

**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: **08-10-2026**

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>
12VAC35-105-280. A. - The physical environment, design, structure, furnishings, and lighting shall be appropriate and safe for the individuals served and the services provided.	N	Acute Care Unit This regulation was NOT MET as evidenced by: At the time of the inspection, the provider was observed to have ripped ceiling plaster in the group shower room and holes in the wall in resident's room.	PR) 09/10/2026 1. Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. The issue was caused by patient damage. Items were repaired on 9/3/2026 2. Include a plan of action to address systematic changes (process/protocols, etc) that have been or will be implemented to ensure you remain in compliance of the regulation. In-service email to facility staff to be sent reminding all of reporting maintenance deficiencies. 3. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist). POC: Director of Plant Operations. Will verify via random rounding and monthly Environment of Care rounds 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9.25.2026 OLR) Accepted 09/15/2026	9/25/2026

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General Comments / Recommendations: Please utilize the guidance below when responding: Refer to staff by staff roles, titles and/or employee identifiers referencing the HIPAA Form, not by specific staff names. Ensure your responses to the CAP do not violate HIPAA practices, refer to the identifiers in the HIPAA Forms. The HIPAA Forms are provided on the Provider Portal when responding to violations. Include all 4 points below, in detail, in your response to each violation: 1. Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. 2. Include a plan of action to address systematic changes (process/protocols, etc) that have been or will be implemented to ensure you remain in compliance of the regulation. 3. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist). 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented).							
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.							
<table style="width: 100%; border: none;"><tr><td style="width: 33%; border-top: 1px solid black; text-align: center;">James Butts, Licensing Specialist</td><td style="width: 33%; border-top: 1px solid black; text-align: center;">(Signature of Organization Representative)</td><td style="width: 33%; border-top: 1px solid black; text-align: center;">Date</td></tr></table>					James Butts, Licensing Specialist	(Signature of Organization Representative)	Date
James Butts, Licensing Specialist	(Signature of Organization Representative)	Date					
C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined							