation at 2230 on 7-21-22 also confirms no report of the injury or treatment was reported by Employee #12 to Guardian at that time as well.	PR) 08/22/2022 • Internal investigation completed. Areas in which nursing staff deviated from standard of care was addressed with corrective action. (08/05/22) • Leadership meeting to include key leaders conducted twice daily. Shift Lead and Charge Nurse provide report on patient care issues, program compliance, and critical incident review for immediate problem solving and resolution. (08/08/22) • Chief Operating Officer developed incident tracking log to ensure all patient care issues are identified and tracked for reporting and action. Patient Advocate maintains tracking log and ensures facility follow-up. Tracking log is monitored monthly in Quality Council. (08/22/22) • Director of Risk Management developed and implemented process to review all episodes of restraint in a timely manner to identify any deviations from standard practice. Any issues are immediately addressed. (09/09/22) • Director of Risk Management developed internal investigation process to ensure all serious incidents are reviewed and investigated in a timely and through manner. Incidents of staff policy violations or deviation from standards of care result in disciplinary action up to and including termination. (09/09/22) OLR) Accepted 09/12/2022	9/30/2022
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:	PR) 08/22/2022 • Internal investigation completed. Areas in which nursing staff deviated from standard of care was addressed with corrective	9/30/2022

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		A review of the internal Serious Event Report did not mention anything about the injury or harm to Resident #1 despite staff reports of witness to the swelling of Resident #1's face when they were checked over. Resident #1 was given Medication #1 for the injury and specifically explained it was for right eye swelling and pain. This information about an injury, which would have prompted an immediate investigation into how the injury was inquired, was not included in the Serious Event Report. Resident #1's guardian was not told about the injury until Entity #1 had outreach to the guardian much later after there was a physical assessment at Entity #1.	action. (08/05/22) • Leadership meeting to include key leaders conducted twice daily. Shift Lead and Charge Nurse provide report on patient care issues, program compliance, and critical incident review for immediate problem solving and resolution. (08/08/22) • Chief Executive Officer facilitated CHRIS reporting and video review access to key leaders to ensure adequate number of leaders have access to review and report incidents in a timely manner. (08/22/22) • Chief Operating Officer developed incident tracking log to ensure all patient care issues and patient complaints are identified and tracked for follow up action. Patient Advocate maintains tracking log and ensures facility follow-up. Tracking log is monitored monthly in Quality Council. (08/22/22) • Director of Risk Management developed and implemented process to review all episodes of restraint in a timely manner to identify any deviations from standard practice. Any issues are immediately addressed. (09/09/22) • Director of Risk Management developed internal investigation process to ensure all serious incidents are reviewed and investigated in a timely and through manner. Incidents of staff policy violations or deviation from standards of care result in disciplinary action up to and including termination. (09/09/22) OLR) Accepted 09/12/2022	

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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 internal Serious Event Report did not mention anything about Resident #1's injury from the incident on7-21-22. Resident #1 was given an icepack and received Mediation #1 from Employee #6, but this information pertaining to the injury and action taken as a result of the injury was not included as part of the action taken in the report written by Employee #6. A review of CM documentation revealed that Employee #7 documented that on 7-22-22, Individual #1's MCO Clinical Care Manager had outreach to the Hughes Center Case Manager regarding the injuries sustained from 7-21-22. The note reads that there was documentation that nursing had reported a swollen eye and that Employee #8, Employee #9, and Employee #10 were notified for follow up and investigation. However, Employee #10 reported to the Licensing Specialist the first time they heard about the injury for an initiation of an abuse allegation was not until the following day on 7-23-22 when Individual #1's Guardian inquired about injuries per report they received from the treating Entity #1. This delay in the initiation of the investigation as to how the injuries were sustained is a violation of statutes related to abuse or neglect of children.	PR) 08/22/2022 • Chief Operating Officer developed incident tracking log to ensure all patient care issues and patient complaints are identified and tracked for follow up action. Patient Advocate maintains tracking log and ensures facility follow-up. Tracking log is monitored monthly in Quality Council. (08/22/22) • Chief Executive Officer facilitated CHRIS reporting and video review access to key leaders to ensure adequate number of leaders have access to review and report incidents in a timely manner. (08/22/22) • Chief Executive Officer conducted investigations of non-compliance with investigation and incident reporting standards. Incidents of deviation resulted in disciplinary action. (08/05/22) OLR) Accepted 09/12/2022	9/30/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-300. B. (9) - The records of each employee shall include: 9. Documentation of all training required by these regulations and any other training received by individual staff;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Personnel Records reviewed for Employee #1 and Employee #2 were found to have numerous required training documents to be incomplete. Many training documents to include certificates, tests, and attestations of training did not include the staff name, dates of training, scores for tests, and staff responsible for the training. Some examples of the missing documentation of training include: The Patient Observation Rounds Expectations Acknowledgement found in Employee #1's personnel file did not include if this was orientation or re-training, the trainer information and title of the trainer was left blank, the employee signature, employee date, and printed name are also blank. The Employee Agreement to Report Abuse and Neglect found in Employee #1's personnel file was a blank form; it did not have the staff printed name, staff signature, or a date. The VA Human Rights test found in Employee #1's personnel file did not have the printed name, date of completion, or a grade for the test.	PR) 08/22/2022 • Human Resources Manager developed and implemented monthly file audit process to ensure compliance with all mandatory training. Compliance report is presented in Quality Council. (09/30/22) • Human Resources Manager developed and implemented audit process for all new hires completing orientation to include certificates, tests, and attestations of training to ensure all documents are complete. (09/30/22) • Human Resources Manager revised orientation documentation processes to streamline collection of required information by creating a single attestation page of each policies reviewed during the orientation process. Attestation page identifies all areas of orientation in which the employee attended. Human Resources Manager audits attestation page to ensure completion. (09/30/22) OLR) Accepted 09/12/2022	9/30/2022
12VAC35-46-320. (3) - The provider shall develop and implement written policies and procedures regarding the supervision of employees, volunteers, contractors, and students/interns. These	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Resident #1's Patient Observation Record for intervals of 15 minute checks had missing documentation around the time of the incident. The 1615 time on the date of the incident was left blank for behavior, location, and staff	PR) 08/22/2022 • Chief Executive Officer, Director of Risk Management and Director of Nursing conduct video review rounds weekly to ensure patient supervision, milieu management, and program adherence. Results are reported to Corporate Risk Management and Quality Council by Director of Risk Management. Follow up is	9/30/2022

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policies and procedures shall include: 3. How the supervision will be documented.		initials. The 1630 check was marked as 3 "Cooperative," despite resident being put into a restraint for reported aggression towards staff. The 1630 check did not include the location. The 1645 check has the behavior code scratched out, no location, and no staff initials. The 1700 check shows Resident #1 as 3 "cooperative," but does not have a location or staff initials.	required for any action observed outside of policy with incident report completed. (08/29/22) • Key leaders conduct in-person Senior Leader Rounds weekly using the structured audit report. Data is collected and reviewed by Quality Council monthly by Chief Operating Officer. Audit report focuses on program fidelity including patient observation, staff supervision, Staff-patient interactions and milieu management. (08/22/22) • Director of Nursing stationed nursing staff in cottages to increase visibility, rounding, and supervision of patient care. Director of Nursing provided training on rounding, patient care, and MHT/patient interaction expectations. (09/19/22) • Key leaders' offices stationed in cottages to increase visibility, rounding, and supervision of patient care. (09/12/22) • Chief Executive Officer outlined roles, responsibilities, and leadership expectations with Program Coordinators. Expectations reviewed during 1:1 meetings with CEO. This includes schedule adherence, identification of patient needs concerns including issues of dignity/freedoms of everyday life, environment of care rounding, and staff/patient engagement. (08/22/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. 08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Management, Patent Observation Standards, and Effective Implementation of Behavior Support Plans. (10/21/22) OLR) Accepted 09/12/2022	
12VAC35-46-60. K. - Providers shall not engage in willful action or gross negligence that jeopardizes the care or protection of residents.	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of video footage on 7-25-22 for an incident occurring on 7-21-22 showed that Employee #1 used excessive force during an inappropriate physical altercation with Resident #1. Video footage reviewed on 7-25-22 confirmed that Employee #1 physically assaulted Resident #1 on 7-21-22. Video footage showed that Employee #2 and Employee #3 did not intervene appropriately when they witnessed Employee #1 holding Resident #1 in an inappropriate restraint. Employee #2 and Employee #3 walked around Employee #1 holding Resident #1 in an inappropriate restraint. Employee #1, Employee #2, and Employee #3 did not follow agency protocols to ensure the safety of the residents, resulting in negligence that jeopardized the care and protection of Resident #1 and their peers who were left in the room during the incident on 7-21-22.	PR) 08/22/2022 The facility has made the following systemic changes to our internal processes to ensure compliance with the regulation in the future: • Human Resources Manager and Director of Risk Management conducted investigations of staff non-compliance with policy and performance standards. Incidents of staff policy violations and deviation from standards of care resulted in disciplinary action. (08/05/22) • Chief Executive Officer, Director of Risk Management and Director of Nursing conduct video review rounds weekly to ensure patient supervision, milieu management, and program adherence. Results are reported to Corporate Risk Management and Quality Council by Director of Risk Management. Video review is conducted to address any employee misconduct or deviations from standard of care. (08/29/22) • Handle with Care and Verbal De-escalation training is provided twice annually to ensure crisis intervention techniques are aligned with standards of care. Human Resources Manager reports training compliance in Quality Council. (09/30/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. (08/18/22)	9/30/2022

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			• Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, and Effective Implementation of Behavior Support Plans. (10/21/22) • Leadership meeting (08/05/22) and Town Hall meetings (08/23/22) conducted by Chief Executive Officer to review expectations and address identified issues. OLR) Accepted 08/30/2022	
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	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of video footage on 7-25-22 for an incident occurring on 7-21-22 showed that Employee #1 did not provide positive behavior supports to Resident #1. Employee #1 did not allow Resident #1 to remain outside after Employee #4 had already given Resident #1 their rounding sheets to take with them to go outside. It was confirmed by Employee #5 on 7-25-22 that Resident #1 should have been allowed to remain outside. Employee #1 used physical force outside of the agency behavior intervention techniques to get Resident #1 back inside of their cottage. Employee #1 continued to utilize excessive force, causing injury to Resident #1 before a three-person proper restraint was implemented. Employee #1 did not provide appropriate positive behavior supports as outlined in Resident #1's Service Plan and Behavior Support Plan. Employee #1 did not apply any of the strategies listed in their Behavior Support Plan to calm down Resident #1 when they became escalated after video footage showed Employee #1 had sent Resident #1 back inside.	PR) 08/22/2022 • Director of Program Operations and Program Coordinators provided retraining to MHT staff on therapeutic interactions, managing a crisis, mandated reporting, and therapeutic schedules. Training and attestation are completed twice annually. (09/30/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. (08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, and Effective Implementation of Behavior Support Plans. (10/21/22) • Director of Clinical Services conducts therapeutic milieu and Behavior Support Plan training to Mental Health Techs. Training addresses the specific needs of patients and how to individualize the treatment and care while implementing the Behavior Support Plan. Monthly	9/30/2022

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supports;			training is monitored and tracked by Human Resources Department and reviewed monthly in Quality Council. (09/09/22) • Director of Program Operations revised and implemented daily therapeutic schedule to increase program structure and fidelity. Program Coordinators provided clear expectations of schedule adherence and how to effectively implement the schedule to MHTs. Schedule adherence is monitored during leadership rounding. (09/23/22) • Leadership meeting to include key leaders conducted twice daily. Shift Lead and Charge Nurse provide report on patient care issues, program compliance, and critical incident review for immediate problem solving and resolution. (08/08/22) • Corporate Clinical Director conducts monthly program fidelity review with facility to ensure compliance with key clinical indicators including therapeutic schedule adherence, patient rounding, and behavior support plan implementation. (08/09/22) • Chief Executive Officer identified and contracted with resources specializing in treatment modalities for children with Autism and/or Intellectual Disabilities to enhance training and professional development of direct care staff. Training is conducted quarterly to program staff. (09/30/22) • Human Resources Manager engaged in recruitment strategies for Board Certified Behavior Analyst to enhance programming support. Position posted on	

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			Indeed platform. (09/12/22) OLR) Accepted 09/12/2022	
12VAC35-46-650. - Each resident shall be placed in the least restrictive level of programming appropriate to individual functioning and available services.	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Video footage showed that Employee #1 denied Resident #1 the opportunity to go outside and play basketball with their peers on 7-21-22. Video footage showed Employee #4 allowing Resident #1 to go outside as Resident #1 was given their rounding sheet to take with them. Video footage shows Resident #1 being brought back inside by Employee #1 briefly after they had been allowed to go outside. The provider self-reported on 7-25-22 that residents can participate in activities of their choosing and this resident should have been allowed to remain outside with peers.	PR) 08/22/2022 • Leadership meeting to include key leaders conducted twice daily. Shift Lead and Charge Nurse provide report on patient care issues, program compliance, and critical incident review for immediate problem solving and resolution. (08/08/22) • Director of Nursing stationed nursing staff in cottages to increase visibility, rounding, and supervision of patient care. Director of Nursing provided training on rounding, patient care, and MHT/patient interaction expectations. (09/19/22) • Key leaders offices stationed in cottages to increase visibility, rounding, and supervision of patient care. (09/12/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. (08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, and Effective Implementation of Behavior Support Plans. (10/21/22) • Chief Executive Officer identified and contracted with resources specializing in treatment modalities for children with Autism and/or Intellectual Disabilities to enhance training and professional development of direct care staff. Training is conducted quarterly to program staff. (09/30/22) • Human Resources Manager engaged in recruitment strategies for Board Certified	9/30/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Behavior Analyst to enhance programming support. Position posted on Indeed platform. (09/12/22) OLR) Accepted 09/12/2022	
12VAC35-46-70. - Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115).	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: See OHR Citations.	PR) 08/22/2022 • Key leaders participated in additional Human Rights training provided by the Department of Behavioral Health and Developmental Disabilities. (08/18/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. (08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, and Effective Implementation of Behavior Support Plans. (10/21/22) • Program Coordinators ensure each individual has sufficient and suitable clothing for his/her exclusive use. Each patient's belongings are inventoried at the time of admission by MHT. The Program Coordinator meets with patient monthly to review any clothing or other belonging needs. Program Coordinator collaborates with the treatment team in obtaining any needed items. Log of needs and purchases is maintained by the Program Coordinator. Assigned staff are responsible for ensuring patients are wearing appropriate clothing and reporting any concerns to the Program Coordinator. (09/16/22) • Director of Risk Management and Human Resources Manager revised Human Rights training to include specific	9/30/2022

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			examples employees may encounter in residential level of care. Training includes emphasis on freedoms of everyday life, dignity, and use of restraints. (09/30/22) • Chief Executive Officer enhanced Administrator on Call and Program Coordinator presence on off hours and weekends to increase visibility, ensure program fidelity, and supervision of patients. During rounding Administrator obtains report from Shift Lead and Charge Nurse to identify and problem solve patient and facility issues. Rounding is monitored through rounding tool reviewed by Chief Operating Officer and reported monthly to Quality Council. (08/08/22) • Leadership meeting (08/05/22) and Town Hall meetings (08/23/22) conducted by Chief Executive Officer to review expectations and address identified issues. OLR) Accepted 09/12/2022	
12VAC35-46-800. A. (2) - There shall be evidence of a structured program of care designed to: 2. Provide protection, guidance, and supervision;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Employee #2 and Employee #3 arrived in the common area and witnessed Resident #1 being held down in an unapproved restraint. Employee #2 and Employee #3 walked around Resident #1 being held down by Employee #1 and did not intervene to provide protection, guidance, or appropriate supervision to Resident #1 or the other residents who were in the room while Employee #1 was holding Resident #1 down. After walking around Employee #1 holding Resident #1 down, Employee #2 and Employee #3 leave the area. Employee #2 returns to the area for some time after and is seen via video footage facing	PR) 08/22/2022 • Director of Program Operations revised and implemented daily therapeutic schedule to increase program structure and fidelity. Program Coordinators provided clear expectations of schedule adherence and how to effectively implement the schedule to MHTs. Schedule adherence is monitored during leadership rounding. (09/23/22) • Leadership meeting to include key leaders conducted twice daily. Shift Lead and Charge Nurse provide report on patient care issues, program compliance, and critical incident review for immediate problem solving and resolution. (08/08/22)	9/30/2022

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		towards the line of sight where Employee #1 is seen striking Resident #1. Employee #2 did not report this or intervene at that time to provide any protection to Resident #1.	• Director of Nursing stationed nursing staff in cottages to increase visibility, rounding, and supervision of patient care. Director of Nursing provided training on rounding, patient care, and MHT/patient interaction expectations. (09/19/22) • Key leaders offices stationed in cottages to increase visibility, rounding, and supervision of patient care. (09/12/22) • Handle with Care and Verbal De-escalation training is provided twice annually to ensure crisis intervention techniques are aligned with standards of care. Human Resources Manager reports training compliance in Quality Council. (09/30/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. (08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, and Effective Implementation of Behavior Support Plans. (10/21/22) • Corporate Clinical Director conducts monthly program fidelity review with facility to ensure compliance with key clinical indicators including therapeutic schedule adherence, patient rounding, and behavior support plan implementation. (08/09/22) • Chief Executive Officer identified and contracted with resources specializing in treatment modalities for children with Autism and/or Intellectual Disabilities to enhance training and professional	

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			development of direct care staff. Training is conducted quarterly to program staff. (09/30/22) • Human Resources Manager engaged in recruitment strategies for Board Certified Behavior Analyst to enhance programming support. Position posted on Indeed platform. (09/12/22) OLR) Accepted 09/12/2022	

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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 behaviors. Each individualized behavior support plan shall include: 3. Identification of successful intervention strategies for problem behavior;	NS	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of video footage from 7-21-22 found Employee #1, Employee #2, and Employee #2 did not implement the written behavior plan that allowed the resident to self-manage their own behaviors. Resident #1 was improperly restrained and remained in the care of Employee #1 in lieu of following their plan examples of "What helps me calm down or stay calm" and "What can staff do to help me" as outlined in their behavior support plan.	PR) 08/22/2022 • Director of Clinical Services conducts therapeutic milieu and Behavior Support Plan training to Mental Health Techs. Training addresses the specific needs of patients and how to individualize the treatment and care while implementing the Behavior Support Plan. Monthly training is monitored and tracked by Human Resources Department and reviewed monthly in Quality Council. (09/09/22) • Handle with Care and Verbal De-escalation training is provided twice annually to ensure crisis intervention techniques are aligned with standards of care. Human Resources Manager reports training compliance in Quality Council. (09/30/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. (08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, and effective Implementation of Behavior Support Plans. (10/21/22) • Director of Program Operations and Program Coordinators provided retraining to MHT staff on therapeutic interactions, managing a crisis, mandated reporting, and therapeutic schedules. Training and attestation are completed twice annually. (09/30/22) OLR) Accepted 09/12/2022	9/30/2022

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12VAC35-46-990. A. (5) - The provider shall have a written description of its recreation program that describes activities that are consistent with the facility's total program and with the ages, developmental levels, interests, and needs of the residents that includes: 5. Regularly scheduled indoor and outdoor recreational activities that are structured to develop skills and attitudes.	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: A review of video footage from 7-21-22 showed Resident #1 was not allowed by Employee #1 to remain outside despite being given approval by Employee # 4 as evidenced by Employee #4 giving Resident #1 their rounding sheet and being escorted outside by Employee #4. Administrative staff confirmed on 7-25-22 there was no reason why Resident #1 should have been taken back inside after being given approval to go outside. Employee #1 making Resident #1 go back inside was an infringement on Resident #1's right to go outside with peers during regularly scheduled outdoor recreation time. It was likely, per video footage and discussion with administrative staff that Resident #1's escalation was initiated by being sent back inside by Employee #1. Not being allowed to remain outside with peers was also confirmed by Resident #1's report to their guardian as the reason for their escalation as well.	PR) 08/22/2022 • Director of Program Operations revised and implemented daily therapeutic schedule to increase program structure and fidelity. Program Coordinators provided clear expectations of schedule adherence and how to effectively implement the schedule to MHTs. Schedule adherence is monitored during leadership rounding. (09/23/22) • Director of Program Operations and Program Coordinators provided retraining to MHT staff on therapeutic interactions, managing a crisis, mandated reporting, and therapeutic schedules. Training and attestation are completed twice annually. (09/30/22) • Director of Clinical Services conducts therapeutic milieu and Behavior Support Plan training to Mental Health Techs. Training addresses the specific needs of patients and how to individualize the treatment and care while implementing the Behavior Support Plan. Monthly training is monitored and tracked by Human Resources Department and reviewed monthly in Quality Council. (09/09/22) • Chief Executive Officer outlined roles, responsibilities, and leadership expectations with Program Coordinators. Expectations reviewed during 1:1 meetings with CEO. This includes schedule adherence, identification of patient needs, environment of care rounding, and staff/patient engagement. (08/22/22) OLR) Accepted 09/12/2022	9/30/2022

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12VAC35-115-260. B. (2d) - Providers shall require their employees to: 2. Protect individuals from any form of abuse, neglect, or exploitation by: 2d. Reporting all suspected abuse, neglect, or exploitation to the director;	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Per the investigative review of The Office of Human Rights Advocate and Office of Licensing Specialist, Employee #2 and Employee #3 failed to report abuse to the director of Entity #1. This review was conducted through the review of interviews, internal event reports, and documentation review.	PR) 08/22/2022 • Chief Executive Officer, Director of Risk Management and Director of Nursing conduct video review rounds weekly to ensure patient supervision, milieu management, and program adherence. Results are reported to Corporate Risk Management and Quality Council by Director of Risk Management. Follow up is required for any action observed outside of policy with incident report completed. (08/29/22) • Key leaders conduct in-person Senior Leader Rounds weekly using the structured audit report. Data is collected and reviewed by Quality Council monthly by Chief Operating Officer. Audit report focuses on program fidelity including patient observation, staff supervision, Staff-patient interactions and milieu management. (08/22/22) • Director of Nursing stationed nursing staff in cottages to increase visibility, rounding, and supervision of patient care. Director of Nursing provided training on rounding, patient care, and MHT/patient interaction expectations. (09/19/22) • Key leaders' offices stationed in cottages to increase visibility, rounding, and supervision of patient care. (09/12/22) • Chief Executive Officer outlined roles, responsibilities, and leadership expectations with Program Coordinators. Expectations reviewed during 1:1 meetings with CEO. This includes schedule adherence, identification of patient needs concerns including issues of dignity/freedoms of everyday life,	9/30/2022

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			environment of care rounding, and staff/patient engagement. (08/22/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. 08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, Patent Observation Standards, and Effective Implementation of Behavior Support Plans. (10/21/22) OHR/OLR) Accepted 09/16/2022	
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Individual #1 was placed in numerous excessive restraints by Employee #1. Employee #1 also delivered several blows with his left first to Individual #1's face. During this time Employee #2 and Employee #3 witness the restraint with Employee #2 witness the final blow. Neither Employee #2 nor Employee #3 reported the incident and/or stepped in to provide a safe and correct restraint for Individual #1. "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Examples of abuse include acts such as: 2. Assault or battery;	PR) 08/22/2022 • Human Resources Manager and Director of Risk Management conducted investigations of staff non-compliance with policy and performance standards. Incidents of staff policy violations and deviation from standards of care resulted in disciplinary action. (08/05/22) • Handle with Care and Verbal De-escalation training is provided twice annually to ensure crisis intervention techniques are aligned with standards of care. Human Resources Manager reports training compliance in Quality Council. (09/30/22) • Milieu Management Corporate Trainer provided program review and assessment to identify training needs. (08/18/22) • Milieu Management Corporate Trainer provided training to MHT staff and Program Coordinators on Therapeutic Communication, Effective Milieu Management, and Effective Implementation of Behavior Support Plans. (10/21/22)	9/30/2022

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		Per the provider's investigation and through the review of camera footage reviewed by Office of Human Rights Advocate and Office of Licensing Specialist. Employee #1 was seen delivering seven blows to the right side of Individual #1's face. Thus, abuse was substantiated. This regulation was NOT MET as evidenced by: Employee #1 was seen through video camera footage delivering several excessive and improper restraints towards Individual #1. Employee #1 is seen at one time pushing Individual #1's head into the door during a hold. Furthermore, Employee #1 is seen throwing Individual #1 into the floor and throwing him around by his shirt. Lastly, Individual #1 uses his knee in several restraints on the floor on top of Individual #1's chest and legs. "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Examples of abuse include acts such as: 5. Use of excessive force when placing a person in physical or mechanical restraint; This regulation was NOT MET as evidenced by: Per the review of video camera footage by the Office of Human Rights Advocate and Office of Licensing Specialist #2 and Employee #3 watched Employee #1 place Individual #1 in an incorrect restraint without intervening. Furthermore; Employee #2 watched Employee #1 deliver the 7th both to Individual #1 and did not report the seen abuse. "Neglect" means failure by a person, program, or facility	• Chief Executive Officer enhanced Administrator on Call and Program Coordinator presence on off hours and weekends to increase visibility, ensure program fidelity, and supervision of patients. During rounding Administrator obtains report from Shift Lead and Charge Nurse to identify and problem solve patient and facility issues. Rounding is monitored through rounding tool reviewed by Chief Operating Officer and reported monthly to Quality Council. (08/08/22) • Chief Executive Officer, Chief Operating Officer, and Director of Nursing meet with random patient at least weekly for check in (i.e. How is your day going, do you feel safe, has anyone been particularly helpful to you, how can we make your experience better) (08/29/22) • Chief Operating Officer revised Leadership Rounding Tool to include schedule adherence and behavior plan acknowledgement / implementation. CEO provided training to leaders on revisions and expectations. (08/15/22) • Chief Executive Officer, Director of Risk Management and Director of Nursing conduct video review rounds weekly to ensure patient supervision, milieu management, and program adherence. Results are reported to Corporate Risk Management and Quality Council by Director of Risk Management. Follow up is required for any action observed outside of policy with incident report completed. (08/29/22) • Key leaders conduct in-person Senior Leader Rounds weekly using the	

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		operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. See § 37.2-100 of the Code of Virginia. This regulation was NOT MET as evidenced by: Through a thorough investigation conducted by the Office of Human Rights Advocate and Office of Licensing Specialist, Entity #1 failed to suspend Employee #2 and Employee #3 as they failed to intervene in the restraint used on Individual #1 by Employee #1. Investigation modalities included: interviews, staff and individual chart reviews, serious event report review, and video camera footage review. "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. See § 37.2-100 of the Code of Virginia. This regulation was NOT MET as evidenced by: Entity #1 failed to send a staff member with Individual #1 to the hospital until Individual #1 was admitted into care. "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding	structured audit report. Data is collected and reviewed by Quality Council monthly by Chief Operating Officer. Audit report focuses on program fidelity including patient observation, staff supervision, Staff-patient interactions and milieu management. (08/22/22) • Director of Nursing stationed nursing staff in cottages to increase visibility, rounding, and supervision of patient care. Director of Nursing provided training on rounding, patient care, and MHT/patient interaction expectations. (09/19/22) • Key leaders offices stationed in cottages to increase visibility, rounding, and supervision of patient care. (09/12/22) • Director of Programming and Program Coordinators provided education to MHTs on the role of nursing staff in the supervision of patient care activities including program adherence, BSP implementation, and medical needs of the patient. (09/19/22) • Chief Executive Officer outlined roles, responsibilities, and leadership expectations with Program Coordinators. Expectations reviewed during 1:1 meetings with CEO. This includes schedule adherence, identification of patient needs, environment of care rounding, and staff/patient engagement. (08/22/22) • Director of Program Operations and Program Coordinators provided retraining to MHT staff on therapeutic interactions, managing a crisis, mandated reporting, and therapeutic schedules. • Key leaders participated in additional	

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		those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. See § 37.2-100 of the Code of Virginia. This regulation was NOT MET as evidenced by: Per video camera footage review conducted by Office of Human Rights Advocate and Office of Licensing Specialist, Employee #2 and Employee #3 failed to remove other peers from the day room, where Individual #1 and Employee #1 were, thus resulting in the peers being able to watch both the abuse and restraint, compromising the other peers safety. "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. See § 37.2-100 of the Code of Virginia.	Human Rights training provided by the Department of Behavioral Health and Developmental Disabilities. (08/18/22) • Director of Risk Management and Human Resources Manager revised Human Rights training to include specific examples employees may encounter in residential level of care. Training includes emphasis on freedoms of everyday life, dignity, and use of restraints. (09/30/22) • Director of Clinical Services conducts therapeutic milieu and Behavior Support Plan training to Mental Health Techs. Training addresses the specific needs of patients and how to individualize the treatment and care while implementing the Behavior Support Plan. Monthly training is monitored and tracked by Human Resources Department and reviewed monthly in Quality Council. (09/09/22) OHR/OLR) Accepted 09/16/2022	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-115-50. C. (1) - In services provided in residential and inpatient settings, each individual has the right to: 1. Have sufficient and suitable clothing for his exclusive use.	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Per the report of Individual #1's guardian, Individual #1 arrived to the hospital with shoes and pants that were too large and of the wrong size as well as a shirt that appeared worn with holes.	PR) 08/22/2022 • Program Coordinators ensure each individual has sufficient and suitable clothing for his/her exclusive use. Each patient's belongings are inventoried at the time of admission by MHT. The Program Coordinator meets with patient monthly to review any clothing or other belonging needs. Program Coordinator collaborates with the treatment team in obtaining any needed items. Log of needs and purchases is maintained by the Program Coordinator. Assigned staff are responsible for ensuring patients are wearing appropriate clothing and reporting any concerns to the Program Coordinator. (09/16/22) • Key leaders participated in additional Human Rights training provided by the Department of Behavioral Health and Developmental Disabilities. (08/18/22) • Director of Risk Management and Human Resources Manager revised Human Rights training to include specific examples employees may encounter in residential level of care. Training includes emphasis on freedoms of everyday life, dignity, and use of restraints. (09/30/22) OHR/OLR) Accepted 09/16/2022	9/30/2022

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12VAC35-115-60. B. (1) - The provider's duties. 1. Providers shall develop, carry out, and regularly monitor policies and procedures prohibiting discrimination in the provision of services. Providers shall comply with all state and federal laws, including any applicable provisions of the Americans with Disabilities Act (42 USC § 12101 et seq.), that prohibit discrimination.	N	**HEALTH AND SAFETY VIOLATION** The Hughes Center This regulation was NOT MET as evidenced by: Per the investigative review of The Office of Human Rights Advocate and Office of Licensing Specialist, Employee #2 and Employee #3 failed to report the abuse of Individual #1; therefore, violating mandated reporting.	PR) 08/22/2022 • Director of Program Operations and Program Coordinators provided retraining to MHT staff on therapeutic interactions, managing a crisis, mandated reporting, and therapeutic schedules. Training and attestation are completed twice annually. (09/30/22) • Director of Risk Management and Human Resources Manager revised Human Rights training to include specific examples employees may encounter in residential level of care. Training includes emphasis on freedoms of everyday life, dignity, and use of restraints. (09/30/22) OHR/OLR) Accepted 09/16/2022	9/30/2022

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General Comments / Recommendations:
Please review and return on or before the due date. Include any supporting documents, if appropriate.

Ensure you review the Licensing Report Response Guidance in the attached letter to ensure all 4 points are addressed in your responses.

Please feel free to reach out to me if you have any questions or concerns about this licensing report.

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