

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

Page: 1 of 6

License #: **841-14-001**

Organization Name: **Newport News Behavioral Health Center**

Date of Inspection: **07-15-2026**

Program Type/Facility Name: **14-001 Newport News Behavioral Health**

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-46-70. - 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	Newport News Behavioral Health This regulation was NOT MET as evidenced by: See citations below.		
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	Newport News Behavioral Health This regulation was NOT MET as evidenced by: "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." Upon review CHRIS entry A20260129 the provider's investigation includes staff admission	PR) 08/25/2026 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 that led to non-compliance was the failure to complete patient safety observation rounds in a timely manner as required. To correct this deficient practice, the staff members responsible received corrective action and were re-educated on the requirements for timely completion of safety observation rounds. In addition, leadership implemented weekly audits of overnight patient safety observation rounds to monitor compliance, identify any deficiencies, and ensure sustained adherence to established	8/2/2026

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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Page: 2 of 6

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		and eyewitness statements which revealed that determined that Employee #1 failed to adhere to the facility's de-escalation techniques resulting in a physical altercation with Individual #1. Based on the investigative findings of the provider, there is a preponderance of evidence to support the provider's substantiated finding.	policies and procedures 2. Include a plan of action to address systematic changes. This may require updating policies, procedures, forms or conducting any needed training or retraining for staff, or other steps that could alleviate the problem in order to minimize the possibility that the violation will occur in the future. To address this deficiency and minimize the risk of recurrence, the facility implemented several systemic corrective actions. The patient safety observation process was reviewed and revised, including updating the observation documentation sheets from 15-minute intervals to 12-minute intervals to provide staff with additional time to complete and document rounds within the required timeframe. Leadership also implemented weekly audits of overnight patient safety observation rounds to monitor compliance, identify trends, and provide immediate feedback when concerns are identified. Staff who fail to meet compliance expectations will be subject to progressive corrective action. 3. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist, etc.). Weekly audits 4. Include the position of the person responsible for monitoring the plan of action. Do not include staff/employee names. Persons responsible for monitoring are Program Managers, Director of Residential Services,	

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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Page: 3 of 6

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			Director of Risk/PI, DON, Acute Nurse Manager 5. Enter the Planned Completion Date and the Actions to be Taken in the Response screen. If there are steps in the plan of action that have different planned completion dates, please enter the overall Planned Completion Date on the screen. All steps have been taken and are being included as scheduled. OHR/OLR) Partially Accepted 08/26/2026 PR) 09/02/2026 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 deficient practice occurred when a staff member failed to follow the facility's approved verbal de-escalation techniques, resulting in a physical altercation with an individual served. This failure to adhere to established crisis intervention procedures constituted non-compliance with facility policy and expectations for maintaining a safe therapeutic environment. The facility addressed the violation by terminating the employee involved in the incident. In addition, all staff members have been issued retraining on verbal de-escalation techniques, appropriate crisis intervention practices, and the expectation to utilize non-physical strategies to prevent escalation whenever possible.	

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Page: 4 of 6

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			2. Include a plan of action to address systematic changes. This may require updating policies, procedures, forms or conducting any needed training or retraining for staff, or other steps that could alleviate the problem in order to minimize the possibility that the violation will occur in the future. The facility is to implement monthly mock drills for all direct care staff to practice and reinforce verbal de-escalation techniques, crisis intervention strategies, and the safe and appropriate use of approved restraint procedures. Additionally, all staff are required to complete mandatory bi-annual refresher training on de-escalation, behavior management, and restraint techniques to ensure continued competency and compliance with facility policies. Additionally, Risk Management is to review all crises involving restraints via video footage. 3. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist, etc.). Camera reviews will occur through Risk Department of all crisis events involving restraints and monthly through fidelity audits of staff mock drills to ensure compliance with de-escalation and restraint procedures. Bi-annual facility wide refreshers will take place every 6 months (February and August) 4. Include the position of the person responsible	

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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Page: 5 of 6

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			for monitoring the plan of action. Do not include staff/employee names. Persons responsible for monitoring are the Director of Residential Services, Patient Advocate, HWC trainers, Director of Risk Management and Performance Improvement 5. Enter the Planned Completion Date and the Actions to be Taken in the Response screen. If there are steps in the plan of action that have different planned completion dates, please enter the overall Planned Completion Date on the screen. The employee involved was terminated immediately. Facility-wide retraining on verbal de-escalation, crisis intervention, and restraint procedures was completed in August 2026, with monthly mock drills beginning in September 2026. OHR/OLR) Accepted 09/11/2026OHR Response: The response to the CAP is not specific to the citation.	

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
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Page: 6 of 6

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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.				
_____ Latoya Wilborne, Human Rights		_____ (Signature of Organization Representative)		_____ Date
C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined				