hopestarter RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

Voice/TDD (540) 373-3223 | Fax (540) 371-3753

NOTICE

To: Program Planning and Evaluation Committee
Nancy Beebe, Glenna Boerner, Claire Curcio, Ken Lapin, Jacob Parcell, Sarah Ritchie, Carol Walker, Matt Zurasky

From: Joseph Wickens
Executive Director

Subject: Program Planning and Evaluation Meeting
May 9, 2023 10:30 AM
600 Jackson Street, Board Room 208, Fredericksburg, VA

Date: May 2, 2023

A Program Planning and Evaluation Committee Meeting has been scheduled for Tuesday, May 9, 2023 at 10:30 AM. The meeting will be held at 600 Jackson Street, Board Room 208, Fredericksburg VA 22401.

Looking forward to seeing you on May 2, 2023 at 10:30 AM.

Cc: Nancy Beebe, Chairperson

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Program Planning and Evaluation Committee Meeting

May 9, 2023 – 10:30 AM

600 Jackson Street, Room 208 Fredericksburg, VA 22401

Agenda

I. Extraordinary Barriers List, *Newman* 3
II. Independent Assessment Certification and Coordination Team Update, *Andrus* . 4
III. Information Technology/Electronic Health Record Update, *Poe* 6
IV. Crisis Intervention Team Assessment Center Report, *Kobuchi* 9
V. Emergency Custody Order/Temporary Detention Order, *Kobuchi* 11
VI. Waitlist, *Terrell* 15
VII. Licensing Reports, *Terrell* 19
VIII. 3rd Quarter FY2023 Incident Report Review, *Terrell* 29
IX. Quality Assurance Report, *Terrell* 34
X. Other Business, *Beebe*

MEMORANDUM

TO: Joe Wickens, Executive Director

FROM: Patricia Newman – Mental Health Case Management Supervisor
Elizabeth Wells – Lead State Hospital Liaison & NGRI Coordinator
Chanda Bernal – Adult Mental Health Case Manager

PC: Brandie Williams – Deputy Executive Director
Jacqueline Kobuchi, LCSW – Clinical Services Director
Amy Jindra – Community Support Services Director
Nancy Price – MH Residential Coordinator
Tamra McCoy – ACT Coordinator
Jennifer Acors – Coordinator Developmental Services Support Coordination

SUBJECT: Extraordinary Barriers List (EBL)

DATE: May 9, 2023

RACSB currently has three individuals on the Extraordinary Barriers List (EBL) who are hospitalized at Northern Virginia Mental Health Institute (NVMHI), Western State Hospital (WSH) and Catawba Hospital. Individuals ready for discharge from state psychiatric hospitals are placed on the EBL when placement in the community is not possible within 7 days of readiness, due to barriers caused by waiting lists, resource deficits, or pending court dates.

Northern Virginia Mental Health Institute

Individual #1: Was placed on the EBL 3/15/23. Barriers to discharge include identifying and being accepted to a Developmental Disability Group Home. This individual has diagnosis of both a Developmental Disability and mental health concerns. The treatment team continues to explore possible group home placements and this individual will interview with Angel Gate group home on 5/3/23. This individual will have a Developmental Disability waiver and will not require Discharge Assistance Program (DAP) funding.

Western State Hospital

Individual #2: Was placed on the EBL 4/17/23. Barriers to discharge include being accepted to a supervised and transitional residential program. This individual has resided in the community, independently in the past and utilized Assertive Community Treatment (ACT) Services, however they struggled to maintain stability and participation in an independent setting. A trial pass to Home Road as well as a living skills assessment will be completed to determine if they will be accepted to the program. Discharge will take place once housing and services are established.

Catawba Hospital

Individual #3: Was placed on the EBL 4/7/23. Barriers to discharge include identifying and being accepted to a residential placement that is able to support this individual's needs. This individual has resided in a variety of different settings in the community to include with family, a supervised apartment as well as an assisted living facility, however they have struggled to maintain stability and have required hospitalization. This individual would prefer to reside independently, however at this time it has been determined that they would benefit from supervision, medication administration as well as education in the area of independent living. Discharge will take place once they are accepted to a supervised residential program.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director

From: Donna Andrus, Child and Adolescent Support Services Supervisor

Date: May 1, 2023

Re: Independent Assessment Certification and Coordination Team (IACCT) Update

****

I am writing to provide an update to the Independent Assessment Certification and Coordination Team (IACCT) program. The Department of Medical Assistance Services (DMAS) with Magellan launched the IACCT program July 1, 2017. The Rappahannock Area Community Services Board is the IACCT provider for Planning District 16.

RACSB received eleven IACCT referrals and completed ten assessments in the month of April. One IACCT has not been completed yet. Five referrals were initial IACCT assessments and six were re-authorizations. Four were from Spotsylvania, one from Stafford, one from Caroline, two from King George and three from the City of Fredericksburg. Of the ten completed assessments in April, five recommended Level C Residential, three recommended Level B Group Home, one recommended community based services and one reauthorizations recommended discharge. One initial request was for a child to move from one residential facility to another facility and one initial request was for a child to remain in residential after initially being placed under private insurance and then qualifying for Medicaid. Five extensions were requested to meet the timeline.

Attached is the monthly IACCT tracking data for April 2023.

600 Jackson Street
Fredericksburg, VA 22401
540-373-3223

RappahannockAreaCSB.org

hopestarter

Report Month/Year	Apr-23
1. Total number of Referrals from Magellan for IACCT:	11
1.a. total number of auth referrals:	5
1.b. total num. of re-auth referrals:	6
2. Total number of Referrals per county:	
Fredericksburg:	3
Spotsylvania:	4
Stafford:	1
Caroline:	1
King George:	2
Other:	0
3. Total number of extensions granted:	5
4. Total number of appointments that could not be offered within the prescribed time frames:	0
5. Total number of "no-shows":	0
6. Total number of cancellations:	0
7. Total number of assessments completed:	10
8a. Total number of ICA's recommending: **residential:**	5
8b. Total number of ICA's recommending: **therapeutic group home:**	3
8c. Total number of ICA's recommending: **community based services:**	1
8g.Total number of ICA's recommending: **Other:**	0
8h.Total number of ICA's recommending: **no MH Service:**	0
9. Total number of reauthorization ICA's recommending: **requested service not continue:**	1
10. Total number of notifications that a family had difficulty accessing **any** IACCT-recommended service/s:	0

To: Joe Wickens, Executive Director

From: Nathan Reese, IT Coordinator

Re: Information Technology and Electronic Health Record Update

Date: May 2, 2023

This report provides an update on projects related to Information Technology and the Electronic Health Record. Information is provided on state reporting initiatives, facility technology needs, and on-going projects.

Information Technology and Electronic Health Record Update

IT Systems Engineering Projects
During April 2023, 910 tickets where closed by IT Staff compared to March – 1098, February – 1050, and January – 983. In 2022, the IT department averaged closure of 1,023 tickets per month.

Community Consumer Submission 3
The March 2023 CCS was submitted on April 27, 2023.

Waiver Management System (WaMS)
WaMS 3.4 testing opened April 1, 2023 however RACSB's testing window was significantly shortened due to Avatar losing connection between its Build and Test Avatar systems. The 3.4 changes were loaded into the Build system prior to the testing period, then once Netsmart completed their backend changes during the first week of testing, IT attempted to move forms to the Test Avatar system but had a critical error. From April 12th through April 27th, we were not able to test. Once Netsmart diagnosed and fixed the connection issue, testing resumed. WaMS 3.4 specifications go live on May 2, 2023. The WaMS testing site will continue to be used until successful submission is accomplished.

Trac-IT Early Intervention Data System
In November, RACSB program and IT staff attended a demo on the upload functionality for Trac-It. This functionality will be key for our ability to meet expanded data requirements when the new date for that implementation is announced. After the demo, there were system-wide concerns around the functionality. We met as part of the DMC Trac-IT workgroup with DBHDS Part C Staff to express our concerns. DBHDS advertised an updated EHR demo kick off which was held at the end of March 2023. Both program staff and information technology staff attended the webinar. The presenter of the webinar indicated that there had been no changes in functionality since last May and ended the webinar an hour early due to multiple concerns being expressed by participants.

Starting April 6th, 2023, Netsmart state reporting team, PEID, and IT staff began participating in the Trac-IT EHR committee to discuss the technical aspects of Trac-IT interoperability. This group meets monthly with the goal of producing a collaboratively developed process to facilitate the data exchange between Avatar and Trac-IT.

Zoom
We continue to utilize Zoom for telehealth throughout the agency.

- April 2023 – 2,410 video meetings with a total of 6,685 participants
- March 2023 – 2,821 video meetings with a total of 7,479 participants
- February 2023 – 2,475 video meetings with a total of 6,731 participants
- January 2023 – 2,402 video meetings with a total of 6,668 participants
- Average from January to December 2022 was 2,800 video meetings and 8,154 Participants
- Average from January to December 2021 was 3,648 video meetings and 11,087 Participants

Avatar
IT is beginning a new project to streamline and increase Avatar credentials. IT will kick-off Netsmart's single sign on, project on May 3, 2023. Once implemented NIAM will allow staff the ability to login to Avatar with the same password as their email. NIAM also allows users to set up 2 factor authentications to increase security. Lastly, NIAM will increase the efficiency by providing a single place for IT to manage account access, creation, and removal.

Staffing

Suzanne Poe is retiring from the agency after 26 years on July 28, 2023. Nathan Reese has been promoted to the IT Coordinator position, starting May 28, 2023. IT hired Rory Paule as an IT Specialist starting May 1, 2023. We currently have one vacancy for Assistant IT Coordinator.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Kari Norris, Emergency Services Coordinator
Date: May 2, 2023
Re: Crisis Assessment Center and CIT report April

The CIT Assessment Center assessed 27 individuals in the month of April 2023. The number of persons served by locality were the following: Fredericksburg 4; Caroline 1; King George 2; Spotsylvania 8; Stafford 12.

Please see attached CIT data sheet

April 2023 RACSB CIT Assessment Center Data

Date	Number of ECOs Eligible To Utilize CAC Site	Number of Individuals Assessed at CAC Site	Locality who brought Individual	Locality working at the Assessment Site
4/1/2023	2	1	Stafford	King George/Spotsylvania
4/2/2023	1	0	n/a	King George/Fredericksburg
4/3/2023	0	0	n/a	Stafford
4/4/2023	1	1	Spotsylvania	Fredericksburg/Spotsylvania/King George
4/5/2023	2	2	King George; Stafford	Spotsylvania/Stafford
4/6/2023	3	2	Stafford; Spotsylvania	Spotsylvania
4/7/2023	4	2	Spotsylvania	Spotsylvania
4/8/2023	1	1	Fredericksburg	Spotsylvania/Stafford
4/9/2023	3	0	n/a	VACANT
4/10/2023	6	2	Stafford (2)	Spotsylvania/Stafford
4/11/2023	1	0	n/a	Spotsylvania/Stafford
4/12/2023	0	0	n/a	STafford
4/13/2023	2	2	Stafford; Fredericksburg	Fredericksburg/Spotsylvania
4/14/2023	1	0	n/a	Fredericksburg/Stafford
4/15/2023	4	1	Spotsylvania	Spotsylvania
4/16/2023	1	0	n/a	Spotsylvania/Stafford
4/17/2023	3	0	n/a	Spotsylvania/Stafford
4/18/2023	2	2	Stafford (2)	Spotsylvania
4/19/2023	2	1	Stafford	Spotsylvania/Stafford
4/20/2023	2	1	Fredericksburg	Spotsylvania
4/21/2023	4	2	Fredericksburg; Spotsylvania	Spotsylvania
4/22/2023	0	0	n/a	Spotsylvania
4/23/2023	1	1	Spotsylvania	Spotsylvania
4/24/2023	0	0	n/a	Stafford
4/25/2023	3	1	Stafford	Fredericksburg/Spotsylvania
4/26/2023	1	0	n/a	Spotsylvania
4/27/2023	5	2	Stafford; Caroline	Spotsylvania/Fredericksburg/Stafford
4/28/2023	3	1	King George	Spotsylvania/Stafford
4/29/2023	1	1	Stafford	Spotsylvania
4/30/2023	4	1	Spotsylvania	Spotsylvania/Stafford
Total	63	27		

Total Assessments at Center in April: 27

Brought by:		**Cumulative Total:**
Caroline	1	148
Fred City	4	1017
Spotsylvania	8	974
Stafford	12	1021
King George	2	127
Other	0	4

Cumulative number of Assessment since September 2016: 3291

MEMORANDUM

To: Joe Wickens, Executive Director

From: Kari Norris, Emergency Services Coordinator

Date: May 2, 2023

Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – April, 2023

In April 2023, Emergency Services staff completed 325 emergency evaluations. Sixty-five emergency custody orders were assessed and seventy-seven total temporary detention orders served of the 325 evaluations. Staff facilitated five admissions to a state hospital. One adult admission went to NVMHI. Three adolescent admissions went to CCCA. One geriatric admission went to Piedmont.

A total of 17 individuals were involuntarily hospitalized outside of our catchment area in April. Three individuals were able to utilize alternative transport.

Please see attached data reports.

DATE: 5.2.2023

Emergency Services Activity Reports

Month	Contacts	Evaluations	ECOs	TDOs Issued	TDOs Executed
December 2020		373	75	79	79
January 2021		374	88	89	89
February 2021		358	84	83	83
March 2021		465	82	100	100
April 2021		449	92	100	100
May 2021		507	93	93	93
June 2021		453	95	95	92
July 2021		379	76	74	74
August 2021		394	86	77	77
September 2021		517	98	86	86
October 2021		422	60	72	72
November 2021		425	59	60	60
December 2021		401	67	66	66
January 2022		355	74	63	63
February 2022		442	87	64	64
March 2022		375	74	81	81
April 2022		390	85	87	87
May 2022		417	92	73	73
June 2022		342	75	66	66
July 2022		343	77	83	83
August 2022		367	79	76	76
Setpember 2022		341	66	76	76
October 2022		351	70	75	75
November 2022		359	69	73	73
December 2022		296	55	51	51
January 2023		389	81	86	86
February 2023		340	65	67	67
March 2023		406	83	93	93
April 2023		325	65	78	78

FY23 CSB/BHA Form (Revised: 06/28/2022)

CSB/BHA	Rappahannock Area Community Services Board	Month	April 2023

1) Number of Emergency Evaluations	2) Number of ECOs			3) Number of Civil TDOs Issued	4) Number of Civil TDOs Executed				5) Number of Criminal TDOs Executed
	Magistrate Issued	Law Enforcement Initiated	Total		Minor	Older Adult	Adult	Total	
325	33	32	65	77	10	6	61	77	1
			0					0	
			0					0	

FY '23 CSB/BHA Form (Revised: 06/28/2022)

CSB/BHA	Rappahannock Area Community Services	Reporting month	April 2023	No Exceptions this month ➡

Date	Consumer Identifier	1) Special Population Designation (see definition)	1a) Describe "other" in your own words (see definition)	2) "Last Resort" admission (see definition)	3) No ECO, but "last resort" TDO to state hospital (see definition)	
4/6/23	79934	Adult (18-64) with ID or DD		No	Yes	NVMHI
4/7/23	109832	Adolescent		Yes	No	CCCA
4/15/23	47969	Adolescent		Yes	No	CCCA
4/21/2023	105396	Adolescent		Yes	No	CCCA
4/25/2023	88885	Older adult		Yes	No	Piedmont

ALTERNATIVE TRANSPORT DATA April 2023

Date	ID	LE DEPT	Location of Individual	Receiving Hospital	Travel time Round Trip (minutes)	ECO Y or N	Gender	Age	TDO criteria	Presented for AT: Y or N	Reason for Decline
4/1/23	64331	Caroline	MWH ED	Ridgeview Pavilion		yes	F	34	Danger to self	No	Historically refuses and declines AT
4/1/23	109762	Stafford	MWH ED	Twin County		yes	F	24	Danger to self	Yes	Utilized AT
4/2/23	99766	Stafford	MWH ED	VCU		no	F	15	Danger to self	no	Client too impulsive
4/6/23	79934	Stafford	MWH ED	NVMHI		no	M	31	Danger to others; Inability to care	no	Aggression and poor impulse control
4/7/23	109832	Stafford	MWH ED	CCCA		yes	F	16	Danger to others; Inability to care	no	Too impulsive and elopement risk
4/7/23	52865	King George	MWH ED	Twin County		yes	F	51	Inabiltiy to care	no	Too impulsive and elopement risk
4/9/23	109838	Stafford	MWH ED	Dickenson		yes	F	77	Inabiltiy to care	Yes	AT Utilized
4/10/23	108072	Stafford	MWH ED	Poplar Springs		yes	F	16	others	No	Elopement risk
4/15/23	47969	Stafford	MWH ED	CCCA		yes	F	17	Danger to self and others	No	Elopement risk
4/15/23	30217	Spotsylvania	MWH ED	Dickenson		yes	F	60	Danger to others; Inability to care	No	Post commitment client
4/17/23	79868	Stafford	MWH ED	Poplar Springs		yes	F	18	Danger to self and others	No	Too aggressive and actively self injuring
4/18/23	109652	Stafford	MWH ED	Northsprings		yes	F	13	Danger to self	Yes	Accepting facility needed a faster transport
4/19/23	104075	Stafford	MWH ED	Newport News		yes	F	15	danger to self and others	No	Too impulsive and aggressive
4/19/23	48244	Stafford	MWH ED	Pavilion at Williamsburg		no	F	47	Inabiltiy to care	Yes	AT Utilized
4/21/23	105396	King George	MWH ED	CCCA		yes	M	16	Danger to others	No	Too impulsive and active HI
4/25/23	88885	Spotsylvania	SRMC-ED	Piedmont		yes	F	67	Danger to self	No	Combative with LE
4/27/23	54962	Stafford	Stafford Hosp-ED	VA Beach Psych.		no	F	27	Danger to self; Inability to care	No	Elopement risk

Total Out of Area			
17			
Total Utiliz	Utilize	Total Appropriate for AT	
3	18%	4	24%

MEMORANDUM

To: Joe Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: May 1, 2023
Re: April 2023 Waiting Lists

Identified below you will find the number of individuals who were on a waiting list as of April 30, 2023.

OUTPATIENT SERVICES

- Clinical services: As of April 30, 2023, there are 193 individuals on the wait list for outpatient therapy services.
  - Individuals are placed on the wait list if they cannot be seen at a regularly scheduled appointment within 30 days of request. Individuals who fall in a priority category are seen during open access.
    - Due to an increase in request for outpatient services, the Fredericksburg Clinic implemented a waitlist for new clients seeking outpatient services beginning October 5, 2021, the Spotsylvania Clinic implemented a waitlist beginning May 2022, and the Caroline Clinic implemented a waitlist beginning November 2022.
      - The waitlist in Fredericksburg is currently at 55 clients.
      - The waitlist in Spotsylvania is currently at 58 clients.
      - The waitlist in Caroline is currently at 80 clients.
      - This is a decrease of 27 from the March 2023 waitlist.
    - If an individual is not in a priority category the following may occur: 1) he or she may be placed on a waiting list and called weekly by a therapist to review presenting situation. Individuals are then offered an appointment as one becomes available; 2) if an individual has private insurance staff will assist in locating a private provider if the individual does not wish to wait for an appointment. Staff are working to avoid scheduling an individual too far into the future as this increases the likelihood of no-shows.
  - Clinical services are initiated through Same Day Access. Due to COVID-19 concerns, Same Day Access appointments are scheduled versus having multiple individuals come to the clinic and having to wait for their appointment time. Same Day Access schedules are as follows:
      - Fredericksburg Clinic: Monday, Wednesday, and Thursday 8:30a.m. to 2:30 pm
Tuesday 9:30am – 2:30PM
      - King George Clinic: Tuesday-1:00 pm-5:00 pm and Wednesday- 8:00 am- 12:00 pm
      - Stafford Clinic: Tuesday and Thursday 9:00 am – 12:00 pm
      - Spotsylvania Clinic: Tuesday, Wednesday, and Thursday 9:00 am – 2:00 pm
      - Caroline Clinic: Tuesday and Thursday 8:30am – 11:30 am
- Psychiatry intake: As of May 1, 2023, there are four older adolescents and adults waiting longer than 30 days for their intake appointment. This is a decrease of one from the March 2023 waitlist. The furthest out appointment is 6/27/2023. There are no children age 13 and below waiting longer than 30 days for their intake appointment.

PSYCHIATRY INTAKE – As of May 1, 2023 the number of individuals waiting longer than 30 days for a regularly scheduled psychiatric intake appointment include:

	Adults		Children: Age 13 and below
○	Fredericksburg –	2 (5)	0 (0)
○	Caroline –	1 (0)	0 (0)
○	King George –	1 (0)	0 (0)
○	Spotsylvania –	0 (0)	0 (0)
○	Stafford –	0 (0)	0 (0)
	Total	**4 (5)**	**0 (0)**

	Appointment Dates
Fredericksburg Clinic	
	6/14/2023 6/27/2023
Caroline Clinic	
	6/2/2023
King George	
	6/5/2023
Spotsylvania Clinic	
	N/A
Stafford Clinic	
	N/A

Community Support services:

Waitlist Definitions

Needs List - A person is placed on the Needs List when an individual, family member, RACSB staff, or external agency notifies that particular program service that the individual needs services provided by that program.

Referral - Persons are placed on this Referral List when services have been requested and all necessary documentation for the referral process is submitted to the program Coordinator. At this time, the person is placed on the Referral List and removed from the Needs List.

All referrals are sent to the Coordinator for initial review. The Coordinator determines that all information is in the packet and makes a disposition for acceptance, rejection, or assessment. The Coordinator will forward the referral packet to the appropriate staff for assessment. Time frame for completion of assessment is also be indicated.

If the assessment leads to acceptance, the client will be placed on the acceptance list. If the assessment leads to a decision which does not involve acceptance, the program Coordinator will reach a decision about disposition of the referral.

Acceptance List - This list includes all persons who have been assessed for services and accepted to the program. These individuals are waiting for appropriate supports.

MH RESIDENTIAL SERVICES - 6

Needs List: 0
Referral List: 3
Acceptance List: 3

Count by County:

Caroline 0
King George 0
Fredericksburg 3
Spotsylvania 1
Stafford 0
Culpepper 2

- We have three individuals who are on the acceptance list. All three are from Western State and have conditional passes that they must first complete before moving in. We have three individuals on the referral list. Two are in Western and were unable to complete the CSS assessment due to psychosis and mental instability. We have one from the community that is waiting to complete his CSS assessment.

Intellectual Disability Residential Services – 97

Needs List: 92
Referral List: 5
Acceptance List: 0

Count by County:
Caroline 10
King George 7
Fredericksburg 8
Spotsylvania 34
Stafford 37
Richmond 1

Assertive Community Treatment (ACT)– 17

Caroline: 1
Fredericksburg: 7
King George: 1
Spotsylvania: 4
Stafford: 4

Total Needs: 6
Total Referrals: 11
Total Acceptances: 0

Total program enrollments = 51

Admissions: 1
Discharges: 0

ID/DD Support Coordination

There are 812 individuals on the waiting list for a DD waiver.

P-1 341
P-2 185
P-3 286

RAAI – 37

Caroline: 3
Fredericksburg: 2
King George: 3
Spotsylvania: 13
Stafford: 9
Other: 7

Total Referrals: 33
Total Assessing: 1
Total Acceptances (waiting to add more days): 3

Total program enrollments = 112

MEMORANDUM

To: Joe Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance and Human Rights

Date: April 28, 2023

Re: Licensing Reports

The Department of Behavioral Health and Developmental Services' (DBHDS), Office of Licensing issues licensing reports for areas in which the Department finds agencies in non-compliance with applicable regulations. The licensing report includes the regulatory code which applies to the non-compliance and a description of the non-compliance. The agency must respond to the licensing report by providing a corrective action plan (CAP) to address the areas of noncompliance.

Rappahannock Area Community Services Board (RACSB) obtained approval for three Corrective Action Plans (CAPs) during the month of April 2023. Leeland Road Group Home received a report due to an incident which occurred involving a resident of Leeland and Lucas Street ICF received two reports for incidents involving two different residents of Lucas Street ICF.

The attached CAPs provide addition details regarding the citation and RACSB's response.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-27-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-100. A. (1a) - From admission until discharge from a service, each individual is entitled to: 1. Enjoy all the freedoms of everyday life that are consistent with his need for services, his protection, and the protection of others, and that do not interfere with his services or the services of others. These freedoms include: 1a. Freedom to move within the service setting, its grounds, and the community;	N	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: During an internal investigation the provider substantiated the allegation due to the following: • Employee 1 admitted to locking Individual 1's door in an effort to keep others out. • Individual 1 stated no one asked if they could lock the door and does not like when staff lock the door.	PR) 04/19/2023 PR: The staff member alleged to have restricted the freedoms of everyday life for the individual was placed on administrative leave pending the outcome of an internal investigation. Upon substantiation of the allegation following the investigation procedures, the staff member responsible for the incident was separated from employment by the agency effective 4/3/23. Systematically, Human Resources will continue to conduct mandated background checks and ensure at onboarding that no barrier crimes are present in the past of any potential employee. All RACSB staff, volunteers, and contractors will be required to undergo an annual	4/3/2023

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-27-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly. Any staff member suspected or alleged to violate the Code of Virginia and any related human rights regulations adopted by the state board will immediately be put on	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-27-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			administrative leave pending the outcome of an investigation. OHR/OLR) Accepted 04/20/2023	

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.

Cassie Purtlebaugh, Human Rights

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-22-2023**
Program Type/Facility Name: **01-001 Leeland Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Leeland Road Group Home This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-110. A. - Each individual is entitled to be completely free from any unnecessary use of seclusion, restraint, or time out.	N	Leeland Road Group Home This regulation was NOT MET as evidenced by: CHRIS Abuse #20230009 & CHRIS Abuse #20230010/Incident date: 2.21.2023 & 2.28.2023 "Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means, so that the individual cannot leave it. Provider substantiated for seclusion due to the following: • While conducting a routine check in the home, the staff observed a recliner placed against the space between the end of resident's bedrail and the foot board. The recliner was placed in this position in order to physically block the individual from leaving the room. Physically blocking an individual from leaving the room meets the regulatory definition of seclusion.	PR) 03/29/2023 PR: The staff members responsible for the incidents were each put on administrative leave following the discovery of the incident. They will receive corrective coaching by 4/15/23 to ensure they understand the dynamics of providing safety supports in such a way that are not intrusive or secluding in nature for individuals. Systematically, Human Resources will continue to conduct mandated background checks and ensure at onboarding that no barrier crimes are present in the past of any potential employee. All RACSB staff, volunteers, and contractors will be required to undergo an annual Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency	4/15/2023

License #: **101-01-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-22-2023**
Program Type/Facility Name: **01-001 Leeland Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			orientation. Program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly. Any staff member suspected or alleged to violate the Code of Virginia and any related human rights regulations adopted by the state board will immediately be put on administrative leave pending the outcome of an investigation. OHR/OLR) Accepted 03/29/2023	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-001**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-22-2023**
Program Type/Facility Name: **01-001 Leeland Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

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.

Cassie Purtlebaugh, Human Rights	(Signature of Organization Representative)	Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-29-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-50. D. (1) - The provider's duties: 1. Providers shall recognize, respect, support, and protect the dignity rights of each individual at all times. In the case of a minor, providers shall take into consideration the expressed preferences of the minor and the parent or guardian.	N	Lucas Street (ICF/IID) This regulation was NOT MET as evidenced by: During an internal investigation the provider determined the following: • Employee 1 instructed other staff to allow Individual 1 to walk around the group home setting naked due to the frequency in which Individual 1 disrobed • Individual 1 was allowed to walk around the services setting in front of peers in a state of undress • This is a violation of Individual 1's right to dignity rights	PR) 04/19/2023 PR: The staff member alleged to have violated the dignity rights of the individual was placed on administrative leave pending the outcome of an internal investigation. Upon substantiation of the allegation following the investigation procedures, the staff member responsible for the incident was separated from employment by the agency effective 4/3/23. Systematically, Human Resources will continue to conduct mandated background checks and ensure at onboarding that no barrier crimes are present in the past of any potential employee. All RACSB staff, volunteers, and contractors will be required to undergo an annual	4/3/2023

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-29-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Human Rights training to help ensure continued promotion and support of individuals' rights and freedoms. Newly hired staff will be assigned this course upon hire during the week of their agency orientation. The program leaders will monitor staff and continue to ensure all Human Rights regulation violations are immediately reported to RACSB's Office of Consumer Affairs. They will likewise ensure best person-centered practices are being followed by staff through direct and indirect supervision (viewing cameras, ongoing discussion of person-centered plans and practices, conducting random direct supervision of staff working with individuals). The Quality Assurance team will monitor incident reports and any allegations or reports of human rights violations on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly. Any staff member suspected or alleged to violate the Code of Virginia and any related human rights regulations adopted by the state board will immediately be put on	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-01-005**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **03-29-2023**
Program Type/Facility Name: **01-005 Lucas Street (ICF/IID)**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			administrative leave pending the outcome of an investigation. OHR/OLR) Accepted 04/20/2023	

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.

Cassie Purtlebaugh, Human Rights

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined

MEMORANDUM

To: Joseph Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance and Human Rights
Date: April 14, 2023
Re: 3rd Quarter FY 2023 Incident Report Review

The third quarter incident summary report provides an overview of incident reports submitted by Rappahannock Area Community Services Board (RACSB) staff during the months of January 1, 2023 through March 31, 2023. The purpose of the report is to communicate information about trends, remain vigilant for emerging issues, and use data to plan, prioritize and implement preventative initiatives.

The population covered includes all people receiving services by the RACSB, which includes Mental Health, Substance Use, Developmental Disability, and Prevention services. RACSB provided services to 7,142 individuals, unduplicated by service area, from January 1, 2023 through March 31, 2023.

Quality Assurance Staff received and triaged 597 Incident Reports from January 1, 2023 through March 31, 2023 (an overall increase of 41 reports). Of the 597 incident reports received, 99 incidents were reported to Department of Behavior Health and Developmental Services (DBHDS) through the Computerized Human Rights Information System (CHRIS) as a serious incident.

Quality Assurance staff triaged all incident reports into one of four categories.

1. **N/A** – these reports do not fit into DBHDS definitions of a serious incident. Incidents of this sort may be a staff having to report a child protective or adult protective case to the Department of Social Services, or an incident which occurs when the individuals is not in the provision of care, such as when a report is received by a Support Coordinator regarding an individual who resides with parent/guardian or a private provider.

DBHDS categories of serious incidents

2. **Level I**: a serious incident that occurs or originates during the provision of a service or on the premises of the provider that do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention, or events that have the potential to cause serious injury, even when no injury occurs."

3. **Level II**: a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. Level II serious incident; also includes a significant harm or threat to the health or safety of others caused by an individual.

4. **Level III**: a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in:
   1) Any death of an individual;
   2) A sexual assault of an individual;
   3) A serious injury of an individual that results in or likely will result in permanent physical or psychological impairment;

4) A suicide attempt by an individual admitted for services that results in a hospital admission."

In addition to the nonfiction to QA staff, program supervisors and coordinators, staff must also notify the individual's parent/guardian/authorized representative, as appropriate, regarding the incident. Verification of the notification and the parent/guardian/authorized representative response is to be included on the incident report.

Below is a list of the incident categories and the definition:

- Aggressive Behavior –Physical - hit, slap, push, shove, pull hair, spit, bite, intimidate, demean, threaten, curse etc…
- Aggressive Behavior –Verbal - yelling, screaming, intimidate, demean, threaten, curse etc…
- Individual Safety - situations that may cause a safety risk for individuals served involving physical environment or structures (faulty equipment, smoking.)
- Individual Injury - situations that may cause a safety risk for individuals served involving minor injury such as a scraped knee
- Health Concerns - individual served exhibiting health concerns, i.e. possible seizure activity, sick, sudden weight +/-, etc.
- Elopement/Wandering - unexpectedly leaving program/premises with possible risk to safety
- Biohazardous Accident - needle stick or instance requiring testing of individual served or staff
- Infection Control - lack of infection control and use of universal precautions in relation to risk of non-life-threatening communicable diseases i.e. Flu, Lice… etc…
- Exposure to Communicable Diseases - instance of exposure due to lack of infection control and/or use of universal precautions in relation to risky communicable diseases i.e. TB, HIV/AIDS, HEP A, B, C or MRSA…
- Vehicle Accident - Accident of RACSB or personal vehicle while delivering services. This requires additional paperwork and follow up to protocol contact Human Resources & Supervisor
- Property Damage - damage to property
- Weapon Use/Possession - Weapons are not allowed in any RACSB facility. Knives, carpet knives, swords, guns etc…
- Staff Injury - injury to staff- ensure proper HR forms are completed
- Use of Seclusion/Restraint - if emergency intervention required to deescalate threatening behavior
- Med Non-Compliance - not following medication regime- staff attempt evident- non-compliance
- Med Error- Staff additionally to complete med error report. error has been made in administering a medication to an individual (wrong- med, individual, route, dose, time)
- Possession of Illicit/Licit Substance - possession of illegal or non-prescribed drug –possible intent of abuse
- Sexual Assault - is an act in which a person intentionally sexually touches another person without that person's consent, or coerces or physically forces a person to engage in a sexual act against their will
- Suicide/Suicide Attempt - is the act of intentionally causing one's own death/ is the act of intentionally unsuccessfully trying to cause one's own death

- Sentinel Events - An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof- warrants immediate investigation and response
- Other – incident which does not fit into a category above

Type	Total
Accidental Overdose	2
Aggressive Behavior - Physical	39
Aggressive Behavior - Verbal	19
Bio hazardous Accident	0
COVID	28
Elopement/Wandering	9
Exposure to Communicable Diseases	0
Health Concern	185
Individual Served Injury	102
Individual Served Safety	73
Infection Control	0
Med Error	23
Med Non-Compliance	8
Medication non-adherence	11
Medication poor adherence	19
other	0
Possession of Illicit/Licit Substances	0
Property Damage	7
Sentinel Event	9
SIBs	13
Sexual Assault	4
Staff Injury	4
Suicide (non-completion)	29
Use of Seclusion/Restraint	4
Vehicle Accident	7
Weapon Use/Possession	0
Missing Person	2
Total	597

The table above depicts the total number of incident reports received, January 1, 2023 through March 31, 2023 by category.

Approximately 32% of the incident reports received were categorized as health concerns. When compared to previous quarters, health concerns continue to be the category with the highest number of incidents. This can be contributed to all health-related conditions, such as colds, flu, and vomiting or diarrhea. RACSB Residential Services submitted 30 of 184 health concern reports. Reports consisted of concerns related to abnormal pain, nausea, feeling ill, seizure, cellulitis, bruising, UTIs, and bowel obstruction. Churchill Group Home submitted the highest number of health concern incident reports (5) for Developmental Disability Group Home Services; however, no two concerns were the same. Review of reports revealed no trend concerns.

Twenty-eight COVID related reports were submitted during January 1, 2023 through March 31, 2023 time frame. This category includes incident reports for individuals who were tested and for individuals who received positive test results. Of the 28 reports, 13 noted positive cases of COVID. Case Management (10), ACT (1), SA Outpatient (1), and Sponsored Placement (1), all reported positive cases. Residential programs owned and operated by RACSB followed CDC guidelines related to COVID. In addition, program staff were provided personal protective equipment during working hours. RACSB will continue to follow CDC guidelines in an effort to keep everyone safe and healthy.

In analyzing the reports for the program with the highest occurrence of health concerns reported, Developmental Disabilities (DD) Support Coordination Services submitted the highest number of reports (82). The health concerns consisted of individuals that reside either with family or in a non-RACSB residential program. The program with the second highest number of reports submitted, with reports submitted related to health concerns is the DD Residential Services Programs (30). Due to the nature of the DD Residential Services, it is projected that there would be a high number of health concerns incident reports. Review of reports reveled no trend concerns.

RACSB DD Residential programs submitted 114 incident reports. There were 36 reports regarding health concerns. Health concerns reported included concerns related to abnormal pain, nausea, feeling ill, seizure, bruising, UTIs, self-injurious behaviors, and general just not feeling well. There was a total of 13 medication errors which occurred in RACSB residential programs. Seven errors related to single dose missed, one categorized as "other" (noting the PM medications given in the AM time frame), three categorized as a wrong dose, and two multiple doses missed. Review and analysis of medication policy, medication administration area, staffing pattern, and cause of errors took place in an attempt to mitigate future errors. There were seven incidents of physical aggression reported by Residential programs. Of the seven incidents, there were four individuals involved and all four have behavioral intervention plans which were reviewed after the incident and deemed appropriate.

There was a total of 29 incident categorized as a level I. Of the 29 incidents categorized as a level I, the majority were the result of minor or superficial cuts, scratches, or bruises, which required first aid. Sixteen of the incidents occurred in residential services, and 4 of the incidents occurred at RAAI Day Support. Level 1 reports included the following

- Urgent Care visits:
  - COVID testing,
  - infected nail bed,
  - cold symptoms,
  - tooth pain,
  - irritable bowel syndrome
  - foot injury,
  - self-injurious behaviors,
  - bronchitis,

- First Aid administered for a minor burns and scrapes.
- Falls requiring first aide and/or urgent care visits.
- Wound clinic visits for lymphedema & minor skin break-down.

Based on review of the level 1 incidents, there does not appear to be patterns or trends.

There were 55 incidents classified as a level 2 and 15 incidents classified as level 3. Root Cause Analyses were conducted for all Level 2 and Level 3 Incidents. No extended root cause analyses were required during this quarter. Based on review of the Level 1, Level 2 and Level 3, there does not appear to be a pattern or trends.

Program actions as a result of Incident Reports

1. A review of medication errors showed that the errors occurred due to staff being distracted during the time they were administering medications or staff not following policy as written. Medication Errors resulted in both personnel action and remedial training depending on the error. The current medication administration policy includes procedure for staff to follow to eliminate distraction.
2. Based on review of medication non-compliance, program staff continue to assess the ability of individuals enrolled in the program to continue self-administration of medication. Staff counseled and educated individual on the importance of taking their medication and are working with family member to assist individuals in maintaining and improving individual's medication compliance.
3. Action plans for aggressive behavior included recommendations for behavior plans, assisting the individual in learning and using coping skills during times when they become upset, review and revision of individual's service plan, and continuance of using interventions that are currently in the individual's service plan.
4. Action plans for health concerns varied based on the concern. RACSB staff contact 911 in cases of medical emergencies. Ad-hoc medical appointments will continue to be made by RACSB staff to address health concerns for those individuals residing in RACSB residential programs. In addition, for RACSB non-residential programs staff will continue to assist individuals and family members with health concerns that are identified during program hours. RACSB utilizes CDC precautions and program contingency plans during active cases of COVID-19.
5. For those incidents which involve individuals that do not reside in RACSB residential programs, Support Coordinators and Case Managers monitor health concerns and document in case notes.
6. Root cause analyses were conducted on all incidents that fell into the level 2 or level 3 category. Findings of root cause analysis resulted in programs revising individual service plans, ad-hoc reviews of program files, policy and procedure revisions, staff training, and personnel action.

MEMORANDUM

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: May 2023

Re: Quality Assurance Report

The Quality Assurance (QA) staff completed chart reviews for the following Rappahannock Area Community Services Board (RACSB) programs:

- Mental Health Outpatient Stafford
- Leeland Intellectual Disability Group Home
- Stonewall Intellectual Disability Group Home

Mental Health Outpatient Stafford

There were two staff members responsible for the randomly selected charts.

Findings for the seven open and two closed charts reviewed for Mental Health Outpatient-Stafford were as follows:

- Seven charts were reviewed for Assessment compliance:
  - **Discrepancies noted with Assessments:**
    - One chart had a Comprehensive Needs Assessment (CNA) that was expired.
- Seven charts were reviewed for Individual Service Plan (ISP) compliance:
  - **Discrepancies noted with Service Plan:**
    - One ISP was not in the chart during the audit process.
- Seven charts were reviewed for Progress Note compliance:
  - **Discrepancies noted with Progress Notes:**
    - Four charts contained notes which were completed more than 24hrs late.
- Seven charts were reviewed for Quarterly Review compliance:
  - **Discrepancies noted with Quarterly Reviews:**
    - One chart was missing current quarterly review.
- Seven charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - One chart was missing the Consumer Orientation.
- Two charts were reviewed for Discharge compliance:
  - **No discrepancies noted with Documentation:**

Comparative Information:

In comparing the audit reviews of Mental Health Outpatient Stafford charts from the previous audits to the current audits, the average score increased from 72 to 81 on a 100-point scale.

Corrective Action Plan:

1. **Corrections made to include discrepancies:** One staff was removed from the audit due to her working at another location. One staff is no longer employed with RACSB. The discrepancies for the third staff member were late entries for notes, which could not be corrected.

2. **Descriptions of the actions to be taken that will minimize the possibility that the discrepancy will occur again:** The Stafford Clinic has several vacancies and has been without a coordinator for nine months. The newly hired Coordinator will participate in QA training. The remaining therapist has resigned. Her charts will be audited to ensure they are as up-to-date as possible prior to her last day. The Coordinator will meet with new staff to train them on documentation expectations and will ensure they have time each day to complete appropriate documentation.

3. **Date of the completion for each corrective action:** Unclear when new staff will be hired.

4. **Who is responsible for overseeing that the corrective action is taken:** Stafford Clinic Coordinator and Director of Clinical Services

Leeland Intellectual Disability Group Home

There were two staff members responsible for the selected charts.

Findings for the four open charts reviewed for Leeland Intellectual Disability Group Home were as follows:

- Four charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - Three charts were missing consumer orientations.
    - Two charts were missing the program agreement.
    - Three charts were missing releases.

- Four charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - Four charts were missing the signature pages for the ISP.

- Four charts were reviewed for Quarterly Review compliance:
  - **Discrepancies noted with Quarterly Review:**
    - Three charts had quarterly reviews completed late.

- Four charts were reviewed for Progress Note compliance:
  - **Discrepancies noted with Progress Notes:**
    - Four charts had multiple notes completed more than 24hrs late.

- Four charts were reviewed for Medical compliance:
  - **Discrepancies noted with Medical:**
    - Four charts were missing multiple prescriptions and medication administration records (MARs).

Comparative Information:
In comparing the audit reviews of Leeland Intellectual Disability Group Home charts from the previous audits to the current audits, the average score decreased from 47 to 41 on a 100-point scale.

Corrective Action Plan:
Leeland Road Group Home – QA Audit: March 2023

1. The program manager responsible for the deficiencies recently left the agency as of 2/13/2023. Once hired, a new manager will be trained to ensure charting is complete and timely moving forward. A focus will be placed on obtaining signatures on plans, completing timely annual paperwork at the time of the ISP, completing timely quarterlies, ensuring all documentation requiring upload be entered into the EHR timely, and monitoring to ensure that staff are entering timely notes.
2. Charting standards and expectations will continue to be discussed through weekly DD Residential Supervisor meetings, supervision, offered training opportunities, and through periodic program audits of charting.
3. Charting and documentation expectations will continue to be reinforced through documented supervision and through the peer auditing and supervision processes to help ensure compliance.
4. Should there be further issue with meeting these expectations, progressive corrective action will be issued to the person or persons responsible for the charting.
5. Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.

Stonewall Intellectual Disability Group Home

There were two staff members responsible for the selected charts.

Findings for the four open charts reviewed for Stonewall Intellectual Disability Group Home were as follows:

- Four charts were reviewed for Documentation compliance:
  - **Discrepancies noted with Documentation:**
    - One chart was missing consumer orientations.
    - Four charts were missing the program agreement.
    - Three charts were missing releases.
    - One chart was missing authorized representative paperwork.

- Four charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - Two charts were missing signature pages.

        - Two charts contained plans that were scanned in late and not in the chart at the time of the audit.

- Four charts were reviewed for Quarterly Review compliance:
    - **Discrepancies noted with Quarterly Review:**
        - Two charts contained quarterly reviews that were scanned in late and not present at the time of audit.

- Four charts were reviewed for Progress Note compliance:
    - **Discrepancies noted with Progress Notes:**
        - Four charts had multiple notes completed more than 24hrs late.

- Four charts were reviewed for Medical compliance:
    - **Discrepancies noted with Medical:**
        - Three charts were missing multiple prescriptions and medication administration records (MARs).

Comparative Information:
In comparing the audit reviews of Stonewall Intellectual Disability Group Home charts from the previous audits to the current audits, the average score decreased from 70 to 30 on a 100-point scale.

Corrective Action Plan:
Stonewall Group Home – QA Audit: March 2023

1. Corrective supervision and coaching have been completed with the program manager to ensure charting is complete and timely moving forward. A focus will be placed on obtaining signatures on plans, completing timely annual paperwork at the time of the ISP, completing timely quarterlies, ensuring all documentation requiring upload be entered into the EHR timely, and monitoring to ensure that staff are entering timely notes.
2. Charting standards and expectations have been and will continue to be discussed through weekly DD Residential Supervisor meetings, supervision, offered training opportunities, and through periodic program audits of charting. (See notes in spreadsheet for corrections made and to be made to the charting.)
3. Charting and documentation expectations will continue to be reinforced through documented supervision and through the peer auditing and supervision processes to help ensure compliance.
4. Should there be further issue with meeting these expectations, progressive corrective action will be issued.
5. Oversight and corrective action will continue to be overseen by the DD Residential Coordinator and the DD Assistant Coordinators.