RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

September 16, 2025

600 Jackson Street, Board Room 208
Fredericksburg, VA, 22401

AGENDA

I. Call to Order, *Parcell*

II. *Minutes, Board of Directors, August 19, 2025, *Parcell*……....4

III. Public Comment, *Parcell*

IV. Employee Service Awards, *Wickens*
- A. Five Years:
  1. Mario Anthony-Williams, ICF Manager, Ross
  2. Lori Zuniga, Licensed Outpatient Therapist, Fredericksburg
- B. Twenty-Five Years:
  1. Donna Andrus, Supervisor, Child/Adolescent
  2. Amy Wanderer, Case Manager, Adult MH, Fredericksburg

V. Licensures: *Wickens*
1. Kyle Mathis, Emergency Services Therapist, LCSW
2. Hannah Smith, Co-Response Therapist, LPC

VI. Board Core Behaviors, *Curcio*……14

VII. **Presentation**: Atlantic Union Bank, Investment Fund Proposal, *Jackson*

VIII. Program Reports
- A. Community Support Services
  1. Program Update, *Fisher Curtis*……15
  2. Residential Vacancies, *Fisher Curtis*……18
- B. Crisis Intervention Services
  1. Program Update, *Jindra*……20
  2. Sunshine Lady House Utilization Report, *Jindra*……22

IX. Report from the Executive Director, *Wickens*

X. Board Time

XI. Closed Session

XII. Adjournment

August 2025 Board of Directors Meeting Minutes

I. CALL TO ORDER

A meeting of the Board of Directors of the Rappahannock Area Community Services Board was held on August 19, 2025, at 600 Jackson Street and called to order by Chair, Jacob Parcell at 3:00 p.m. *Attendees included*: Claire Curcio, Matthew Zurasky, Bridgette Williams, Carol Walker, Ken Lapin Melissa White, Greg Sokolowski, Nancy Beebe, Susan Gayle, Susan Slyer and Shawn Kiger.

II. MINUTES, BOARD OF DIRECTORS, **June 17, 2025**

The Board of Directors approved the minutes from the June 17, 2025 meeting.

ACTION TAKEN: The Board approved the June 17, 2025 minutes.
Moved by: Ms. Bridgette Williams
Seconded by: Mr. Matt Zurasky

III. MINUTES, EXECUTIVE COMMITTEE MEETING **June 30, 2025**

The Board of Directors approved the minutes from the June 30, 2025 meeting.

ACTION TAKEN: The Board approved the June 30, 2025 minutes.
Moved by: Ms. Bridgette Williams
Seconded by: Ms. Claire Curcio

IV. MINUTES, EXECUTIVE COMMMITTEE MEETING, **August 19, 2025 as amended: Note: top of page: attendees: keep Executive Committee members separate from other Board Members and staff**

The Board of Directors approved the minutes from the August 19, meeting.

ACTION TAKEN: The Board approved the August 19, 2025 minutes.
Moved by: Mr. Matt Zurasky
Seconded by: Ms. Claire Curcio

V. MINUTES, BOARD OF DIRECTORS STRATEGIC PLAN WORK GROUP, **July 7, 2025**

The Board of Directors approved the minutes from the July 7, 2025 meeting.

ACTION TAKEN: The Board approved the July 7, 2025 minutes.
Moved by: Ms. Claire Curcio
Seconded by: Ms. Bridgette Williams

VI. PUBLIC COMMENT

No Action Taken

VII. SERVICE AWARDS

Mr. Joe Wickens recognized all employees with awards:

5 years

Doris Laniyi, Direct Support Professional, New Hope

Heather Cuozzo, Licensed Outpatient Therapist, Fredericksburg (not in

attendance)

Amenah Heath, MH Residential Coordinator, PSH

10 years

Blaise Forzi, Direct Support Professional, Churchill

Angie Reiordan-Horn, Nurse Manager, ICF

Laura Payne, MH Nurse, RN, Outpatient, Fredericksburg

15 years

Shaborah Noriega, Developmental Services Support Coordinator

20 years

Lacey Fisher Curtis, Coordinator, RAAI

Sherry Norton-Williams, Prevention Specialist

Employee of the 4th Quarter (Apr-June) – Anne Martin, Peer Recovery Specialist

Thank you plaque presented to former Board Chair, Nancy Beebe (2023-2025), by current Board Chair, Jacob Parcell, for her service to the board.

VIII. BOARD CORE BEHAVIORS, *Ms. Claire Curcio*

Ms. Curcio asked the Board to keep the core behaviors in mind throughout the discussions.

IX. BOARD PRESENTATION-Board Financial Report and Governance for the year ended June 30, 2024, *Mr. Joshua Roller, Robinson, Farmer, Cox*
The Board of Directors approved the Board Financial Report.

ACTION TAKEN:
Moved by: Mr. Carol Walker
Seconded by: Ms. Bridgette Williams

X. PROGRAM REPORTS

A. PREVENTION & EARLY INTERVENTION, *Ms. Michelle Wagaman*

1. **Program Update** – Ms. Wagaman gave her program update. The Prevention department is on track to have a record number of NARCAN dispensed for the month of August. Next month is Suicide Prevention month.
2. **Part C Monitoring Report** – Ms. Standring gave an update on Part C monitoring for three compliance indicators for the months July 1, 2024 through June 30, 2025.
3. **Child Abuse and Neglect Prevention Service Grant (CBCAP) and Family, Opportunity, Resilience, Grit, Engagement Grant (FORGE)** – Ms. Wagaman presented two grants to the Board for approval.

The Board of Directors approved both grants.

ACTION TAKEN:
Moved by: Ms. Nancy Beebe
Seconded by: Ms. Susan Gayle

B. DEPUTY EXECUTIVE DIRECTOR, *Ms. Brandie Williams*

1. **Program Update** – Ms. Williams highlighted in her update that the data exchange successfully transitioned by the due date of July 1st despite the heavy lift. There have been over 2.7 million messages exchanged with CSBs in the new system since its implementation on July 1st. It is going well and they are celebrating this win system-wide. The new data exchange allows us to be more responsive and use data in a more timely manner.
2. **Combined Dashboards Data Report** -Ms. Williams gave an update. This is the last time the report will be in this format. DBHDS will have to re-work each metric as a result in the change in data collection.
3. **Performance Contract Master AGMT. & Supp. Documents-**. Ms. Williams provided an overview of this year's DBHDS Performance Contract which will be brought back to the September Board meeting for approval. RACSB has posted the contract for the required 30-day comment period and received no public comment. The contract has also been sent to each locality for approval.

   Mr. Zurasky asked how we note typos to the contract. Ms. Williams said we have very little recourse in negotiating changes at this time. She said a joint committee of DBHDS and VACSB meet again next week to discuss the new round of changes to the contract. VACSB committee members will review the process with DBHDS to prevent some challenges experienced this past year, such as significant changes presented to the group three days before it was sent out. Ms. Williams said if Mr. Zurasky has changes to the contract to please let her know what they are and she will pass them along to this group. Mr. Zurasky also noted that on Exhibit G of the Performance Contract pregnant woman jump to the front of the line. Ms. Williams said pregnant women with substance use are a identified priority population. The goal for RACSB is to provide priority access to all individuals in need of service.

4. **Strategic Plan 2025-2028**- Ms. Williams presented the final strategic plan for approval and thanked all those who worked so hard in making it happen. She gave a short overview of the final plan including a one-page profile. Ms. Williams noted that this will be a living document. Mr. Zurasky asked if the plan needed to be approved today. Ms. Williams said she would like for it to be approved as it is dated July and she would like to start working on it. Mr. Zurasky said he likes the plan, although, there are some things in the plan that he would like to give his comments on. Below are Mr. Zurasky's comments with corresponding page numbers from the August Board Packet:

Pg 165

Values

The five values need to be defined as appropriate for this strategic plan. Rather than allowing the reader to apply their own understanding and definitions, we need to explain the significance of these terms to the document

Pg 165

Accreditation and Compliance

All of these accreditations relate to Behavioral Health. Unless we add others for the DD/ID and SA service areas we should rename this section *Behavioral Health Accreditation and Compliance.*

Pg 166

Input to Strategic Plan

The acronym KFF should be spelled out [Kaiser Family Foundation].

Pg 167

Access to Services Strategic Goals

The goal is to increase total number of individuals served by 5% in three years. However, the population is expected to increase by 5.8% by 2030. Previous population growth estimates have been found to undercount the actual population. So, increasing by 5% in three years will likely only be treading water. This will not be an increase in services.

Pg 168

Access to Services Year 1, Strategy 5

We should include mental health (in particular, suicide prevention) in our school partnerships.

Pg 169

Effective and Quality Services Strategic Goals

These goals/initiatives seem to be focused on Behavioral Health (e.g, CCHBC certification checklist items) and not DD/ID services. If it's not, are there external benchmarks we can identify for DD/ID?

Pg 170

Staff Retention, Workforce Support, and Talent Development

As I've stated previously, I don't believe retention is a problem. Certainly not to such a degree that we need to dedicate the strategic plan to address it. RACSB data for

March 2025 showed a 1.72% turnover rate. The overall standard for the Education and Health industry is 2.4%. The Bureau of Labor Statistics data for this year regarding the Health and Social Assistance category show turnover rates of 2.0% (January), 1.9% (February), and 2.1% (March). A certain amount of turnover is necessary for employee growth and advancement. Furthermore, the yearly initiatives don't directly address staff retention. I suggest we remove *Staff Retention* from the section title and text to concentrate on *staff engagement* and *talent development*.

Pg 170

Fiscal and Operational Excellence

The key initiatives for this section for operational excellence seem to be predicated on better training and application. I think we should also look at using automation to ensure that mistakes that could cause rejection of payments are avoided completely. Such as, software that immediately flags a record if a signature is missing or if a document is not attached. I'm pretty sure such a system can be specified and built within the three-year window.

Should we also include an initiative to (1) complete the write-off process to eliminate the claims aged more than 120 days and (2) to prevent claims from aging that long? That would show fiscal excellence.

The Board of Directors approved the 2025-2028 Strategic Plan
ACTION TAKEN:
Moved by: Ms. Bridgette Williams
Seconded by: Ms. Claire Curcio

Recognition was given to Ms. Brandie Williams by the Board for her hard work on the strategic plan. Ms. Williams then thanked the following Board members who participated in the Strategic Planning Group Work Sessions: Carol Walker, Claire Curcio, Jacob Parcell, Nancy Beebe, Matt Zurasky and Ken Lapin.

C. COMMUNITY SUPPORT SERVICES, *Ms. Amy Jindra*

1. **Program Update** – Ms. Jindra gave her program update.
2. **RAAI Kovar Grant** – Ms. Fisher shared that RAAI has submitted a $20,000 grant to the Knights of Columbus Virginia for the King George location (furniture).

   The Board moved to approve the Grant Application
   ACTION TAKEN: The Board approved the Grant Application
   Moved by: Mr. Ken Lapin
   Seconded by: Ms. Susan Gayle

3. **Residential Vacancies** – Ms. Jindra shared that they are anticipating 5 individuals to move in by the end of October. Devon, Galveston, and Stonewall group homes will be full. Igo will have two of its three remaining filled and Ross will have one of its two remaining filled. MH Residential is are supporting individuals transitioning into the program who are waiting on HUD vouchers or moving through the NGRI process to discharge from the state hospital.. PSH

continues to strive to place individuals in housing. They have nine individuals currently awaiting housing. All individuals on the list are receiving case management services. Ms. Beebe asked about the licensing process for Myers, she wanted to know how long that takes. Ms. Jindra said they are waiting for the state's approval. Ms. Terrell said it takes approximately 30 to 45 days.

4. **Sunshine Lady House** – Ms. Jindra said they were busy in July. They hit 67% utilization in July. The program experienced 241 beds occupied during the month of July.

D. CLINICAL *Ms. Jacque Kobuchi*

1. **Program Update –** In addition to her program update, Ms. Kobuchi announced the exciting news that they received approval from the City of Fredericksburg for the Therapeutic Docket and have begun assessing people for that docket.
2. **C&A Case Management Residential Placement Qtrly. Report** – Ms. Kobuchi gave an update and went over the numbers by localities.
3. **State Hospital Census Report** -Ms. Kobuchi shared that there are currently three individuals on the Extraordinary Barriers List. They have 33 individuals that are at state hospitals receiving treatment.
4. **Emergency Custody Order (ECO)/ Temporary Detention Order (TDO) Report – June/July 2025**. Ms. Kobuchi stated that Emergency Services staff completed 203 emergency evaluations in July. Seventy individuals were assessed under an emergency custody order and seventy-three total temporary detention orders were served. Staff facilitated one admission to Northern Virginia Mental Health Institute and two admissions to Western State. A total of four individuals were involuntarily hospitalized outside of our catchment area in July. Data reports submitted.
5. **CIT and Co-Response Report**- Ms. Kobuchi reported that the CIT Assessment Center served 20 individuals in the month of July. She took the Board through a chart indicating the number of Emergency Custody orders by locality, those that were able to be transferred into CAC custody, and those who could have used the assessment center if there was additional capacity. The Co-Response Team served 24 individuals in July. The therapist for the Fredericksburg team remains vacant.
6. **Same Day Access** – Ms. Kobuchi stated that they continue to have no waitlist and now they are tracking the number of individuals seen through Same Day Access. Data report submitted.

The Board took a ten-minute break

E. COMPLIANCE, *Ms. Stephanie Terrell*

1. **Program Update** – Ms. Terrell shared that they received notification from CARF delaying the accreditation survey process until the Spring. They have extended our current accreditation until the survey visit can be completed.
2. **4th Quarter Incident Report** – Ms. Terrell provided overview of incident reports submitted by staff during the months of April 2025 through June 2025. The population covered includes all people receiving services by the RACSB,

which includes Mental Health (MH), Substance Use (SU), Developmental/ Intellectual Disability (DD), and Prevention Services. RACSB provided services to 7,757 individuals, unduplicated by service area, from April 1, 2025 through June 30, 2025.

Compliance Staff received and triaged 868 Incident Reports from April 1, 2025 through June 30, 2025 (an overall increase of 16 reports from last quarter). Of those 868 incident reports received, 105 incidents were reported to the Department of Behavioral Health and Developmental Services (DBHDS) through the Computerized Human Rights Information System (CHRIS) (83 Level 2, 22 Level 3, 5 Abuse/Neglect/Exploitation (ANE), and 1 Complaint).

Mr. Lapin stated that he didn't think all of the information on the medical incidents was necessary, although, he realizes it must have taken a lot of time to gather the information. Mr. Zurasky added that he likes to see trends, are we improving, are we learning from our mistakes. He said the individual numbers we might get lost in. Mr. Sokolowski said that the he likes to see the corrective actions and the trends. Ms. Terrell said she does look for trends. She said that she will trim down the next report while providing more detail on the root cause analysis.

3. **Quality Assurance Reports June and July** – Ms. Terrell stated the Quality Assurance staff completed chart reviews for the following programs for June and July: MH Residential, Home Road and Lafayette Boarding House, Project LINK, Child Adolescent Case Management and Psychosocial Rehabilitation. Corrective Action Plans were submitted for all discrepancies.
4. **Licensing Reports** – Ms. Terrell said we received four licensing reports. Two reports related to late reporting of serious incident reports into the DBHDS Computerized Human Rights Information System (CHRIS). Ms. Terrell provided Corrective Action Plans with additional details regarding citation and RACSB's response.

   The Board moved to approve the Licensing Reports
   ACTION TAKEN: The Board approved the Licensing Reports
   Moved by: Ms. Susan Gayle
   Seconded by: Mr. Ken Lapin

5. **Corporate Responsibility-** Ms. Terrell said this is a CARF requirement stating that we will follow all of the regulatory requirements and standards, and that we will also establish policies and procedures to ensure we are following the regulatory standards. We attest to maintaining documentation in individuals records that is accurate and authentic. We will follow the requirements for both subpoenas and search warrants, conduct investigations of any wrong doing, we implement policies and procedures that will mitigate fraud, waste and abuse, and that we train staff on corporate responsibilities.

   The Board moved to approve the Corporate Responsibility
   ACTION TAKEN: The Board approved the Corporate Responsibility

Moved by: Ms. Bridgette Williams
Seconded by: Ms. Claire Curcio

F. COMMUNICATIONS, *Ms. Amy Umble*

1. **Communications Plan FY26** – Ms. Umble took the Board through the FY26 Communications Plan. External Communications will be the focus for the upcoming year. Ms. Umble also provided the Board a copy of the August Newsletter.

G. FINANCE, *Ms. Sara Keeler*

1. **Program Update** – Ms. Keeler provided her program update. She noted on the reimbursement side they are focusing on ways to bring more money into the agency. They are working on getting a financial agreement on file for everyone. On the accounting side, they are playing catch up on all of the reimbursement items that had fallen behind like web grants and LIPOS.
2. Ms. Keeler reviewed the Summary of Cash Investments.
3. Ms. Keeler reviewed the Other Post Employment Benefit.
4. Ms. Keeler reviewed the Health Insurance.
5. Ms. Keeler reviewed the Summary of Investments.
6. Ms. Keeler reviewed the Fee Revenue Reimbursement and Collections.
7. Ms. Keeler reviewed the Write-Off Report.
8. Ms. Keeler reviewed the Payroll Statistics.
9. Ms. Keeler reviewed the Financial Summary.

The Board moved to approve the financial summaries for May and June.
ACTION TAKEN: The Board approved the financial summaries for May and June.
Moved by: Mr. Matt Zurasky
Seconded by: Mr. Shawn Kiger

H. HUMAN RESOURCES, *Mr. Derrick Mestler*

1. **Program Update** – Mr. Mestler provided his program update and said that the team onboarded two new psychiatrists and also onboarded two previously contracted psychiatrists to the team as employees, for a total of four new psychiatrists for the agency.
2. **Applicant and Recruitment Update** – Mr. Mestler noted that for the month of July, RACSB received 324 applications. Of the applications, 35 applicants listed the RACSB applicant portal as their recruitment source, 12 stated employee referrals as their recruitment source, and 277 listed job boards as their recruitment source. At the end of July, there were 13 open positions, 10 full-time, 3 part-time.
3. **Turnover Report** – Mr. Mestler shared that HR processed a total of 8 employee separations for the month of July. Of the separations, all were voluntary. He stated that in July, they started to do exit interviews with all voluntary resignations. He said out of the eight in July, they had five that completed the exit interviews.. Ms. Beebe asked if there was anything of interest in those early exit interviews that Mr. Mestler could share. Mr. Mestler said not

yet. He did add that people do like where they work. Of the five, three of them said this was not the right fit for them from the start.

4. **DBHDS Workforce Reporting Overview** – Mr. Mestler provided the Board with workforce data for certain position categories for reporting vacancy rate, turnover rate, and salary information submitted to the Department of Behavioral Health and Developmental Services (DBHDS) for the fourth quarter of FY2025.

   Mr. Lapin asked if Mr. Mestler would provide a summary of the various ways the bonuses are paid from the annual evaluation scores.

   Ms. Williams asked if the resignations are a trend that are coming from a particular department. Mr. Mestler said he would bring more data back next meeting.

XI. REPORT FROM THE EXECUTIVE DIRECTOR, *Mr. Joseph Wickens*

Mr. Wickens gave an update on the performance contract. He said Ms. Williams went to Stafford this evening to represent at the Board of Supervisors meeting. Ms. Wagaman went along as they were asked to go along to be recognized for the Stafford International Opioid Awareness Day Proclamation.

VACSB Conference is coming up in October. There are still seats available, please let Joe know if you're interested in attending.

Joe thanked the Board for the approval of the CRC $8.5 million purchase (given at the August 19, 2025, Executive Committee Meeting). He said he appreciates the support. Closing will be on August 21, 2025.

Joe shared that there has been a reorganization within the agency. There is a new division and a new Director (named: Crisis Intervention Services Director) that will head the Emergency Services, Sunshine Lady House, ACT, and 23-Hour Observation Program for adults as well as children. Ms. Amy Jindra will take over the new role. Mr. Wickens then announced that Ms. Lacey Fisher Curtis will take over the role of Community Support Services Director effective September 1st. He also added that there was a change with Early Intervention in that PEID is now under the new Prevention and Early Intervention department that Ms. Wagaman will head.

Mr. Zurasky asked if the financial reports will reflect the divisions or the program areas. Mr. Wickens said they have not yet worked that out. Ms. Keeler prefers to keep the report as it is with the understanding we are sunsetting Great Plains and not to do a lot of work to change the format but she said she can get with the consultant to work to create new reports if that is what the Board wants. Mr. Wickens said we haven't made many of these decisions yet.

Mr. Sokolowski asked if, with the purchasing of the Goodwill building, are we still within the timeframe to get any of the funds from the state. Mr. Wickens said we have an agreement in place, a draft agreement that looks good. There is still a little unknown but he said he's received commitment in every other way.

XII. BOARD TIME

A. Mr. Zurasky, nothing to add on the format, I'm excited that we are at this point, that we are going to put a signature on a contract. That people are moving into new positions, this is really cool, this is the right thing to do, we are stepping out in some ways this community really needs.
B. Ms. Williams, very happy we secured the building, I think everyone does a great job, just keep doing what you're doing.
C. Mr. Lapin, kudos to the staff, welcome Lacey. Thank you.
D. Ms. Beebe, happy to see Stephanie back, thank you for the plaque and recognition, and I'm over the moon for all the changes, we've waited a long time, thank you.
E. Ms. Curcio, I think it's exciting to be a part of this Board with all this stuff going on, I'm glad to be here.
F. Ms. Slyer, so glad to see the growth over the past few years, and Joe you're at the head of it, I'm really proud of you, thank you so much.
G. Mr. Kiger, thanks to all of you for all that you do, excited about the new building and the impact it will have on all of our communities. Very excited about that.
H. Ms. Walker, it's very exciting, I feel very humble to be a part of this group because the way you all serve this community, I was born and raised here, and the work you do here is amazing and I am humbled by it.
I. Mr. Sokolowski, ditto, thank you.
J. Ms. Gayle, thank you all for all that you do.
K. Ms. White, thank you all for all that you do, very exciting.

XIII. ADJOURNMENT

The Board moved to adjourn.
ACTION TAKEN: The Board moved to adjourn.
Moved by: Mr. Ken Lapin
Seconded by: Ms. Claire Curcio

The meeting adjourned at 5:56 PM.

Board of Directors Chair

Executive Director

Board Core Behaviors

Open and Honest
Communication

Ask
Tough Questions

Next Level
Decision Making

Community Support Services Program Updates

September 2025

Developmental Disabilities Support Coordination Services - Jen Acors

In addition to the 4 positions recently unfrozen in August due to new waivers, we have had 2 resignations creating 6 support coordination vacancies. As of Oct 12th, we anticipate 3 of these positions to be filled. The Waiver Selection Advisory Committee met on 8/28/25 and will assign approximately 30 waiver slots early in September

Developmental Disabilities Day Support Rappahannock Adult Activities, Inc. (RAAI) – Raven Neal

RAAI is currently supporting 120 individuals across 7 teams. We have multiple assessments being conducted to admit new individuals across multiple sites. We are strongly focusing on the growth of our community-only groups, and are in the process of opening our third group at both the Ron Rosner and Massad YMCA branches. RAAI annual Inservice is scheduled for Sept 12th, 2025; this will consist mainly of staff trainings that have needed to be scaled back throughout the year due to eliminated positions. The RAAI Fall Plant Sale is scheduled to start on Monday, September 22nd, at 10 am. RAAI's 4th annual Trunk or Treat is scheduled for Sunday, October 12th at 4:30 pm. Fall workshops will be announced soon!

Developmental Disabilities (DD) Residential Services - Stephen Curtis

One individual moved into Igo Road Group home on 8/15 and one moved into Ross Drive ICF on 8/22. At a minimum, we are projecting move-ins for September that will fill Galveston and Devon, as well as 1 apartment vacancy. We also have 3 individuals slated for permanent beds at Myers Drive that we'll be planning for as we await our service modification to make its way through the licensing process.

Long-time DD Residential Assistant Coordinator Courtney Ross received her MS in Psychology with a focus in Industrial/Organizational Psychology on July 31. Courtney has contributed so much to the DD Residential programs during her tenure, and we congratulate her on this latest achievement. We know she'll put what she has learned towards the betterment of our agency.

Mental Health (MH) Residential Services - Nancy Price

MH Residential did not have any new admissions or transitions this month, but has been busy preparing for numerous upcoming moves in September. Two individuals will move within MH Residential to programs with less support, two individuals applied to apartments in the community, and there are two community referrals that will be completing passes at Home Road and Lafayette in early September.

PSH currently has 79 individuals enrolled, 73 of which are now housed with PSH. The PSH housing locator supported three individuals with securing housing in August! Per DBHDS guidance, Community PSH referrals are currently on hold to allow time to support our current individuals with finding housing. We are hoping to begin accepting referrals again in late September or early October for the remaining 12 slots we have available.

On August 4, Jessica Vaz Williams started in her new position of Community Outreach Case Manager, which is fully funded by the City of Fredericksburg. This position is focused on providing supports and resources to those in the city who are experiencing homelessness. Jessica has had a full month of meeting and training with local law enforcement, the Continuum of Care, Micah Ministries, various community resources and agencies, downtown businesses and RACSB programs including Emergency Services, ACT, Prevention, Kenmore Club, MHCM and PSH. Jessica will work in collaboration with the Fredericksburg PD, the CoC, and local businesses to be present in the community, offer support to business owners, be a familiar face to those in need of resources, and help minimize the involvement of Fredericksburg PD. Jessica has already had several positive interactions with individuals in the community that are in need of housing and resources.

Nancy Price developed and maintains a spreadsheet of Medicaid cases that are pending with Fredericksburg DSS. A new process was implemented in August, after much discussion with Fredericksburg DSS, to streamline the process for communicating individual benefit needs for outstanding cases. Previously, some spend downs and Medicaid applications were pending for over a year, with no response from DSS. With the new process, Nancy Price sends the spreadsheet to Ms. Buckner at Fredericksburg DSS each Tuesday, which highlights the outstanding cases that need to be processed by DSS. Ms. Buckner replies to Nancy Price by Friday of each week with the status of each case and provides copies of the Notice of Action.

This process has allowed MH Residential to resolve all outstanding Medicaid cases, and has allowed individuals in ACT to process cases that were previously pending. Nancy Price hopes to implement this process with Stafford DSS in the upcoming months.

Psychosocial Rehabilitation: Kenmore Club - Anna Loftis

In August, we had a lot of pool time trying to enjoy the last of the summer. We went hiking, and lots of trips to the mall for tax-free weekend. We also welcomed back our staff who was out on leave for the past few months. Coming up in September, we have our Talent Show to look forward to. We also took the first step in being an accredited clubhouse by officially joining Clubhouse International.

Memorandum

To: Joe Wickens, Executive Director

From: Lacey Fisher Curtis, CSS Director

Date: September 3, 2025

Re: Mental Health and Developmental Disabilities Residential Vacancies

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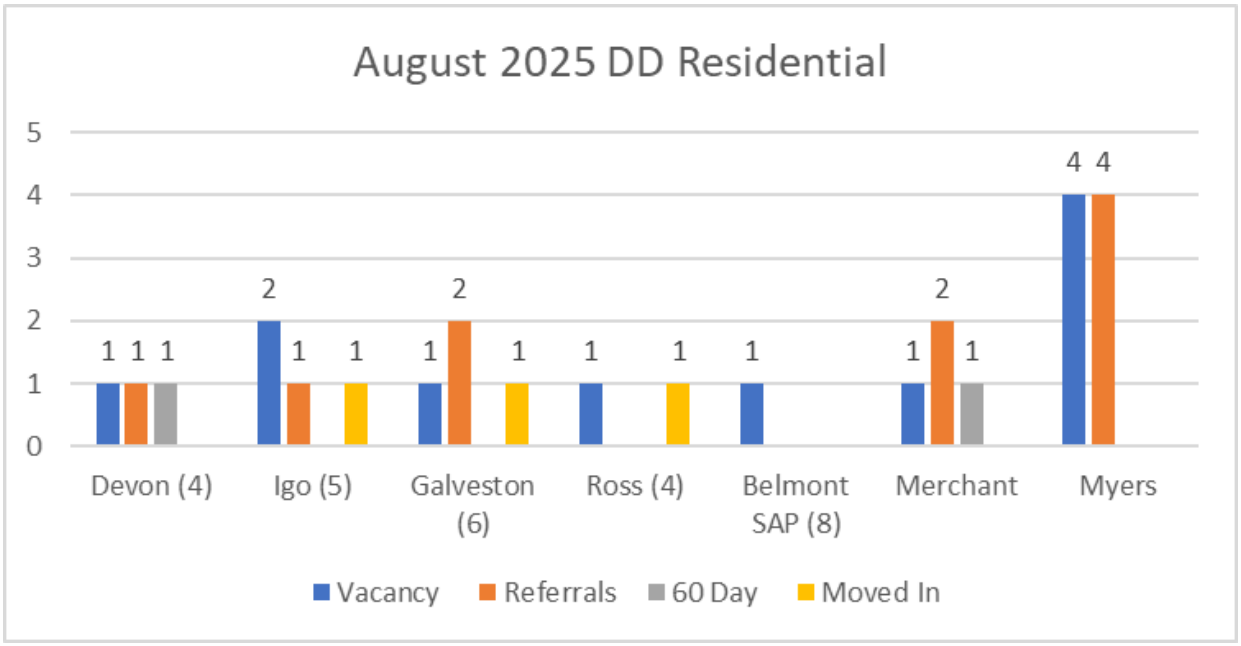
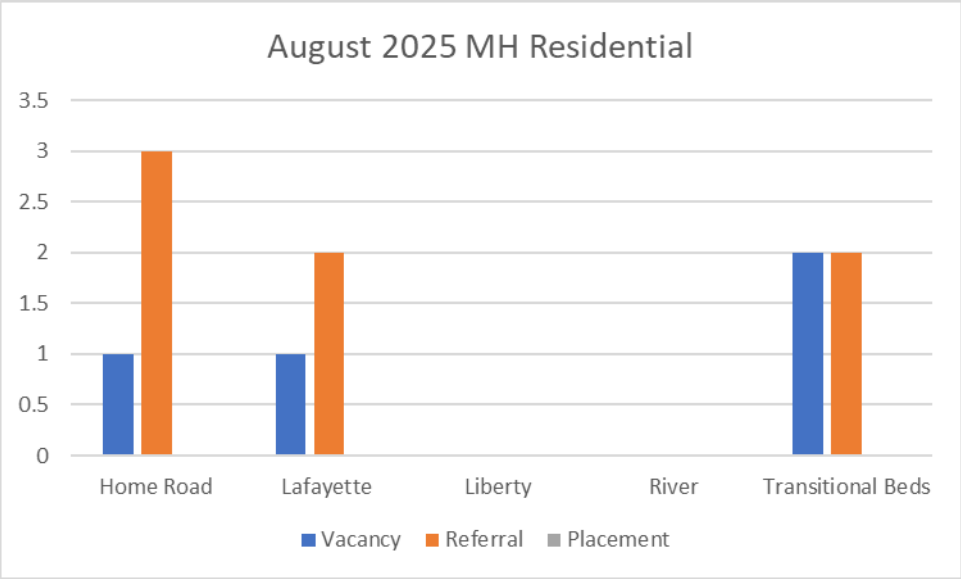
RACSB residential programs continue to provide vital 24-hour care to individuals with intellectual developmental services as well as those individuals with serious mental illness.

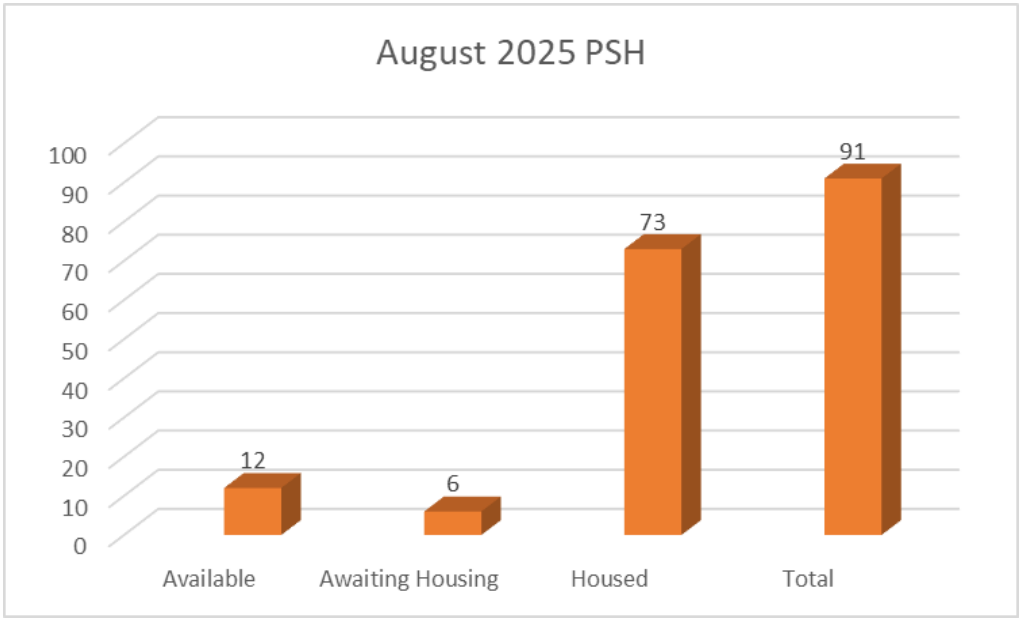
In August, DD Residential services supported 3 individuals with moving into programs. Consequently, Galveston Group Home no longer has a bed vacancy. Ross and Igo have only 1 remaining vacancy in each program. Devon and Merchant have individuals scheduled to move in late September and early October. By the end of October, DD Residential anticipates having 1 remaining vacancy at Ross ICF, Igo Group Home, and Belmont Support Apartment. Transitioning Myers from a 6 bed respite to a combined 4 bed resident and 2 bed respite program, has opened the opportunity to support 4 more individuals in a permanent setting. Myers currently is awaiting licensure approval from DBHDS. All required paperwork has been submitted. Myers has 4 individuals interested in moving into the program and has already started processing referrals.



Mental Health Residential services supported 2 individuals to moving to more independent setting. One individual moved to River Place and the other moved to Home Road. The program currently has 1 vacancy at Home Road, 1 at Lafayette, and two transitional beds. Currently, MH Residential is processing 5 community bed referrals between Home Road and Lafayette. They are also working with the state hospital to process and assess two individuals referred for transitional beds.



Permanent Supportive Housing (PSH) has 73 individuals currently housed. The program has 6 individuals as of August awaiting placement. PSH recently assisted 2 individuals into moving into their own homes after an extended period of homelessness. PSH provides case management to those individuals who are awaiting housing. The program has 12 individuals who are waiting for enrollment into services. Should all 12 individuals enroll, the program will meet its service capacity of 91.



Crisis Intervention Services Program Updates

September 2025

Crisis Intervention Services, Amy Jindra

The new Crisis Intervention Services Division started the month of September by bidding farewell to several programs and staff's involvement in the Community Support Services Division. The new Crisis Intervention Services Division includes Assertive Community Treatment, Sunshine Lady House for Mental Health and Wellness, and Emergency Services. New services will be added to the division with the building of the Crisis Receiving Center. We look forward to the development of adult and children 23-hour observation, and the addition of children's residential crisis stabilization services to accompany our current services.

Assertive Community Treatment (ACT) - Sarah McClelland

On 8/18 and 8/19, ACT North participated in a TMACT Review to evaluate how faithful we are to the ACT Fidelity Model. The reviewers were from University of North Carolina Institute of Best Practices as well as DBHDS. We shared information about our program and our clients with the reviewers who also interviewed our staff, several clients, and sat in on team meetings. This was a helpful process to examine our processes and procedures and get us thinking about areas in which we can grow as a program to better serve our clients. The reviewers remarked on a number of strengths ACT North demonstrates daily, which is a source of pride for us. These strengths included how responsive ACT North is to their client's emerging needs and how they manage to take care of individual clients in a proactive manner. The reviewers also commented on the creativity and person-centered focus of interventions used to connect with these seriously mentally ill clients. One example of such intervention was EcoTherapy, in which a client participates in therapy while feeding turtles at a pond, something he looks forward to and enjoys. Areas of growth, which are already being incorporated into our practice, include increased focus on vocational assessment and training for clients, as well as substance use assessment and interventions focused on each client's readiness for change. ACT North anticipates receiving a formal report in several months that will contain every component

of the review. Overall, it was a good experience. ACT will anticipate another TMACT review for our South team at some point in the coming months.

Sunshine Lady House, Crisis Stabilization, Latroy Coleman

SLH received 67 prescreens in the month of August 2025. Thirty-seven individuals were admitted into the program. SLH served three individuals under medically-managed detox services. Seven individuals were not able to admit due to medical acuity.

Sunshine Lady House currently has three positions vacant. The program continues to experience vacancies within our QMHP team and nursing team. Interviews are being conducted for all positions. Although, there has been limited qualified applicants for the QMHP position.

Sunshine Lady House is preparing to celebrate three employees on their upcoming nuptials. The team is excited and looks forward to continued celebrations within our program.

Memorandum

To: Joe Wickens, Executive Director

From: Amy Jindra, CIS Director

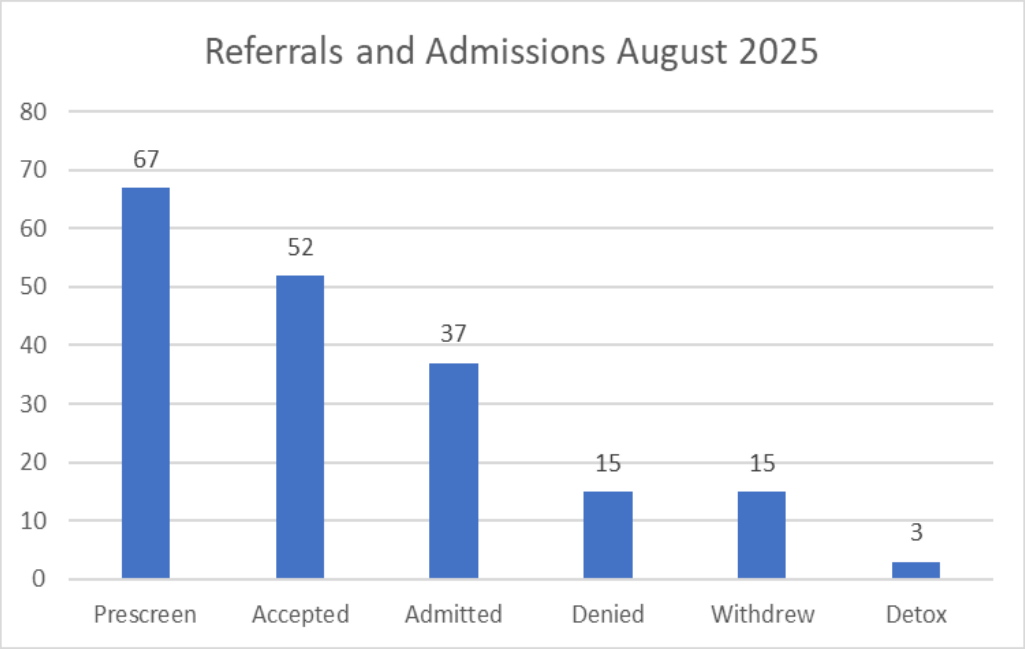
Date: September 5, 2025

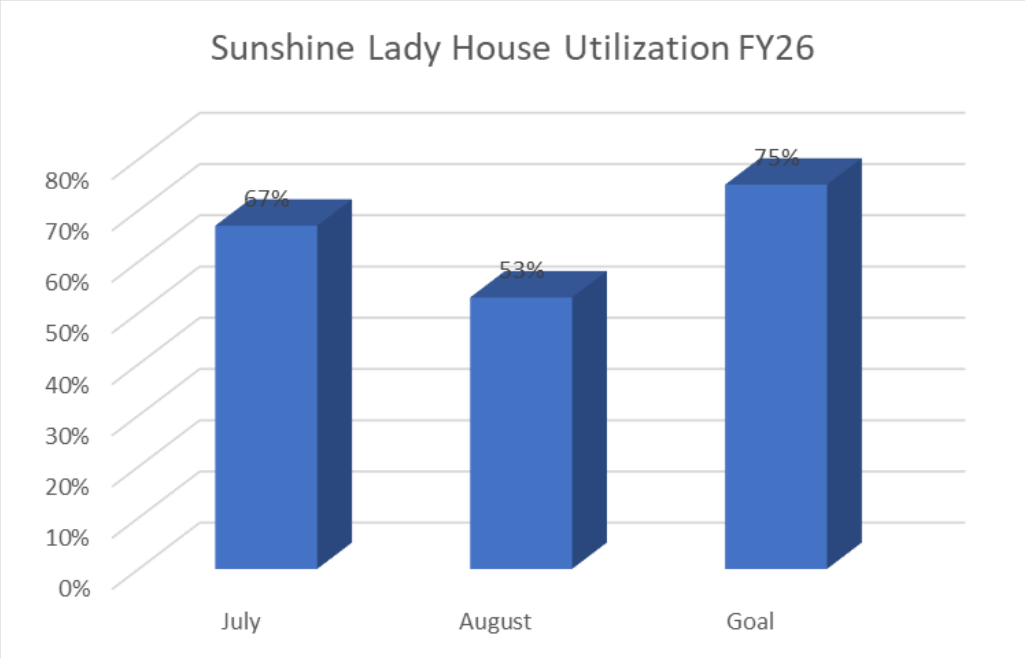
Re: Sunshine Lady House Utilization

Sunshine Lady House for Wellness and Recovery, is a 12 bed, adult residential crisis stabilization unit. The program provides 24/7 access to services for individuals experiencing a psychiatric crisis. Services include medication management, therapy, peer support, nursing, restorative skill development, crisis interventions, coordination of care, and group support. The program strives to maintain a utilization rate of 75%.

During the month of August, Sunshine Lady House (SLH) received 63 prescreens. The program continues to serve as a regional adult residential crisis stabilization program. Consequently, 13 of the 63 referrals were for individuals outside of RACSB's catchment. Of those 13 individuals, 5 individuals were admitted to the program, 7 were denied due to medical reasons or recent violent behavior, and 1 individual declined admission. The remaining 50 prescreens were for individuals within the RACSB service delivery area. Of the 50, 3 individuals received medically managed detox services before also transitioning to crisis stabilization services at SLH. The program supported another 26 of the 50 local referrals for crisis stabilization services. An additional 10 individuals declined services while 6 required inpatient detoxification support or more intensive medical care prior to admission. Those individuals were referred to local medical providers. SLH had to decline admission to 2 individuals due to recent violent behavior and 1 individual due to not meeting criteria for services.

The program provided a total of 17 medically managed detox bed days for the 3 individuals receiving ASAM 3.7 substance use treatment. The total utilization for the program was 190 days for an average of 53% for the month.


Referrals and Admissions August 2025
80
70
60
50
40
30
20
10
0
67
52
37
15
15
3
Prescreen
Accepted
Admitted
Denied
Withdrew
Detox


Sunshine Lady House Utilization FY26
80%
70%
60%
50%
40%
30%
20%
10%
0%
67%
53%
75%
July
August
Goal

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

To: Joseph Wickens, Executive Director

From: Jacqueline Kobuchi, Director of Clinical Services

Date: 9/5/25

Re: Clinical Division Program Updates for the September Board Meeting

Outpatient Services

Caroline Clinic - Nancy Love, LCSW

The Caroline Clinic continues to provide two weekly substance use groups. Three individuals successfully completed their treatment for probation and one of them requested to continue to attend the group voluntarily. Clinicians completed 31 intakes during August. Fifteen were seen the same day they called in and 16 were scheduled. Staff completed trainings on Motivational Interviewing and Trauma Informed Care. A clinician shared the following recent success story. A teen who went into foster care last winter, because of her defiance and emotional dysregulation, reported that counseling enabled her to change her attitude and behaviors and she was able to return home to her grandma before the start of the new school year.

Fredericksburg and Children's Services Clinic - Megan Hartshorn, LCSW

During the month of August, the Fredericksburg Clinic completed 98 intakes on adults seeking outpatient services. Out of 98 intakes, 68 were scheduled the same day they called in for services. Fifty-one intake assessments were completed over ZOOM while 47 intake assessments were completed in person. The Children's Services Clinic completed 17 intake assessments for outpatient services on children/adolescents. Our Mental Health Peer Recovery Specialist attended the annual Year of the Peer Conference and co-presented a workshop, "Growing the Hearing Voices Network in the Commonwealth" at the end of August and received positive feedback regarding her workshop. The Fredericksburg Clinic plans to add additional peer drop-in groups to support individuals served, as well as begin a LGBTQ+ wellness psychotherapy group.

King George Clinic - Sarah Davis, LPC

The King George Clinic continues to offer two weekly substance use groups that are well attended. During the month of August, group topics included Stages of Addiction, Roadmap to Recovery, Survival System, and Tree of Life. There were three individuals who successfully completed their group treatment in August. The King George Clinic completed 22 new patient intakes during August. Seventeen were through Same Day Access, two were scheduled intakes, and three were child/adolescent intakes. Two King George staff attended an Ethics Over Utilization and Over Performance training during August. The King George Clinic provided two individuals with Narcan training and Narcan kits this month.

Spotsylvania Clinic - Katie Barnes, LPC

The Spotsylvania Therapists completed a total of 53 intakes in August. Forty adult intakes were completed through Same Day Access. Thirteen Child and Adolescent intakes were completed through scheduled assessments. The clinic continues to offer two Substance Use groups weekly. A candidate for the Central Access Associate position was selected. They begin employment on 9/15/2025.

RACSB continues to employ a Child and Adolescent Therapist who provides Trauma-Focused Cognitive Behavioral Therapy at Safe Harbor Child Advocacy Center. This therapist continues to provide therapy to children to promote healing after experiencing traumatic events.

The School-Based Therapist has resumed therapy at Hugh Mercer Elementary and James Monroe High School. This program is designed to increase access to mental health services to students who may be unable to access services outside of the school setting.

Stafford Clinic - Lindsay Steele, LCSW

During the month of August, the Stafford clinic met with clients in-person, as well as virtually. Stafford clinicians completed 43 intakes for adults and children, 16 of these intakes were completed via same day access and nine of these intakes were scheduled child/adolescent intakes. The Stafford clinic has one vacant therapist position with a therapist beginning in October to fill this position. The child/adolescent therapist continues to engage in EMDR training and the Mental Health and Substance Use therapist facilitates weekly substance use groups.

Medical Services - Jennifer Hitt, RN

During the month of August, 115 individuals were seen for psychiatric assessments to begin services. Katherine Emmer, LPN, has joined the outpatient nursing team full-time.

Case Management - Adult - Patricia Newman

The Adult Mental Health Case Management program regularly receives referrals from within RACSB, local hospitals, RRJ, private providers as well as individuals themselves seeking services. Since August 1, 2025, we enrolled 20 individuals into the MHCM program. We also saw 20 admissions to state hospitals across the Commonwealth from our area.

Child and Adolescent Support Services - Donna Andrus, MS

Child and Adolescent Case Management had a staff member become a Therops Trainer in August. This is the first time in over 10 years that a staff member from child and adolescent services has been a Therops trainer. School started back in August, so we have seen an increase in contacts with School Social Workers to ensure we are supporting working collaboratively to support the children and families we work with.

Substance Use Services - Eleni McNeil, LCSW

During the month of August, we conducted interviews for the mobile OBOT program. A tour of the mobile recovery unit was given to members of Stafford County government.

Skypoint Recovery and Warrenton Woods presented to staff members providing case management to clients with substance use disorders on their treatment services. The SUD Services Coordinator attended community meetings to include Save1Life and Recovery Behind Walls, as well as connecting to Mary Washington staff to establish a smoother referral process for those using opioids.

Emergency Services - Natasha Randall, LCSW

In the month of August, our co-response therapist started within Stafford County Sheriff's Department. She had an opportunity to provide education to the Stafford County Public Schools on RACSB community-based services. The Community Based Crisis Stabilization therapist was able to attend a training called Non-Suicidal Self-Injury: Clinical Insights and Intervention Strategies.

Specialty Dockets - Nicole Bassing, LCSW

During the month of August, Specialty Dockets continued to progress, welcome new participants and celebrate graduations. Adult Recovery Court added two new clients and finished the month with 32 active participants. Adult Recovery Court had one termination this month due to non-compliance and one successful graduation. The Rappahannock Veterans Docket finished the month with 13 participants and did not have any new participants, terminations or graduations this month. Spotsylvania Behavioral Health Docket currently has 10 participants after welcoming one new member this month. We celebrated two graduations at the end of August. The Juvenile Recovery Court currently has three participants and three pending evaluations and entrance into the program. The Fredericksburg Therapeutic Docket has been approved to begin operations and expects our first participant to plead into the program in September.

On August 4-6, several members of our Specialty Dockets team attended the annual Specialty Dockets and DUI Training in Harrisonburg, VA. This was a three-day training event focused on identifying best practices in the field and learning ways to implement them into our programs.

Jail and Detention Services - Portia Bennett

The detention center has a current census of 45 residents. A total of 37 residents were seen for crisis, therapeutic, and medication management services in August. At the jail, a total of 128 individuals received crisis and/or therapeutic services in August and a total of 42 individuals received substance use services. A total of 76 individuals were seen by the Psychiatric Nurse Practitioner and 332 individuals are prescribed psychotropic medications.

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
Lacey Fisher Curtis – Community Support Services Director
Amy Jindra, Crisis Intervention Services Director
Nancy Price – MH Residential Coordinator
Sarah McClelland - ACT Coordinator
Jennifer Acors – Coordinator Developmental Services Support Coordination

SUBJECT: State Hospital Census Report

DATE: September 16, 2025

State Hospital	New	Discharge	Civil	NGRI	Forensic	EBL	Total Census
Catawba Hospital	1	1	1				1
Central State Hospital							0
Eastern State Hospital					1		1
Northern Virginia Mental Health Institute	2	1	1				1
Piedmont Geriatric Hospital	2	1	6		1		7
Southern Virginia Mental Health Institute				1			1
Southwestern Virginia Mental Health Institute							0
Western State Hospital	4	6	3	4	13	3	20
Totals	9	9	11	5	15	3	31

Extraordinary Barriers List:

RACSB has three individuals on the Extraordinary Barriers List (EBL) who are hospitalized at Western State Hospital (WSH). 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.

Western State Hospital

Individual #1: Was placed on the EBL 12/12/2024. Barriers to discharge include working through the Developmental Disability (DD) Waiver process, identifying and being accepted to a group home as well as working through the guardianship process. This individual previously resided in the community with family but will be best supported in a group home setting at time of discharge. Bridges was assigned as this individual's public guardian on 9/3/2025. At this time, group homes are being explored and referrals are being completed. This individual will discharge once they are accepted to a group home.

Individual #2: Was placed on the EBL 8/05/2025. Barriers to discharge include identifying and being accepted to a supervised residential program. This individual has a diagnosis of Schizophrenia. They were initially admitted to Western State Hospital for restoration services and was found unrestorable. This individual has been referred to Liberty transitional program through Gateway Homes. They will begin passes to this program over the next few weeks and will discharge once three successful passes are completed.

Individual #3: Was placed on the EBL 9/2/2025. Barriers to discharge include identifying and being accepted to an assisted living facility. This individual has a diagnosis of a neurocognitive disorder and at this time is resistant to discussing discharge plans. They will discharge to the community once accepted to an assisted living facility.

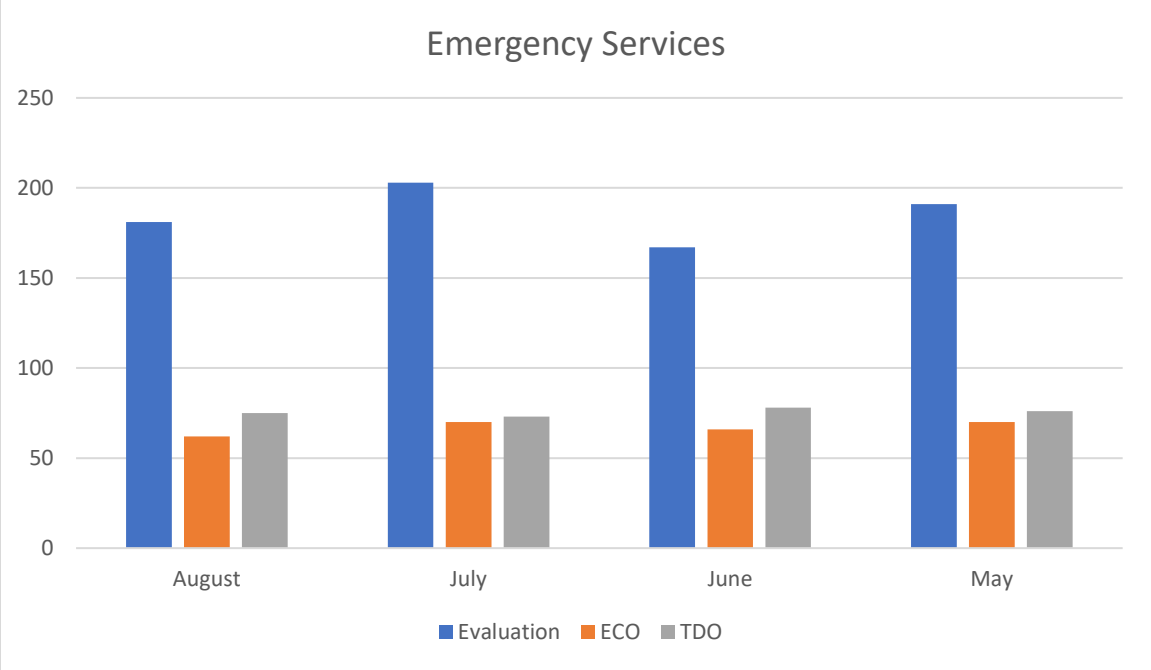
RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Natasha Randall, Emergency Services Coordinator
Date: September 4, 2025
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – August 2025

In August, Emergency Services staff completed 181 emergency evaluations. Sixty-three individuals were assessed under an emergency custody orders and seventy-five total temporary detention orders were served. Staff facilitated two admissions to Western State Hospital, one admission to Catawba, two admissions to Northern Virginia Mental Health Institute along with one admission to Piedmont Geriatric Facility. A total of eight individuals were involuntarily hospitalized outside of our catchment area in August.

Please see the attached data reports.



FY26 CSB/BHA Form (Revised: 07/01/2025)

CSB/BHA	Rappahannock Area Community Services Board	Month	August 2025

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	
181	26	37	63	75	5	3	67	75	1

FY '26 CSB/BHA Form (Revised: 07/01/2025)

CSB/BHA	Rappahannock Area Community Services	Reporting month	August 2025		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) Additional Relevant Information or Discussion (see definition)
8/1/2025	119283	Adult (18-64) with Medical Acuity		Yes		western state hospital
8/7/2025	119344	Adult (18-64) with Medical Acuity		Yes		catawba
8/20/2025	72334	Adult (18-64) with ID or DD		yes		NVMHI
8/21/2025	118998	Adult (18-64) with ID or DD		Yes		NVMHI
8/25/2025	46046	Older Adult with Medical Acuity		Yes		Piedmont
8/28/2025	17712	Adult (18-64) with Medical Acuity		Yes		western state hospital

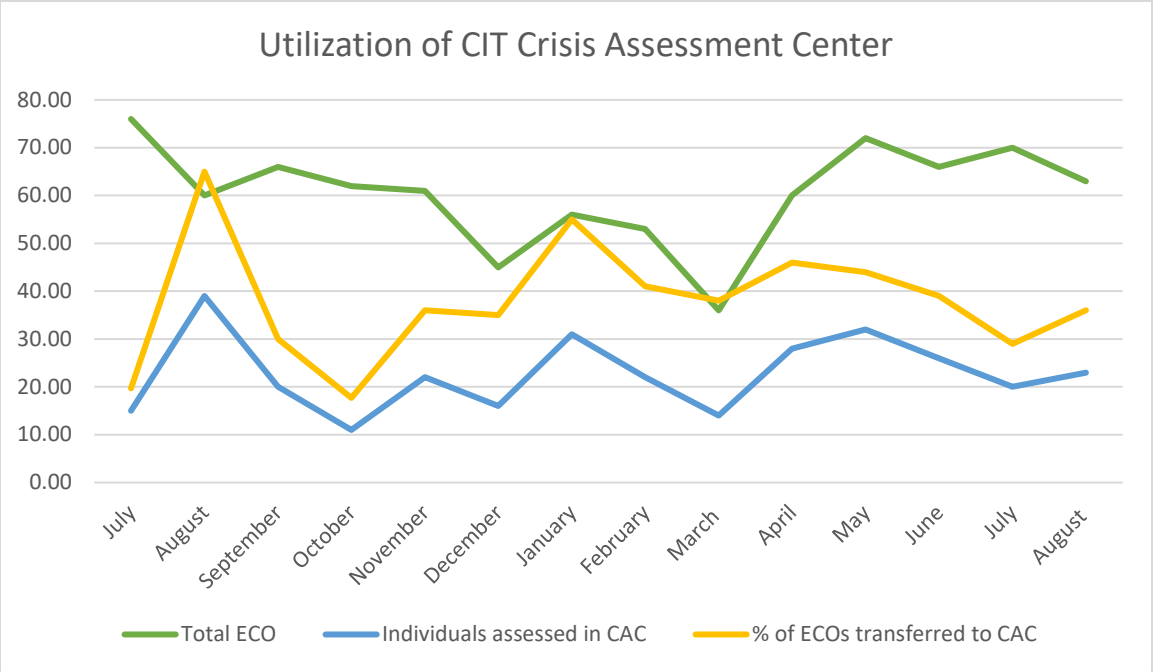
MEMORANDUM

To: Joe Wickens, Executive Director
From: Natasha Randall, LCSW Emergency Services Coordinator
Date: August 5, 2025
Re: CIT and Co-Response Report

The CIT Assessment Center served 23 individuals in the month of August 2025. The number of persons served by locality were the following: Fredericksburg 6; Caroline 2; King George 0; Spotsylvania 7; Stafford 8; and 1 from other jurisdictions.

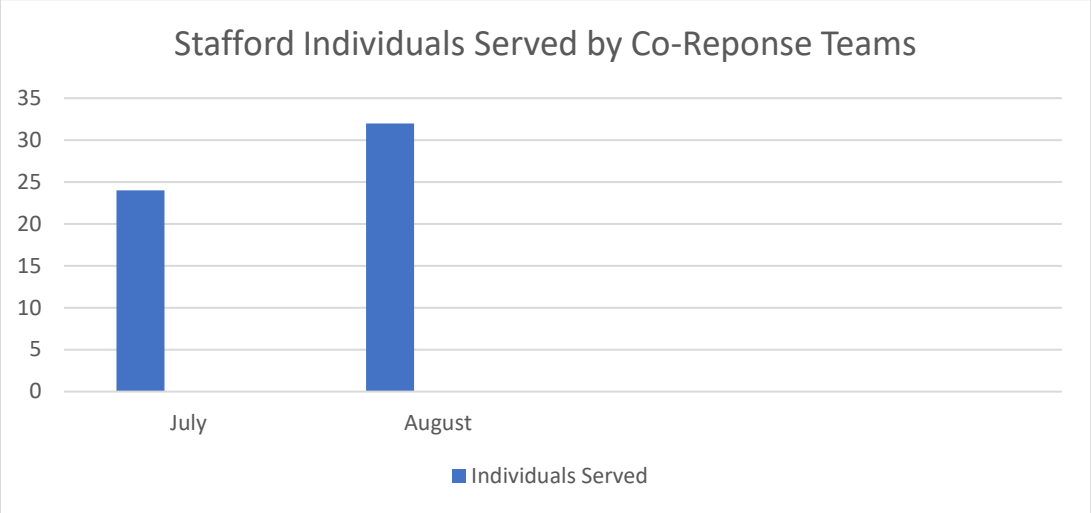
The chart below indicates the number of Emergency Custody orders by locality, those that were able to be transferred into CAC custody, and those who could have used the assessment center if there was additional capacity:

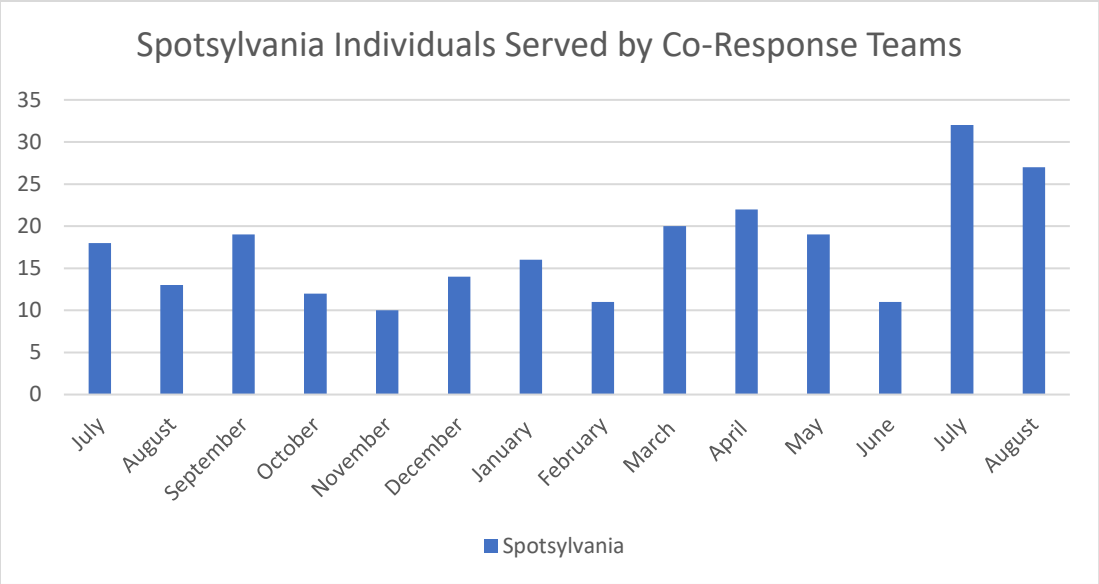
Locality	Total ECO	Custody Transfer to CAC	Appropriate for CAC if Capacity
Caroline	4	2	2
Fredericksburg	16	6	10
King George	2	0	2
Spotsylvania	12	7	5
Stafford	29	8	21
Totals	**63**	**23**	**40**



Co-Response

The Spotsylvania Co-Response Team served 27 individuals in August and the Stafford Co-Response team served 32 individuals. The Fredericksburg Co-Response Therapist position remains vacant.





CIT Training

In August, nine local dispatchers completed Crisis Intervention Team training.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

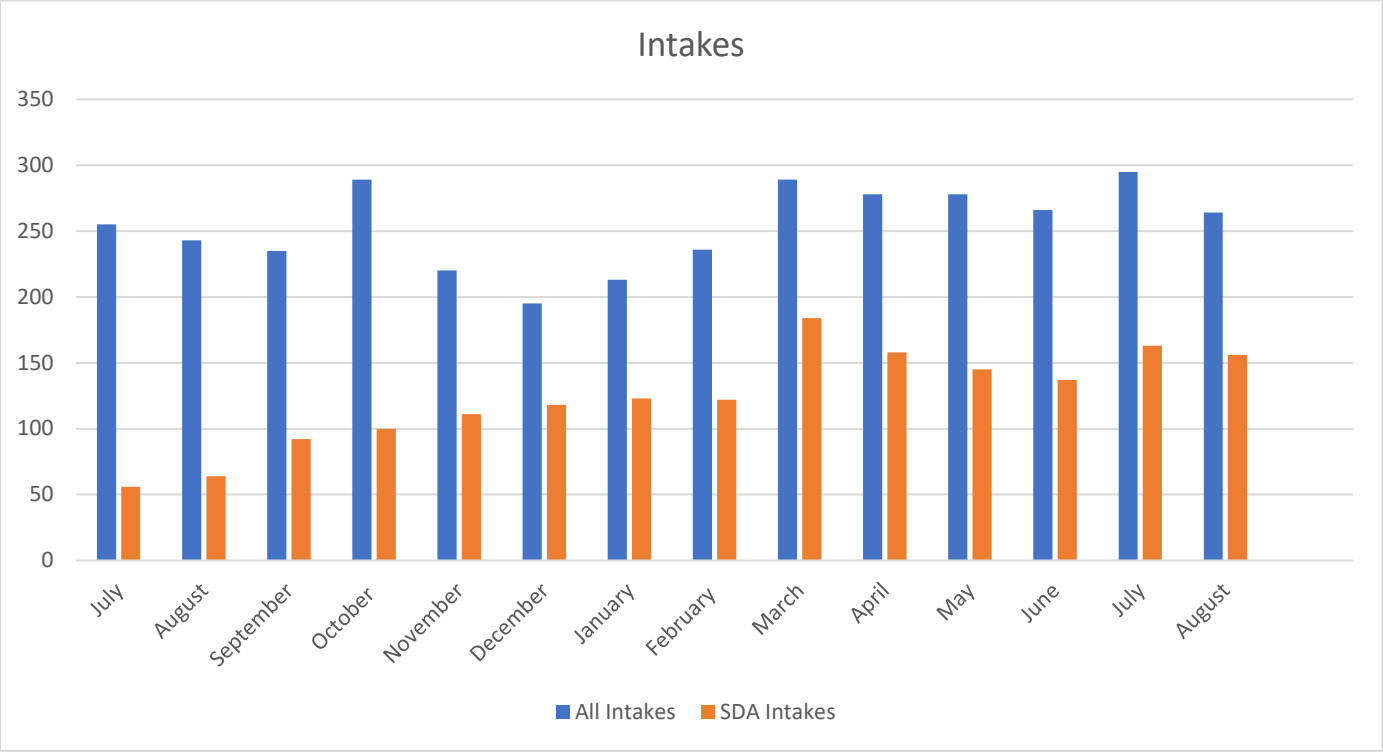
To: Joe Wickens, Executive Director

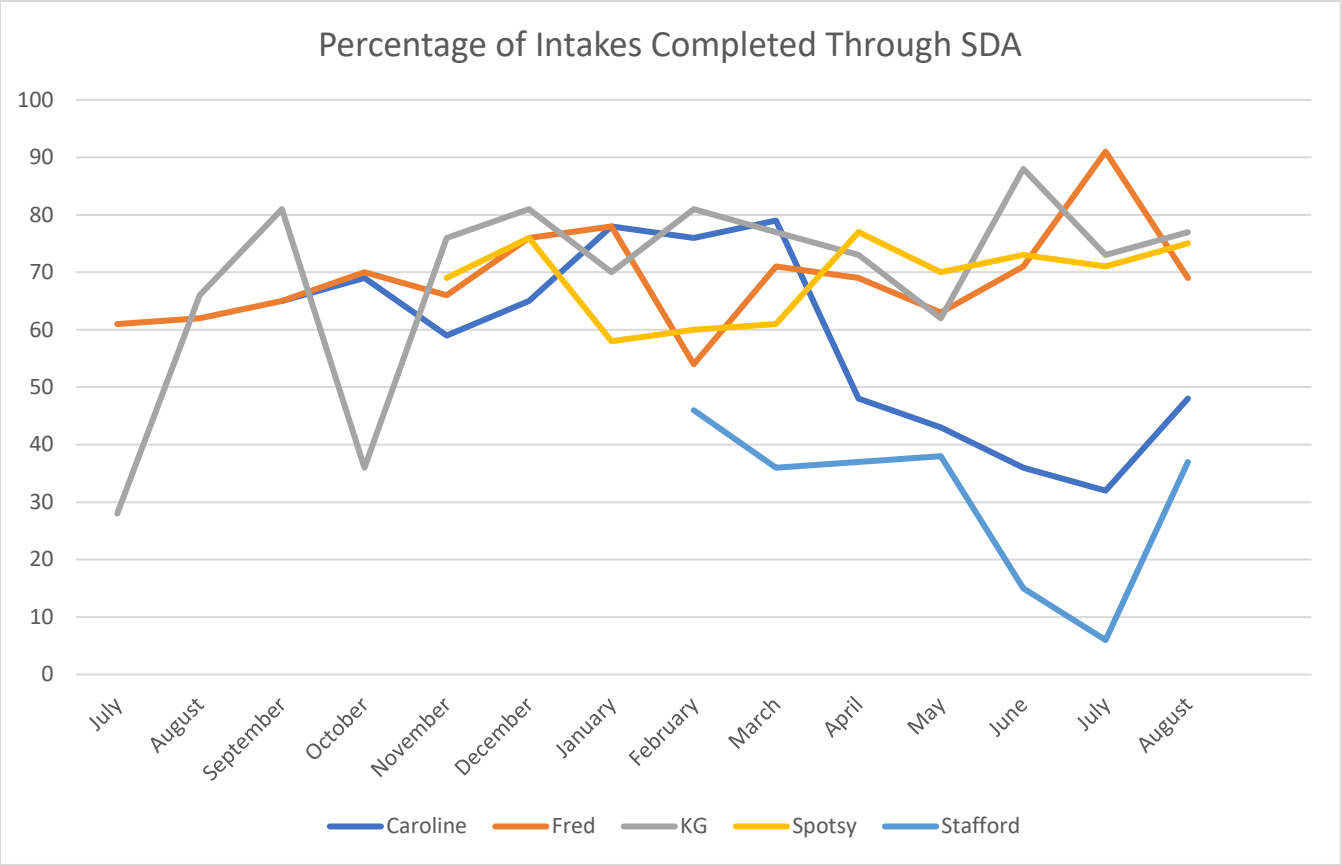
From: Jacqueline Kobuchi, LCSW, Director of Clinical Services

Date: September 5, 2025

Re: Same Day Access

Below is data on the number of intakes completed at our outpatient clinics, and the percentage of those are completed through Same Day Access.




Percentage of Intakes Completed Through SDA
100
90
80
70
60
50
40
30
20
10
0
July
August
September
October
November
December
January
February
March
April
May
June
July
August
Caroline
Fred
KG
Spotsy
Stafford

RACSB
Program Update Report
Compliance
August 2025

Incident Reports

- There were 239 Incident Reports entered into the Electronic Incident Report Tracker during the month of August. This is a decrease of 72 from the month of July; and a decrease of 56 from the month of June. All incident reports submitted were triaged by the compliance team.
- The top three categories of reports submitted were Health Concerns (99 reports), Individual Served Injury (34 reports), and Individual Served Safety (18 reports).
- The compliance team entered 40 incident reports into the Department of Behavioral and Developmental Services (DBHDS) electronic incident reporting system (32-Level 2, 8-Level 3) during the month of August; there were no changes in the submission of Level 2 or Level 3 from the month of July (32-Level 2, 8-Level 3); a decrease of one during the month of June (31-Level 2, 7-Level 3).
- There was one report elevated to a care concern by DBHDS related to a fall. These are reports that, based on the Office of Licensing's review of current serious incidents, as well as a review of other recent incidents related to this individual, the Office of Licensing recommends the provider consider the need to re-evaluate the individual's needs as well as review the current individual's support plan. DBHDS recommends provider review the results of root-cause analyses completed on behalf of this individual. In addition, take the opportunity to determine if systemic changes such as revisions to policies or procedures and/or re-evaluating and updating risk management and/or quality improvement plan.
- DBHDS requires the completion of a root cause analysis for selected incident reports. The root cause analysis must be conducted within 30 days of staff's discovery of the incident. The compliance team requested specific programs, based on submitted incident report, to complete the required root cause analysis. A total of 41 root cause analyses were requested in the month of August an increase of two requested from the month of July and a decrease of one that were requested in the month of June. Of the 41 requested RCA, a total of 11 were categorized as expanded root cause analyses.

Human Rights Investigations:

- The compliance team initiated one Human Rights investigation based on an allegation of neglect.

External Reviewers:

- Compliance team received and responded to 19 documentation requests totaling 286 charts. (1 request from Aetna, 1 request from Anthem, 7 requests from Clinix, 9 requests from Datavant, and 1 request from Molina).

Special Projects

- Prospective Audits

- Compliance Specialist reviewed 44 quarterlies and 32 Individual Service Plans (ISPs) for ID/DD Residential Programs during the month of August. Feedback related to any discrepancies was provided to the group home supervisor and assistant coordinator.

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: August 2025

Re: Quality Assurance Report

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

- Substance Abuse Outpatient: Spotsylvania
- Mental Health Outpatient: Fredericksburg

Substance Abuse Outpatient: Spotsylvania

There were three staff members responsible for the selected charts.

Findings for the ten open charts and one closed chart reviewed for Substance Abuse Outpatient: Spotsylvania were as follows:

- Ten charts were reviewed for Assessment compliance:
  - **No discrepancies noted with Assessments.**
- Ten charts were reviewed for Individual Service Plan compliance:
  - **No discrepancies noted with Individual Service Plans.**
- Ten charts were reviewed for Quarterly Review compliance:
  - **No discrepancies noted with Quarterly Reviews.**
- Ten charts were reviewed for Progress Note compliance:
  - **No discrepancies noted with Progress Notes.**
- Ten charts were reviewed for General Documentation compliance:
  - **No discrepancies noted with General Documentation.**
- One chart was reviewed for Discharge compliance:
  - **No discrepancies noted with Discharge.**

Comparative Information:
In comparing the audit reviews of Substance Abuse Outpatient: Spotsylvania from the previous audits to the current audits, the average score increased from 78 to 100 on a 100-point scale.

Mental Health Outpatient: Fredericksburg

There were thirteen staff members responsible for the selected charts.

Findings for the fifty open charts and two closed charts reviewed for Mental Health Outpatient: Fredericksburg were as follows:

- Fifty charts were reviewed for Assessment compliance:
  - **Discrepancies noted with Assessments:**
    - Seven charts were missing a six-month DLA20 assessment.
    - Two charts contained a Comprehensive Needs Assessment which was completed late.

- Fifty charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plans:**
    - Eight charts contained an Individual Service Plan that was finalized after the start of the plan.
    - One chart had an Individual Service Plan that was beyond the 30-day grace period from the Preliminary Plan.
    - Two charts had an annual Individual Service Plan that was missing.

- Fifty charts were reviewed for Quarterly Review compliance:
  - **Discrepancies noted with Quarterly Reviews:**
    - Five charts contained a late Quarterly Review.
    - Seven charts had a Quarterly Review that was missing.

- Fifty charts were reviewed for Progress Note compliance:
  - **No discrepancies noted with Progress Notes.**

- Fifty charts were reviewed for General Documentation compliance:
  - **No discrepancies noted General Documentation.**

- Two charts were reviewed for Discharge compliance:
  - **No discrepancies noted Discharge Documentation.**

Comparative Information:
In comparing the audit reviews of Mental Health Outpatient: Fredericksburg charts from the previous audits to the current audits, the average score increased from 77 to an 88 on a 100-point scale.

Corrective Action Plan:
1. Chart audits were reviewed. Missing documentation completed and charts closed by assigned clinician, if out of compliance, by 9/1/25.

2. Clinic Coordinator will complete chart audits on a monthly basis in administrative supervision on at least 10 charts.

3. Clinicians will put quarterly reviews on the scheduling calendar, beginning in September, in order to track quarterlies more efficiently.

4. Clinic Coordinator will review documentation requirements at monthly staff meeting in September.

MEMORANDUM

To: Joe Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance

Date: September 8, 2025

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 non-compliance.

Rappahannock Area Community Services Board (RACSB) obtained approval for nine CAPs during the month of August. Six of the CAPs are related to the annal Office of Licensing inspections of Developmental Disability (DD) Services. (Galveston Group Home, RAAI (group day and community engagement services), Myers Respite, DD Support Coordination, and Sponsored Placement). Two are related to late reporting, (Emergency Services and Act South) and one (Galveston Group Home) is the result of a substantiated allegation of abuse.

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

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. G. - The provider shall implement their written corrective action plan for each violation cited by the date of completion identified in the plan.	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: The provider was previously cited related to regulation 12VAC35-105-620.C.5. and 12VAC35-105-665.A.6. in January 2024. The provider does not have any documentation to demonstrate that they fully implemented their approved CAP.	PR) 06/24/2025OLR) Pending Response 07/03/2025 PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation of approved CAPs. The Compliance Team will revise the current process to include monitoring implementation and collection of data to verify CAP is implemented. The current data collection spreadsheet will be revised to include review of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the the implementation of CAPs during the projected follow-ups. If it is determined the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025

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

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. H. (1) - The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall: 1. Continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies; or	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: The provider's approved CAP related to 12VAC35-105-620.C.5. and 12VAC35-105-665.A.6. from the January 2024 inspection did not prevent the recurrence of the regulatory violation or correct any systemic deficiencies; and the provider did not continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies.	PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include reviewing effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the the implementation and effectiveness of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025

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

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. H. (2) - The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall: 2. Submit a revised corrective action plan to the department for approval.	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: The provider's approved CAP related to 12VAC35-105-620.C.5. and 12VAC35-105-665.A.6. from the January 2024 inspection did not prevent the recurrence of the regulatory violation or correct any systemic deficiencies; and provider did not submit a revised corrective action plan to the department for approval.	PR) 07/24/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the the implementation of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025
12VAC35-105-280. C. - The physical environment and furnishings shall be clean, dry, free of foul odors, safe, and well-maintained.	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: While overall the home was neat, clean, and well maintained, it was observed that there was a stain on the carpet in the den and broken blinds in one of the vacant bedrooms.	PR) 07/24/2025 The stain on the carpet will be professionally cleaned. The broken blind will be replaced. Both items will be completed on or before 8/22/25. Systematically, all DD Residential Programs will ensure any carpeting stains are professionally cleaned and blinds are removed and replaced when broken. A reminder/directive will be given to all managers and assistant managers at the DD Residential Supervisor meeting to be held on 8/6/25.	8/25/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			All program supervisors will be responsible for coordinating program maintenance and upkeep needs. Failure to meet these expectations will result in corrective action for responsible staff. The RACSB Compliance team as well as the DD Residential Assistant Coordinators will help with oversight and monitoring that these efforts are maintained OLR) Partially Accepted 08/12/2025Please include how the program supervisors will monitor program maintenance, upkeep needs and the frequency of this monitoring. Please also the frequency and how the compliance team and DD residential assistant coordinators will monitor oversight. PR) 08/26/2025 The stain on the carpet will be professionally cleaned. The broken blind will be replaced. Both items will be completed on or before 8/22/25. Systematically, all DD Residential Programs will ensure any carpeting stains are professionally cleaned and blinds are removed and replaced when broken. A reminder/directive will be given to all managers and assistant managers at the DD Residential Supervisor meeting to be held on 8/6/25. All program supervisors will be responsible for coordinating program maintenance and upkeep needs. Monthly, all DD Residential Managers will complete a facility checklist to help identify maintenance issues. Failure to meet these	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			expectations will result in corrective action for responsible staff. The RACSB Compliance team as well as the DD Residential Assistant Coordinators will help with oversight and monitoring that these efforts are maintained through tracking a reviewing completion of the facility checklists on a monthly basis. OLR) Accepted 09/02/2025	
12VAC35-105-520. C. (5) - The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following: 5. A review of serious incidents.	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: Review of the systemic risk assessment revealed while the provider did have a review of serious incidents including Level I, Level II and Level III incidents the documentation submitted did not include quarter over quarter and year over year trends and patterns based on the baseline data.	PR) 07/25/2025 The Compliance Team reviewed the current process for developing quarterly IR reports. The process will be revised to include review of quarter over quarter and annually. The Compliance Team will review and monitor IR quarterly reports to ensure they include quarter over quarter data and at the end of FY the 4th quarter review will also include annual data to identify risk and trends to mitigate risk of harm to individuals receiving services. the new process will begin with first quarter data for FY2026. OLR) Accepted 08/12/2025	10/15/2025

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Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-620. C. (2) - The quality improvement plan shall: 2. Define measurable goals and objectives;	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while most of the goals and objectives were measurable, not all the goals and objectives were measurable.	PR) 07/25/2025 The Quality Improvement Plan was reviewed to determine which goals and objectives were not measurable. The Quality Improvement Plan will be revised to include measurable goals and objectives. Moving forward the Quality Improvement Plan will be added as a quarterly agenda item for the Compliance Committee for monitoring. OLR) Accepted 08/12/2025	8/15/2025
12VAC35-105-620. C. (4) - The quality improvement plan shall: 4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170;	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while the documentation submitted demonstrated that the agency was monitoring the implementation of corrective actions plans, the documentation submitted did not demonstrate that the agency was monitoring the effectiveness of the corrective action plan following its implementation.	PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include monitoring of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation and effectiveness of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025

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Date of Inspection: **05-21-2025**
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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-620. C. (5) - The quality improvement plan shall: 5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.	NS	Galveston Road Group Home This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that the provider failed to show evidence of ongoing monitoring and evaluation of progress toward meeting their established goals and objectives. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/25/2025 The Quality Improvement Plan was reviewed to determine which documents submitted for review did not show ongoing monitoring of goals. Moving forward the Quality Improvement Plan will be added as a quarterly agenda item for the Compliance Committee. The Committee will monitor and evaluate progress towards established goals and objectives. Information regarding progress will be captured in meeting minutes. OLR) Accepted 08/12/2025	8/30/2025
12VAC35-105-665. A. (6) - The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the assessment. The ISP shall include: 6. A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;	NS	Galveston Road Group Home This regulation was NOT MET as evidenced by: During a review of Individual #1's ISP, it was revealed that the ISP did not include a safety plan or supports for Exceptional Support Need #1 as identified in the SIS. The provider failed to address all identified risks as part of the ISP for Individual #1. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/24/2025 PR: The ISP for Individual #1 will be reviewed and appended by 8/22/25 to ensure that it includes a safety plan and supports that address all identified risks to the individual, including Exceptional Support Need #1 as identified in the SIS. Systematically, residential programs will be tasked at the DD Residential Supervisor meeting to be held on 8/6/25 to review current ISP's to ensure all identified risks from the SIS for each individual are addressed. All program supervisors will be responsible for this information in each individual's chart. Failure to meet these expectations will result in corrective action for responsible staff. The RACSB Compliance team as well as the DD Residential Assistant Coordinators will help with oversight and monitoring that this information is	8/22/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			in the individual's record. OLR) Partially Accepted 08/12/2025Please include how program supervisors will be responsible for monitoring the procedures implemented to ensure you stay in compliance with the regulation. Also please identify the frequency of monitoring by program supervisors, the compliance team and DD Residential Assistant Coordinators. Please also address how this corrective action will be monitored. PR) 08/26/2025 PR: The ISP for Individual #1 will be reviewed and appended by 8/22/25 to ensure that it includes a safety plan and supports that address all identified risks to the individual, including Exceptional Support Need #1 as identified in the SIS. Systematically, residential programs will be tasked at the DD Residential Supervisor meeting to be held on 8/6/25 to review current ISP's to ensure all identified risks from the SIS for each individual are addressed. Annually thereafter, in preparation to write each individual's ISP, program supervisors will re-review the individual's SIS to inform and ensure all safety plan requirements are included in the ISP. All program supervisors will be responsible for this information in each individual's chart. Failure to meet these expectations will result in corrective action for responsible staff. The RACSB Compliance team as well as the DD Residential Assistant Coordinators will help with	

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Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			oversight and monitoring that this information is in the individual's record through periodic annual reviews of documentation. OLR) Accepted 09/02/2025	
12VAC35-105-680. - The provider shall use signed and dated progress notes or other documentation to document the services provided and the implementation of the goals and objectives contained in the ISP.	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: During a review of Individual #1's ISP regarding Exceptional Support Need #2, it states, "If staff notice a new mark they will mark 'A' on the body chart, report to management and complete an IR." On May 9th, staff documented a new mark on Individual #1 but did not document "A" on the body chart or complete and IR for the new mark. The provider failed to use other documentation to document the implementation of the goals and objectives contained in the ISP.	PR) 07/24/2025 PR: All program staff will be reoriented to the body charting processes and expectations through a refresher training at the staff meeting to be held on 7/23/25. The Program Manager and assistant manager will provide ongoing monitoring and oversight to ensure body charting is completed thoroughly and accurately in accordance with established protocols. Systematically across all DD Residential Programs, all program managers and assistant managers will ensure body charting is completed thoroughly and accurately in accordance with established protocols through monitoring. DD Residential managers/assistant managers will be reoriented to this expectation at the DD Residential Supervisor team meeting to be held on 8/6/2025. Failure on the part of staff to meet body charting expectations in accordance with established protocols will result in corrective action for responsible staff. The RACSB Compliance team as well as the DD Residential Assistant Coordinators will help with oversight and monitoring adherence to these standards.	8/6/2025

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Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			OLR) Partially Accepted 08/12/2025Please include how the program manager and assistant manager will monitor body charting and their frequency of monitoring. Please also include the frequency and how the compliance team and DD Residential Assistant Coordinators will help oversight and monitoring. PR) 08/26/2025 PR: All program staff will be reoriented to the body charting processes and expectations through a refresher training at the staff meeting to be held on 7/23/25. The Program Manager and assistant manager will provide ongoing monitoring and oversight to ensure body charting is completed thoroughly and accurately in accordance with established protocols. Systematically across all DD Residential Programs, all program managers and assistant managers will ensure body charting is completed thoroughly and accurately in accordance with established protocols through monitoring. DD Residential managers/assistant managers will be reoriented to this expectation at the DD Residential Supervisor team meeting to be held on 8/6/2025. They will review data collection of the body charting at a minimum of monthly to help ensure expectations are being maintained. Failure on the part of staff to meet body charting expectations in accordance with established protocols will result in corrective action for responsible staff.	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The RACSB Compliance team as well as the DD Residential Assistant Coordinators will help with oversight and monitoring adherence to these standards through periodic annual reviews of documentation. OLR) Accepted 09/02/2025	
12VAC35-105-770. C. - Medications shall be administered only to the individuals for whom the medications are prescribed and shall be administered as prescribed.	N	Galveston Road Group Home This regulation was NOT MET as evidenced by: While reviewing Individual #2's medications it was revealed that Medication #1, Medication #2 and Medication #3 were listed on the medication administration record; however, they were not located on-site. Had Individual #2 required any of these medications, the provider would be unable to administer the medications as prescribed.	PR) 07/25/2025 PR: The medications not located onsite for Individual #2's regiment were acquired through contact and follow up with the prescribing doctor and pharmacy and are available onsite per confirmation of the program manager on 7/21/25. All doctor ordered medications are confirmed available onsite for all individuals as confirmed by the program manager on 7/21/25. The Program Manager and assistant manager will provide ongoing monitoring and oversight to ensure all individuals' ordered medications are available on-site at all times. Systematically across all DD Residential Programs, all program managers and assistant managers will ensure that all medications for all individuals are available on site and that all medication management policies and procedures are adhered to. DD Residential managers/assistant managers will be reoriented to this expectation at the DD Residential Supervisor team meeting to be held on 8/6/2025. Oversight of the medication management policy and insurance that processes are occurring in	7/21/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			accordance with the policy will be monitored by the DD Residential Assistant Coordinators and the Compliance Team. Staff who are identified as not following established protocols, regulations, and processes as described will receive corrective action in an effort to prevent future occurrences of a similar nature. OLR) Partially Accepted 08/12/2025Please include the frequency and how the program manager and assistant manager will monitor ordered medications to continue to meet compliance. Also please include how the DD Residential Assistant Coordinators and the Compliance team will insure that processes are occurring in accordance with the medication management policy. PR) 08/26/2025 PR: The medications not located onsite for Individual #2's regiment were acquired through contact and follow up with the prescribing doctor and pharmacy and are available onsite per confirmation of the program manager on 7/21/25. All doctor ordered medications are confirmed available onsite for all individuals as confirmed by the program manager on 7/21/25. The Program Manager and assistant manager will provide monthly monitoring and oversight to ensure all individuals' ordered medications are available on-site at all times. Systematically across all DD Residential Programs, all program managers and assistant	

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Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			managers will ensure that all medications for all individuals are available on site and that all medication management policies and procedures are adhered to. DD Residential managers/assistant managers will be reoriented to this expectation at the DD Residential Supervisor team meeting to be held on 8/6/2025. Oversight of the medication management policy and insurance that processes are occurring in accordance with the policy will be monitored through periodic annual reviews of documentation by the DD Residential Assistant Coordinators and the Compliance Team. Staff who are identified as not following established protocols, regulations, and processes as described will receive corrective action in an effort to prevent future occurrences of a similar nature. OLR) Accepted 09/02/2025	

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Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

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

General Comments / Recommendations:
Licensing specialist reminded group home manager on-site during the inspection to utilize the key on the PCP goals data sheet and document "C" on data sheets to represent individuals choosing not to participate in their goal for the day.

The licensing specialist recommends the provider review 12VAC35-105-620 as well as the Guidance for a Quality Improvement Program (November 2020). The specialist also recommends the provider access the resources and training related to quality improvement on the Office of Licensing webpage, under the QUALITY IMPROVEMENT-RISK MANAGEMENT RESOURCES FOR LICENSED PROVIDERS.

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.

Angela DAngelo, Licensing Specialist	(Signature of Organization Representative)	Date

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

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

Date of Inspection: **08-04-2025**
Program Type/Facility Name: **01-001 Galveston 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	Galveston Road Group Home This regulation was NOT MET as evidenced by: See OHR citation 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	Galveston Road Group Home This regulation was NOT MET as evidenced by: CHRIS #20250015, #20250016 and #20250018 "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Provider substantiated abuse due to the following. Employee #1 was overheard by staff saying, "I'm going to kill you. I'm going to beat you," when Individual #1 grabbed Employee #1. Employee #1 one was overheard by staff saying, "Well, I'm not cleaning that," when Individual #2 had an accident.	PR) 08/21/2025 PR: The staff member responsible for the incidents of abuse (Employee #1) was immediately put on administrative leave pending the outcome of an internal investigation. Upon substantiation of the abuse allegations following the investigation procedures, the staff member responsible for the incident separated from employment with the agency effective 7/25/25 prior to termination. Program staff were re-trained on the importance of Human Rights specific to all forms of abuse, mandated reporting requirements, and person-centered thinking on 7/23/25 at their staff meeting. Staff on leave at the time of the meeting were all oriented to this material by 8/9/25. Staff each signed off attesting to their understanding and agreement to abide by each of these requirements and obligations.	08/09/2025 00:00:00

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Date of Inspection: **08-04-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		While Individual #3 was eating, Employee #1 was overheard saying, "You're being sloppy. That is nasty. Clean your face." to Individual #1. Use of language that demeans, threatens, intimidates, or humiliates the person meets the regulatory definition of "abuse" and is a violation of 12VAC35-115-50(B)(2).	All RACSB staff and volunteers will be required to undergo an annual Human Rights training, a Mandated Reporter training, and an annual review of the RACSB Employee Code of Ethics to help ensure continued promotion and support of meeting needs of residents. Newly hired staff will be assigned these courses upon hire during the week of their agency orientation. Human Resources will continue to track these annual trainings for compliance by all staff through its electronic training system/database. 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. The Compliance 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. 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	

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Date of Inspection: **08-04-2025**
Program Type/Facility Name: **01-001 Galveston Road Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			individuals). 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. Any staff member failing to abide by human rights regulations, or failing to intervene or report instances of human rights violations will receive corrective action measures. OHR/OLR) Accepted 08/21/2025	

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 #: **101-02-008**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **02-008 Fredericksburg**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. G. - The provider shall implement an approved written corrective action plan for each violation cited by the date of completion identified in the plan.	N	Fredericksburg This regulation was NOT MET as evidenced by: The provider was previously cited related to regulation 12VAC35-105-620.C.5 in January 2024. The provider does not have any documentation to demonstrate that they fully implemented their approved CAP.	PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation of approved CAPs. The Compliance Team will revise the current process to include monitoring implementation and collection of data to verify CAP is implemented. The current data collection spreadsheet will be revised to include effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/11/2025	9/1/2025

License #: **101-02-008**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **02-008 Fredericksburg**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. H. (1) - The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall: 1. Continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies; or	N	Fredericksburg This regulation was NOT MET as evidenced by: The provider's approved CAP related to 12VAC35-105-620.C.5 from the January 2024 inspection, did not prevent the recurrence of the regulatory violation or correct any systemic deficiencies; and the provider did not continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies.	PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/11/2025	9/1/2025

License #: **101-02-008**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **02-008 Fredericksburg**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. H. (2) - The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall: 2. Submit a revised corrective action plan to the department for approval.	N	Fredericksburg This regulation was NOT MET as evidenced by: The provider's approved CAP related to 12VAC35-105-620.C.5. from the January 2024 inspection, did not prevent the recurrence of the regulatory violation or correct any systemic deficiencies; and provider did not submit a revised corrective action plan to the department for approval.	PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/11/2025	9/1/2025
12VAC35-105-400. C. - The provider shall submit all personally descriptive applicant information necessary to complete the criminal history background checks and registry searches.	N	Fredericksburg This regulation was NOT MET as evidenced by: Review of Employee #2's personnel record revealed there was no documentation of a background FBI check. The provider failed to show results of the required criminal background check.	PR) 07/25/2025 Employee #2's background check was located in the personnel file. Please see the attached. OLR) Accepted 08/11/2025	7/25/2025

License #: **101-02-008**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **02-008 Fredericksburg**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-520. C. (5) - The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following: 5. A review of serious incidents.	N	Fredericksburg This regulation was NOT MET as evidenced by: Review of the systemic risk assessment revealed while the provider did have a review of serious incidents including Level I, Level II and Level III incidents the documentation submitted did not include quarter over quarter and year over year trends and patterns based on the baseline data.	PR) 07/25/2025 The Compliance Team reviewed the current process for developing quarterly IR reports. The process will be revised to include review of quarter over quarter and annually. The Compliance Team will review and monitor IR quarterly reports to ensure they include quarter over quarter data and at the end of FY the 4th quarter review will also include annual data to identify risk and trends to mitigate risk of harm to individuals receiving services. the new process will begin with first quarter data for FY2026. OLR) Accepted 08/11/2025	10/15/2025
12VAC35-105-620. C. (2) - The quality improvement plan shall: 2. Define measurable goals and objectives;	N	Fredericksburg This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while most of the goals and objectives were measurable, not all the goals and objectives were measurable.	PR) 07/25/2025 The Quality Improvement Plan was reviewed to determine which goals and objectives were not measurable. The Quality Improvement Plan will be revised to include measurable goals and objectives. Moving forward the Quality Improvement Plan will be added as a quarterly agenda item for the Compliance Committee for monitoring. OLR) Accepted 08/11/2025	8/15/2025

License #: **101-02-008**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **02-008 Fredericksburg**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-620. C. (4) - The quality improvement plan shall: 4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170;	N	Fredericksburg This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while the documentation submitted demonstrated that the agency was monitoring the implementation of corrective actions plans, the documentation submitted did not demonstrate that the agency was monitoring the effectiveness of the corrective action plan following its implementation.	PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include monitoring of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation and effectiveness of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/11/2025	9/1/2025

License #: **101-02-008**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **02-008 Fredericksburg**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-620. C. (5) - The quality improvement plan shall: 5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.	NS	Fredericksburg This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that the provider failed to show evidence of ongoing monitoring and evaluation of progress toward meeting their established goals and objectives. This citation is considered non-compliant systemic due to being previously cited on 1/28/2024.	PR) 07/25/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include monitoring of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation and effectiveness of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/11/2025	8/30/2025

License #: **101-02-008**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **02-008 Fredericksburg**

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

General Comments / Recommendations:
The licensing specialist recommends the provider review 12VAC35-105-620 as well as the Guidance for a Quality Improvement Program (November 2020). The specialist also recommends the provider access the resources and training related to quality improvement on the Office of Licensing webpage, under the QUALITY IMPROVEMENT-RISK MANAGEMENT RESOURCES FOR LICENSED PROVIDERS.

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.

Angela DAngelo, Licensing Specialist	(Signature of Organization Representative)	Date

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

License #: **101-02-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **08-06-2025**
Program Type/Facility Name: **02-006 Fredericksburg**

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	Fredericksburg 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	Fredericksburg 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 During an internal investigation into CHRIS Abuse 20250019 the provider determined the following: • Employee 1 was helping Individual 1 transfer from Individual 1's bus seat into Individual 1's wheelchair when Individual 1's chair started sliding in the process of trying to transfer Individual 1. • Individual 1 then took a step back to sit on the wheelchair when Individual 1 fell to the side. • As Individual 1 fell, Employee 1 held on to Individual 1 to guide the fall in an attempt to protect Individual 1 from injury.	PR) 08/27/2025 Employee #1 was terminated; no corrective action was given for this incident of neglect. New Employees continue to receive safe wheelchair transport upon hire from the transportation Supervisor and Site Leaders. Human Resources will maintain certificate of training in the individual's personnel file. Site Leaders continue to train new employees on specific protocols for each individual according to their plan. HR will conduct monthly auditing of 1% of current employee files to find deficiencies. In addition, monitoring is completed by the site leader during semi- annual direct observations at a minimum. Employee 2 resigned and is no longer employed;	10/30/2025 00:00:00

License #: **101-02-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **08-06-2025**
Program Type/Facility Name: **02-006 Fredericksburg**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		• During the investigation, it was determined that Employee 1 failed to relock the wheelchair wheels prior to assisting Individual 1 with the transfer from the bus seat to the wheelchair. During an internal investigation into CHRIS Abuse 20250020, Abuse 20250021, and Abuse 20250022 the provider determined the following: • Employee 2 was transporting Individual 2, Individual 3, and Individual 4 in a vehicle. • Employee 2 was pulled over by law enforcement and issued a citation for driving 14 miles over the speed limit. • Employee 2 failed to follow the posted safe speed limits while providing transport for Individual 2, Individual 3, and Individual 4.	corrective action was not given for this incident of abuse. Employee driving records are checked at time of employment and annually thereafter to mitigate risk. Reminder of being contentious of speed limits will be discussed with annually during staff meeting. Additional transportation training will be provided by the transportation supervisor and employees will review the transportation manual. This training will take place by October 30, 2025 OHR/OLR) Accepted 09/04/2025	

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

License #: **101-01-036**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **08-04-2025**
Program Type/Facility Name: **01-036 Myers Drive**

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	Myers Drive This regulation was NOT MET as evidenced by: See OHR citation 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	Myers Drive This regulation was NOT MET as evidenced by: CHRIS #20250017 "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. "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.	PR) 08/21/2025 PR: The staff member responsible for failing to follow Individual #1's diet and plan of supports (Employee #1) received disciplinary corrective action on 7/28/25. Employee #1 has since left the agency. The staff member who failed to fully follow emergency protocols and failed to follow Individual #1's plan of supports (Employee #2), thereby substantiating abuse and neglect, will be separated from employment upon returning from extended leave on 8/25/2025. All program staff will be re-trained on the importance of Human Rights specific to all forms of abuse and neglect at the staff meeting on 8/25/25. Staff will sign off attesting to their understanding and agreement to abide by each of these requirements and obligations. All RACSB staff and volunteers will be required to undergo an annual Human Rights training and	08/25/2025 00:00:00

License #: **101-01-036**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **08-04-2025**
Program Type/Facility Name: **01-036 Myers Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		Provider substantiated abuse and neglect based on the following: Employee #1 failed to follow Individual #1's diet and plan of supports. Employee #2 failed to fully follow the emergency protocols; Employee #2 also failed to follow Individual #1's plan of supports, which states that staff will provide assistance with mobility in order to reduce the risk of falls if Individual #1 were to have a seizure. Employee #2 allowed Individual #1 to walk alone resulting in Individual #1having a laceration above the right eyebrow. Knowingly, recklessly and intentionally not following the plan of supports which caused physical harm, and failing to provide the services necessary to the health, safety and welfare of the individual are all violations of 12VAC35-115-50 (B)(2).	an annual review of the RACSB Employee Code of Ethics to help ensure continued promotion and support of meeting needs of individuals. Newly hired staff will be assigned these courses upon hire during the week of their agency orientation. Human Resources will continue to track these annual trainings for compliance by all staff through its electronic training system/database. 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. The Compliance 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. 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).	

License #: **101-01-036**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **08-04-2025**
Program Type/Facility Name: **01-036 Myers Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			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. Any staff member failing to abide by human rights regulations, or failing to intervene or report instances of human rights violations will receive corrective action measures. OHR/OLR) Accepted 08/21/2025	

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 #: **101-16-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **16-002 Stafford DD Casemanagement**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. G. - The provider shall implement their written corrective action plan for each violation cited by the date of completion identified in the plan.	N	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: The provider was previously cited related to regulation 12VAC35-105-620.C.5. and 12VAC35-105-665.A.6. in January 2024. The provider does not have any documentation to demonstrate that they fully implemented their approved CAP.	PR) 07/30/2025 The Compliance Team reviewed the current process regarding implementation of approved CAPs. The Compliance Team will revise the current process to include monitoring implementation and collection of data to verify CAP is implemented. The current data collection spreadsheet will be revised to include review of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the the implementation of CAPs during the projected follow-ups. If it is determined the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025
12VAC35-105-430. A. (6) - Employee or contractor personnel records, whether hard-copy or electronic, shall include: 6. Results of the required criminal background checks and searches of the registry of founded complaints of child abuse and neglect;	N	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: Review of Employee #1's personnel record revealed there was no documentation of a background FBI check. The provider failed to show results of the required criminal background check.	PR) 07/30/2025 The document was located in the individual's chart. OLR) Accepted 08/12/2025	7/30/2025

License #: **101-16-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **16-002 Stafford DD Casemanagement**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-520. C. (5) - The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following: 5. A review of serious incidents.	N	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: Review of the systemic risk assessment revealed while the provider did have a review of serious incidents including Level I, Level II and Level III incidents the documentation submitted did not include quarter over quarter and year over year trends and patterns based on the baseline data.	PR) 07/30/2025 The Compliance Team reviewed the current process for developing quarterly IR reports. The process will be revised to include review of quarter over quarter and annually. The Compliance Team will review and monitor IR quarterly reports to ensure they include quarter over quarter data and at the end of FY the 4th quarter review will also include annual data to identify risk and trends to mitigate risk of harm to individuals receiving services. the new process will begin with first quarter data for FY2026. OLR) Accepted 08/12/2025	10/15/2025
12VAC35-105-620. C. (2) - The quality improvement plan shall: 2. Define measurable goals and objectives;	N	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while most of the goals and objectives were measurable, not all the goals and objectives were measurable.	PR) 07/30/2025 The Quality Improvement Plan was reviewed to determine which goals and objectives were not measurable. The Quality Improvement Plan will be revised to include measurable goals and objectives. Moving forward the Quality Improvement Plan will be added as a quarterly agenda item for the Compliance Committee for monitoring. OLR) Accepted 08/12/2025	8/15/2025

License #: **101-16-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **16-002 Stafford DD Casemanagement**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-620. C. (4) - The quality improvement plan shall: 4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170;	N	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while the documentation submitted demonstrated that the agency was monitoring the implementation of corrective actions plans, the documentation submitted did not demonstrate that the agency was monitoring the effectiveness of the corrective action plan following its implementation.	PR) 07/30/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include monitoring of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation and effectiveness of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025
12VAC35-105-620. C. (5) - The quality improvement plan shall: 5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.	NS	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that the provider failed to show evidence of ongoing monitoring and evaluation of progress toward meeting their established goals and objectives. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/30/2025 The Quality Improvement Plan was reviewed to determine which documents submitted for review did not show ongoing monitoring of goals. Moving forward the Quality Improvement Plan will be added as a quarterly agenda item for the Compliance Committee. The Committee will monitor and evaluate progress towards established goals and objectives. Information regarding progress will be captured in meeting minutes. OLR) Accepted 08/12/2025	8/30/2025

License #: **101-16-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **16-002 Stafford DD Casemanagement**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-660. D. (3b) - The initial ISP and the comprehensive ISP shall be developed based on the respective assessment with the participation and informed choice of the individual receiving services. 3. Whenever there is a change to an individual's ISP, it shall be clearly documented within the ISP, or within documentation attached to the ISP that: 3b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative;	NS	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: During a review of Individual #1's Virginia Informed Choice form, the section showing evidence of proposed and alternative services with risk and benefits being discussed was not filled out. The provider failed to show evidence of documented proposed and alternative services with risks and benefits. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/30/2025 The SC will be directed to discuss all services with the individual/SDM and complete a new VIC completed no later than 9/1/25 with individual and sent to SDM for signature no later than 9/1/25. SCs will be reminded to complete the VIC form in its entirety to document that the proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative no later than 9/1/25 When completing chart audits during supervision, DSSC supervisor will review the VIC to ensure it is completed correctly. If not, this will be discussed with the SC during supervision and the SC will be directed to complete a new VIC with the individual/SDM. Once completed, the SC will upload into the EHR and will ensure DSSC supervisor is notified that this is complete. OLR) Accepted 08/12/2025	9/1/2025

License #: **101-16-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **16-002 Stafford DD Casemanagement**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-1245. - Case managers shall meet with each individual face to face as dictated by the individual's needs. At face-to-face meetings, the case manager shall (i) observe and assess for any previously unidentified risks, injuries, needs, or other changes in status; (ii) assess the status of previously identified risks, injuries, or needs, or other changes in status; (iii) assess whether the individual's service plan is being implemented appropriately and remains appropriate for the individual; and (iv) assess whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.	N	Stafford DD Casemanagement This regulation was NOT MET as evidenced by: During a review of Individual #2's records, it was discovered that the Individual was moved from ECM to TCM. There was no documentation identifying the reason Individual #2 was moved from ECM. The provider failed to meet with each individual face to face as dictated by the individual's needs.	PR) 07/30/2025 The SC will be directed to discuss all services with the individual/SDM and complete a new VIC completed no later than 9/1/25 with individual and sent to SDM for signature no later than 9/1/25. SCs will be reminded to complete the VIC form in its entirety to document that the proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative no later than 9/1/25 When completing chart audits during supervision, DSSC supervisor will review the VIC to ensure it is completed correctly. If not, this will be discussed with the SC during supervision and the SC will be directed to complete a new VIC with the individual/SDM. Once completed, the SC will upload into the EHR and will ensure DSSC supervisor is notified that this is complete. OLR) Accepted 08/12/2025	9/1/2025

License #: **101-16-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **16-002 Stafford DD Casemanagement**

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

General Comments / Recommendations:
Licensing specialist recommends more detailed/ person-centered closely representing the Important To's of the individual.

The licensing specialist recommends the provider review 12VAC35-105-620 as well as the Guidance for a Quality Improvement Program (November 2020). The specialist also recommends the provider access the resources and training related to quality improvement on the Office of Licensing webpage, under the QUALITY IMPROVEMENT-RISK MANAGEMENT RESOURCES FOR LICENSED PROVIDERS.

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.

Angela DAngelo, Licensing Specialist	(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 #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. G. - The provider shall implement their written corrective action plan for each violation cited by the date of completion identified in the plan.	N	Dune Street This regulation was NOT MET as evidenced by: The provider was previously cited related to regulation 12VAC35-105-620.C.5., 12VAC35-105-410.A.1.,12VAC35-105-410.A.2., 12VAC35-105-410.A.3., 12VAC35-105-410.A.4. and 12VAC35-105-430.A.5. in January 2024. The provider does not have any documentation to demonstrate that they fully implemented their approved CAP.	PR) 07/30/2025 The Compliance Team reviewed the current process regarding implementation of approved CAPs. The Compliance Team will revise the current process to include monitoring implementation and collection of data to verify CAP is implemented. The current data collection spreadsheet will be revised to include review of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the the implementation of CAPs during the projected follow-ups. If it is determined the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. H. (1) - The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall: 1. Continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies; or	N	Dune Street This regulation was NOT MET as evidenced by: The provider's approved CAP related to 12VAC35-105-620.C.5., 12VAC35-105-410.A.1., 12VAC35-105-410.A.2., 12VAC35-105-410.A.3., 12VAC35-105-410.A.4. and 12VAC35-105-430.A.5.from the January 2024 inspection, did not prevent the recurrence of the regulatory violation or correct any systemic deficiencies; and the provider did not continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies.	PR) 07/30/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-170. H. (2) - The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall: 2. Submit a revised corrective action plan to the department for approval.	N	Dune Street This regulation was NOT MET as evidenced by: The provider's approved CAP related to 12VAC35-105-620.C.5., 12VAC35-105-410.A.1., 12VAC35-105-410.A.2., 12VAC35-105-410.A.3., 12VAC35-105-410.A.4. and 12VAC35-105-430.A.5. from the January 2024 inspection, did not prevent the recurrence of the regulatory violation or correct any systemic deficiencies; and provider did not submit a revised corrective action plan to the department for approval.	PR) 07/30/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-410. A. (1) - Each employee or contractor shall have a written job description that includes: 1. Job title;	NS	Dune Street This regulation was NOT MET as evidenced by: During a review of Employee #1's file there was no job description present. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/31/2025 This information can be found in the contractors Sponsored Placement Agreement. Working title is : Provider RACSB Sponsored Placement program and HR will review this standard and add more specific details in the Agreement or add an additional document to the agreement that clearly states the required information. HR Specialists will review when applicable employment actions take place and monthly auditing of current files. OLR) Accepted 08/12/2025	12/1/2025
12VAC35-105-410. A. (2) - Each employee or contractor shall have a written job description that includes: 2. Duties and responsibilities required of the position;	NS	Dune Street This regulation was NOT MET as evidenced by: During a review of Employee #1's file there was no job description including duties and responsibilities required of the position. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/30/2025 This information can be found in the contractors Sponsored Placement Agreement. The Provider reports to RACSB as refenced in the agreement. RACSB Sponsored Placement program and HR will review this standard and add more specific details in the Agreement or add an additional document to the agreement that clearly states the required information. HR Specialists will review when applicable employment actions take place and monthly auditing of current files. OLR) Accepted 08/12/2025	12/1/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-410. A. (3) - Each employee or contractor shall have a written job description that includes: 3. Job title of the immediate supervisor;	NS	Dune Street This regulation was NOT MET as evidenced by: During a review of Employee #1's file there was no job title of the immediate supervisor present. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/31/2025 This information can be found in the contractors Sponsored Placement Agreement. The Provider reports to RACSB as refenced in the agreement. RACSB Sponsored Placement program and HR will review this standard and add more specific details in the Agreement or add an additional document to the agreement that clearly states the required information. HR Specialists will review when applicable employment actions take place and monthly auditing of current files OLR) Accepted 08/12/2025	12/1/2025
12VAC35-105-410. A. (4) - Each employee or contractor shall have a written job description that includes: 4. Minimum knowledge, skills, and abilities, experience or professional qualifications required for entry level as specified in 12VAC35-105-420.	NS	Dune Street This regulation was NOT MET as evidenced by: During a review of Employee #1's file there was no minimum knowledge, skills, and abilities, experience or professional qualifications present. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/31/2025 While the Sponsored Placement Agreement does not specify the KSAs, experience or qualifications, it does certify that the Provider is qualified by RACSB. Provisions #4. RACSB Sponsored Placement program and HR will review this standard and add more specific details in the Agreement or add an additional document to the agreement that clearly states the required information. HR Specialists will review when applicable employment actions take place and monthly auditing of current files. OLR) Accepted 08/12/2025	12/1/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-430. A. (5) - Employee or contractor personnel records, whether hard-copy or electronic, shall include: 5. Results of reasonable efforts to secure job-related references and reasonable verification of employment history;	NS	Dune Street This regulation was NOT MET as evidenced by: During a review of Employee #1's file there was no evidence of references being contacted. While there were reference names listed, the provider failed to show reasonable efforts to secure job-related references and reasonable verification of employment history. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/31/2025 This was an oversight that took place twelve years ago. Current process in place makes sure an offer or contract of employment does not go out until there is documentation of references. a. Checklists in place for all stages of employee movement in positions (New hires, transfers, promotions/demotions). b. Monthly auditing of 1% of current employee files to find deficiencies HR Specialists will review when applicable employment actions take place and monthly auditing of current files. OLR) Accepted 08/12/2025	12/1/2025
12VAC35-105-520. C. (5) - The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following: 5. A review of serious incidents.	N	Dune Street This regulation was NOT MET as evidenced by: Review of the systemic risk assessment revealed while the provider did have a review of serious incidents including Level I, Level II and Level III incidents the documentation submitted did not include quarter over quarter and year over year trends and patterns based on the baseline data.	PR) 07/31/2025 The Compliance Team reviewed the current process for developing quarterly IR reports. The process will be revised to include review of quarter over quarter and annually. The Compliance Team will review and monitor IR quarterly reports to ensure they include quarter over quarter data and at the end of FY the 4th quarter review will also include annual data to identify risk and trends to mitigate risk of harm to individuals receiving services. the new process will begin with first quarter data for FY2026. OLR) Accepted 08/12/2025	10/15/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-620. C. (2) - The quality improvement plan shall: 2. Define measurable goals and objectives;	N	Dune Street This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while most of the goals and objectives were measurable, not all the goals and objectives were measurable.	PR) 07/31/2025 The Quality Improvement Plan was reviewed to determine which goals and objectives were not measurable. The Quality Improvement Plan will be revised to include measurable goals and objectives. Moving forward the Quality Improvement Plan will be added as a quarterly agenda item for the Compliance Committee for monitoring. OLR) Accepted 08/12/2025	8/15/2025
12VAC35-105-620. C. (4) - The quality improvement plan shall: 4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170;	N	Dune Street This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that while the documentation submitted demonstrated that the agency was monitoring the implementation of corrective actions plans, the documentation submitted did not demonstrate that the agency was monitoring the effectiveness of the corrective action plan following its implementation.	PR) 07/31/2025 The Compliance Team reviewed the current process regarding implementation and monitoring effectiveness of approved CAPs. The Compliance Team will revise the current process to include revision of data collection for CAPs. The current spreadsheet will be revised to include monitoring of effectiveness at planned completion date, at 3 months and 6 month follow-up. The Compliance Team will monitor the implementation and effectiveness of CAPs during the projected follow-ups. If it is determined that the corrective action plan implemented did not prevent recurrence of the regulator violation or correct any systemic deficiencies a revised corrective action plan will be developed and sent for approval. OLR) Accepted 08/12/2025	9/1/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **05-21-2025**
Program Type/Facility Name: **08-011 Dune Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-620. C. (5) - The quality improvement plan shall: 5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.	NS	Dune Street This regulation was NOT MET as evidenced by: Review of the quality improvement plan revealed that the provider failed to show evidence of ongoing monitoring and evaluation of progress toward meeting their established goals and objectives. This citation is considered non-compliant systemic due to being previously cited in January 2024.	PR) 07/31/2025 The Quality Improvement Plan was reviewed to determine which documents submitted for review did not show ongoing monitoring of goals. Moving forward the Quality Improvement Plan will be added as a quarterly agenda item for the Compliance Committee. The Committee will monitor and evaluate progress towards established goals and objectives. Information regarding progress will be captured in meeting minutes. OLR) Accepted 08/12/2025	9/1/2025

General Comments / Recommendations:
Licensing specialist recommended to the provider on-site to clean the door and closet to their HVAC unit.

The licensing specialist recommends the provider review 12VAC35-105-620 as well as the Guidance for a Quality Improvement Program (November 2020). The specialist also recommends the provider access the resources and training related to quality improvement on the Office of Licensing webpage, under the QUALITY IMPROVEMENT-RISK MANAGEMENT RESOURCES FOR LICENSED PROVIDERS.

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.

Angela DAngelo, Licensing Specialist	(Signature of Organization Representative)	Date

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

License #: **101-07-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-30-2025**
Program Type/Facility Name: **07-006 Kenmore Ave**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-160. D. (2) - The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or	N	Kenmore Ave This regulation was NOT MET as evidenced by: CHRIS Number: 20250243 Date/Time of Discover: 07/11/2025 1:00PM Enter Date/Time: 07/12/2025 8:41PM Reporting Delay: 7:41:00 Location Name: Kenmore Ave	PR) 08/20/2025 The late reporting of this incident was related to administration error in reviewing incident reports prior to departing from shift. The Compliance Coordinator became aware of the delay in reporting on July 12, 2025. Shortly after becoming aware the report was entered into the Computerized Human Rights Information System (CHRIS) by the Compliance Specialist. The Compliance Coordinator addressed the lateness of reporting through a verbal reminder to the Compliance team on July 14, 2025. The requirement of reporting Human Rights regulation violations and Level II and Level III Serious Incidents within 24 hours of the reported incident into CHRIS was addressed. The Compliance team will undergo a refresher training on the timeliness of Serious Incident Reporting at their next staff meeting on August 4, 2025. This will help ensure staff understand the expected timelines for submitting serious incidents into the Computerized Human Rights Information System (CHRIS). The Compliance Coordinator is responsible for monitoring and providing oversight to the Compliance team to ensure the timeliness of reporting Human Rights regulation violations and the timeliness of reporting Level II and Level III Serious Incidents into the CHRIS system. Systematically, the Compliance Coordinator and the Compliance team will monitor for serious incidents and timeliness of reporting on a daily	8/4/2025

License #: **101-07-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-30-2025**
Program Type/Facility Name: **07-006 Kenmore Ave**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
circumstances of the death and any treatment received. For all other Level II and Level III serious incidents, the reported information shall also include the consequences that resulted from the serious incident. Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.			basis for all programs to ensure any Human Rights regulation violations and Level II and Level III incidents are entered in a timely fashion into the CHRIS system. OLR) Accepted 08/21/2025	

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.

Lakesha Steele, Incident Management Unit	(Signature of Organization Representative)	Date

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

License #: **101-18-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-17-2025**
Program Type/Facility Name: **18-002 ACT South**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-160. D. (2) - The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or	N	ACT South This regulation was NOT MET as evidenced by: CHRIS Number: 20250226 Date/Time of Discover: 06/30/2025 3:30PM Enter Date/Time: 07/02/2025 9:32AM Reporting Delay: 18:2:00 Location Name: ACT South	PR) 07/30/2025 Individual was in crisis and an Emergency Custody Order was obtained. The Incident Report was turned in late, the following day. This error will be corrected in the future by completing required documentation at end of business or the during daily morning meeting the following day. This will ensure that an IR is not late again. Required documentation that is unable to be completed the same day will be done at the daily morning team meeting in order to prevent the Incident Report from being late. The ACT Coordinator, will monitor the procedure to ensure compliance with the regulation. This will occur for every incident report. Procedures and expectations will be reviewed with all staff for both ACT North and ACT South. OLR) Accepted 08/14/2025	7/31/2025

License #: **101-18-002**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-17-2025**
Program Type/Facility Name: **18-002 ACT South**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
circumstances of the death and any treatment received. For all other Level II and Level III serious incidents, the reported information shall also include the consequences that resulted from the serious incident. Deaths that occur in a hospital as a result of illness or injury occurring when the individual was in a licensed service shall be reported.				

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.

Lakesha Steele, Incident Management Unit	(Signature of Organization Representative)	Date

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

Communications Update

RACSB disseminated one media release in August.

RACSB was mentioned in:

- Fredericksburg Free Press: RACSB Purchases Spotsylvania Building to Serve as Crisis Receiving Center
- Fredericksburg Free Press: Biz Beat Roundup, Aug. 27
- Fredericksburg Free Press: 'One Pill Can Kill' forum focuses on dangers of fentanyl, power of Narcan
- Fredericksburg Advance, Mental Health Services Get $5.5 Million Boost, Aug. 22
- The Free Lance-Star, New Center Would Help Those With Psychiatric Crises 24/7 Aug. 26
- The Free Lance-Star, Riverside Addresses Mental Health with Show, Speaker Series July 3
- Potomac Local News: One Pill Can Kill: Miyares, Durant, and Survivors Lead Fentanyl Awareness Talk in Spotsy, Aug. 20
- Fredericksburg Parent and Family Magazine, Easing the Back-to-School Transition: Mental Health, August edition
- Fredericksburg City media release about the street outreach coordinator, Aug. 11

RACSB was present at these community events:

- July 10, "Next to Normal," Riverside Dinner Theater
- July 12, Praise in the Park
- July 26, Caroline's Promise Back-to-School event

- Aug. 5, National Night Out
- Aug. 16, King George Community Health Expo
- Aug. 19, One Pill Can Kill
- Aug. 19, The Table produce distribution
- Sept. 2, Fredericksburg Veterans Roundtable Discussion (Clinical Services Director Jacque Kobuchi was on the panel)

Additional communications information:

In August, RACSB had 93 social media posts and one blog post. The communications coordinator worked on details for the employee and family picnic, which will be held Sept. 18. One issue of Inside RACSB was published, and one community e-newsletter was disseminated. The internal communications and employee engagement committee met once. The communications coordinator oversaw two spirit days. There were two news posts on Spark and nine posts on Engage. One merch-making event was held.

The communications coordinator also resurrected the CSB Communicators group, which had not met in six months. RACSB is now coordinating this group, which meets quarterly and has other discussions as needed.

MEDIA RELEASE

Rappahannock Area Community Services Board
600 Jackson Street, Fredericksburg, VA 22401
540-373-3223 Fax: 540-371-3753
www.rappahannockareacsb.org

FOR IMMEDIATE RELEASE
Aug. 22, 2025, Fredericksburg, VA
For more information, contact: Amy Umble, Communications Coordinator
540-940-2314 or aumble@rappahannockareacsb.org

Community Services Board Acquires New Building to Expand Crisis Care

Fredericksburg, Virginia –Rappahannock Area Community Services Board (RACSB) today announced a step forward in enhancing behavioral healthcare services for the greater Fredericksburg community with the purchase of a Spotsylvania County facility to develop a Crisis Receiving Center (CRC).

The 79,420-square-foot building previously belonged to Rappahannock Goodwill Industries and will undergo renovations to transform it into a 24-hour crisis center that will provide a safe, calming space for individuals experiencing psychiatric emergencies for assessment and stabilization.

“The ultimate goal is to avoid hospitalizations when possible and to allow people in crisis to receive care in our community,” Executive Director Joe Wickens said. “Unfortunately, folks are having to be hospitalized or sent out of our area, and it’s avoidable.”

The newly acquired building at 4701 Market Street is strategically located near the newly opened Veterans Affairs outpatient center and a standalone emergency department operated by Mary Washington Healthcare and between two major hospitals.

Wickens estimates that renovations for the CRC will cost about $6.5 million and will be complete in time for services to start in spring 2027. The space provides room for RACSB to provide its current crisis services—assessment, immediate crisis intervention, and residential stabilization—while also expanding to offer 23-hour observation and children’s crisis services.

"We sought this property because we recognized the need for a 24-hour walk-in behavioral healthcare clinic for people experiencing behavioral health crises, which doesn't exist in our community," Wickens said. "Buying this building represents RACSB's long history of stepping in to fill gaps in our community."

That need aligned with the goals of Virginia's Right Help, Right Now initiative, which distributed money throughout the state to expand emergency services for behavioral health. The state awarded RACSB $12 million for this project along with additional money for ongoing operational expenses.

"We didn't merely purchase a building," Wickens said. "This space will become a lifeline for individuals and families in our community and will provide a glimmer of hope in situations where that can be hard to find."

Founded in 1970, RACSB provides public behavioral health and developmental disability services to residents of the City of Fredericksburg and the counties of Caroline, King George, Spotsylvania and Stafford. To learn more, visit www.rappahannockareacsb.org.

# # #

Social Media Performance Overview

August 2025

• Summary Metrics

Total Followers:	458	Impressions:	3,851
Posts:	37	Reactions:	122

• Top-Performing Content: Instagram

Engagement:	22.22%
Likes:	9
Views:	100

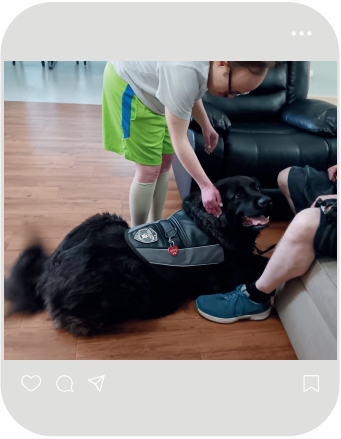
Analysis

HopeStarter of the Quarter is always a popular post; content praising staff is a sure hit. Wednesday afternoon.

Engagement:	18.42%
Likes:	13
Views:	199

Analysis

Carousel post, introduces some news--the MRU, has photos of staff, and photos of county government staff. Tuesday evening.



Engagement:	13.63%
Likes:	6
Views:	96

Analysis

Carousel, photos of individual served and a dog. Monday afternoon.

Social Media Performance Overview

August 2025

Summary Metrics

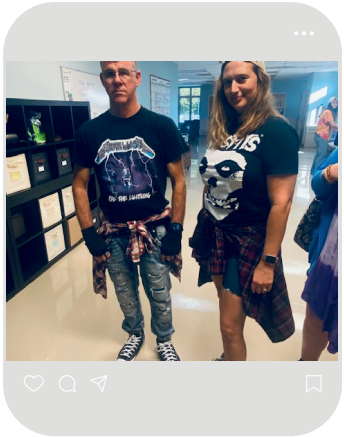
Total Followers:	3,117	Impressions:	68,071
Posts:	45	Reactions:	1,048

Top-Performing Content: Facebook

Engagement:	44.89%
Likes:	31
Views:	1,529

Analysis

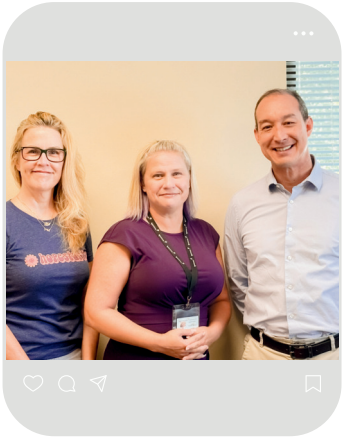
Fun topic, staff photos, tagged law firm. Emojis. Wednesday afternoon.



Engagement:	32.32%
Likes:	19
Views:	1,026

Analysis

Spirit days photos always do well, several staff photos, fun topic. Emojis. Eight hashtags. Tuesday afternoon.



Engagement:	29.13%
Likes:	35
Views:	3,632

Analysis

Staff photos, important topic. Emojis, four hashtags, links for information with clear call to action. Friday evening.

Social Media Performance Overview

August 2025

- **Summary Metrics**

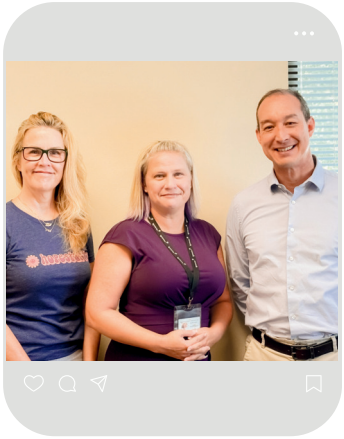
Total Followers:	725	Impressions:	812,1472
Posts:	20	Reactions:	96

- **Top-Performing Content: LinkedIn**

Engagement:	52.21%
Likes:	6
Impressions:	136

Analysis

Photos of staff, fun topic. Use of emojis. Wednesday afternoon.



Engagement:	49.62%
Likes:	5
Impressions:	135

Analysis

Photos of staff, important topic, links to information about naloxone with a call to action to spread the word. Friday evening.

Engagement:	27.08%
Likes:	8
Impressions:	192

Analysis

Photos of staff and government officials. Emojis. Three hashtags. Tuesday evening.

Special Mention

Facebook

Engagement: 18.28%

Likes: 1,937

Views: 81,776

Analysis

This post about our purchase of the Market Street building had a lower engagement rate than the top posts, but that is because it had so many views. This post was shared 240 times and received 41 comments. And it had 718 clicks on the link to our media release.
Of the people who viewed this post, 11% were followers of the RACSB Facebook page. We increased our followers by 55 in one day.

LinkedIn

Engagement: 13.25%

Likes: 24

Impressions: 536

Analysis

This post about our purchase of the Market Street building had a lower engagement rate than the top posts, but that is because it had so many views. This post was shared three times and received three comments. We gained two LinkedIn followers in one day.

Prevention and Early Intervention Services Program Updates

Michelle Wagaman, Director **September 2025**
mwagaman@rappahannockareacsb.org
540-374-3337, ext. 7520

Top 5 for September:

1. Another successful ACE Interface train-the-presenter was held August 27-29, 2025 with 19 new certified presenters.
2. Healthy Families Rappahannock Area is gearing up for a graduation carnival being hosted by Jubilation 55+ community on September 13, 2025.
3. Stafford County Board of Supervisors recognized RACSB with a proclamation for efforts to address the opioid epidemic.
4. RACSB trained a record 335 in REVIVE in August! This was attributed to National Night Out, requests by organizations, and events organized in recognition of International Overdose Awareness Day on August 31st.

Parent Education – Infant Development Program

There are currently 515 children enrolled in the program receiving a combination of services to include service coordination, speech therapy, physical therapy, occupational therapy and educational developmental services. We are scheduling 16 consistent assessments per week. We had 66 referrals in August (an increase from 57 in July). There are currently 15 providers on staff. PE-ID has no open positions at this time.

Part C and Infant/Child Case Management

Alison Standring, Part C System Manager, represented RACSB and/or the Council Coordinators Association (CoCoA) as co-chairperson in the following groups and/or meetings since the last report: VACSB CCC+ Statewide Steering committee meeting August 18th; VACSB Developmental Services Council meeting August 18th; Rappahannock Area Interagency Coordinating Council meeting August 21st; House Bill 1760 Workgroup on Early Childhood Mental Health August 25th; VACSB Public Policy committee meeting August 27th; Northern Virginia Regional Local System Managers meeting September 2nd; CoCoA Steering (co-chair) September 4th; and Health Department September 4th to review Interagency Agreement/

Substance Abuse Prevention

RACSB Prevention Services continues substance abuse prevention efforts specifically targeting youth. In response to the opioid epidemic and legalization of adult-use cannabis, our target demographics includes adults.

Youth Education/Evidence Based Curriculums – Jennifer Bateman, Prevention Specialist, continues this round of facilitation of the Second Step social emotional learning curriculum with St. Paul's and 4Seasons day care/preschool centers in King George County. Year 3 facilitation of the Second Step Bully Prevention curriculum for the elementary grade levels 3-5 within Caroline County Public Schools is underway. Facilitation at Bowling Green Elementary began September 3, 2025.

Coalitions – The Community Collaborative for Youth and Families next meeting is scheduled for October 10. To learn more: https://www.thecommunitycollaborative.org/

Tobacco Control – The Prevention Services Team is actively working to complete the new cycle of the merchant education by June 30, 2026. We will be visiting nearly 300 tobacco and vape merchants to provide education and complete store audits.

Alcohol and Vaping Prevention Education – Jennifer Bateman, Prevention Specialist, continues scheduling for the new academic year with increased outreach to middle schools.

Suicide Prevention Initiatives

RACSB Prevention Services takes an active role in suicide prevention initiatives including:

ASIST (Applied Suicide Intervention Skills Training) – This Living Works curriculum is a 2-day interactive workshop in suicide first aid. Participants learn how to recognize when someone may have thoughts of suicide and to work with the individual to create a plan that will support their immediate safety. LivingWorks has updated their trainer portal and facilitation guidance.

We have one additional training scheduled for 2025 on October 23-24. It is currently at capacity with 30 registered.

To register for the wait list: https://www.signupgenius.com/go/RACSB-ASIST-Training2025

Mental Health First Aid – This 8-hour course teaches adults how to identify, understand, and respond to signs of mental health and substance use disorders. The training introduces common mental health challenges and gives participants the skills to reach out and provide initial support to someone who may be developing a mental health or substance use problem and connect them to the appropriate care.

Adult Mental Health First Aid trainings will be held on the remaining dates in 2025: September 4; and December 9 (from 8:30 a.m. to 5:00 p.m.). Most of the registrations for the September

training are individuals affiliated with Shiloh Baptist New Site Church. We added a training on September 24 for the Central Virginia Housing Authority.

Mental Health First Aid in Spanish training is scheduled for November 13. The August training was cancelled due to low registrations and late cancellations.

Youth Mental Health First Aid training is scheduled for the remaining dates in 2025: October 7; and December 2 (from 8:30 a.m. to 5:00 p.m.). We added a training on September 22 for Spotsylvania County Public School nurses.

To register for Adult Mental Health First Aid Training:
https://www.signupgenius.com/go/RACSB-MHFA-Training2025

To register for Adult Mental Health First Aid in Spanish Training:
https://www.signupgenius.com/go/RACSB-MHFA-Spanish2025

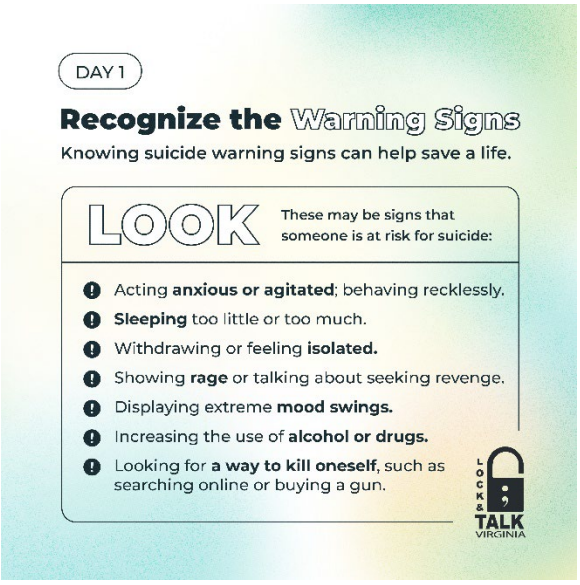
To register for Youth Mental Health First Aid Training:
https://www.signupgenius.com/go/RACSB-YouthMHFA-Training2025

safeTALK – This 3-hour suicide alertness training encourages participants to learn how to prevent suicide by recognizing signs, engaging the individual, and connecting them to community resources for additional support.

safeTALK is scheduled for these remaining dates in 2025: September 23 (9:00 a.m. to noon); and November 17 (1:00 p.m. to 4:00 p.m.). As of the time of this report, we have enough registered to host the September course.

To register: https://www.signupgenius.com/go/RACSB-safeTALK2025

Lock and Talk Virginia – The new awareness campaign for September as Suicide Prevention Month is receiving great feedback. Building upon the May campaign, it's titled "Tools for Tomorrow" with daily tips and tools (call to action) in the lead up World Suicide Prevention Day on September 10, 2025.



DAY 1

Recognize the Warning Signs

Knowing suicide warning signs can help save a life.

LISTEN Because individuals considering suicide may talk about:

- Feeling **trapped** or in unbearable pain.
- Being a **burden** to others.
- Feeling **hopeless** or having no reason to live.
- Wanting **to die** or to kill oneself.

lockandtalk.org/tools

LOCK & TALK VIRGINIA

DAY 2

Ask Direct Questions

ASK THE QUESTION	*"Are you thinking about suicide?"*

- Asking directly shows you **care.**
- It **won't put the idea** in their head.
- It could **save** their life.

Call or text **988** for support.

LOCK & TALK VIRGINIA

lockandtalk.org/tools

DAY 3

Secure Firearms & Medications

Securing firearms and medications is a simple yet powerful way to protect your loved ones and prevent suicide.

For Firearms:

- Use a **lock box**, gun safe, or cable lock.
- Store firearms **unloaded** and separate from ammunition.
- **Keep keys** or combinations in a secure, inaccessible location.

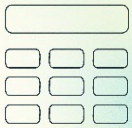
LOCK & TALK VIRGINIA

DAY 3

Secure Firearms & Medications

For Medications:

- Store in a **safe place**. Use a lockable medication box or cabinet.
- **Dispose** of unused or expired medications safely (check for local take-back programs).
- Keep all medications **out of reach of children** and others at risk.
- Only use what's **prescribed** to you.



LOCK & TALK VIRGINIA

lockandtalk.org/tools

DAY 4

Know the Resources

Local Resources:

Many communities have **local crisis lines** and mental health agencies that provide immediate support and ongoing care.

Contact your local **Community Services Board (CSB)** for more information. Ask to speak to a **CIT (Crisis Intervention Team) Officer.**

National Resources:

- 988 Suicide & Crisis Lifeline: Call or text **988**, or visit **988lifeline.org**.
  - Veterans Crisis Line: Call **988**, press 1.
- For immediate emergencies, call **911**.

LOCK & TALK VIRGINIA

lockandtalk.org/tools

DAY 5

Build Social Connection

5 Ways to Build Social Connection

1. **Reach Out to Loved Ones:** Call, text, or check in regularly with friends and family.
2. **Join a Group or Club:** Participate in hobbies, sports, or volunteer activities to meet new people.
3. **Spend Quality Time Together:** Plan a coffee date, meal, or walk with someone you care about.
4. **Reconnect with Old Friends:** Reach out to someone you haven't spoken to in a while.
5. **Be Present in Your Community:** Attend local events or introduce yourself to neighbors.

LOCK & TALK VIRGINIA

lockandtalk.org/tools

DAY 6

Avoid Substance Use

Tips for Avoiding Substance Use

1. **Identify Triggers:** Recognize and plan for situations or emotions that lead to substance use.
2. **Find Healthy Coping Strategies:** Replace substances with activities like exercise, journaling, or mindfulness.
3. **Build a Support System:** Lean on friends, family, or groups who encourage healthy habits.
4. **Remove Temptations:** Keep substances out of your home and create a supportive environment.
5. **Seek Professional Help:** Reach out to a counselor, therapist, or support group for guidance.

LOCK & TALK VIRGINIA

DAY 6

Avoid Substance Use

Where to Find Support

- **988 Suicide & Crisis Lifeline:** Call or text 988 for free, confidential support 24/7.
- **SAMHSA's National Helpline:** Call 1-800-662-HELP (4357) for substance use treatment and mental health resources.
- **Local Support Groups:** Look for Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other peer support groups in your area.
- **Community Resources:** Contact your local Community Services Board (CSB).

lockandtalk.org/tools

LOCK & TALK VIRGINIA

DAY 7

Practice Healthy Habits

Your mental health matters, and small healthy habits can make a big difference.

- Prioritize sleep
- Nourish your body with balanced meals
- Move your body daily
- Take time to breathe and reflect

lockandtalk.org/tools

LOCK & TALK VIRGINIA

DAY 8

Take Digital Breaks

Social media and screen fatigue can increase stress and anxiety.

Set boundaries with technology and take time offline.

lockandtalk.org/tools

LOCK & TALK VIRGINIA

DAY 9

Have Conversations Early

Try these conversation starters:

"How have you been feeling lately?"

"I'm here to listen if you need to talk."

"What can I do to support you?"

lockandtalk.org/tools

LOCK & TALK VIRGINIA

DAY 10

Make a Safety Plan

A personalized, written safety plan helps navigate tough moments by outlining steps to stay safe and access support.

Example Safety Plan Outline

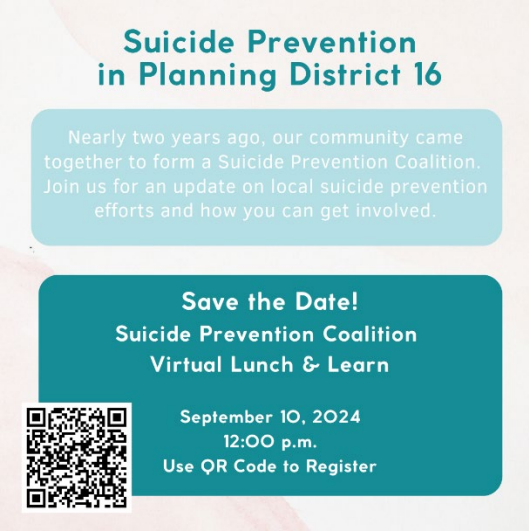
1. Warning Signs
2. Coping Strategies
3. Trusted People to Contact
4. Professional Resources
5. Steps to Create a Safe Environment
6. Reasons to Keep Going

LOCK & TALK VIRGINIA

lockandtalk.org/tools

Suicide Prevention Coalition – The subgroups formed to address focus areas of teens/young adults; older adults; and first responders/veterans continue to meet and develop goals. The next coalition meeting will be held October 27, 2025 at 1:00 p.m. at River Club. A virtual lunch and learn is scheduled for September 10 at noon. Another virtual lunch and learn is scheduled for September 23 with the focus on safety planning.

The Youth and Young Adult Workgroup collaborated with Mental Health America of Fredericksburg to host a Teen Mental Health Summit on September 6 at Germanna Community College. There were nearly 50 students registered.



State Opioid Response (SOR)

RACSB Prevention Services is actively engaged with community partners to address the opioid response in the areas of prevention, harm reduction, treatment, and recovery.

Coalitions – The Opioid Workgroup meets monthly and is an interdisciplinary professional group. Meetings continued to be scheduled and held with local medical providers as we work to increase knowledge and understanding of prevention and harm reduction strategies.

We hosted a Hidden in Plain Sight on August 27, 2025 at the mall substation from noon to 1:00 p.m. Following the tour of a mock adolescent bedroom, attendees heard from a local panel.

To learn more about the Save 1 Life harm reduction initiative: https://www.save1lifefxbg.org/

REVIVE! Naloxone Training and Dispensing – RACSB continues to host virtual trainings twice a month. Additionally, we schedule and host trainings upon the request of community partners. We continue to experience an increase in training/dispensing requests from community organizations.

Virtual training dates for 2025: https://www.signupgenius.com/go/5080F48A5A629A5FF2-54093052-opioid

RACSB is collaborating with Rappahannock Area Health District to support local school divisions implement the new requirement that high school students receive overdose awareness training prior to graduation.

RACSB provided REVIVE training at a fentanyl awareness event hosted by the Office of the Attorney General on August 19, at Salem Fields Community Church. This is part of the "**One Pill Can Kill**" awareness campaign.

Additional Initiatives

Responsible Gaming and Gambling – Michelle Wagaman is serving on a DBHDS committee that has created a statewide awareness campaign titled "Beyond the Bet." The campaign includes social media graphics (provided); brochure; bus ads; billboards; and flyers. A school curriculum is also now available.

RACSB is a member of the Virginia Council on Problem Gambling. To learn about this organization, please visit www.vcpg.net.

ACEs Interface – RACSB Prevention Services offers in-person trainings for community members to learn more about the impact of adversity in childhood on brain development and how toxic stress can impact individual and community health.

The Understanding ACEs training will be held on the remaining dates in 2025: September 9 (9:00 a.m. to noon); and October 28 (9:00 a.m. to noon). To register: https://www.signupgenius.com/go/RACSB-ACEs-Training2025

Our train-the-trainer was held August 27-28-29, 2025. Keith Cartwright from DBHDS co-trained with RACSB Master Trainers Amy Jindra and Michelle Wagaman. A total of 19 new presenters are now certified. We had representatives from Alleghany-Highlands CSB, Arlington CSB, Blue Ridge Behavioral Health, Colonial Behavioral Health, Norfolk CSB, Northwestern CSB, Portsmouth CSB, DBHDS, Virginia Department of Aging and Rehabilitative Services, and Spotsylvania County Public Schools. Additionally, a couple who reside in Dubai spent part of their state-side visit to complete the training and help take ACE Interface international.

RACSB Prevention is part of the Trauma Informed Care Workgroup under the Criminal Justice Reform Alliance. A second book club is being planned for October. And planning is underway to hosts quarterly virtual lunch and learns in 2026.

Community Resilience Initiative –Course 1 Trauma Informed and Course 2 Trauma Supportive are each 6- hour courses that cover brain science, the individual experiences and ways to build individual and community resilience. (Course 1 is a pre-requisite for Course 2). The training is held from 9:00 a.m. to 4:00 p.m.

In 2025, have one remaining Course 1 scheduled for September 25 and one remaining Course 2 on December 4 (nearing registration capacity).

To register: https://www.signupgenius.com/go/RACSB-CRI-Training2025

Activate Your Wellness – DBHDS initiative that is primarily a social norms campaign with social media, print materials, and short videos. RACSB continues utilizing this content for "Wellness Wednesday" posts.

Rappahannock Area Kids on the Block

Rappahannock Area Kids on the Block (RAKOB) will be performing at the Healthy Families Rappahannock Area graduation celebration on September 13 and the disAbility Resource Center's annual fall festival on September 20.

Healthy Families Rappahannock Area

HFRA helps parents **IDENTIFY** the best version of themselves, **PARTNERS** with parents with success in parenting, and **EMPOWERS** parents to raise healthy children.

August 2025

LOCALITY	NUMBER OF REFERRALS	ASSESSMENTS	NUMBER OF FAMILIES RECEIVING HOME VISITS	NEW ENROLLEES YEAR-TO-DATE
CAROLINE COUNTY	1	1	8	1
CITY OF FREDERICKSBURG	6	2	38	4
KING GEORGE COUNTY	0	3	6	0
SPOTSYLVANIA COUNTY	8	7	51	1
STAFFORD COUNTY	4	5	48	5
OUT OF AREA (REFERRED TO OTHER HF SITES)	0	0	0	0
TOTAL	**19**	**18**	**151**	**11**

- Started the Monthly Giving Circle with the goal to raise at least $625 in reoccurring monthly donations. This will cover annual national dues. We currently have $147 pledged monthly. https://www.zeffy.com/donation-form/together-we-grow-2
- Hosting the Tiny Caps and Gold Hats Celebration Carnival with Jubilation 55+ community on September 13th
- Started the Krispy Kreme Fundraising Campaign Starting September 5th – October 31st. For every $15 order, HFRA will receive 50%. Goal is $2,000 minimum. https://www.groupraise.com/oc/62873?utm_campaign=ocmp_copy_url&utm_medium=social&utm_source=offers_promo
- Program Coordinator, Melodie Jennings, participated in her first Healthy Families America Site Peer Review in Crystal River, Florida.
- Del. Josh Cole shadowed a home visit and Del. Phillip Scott is planning to do so in September.

September 2025

Healthy Families Rappahannock Area Newsletter

Families are the foundation of every community, yet too often their struggles go unheard. Parents balancing the demands of work, childcare, and household responsibilities face challenges that can feel overwhelming—especially in the earliest years of a child's life. When stress, isolation, or limited resources enter the picture, families may feel invisible in the very communities they call home. Being a voice for families means ensuring their needs, concerns, and triumphs are not only acknowledged but amplified where it matters most.

Advocacy for families extends beyond offering support; it is about representing their realities in policy discussions, community planning, and local decision-making. It means lifting up the voices of parents who may not have the time, platform, or confidence to speak for themselves, and ensuring their perspectives are part of the conversations that shape schools, healthcare, childcare access, and neighborhood safety. When families are heard, communities can create solutions that reflect real-life needs rather than assumptions.

Organizations like **Healthy Families Rappahannock Area** serve as this bridge, walking alongside parents while also speaking up on their behalf. Through home visiting services, staff hear firsthand the joys and challenges parents face—and carry those stories forward to inform community partners, funders, and leaders. This advocacy not only strengthens individual families but also fosters a culture of empathy, equity, and shared responsibility for raising the next generation.

Ultimately, being a voice for families is about ensuring no parent feels alone, and no child grows up in silence. It is about transforming private struggles into public understanding, and building a community where every family feels supported, seen, and valued. When we amplify the voices of families, we don't just strengthen households—we strengthen the entire community.

Village Shoutouts

This month's shout outs belong to

- **Project Linus**
- **From the Heart**
- **Community Threads**
- **Delegate Joshua Cole**
- **Project Belong VA**

Be A Part of the Village

Scan to Donate

www.healthyfamiliesrappahannock.org

Community Shoutout

September 2025

hopestarter | RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

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

Healthy Families Rappahannock Area (HFRA) is proud to recognize the **Rappahannock Area Community Services Board** (RACSB) for their longstanding partnership and support of families throughout the region.

For more than 25 years, RACSB has served as the fiscal agent for Healthy Families Rappahannock Area, providing critical oversight and infrastructure that allows the program to operate with efficiency, transparency, and sustainability.

RACSB's commitment has not only strengthened the Healthy Families program, but has also supported the broader community by ensuring families have access to the tools and resources they need to thrive. This partnership has enabled thousands of local parents and children to receive trusted home visiting services, guidance, and connection to community supports during the most important years of child development.

HFRA and the RACSB share a vision of a healthier, more resilient community where families are supported, children are nurtured, and every household has the opportunity to thrive.

Stronger families = Stronger Communities!!

Scan to Donate

www.healthyfamiliesrappahannock.org

hopestarter | RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

What's Happening This Month

September 2025

EMPOWER PARTNER IDENTIFY
Healthy Families Rappahannock Area

Saturday September 13, 2025

Tiny Caps and Gold Hats Graduation Carnival

11 a.m. - 1 p.m. Jubilation 55+ Pavilion

VOLUNTEERS NEEDED

Email Mel today if you can help...

mjennings@rappahannockareacsb.org

Costume Cuties Playgroup

October 8, 2025

Morning Session
10 am - 11 am
Howell Branch Library

Afternoon Session
1pm - 2 pm
Salem Church Branch

Playgroups are Open

Contact Laurie: lstrother@rappahannockareacsb.org

if you are interested in supporting

Krispy Kreme Fundraising Campaign

Sept 5, 2025 thru Oct 31, 2025

Every $15 dozen purchased HFRA receives 50% of the sales

https://www.groupraise.com/oc/62873?utm_campaign=ocmp_copy_url&utm_medium=social&utm_source=offers_promo

CONTACT US

hfra@rappahannocareacsb.org

540-374-3366

www.healthyfamiliesrappahannock.org

hopestarter | RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Scan to Donate

Light Up the Night with Purple

September 30, 2025
6:00 p.m.

Spotsylvania County Public Safety Building
9119 Dean Ridings Lane
Spotsylvania, VA. 22553

Mental health and substance information tables, speakers, Rappahannock Area Community Services Board's New Mobile Recovery Unit, free Narcan/naloxone with rapid training. Purple glowlights in support of unity and hope.

Promote Awareness, Support Recovery, and Come Together

September is Recovery Month, celebrating the progress of those in recovery, highlighting that mental health is vital to overall well-being. Prevention works, treatment is effective, and recovery is possible!

Reserve Your Free Purple GlowLight

Who should attend?

- Individuals in recovery
- friends
- family
- all community members

https://gqr.sh/R5e6

Community Partners

hopestarter | RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

Suicide Prevention Initiatives
Fiscal Year 2025 Year-end Summary

RACSB continues to facilitate suicide prevention initiatives to include trainings, safe messaging campaigns, and distribution of lethal means safety devices through Lock and Talk Virginia.

Curriculum (Year RACSB began implementing)	FY 2025		Cumulative	
	# Trainings	# Participants	# Trainings	# Participants
Mental Health First Aid (2014)	28	503	269	4,794
teenMHFA (2025)	2 schools; 22 classes	557	22	557
ASIST (2019)	3	56	15	213
safeTALK (2023)	2	20	10	152
Total:	55	1,136	316	5,716

In FY 2025, RACSB distributed:

- 232 Medication Lock Boxes
- 701 Cable Gun Locks
- 540 Trigger Gun Locks
- 2,675 Medication Deactivation Kits
- 13,400+ Wallet Resource Cards

Deaths by Suicide

The Virginia Department of Health recently released the Office of the Chief Medical Examiner 2023 Annual Report: https://www.vdh.virginia.gov/medical-examiner/annual-reports/

Death by suicide was relatively stable between 2020 and 2022 on the state level. Between 2022 and 2023, the state experienced an increase of 29 deaths by suicide. Within Planning District 16, there was an increase of seven (7) from 52 deaths in 2022 to 59 deaths in 2023. This is the first time in 2015 that we have not “yo-yoed.”

Additionally, four of the five localities within Planning District 16 continue to exceed the state rate per 100,000 population.

In Virginia, the largest number of victims continue to be male (78.6%) and white (75.7%). Those aged 55-64 years old (16.6%) now exceed those aged 25-34 years old which had been the highest rate for most of the past decade. Males die by suicide at a rate of 3.7 compared to females (this is a decrease from 4.1 the prior year). Firearms were used in 58.9% of all suicides (decrease from 60.9%).

Death by Suicide by Locality of Residence

	2020		2021		2022		2023	
	No.		No.		No.		No.	
Locality	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**	**Deaths**	**Rate**
Caroline	6	**19.4**	6	**19.4**	6	**18.8**	7	**21.4**
Fredericksburg	6	**20.3**	4	**13.6**	6	**20.9**	6	**20.7**
King George	6	**21.9**	1	3.7	6	**21.5**	8	**42**
Spotsylvania	15	10.8	15	10.8	20	**13.6**	21	**14**
Stafford	23	**15.3**	16	10.2	14	8.6	17	10.3
Planning District 16 total	*55*		*42*		*52*		*63*	*14.9*
State Total	**1147**	**13.4**	**1138**	**13.2**	**1152**	**13.3**	**1230**	**14.1**
Out of state/unknown	62		63		59		63	
Total	1209	14.1	1201	14	1211	13.9		

Mental Health First Aid Trainings

RACSB trainers are certified to facilitate the adult, youth, higher education, and public safety curriculums.

In FY 2024, two (2) staff with Healthy Families Rappahannock Area became certified to facilitate adult MHFA in Spanish. RACSB has been able to offer this training just once in FY 2025. Meeting the minimum number of registrations needed to host the training has been an ongoing challenge.

RACSB was able to host a second train-the-trainer for teenMHFA in summer 2025 (June through July). This was in partnership with Caroline County Public Schools, Fredericksburg City Schools, and the CHAMP program with Stafford County Public Schools. This will support ongoing sustainability within Caroline County Public School and expand capacity within the other two divisions.

We continue to provide the Public Safety curriculum to all recruits at the Rappahannock Regional Criminal Justice Academy. We also partner with the University of Mary Washington to train new resident life staff twice a year.

In FY 2025, 503 community members were trained (21 adult and 7 youth trainings held). This is a decrease from 609 trained in FY 2024 which was a record year for both the number of trainings held and the number of training participants. (In FY 2024, we added four (4) trainings at the request of the library. Additionally, we did not facilitate trainings for the U.S. Air Force or Wounded Warrior Regiment at Quantico as we have in prior years. They have been able to bring the training inhouse.)

Since RACSB began offering the Mental Health First Aid training in 2014, a total of 4,794 community members have been trained in the adult and youth curriculums.

With the addition of teenMHFA in the 2024-2025 academic year, we trained 557 high school 10th grade students in FY 2025. Combined with the adults trained, we have now exceeded 5,000 with a total of 5,351 receiving a Mental Health First Aid curriculum. In FY 2026, we will be implementing in three (3) high schools.

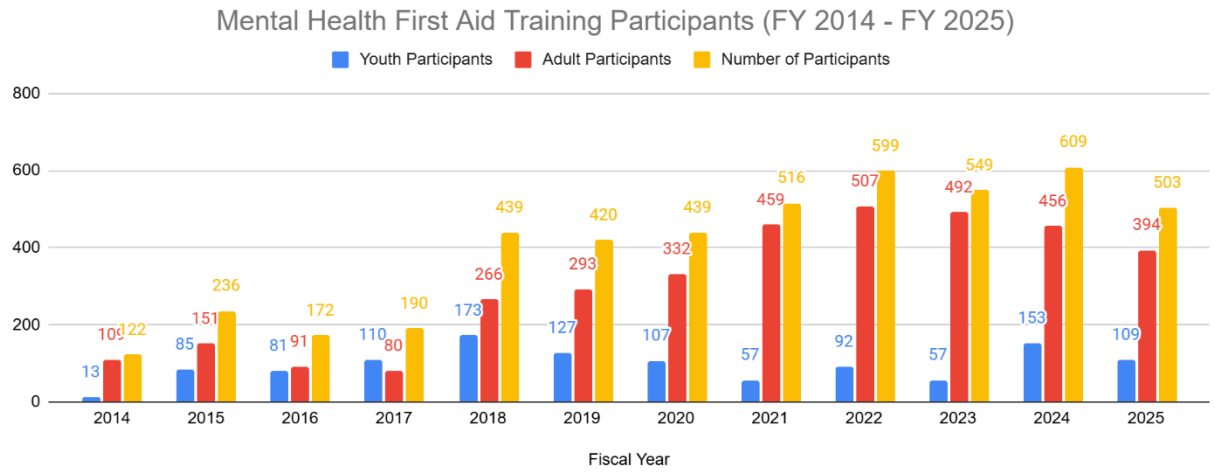
In addition to hosting numerous trainings that were open within the community, trainings were held in partnership with the following organizations:

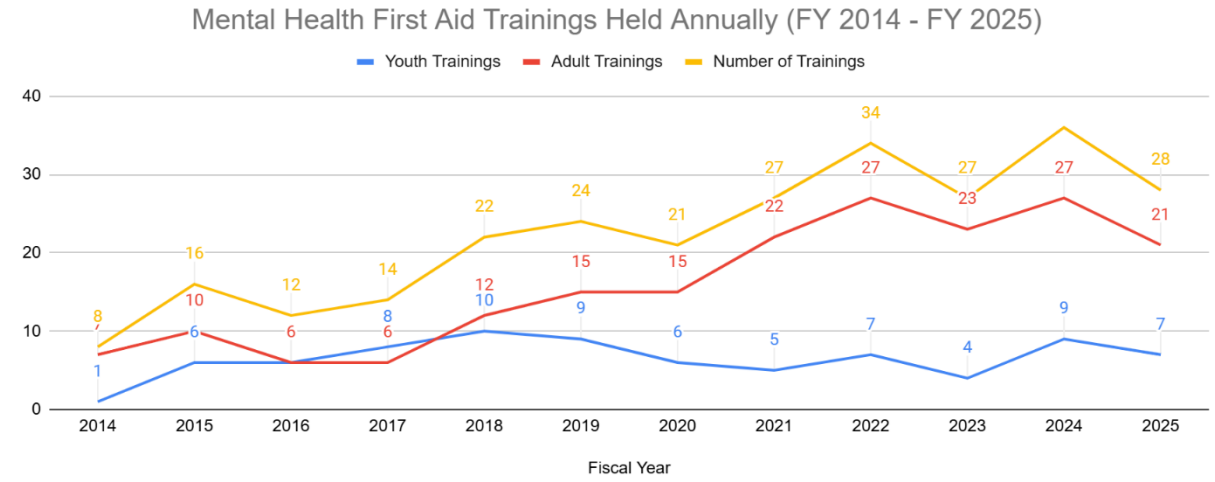
- McLane Mid-Atlantic (two trainings added)
- Rappahannock Regional Criminal Justice Academy
- University of Mary Washington
- Caroline County Public Schools
- Fredericksburg City Schools
- Stafford County Government

To learn more and/or register for Adult Mental Health First Aid:
https://www.signupgenius.com/go/RACSB-MHFA-Training2025

To learn more and/or register for Youth Mental Health First Aid:
https://www.signupgenius.com/go/RACSB-YouthMHFA2025

To learn more and/or register for Mental Health First Aid in Spanish:
https://www.signupgenius.com/go/RACSB-MHFA-Spanish2025





*teenMHFA not included

Lock and Talk Virginia

RACSB is one of the eight founding CSBs of Lock and Talk Virginia. It has since grown from Health Planning Region 1 to across the Commonwealth with all 40 CSBs participating. Seven communities in New York have formally signed on as Lock and Talk partners. One county in Maryland joined in FY 2025. It's an identified best practice by The Governor's Challenge to Prevent Suicide Among Service Members and their Families.

In addition to providing gatekeeper trainings like ASIST, safeTALK, and Mental Health First Aid, the initiatives promote help seeking behaviors and lethal means safety.

RACSB distributes medication lock boxes and gun locks through our clinics, trainings, and prevention outreach efforts.

In FY 2025, RACSB distributed:

- 232 Medication Lock Boxes
- 701 Cable Gun Locks
- 540 Trigger Gun Locks
- 2,675 Medication Deactivation Kits
- 13,400+ Wallet Resource Cards

Much of FY 2025 was spent expanding the graphics library and implementing a series of social media campaigns (adolescent mental wellness, Suicide Prevention Month, Caregiver Awareness Month, Mental Health Month). We also continued efforts to refine the data evaluation plan. The newly developed evaluation tool was piloted with three CSBs in June and will launch across the state in September.

In FY 2023, we partnered with the Central Rappahannock Regional Library to have Lock and Talk information as well as lethal means safety devices on display and available to community members at each branch. That effort continued in FY 2025.

The Gun Shop Project to provide education to firearm retailers resumed in FY 2025 with support from the Suicide Prevention Coalition.

ASIST: Applied Suicide Intervention Skills Training

This suicide prevention “first aid” is a 2-day in-person training the supports participants to identify and intervene to help keep a person with thoughts of suicide safe for now. We were successful in getting a second internal instructor certified in March 2022 and resumed offering this training in FY 2023.

In response to the Virginia ASIST evaluation survey, upon completion of the training, 100% of respondents agreed or strongly agreed that they feel confident to assist a person at risk of suicide.

Fiscal Year	# Trainings	# Participants
2019	1	8
2020	1	15
2021*	0	0
2022	1	30
2023	6	53

2024	3	51
2025	3	56
Total:	15	213

*COVID and lack of required second trainer.

To learn more and/or register:
https://www.signupgenius.com/go/RACSB-ASIST-Training2025

SafeTALK

SafeTALK is a 3-hour suicide alertness training. It helps participants recognize a person with thoughts of suicide and connect them with resources who can help them in choosing life. TALK stands for Tell, Ask, Listen, and KeepSafe. We began offering this training in FY 2023.

Three (3) scheduled trainings were cancelled in FY 2025.

Fiscal Year	# Trainings	# Participants
2023	4	71
2024	4	61
2025	2	20
Total:	10	152

To learn more and/or register:
https://www.signupgenius.com/go/RACSB-safeTALK-Training2025

Suicide Prevention Coalition

In October 2023, RACSB collaborated with the Rappahannock Area Health District and Veteran's Administration to host a webinar to gain interest in the formation of a local suicide prevention coalition. As a result, approximately 50 community members expressed interest and continue to meet regularly. The full group meets in even months and the three (3) workgroups meet in odd months. In FY 2025, we created a rack card, hosted several workshops, and completed a strategic plan with identified goals per workgroup.

Finance Department
August 2025 Program Updates

Staffing Changes and Opportunities:

There are currently three open positions in the Finance Department: Accounting Coordinator (currently posted), Accounting Specialist (not yet posted) and Financial Analyst (currently on hold/eliminated). We continue to appreciate our financial consultant, Kelly Young Marinoff, who has been working with Sara to help catch up bank reconciliations.

Reimbursement Department:

The Reimbursement team is focused on implementing new processes to automate billing, allowing for more efficient follow-up on outstanding issues. Additionally, efforts are underway to introduce procedures that help programs identify eligibility changes more quickly.

Accounting Department:

The Accounting Department has been working on updating allocations and reporting for the new fiscal year. The Year-end FY2025 financial close-out/audit preparation work is still under way and expected to continue over the next few months. The DBHDS Year-End report is also underway and will be submitted in early September. Efforts continue to catch up outstanding grant reimbursement requests through Web Grants. Investment discussions were also held with our banking partners at Atlantic Union to determine options for our investment future. These will be discussed at the September board meeting.

Summary of Cash Investments

Depository			Rate	Comments
Atlantic Union Bank				
Checking	$	5,341,148	3.25%	
Investment Portfolio				
Cash Equivalents		3,694,012		
Fixed Income		5,520,085		
Total Investment	$	9,214,097		
Total Atlantic Union Bank	$	14,555,244		
Other				
Local Gov. Investment Pool		37,030	4.41%	Avg. Monthly Yield
Total Investments	**$**	**14,592,275**		

Other Post-Employment Benefit (OPEB)

	Cost Basis	Cost Variance From Inception	Market Basis	Market Variance From Inception
Initial Contribution	$ 954,620		$ 954,620	
FY 2024 Year-End Balance	$ 2,131,014	$ 1,176,394	$ 4,489,220	$ 3,534,600
Balance at 09/30/2024	$ 2,132,565	$ 1,177,945	$ 4,358,454	$ 3,403,834
Balance at 10/31/2024	$ 2,131,983	$ 1,177,363	$ 4,270,641	$ 3,316,021
Balance at 11/30/2024	$ 2,131,983	$ 1,177,363	$ 4,403,710	$ 3,449,090
Balance at 12/31/2024	$ 2,131,983	$ 1,177,363	$ 4,334,837	$ 3,380,217
Balance at 1/31/2025	$ 2,131,455	$ 1,176,835	$ 4,392,771	$ 3,438,151
Balance at 2/28/2025	$ 2,131,455	$ 1,176,835	$ 4,374,439	$ 3,419,819
Balance at 3/31/2025	$ 2,131,455	$ 1,176,835	$ 4,272,529	$ 3,317,909
Balance at 4/30/2025	$ 2,130,913	$ 1,176,293	$ 4,264,954	$ 3,310,334
Balance at 5/31/2025	$ 2,130,913	$ 1,176,293	$ 4,391,577	$ 3,436,957
FY 2025 Year-End Balance	$ 2,130,913	$ 1,176,293	$ 4,527,191	$ 3,572,571
Realized Gain/(Loss)			$ 568	
Unrealized Gain/(Loss)			$ 25,740	
Fees & Expenses	$ (500)		$ (1,068)	
Balance at 7/31/2025	$ 2,130,413	$ 1,175,793	$ 4,552,431	$ 3,597,811

Health Insurance

FY 2026	Monthly Premiums	Monthly Claims & Fees	Interest	Balance
Beginning Balance				$3,033,340
July	$5,773	$305,482	$1,209	$2,734,840
August	$5,721	$351,112	$1,076	$2,390,525
YTD Total	**$11,494**	**$656,594**	**$2,285**	**$2,390,525**

Historical Data	Average Monthly Claims	Monthly Average Difference from PY	Highest Month
FY 2026	**$328,297**	**$31,033**	**$351,112**
FY 2025	**$297,264**	**$41,811**	**$380,808**
FY 2024	**$255,453**	**$41,076**	**$593,001**
FY 2023	**$214,376**	**($97,137)**	**$284,428**
FY 2022	**$311,513**	**($24,129)**	**$431,613**
FY 2021	**$335,642**	**$14,641**	**$588,906**

Summary of Investments

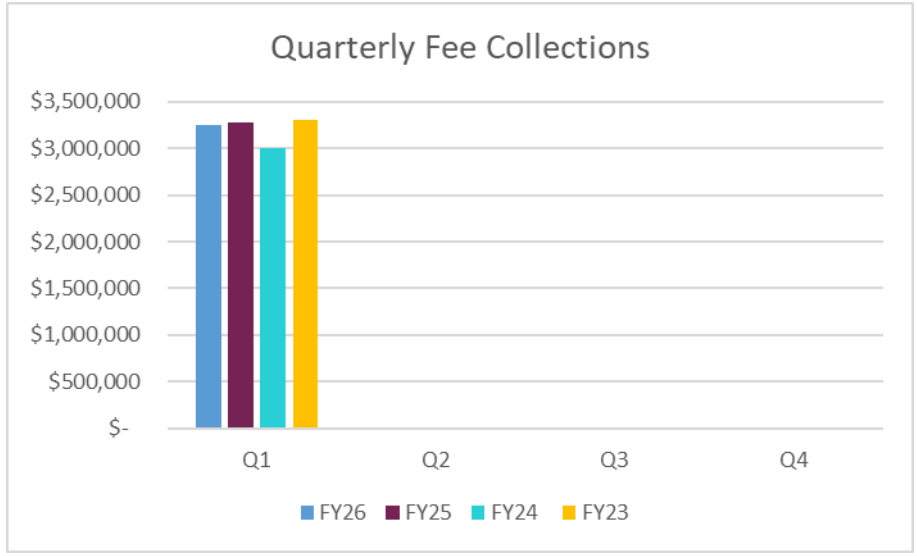
Asset Description	Shares/Face Value	Market Value	Total Cost	Unrealized Gain/Loss	Est. Income	Yield to Maturity	Yield to Cost
Fidelity IMM Gov Class I Fund #57	$70,325.27	$70,325.27	$70,325.27	$ -	$2,953.00	4.20%	4.20%
Income Cash	$19,375.00	$19,375.00	$19,375.00		$813.75	4.20%	4.20%
US Treasury Bill (11/13/2025)	$500,000.00	$489,720.48	$489,623.47	$97.01	$10,376.53	3.94%	4.24%
US Treasury Bill(11/28/2025)	$500,000.00	$491,209.72	$491,040.83	$168.89	$8,959.17	3.96%	4.26%
US Treasury Bill(12/26/2025)	$500,000.00	$486,935.00	$487,100.00	($165.00)	$12,900.00	3.97%	4.00%
US Treasury Bill (01/22/2026)	$500,000.00	$484,617.81	$484,805.21	($187.40)	$15,194.79	3.89%	3.91%
US Treasury Bill(02/19/2026)	$700,000.00	$683,005.38	$682,488.58	$516.80	$17,511.42	3.87%	4.12%
US Treasury Bill(03/19/2026)	$500,000.00	$485,851.30	$485,496.71	$354.59	$14,503.29	3.84%	4.05%
US Treasury Bill(07/09/2026)	$500,000.00	$482,971.81	$482,569.63	$402.18	$17,430.37	3.79%	3.93%
Total Cash Equivalents	**$ 3,789,700.27**	**$ 3,694,011.77**	**$ 3,692,824.70**	**$ 1,187.07**	**$ 100,642.32**		
US Treasury Note (10/15/2025)	$1,000,000.00	$999,980.00	$1,005,781.25	($5,801.25)	$42,500.00	4.26%	4.06%
US Treasury Note (09/30/2025)	$500,000.00	$500,210.00	$504,570.31	($4,360.31)	$25,000.00	4.22%	4.50%
US Treasury Note (10/15/2026)	$500,000.00	$504,405.00	$506,738.28	($2,333.28)	$23,125.00	4.26%	4.15%
US Treasury Note (06/15/2026)	$500,000.00	$500,750.00	$500,810.85	($60.85)	$20,625.00	3.94%	4.00%
US Treasury Note(01/31/2027)	$500,000.00	$502,540.00	$502,623.20	($83.20)	$20,625.00	3.76%	3.79%
US Treasury Note (03/15/2027)	$500,000.00	$503,985.00	$496,308.59	$7,676.41	$21,250.00	3.72%	4.57%
US Treasury Note (04/30/2026)	$500,000.00	$502,825.00	$499,023.44	$3,801.56	$24,375.00	4.01%	4.04%
US Treasury Note (08/15/2027)	$500,000.00	$501,075.00	$495,292.97	$5,782.03	$18,750.00	3.75%	4.15%
US Treasury Note (8/31/2026)	$500,000.00	$499,450.00	$495,195.31	$4,254.69	$18,750.00	3.64%	4.36%
US Treasury Note (02/29/2028)	$500,000.00	$504,865.00	$499,960.94	$4,904.06	$20,000.00	3.88%	4.04%
Total Fixed income	**$ 5,500,000.00**	**$ 5,520,085.00**	**$ 5,506,305.14**	**$ 13,779.86**	**$ 235,000.00**	**4.22%**	**4.19%**
8/31/2025		**$ 9,214,096.77**	**$ 9,199,129.84**	**$ 14,966.93**	**$ 335,642.32**	**3.98%**	**4.18%**

Fee Revenue Reimbursement- July 31, 2025

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD
FEE REVENUE REIMBURSEMENT REPORT AS OF July 31, 2025

AGED CLAIMS		Current Month		Prior Month		Prior Year	
Total Claims Outstanding	**Total**	100%	$5,869,626	100%	$4,585,936	100%	$7,042,960
	Consumers	31%	$1,838,452	42%	$1,926,985	50%	$3,544,464
	3rd Party	69%	$4,031,175	58%	$2,658,952	50%	$3,498,496
Claims Aged 0-29 Days	**Total**	61%	$3,588,264	51%	$2,336,271	48%	$3,381,840
	Consumers	1%	$36,194	1%	$36,084	2%	$162,235
	3rd Party	61%	$3,552,070	50%	$2,300,187	46%	$3,219,605
Claims Aged 30-59 Days	**Total**	4%	$239,460	3%	$155,740	2%	$124,085
	Consumers	0%	$9,810	1%	$41,321	1%	$42,409
	3rd Party	4%	$229,649	2%	$114,419	1%	$81,676
Claims Aged 60-89 Days	**Total**	2%	$105,858	2%	$85,771	1%	$96,910
	Consumers	0%	$25,277	1%	$46,905	0%	$792
	3rd Party	1%	$80,580	1%	$38,866	1%	$96,118
Claims Aged 90-119 Days	**Total**	1%	$52,917	2%	$105,851	2%	$105,701
	Consumers	0%	$27,789	1%	$49,594	1%	$85,244
	3rd Party	0%	$25,128	1%	$56,257	0%	$20,457
Claims Aged 120+ Days	**Total**	32%	$1,883,128	41%	$1,902,304	47%	$3,334,425
	Consumers	30%	$1,739,381	38%	$1,753,082	46%	$3,253,784
	3rd Party	2%	$143,747	3%	$149,222	1%	$80,641

CLAIM COLLECTIONS	
Current Year To Date Collections	$3,246,507
Prior Year To Date Collections	$3,283,723
$ Change from Prior Year	-$37,216
% Change from Prior Year	-1%



Write-off Report

Month: July 2025		
Write Off Code	Current YTD	Prior YTD
BAD ADDRESS	$ 3,109	$ 39,499
BANKRUPTCY	$ 2,470	$ -
DECEASED	$ 195	$ 340
NO FINANCIAL AGREEMENT	$ 26,076	$ 11,010
SMALL BALANCE	$ 259	$ 75
UNCOLLECTABLE	$ 1,469	$ 124
FINANCIAL ASSISTANCE	$ 346,915	$ 123,452
NO SHOW	$ 7,918	$ 1,650
MAX UNITS/BENEFITS	$ 56,153	$ 36,358
PROVIDER NOT CREDENTIALED	$ 610	$ 370
DIAGNOSIS NOT COVERED	$ 320	$ 480
NON-COVERED SERVICE	$ 16,793	$ 3,134
SERVICES NOT AUTHORIZED	$ 44,635	$ 44,463
PAST BILLING DEADLINE	$ 110	$ 1,040
MCO DENIED AUTH	$ 13,387	$ 6,612
INCORRECT PAYER	$ 5,459	$ 3,508
NO PRIMARY EOB	$ -	$ 285
SPENDDOWN NOT MET	$ 11,637	$ 8,376
TOTAL	**$ 537,516**	**$ 280,778**

Payroll Statistics FY2026

Pay Date	Overtime Hours	Overtime Cost	Average Cost per hour-Overtime	2P Hours	2P Cost	Average Cost per hour-2p	Total Hours	Total Costs
7/11/2025	73.5	$2,911.46	$39.61	33.5	$1,421.70	$42.44	107	$4,333.16
7/25/2025	105	$4,242.78	$40.41	62	$2,274.32	$36.68	167	$6,517.10
8/8/2025	113.25	$4,479.56	$39.55	27.5	$1,024.79	$37.27	140.75	$5,504.35
8/22/2025	105	$4,497.43	$42.83	65.75	$2,703.77	$41.12	170.75	$7,201.20
9/5/2025	100	$4,460.95	$44.61	45.5	$3,331.48	$73.22	145.5	$7,792.43
Grand Total	**496.75**	**$20,592.18**	**$41.45**	**234.25**	**$10,756.06**	**$45.92**	**731**	**$31,348.24**

RACSB
FY 2026 FINANCIAL REPORT
Fiscal Year: July 1, 2025 through June 30, 2026
Report Period: July 1, 2025 through July 31, 2025

MENTAL HEALTH

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2026	ACTUAL YTD	%	BUDGET FY 2026	ACTUAL YTD	%		
INPATIENT	0	148,850	0.00%	0	0	0.00%	148,850	100%
OUTPATIENT (FED)	3,559,688	333,228	9.36%	3,559,688	290,998	8.17%	42,230	13%
MEDICAL OUTPATIENT (R) (FED)	4,432,876	514,242	11.60%	4,432,876	336,989	7.60%	177,254	34%
ACT NORTH (R)	1,108,186	95,530	8.62%	1,108,186	91,118	8.22%	4,412	5%
ACT SOUTH (R)	1,057,760	96,783	9.15%	1,057,760	87,639	8.29%	9,144	9%
CASE MANAGEMENT ADULT (FED)	1,377,302	115,366	8.38%	1,377,302	115,021	8.35%	345	0%
CASE MANAGEMENT CHILD & ADOLESCENT (FED)	1,171,251	109,313	9.33%	1,171,251	99,026	8.45%	10,287	9%
PSY REHAB & KENMORE EMP SER (R) (FED)	861,864	65,291	7.58%	861,864	71,687	8.32%	(6,396)	-10%
PERMANENT SUPPORTIVE HOUSING (R)	4,079,960	269,145	6.60%	4,079,960	263,432	6.46%	5,712	2%
CRISIS STABILIZATION (R)	2,984,567	337,648	11.31%	2,984,567	242,868	8.14%	94,781	28%
SUPERVISED RESIDENTIAL	702,775	34,016	4.84%	702,775	59,355	8.45%	(25,339)	-74%
SUPPORTED RESIDENTIAL	1,115,708	61,831	5.54%	1,115,708	85,954	7.70%	(24,124)	-39%
JAIL DIVERSION GRANT (R)	0	0	#DIV/0!	0	0	#DIV/0!	-	0%
JAIL & DETENTION SERVICES	796,633	19,317	2.42%	796,633	61,511	7.72%	(42,194)	-218%
SUB-TOTAL	**23,248,570**	**2,200,560**	**9%**	**23,248,570**	**1,805,597**	**8%**	**394,963**	**18%**

DEVELOPMENTAL SERVICES

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2026	ACTUAL YTD	%	BUDGET FY 2026	ACTUAL YTD	%		
CASE MANAGEMENT	5,009,320	1,321,945	26.39%	5,009,320	380,344	7.59%	941,602	71%
DAY HEALTH & REHAB *	5,928,581	666,377	11.24%	5,928,581	506,269	8.54%	160,108	24%
GROUP HOMES	7,177,971	564,214	7.86%	7,177,971	579,329	8.07%	(15,114)	-3%
RESPITE GROUP HOME	742,838	14,787	1.99%	742,838	50,728	6.83%	(35,941)	-243%
INTERMEDIATE CARE FACILITIES	5,382,884	471,014	8.75%	5,382,884	349,622	6.50%	121,391	26%
SUPERVISED APARTMENTS	1,869,743	226,251	12.10%	1,869,743	155,921	8.34%	70,330	31%
SPONSORED PLACEMENTS	2,412,624	193,108	8.00%	2,412,624	317,787	13.17%	(124,679)	-65%
SUB-TOTAL	**28,523,961**	**3,457,697**	**12.12%**	**28,523,961**	**2,340,000**	**8.20%**	**1,117,697**	**32%**

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

RACSB
FY 2026 FINANCIAL REPORT
Fiscal Year: July 1, 2025 through June 30, 2026
Report Period: July 1, 2025 through July 31, 2025
SUBSTANCE ABUSE

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET FY 2026	ACTUAL YTD	%	BUDGET FY 2026	ACTUAL YTD	%	ACTUAL VARIANCE	VARIANCE / REVENUE
SA OUTPATIENT (R) (FED)	2,049,386	464,097	22.65%	2,049,386	165,955	8.10%	298,142	64%
MAT PROGRAM (R) (FED)	1,254,477	69,733	5.56%	1,254,477	98,544	7.86%	(28,811)	-41%
CASE MANAGEMENT (R) (FED)	404,098	108,386	26.82%	404,098	17,332	4.29%	91,054	84%
RESIDENTIAL (R)	36,612	3,051	8.33%	36,612	0	0.00%	3,051	100%
PREVENTION (R) (FED)	521,955	350,675	67.18%	521,955	42,964	8.23%	307,711	88%
LINK (R) (FED)	-	5,937	#DIV/0!	0	22,520	#DIV/0!	(16,583)	-279%
SUB-TOTAL	**4,266,528**	**1,001,879**	**23%**	**2,217,142**	**347,315**	**16%**	**356,423**	**36%**

SERVICES OUTSIDE PROGRAM AREA

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET FY 2026	ACTUAL YTD	%	BUDGET FY 2026	ACTUAL YTD	%	ACTUAL Variance	VARIANCE / REVENUE
EMERGENCY SERVICES (R)	2,040,456	262,897	12.88%	2,040,456	143,069	7.01%	119,828	46%
CHILD MOBILE CRISIS (R)	271,050	25,157	9.28%	271,050	12,821	4.73%	12,336	49%
CIT ASSESSMENT SITE (R)	329,029	25,586	7.78%	329,029	20,842	6.33%	4,744	19%
CONSUMER MONITORING (R) (FED)	-	19,408	#DIV/0!	0	33,277	#DIV/0!	(13,869)	-71%
ASSESSMENT AND EVALUATION (R)	514,373	50,406	9.80%	514,373	43,655	8.49%	6,751	13%
SUB-TOTAL	**3,154,908**	**383,453**	**12.15%**	**3,154,908**	**253,664**	**8.04%**	**129,789**	**34%**

ADMINISTRATION

PROGRAM	REVENUE			EXPENDITURES			
	BUDGET FY 2026	ACTUAL YTD	%	BUDGET FY 2026	ACTUAL YTD	%	ACTUAL VARIANCE
ADMINISTRATION (FED)	826,292	70,945	8.59%	826,292	70,945	8.59%	0
PROGRAM SUPPORT	27,600	2,300	8.33%	27,600	2,300	8.33%	0
SUB-TOTAL	**853,892**	**73,245**	**8.58%**	**853,892**	**73,245**	**8.58%**	**0**
ALLOCATED TO PROGRAMS				4,268,473	3,126,283	73.24%	

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

RACSB
FY 2026 FINANCIAL REPORT
Fiscal Year: July 1, 2025 through June 30, 2026
Report Period: July 1, 2025 through July 31, 2025
FISCAL AGENT AND OTHER PROGRAMS

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2026	ACTUAL YTD	%	BUDGET FY 2026	ACTUAL YTD	%		
INTERAGENCY COORDINATING COUNCIL (R)	1,896,364	155,875	8.22%	1,896,364	135,361	7.14%	20,514	13%
INFANT CASE MANAGEMENT (R)	939,818	66,974	7.13%	939,818	81,564	8.68%	(14,591)	-22%
EARLY INTERVENTION (R)	2,719,353	176,775	6.50%	2,719,353	225,990	8.31%	(49,215)	-28%
TOTAL PART C	**5,555,535**	**399,624**	**7.19%**	**5,555,535**	**442,916**	**7.97%**	**(43,292)**	**-11%**
HEALTHY FAMILIES (R)	1,246,855	3,793	0.30%	1,246,855	103,710	8.32%	(99,917)	-2634%
HEALTHY FAMILIES - MIECHV Grant (R) (REIM)	0	29,558	#DIV/0!	0	0	#DIV/0!	29,558	100%
HEALTHY FAMILIES-TANF & CBCAP GRANT (R) (REIM)	0	0	#DIV/0!	0	0	#DIV/0!	0	0%
TOTAL HEALTHY FAMILY	**1,246,855**	**33,351**	**2.67%**	**1,246,855**	**103,710**	**8.32%**	**(70,359)**	**-211%**
COMMUNITY OUTREACH	118,307	0	0.00%	118,307	838	0.71%	(838)	0%
TOTAL COMMUNITY OUTREACH	**118,307**	**0**	**0.00%**	**118,307**	**838**	**0.71%**	**(838)**	**0%**

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

RACSB
FY 2026 FINANCIAL REPORT
Fiscal Year: July 1, 2025 through June 30, 2026
Report Period: July 1, 2025 through July 31, 2025

RECAP FY 2026 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	2,200,560	1,805,597	394,963	18%
DEVELOPMENTAL SERVICES	3,457,697	2,340,000	1,117,697	32%
SUBSTANCE ABUSE	1,001,879	347,315	654,564	65%
SERVICES OUTSIDE PROGRAM AREA	383,453	253,664	129,789	34%
ADMINISTRATION	73,245	73,245	0	0%
FISCAL AGENT PROGRAMS	432,975	547,464	(114,489)	-26%
TOTAL	**7,549,810**	**5,367,285**	**2,182,525**	**29%**

RECAP FY 2025 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	4,818,837	1,845,294	2,973,543	62%
DEVELOPMENTAL SERVICES	3,260,373	2,350,398	909,975	28%
SUBSTANCE ABUSE	235,567	314,027	(78,461)	-33%
SERVICES OUTSIDE PROGRAM AREA	651,136	274,261	376,875	58%
ADMINISTRATION	20,098	20,098	0	0%
FISCAL AGENT PROGRAMS	996,771	656,198	340,572	34%
TOTAL	**9,982,781**	**5,460,277**	**4,522,504**	45%

	$ Change	% Change
Change in Revenue from Prior Year	$ (2,432,972)	-24.37%
Change in Expense from Prior Year	$ (92,991)	-1.70%
Change in Net Income from Prior Year	$ (2,339,979)	-51.74%

*Unaudited Report

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

HUMAN RESOURCES PROGRAM UPDATE- August 2025

Training & Compliance

- Facilitated in-person training to 122 staff.
- Continuing our HR file audit, we have audited 59% of our workforce.
- Continuing to build our online performance evaluation tool in Relias. We are set to start training staff in late September.
- Completed an I-9 audit.
- Successfully ran the first automated annual report from the DMV continuous monitoring system.
- Continued to participate in the DBHDS & Region 1 training matrix collaboration.

FY '25 Performance Evaluation and Merit Bonus

- We had 426/452 eligible staff members received merit bonuses in July.
- The overall agency average score was 3.72/5.0.
    - 70 - $1,500 = 4.5 – 5.0
    - 118 - $750 = 4.0- 4.49
    - 238 - $375 = 3.- 3.99

Benefits

- Held our annual post-renewal strategy meeting with USI.

Recruitment Notes

- The 5th Germanna/RACSB BHT internship class started with four interns.
- Two of our contract Psychiatrists became full-time.
- The Community Outreach Case Manager, Fredericksburg City-funded RACSB position, started.

Office of Human Resources

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

RappahannockAreaCSB.org

MEMORANDUM

To: Joe Wickens, Executive Director

From: Derrick Mestler, Human Resources Director

Date: September 5, 2025

Re: Summary – August 2025 Applicant and Recruitment Update

For August 2025, RACSB received 520 applications.

Of the applications received, 80 applicants listed the RACSB applicant portal as their recruitment source, 20 stated employee referrals as their recruitment source, and 420 listed various job boards as their recruitment source.

As of the end of August, 15 positions, 11 full-time and 4 part-time, were actively being recruited for.

A summary is attached, indicating the number of external applicants hired, internal applicants promoted, and the total number of applicants who applied for positions for August 2025.

APPLICANT DATA REPORT
RACSB FY 2026

APPLICANT DATA	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Female	212	319										
Male	37	72										
Not Supplied	75	129										
Total	324	520										
ETHNICITY												
White	85	106										
African American	118	195										
Hispanic	7	25										
Asian	5	11										
American Indian	2	2										
Native Hawaiian	3	0										
Two or More Races	92	126										
Not Supplied	12	55										
RECRUITMENT SOURCE												
RACSB Website	35	80										
Employee Referrals	12	20										
Indeed.com	232	387										
Other -	34	23										
Zip Recruiter	11	10										
Job Fair	0	0										
Total # of Applicants	324	520	0	0	0	0	0	0	0	0	0	0

RECRUITMENT REPORT FY 2026

MONTHLY RECRUITMENT	***JULY***	***AUGUST***	***SEPTEMBER***	***OCTOBER***	***NOVEMBER***	***DECEMBER***	***JANUARY***	***FEBRUARY***	***MARCH***	***APRIL***	***MAY***	***JUNE***	***TOTAL YTD***
External Applicants Hired:													
Part-time	0	1											1
Full-time	4	3											7
Sub Total External Applicants Hired	**4**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		8
Internal Applicants Moved:													
Part-time to Full-time	0	0											0
PRN As Needed to Full-Time	0	0											0
Sub Total Internal Applicant Moves	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		0
Total Positions Filled:	**4**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**		8
Total Applications Received:													
Actual Total of Applicants:	**324**	**520**											844
Total External Offers Made:	**4**	**4**											8
Total Internal Offers Made:	**0**	**0**											0

Vacancy Report 8/25/2025

8/25/2025							
Actively Recruiting to Hire							
Original Date Listed	Days Open	Job Title	RU	Division	Location (was Department)	FT	PT
12/20/2024	248	ACCOUNTING COORDINATOR (Accounting Manager in ads)	1000	Admin	Fredericksburg City Administrative - Accounting	1	
2/5/2025	201	CENTRAL ACCESS ASSOCIATE	1100	Clinical	Spotsylvania County Clinical Services	1	
8/18/2025	7	STAFFORD CHILD/ADOLESCENT CASE MANAGER	2500	Clinical	Stafford County Clinical Services - Child & Adolescent Services	1	
2/26/2025	180	PSYCHIATRIC NURSE PRACTITIONER, OBOT	4261	Clinical	Fredericksburg City Clinical Services - SA Services	1	
8/5/2025	20	ASSISTANT COORDINATOR - EMERGENCY SERVICES	2000	CIS	Fredericksburg City Clinical Services - Emergency Services	1	
7/29/2025	27	ES THERAPIST, CO-MOBILE RESPONSE	2000	CIS	Fredericksburg CSS - Emergency Services	1	
8/18/2025	7	UNLICENSED EMERGENCY SERVICES THERAPIST	4000	CIS	Fredericksburg CSS - Emergency Services	1	
8/5/2025	20	MH RESIDENTIAL SPECIALIST - CRISIS STABILIZATION	2770	CIS	Fredericksburg City CSS - MH Crisis Stabilization Program	1	
6/23/2025	63	NURSE, RN - CRISIS STABILIZATION	2770	CIS	Fredericksburg City CSS - Crisis Stabilization Program		1
6/23/2025	63	NURSE, RN - CRISIS STABILIZATION	2770	CIS	Fredericksburg City CSS - Crisis Stabilization Program	1	
8/5/2025	20	DEVELOPMENTAL SERVICES SUPPORT COORDINATOR - STAFFORD	3300	CSS	Stafford County CSS - ID/DD Support Coordination	1	
7/11/2025	45	DIRECT SUPPORT PROFESSIONAL - DAY SUPPORT	3652	CSS	Stafford County CSS - Day Health and Rehabilitiation Services		1
5/27/2025	90	DIRECT SUPPORT PROFESSIONAL - DAY SUPPORT - KINGS HWY	3652	CSS	Stafford County CSS - Day Health and Rehabilitiation Services		1
8/21/2025	4	COORDINATOR, DAY SUPPORT PROGRAM	3656	CSS	Fredericksburg City CSS - Day Health and Rehabilitation Services	1	
8/5/2025	20	ASST GROUP HOME MGR - DD RESIDENTIAL - IGO	3777	CSS	King George CSS - ID/DD Residential	1	
8/5/2025	20	DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS	Stafford County CSS - ID/DD Residential	1	
8/22/2025	3	GROUP HOME/RESPITE MANAGER - MYERS DRIVE	3794	CSS	Stafford County CSS - ID/DD Residential	1	
8/8/2025	17	DIRECT SUPPORT PROFESSIONAL - DAY SUPPORT ICF	3656	CSS	Fredericksburg City CSS - Day Health and Rehabilitation Services		1
Avg days open	**58.61**					**11**	**4**
					Cumulative:	**15**	
Budgeted Vacant		**Job Title**	**RU**	**Division**		**FT**	**PT**
		COMPLIANCE COORDINATOR	1000	Admin	Fredericksburg City Administrative - Quality Assurance	1	
		ACCOUNTING SPECIALIST	1000	Admin	Fredericksburg City Administrative - Finance	1	
				Prevention & EI			
		EMERGENCY SERVICES THERAPIST	2070	CIS		1	
		LICENSED EMERGENCY SERVICES THERAPIST	2070	CIS		1	
		MH RESIDENTIAL SPECIALIST - CRISIS STABILIZATION	2770	CIS		1	
		CO-OCCURRING SPECIALIST	2372	CIS		1	
		PEER SUPPORT PROFESSIONAL - PSH	2760	CSS		1	
		RESIDENTIAL COUNSELOR I - LAFAYETTE BOARDING	2786	CSS		1	
		DEVELOPMENTAL SERVICES SUPPORT COORDINATOR	3300	CSS		1	
		DEVELOPMENTAL SERVICES SUPPORT COORDINATOR	3300	CSS		1	
		DEVELOPMENTAL SERVICES SUPPORT COORDINATOR	3300	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - KINGS HIGHWAY	3652	CSS			1
		DIRECT SUPPORT PROFESSIONAL - DAY SUPPORT ICF	3656	CSS			1
		DIRECT SUPPORT PROFESSIONAL - DEVON	3774	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - IGO	3777	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - IGO	3777	CSS			1
		DIRECT SUPPORT PROFESSIONAL - NEW HOPE	3778	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - BELMONT	3781	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - BELMONT	3781	CSS			1
		DIRECT SUPPORT PROFESSIOANL - GALVESTON	3790	CSS			1
		DIRECT SUPPORT PROFESSIONAL - CHURCHILL	3791	CSS			1
		DIRECT SUPPORT PROFESSIONAL - ROSS ICF	3792	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - LUCAS ICF	3793	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS		1	
		DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS			1
		DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS			1
		PSYCHIATRIST	2201	Clinical		1	
		PSYCHIATRIC NURSE PRACTITIONER	2201	Clinical		1	
		LICENSED OUTPATIENT THERAPIST - FREDERICKSBURG CLINIC	2200	Clinical			1
					Totals:	**19**	**9**
					Cumulative:	**28**	

Office of Human Resources
600 Jackson Street ▪ Fredericksburg, VA 22401 ▪ 540-373-3223
RappahannockAreaCSB.org

MEMORANDUM

To: Joe Wickens, Executive Director

From: Derrick Mestler, Human Resources Director

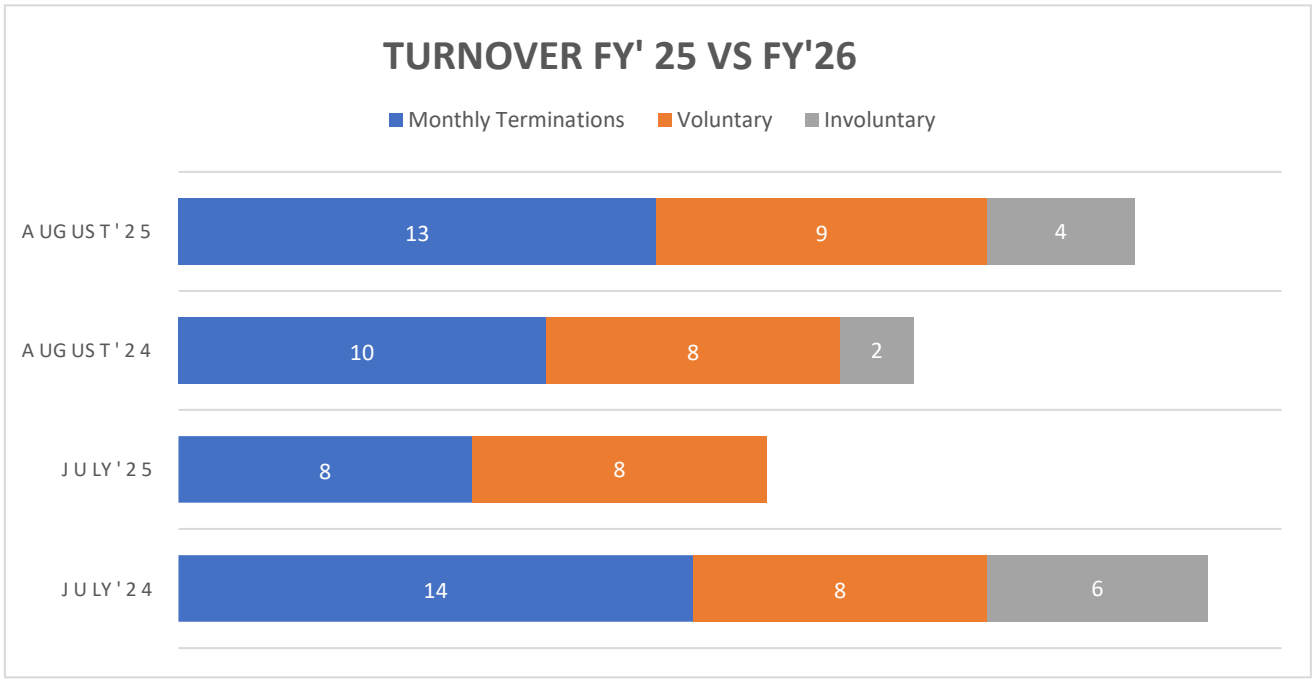
Date: September 5, 2025

Re: Summary – Turnover Report – September 2025

Human Resources processed thirteen (13) employee separations in September 2025. Nine (9) were voluntary, and four (4) were involuntary.

In FY ’25, our top three positions for turnover were Direct Support Professionals, Therapists, and Residential Specialists. For FY ’26, to date, the top three positions are Direct Support Professionals, LPNs and RNs, and Support Coordinators.

In FY ’25, our top three programs for turnover were Residential, Day Support, and Crisis Stabilization. For FY ’26, to date, the top three programs are Residential, Day Support, and Crisis Stabilization.



RACSB MONTHLY TURNOVER REPORT
Aug-25

ORGANIZATIONAL UNIT	NUMBER OF TERMS	VOLUNTARY	INVOLUNTARY	EXPLANATION
Administrative		2		Resigned - other opportunity
			1	For cause
Unit Totals	**3**	**2**	**1**	
Clinical Services				
Unit Totals	**0**	**0**	**0**	
Community Support Services		3		Resigned - other opportunity
		1		Resigned - relocated
		3		Resigned - no notice
			3	For cause
Unit Totals	**10**	**7**	**3**	
Crisis Intervention Services				
Unit Totals	**0**	**0**	**0**	
Prevention & Early Intervention Services				
Unit Totals	**0**	**0**	**0**	
Grand Totals for the Month	**13**	**9**	**4**	

Total Average Number of Employees	**553**
Retention Rate	**97.65%**
Turnover Rate	**2.35%**

Total Separations	**13**

RACSB Turnover FY '26

Employees	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Average Headcount	558	553										
Monthly Terminations*	8	13										
Turnover by Month	1.43%	2.35%										
Cumulative Turnover YTD	1.43%	3.78%										
Average % Turnover per Month YTD	1.43%	1.89%										

***Monthly Terminations, FT, PT, PRN, Does Not Include Interns/Volunteers**

RACSB DEPUTY EXECUTIVE DIRECTOR REPORT
August 2025 Monthly Updates

Opportunities for Partnership/Input:

- Attended multiple meetings on DMAS Behavioral Health Re-Design and coordinated internal efforts to submit the required provider readiness survey.
- Attended a meeting with Stafford County and Caroline County Board of Supervisors meetings for Performance Contract, OAA application, and Stafford's Proclamation for Opioid Overdose Awareness.
- Provided tour of Mobile Response Unit for Stafford County staff.
- Met minimum of three times a week regarding transition to new statewide data exchange. RACSB and Netsmart began testing the last week of January. Please see detailed information below on the status of this project.
- Served on the DBHDS Charter Finance Group to work towards streamlining fiscal requirements and building in flexibility around funding lines.
- Ongoing participation at least twice a month on the VACSB CCBHC Steering Committee and selected as chair for the Data and Outcomes sub-work group for this project.
- Supported the strategic plan activities and workgroup meetings.
- Negotiated a number of Exhibits D, funding specific addendums for the Performance Contract.
- Guided procurement of Crisis Services Consulting RFP and contract.
- Participated in first meeting of the FY26 HL7 Expansion workgroup.

Community Consumer Submission 3

DBHDS staff and CSB staff continue to meet weekly about the CCS 3 replacement project. Rappahannock Area Community Services Board continues to be the lead Netsmart Community Services Board, for those that use MyAvatar. We successfully went live on June 30, 2025. We continue to troubleshoot any errors that are identified.

VACSB DMC Data Mapping of DBHDS Required Reporting Workgroup

RACSB staff serve as chair of the DMC Data Mapping workgroup charged with mapping out the data requirements from DBHDS which CSBs have to complete. The new EDW project was meant to modernize and streamline required data reporting. To that end, a few years ago, there was a memo issued by DBHDS to stop any new data reporting requirements. However, CSBs have been receiving a substantial amount of additional data reporting and new, disparate date reporting mechanisms. The workgroup began in August to define, quantify, and map the required data element. The group initially identified 55 different reports/platforms. There are 16 major data platforms, 12 of which (75%) are new or significantly overhauled platforms. There are 39 ad-hoc reporting mechanisms (spreadsheets, Microsoft forms, etc.) required. 18 of these, or 46% are new or significantly changed since the memo pausing data requirements. As the group has begun the mapping work, more reports have been identified.

Information Technology Department Data		
Number of IT Tickets Completed	**Zoom Meetings**	**Total Zoom Participants**
Aug 2025- 958	1,995	4,275

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Amended and Restated FY2026 and FY2027 Community Services Performance Contract Master Agreement and Supplemental Documents

Date: September 8, 2025

The Rappahannock Area Community Services Board (RACSB) has a biennial agreement with the state's Department of Behavioral Health and Developmental Services (DBHDS) called the Performance Contract (PC). Specific changes for the upcoming fiscal year are noted in the attached letter from DBHDS. Also included is an executive summary grid of changes which equate to new requirements. This performance contract needs to be approved by our governing bodies, by RACSB, and by the Department, on or before September 30th in order to continue to receive state-controlled funds.

RACSB has submitted the FY26-27 Amended and Restated Community Services Performance Contract to all localities for review and approval. At the time of report, Stafford, Spotsylvania, and Caroline County have approved the contract. The Fredericksburg City Council has this item on the agenda for their September 9, 2025 meeting. King George has not yet placed the item on their agenda. All approvals must be received and the contract executed prior to September 30, 2025. If locality approval is not gained by this date, the contract is deemed approved.

The amendments were posted on the RACSB website for public comment on June 16, 2025. During the required 30-day comment period, there were no comments submitted. The document is still available for review at the link below.

https://rappahannockareacsb.org/wp-content/uploads/2025/06/Amendments.pdf

RACSB staff seeking Board approval of the FY2026 and FY2027 Community Services Performance Contract.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Legislative Updates and Priorities

Date: September 5, 2025

The Rappahannock Area Community Services Board (RACSB) is committed to advocacy to improve performance, quality, and demonstrate the value of services. We recognize the impact that legislative activity at the federal, state, and local level impact the services we offer to the community. This report will provide specific information on current legislative or regulatory topics which impact RACSB.

DBHDS Funding Actions:

- DBHDS sent notice on Monday, May 5, 2025 of reallocation of certain STEP-VA funds starting July 1, 2025. They provided a list of indicators involved in the decision-making and highlighted three key indicators: well-being score, adult and child uninsured rates, and rurality. RACSB was impacted negatively in the amount of $28,355 and applied to Same Day Access Psychiatric Rehabilitation, and Case Management STEP-VA Funding streams. This funding was later re-instated, but moved to a reimbursement model which must be spent first and by September 30, 2025.
- DHBDS states "the impact of applying these new percentages across any given funding stream is evaluated. It can be demonstrated that these new percentages are successful at moving funds to CSBs which are insufficiently funded based on the indicators used in this version".
- DBHDS has formed a workgroup to discuss adjusting the funding formula model and using it to re-allocate state funds.
- DBHDS has proposed to the State Board to rescind Policy 6005(FIN)94-2 Retention of Unspent Funds by Community Services Boards and move any policy around unspent funds to the Performance Contract. RACSB has submitted comments opposing this action as it removed the checks and balances provided by keeping it under Board authority.
- The current DBHDS Performance Contract introduces a new quarterly reporting requirement around each CSB's Accounts Receivable.

Impacts of recent Federal-level actions:

- The impacts of federal-level budget impacts on grant-based programs remain uncertain.
- Large-scale impacts of federal-level changes to Medicaid. Specific details, including impact, remain unclear.
    - The majority of the provisions require further guidance from CMS.
    - Eligibility re-determination for expansion population will occur every six months vs annual.
    - Limits the period of retroactive payments to one month for the expansion population and two months for all others.
    - For expansion population, implements requirement that to retain eligibility they must be engaged in qualified work activity at least 80 hours per month. There are some exceptions, but CMS has not provided guidance.
    - Cost-sharing requirements for the expansion population, but exceptions for some services which include BH and SUD, but have not been defined.

Virginia DMAS Behavioral Health Re-design

- DMAS is re-designing some of the current community Mental Health services including Psychosocial Rehabilitation, Mental Health Skill Building Services, and Mental Health Targeted Case Management for both adults and children.
    - As of July 1, 2026, Psychosocial Rehabilitation and Mental Health Skill Building Services will no longer be able to be billed to DMAS.
    - Replacing these services is a new service "Community Psychiatric Support and Treatment (CPST)".
    - New requirements include staff caseload limits, new accreditation requirements, new requirements for higher-level clinical staff with stringent supervision limits, new rate structure, new max units limits, and new training requirements.
    - Each of these services will be based on a new tier-based system and will require a new assessment to be completed to determine the individual's tier.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Department of Behavioral Health and Developmental Services CSB Operational Review

Date: September 8, 2025

The Department of Behavioral Health and Developmental Services conducts operational reviews of CSBs to evaluate the fiscal accountability and transparency in managing funds awarded to the organization by DBHDS, compliance with the DBHDS performance contract, existence and functioning of internal controls, and the efficiency and economy of processes. DBHDS conducted its initial review in 2023. This most recent review was conducted as a second follow-up review.

SUMMARY OF FINDINGS

DBHDS reviewed the following three findings from the last audit to ensure appropriate corrective action has been implemented:

- DD Waiver Active Without Services
- Expenditures and appropriate back-up documentation
- Contract Administration

After DBHDS review, they have indicated the expenditures and contract findings have been resolved. The DD Waiver Active Without Services remain outstanding and will have another review to confirm appropriate corrective action. Please see attached memo for further details.

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

VIRGINIA DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

MEMORANDUM

TO: Nelson Smith, Commissioner of DBHDS
Joseph Wickens, Executive Director of Rappahannock Area Community Services Board

FROM: Divya Mehta, Director of Internal Audit

SUBJECT: Rappahannock Area Community Services Board Operational Review FY26 Follow-up

DATE: September 08, 2025

BACKGROUND & OBJECTIVES:

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) Office of Internal Audit conducted a second follow-up review of the FY23 Rappahannock Area Community Services Board (RACSB) Operational Review. The focus of this review was to ensure corrective actions were implemented for the findings noted in the follow-up memo dated November 8, 2024. The FY25 memo noted three findings in the areas of DD Waiver monitoring of consumers in active without services status, contract administration, and expenditures.

FINDINGS:

We conducted this review by requesting documentation to support management's corrective actions taken since the follow-up memo was issued. The following repeat findings were noted:

DD Waiver Active Without Services

We asked RACSB about consumers noted on the Active without Services report. Responses were provided for 14 clients. The following was noted:

- 5 of 14 (36%) of consumers on the Active Without Services Report no longer needed slots and should have been released.

CONCLUSION:

The follow-up review indicated corrective action plans have been implemented for two of three findings. A third follow-up will be performed on the final corrective action.