OFFICE OF THE STATE INSPECTOR GENERAL

Unannounced Inspections

Of

Behavioral Health and Developmental Services Facilities

Calendar Year 2021

Michael C. Westfall, CPA
State Inspector General

Report No. 2022-BHDS-002

COMMONWEALTH OF VIRGINIA

Office of the State Inspector General

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April 18, 2022

The Honorable Glenn Youngkin
Governor of Virginia
P.O. Box 1475
Richmond, VA 23219

Dear Governor Youngkin:

The Office of the State Inspector General performed unannounced inspections at all facilities operated by the Department of Behavioral Health and Developmental Services pursuant to *Code of Virginia* § 2.2-309.1[B](1). The goal of unannounced inspections is to review the quality of services provided to patients at the facilities; make policy and operational recommendations to prevent problems, abuses and deficiencies; and improve the effectiveness of programs and services.

OSIG would like to thank former DBHDS Commissioner Alison Land and the DBHDS staff for their cooperation and assistance during these unannounced inspections.

Sincerely,

Michael C. Westfall, CPA
State Inspector General

cc: The Honorable Jeff Goettman, Chief of Staff to Governor Youngkin
The Honorable John Littel, Secretary of Health and Human Resources
The Honorable Patrick A. Hope, Chair, Joint Commission on Health Care
The Honorable George L. Barker, Vice Chair, Joint Commission on Health Care
Nelson Smith, Commissioner, DBHDS
Angela Harvell, Deputy Commissioner for Facility Services, DBHDS
Dev Nair, Assistant Commissioner of Quality Management and Development, DBHDS
Alvie Edwards, Assistant Commissioner for Compliance, Risk Management and Audit, DBHDS

DBHDS Unannounced Inspections

What OSIG Found

DBHDS Facility Policy Regarding Sexual Allegations Does Not Adequately Describe Sexual Abuse As Defined In the *Code of Virginia* § 18.2-67.10

In the four facilities (CCCA, CSH, SEVTC and SVMHI) inspected for handling of sexual allegations, staff did not have adequate guidance in terms of identifying the elements that constitute sexual abuse as defined in § 18.2-67.10. Without adequate definitions and training, staff might not document and investigate reports of sexual abuse and potentially expose patients to harm.

DBHDS Facilities Had Unresolved Virginia Fire Marshal Citations During OSIG's Inspections

Three of four facilities (HDMC, NVMHI and VCBR) inspected for public safety compliance had outstanding citations that were unresolved. Citations covering the fire drills not being conducted at proper intervals (405.2), annual fire door inspection report deficiencies that had not been corrected (703.2.1), fire-rated doors that had gaps greater than allowed according to NFPA 80 (703.2) and failure of the water-based fire protection system (901.4.1) were unresolved during OSIG's inspections. The facilities have made the corrections, which OSIG has verified.

DBHDS Records Did Not Include Authorized Signatures on the Treatment Plans Indicating Parties Were In Agreement With the Proposed Treatment Goals

In three of four facilities (PGH, SEVTC and WSH) inspected for patient procedure compliance, signatures of the patient, authorized representative or guardian indicating they were in agreement with proposed treatment goals were not completed.

OSIG provided 40 recommendations for corrective actions. OSIG will conduct follow-up procedures with Central Office and facilities to determine if conditions have been corrected.

April 2022

HIGHLIGHTS

Why OSIG Performed This Inspection

OSIG completed this inspection in accordance with *Code of Virginia* § 2.2-309.1.B.1, which requires OSIG to, "Provide inspections of and make policy and operational recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities, in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services."

What OSIG Recommends

- DBHDS should amend facility policy regarding the definition of sexual abuse to align with *Code of Virginia* § 18.2-67.10 and provide staff with more detailed guidance on properly identifying and reporting sexual allegations.
- Adopt a fire drill policy that complies with Section 405 of the Virginia Statewide Fire Prevention Code. In accordance with NFPA 25, maintain all water-based fire protection systems in good working order.
- Ensure the patient, authorized representative or guardian are in agreement with the proposed treatment by requesting a signature either during the meeting if in attendance or via a mailed or emailed copy if not in attendance.

For more information, contact OSIG at 804-625-3255 or www.osig.virginia.gov.

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REPORT ACRONYMS

The following is an alphabetical list of acronyms used in the report.

AR – Authorized Representative
ADA – American Diabetes Association
AED – Automated External Defibrillator
APS – Adult Protective Services
BHDS – Behavioral Health and Developmental Services
BSP – Behavior Support Plan
CAT – Catawba Hospital
CCCA – Commonwealth Center for Children and Adolescents
CHRIS – Computerized Human Rights Information System
CSB – Community Services Board
CSH – Central State Hospital
CT – Computed Tomography
DBHDS – Department of Behavioral Health and Developmental Services
DCJS – Department of Criminal Justice Services
DI – Departmental Instruction
DPS – Department of Public Safety
DSP – Direct Support Professional
ERC – Emergency Restraint Chair
ESH – Eastern State Hospital
HDMC – Hiram Davis Medical Center
ID/DD – Intellectual Disability/Developmental Disability
IMMP – Individual Milieu Management Plan
IPOC – Interdisciplinary Plan of Care
ISP – Individualized Service Plans
LRA – Labor Relations Alternative
MRI – Magnetic Resonance Imaging
NFPA – National Fire Protection Association
NVMHI – Northern Virginia Mental Health Institute
OSIG –Office of the State Inspector General
PAIRS – Protection and Advocacy Incident Reporting System
PGH – Piedmont Geriatric Hospital
ROM – Range of Motion
SEVTC – Southeast Virginia Training Center
SVMHI – Southern Virginia Mental Health Institute
SWMHI – Southwestern Virginia Mental Health Institute
TDO – Temporary Detention Order
TJC – The Joint Commission

REPORT ACRONYMS (continued)

TOVA – Therapeutic Options of Virginia
UAI – Unannounced Inspections
VAC – Virginia Administrative Code
VCBR – Virginia Center for Behavioral Rehabilitation
VDEM – Virginia Department of Emergency Management
VSRP – Virginia Statewide Fire Prevention
VSP – Virginia State Police
WSH – Western State Hospital

BACKGROUND

Every year, pursuant to *Code of Virginia* § 2.2-309.1 Additional powers and duties; behavioral health and developmental services, OSIG conducts an unannounced inspection of each facility operated by DBHDS. In accordance with the *Code,* OSIG shall, "Provide inspections of and make policy and operational recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities, in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services."

OSIG researches industry and regulatory standards to assist with evaluating DBHDS facilities and makes recommendations to improve the quality of care; prevent problems, abuses and deficiencies; and improve the effectiveness of DBHDS facilities' programs and services. This includes making recommendations to DBHDS Central Office to ensure proper and consistent management and oversight of the facilities.

DBHDS is established in the executive branch of government responsible to the Governor. DBHDS is under the supervision and management of the Commissioner and the Commissioner carries out the management and supervisory responsibilities in accordance with policies and regulations of the State Board of Behavioral Health and Developmental Services and applicable federal and state statutes and regulations. The Board has the statutory authority, as outlined in *Code* § 37.2-203, to develop and establish policies governing the operations of DBHDS, state facilities and community services boards. CSBs act as the doorway to the Virginia mental health system.

DBHDS operates 12 facilities across the Commonwealth of Virginia: Eight behavioral health facilities for adults, one training center, a psychiatric facility for children and adolescents, a medical center and a center for behavioral rehabilitation. State facilities provide highly structured, intensive services for individuals with mental illness or developmental disabilities, or who are in need of substance use disorder services.

In planning for the calendar year 2021 unannounced inspections, OSIG took into account the unprecedented times and the impact of COVID-19 on state mental health facilities operations. State mental health facilities are, just like standard medical facilities, tasked with caring for individuals 24 hours a day, seven days a week. This required a unique approach to the planning and execution of the unannounced inspections. The COVID-19 climate required OSIG to consider facility challenges and adapt to changing conditions.

SCOPE

OSIG inspected the facilities listed below:

Facility	Facility Location	Facility	Facility Location
CAT	Catawba Hospital Catawba, Virginia	PGH	Piedmont Geriatric Hospital Burkeville, Virginia
CCCA	Commonwealth Center for Children & Adolescents Staunton, Virginia	SEVTC	Southeastern Virginia Training Center Chesapeake, Virginia
CSH	Central State Hospital Petersburg, Virginia	SVMHI	Southern Virginia Mental Health Institute Danville, Virginia
ESH	Eastern State Hospital Williamsburg, Virginia	SVWMHI	Southwestern Virginia Mental Health Institute Marion, Virginia
HDMC	Hiram Davis Medical Center Petersburg, VA	VCBR	Virginia Center for Behavioral Rehabilitation Burkeville, Virginia
NVMHI	Northern Virginia Mental Health Institute Falls Church, Virginia	WSH	Western State Hospital Staunton, Virginia

OSIG completed full, on-site, inspections of the four facilities listed below:

Commonwealth Center For Children & Adolescents	Hiram Davis Medical Center
Central State Hospital	Southeastern Virginia Training Center

Due to pandemic precautions issued during the UAI process, OSIG conducted brief, on-site inspections of the remaining eight facilities and completed the reviews virtually:

Catawba Hospital	Southern Virginia Mental Health Institute
Eastern State Hospital	Southwestern Virginia Mental Health Institute
Northern Virginia Mental Health Institute	Virginia Center for Behavioral Rehabilitation
Piedmont Geriatric Hospital	Western State Hospital

OBJECTIVES

- Review the quality of services provided by the Department of Behavioral Health and Developmental Services' 12 state facilities.
- Identify problems individualized to specific facilities as well as any systemic issues.
- Identify potential concerns of abuse, neglect or inadequate care.
- Make recommendations to eliminate system failures and prevent human errors in order to mitigate risk in facilities.

The 2021 UAI included two topics for each facility. OSIG selected the topics using information from the following, and other, resources:

- Complaints received by the OSIG BHDS Complaint Line.
- Reports from various DBHDS databases.
- DBHDS reports.

OSIG selected the following six topics:

- **Sexual Allegations –** To ensure the facility is handling incidents involving sexual allegations appropriately.
- **Public Safety and Facility Management** – To ensure the facility complies with safety codes and procedures.
- **Seclusion and Restraint –** To ensure the facility complies with regulations and policies when resorting to seclusion and restraint.
- **Patient Procedures** – To ensure the facility is addressing patients' medical and psychological concerns.
- **Patient Administration –** To ensure the facility is handling patients' complaints according to policy.
- **Dietary Compliance and Food Safety** – To ensure the facility complies with regulations governing food safety and implements patients' dietary needs and restrictions appropriately.

OSIG designated the following topics to each facility as listed:

Facility	Topics
CAT	Seclusion/Restraint Patient Administration
CCCA	Sexual Allegations Seclusion/Restraint
CSH	Sexual Allegations Patient Administration
ESH	Seclusion/Restraint Dietary Comp. & Food Safety
HDMC	Public Safety & Facility Mgmt. Dietary Comp. & Food Safety
NVMHI	Public Safety & Facility Mgmt. Patient Administration

Facility	Topics
PGH	Patient Procedures Dietary Comp. & Food Safety
SEVTC	Sexual Allegations Patient Procedures
SVMHI	Sexual Allegations Public Safety & Facility Mgmt.
SWVMHI	Patient Administration Dietary Comp. & Food Safety
VCBR	Public Safety & Facility Mgmt. Patient Procedures
WSH	Seclusion/Restraint Patient Procedures

METHODOLOGY

OSIG conducted this inspection in accordance with the principles and standards for offices of inspectors general. Those standards require that OSIG plan and perform the inspections to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the inspection objectives. The evidence obtained provides a reasonable basis for the findings and conclusion based on the inspection objectives.

OSIG applied various methodologies during the inspection process to gather and analyze information pertinent to the inspection scope and to assist with developing and testing the inspection objectives. The methodologies included the following:

Physical Inspection

On July 29, 2021, OSIG conducted its first on-site inspection at CSH. OSIG followed up by doing on-site inspections at SEVTC, HDMC and CCCA. On September 3, 2021, OSIG received written notification from DBHDS Commissioner Land that stated, "DBHDS facilities will move to a restricted visitation policy." As a result, the remaining facilities received an on-site, video inspection by the OSIG BHDS Unit Manager. OSIG also completed virtual reviews of specific areas or items throughout the facilities. Areas and items of review included, but were not limited to, facility crash carts, life safety equipment, oxygen tanks, fire extinguishers, exit doors and signs, fire doors, kitchens, dining rooms, seclusion rooms and emergency restraint chairs.

Policy Review

The facilities provided electronic copies of DBHDS policies and departmental instructions requested and reviewed by OSIG related to UAI topics.

Medical Records Review

OSIG provided the facilities a list of patient names for review. Facilities provided OSIG with paper copies of records on-site or through secure email. DBHDS assigned OSIG a Super User of the electronic health records system to assist with navigation of the health records, both on-site and virtually.

Complaint Follow-Up

OSIG selected patient-specific complaints from the BHDS Complaint Line for follow-up with facility advocates and complaint coordinators. BHDS staff coordinated with facility staff either on-site or virtually to fulfill this portion of the review.

Staff Interviews

Upon initiation of the UAI, OSIG provided each facility a list of staff it wanted to interview on UAI topics.

Further Clarification

After OSIG collected documentation, inspected the facilities and interviewed staff, OSIG sent additional questions or information requests to the facilities if OSIG needed further clarification.

Additional Observations and Suggestions

OSIG provided 10 of the 12 facilities (CCCA, ESH, HDMC, NVMHI, PGH, SEVTC, SVMHI, SVMHI, VCBR and WSH) a memo containing observations and suggestions that were less significant to help them make additional improvements to operations.

RESULTS

DBHDS Central Office

Departmental Instructions

Finding 1 - Language

a) The language in DI 401 (RM) 03, sections 6 and 8 vary, which changes the meaning of the intended instruction. This difference in language could contribute to the underreporting of serious incidents at facilities. The omission of the language in DI (RM) 03-6 led one facility (CSH) to misinterpret reporting criteria for sexual allegations. Staff did not report instances that staff did not witness or discover.

DI 401(RM) 03 *Risk and Liability Management*, section 401-6 states, "Any employee, volunteer, contractor, or student who witnesses or discovers any incident that causes or has the potential to cause harm or injury to an individual or any incident that poses risks or liability to the organization or facility, shall immediately complete, date, and sign a Facility Incident Report Form (158) and submit report to his immediate supervisor or staff person in charge."

DI 401(RM) 03-8 states, "Any employee, volunteer, contractor, or student who is involved in, witnesses, or receives a report of an incident that causes or has the potential to cause harm or injury to any individual or an incident that poses risks or liabilities to the agency or the Commonwealth, shall enter the incident in the Incident Tracker as determined by the facility or complete, date, and sign a Facility Incident Report Form (158), and submit the report to his immediate supervisor, unit manager, or staff person in charge if not entered into the Incident Tracker by the employee."

b) In the definition section of DI 401, the definition of Incident Tracker states, "All Facility Incident Report Forms (158) must be entered into this tracker by the witness of the incident or the Risk Manager." This language does not include the staff member to whom a patient submitted a "report of" from an incident that was unwitnessed.

Recommendation 1

a) Revise the DI 401(RM) 03 to align language in sections 6 and 8 and throughout the instruction to include "reports of" incidents from patients.
b) Revise the language in the DI 401 definition of Incident Tracker to include the language "reports of" with relation to incident reporting.

Update on Recommendation 1a

Due to the potential seriousness of the nature of this finding, OSIG informed DBHDS of this finding on August 5, 2021.

In addition, OSIG conducted a separate review of the language used in the reporting policies for the other 11 facilities. Four facilities (CCCA, SVMHI, SWVMHI and HDMC) did not include the correct language that aligned with DI 401-6.

Finding 2 – Improbable Allegations

DI 201-8, Improbable Allegations – "If the clinical assessment determines that the allegation is more likely than not to be symptomatic of the patient's illness or disability, then no further investigation need take place."

The way in which the DI-201-8, Improbable Allegations is written may lead to potential exploitation of vulnerable populations. Relying solely on a clinical assessment of a patient's mental health and symptoms to determine the validity of a new allegation may prevent staff from performing a thorough investigation.

Recommendation 2

Ensure that DBHDS thoroughly investigates all allegations of abuse and neglect regardless of a patient's mental health status and past allegations.

Sexual Allegations

Sexual Allegations	Reviewed
Patient Records	11
Staff Training Records	31
Facility Policies	21
Interviews Conducted	34
Departmental Instructions	5

Facilities	Date(s) Inspected
CSH	07/29/21 & 08/04/21
SEVTC	08/10/21
CCCA	08/24/21
SVMHI	09/16/21 & 10/05/21

Finding 3

In all four facilities (CCCA, CSH, SEVTC and SVMHI) inspected, staff did not have adequate guidance in terms of identifying the elements that constitute sexual abuse as defined in *Code* of Virginia § 18.2-67.10. Without adequate definitions and proper training, staff may not document and investigate reports of sexual abuse and potentially expose patients to harm.

Recommendation 3

a) Amend the following policies to align with *Code* of *Virginia* §18.2-67.10 definitions:
   - CCCA 2433
   - CSH RM-5h
   - SEVTC 2650
   - SVMHI 209(RTS) 02-12

b) Provide staff with more detailed guidance on properly identifying and reporting sexual allegations.

c) Complete the 158 form (or electronic version) for every incident involving a sexual allegation.

Finding 4

As part of the oversight process through the monitoring of serious incident reports, OSIG presented three serious incidents of a sexual nature that occurred between January 1 and June 30, 2021, to CSH during the inspection. CSH provided three additional incidents of a sexual nature to OSIG.

OSIG determined that staff had not completed incident forms (158s) for any of the six incidents, as required. According to the Assistant Director of Administration at CSH, "An incident form is not completed for serious incidents that are not witnessed or discovered by staff." All six incidents were "reports of" incidents that patients submitted. The ADA referred to CSH policy RM-06h, Incident Reporting and Management, which states in section III-A (1), "Any employee, volunteer, contractor, or student who witnesses or discovers any incident that causes or has the potential to cause harm or injury to any individual or an incident that poses risks or liability to the organization or facility, shall immediately complete an Incident Report."

The CSH Nursing Policies and Procedures Manual also refers to policy RM-06h stating, "All occurrences related to safety shall be reported and Incident Reports (158's) completed."

DI 401(RM) 03 Risk and Liability Management, section 401-6 states, "Any employee, volunteer, contractor, or student who witnesses or discovers any incident that causes or has the potential to cause harm or injury to an individual or any incident that poses risks or liability to the organization or facility, shall immediately complete, date, and sign a Facility Incident Report Form (158) and submit report to his immediate supervisor or staff person in charge."

According to the CSH ADA, the CSH policy RM-06h was created from section 6 of DI 401 (RM) 03, which does not include the language "reports of" when referring to incidents.

However, DI 401 (RM) 03 section 8, states, "Any employee, volunteer, contractor, or student who is involved in, witnesses, or receives a report of an incident that causes or has the potential to cause harm or injury to any individual or an incident that poses risks or liabilities to the agency or the Commonwealth, shall enter the incident in the Incident Tracker as determined by the facility or complete, date, and sign a Facility Incident Report Form (158), and submit the report to his immediate supervisor, unit manager, or staff person in charge if not entered into the Incident Tracker by the employee." This section of the DI does include "reports of" in reference to incidents.

Also in section 8 of DI 401 (RM) 03, it clearly states, "All incidents shall be reported regardless of whether they occurred:

- In the facility or away from the facility.
- With or without staff present.
- While the individual receiving services was on authorized leave, missing or on special hospitalization."

Also, in the definitions of DI 401 (RM) 03, it states the definition of Facility Incident Report is, "A form (158) used by department employees to notify their supervisors, facility risk managers, and other appropriate management of an incident that presents either actual or potential risk or liability. Facility Incident Report Forms (158) should be reported during the shift in which they occur, but no later than 48 hours."

The instruction DI 201, Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities, section 201-5 states, "Each individual receiving services in a state facility has the right to have all allegations of abuse and neglect investigated in accordance with the procedures and time frames in the Human Rights Regulations and this DI."

Not accepting reports of abuse and/or neglect from patients as criteria to warrant the completion of an Incident Form (158) could potentially contribute to underreporting of serious incidents in facilities. It may also deprive a patient of their right to pursue legal action by filing charges against a perpetrator when an offense occurs. The limiting of incident reports to "only witnessed" incidents could place patients at risk and therefore deprive them of their right of protection from abuse, neglect and exploitation. It also diminishes the ability of the facility to track such incidents and ensure that staff has taken reasonable measures to mitigate the risk.

Recommendation 4

Revise policy RM-06h section III-A to include the language "reports of" in addition to the current language "witnesses or discovers an incident" as reflected in DI 401 (RM) 03, section 8.

Finding 5

As part of the oversight process through the monitoring of serious incident reports, OSIG identified four serious incidents of a sexual nature that occurred between January 1 and June 30, 2021, at SVMHI. In all of these incidents, staff did not provide the victims with the opportunity to speak with law enforcement or a magistrate in order to seek criminal remedy.

According to DI 205 (RTS) 89, section 205-5 Specific Guidance, section Criminal Activity towards Peers, "Individuals who are the victims of a crime resulting from a peer-to-peer act at the facility must be given the opportunity to report the crime to law enforcement if they choose." OSIG requested documentation for the four alleged sexual offenses at SVMHI. SVMHI was unable to provide any documentation indicating that staff gave the victim(s) the opportunity to report the crime to law enforcement or a magistrate.

Recommendation 5

A. Provide patients and court-appointed guardians written, detailed information of their rights (upon admission and when an incident occurs) to report any criminal act, including sexual abuse, to law enforcement. Include the following information:
    1. Detailed information about a victim's rights to report and file charges.
    2. The timeframe to report and file charges (statute of limitations).
    3. A statement that the patient may report the crime even after discharge of the perpetrator or the victim, as long as it falls within the statute of limitations.
    4. A statement informing the patient of the right to waive reporting of the crime.

B. Include the following in facility documentation:
    1. Verification through signature that staff informed the patient of their rights on admission and in the event of a criminal incident.
    2. Verification through signature if the patient waived their right to seek prosecution.

3. Verification that the facility immediately notified the authorized representative or guardian about the incident and that the AR or guardian served as proxy in the decision-making process in filing of charges when the victim lacked capacity.
4. Clear and adequate documentation in the victim's record should include the following:
    a. Appropriate incident forms completed.
    b. Action taken by all appropriate entities (Virginia State Police, Adult Protective Services, patient advocate, AR, treatment team, etc.) notified and action taken.
    c. Detailed description of the offense and when it occurred.
    d. Detailed description of the patient's status, both physical and mental because of the offense.
    e. Detailed description of the steps taken to address any physical or mental concerns because of the offense.
    f. Detailed description of the steps taken to mitigate the risk of future offenses.
    g. Detailed notes in the days following the incident to monitor any further concerns or changes in the patient's status.
    h. Documentation from the patient advocate visit and treatment team meetings.
    i. Video tape, witness statements and any other evidence related to the incident, if available.
5. Clear and adequate documentation in the perpetrator's record should include the following:
    a. Appropriate incident forms completed.
    b. Action taken by all appropriate entities (Virginia State Police, Adult Protective Services, patient advocate, AR, treatment team, etc.) notified and action taken.
    c. Detailed description of the offense and when it occurred.
    d. Detailed description of the perpetrator's status, both physical and mental, at the time of the incident.
    e. Detailed description of the steps taken to address any physical or mental concerns because of the offense.
    f. Detailed description of the steps taken to mitigate the risk of future offenses.
    g. Detailed notes in the days following the incident, to monitor any further concerns or changes in patient's status or signs of potential re-offense in the future.

h. Documentation from the patient advocate visit and treatment team meetings.
i. Video tape, witness statements and any other evidence related to the incident, if available.

Finding 6

During the inspection of CSH, OSIG reviewed seven sexual allegations. Staff deemed two of the seven complaints improbable and did not conduct a complete investigation. Staff did not provide OSIG with any clinical assessments that involved an interview of the patient by a clinician regarding the improbable allegation. During the time of this inspection, DBHDS was utilizing the LRA Investigations Manual as a training tool for new investigators. A review of the LRA Manual revealed that the process of investigating an improbable allegation was not covered.

Below are details from OSIG's review of the seven sexual allegations:

Patient A:

- During the investigation of a sexual allegation, staff did not take a formal statement from the patient or the accused.
- The DI-201 report made no mention of staff completing a videotape review as part of the investigation of a sexual allegation.

Patient B:

- Staff did not conduct interviews with the alleged perpetrator or witnesses.
- Language in findings (conclusions) differ between the investigation memo and the letters provided to patient and staff.
- Staff did not give the patient the opportunity to file charges per DI205.
- Staff did not provide OSIG with a treatment note, as required by DI201, describing what, if any, treatment interventions staff implemented to address this aspect of the individual's behavior.

Patient C:

- Staff did not conduct interviews with the victim, alleged perpetrator or witnesses.
- The language in the findings (conclusion) differs between the Investigation Memo and letters to patient and staff.
- Staff did not afford the patient the opportunity to file charges per DI205.
- The investigator posed a leading question in an email to the psychiatrist as part of the investigation.
- Staff did not take a formal statement from the victim or alleged perpetrator.

- Staff did not provide OSIG with a treatment note, as required by DI201, describing what, if any, treatment interventions staff implemented to address this aspect of the individual's behavior.

Patient D:

- CSH filed a report with the Virginia State Police.

Patient E:

- The nurse from the night shift confirmed that a peer attacked the patient in his room at 1:30 a.m. There was documentation stating the patient sustained bruises.

Patient F:

- Staff did not include the peer's (alleged perpetrator) information in the DPS report.
- Information provided to OSIG does not support that staff conducted an investigation.

Patient G:

- Staff reported this incident in CHRIS, but never reported it to DPS. Therefore, DPS did not investigate in accordance with CSH Policy RM-5h.
- The Medical Officer on Duty denied the patient's request to be moved to a different unit.
- The 158 form indicated the incident was labeled as "low/minor risk or liability," when the risk should have been labeled higher.
- The facility failed to provide guidance about the patient's rights to seek legal remedy by law enforcement and/or magistrate.

"Improbable Allegation – If the clinical assessment determines that the allegation is more likely than not to be symptomatic of the individual's illness or disability, then no further investigation need take place." (*CSH policy RTS-15b, pg. 6)*

Investigations that staff did not complete due to improbable allegations could increase the risk of exploitation of vulnerable populations. Staff might not also afford victims the opportunity to file charges against alleged perpetrators and ensure patients of their right to be free from abuse, neglect and exploitation.

"All incidents involving sexual assault shall be reported to law enforcement" (DI-(RM 401)05).

"Each individual receiving services in a hospital operated by DBHDS shall be assured his legal rights and care consistent with basic human dignity. He shall retain his legal rights as provided by the state and federal law. Patient shall be treated with dignity as a human being and be free from abuse and neglect" (*Code of Virginia* Title 37.2-400*).*

Recommendation 6

a) Interview and record statements from the victim, alleged perpetrator and any witnesses.
b) Immediately mitigate incidents that involve peer-to-peer sexual allegations (i.e. moving a patient to safety) to ensure patient safety.
c) Staff should report incidents involving sexual allegations to the Facility Director, DPS and VSP.
d) Document incidents involving sexual allegations in:
    1) Incident tracker.
    2) CHRIS.
    3) PAIRS.
e) Include all investigation documentation pertinent to the case.
f) If staff reports an incident to VSP, in accordance with policy, request and document updates from VSP or the Commonwealth Attorney while the victim is hospitalized.
g) In order to conduct an impartial investigation, refrain from posing leading questions and allow the interviewee to provide pertinent information.
h) Inform patients of and afford them the opportunity to file charges in any criminal incident.
i) As part of a sexual allegation investigation, view and store any video pertaining to the incident.
j) Write findings letters that correlate directly to the Investigation Memo using clear, concise and consistent language.
k) For investigations deemed improbable, include treatment notes that describe what, if any, interventions staff are implementing to address the patient's behavior.

Finding 7

The DI 201 (RTS03), section 8 Improbable Allegations states, "If the facility director, investigator, or advocate believes at any time that the case warrants further investigation, the case shall proceed through the regular investigative process." However, this language was omitted from CSH policy RTS-15b Patient Abuse, Reporting and Investigation of Allegations.

The omission of this language could prevent incidents of sexual allegation from receiving a full investigation.

Recommendation 7

Amend Policy RTS-15b to reflect the language as in DI201 (RTS03) section 8 to instruct the facility with regard to improbable allegations to proceed with further investigation when the case warrants it.

Finding 8

The four incident reports (158) reviewed at SVMHI involving sexual allegations were marked risk index "N" that indicates no risk or liability identified. According to DI 401 (RM) 03, these incidents should have been marked "H," which indicates incidents involving criminal activity. Risk index of "H" requires additional reporting to patient advocacy and regulatory agencies that may elect to review further. SVMHI policy 401(RM) 04/18 also requires the Risk Manager initiate a formal review or a root cause analysis.

Recommendation 8

Assign incident reports (158) the appropriate risk index in order to identify high-risk incidents requiring additional review. Provide staff with additional training on the assignment of risk as defined in DI 401 (RM) 03.

Public Safety and Facility Management

Public Safety and Facility Management	Reviewed
Patient Records	0
Staff Training Records	20
Facility Policies	36
Interviews Conducted	17

Facilities	Date(s) Inspected
HDMC	08/12/21
VCBR	09/07/21 & 09/14/21
NVMHI	09/10/21 & 10/19/21
SVMHI	09/16/21 & 10/05/21

Finding 9

During the unannounced inspection site visit conducted on August 12, 2021, OSIG discovered that Hiram Davis Medical Center received a citation on May 26, 2021, from the Commonwealth of Virginia State Fire Marshal under the following *Code* section:

Code Section	Violation	Correct By
703.2.1	There are deficiencies noted in the annual fire door inspection report that have not been corrected.	07/30/2021
703.2	There are fire rated doors that have gaps that are greater than allowed according to NFPA 80 between the door and the doorframe and between the doors at various locations.	07/30/2021
703.2.4	There are fire rated doors that are held open with non-approved hold open devices at various locations in the building. There is a door coordinator for the fire rated doors in the smoke barrier near Central Medical Equipment Supply that is not working properly and does not allow the doors to close fully.	07/30/2021
901.6	Security tab for the fire extinguisher pin is missing in the Dental Lab. Sprinkler head escutcheons missing in south shower room 224 and the sprinkler head is dirty.	07/30/2021

As of August 12, 2021, HDMC had not made the recommended repairs as cited by the State Fire Marshal. HDMC reported that its fire safety vendor was unable to obtain parts to take corrective action in the time allowed.

Recommendation 9

Seek another fire safety vendor that can provide the recommended repairs, immediately.

Update for Recommendation 9

OSIG received confirmation from National Security & Door that all corridor repairs noted in the May 26, 2021, Fire Marshal Inspection report were completed and should be in compliance with NFPA 80.

On September 29, 2021, the State Fire Marshal acknowledged that violation(s) noted on the previous inspection report had been corrected.

Finding 10

NVMHI had unresolved life safety vendor citations. In accordance with NFPA 25, 2014 Edition, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection System, contracted vendor VSC Fire & Security Inc. found five deficiencies during an inspection that occurred from April 5-7, 2021. The five areas that were marked Fail during this inspection were:

- EP-3 Duct Smoke Detector- Fail (Quantity 1)
- EP1 EP2- Tamper Switch-Fail (Quantity 3)
- HVAC Shutdown- Fail (Quantity 1)

Recommendation 10

In accordance with NFPA, maintain all water-based fire protection systems in good working order. Make necessary repairs and have the system inspected by a qualified vendor.

Update to Recommendation 10

On January 14, 2022, OSIG received an update from NVMHI in an email documenting an inspection conducted by the Virginia State Fire Marshal and contracted vendor VSC Fire & Security Inc. on December 2, 2021, that all devices tested were found to be in operative condition at the time of inspection.

Finding 11

HDMC had unresolved life safety vendor citations. On July 8, 2021, Carter Machinery noted on a Generator Preventative Maintenance Report that the Fuel PSI gauge was inoperable as "the gauge needle was broken off."

In accordance with NFPA 110, an emergency power generation system must have inspections and periodic maintenance to ensure they work on demand.

Recommendation 11

Repair this fuel PSI gauge in order to ensure safe operation of the generator. HDMC should make vendor-recommended repairs noted on inspections reports in a timely manner.

Update for Recommendation 11

OSIG received a completed work order from Carter Machinery dated September 24, 2021, noting that it replaced the fuel pressure gauge and verified it to be accurate during testing.

Finding 12

HDMC had unresolved life safety vendor citations. HDMC received a bulk oxygen tank inspection report from its contracted vendor Airgas on August 11, 2020, noting that (a) the medical gas (oxygen) cylinder storage racks contained combustible material (wood) and (b) the bulk medical gas storage tank (2000L) low-level alarm was inoperable.

In accordance with NFPA 99, (a) interior medical gas cylinder tank storage must be of noncombustible or limited combustible material and (b) all medical gas (oxygen) cylinder storage systems should be maintained in working order.

Recommendation 12

(a) Replace tank storage racks with noncombustible alternatives and (b) replace the bulk medical gas storage tank low-level alarm to ensure that adequate oxygen supply is available to meet patient demand.

Update for Recommendation 12

(a) OSIG received photographic confirmation on October 8, 2021, documenting that staff replaced the tank storage racks with a noncombustible alternative (metal). (b) On November 30, 2021, the medical gas storage tank low-level alarm was repaired and in working order.

Finding 13

VCBR had unresolved State Fire Marshal citations. During the unannounced inspection conducted on September 14, 2021, OSIG discovered that VCBR received a citation on January 28, 2021 from the Commonwealth of Virginia State Fire Marshal under the following *Code* sections:

Code Section	Violation	Correct By
405.2	Frequency (1) Fire evacuation drills not being conducted at proper intervals.	2/27/2021

In a review of facility safety policies, the Fire Marshal determined that VCBR did not maintain a comprehensive fire drill schedule. In accordance with Section 405 of the Virginia Statewide Fire Prevention Code, staff shall hold drills at unexpected times and under varying conditions to simulate the unusual conditions that occur in case of fire. Staff shall hold emergency evacuation drills to familiarize occupants with the evacuation plans and procedure.

Recommendation 13

Adopt a fire drill policy that complies with Section 405 of the Virginia Statewide Fire Prevention Code.

Update on Recommendation 13
On December 1, 2021, VCBR issued the final Safety Guidelines, facility instruction 408, mandating fire drills to be conducted in accordance with the Statewide Fire Prevention Code.

Finding 14
In the review of facility safety policies, OSIG requested information about the replacement schedule for oxygen cannulas, tubing, humidifiers and filters. Three of four facilities inspected (HDMC, NVMHI and VCBR) did not provide a comprehensive policy or clinical procedure that covered the frequency of replacement and cleaning of oxygen-related supplies.

Recommendation 14
Develop a comprehensive policy or clinical procedure that outlines the replacement and cleaning schedule for oxygen cannulas, tubing, humidifiers and filters in order to optimize oxygen flow and reduce the risk of bacterial infection.

Update on Recommendation 14
On January 20, 2022, HDMC updated Clinical Procedure 67, Oxygen Therapy Guidelines, and Clinical Procedure 68, Administration of Oxygen, to include the replacement and cleaning schedule for oxygen cannulas, tubing, humidifiers and filters.

Finding 15
In the review of facility safety policies, OSIG determined that VCBR did not maintain a comprehensive medical gas and related equipment policy. In accordance with the Joint Commission's Life Safety & Environment of Care Document List and Review Tool (EC.02.04.01 EP4), VCBR should maintain an inventory of all high-risk medical equipment that includes activities and associated frequencies for maintaining, inspecting and testing all medical equipment on the inventory.

Recommendation 15
Develop a comprehensive policy that outlines activities and associated frequencies for maintaining, inspecting and testing all medical equipment on the inventory.

Finding 16
According to SVMHI Policy II 616 (EM), Use of Video Surveillance Cameras, video availability is six days. The six-day video retention is the lowest number of days on a recorder available before the recording overlap process begins. Providing only six days before the recording overlap begins could impede the investigatory process and destroy demonstrative evidence.

According to the Library of Virginia retention schedule GS-108, series number 012281, Security and Surveillance Tapes: Not Used as Evidence, facility video recording must be maintained for

30 days. Retention schedule GS-108 requires that "all known investigations or court cases involving the listed records must be settled before the records can be destroyed."

Recommendation 16

Review the Library of Virginia retention schedule and ensure that all facilities are in compliance. Consider delays in reporting caused by the patient's diagnosis or illness, communication deficits, comprehension of the incident event and fear of retaliation. Patient and staff safety is paramount, and all efforts to document injuries, abuse, neglect and inadequate care should be undertaken.

Finding 17

On October 19, 2021, OSIG requested NVMHI work orders for safety-related repairs. On October 20, 2021, OSIG sent another email clarifying the request for work orders to NVMHI executive staff. On October 27, 2021, OSIG sent a third request regarding the failure to submit work orders for safety-related repairs. As of the date of this report, OSIG had not received the requested documents or any further request for clarification.

In the review of NVMHI policy, A-55, Work Order System, section III B, the technicians shall assign a priority based on individual and staff safety to work orders. Review of this process was necessary to measure policy compliance in regards to the priority of work order completion. NVMHI policy, A-55 III G states, "Work Order Data shall be reviewed and analyzed to support repair/replacement decisions and to evaluate resource allocation and productivity." Failure to review safety-related repairs will impede the facilities ability to ensure safety.

Recommendation 17

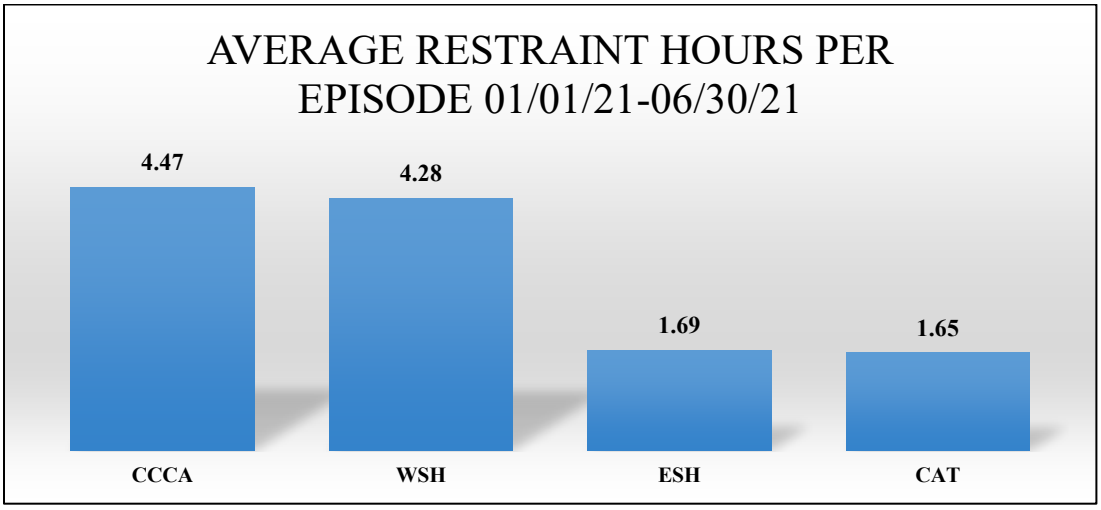
Have Central Office verify that staff are prioritizing and completing work orders timely.

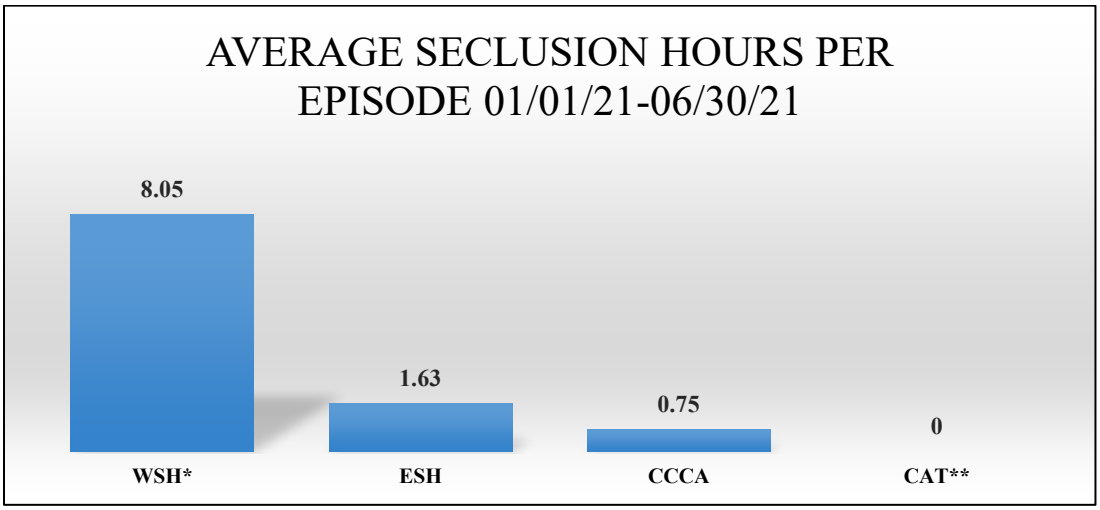
Seclusion and Restraint

Seclusion and Restraint	Reviewed
Patient Records	11
Staff Training Records	31
Facility Policies	21
Interviews Conducted	34
Departmental Instructions	1

Facilities	Date(s) Inspected
CCCA	08/24/21
ESH	09/07/21 & 10/26/21
WSH	09/17/21 & 09/28/21
CAT	09/17/21 & 10/12/21

In an effort to review the use of seclusion and restraint in state-run facilities, staff provided OSIG access to the DBHDS Seclusion and Restraint database, which provided the following data:





*Excluding the patient with the greatest amount of time in seclusion reduces the average seclusion time per episode for WSH from 15.62 hours to 8.05 hours

** Catawba does not utilize seclusion and takes a person-centered approach in order to minimize the use of restraint.

Finding 18

CCCA had the following seclusion/restraint documentation deficiencies in the three patient records reviewed:

a) CCCA was unable to provide a behavioral plan for two patients. Both patients exhibited behaviors resulting in restraints.
b) OSIG reviewed three patients' records in which the documentation was insufficient regarding de-escalation techniques used prior to being placed in restraints.
c) OSIG reviewed two patients' records in which the documentation was insufficient regarding the antecedent (trigger) for behaviors resulting in restraints.
d) OSIG reviewed two patients' records in which the documentation was insufficient to support the continuous use of restraints.

According to CCCA Policy 2326, Behavior Management, "The purpose provides that CCCA employs behavioral principles and methods to encourage and develop adaptive capabilities of children and adolescents at the center. This instruction establishes guidelines for the development, implementation, and evaluation of a range of behavioral applications for patient care."

"If a child or adolescent admitted to treatment at the center has behavioral treatment needs not being adequately met in the therapeutic milieu as described in above or in other treatment modalities, an Individual Milieu Management Plan (IMMP) may be integrated into the treatment plan. The need for an IMMP may be identified through the assessment procedures employed in the treatment planning process or by center-wide behavioral indicators that indicate a potentially severe problem. These indicators typically include dangerous acts toward self and/or others, seclusion and restraint use, non-participation in treatment, and other variables that are considered appropriate for monitoring by the treatment team and center administration." (CCCA Policy 2326 Behavioral Management).

CCCA policy 2411 Seclusion and Restraint, states, "Before initiating restraint or seclusion, staff must first attempt to manage the child's behavior using less restrictive interventions if possible. These should be documented on the seclusion/restraint flow sheet."

"In some instances, the threat of harm to the child or to others may require the use of emergency seclusion or restraint without first attempting less restrictive interventions. In such cases staff must clearly document in the clinical record on the seclusion/restraint flow sheet why less restrictive interventions were not used" (CCCA policy 2411 Seclusion and Restraint*).*

Recommendation 18

a) Include a behavioral treatment plan or IMMP for children that have exhibited behaviors deeming them a danger to self or others, use of seclusion and restraint, non-participation in treatment, and other variables that are considered appropriate for monitoring.
b) Adequately document de-escalation techniques used as a less restrictive response to behaviors.
c) Adequately document the antecedent resulting in the use of seclusion and restraint.
d) Adequately document the reasons, the responses to and the less restrictive interventions used for the use of continuous restraints.

Finding 19

Documentation in one patient's record at WSH stated, "Trauma suspected but not confirmed." The patient had incidents of head banging. During the most recent incident, a patient received a laceration to the head, requiring pressure and steri-strips to stop the bleeding. Staff did not order an MRI, CT scan, neuro consult or a protective helmet following this incident or any other incidents this patient experienced due to head banging. According to the WSH Medical Director, "These diagnostic tests and protective equipment were not ordered because head banging generally does not cause such injuries to the brain."

According to OSIG's Medical Director, "Mental status needs to be evaluated after a head injury of any kind. If there is repeated head banging, or even one incident that was great enough to cause a laceration, there needs to be head imaging performed to rule out acute hemorrhage/injury. Consideration of a helmet could be a low cost risk intervention to help avoid further injury."

Head banging is a common form of self-harm, linked to numerous negative outcomes including significant brain damage. Head banging occurs frequently in forensic services and has documented associations with traumatic brain injury in affected individuals, thus negatively impacting progress through the care pathway and treatment outcomes." (Verity Chester & Regi T. Alexander (2018) Head banging as a form of self-harm among inpatients within forensic mental health and intellectual disability services, The Journal of Forensic Psychiatry & Psychology, 29:4, 557-573, DOI: 10.1080/14789949.2018.1425472)

Recommendation 19

a) In the case of continuous head banging or a head-banging incident that causes an injury, perform appropriate imaging to rule out acute hemorrhage/injury.
b) Consider a helmet as risk intervention for patients with this continuous behavior.

Finding 20

a) ESH utilizes the Philosophy on Seclusion and Restraint form as the record of patient preferences in reference to interventions in the event a patient becomes a danger to self or others. While this form states that, "The least restrictive means of mechanical restraint, as determined for the individual by a physician with knowledge of the patient's preference, will be used to address the patient's behavior," it does not instruct the author to include what that preference is.
b) The Philosophy on Seclusion and Restraint form utilized by ESH has a place for the patient's signature and a box that states, "Patient is unwilling or unable to indicate his desire at this time." However, it did not include a place for the patient's authorized representative to acknowledge the patient's preferences.
c) In one record reviewed at ESH, there was no Philosophy on Seclusion and Restraint form.

"Providers shall meet with the individual or his authorized representative upon admission to the service to discuss and document in the individual's services record his preferred interventions in the event his behaviors or symptoms become a danger to himself or others and under what circumstances, if any, the intervention may include seclusion, restraint, or time out" (*12VAC35-115-110).* Without appropriate documentation of patient preferred interventions, ESH may not comply with human rights regulations for seclusion/restraint.

Recommendation 20

a) Revise the Philosophy on Seclusion and Restraint form to include a place to document the patient's preference.
b) Designate a place for the authorized representative to acknowledge and sign the form.
c) Complete the Philosophy on Seclusion and Restraint form upon admission for every patient.

Finding 21

Three records reviewed at ESH did not include documentation listing any contraindications to seclusion and restraint as required by human rights regulations.

"Providers shall document in the individual's services record all known contraindications to the use of seclusion, time out, or any form of physical or mechanical restraint, including medical contraindications and a history of trauma, and shall flag the record to alert and communicate this information to staff" (*12VAC35-115-110).*

"In psychiatric patients these risks are increased due to multiple factors including poor mobility, restraint, catatonia, sedation, and conventional antipsychotic use" (Intro of a Venous

Thromboembolism Prophylaxis Protocol for Older Psychiatric Patients. Croxford, Anna. BMJ Publishing Group Limited. 2015).

Undocumented contraindications place the patient at risk, especially if the patient has medical issues complicated by immobility or psychological concerns that may cause increased harm to the patient's mental status.

Recommendation 21
Include documentation in the patient record regarding contraindications to seclusion, restraint, and time out as required per regulations.

Finding 22
Two records reviewed at ESH did not include documentation indicating staff offered the patient range of motion, bathroom breaks and fluids during an episode of restraint in the emergency restraint chair.

"Individuals shall be given the opportunity for motion and exercise, to eat at normal meal times, and take fluids, to use the restroom, and bathe as needed" (*12VAC35-115-110).*

Not providing ROM, fluids, food and bathroom breaks could place the patient at risk for complications such as blood clots, dehydration and urinary tract infections.

Recommendation 22

a) Ensure that staff offer all patients ROM, bathroom breaks, fluids, food at meal times and the opportunity to bathe throughout the episode of seclusion, restraint or time out.
b) Document the times staff offered these events or patient's refusal.

Finding 23
ESH policy 450-035 Emergency Use of Seclusion or Restraint states, "Behavioral Health Advance Directive is a document that tells the behavioral health care provider what the person prefers, when the individual is unable or lacks the capacity to do so, as a result of a mental illness. It may include information related to medications, use of physical restraint or seclusion, and whom the person prefers to have contacted to act as their family correspondent or authorized representative."

a) Mechanical restraint is not included as an intervention in this policy.

"Restraint means the use of a mechanical device, medication, physical intervention or hands-on-hold…" *DI 214(RTS)11* Use of Seclusion and Restraint in State Facilities

ESH policy 450-035 states, "If the admission nurse determines that steps 1-3 are not clinically appropriate at the time of admission the treatment team will follow-up when/if they determine

that the patient has the capacity to understand, and the Hospital Philosophy on Seclusion and Restraint form will be presented to the patient for signature."

b) This policy does not include instruction on who will sign the form in place of the individual if they lacks capacity.

ESH policy 450-035 states, "When the patient is determined to lack the capacity for the informed consent by the LIP, the Social Worker will discuss notification of restraint and seclusion events with the family or authorized representative."

c) The Philosophy on Seclusion and Restraint form states, "Do you wish to have your family/authorized representative notified if you are put in seclusion or restraint?" This form does not address contact notification if the patient lacks capacity.

"When it is determined in accordance with *12VAC35-115-145* that an individual lacks the capacity to consent or authorize the disclosure of information, the provider shall recognize and obtain consent or authorization for those decisions for which the individual lacks capacity from the following if available:

- 1-Attorney.
- 2-Appointed health care agent.
- 3-Legal guardian.

If none of the three is available, the director shall designate a substitute decision maker as authorized representative in the following order of priority:

- Individual's family member.
- Next friend of the individual" (*12VAC35-115-146*).

<u>Recommendation 23</u>

a) Revise policy 450-035 to include "mechanical restraint" as part of the Behavioral Health Advanced Directive.
b) Revise policy 450-035 to include staff will present the "authorized representative" the Philosophy on Seclusion and Restraint form in the event patient lacks capacity.
c) Revise the Philosophy on Seclusion and Restraint form to include contact notification if patient lacks capacity.

<u>Update to Finding 23</u>

ESH stated the following via email with regard to this finding:

a) "This policy established in 2018 and supersedes the 2014 policy with the same name. Its last revision was also in 2018 with the inclusion of the 'Application and Termination of the Emergency Restraint Chair.' It would appear that prior to 2018 the ERC, also referred to as a mechanical restraint, was not previously mentioned in ESH policies. Though a substantial oversight, it appears that previous verbiage was utilized in this policy and only

certain sections updated to incorporate the ERC (mechanical restraint). Also under definitions, you will find definitions of restraints, to include mechanical restraints."

b) "The Philosophy of Seclusion and Restraint form is completed upon admission but it is not being sent to the AR if the patient is deemed not to have capacity. A fix would be to include the form in the packet of forms we send to the AR for signature."

Finding 24

ESH policy 450-054 Safety Restraints states, "Only restraints approved by the hospital and appropriately ordered will be used. When unusual circumstances occur, the physician with the medical' director's review and the hospital director's approval, may order restraints other than those on the approved list and document the rationale. Restraints approved for use for safety purposes include but are not limited to: Canopy bed, geri-chair reclined or with table top, seat belts, two side rails up on a bed, helmet, mittens, positioning wedges, jumpsuits, lap belt and restraint chair." The policy does not provide guidance as to what constitutes unusual circumstances.

Recommendation 24

a) Review and revise policy 450-054 to determine what constitutes unusual circumstances and what restraints would be included in the other than those on the approved list. Also, remove restraint chair from the list of safety restraints. Perform a quality assurance review to determine if in any episodes of restraint that staff used the emergency restraint chair under the auspice of safety per policy 450-054, which is intended for medical safety purposes.
b) If it is determined that there are instances of the emergency restraint chair being used for safety, report these instances immediately to the Facility Director, as this action would place ESH out of compliance with human rights regulations.

Update to Finding 24

a) ESH sent an email response to OSIG's inquiry about the above-mentioned language, stating, "It is unclear as to what "unusual circumstances" may mean. However, this current policy is under review currently at MEC for significant changes."
b) When OSIG inquired about whether Central Office had approved this policy, ESH responded, "This particular policy was approved in 2015 and last revised in 2016."
c) When OSIG inquired about why the restraint chair was included as a safety restraint, ESH responded, "The ERC is not a safety restraint and being classified as such is incorrect. This will require retraining and policy updating, which is currently being done."

Finding 25

ESH policy 450-047 Management of Aggressive Behavior, states "…However, if there are no approved techniques to deal with current situation, staff is allowed to utilize non-approved techniques to ensure the safety of the patient or others." The policy does not define what constitutes a non-approved technique.

Recommendation 25

a) Review the above-mentioned policy to determine if non-approved techniques complies with human rights regulations.
b) Have the revised policy 450-047 reviewed and approved by Central Office.
c) Perform a quality assurance review to determine if any episodes of restraint involved non-approved techniques.
d) If it is determined that there are instances of non-approved techniques being used for restraint, these instances shall be reported immediately to the Facility Director, as this action would place ESH out of compliance with human rights regulations.

Update to Finding 25

ESH emailed OSIG stating, "It is unclear what "non-approved techniques" this particular policy is addressing; however, ESH currently has an approved TOVA training with approved techniques, new employee orientation, and annual re-certification requirements. ESH is in the process of approving a new Seclusion Restraint Philosophy Statement and Guidance on Use of Seclusion/Restraint with the goal of reducing the use of both seclusion and restraint."

ESH went on to say, "This policy has been in place since 2014, with the last review being 2018. The policy is currently under review and is being updated to include trauma informed care language and to meet or exceed DI requirements, Virginia laws, LHRC, and other facility policy and procedures, including Emergency Use of Seclusion/Restraint."

ESH continued, "Though not well defined, the policy is attempting to state that a "non-approved technique" would be utilized in a situation where a "physical intervention is required immediately to ensure the safety of the patient or others when approved techniques have failed. The policy has not given specific examples of such situations."

ESH added, "Emergency Seclusion and Restraint Policy" is currently under review, which will include updates to the "Safety Restraint Policy" and the "Management of Aggressive Behavior Policy." The current active policies sent during OSIG inspection have been updated to meet regulatory standards, LHRC, DI, and Virginia laws, and the policies are currently awaiting MEC approval to be sent for final signatures."

Patient Procedures

Patient Procedures	Reviewed
Patient Records	15
Staff Training Records	15
Facility Policies	27
Interviews Conducted	28

Facilities	Date(s) Inspected
SEVTC	08/10/21
PGH	09/07/21 & 09/09/21
VCBR	09/07/21 & 09/14/21
WSH	09/17/21 & 09/28/21

Finding 26

VCBR did not include treatment plans in all three patient records reviewed that addressed medical needs in the electronic health record.

"Each individual receiving services shall receive those services according to law and sound therapeutic practice. Providers shall ensure that all services, including medical services and treatment are at all times delivered in accordance with sound therapeutic practice." *12VAC35-115-60 (A)*

Without proper identification of medical needs and proposed treatment goals for those needs, staff cannot ensure that patients will have sound therapeutic practice.

Recommendation 26

Include treatment plans in the electronic health records that identify and address all medical needs of patients.

Finding 27

VCBR had the following deficiencies in the electronic health record of a patient:

a) Staff had not updated the Against Medical Advice form stating he did not want a diabetic diet as ordered since 2018.
b) The A1C blood tests were ordered for twice yearly (or more often when the value is higher than 7.0); however, there was no value documented for August 2021, as ordered, when the patient's last documented value of 10.0 (high) was in May 2021.
c) The patient was a non-compliant diabetic whose blood values were elevated and would not follow a diabetic diet as ordered. Physician ordered an endocrinology consult on September 8, 2020; however, staff did not scheduled it until June 2021.
d) The patient had an order for TED (anti-embolism) hose for edema; however, OSIG found no documentation to indicate that the patient received them, that staff instructed the patient on how to use them or the outcome of use. There was also no documentation to indicate that staff had instructed the patient to elevate swollen legs to help reduce the edema.
e) Staff never arranged a sleep study for sleep apnea that had been ordered by the provider.

f) Staff did not appropriately complete the documentation in the Individual Observation Record by Direct Support Professionals for every 30-minute monitoring. Staff did not include all 30-minute checks in the record and observations only included time. The documentation lacked observation location and patient status.
g) Vital signs were performed only annually on the patient with a diagnosis of hypertension.
h) Not all physician orders were closed after completion in the electronic health records system. During the virtual review of this patient's EHR, the MD closed several physician's orders that remained open.

"Each individual receiving services shall receive those services according to law and sound therapeutic practice. Providers shall ensure that all services, including medical services and treatment are at all times delivered in accordance with sound therapeutic practice." 12VAC35-115-60 (A)

Without proper identification of medical needs and proposed treatment goals for those needs, staff cannot ensure patients will have sound therapeutic practice.

Recommendation 27

a) Develop and implement a policy regarding a patient's rights to choose and refuse care, the required documentation and the timeframe to update the patient's choice.
b) Implement a quality assurance check to ensure that staff implement timely diagnostic tests, specialty consults and all physician orders and that all completed orders are signed off on in the electronic health record.
c) Conduct staff refresher training on documentation of patient education, observation of patient status and instructions on use of durable medical equipment or other items.
d) Implement and follow a plan to perform vital signs on a routine basis that will establish a baseline for patients and include guidance on performing vital sign checks more often on patients with medical needs that warrant frequent monitoring.
e) Conduct staff training on the documentation of observation flow sheets to include date, time, location and status of patient. A checklist is acceptable except when concerns are noted.

Update on Recommendation 27

OSIG staff, including its Medical Officer, met with the VCBR Facility Director and Medical Director on October 6, 2021, about the above-mentioned findings. VCBR was in agreement with the findings, will implement corrective action and will include that in its response to this report.

Finding 28

PGH had the following deficiencies during the patient record review:

Patient A:
Staff added the IPOC into the electronic health record on August 2021, for this patient who was admitted February 2019. Prior to the plan implementation, the patient did not have a nursing plan; therefore, staff were unable to provide documentation that they addressed the patient's medical needs.

Patient B:
The patient's IPOC in the electronic health record only addressed behavioral diagnoses and did not identify or address the patient's medical needs.

Patients C and D:
Staff did not address COVID in either patient's treatment plan when they had tested positive for the virus.

Patient E:
Staff did not address anemia in the patient's treatment plan.

Patient F:
Staff did not communicate a change in the patient's gait status to nursing or to the physician in order to have the patient re-evaluated to determine the etiology of the status change. The patient was ambulatory with a normal gait on admission; however, according to a physical therapy note on August 2021, the patient "needs rolling walker, ambulation deficit, balance deficit, transfer deficit."

Patient G:
Patient's Treatment Plan did not address the following:

- Medical needs.
- Ambulation status.
- Requirements for total assistance with activities of daily living.

"Each individual receiving services shall receive those services according to law and sound therapeutic practice. Providers shall ensure that all services, including medical services and treatment are at all times delivered in accordance with sound therapeutic practice." 12VAC35-115-60 (A)

Without proper identification of medical needs and proposed treatment goals for those needs, staff cannot ensure medical services and treatment are "delivered in accordance with sound therapeutic practice" (12VAC35-115-60 (A)).

Recommendation 28

a) Identify all medical as well as psychological and behavioral needs of patients. Address those needs in a treatment plan.
b) Report significant changes in patient status, diagnoses, or symptoms to nursing and the physician. Reflect these changes in the patient record.
c) Complete all assessments, including falls risk, in their entirety as often as facility policy requires.

Finding 29

Three of the four records reviewed at PGH did not include patient, authorized representative, or guardian signatures on the treatment plans, indicating they were in agreement with the proposed treatment goals. Due to the current pandemic restrictions, protocols for obtaining signatures has changed. Staff can obtain signatures by mailing the plans and have the signed copies returned to the facility. However, there is no documentation to indicate staff made the attempt to obtain the signature.

"Each individual has a right to participate meaningfully in decisions regarding all aspects of services affecting him. This includes the right to consent or not to consent to receive or participate in services." *12VAC35-115-70 (1)*

"The Individual's services record shall include the signature or other indication of the individuals' or his authorized representative consent." *12VAC-35-115-70 (A-1c)*

The absence of patient, authorized representative or guardian signatures from the treatment plan leaves no indication that they are in agreement with the plan and/or changes implemented.

Recommendation 29

Ensure patient, authorized representative or guardian are in agreement with the proposed treatment by requesting a signature either during the meeting if in attendance or via a mailed or emailed copy if not in attendance. In the event the treatment plan is not returned to the facility, document the efforts made to retrieve it.

Finding 30

a) Ten of the 12 ISPs reviewed at SEVTC did not include patient, authorized representative or guardian signatures, indicating they were in agreement with the proposed treatment goals. Due to the pandemic restrictions, protocols for obtaining signatures has changed. If the patient, authorized representative or guardian are unable to attend the treatment plan meeting in person, staff mails a copy of the ISP and discharge summary for consent. However, staff instructed the authorized representative or guardian to return the signed discharge summary only and not the signed ISP.

b) Staff at SEVTC did not update a patient's individualized service plans as required when a patient's medical condition and/or needs changed. According to nursing staff, they added newly implemented treatments and medications to the treatment binder, and placed orders pertaining to direct support staff on a medical concern form, all stored in the home. However, the ISPs are not updated to reflect these changes.

    Example: *Patient A* – Patient's medical record did not include an ongoing order for catheterization as needed, but SEVTC was able to produce the order. However, the patient's ISP was not updated to reflect the order.

c) SEVTC had no patient, authorized representative or guardian signature forms in the record to indicate they were in agreement with the addition, deletion or modification of a patient's treatment or goals.

"The provider shall actively involve the individual and authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors. 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:

- The individual participated in the development of or revision to the ISP;
- The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative; and
- The reasons the individual or the individual's authorized representative chose the option included in the ISP." *12VAC35-105-660*

"The Social Worker will ensure that the authorized representative or guardian are notified of changes to the ISP, by mailing the ISP Change Note." SEVTC Instruction 2652 Personal support Team and ISP

"The individual's services record shall include the signature or other indication of the individual's or his authorized representative's consent." *12VAC35-115-70*

The absence of patient, authorized representative or guardian signatures from the ISP leaves no indication that they were in agreement with the plan and/or changes implemented. Although signatures were provided on the discharge summaries, this document varies from the ISP that reflects the patient's current treatment goals.

Without the addition of newly implemented treatments and/or goals to the existing ISP, the patient's plan of care will be incomplete. While OSIG recognizes the facility may choose to store orders consistently in a corresponding location in the home, all treatments and goals should be included in the existing ISP, as required.

Recommendation 30

a) Ensure patient, authorized representative or guardian is in agreement with the ISP by requesting a signature either during the meeting if in attendance or via a mailed or emailed copy if not in attendance. In the event the ISP is mailed or emailed and not returned to the facility, document the efforts made to retrieve it.
b) In addition to any locations SEVTC deems appropriate, add all changes, updates or deletions in patient treatment or goals to the ISP when they occur. Make the patient, authorized representative or guardian aware of the changes implemented.
c) Ensure patient, authorized representative or guardian is in agreement with any additions, modifications or deletions in the ISP by requesting a signature. If no signature is obtained, document all efforts made to obtain one.

Finding 31

Two of the four patient records reviewed at WSH did not include patient, authorized representative or guardian signatures indicating they were in agreement with the proposed treatment goals.

"The individual's services record shall include the signature or other indication of the individual's or his authorized representative's consent." *12VAC35-115-70*

Without the patient or authorized representative signatures on the treatment plan, there is no way to determine that the patient and or authorized representative participated in planning the patient's care.

Recommendation 31

Include patient, authorized representative or guardian signatures on all treatment plans and updates. If unable to obtain during the treatment team meeting, then mail or email a copy of the plan with a signature request. If the requested signature is not returned, document in the patient record that staff attempted to obtain the signature.

Finding 32

WSH staff did not complete a 158 Incident Form for an alleged sexual assault for one patient.

DI 401 (RM) 03 states the definition of Facility Incident Report is, "A form (158) used by department employees to notify their supervisors, facility risk managers, and other appropriate management of an incident that presents either actual or potential risk or liability. Facility Incident Report Forms (158) should be reported during the shift in which they occur, but no later than 48 hours."

Without staff completing incident forms (158) about allegations of sexual assault, there will be no way to ensure that staff reported it and followed-up on a patient's allegation as required. A sexual assault might go unreported.

Recommendation 32

Complete 158 incident forms for all reports of witnessed or discovered sexual allegations. Take further action, as deemed necessary, per policy as required.

Patient Administration

Patient Administration	Reviewed
Patient Records	28
Staff Training Records	11
Facility Policies	19
Interviews Conducted	22
Departmental Instruction	1

Facilities	Date(s) Inspected
CSH	07/29/21 & 08/04/21
NVMHI	09/10/21 & 10/19/21
SWVMHI	09/16/21 & 09/21/21
CAT	09/17/21 & 10/12/21

Finding 33

Three of the four facilities (CSH, NVMHI and SWVMHI) inspected were unable to provide adequate documentation that addressed patient complaints and concerns as requested. As part of OSIG's Complaint Line procedure, certain complaints require facility staff and/or Human Rights advocate intervention. Patients, families and staff may also file complaints internally at the facility. The documentation regarding the facility staff and/or Human Rights advocate involvement did not include the following:

a) Details confirming when the facility staff and/or Human Rights advocate visited or called the patient to address the complaint/concerns.
b) Recommendations or resolutions to mitigate the risk, if any, expressed in the complaint/concern.
c) The patient's response to the facility staff and/or Human Rights advocate recommendations/resolutions.
d) The author's signature and date.

"Every entry in a patient's record shall include date and time. Document all facts and pertinent information related to an event, course of treatment, individual's condition, response to care, and deviation from standard treatment. Every entry shall be authenticated by the author" (*CSH Policy MR-06d, pg. 1-9).*

"In receiving services, each individual has the right to have opportunities to communicate in private with lawyers, judges, legislators, clergy, licensed health care practitioners, authorized representatives, advocates, the Office of the State Inspector General and employees of the protection and advocacy agency" (*12VAC35-115-50).*

"CSH maintains a system for reviewing and when possible, resolving patient and family complaints that comply with the rules and regulations to assure the rights of individuals receiving services from providers licensed, funded, or operated by DBHDS. It is the policy of CSH that patient's concerns be addressed promptly and at the lowest organizational level possible related to the Human Rights Rules and Regulations" (*CSH Policy RTS-01e, Patient and Family Complaint Resolution).*

"In receiving all services, each individual has the right to be protected from harm, including abuse, neglect, and exploitation" (*12VAC35-115-50 (B-2).*

"Human Rights Advocates monitor the investigation of all allegations of abuse/neglect to ensure individual rights, protections and safety.
Examples of Evidence of Performance:

- Documentation of compliance reviews.
- Documentation of site visits.
- Documentation of the timely progression of complaints through the human rights system.
- Documentation that the safety and rights of consumers are protected during the investigation of allegations of abuse/neglect." DBHDS Office of Human Rights Practices, Procedures, and Protocols Manual.

Without adequate documentation from the facility staff and/or Human Rights advocate, the facility cannot provide acknowledgement of a patient's complaint; therefore, there is no confirmation that staff provided a recommendation or reached a resolution to mitigate potential risk. A patient could also experience trauma or increased risk of harm if concerns are not addressed, which would deny the patient's right to be free from abuse, neglect and exploitation while in the facility's care.

<u>Recommendation 33</u>

1) Document the following:
    a) The nature of the patient's complaint/concern, date and time of the occurrence.
    b) If the facility staff and/or Human Rights advocate met with the patient in-person or via telephone, the date and time of the meeting.
    c) Recommendations to mitigate risk, if any, and the resolution.
    d) The patient's response to the recommendations or resolution.
    e) If staff needs to follow up or a resolution was reached and no further action is required.
    f) If the Facility Director needed to be notified of the complaint and outcome.
    g) If the Virginia State Police was involved.
    h) If the complaint was referred to the DBHDS Central Office Human Rights Advocate.
    i) The author's signature and date.

2) Facilities should perform quality assurance reviews periodically to ensure they are appropriately addressing patient concerns and that documentation is adequate.

3) Update facility policy to include the following:
    - The process of meeting with the complainant.
    - Required documentation of the meeting.
    - Method of tracking complaints.

Finding 34

SWVMHI staff did not provide a patient with a change of clothing for four days. The location of patient's personal belongings (clothes) was unknown during this time.

"In services provided in residential and inpatient settings, each individual has the right to:

1. Have sufficient and suitable clothing for his exclusive use." *12VAC35-115-50*

Without having sufficient and suitable clothing for the exclusive use of the patient, staff violated the patient's human rights.

Recommendation 34

Ensure staff provides each patient with adequate clothing upon admission and as needed thereafter.

Finding 35

The DBHDS Human Rights Advocate assigned to SWVMHI failed to inquire why staff did not provide the patient a change of clothes for four days. Staff did not initiate a 201 investigation to determine whether these actions constituted neglect.

"Neglect – Means the failure by a program or facility operated by the department, 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, developmental disability, or substance abuse." DI201 (RTS)03 (3)

"Any workforce member who has any knowledge or reason to believe that an individual residing in a facility may have been abused or neglected, or both, shall immediately report this information directly to the facility director or his designee." DI201 (RTS) 03 (06)

Not reporting suspected patient neglect can lead to physical and/or psychological harm to the patient.

Recommendation 35

Report all suspected incidents of abuse, neglect and exploitation to leadership and, if needed, ensure the initiation of an investigation and/or a resolution is reached.

Note: After a review of the patient administrative procedures pertaining to human rights and the complaint process, OSIG determined CAT complied with established policy.

Dietary Compliance and Food Safety

Dietary Compliance and Food Safety	Reviewed
Patient Records	18
Staff Training Records	10
Facility Policies	21
Interviews Conducted	21

Facilities	Date(s) Inspected
HDMC	08/12/21
PGH	09/07/21 & 09/09/21
ESH	09/07/21 & 10/26/21
SWVMHI	09/16/21 & 09/21/21

Finding 36

SWVMHI had these patient specific findings about dietary compliance:

Patient A:

Staff did not mention a patient's diet order in the physician's admission history and physical. Staff noted that the patient had swallowing difficulties on the Nursing Admission Functional Assessment. When the patient experienced a choking incident on May 2021, staff changed the order to soft, bite-sized meals.

During OSIG's inspection, nursing explained that standard diet orders are in a drop down box within the electronic health record, and that there is a second screen in which physicians can choose free text and add any dietary restrictions. Nursing suggested that some physicians might be missing this screen and, therefore, implementing incorrect diet orders.

If diet restrictions for choking are not included in the patient record when an evaluation indicates the need for restrictions, a choking incident could occur.

Patient B:

A patient's nutritional assessment on admission January 2021, suggested a low sodium, low calorie diet for a patient with a weight of 223. However, staff ordered a regular diet. It was not until May 2021, that the order was changed to add a calorie restriction. SWVMHI missed the monthly weight check for this patient for August 2021.

Patient C:

The patient was identified in the medical record as a choking risk and had dietary orders for a pureed diet. Patient records indicate a dysphagia evaluation was completed on April 2018, and December 2019. No current dysphagia evaluation located in patient's record.

"Each individual receiving services shall receive those services according to law and sound therapeutic practice. Providers shall ensure that all services, including medical services and

treatment are at all times delivered in accordance with sound therapeutic practice." 12VAC35-115-60 (A)

According to the DBHDS Health Information Management Manual, annual reassessments are required for all disciplines involved in the treatment of the individual.

Recommendation 36

a) Train staff on the proper use of the electronic health system with regard to dietary orders/restrictions.
b) In accordance with DI 401, conduct quality assurance review, at least quarterly, to ensure staff implements all orders appropriately.
c) Conduct weight checks on patients, as ordered by the provider.
d) Ensure that staff are performing dysphagia evaluations annually, or as needed, to determine if a patient is a new or continued choking risk.

Finding 37

In a review of five patient's records at ESH, one did not include dietary flow sheets adequately completed by staff to indicate the patient's meal consumption or lack thereof.

"All fields on documentation tools such as assessments, flow sheets, and checklist documentations should have some entry made whether or not they apply to the individual receiving services." *DI 701 (INF) 93* Organization and Maintenance of the Clinical Record

A lack of adequate documentation regarding patient's meal consumption could prevent clinical staff from tracking a patient's caloric intake.

Recommendation 37

Thoroughly document the percentages of all meals/snacks the patient consumed or refused.

Note: During this inspection, OSIG found that HDMC and PGH complied with established policy in regards to dietary compliance and food safety.

Crash Cart Compliance

The 2021 Joint Commission Standards Requirements and Recommendations for crash carts states:

- "Crash carts contain high risk medical equipment, such as defibrillators. The organization manages medical equipment risks, inspects, tests, and maintains medical equipment.
- Label each drawer of the crash cart for contents, indicating the expiration date of supplies, if applicable.
- Maintain crash carts in locations that are easily accessible and make sure staff know where they are.
- Reduce complexity through standardization and simplification.
- Clearly arrange drugs in the medication drawer so they are easy to locate and the names are clearly visible (or clearly labeled and visible)."

Medical emergencies have a tendency to create an uneasiness and a sense of chaos during an event. If the emergency equipment is not readily available during an event, confusion could ensue and response times delayed, with the patient's outcome affected. The intent of a code crash cart is to ensure the correct emergency equipment, medications and supplies are readily available to manage the event.

"By improving the efficiency and reliability of the crash cart, and preventing unnecessary delays, you can improve patient outcomes following a crisis event" (Joint Commission Crash Cart Preparedness Quick Safety 32).

OSIG inspected one crash cart at each of the 12 facilities to ensure the following:

- The cart is locked and sealed.
- The drawers are clearly labeled.
- All items have been inventoried and stored appropriately.
- The timeliness of inventory and expiration date inspections, according to policy.

Facility	Cart Locked and Sealed	Drawers Labeled	Items Inventoried and Stored Appropriately	Timeliness of Inventory and Expiration Date Inspections
CAT	√	√	√	√
CSH	√	√	√	√
CCCA	√	√	√	√
ESH	√	√	√	√
HDMC	√	√	√	√
NVMHI	√	√	√	√
PGH	√	√	√	√

SEVTC	X	X	X	√
SVMHI	X	X	X	√
SWVMHI	√	√	√	X*
VCBR	√	√	√	√
WSH	√	√	√	√

*Inspections were completed according to policy, but facility had expired medication.

Finding 38

a) The emergency crash cart (suitcase) at SEVTC consisted of three parts:
   - A 62-inch rolling suitcase, located in the nursing office in building 29.
   - An emergency medication box, located in the nursing office in building 29.
   - A medical gas (oxygen) cylinder, located on the golf cart outside of building 29.

b) Staff maintains emergency medical supplies in a rolling suitcase with no divided sections. Some supplies were stored in separate plastic bags and not clearly labeled.

c) Staff stores emergency medications in a locked cabinet in the nursing office in building 29, separate from the crash cart (suitcase).

d) NFPA 99 (18), Health Care Facilities Code provides guidance to keep patients, staff and the public safe in facilities when using medical gas cylinders. The golf cart designated for the charge nurse contained a medical gas cylinder tank containing medical oxygen. This cylinder tank was stored in the open bed of a golf cart, exposed to varying weather conditions, as well as potential damage to the regulator or neck of the tank.

e) SEVTC is comprised of 15 separate homes, situated on three city blocks. The crash cart (suitcase), emergency medication box and medical gas (oxygen) cylinder are all stored in or near building 29. One emergency crash cart (suitcase), one emergency medication box and one oxygen cylinder are maintained separately on this expansive campus, which may slow response time.

NFPA 99 states that, "Cylinders stored in the open (outdoors) need to be protected from weather extremes. Cylinders cannot be chained to portable or moveable apparatus."

According to SEVTC policy 8110, "Nurse #16 for the shift is responsible for obtaining and bringing the rolling suitcase (supplies) to an emergency and nurse #15 is responsible for obtaining and bringing the locked (medication) box. The nurses will be responding from their current location to building 29 to retrieve emergency supplies and then respond to the location of the emergency."

Recommendation 38

a) Perform a risk assessment of the Code Blue response process to determine whether the use of one crash cart to serve 15 homes is appropriate.

b) Consider purchasing locked containers with drawers for organization. Label the contents of each drawer with a list of the contents posted on each drawer. Maintain an inventory sheet for the crash cart.
c) Maintain emergency medications in the crash cart container. Include in the drawer a list of contents and label medications for easy access by staff during an emergency response. Include expiration dates of medications in the inventory. Emergency medications should be in a locked container at all times.
d) Seek guidance from the State Fire Marshal in regards to approved methods of transporting and storing the emergency medical gas (oxygen) container in accordance with NFPA 99 guidelines.

Finding 39

At SVMHI, emergency medical supplies contained in the emergency response transportable bag were not clearly labeled and organized. Staff maintain the emergency response transportable bag in a rolling suitcase without dividers. There were no specific supply quantities listed in Policy 108(TX) 01-12 that should be maintained in the emergency response transportable bag. The emergency response transportable bag is located in room D64, while staff maintains the oxygen tank in room D70. Emergency medications were not stored in the emergency response transportable bag.

Recommendation 39

a) Perform a risk assessment of the Code Blue response process.
b) Consider utilizing a code crash cart with multiple locked drawers for organization that allows for extra space for the AED, oxygen, suction and other resuscitative equipment.
c) Establish and maintain inventory containing specific supplies and quantities and have staff routinely maintain the inventory. Label the contents of each drawer and post a list of the contents.
d) Maintain emergency medications in each crash cart container. Include in the drawer a list of contents and label medications for easy access by staff during an emergency response. Include expiration dates of medications in the inventory.

Finding 40

The crash cart reviewed at SWVMHI included the following expired items:

Drawer	Item	Expiration Date	Inspection Date
5	Vacutainer Blood Vials (green, purple, red tops)	8/31/21	9/21/21
5	IV Start Kits	6/28/21, 8/28/21	9/21/21

The following item was on backorder:

Drawer	Item	Status	Inspection Date
1	10% Sodium Chloride	Backorder	9/21/21

The items listed above have expiration dates prior to date of OSIG's inspection, and there was no information on when staff ordered the backordered item.

Recommendation 40

Review and replace all soon-to-be expired items and medications on the crash cart prior to their expiration. Ensure that all reasonable efforts are made to secure backordered items for the crash cart.

Note: Nine out of 12 (CAT, CSH, CCCA, ESH, HDMC, NVMHI, PGH, VCBR, and WSH) crash carts inspected by OSIG were in compliance with inspection criteria.

DBHDS reviewed the findings and recommendations and provided comments that resulted in changes to this report. DBHDS also provided OSIG with a corrective action plan. OSIG will conduct follow-up procedures later to determine if conditions have been corrected.

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

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March 15, 2022

Michael Westfall, State Inspector General
Office of the State Inspector General
P.O. Box 1151
Richmond, VA 23218

Dear Mr. Westfall:

DBHDS Central Office and facility leadership have reviewed the findings and recommendations from OSIG's Unannounced Inspection Report. We were pleased to find and would like to highlight that there were no findings noted during your visit and subsequent testing at Catawba Hospital. As noted in the report, corrective actions have been taken for some findings and we will continue to develop more detailed action plans for the remaining items. Several of the findings and recommendations have overarching principals tied to initiatives already underway by DBHDS including policy management and alignment; standardization of documentation in the electronic health record and other systems used across the enterprise; and consistency in handling alleged events and incidents investigated across the system.

As an agency, DBHDS is committed to enhanced oversight of patient care and safety across the system. While each finding and recommendation will continue to be considered further, there are several areas of concern that need to be expressed:

Finding 1: It is important to note incidents were reported to Central State Hospital (CSH) facility management for review despite not being documented on the Facility Incident Report Form, and the incidents were addressed by CSH staff within established procedures.

Finding 2: Facilities do not rely on a previous clinical assessment when evaluating the probability of an allegation. Current clinical assessments are used and the patient involved in the allegation is referred for assessment as part of the allegation review process. Furthermore, it is not acknowledged that improbable 201 investigations are closed like all others, and the individual (to include their authorized representative, if assigned) would be notified. In addition to the human rights advocate having oversight of these allegations and findings, so would the individual and the authorized representative who are also tasked with supporting and ensuring the individual is free from abuse, neglect, and exploitation.

Finding 3: While OSIG has continued to express concern over sexual abuse allegations, DBHDS has not been provided any support to demonstrate that adequate guidance has not been provided to staff, and other state and local law enforcement partners have not had similar concerns with the handling of cases upon further review as requested by OSIG.

Finding 6: According to CSH, the allegations reviewed and used as the basis of findings were either 1) unsubstantiated and did not need to be referred to law enforcement, or 2) deemed possible, referred to law enforcement, but were not pursed further by law enforcement. There are also some subjective and opinion based findings that are in question regarding the completeness of these investigations.

Finding 16: The language of the cited Library of Virginia retention schedule is not clear and may only apply to tapes not used as evidence. DBHDS has started working with the Library of Virginia to review this requirement; however, the current technology infrastructure and resources to acquire a significant increase to digital storage space through the Virginia Information Technologies Agency are not readily available to meet a broader interpretation of this requirement. As such, OSIG support and a recommendation to increase funding to DBHDS for this purpose would be beneficial and would directly impact our ability to implement the current recommendation.

Finding 17: Without specific findings related to the work orders that demonstrate a significant risk to the agency, the existing oversight process will continue without additional intervention by Central Office.

Finding 19: It is critical to note that an order for imaging, or any other treatment or testing, is and will continue to be based on a clinical assessment by a physician.

Finding 29, 30, and 31: As cited as part of the finding, code allows for an "other indication" of consent. The "services record" is defined in the code as "all written and electronic information that a provider keeps about an individual who receives services." In sum, consent needs to be documented in the record, but there is no requirement for it to be documented on the treatment plan. Other forms of consent and communication are available, as well as documentation regarding the patient and authorized representative participation.

Finding 33: Complaints reviewed on behalf of OSIG have been completed in accordance with the OSIG Complaint Line Policy and Procedure Manual. Items a) through d) as noted in the finding are not required by the Complaint Line Manual and are not part of the Complaint Response Form provided and required for use by OSIG. However, the narrative provided in the Complaint Line Response Forms completed by DBHDS routinely confirms that the allegation was reviewed with the patient, notes the concern has been addressed and if recommendations for improvement are noted, and describes the patient's response. DBHDS provides the responses as required, and OSIG has rarely expressed concern regarding the content and thoroughness of the response over the past three years.

It is also critical to note that any complaint referred from OSIG that meets the criteria for a 201 abuse and neglect investigation, as generally described in the last paragraph of finding 33, is handled as such. DBHDS provides the 201 investigation record to OSIG in these instances, and the investigation record requirements already include the elements described in Recommendation 33. Most OSIG complaints do not require that level of investigation, and DBHDS does not have sufficient resources

to complete a 201 investigation for all complaints that do not meet the criteria described in the departmental instruction.

Lastly, OSIG did not request complaint records from the Office of Human Rights during the course of the inspection process and the CSH Policy quotation regarding authentication by the author including the date and time of an entry is not provided in context. This requirement relates to the patient's clinical record, not investigatory records that are maintained in accordance with other policies and procedures, and the human rights advocate's records are not commingled with facility investigation records as the advocate works for central office in an oversight capacity of the facilities. In closing, I am thankful and proud of the DBHDS staff for their commitment to continuous quality improvement. We remain committed to further evaluating areas for improvement related to patient safety and quality to help prevent negative outcomes within our system of care. We also look forward to working with OSIG to enhance the unannounced inspection process through increased awareness and engagement by our staff throughout the inspection cycle next year.

Sincerely,

Nelson Smith
Commissioner