DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **769-14-008**
Organization Name: **Dominion Services for all People, LLC**

Date of Inspection: **06-04-2024**
Program Type/Facility Name: **14-008 DSFAP-First Step**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-1110. D. - In the event of a disaster, fire, emergency, or any other condition that may jeopardize the health, safety, and welfare of residents, the provider shall take appropriate action to protect the health, safety, and welfare of the residents and take appropriate action to remedy the conditions as soon as possible.	N	DSFAP-First Step This regulation was NOT MET as evidenced by: During the time of the unannounced inspection the provider did not have sufficient food or water in the event of an emergency. Failure to have efficient food and water in the event of an emergency lacks the provider's ability to protect the health and safety of the residents. Provide a statement of the issue that led to noncompliance and state how you corrected and or will correct the deficient practice in this specific violation. Include a plan of action to address systematic changes, process, and protocols that have been or will be implemented to ensure you remain in compliance of the regulation. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation.	PR) 07/21/2024 During an unannounced inspection, it was identified that the provider did not have a sufficient supply of food or water available for residents in an emergency. This deficiency compromises the ability to protect the health and safety of the residents, violating regulatory standards for emergency preparedness. To address this violation, the following corrective actions have been implemented: 1. Emergency Supply Acquisition: We have procured and stocked the necessary food to meet the regulatory requirements. The water will added to the food by July 31, 2024 Plan of Action for Systematic Changes: To ensure ongoing compliance and enhance our emergency preparedness, we have developed a comprehensive plan of action, including the following strategies: 1. Emergency Preparedness Policy -Revise a formal emergency preparedness policy that outlines requirements for food and water supplies, including quantities based on resident numbers and recommendations from regulatory agencies. 2. Regular Inventory Checks: Implement a quarterly inventory check to verify the adequacy of food and water supplies. The Lead Counselor will conduct these checks and maintain inventory records. 3. Emergency Supply Protocols: Establish protocols for replenishing emergency supplies. Staff will be trained to promptly assess and	8/1/2024

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			report deficiencies, ensuring supplies are maintained appropriately. Conduct training sessions for all staff on emergency preparedness, including maintaining adequate food and water supplies. A. Monitoring and Reporting: Create a reporting system for staff to inform management of food and water supply issues. Regular meetings will be held to discuss challenges and review improvement preparedness plans. All Direct Care staff: Participate in training and drills, maintain food and water inventory awareness, and report any concerns to the lead counselors. We aim to ensure compliance with emergency food and water supply regulations by implementing these corrective actions and systematic changes. Ongoing monitoring, staff training, and proactive management will be vital to protecting the health and safety of our residents in emergencies. OLR) Accepted 07/22/2024	
12VAC35-46-450. C. - Precautions shall be taken to prevent scalding from running water. Water temperatures shall be maintained between 100°F and 120°F.	N	DSFAP-First Step This regulation was NOT MET as evidenced by: During the time of the unannounced inspection the water temperatures exceeded the regulatory standards. The kitchen water temperature was registered at 140.0 degrees Fahrenheit and the bathroom on the second floor registered at 138.1 degrees Fahrenheit. Provide a statement of the issue that led to noncompliance and state how you corrected and or will correct the deficient practice in this specific violation. Include a plan of	PR) 07/21/2024 During an unannounced inspection, it was observed that the water temperatures in the kitchen and second-floor bathroom exceeded the regulatory standards, with readings of 140.0 degrees Fahrenheit and 138.1 degrees Fahrenheit, respectively. This noncompliance poses a risk of scalding and does not align with the established safety regulations. The following corrective action plan will take place. Upon identification of the issue, the following	7/1/2024

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		action to address systematic changes, process, and protocols that have been or will be implemented to ensure you remain in compliance of the regulation. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation.	corrective actions took place: 1. We adjusted the temperature settings on the water heaters for the kitchen and the second-floor bathroom to ensure that the water temperature remains within the regulatory limits. 2. I held a training session at our June 15, 2024, staff meeting regarding monitoring water temperatures and ensuring compliance with safety regulations. To address and prevent future noncompliance, we have developed a comprehensive plan of action that includes the following components: 1. Regular Monitoring Processes- Implement a daily water temperature log, requiring staff to check and record the water temperatures in all areas, including the kitchen and bathrooms. This log will help ensure temperatures remain compliant with regulatory standards. 2. Monthly Review and Audit: Designate a staff member (Lead counselor) to conduct monthly audits of the water temperatures and review the daily logs for accuracy and compliance. 3. Maintenance Protocols: Schedule quarterly maintenance checks on the water heating systems to ensure they function correctly and address any potential issues proactively. 4. Incident Reporting Protocol: Establish a procedure for staff to report any temperature anomalies immediately, ensuring prompt action can be taken. 5. Compliance Training: Conduct bi-annual training sessions for all staff on regulatory compliance related to safety standards, focusing on water temperature management.	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Regular monitoring and continuous staff training are essential to maintaining compliance and ensuring the safety of all program residents. OLR) Accepted 07/22/2024	
12VAC35-46-750. F. - Each plan and quarterly progress report shall include the date it was developed and the signature of the person who developed it.	N	DSFAP-First Step This regulation was NOT MET as evidenced by: During the time of the unannounced inspection Individual #1's clinical record lacked individual's signature on the 3/19/2024 quarterly. Provide a statement of the issue that led to noncompliance and state how you corrected and or will correct the deficient practice in this specific violation. Include a plan of action to address systematic changes, process, and protocols that have been or will be implemented to ensure you remain in compliance of the regulation. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation.	PR) 07/21/2024 During an unannounced inspection, it was noted that Individual #1's clinical record did not include a signature on the quarterly review dated 03/19/2024. This absence of a signature constituted noncompliance with regulations requiring complete documentation and ensuring that the relevant individuals properly sign all clinical records. To address this specific violation, the following corrective actions have been implemented: 1. Signature Collection: The Lead counselor will contact Individual #1 to obtain their signature on the quarterly review document. This was completed within the next 72 hours of the audit . **To ensure compliance with regulatory standards moving forward, we have developed a comprehensive plan of action that includes the following strategies:** 1. Documentation Verification Process: Implement a new process for reviewing all clinical records for completeness prior to filing. This includes verifying that all necessary signatures are present. Designate a staff member or Executive Director to review clinical records weekly. 2. Monthly Audits: Conduct monthly audits of clinical records to ensure compliance and identify any missing documentation or signatures. The	8/1/2024

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			office manager will oversee these audits The audit results will be documented and reviewed during monthly staff meetings to reinforce the importance of proper documentation. 3. Standard Operating Procedures Develop and implement SOPs regarding documentation requirements, including timelines for securing signatures. These procedures will be provided to all clinical staff and included in training materials. When completing documentation, incorporate a checklist for clinical staff to ensure all necessary components, including signatures, are obtained. By implementing these corrective actions and systematic changes, we aim to ensure compliance with the regulation regarding clinical records and prevent future occurrences of incomplete documentation. Regular monitoring and ongoing training will be key to maintaining compliance as part of our quality assurance efforts. OLR) Accepted 07/22/2024	
12VAC35-46-850. G. (4) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 4. Strength;	N	DSFAP-First Step This regulation was NOT MET as evidenced by: During the time of the unannounced inspection Individual #1's MARS and clinical documentation did not have the correct dosage of medication and documents had confliction dosage. The doctors' orders were missing of the correct dosage and discontinued medication dosages. Provide a statement of the issue that led to noncompliance and state how you corrected and or will correct the deficient practice in this specific violation. Include a plan of action to address systematic changes, process, and	PR) 07/21/2024 During an unannounced inspection, it was identified that Individual #1’s Medication Administration Record (MAR) and accompanying clinical documentation contained incorrect and conflicting dosages for prescribed medications. Additionally, the medical records were missing accurate doctor’s orders regarding the correct dosages and discontinuation of certain medicines. This noncompliance poses significant risks to the health and safety of the resident and violates regulatory standards for medication	8/1/2024

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		protocols that have been or will be implemented to ensure you remain in compliance of the regulation. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation.	management and documentation. To address this specific violation, the following immediate corrective actions have been implemented: 1. Immediate Review and Correction: Conducted an immediate review of Individual #1's MAR and clinical documentation to identify and correct errors in medication dosages. The current dosages and any discrepancies were corrected immediately. The director obtained updated medication orders from the prescribing physician to ensure clarity and compliance regarding dosage and medication discontinuation. 2. Communication with Prescribing: The Director will ensure clear communication with the prescribing physician to confirm all prescribed medications' correct dosages and statuses for not only Individual #1 but all clients. Documentation was updated to reflect accurate details. Plan of Action for Systematic Changes: To prevent future noncompliance and enhance our medication management protocols, we have established the following comprehensive plan of action: 1. Standard Operating Procedures for MAR Documentation: Develop and implement SOPs detailing the processes for updating the MAR, including the critical requirement to verify and document correct medication dosages. Staff will be trained on the new procedures to minimize dosage and medication administration errors. 2. Double-Verification System: The Director will Institute a double-verification process for medication orders and MAR updates. This will	

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			require a lead counselor to enter the dosage and another to verify its accuracy before administration. This system will help to catch errors before they impact patient care. 3. Regular Staff Training: Conduct bi-monthly training sessions for all clinical staff on medication management, focusing on accurate documentation and understanding medication orders. Training will include case studies based on errors, the correct protocol for updating MARS, and communication with healthcare providers. 5. Collaboration with Pharmacists: The agency recently changed to a new pharmacy, which will ensure that all MARS are pre-printed by the pharmacy using the doctor's orders. An RN will review psychotropic medications quarterly to ensure documentation aligns with current best practices in prescribing and administering. Monthly audits will commence following the implementation of new SOPs, starting in the next calendar month. By executing these corrective actions and systematic changes, we aim to ensure compliance with medication management regulations and safeguard the health and safety of our residents through accurate and reliable medication documentation. Regular training, oversight, and collaborative efforts with healthcare providers will sustain these improvements. OLR) Accepted 07/22/2024	

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General Comments / Recommendations:
Please respond to the CAP on or before the due date. If you should have any questions or require further assistant, please contact me via CONNECT or at 804-393-0663.

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.

Donna Ross, Licensing Specialist	(Signature of Organization Representative)	Date

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