

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

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License #: 841-04-005

Organization Name: Newport News Behavioral Health Center

Date of Inspection: 09-07-2023

Program Type/Facility Name: 04-005 Acute Care Unit

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-105-440. (3) - New employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days. The provider shall document that the orientation covers each of the following policies, procedures, and practices: 3. Practices that assure an individual's rights including orientation to human rights regulations;	N	Acute Care Unit This regulation was NOT MET as evidenced by: Upon review of Employee #1's personnel records, the provider failed to cover the practices that assure an individual's rights including orientation to human rights regulations. 1. Please identifying the root cause(s) of the violation; 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again; 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action	PR) 10/19/2023 Provider failed to document human rights training completed within the first week of training. 11/03/2023. This requirement did not meet the 15-business day requirement. Human resources will document training immediately following trainings. Patient Rights course has been added to new employee orientation and will be required on an annual basis. 3. This will be monitored by HR Generalist on a monthly basis to ensure that facility is meeting this requirement. 4. HR Generalist will be responsible for assigning courses, monitoring completion and sending timely notification of non-compliance to supervisors, HR Director and CEO. 5. This change started on December 1, 2023. OLR) Not Accepted 10/30/2023 Please respond to each regulation separately in the appropriate section. PR) 11/03/2023. All staff competencies are due 30 days per UHS corporate requirement. This requirement did not meet the 15 business day requirement. 2. We have already addressed this violation by working to make sure our acute staff are done with competencies within 15 business days instead of 30 days. Patient Rights course has been added to new employee orientation and will be required on an annual basis. 3. This will be monitored by HR Generalist on a monthly basis to ensure that facility is meeting this requirement. 4. HR Generalist will be responsible for assigning courses, monitoring completion and sending timely notification of non-compliance to supervisors, HR Director and CEO. 5. 15	11/3/2023

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			business day completion requirement has already been implemented. This change started on September 11, 2023. OLR) Not Accepted 11/06/2023 PR) 11/06/2023 Provider failed to document human rights training completed within the first week of training. 11/03/2023. This requirement did not meet the 15-business day requirement. Human resources will document training immediately following trainings. Patient Rights course has been added to new employee orientation and will be required on an annual basis. 3. This will be monitored by HR Generalist on a monthly basis to ensure that facility is meeting this requirement. 4. HR Generalist will be responsible for assigning courses, monitoring completion and sending timely notification of non-compliance to supervisors, HR Director and CEO. 5. This change started on December 1, 2023. OLR) Accepted 11/06/2023	
12VAC35-105-450. - The provider shall provide training and development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities. The provider shall develop a training policy that addresses the frequency of retraining	N	Acute Care Unit This regulation was NOT MET as evidenced by: Upon review of the provider's "Employee Training and Development" policy, the provider failed to develop a training policy that addresses frequency of retraining on serious incident reporting, emergency preparedness, and infection control. 1. Please identify the root cause(s) of the violation; 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies,	PR) 10/23/2023 Provider did not have adequate frequency of training and development policy to address serious incident reporting, emergency preparedness, and infection control. 2. Employee Training and Development Policy has been updated to reflect and address frequency of retraining on serious incident reporting, emergency preparedness, and infection control. Courses have also been added to provide additional training to address serious incident reporting, medication administration management (only for nurses) emergency preparedness, and infectious control. All	11/3/2023

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department.		procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again; 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action	trainings are online and in person orientation. 3. The policy is reviewed and updated on an annual basis ensure all training courses are included that address the listed areas. 4. HR Director is responsible for reviewing and updating policy annually to reflect required training. 5. The policy was reviewed and updated on October 6, 2023 to include additional training courses. OLR) Not Accepted 10/30/2023 Please respond to each regulation separately in the appropriate section. PR) 11/03/2023 1. Provider did not have adequate amount of training and development policy to address serious incident reporting, emergency preparedness, and infection control. 2. Employee Training and Development Policy has been updated to reflect and address frequency of retraining on serious incident reporting, emergency preparedness, and infection control. Courses have also been added to provide additional training to address serious incident reporting, medication administration management (only for nurses) emergency preparedness, and infectious control. All trainings are online and in person orientation. 3. The policy is reviewed and updated on an annual basis ensure all training courses are included that address the listed areas. 4. HR Director is responsible for reviewing and updating policy annually to reflect required training. 5. The policy was reviewed and updated on October 6, 2023 to include additional training courses. OLR) Not Accepted 11/06/2023	

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			PR) 11/06/2023 Provider did not have adequate frequency of training and development policy to address serious incident reporting, emergency preparedness, and infection control. 2. Employee Training and Development Policy has been updated to reflect and address frequency of retraining on serious incident reporting, emergency preparedness, and infection control. Courses have also been added to provide additional training to address serious incident reporting, medication administration management (only for nurses) emergency preparedness, and infectious control. All trainings are online and in person orientation. 3. The policy is reviewed and updated on an annual basis ensure all training courses are included that address the listed areas. 4. HR Director is responsible for reviewing and updating policy annually to reflect required training. 5. The policy was reviewed and updated on October 6, 2023 to include additional training courses. OLR) Partially Accepted 11/06/2023 Please submit your updated training and development policy. PR) 11/06/2023 Added Document OLR) Accepted 11/06/2023	
12VAC35-105-60. C. - A change requiring a modification of the	N	Acute Care Unit	PR) 10/19/2023 Provider was not aware of need to submit a	11/3/2023

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<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
license shall not be implemented prior to approval by the commissioner. The department may send the provider a letter approving implementation of the modification pending the issuance of the modified license.		This regulation was NOT MET as evidenced by: Upon the time of the inspection, it was revealed that the provider was conducting renovations on some of the units that were not approved by the department. The provider will need to submit the modification to the department for approval. 1. Please identifying the root cause(s) of the violation; 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again; 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action	modification due to not being at capacity or belief that the work would affect census. Provider will address this issue by adding to Quality improvement policy to meet state regulations and notify DBHDS of any changes through connect portal. Risk Manager and Environment of care director will monitor the quality improvement plan monthly to identify status of the modification and any updates to make any changes to modification. Bldg D (Units Excel/Determination, 24-beds) are offline for use due to a sewer line compromise that stems from the Kitchen/Uptown Cafeteria and runs entirely underneath the Excel/Determination living units. A partial Scope of Work is to completely replace the entire sewer line under Bldg D which, also, required asbestos abatement prior to start of the main project. While the asbestos has been removed, the original project start date in June 2023 encountered an unforeseen delay due to challenges with the primary vendor providing the required temporary kitchen. A replacement vendor for the kitchen has been identified and contractual/logistical planning are underway with a soft project re-start date in October 2023. Project duration is expected to be 03-2024 OLR) Not Accepted 10/30/2023 Please respond to each regulation separately in the appropriate section. PR) 11/03/2023 Bldg D (Units Excel/Determination, 24-beds) are offline for use due to a sewer line compromise that stems from the Kitchen/Uptown Cafeteria and runs entirely underneath the	

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			Excel/Determination living units. A partial Scope of Work is to completely replace the entire sewer line under Bldg D which, also, required asbestos abatement prior to start of the main project. While the asbestos has been removed, the original project start date in June 2023 encountered an unforeseen delay due to challenges with the primary vendor providing the required temporary kitchen. A replacement vendor for the kitchen has been identified and contractual/logistical planning are underway with a soft project re-start date in October 2023. Project duration is expected to be four months. OLR) Not Accepted 11/06/2023 PR) 11/06/2023 Provider was not aware of need to submit a modification due to not being at capacity or belief that the work would affect census. Provider will address this issue by adding to Quality improvement policy to meet state regulations and notify DBHDS of any changes through connect portal. Risk Manager and Environment of care director will monitor the quality improvement plan monthly to identify status of the modification and any updates to make any changes to modification. Bldg D (Units Excel/Determination, 24-beds) are offline for use due to a sewer line compromise that stems from the Kitchen/Uptown Cafeteria and runs entirely underneath the Excel/Determination living units. A partial Scope of Work is to completely replace the entire sewer line under Bldg D which, also, required asbestos abatement prior to start of the main project. While the asbestos has been removed, the original project start date in June 2023 encountered an unforeseen delay due to	

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			challenges with the primary vendor providing the required temporary kitchen. A replacement vendor for the kitchen has been identified and contractual/logistical planning are underway with a soft project re-start date in October 2023. Project duration is expected to be 03-2024 OLR) Accepted 11/06/2023	
12VAC35-105-665. A. (6) - The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the assessment. The ISP shall include: 6. A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;	N	Acute Care Unit This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to include a safety plan that addresses identified risks to the individual or to others in the ISP. 1. Please identifying the root cause(s) of the violation; 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again; 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action	PR) 10/23/2023 1. Please identifying the root cause(s) of the violation - The safety plan was present as a separate document; however, was not present within the ISP. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. - The director will include a safety plan in the ISP. This will include providing staff with a training related to completing the new portions of the ISP. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). - The supervisor/director will complete weekly chart audits of at least five charts to ensure the safety plan is being completed with the ISP. 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. - The Director of Clinical Services will be responsible for monitoring the implementation of the CAP. 5. Include a date of completion for each corrective action. - Completion date. 10/16/23 OLR) Not Accepted 10/30/2023 Please respond to each regulation separately in	11/3/2023

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			the appropriate section. PR) 11/03/2023 This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to include a safety plan that addresses identified risks to the individual or to others in the ISP. 1. Please identifying the root cause(s) of the violation – The safety plan was present as a separate document; however was not present within the ISP. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. – The director will include a safety plan in the ISP. This will include providing staff with a training related to completing the new portions of the ISP. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). – The supervisor/director will complete weekly chart audits of at least five charts to ensure the safety plan is being completed with the ISP. 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. – The Director of Clinical Services will be responsible for monitoring the implementation of the CAP. 5. Include a date of completion for each corrective action. – Completion date. 10/16/23 OLR) Not Accepted 11/06/2023 PR) 11/06/2023	

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			1. Please identifying the root cause(s) of the violation - The safety plan was present as a separate document; however, was not present within the ISP. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. - The director will include a safety plan in the ISP. This will include providing staff with a training related to completing the new portions of the ISP. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). - The supervisor/director will complete weekly chart audits of at least five charts to ensure the safety plan is being completed with the ISP. 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. - The Director of Clinical Services will be responsible for monitoring the implementation of the CAP. 5. Include a date of completion for each corrective action. - Completion date. 10/16/23 OLR) Accepted 11/06/2023	
12VAC35-105-665. B. - The ISP shall be signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services or the authorized representative in order to document	N	Acute Care Unit This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to have ISP signed and dated by the person responsible for implementing the plan and the individual receiving services or the authorized representative in order to document agreement.	PR) 10/23/2023 1. Please identifying the root cause(s) of the violation - The Acute Care Social Workers required re-education of the signature function on the EHR. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility	11/3/2023

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agreement. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason why he was unable to obtain it. The ISP shall be distributed to the individual and others authorized to receive it.		1. Please identifying the root cause(s) of the violation; 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again; 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. 5. Include a date of completion for each corrective action	that the violation will occur again. - The supervisor will provide two trainings with the staff on how to use the signature function on the EHR. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). - The supervisor/director will complete weekly chart audits of at least five charts to ensure the safety plan is being completed with the ISP. 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. - The Director of Clinical Services will be responsible for monitoring the implementation of the CAP. 5. Include a date of completion for each corrective action - Completion date. 10/16/23 OLR) Not Accepted 10/30/2023 Please respond to each regulation separately in the appropriate section. PR) 11/03/2023 This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to have ISP signed and dated by the person responsible for implementing the plan and the individual receiving services or the authorized representative in order to document agreement. 1. Please identifying the root cause(s) of the violation – The Acute Care Social Workers required re-education of the signature function on the EHR. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could	

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			alleviate the problem and minimize the possibility that the violation will occur again.- The supervisor will provide two trainings with the staff on how to use the signature function on the EHR. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). – The supervisor/director will complete weekly chart audits of at least five charts to ensure the safety plan is being completed with the ISP. 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. - The Director of Clinical Services will be responsible for monitoring the implementation of the CAP. 5. Include a date of completion for each corrective action - Completion date. 10/16/23 OLR) Not Accepted 11/06/2023 PR) 11/06/2023 1. Please identifying the root cause(s) of the violation - The Acute Care Social Workers required re-education of the signature function on the EHR. 2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff, or other steps that could alleviate the problem and minimize the possibility that the violation will occur again. - The supervisor will provide two trainings with the staff on how to use the signature function on the EHR. 3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex: monthly audits, weekly chart reviews, quarterly checklist). - The supervisor/director will complete weekly chart audits of at least five charts to ensure the	

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			safety plan is being completed with the ISP. 4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP. - The Director of Clinical Services will be responsible for monitoring the implementation of the CAP. 5. Include a date of completion for each corrective action - Completion date. 10/16/23 OLR) Accepted 11/06/2023	

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Kitisha Green

(Signature of Organization Representative)

Date

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