

**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: **04-05-2024**

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.		

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Date of Inspection: **04-05-2024**

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>
12VAC35-115-50. 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-20240010, the provider's investigation determined Neglect was substantiated based on video review. • Upon review of the provider's written investigation summary received on 4/4/2024, video review revealed: ◦ Staff performed rounds appropriately when the incident occurred. The incident occurred during bedtime routine. However, the video review shows that the first time there was no staff around. The second time the peer entered the room when staff was present. the video review shows that staff were not properly supervising during this incident. Based on preponderance of evidence, the provider failed to ensure the health and safety of Individual #1.	PR) 04/29/2024 In review of this citation, the provider agrees with this citation. Video footage confirms that although staff completed timely rounds, the staff failed to redirect youth who were in a peer's room that they were not assigned too. The staff identified in this incident. received a corrective action plan and received additional training on supervision. A shift wide training on the basic of rounding and supervision was completed on 4/23/24 and 4/24/24. OHR/OLR) Accepted 04/29/2024	4/29/2024

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