

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

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License #: **841-14-003**

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

Date of Inspection: **10-10-2023**

Program Type/Facility Name: **14-003 Project Valor**

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-46-300. B. (3) - The records of each employee shall include: 3. Written references or notations of oral references;	NS	Project Valor This regulation was NOT MET (SYSTEMIC) as evidenced by: At the time of the inspection of the personnel records, the provider failed to provide proof of references for Employee #1. This regulation was cited for systemic non compliance due the provider being cited under services 14-001 and 14-003. 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) 11/29/2023 1. The provided failed to provide proof of reference for Employee #1. 2. Employee #1 was hired in 2016 and no record of references was found. We currently have an electronic system called SkilledSurvey that requires new employees to submit references in the system. 3. This will be monitored by HR Generalist on a weekly basis to ensure that facility is meeting this requirement. 4. HR Generalist will validate that SkillSurvey has been submitted as part of onboarding process. Any issues will be escalated to HR Director for resolution. 5. Already implemented with ongoing monitoring OLR) Accepted 12/20/2023	11/29/2023
12VAC35-46-300. B. (4) - The records of each employee shall include: 4. Reports of required health examinations;	N	Project Valor This regulation was NOT MET as evidenced by: At the time of the inspection of the personnel records, the provider failed to provide reports of required health examinations for Employee #1. 1. Please identifying the root cause(s) of the violation;	PR) 11/29/2023 1. The provider failed to provide reports of the required health examinations for employee #1.	11/29/2023

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		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	1. The plan of action is update of procedure to ensure information is received. 1. This is ongoing daily/weekly/monthly and yearly monitoring. 1. The new employees have required TB PPDs/ Quantiferon tests done off-site prior to orientation. The results are faxed to Infection Control and Director of Nursing, then submitted to HR Generalist The HR Generalist, Infection Control Nurse and Director of Nursing monitor and maintain a shared spreadsheet with results from Quantiferon. Also, the Infection Control Nurse conducts yearly TB screening from date of hire of all employees. Already implemented with ongoing monitoring OLR) Accepted 12/20/2023	

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12VAC35-46-310. A. (3c) - Required initial training: 3. Within 14 days following their begin date, new employees, employees transferring from other facilities operated by the same provider, relief staff, volunteers, and students/interns shall be given orientation and training regarding: 3c. The decision-making plan;	NS	Project Valor This regulation was NOT MET (SYSTEMIC) as evidenced by: At the time of the inspection, the provider failed to ensure Employee #1 and Employee #2 completed decision making plan training. This regulation was cited for systemic non compliance due all employees were non compliance for this regulation. 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) 11/29/2023 1. Provider did not have decision-making plan and incident reporting included in employee orientation. 2. The plan of action was to update the employee orientation to include the decision-making plan and incident reporting. 3. Implemented during every employee orientation. 4. Employee training has been updated to include decision-making plan and incident reporting was also in employee orientation. HR Generalist updates employee orientation schedule and HR Director is responsible for reviewing and updating policy annually to reflect required training. 5. This was implemented during the following orientation class held on 11/13/23 and will be implemented moving forward. Training and Development Policy was updated to reflect the change. OLR) Accepted 12/20/2023	11/29/2023
12VAC35-46-590. B. - The interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. This includes, but is not limited to, required locks, mechanical devices, indoor and	N	Project Valor This regulation was NOT MET as evidenced by: While completing a physical plant inspection of Unit 6 and 7, the provider failed to ensure that the interior and exterior of all building shall be safe, properly maintained, clean, and in good working order. The following deficiencies were revealed:	PR) 11/27/2023 PR) 10/31/2023	12/15/2023

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outdoor equipment, and furnishings.		Unit 6 - Common area - a hole in the ceiling and unpainted areas 220 - there is a hole in the wall - Bathroom - two shower curtains missing and shower curtains dirty Unit 7 213 - two lights need to be replaced - Common area - walls need to be cleaned 1. Please identifying the root cause(s) of each 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	Unit wall repairs/painting underway a/o 9Nov23 Unit wall repairs underway a/o 9Nov23 Facility-wide inventory of missing/dirty shower curtains completed; awaiting delivery Maintenance work order submitted Housekeeping work order submitted	

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			For Maintenance: inadequate identification and reporting of deficiencies requiring repairs by facility staff For EVS: inadequate to attention-to-detail For Maintenance: roll out new, simpler process for direct care staff to report maintenance needs; communication to occur via email and departmental staff meetings For EVS: update and implement daily task list for staff to sign off on as completed; review/validation by EVS Supervisor Monthly through departmental meetings	

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			Support Services Director Maintenance Manager EVS Supervisor This can be reviewed at each itemized violation OLR) Partially Accepted 12/20/2023 Provider must submit documentation showing how deficiencies were completed (i.e. pictures or work order) PR) 12/27/2023 Pictures attached in link OLR) Accepted 12/29/2023	

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12VAC35-46-740. - Within three days following admission, individualized, measurable objectives and strategies for the first 30 days shall be developed, distributed to affected staff and the resident, and placed in the resident's record. The objectives and strategies shall be based on the reasons for admitting the resident.	NS	Project Valor This regulation was NOT MET (SYSTEMIC) as evidenced by: Upon review of Individual #1's records, the provider failed to show proof of the documented objectives and strategies based on the reasons for admission. This regulation was cited for systemic non compliance due the provider being cited under services 14-001 and 14-003. 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) 11/27/2023PR) 11/01/2023 Clinician did not meet the necessary standard 12VAC35-46-740 Director of Clinical Services to provide training each Thursday during the therapist meeting specific to identifying problem/focus areas through assessment and ensuring these issues are addressed in the Master Treatment Plans long term goals, objectives and interventions. Additionally, the team will ensure the report is upload to the resident's record. Monitoring will occur via audits, Friday of each week. Director of Clinical Services OngoingOLR) Accepted 12/20/2023	11/20/2023

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12VAC35-46-765. H. (1e) - Discharge summaries: 1. No later than 30 days after discharge, a comprehensive discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: 1e. Dates of admission and discharge;	NS	Project Valor This regulation was NOT MET (SYSTEMIC) as evidenced by: At the time of the inspection, the provider failed to produce discharge summary documentation showing the dates of admission and discharge. Individual #3 was discharged on 08/11/2023. This regulation was cited for systemic non compliance due the provider being cited under services 14-001 and 14-003. 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) 11/27/2023 PR) 11/01/2023 1. Clinician did not meet the necessary standard 12VAC35-46-740 2. Director of Clinical Services to provide training each Thursday during the therapist meeting specific to discharge summary compliance. This will also include tracking its submission to medical records and subsequent upload to ICANotes. 3. Monitoring will occur via audits, Friday of each week. 4. Director of Clinical Services 5. Ongoing OLR) Accepted 12/20/2023	11/20/2023

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12VAC35-46-765. H. (1f) - Discharge summaries: 1. No later than 30 days after discharge, a comprehensive discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: 1f. Date the discharge summary was prepared and the signature of the person preparing it.	NS	Project Valor This regulation was NOT MET (SYSTEMIC) as evidenced by: At the time of the inspection, the provider failed to produce discharge summary documentation showing the date the discharge summary was prepared and the signature of the person preparing it. Individual #3 was discharged on 08/11/2023. This regulation was cited for systemic non compliance due the provider being cited under services 14-001 and 14-003. 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) 11/27/2023PR) 11/01/2023 Clinician did not meet the necessary standard 12VAC35-46-740 Director of Clinical Services to provide training each Thursday during the therapist meeting specific to dating and signing the discharge summary. This will also include tracking its submission to medical records and subsequent upload to the resident's medical record. Monitoring will occur via audits, Friday of each week. Director of Clinical Services Ongoing(OLR) Accepted 12/20/2023	11/20/2023

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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.				
_____ Kitisha Green		_____ (Signature of Organization Representative)		_____ Date
C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined				