DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **909-14-003**
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **05-06-2024**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
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	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: See OHR 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	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: Neglect means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. See § 37.2-100 of the Code of Virginia. • Per provider's CHRIS report #20240183, Individual #1 was able to gain access to a locked med room on the unit with a broken piece of plastic and allegedly ingested some old medication that they found inside a file cabinet in the med room.	PR) 05/24/2024 **Statement of the Issue** On March 24, 2024, Individual #1 became dysregulated after an altercation with a peer for an incident that occurred between them two months prior. The peer was moved temporarily to the adjacent unit to avoid escalation pending peer mediation. Individual #1 was permitted by Employee #1 to pace the hallway by himself to provide him space to self-regulate and de-escalate, per his behavior support and safety plans. While in the hallway, Individual #1 positioned himself in front of the Medication Room which made it difficult for Employee #1 to have continuous line of sight of Individual #1. While Individual #1 was sitting in front of the Medication Room, the nurse visited the unit multiple times and went into the Medication Room. Employee #1 assumed that Individual #1	6/30/2024

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		• Upon review of the camera footage of the incident, the Human Rights Advocate observed Individual #1 enter the med room 3 different times while Employee #1 is sitting at the end of the unit hall at a table in the day room where approximately 5 or 6 other individuals are sitting. Per provider, Employee #1 is responsible for the supervision of the individuals in the day room as well as Individual #1 who is observed walking up and down the unit hall. • Per the camera footage, Employee #1 is observed sitting in the same location at the table during the entire incident while Individual #1 is going in and out of the med room. Employee #1 does not observe Individual #1 being in the med room until Employee #1 sees Individual #1 sitting on top of the half door that leads into the med room, which is approximately 30 mins after Individual #1 had entered the med room for the first time. • Per Individual #1's Resident Observation Record & Milieu Activities sheet for 3/24/24, Employee #1 recorded Individual #1's location at the time of incident as being in the hall, however per camera footage, Individual #1 is observed being inside of the med room and on top of the half door leading into the med room. • As a result of Employee #1's lack of adequate supervision, Individual #1 was able to gain access to a locked med room and therefore their right to be free from neglect was violated.	was with the nurse during those times, an assumption that was incongruent with facility policy because the nurse was not the direct care staff at the time. Without active supervision, Employee #1 did not realize that the nurse had left the unit, neither did he realize when Individual #1 breached the door to the Medication Room and went in and out multiple times. Individual #1 claimed that while in the Medication Room, he accessed old Seroquel pills which he claimed he swallowed. Individual #1 was taken to the ER for poison and overdose assessment. Initial toxicology reports given by the ER to the facility's DON indicated that Individual #1 did not overdose and was cleared by Poison Control the next day. However, he contracted COVID-19 while at the hospital and was kept for five additional days and discharged to the facility on 03-29-2024. **Include a Plan of Action to Ensure Regulatory Compliance** The facility conducted a comprehensive review of the incident and implemented the following corrective actions to assure regulatory compliance and prevent recurrence: 1. A detailed inspection of the location of the Medication Room relative to the position of Employee #1 revealed a blind spot in visual supervision. This made it impossible for Employee #1 to have physically seen Individual #1 when he silently breached the Medication Room. Unit staff have been educated about that blind spot and have been instructed not to permit residents in the hallway without active proximal supervision. 2. An assessment of access doors to all	

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			Medication Rooms was conducted and the facility resolved to change access doors to all Medication Rooms to prevent breach. Customized multi gauged doors are being built and are due to be installed at all Medication Rooms by 06-30-2024. 3. Meantime, the lock to the Medication Room was secured on the day of the incident (03-24-2024) to prevent unauthorized access. 4. A corrective action was issued to Employee #1 for failing to follow facility policy on patient monitoring. **Staff who will monitor plan of action for continued regulatory compliance** The Director of Risk Management and Director of Residential Services will monitor Employee #1 and all direct care staff to ensure compliance with facility policy on active patient supervision. The Director of Nursing will ensure that all medication cabinets in Medication Rooms are locked to prevent unauthorized access. The Director of Plant Operations is overseeing the purchase and installation of the new doors to all Medication Rooms. **Date(s) corrective action will be completed** 1. The lock to the Medication Room was secured on the night of the incident (03-24-2024) 2. Staff reeducation to the blind spot in the hallway was completed 04-17-2024 3. Cameras were installed in all Medication Rooms 05-21-2024 4. New multi gauge doors to all Medication Rooms are expected to be installed by 06-	

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			30-2024 OHR/OLR) Partially Accepted 06/12/2024 OHR Response: Partially accepted. Provider needs to enter their findings of investigation into the CHRIS system under report #20240183. Provider also needs to upload into CONNECT the following supporting documentation verifying that the corrective actions stated were implemented: re-education of staff regarding the blind spot, verification of new doors installed by 6/30/24, and copy of redacted corrective action administered to Employee #1. PR) 06/12/2024 Staff corrective action has been uploaded. OHR/OLR) Not Accepted 06/13/2024 OHR Response: Not Accepted. Please remove the uploaded document. It references the wrong employee and is not redacted. Please upload the following documentation: **re-education of staff regarding the blind spot, verification of new doors installed by 6/30/24, and copy of redacted corrective action administered to Employee #1**. PR) 06/14/2024 Staff CA was uploaded, CHRIS case was closed. OHR/OLR) Partially Accepted 06/24/2024 OHR Response: Partially Accepted. Provider needs to upload into CONNECT documentation	

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			verifying that the unit staff were trained on the blind spot in the hallway as previously stated on 4/17/24. PR) 09/10/2024 Update: The requested documentation was emailed to the OHR Advocate on 7/23/24 and accepted. OHR/OLR) Accepted 09/10/2024 9/10/24: OHR Response: ACCEPTED. Advocate reviewed the evidence of corrective which included copy of signed attestation form for Employee #1.	

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