

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

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License #: 986-14-003

Organization Name: Poplar Springs Hospital

Date of Inspection: 06-17-2022

Program Type/Facility Name: 14-003 Poplar Springs Hospital

<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	Poplar Springs Hospital This regulation was NOT MET as evidenced by: See OHR citation below.	PR) 07/15/2022 Employee #1 was terminated as a result of the lack of patient supervision resulting in an elopement and staff attendance. The Executive Director of Residential Services and program managers review in shift huddle daily behaviors that indicate a risk for elopement and proper patient supervision. OLR) Accepted 07/20/2022	6/13/2022
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	Poplar Springs Hospital 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. Upon review of CHRIS entry A- 20220263 and A- 20220264, the provider's investigation included video footage which revealed performance issues demonstrated by Employee 1 and neglect was found.	PR) 07/15/2022 Employee #1 was terminated as a result of the lack of patient supervision resulting in an elopement and staff attendance. The Executive Director of Residential Services and program managers review in shift huddle daily behaviors that indicate a risk for elopement and proper patient supervision. OHR/OLR) Accepted 07/20/2022	6/13/2022

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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.				
Tonya Carr, Legal Operations Manager		(Signature of Organization Representative)		Date
C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined				