COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.state.va.us

February 27, 2006

Mr. Taylor Davis, LCSW
Chief Operating Officer
Whisper Ridge of Charlottesville
2101 Arlington Avenue
Charlottesville, Virginia 22903

RE: License # 630-14-001

Dear Mr. Davis:

The Department of Mental Health, Mental Retardation and Substance Abuse Services ("the Department") has determined that Psychiatric Solutions of Virginia, d/b/a Whisper Ridge of Charlottesville ("Whisper Ridge"), whose main offices are located at 2101 Arlington Avenue, Charlottesville, Virginia 22903 is in violation of the *Standards for Interdepartmental Regulation of Children's Residential Facilities,* 22 VAC 42-10-10 *et seq*, the *Regulations Providers of Mental Health, Mental Retardation and Substance Abuse Residential Service for Children*, 12 VAC 35-45-10 *et seq,* and the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services,* 12 VAC 35-115-10 *et seq.* Pursuant to the authority vested in the Commissioner under Virginia Code § 37.2-418, you are hereby notified of the intention of the Department to revoke the license of Whisper Ridge of Charlottesville.

The Office of Licensing (OL) conducted unannounced investigations into numerous incidents at Whisper Ridge on January 19, 20, 23, 27, and 30, 2006 and February 2, 3, 8, 14, 15 and 21, 2006. OL staff participating in these investigations included Senior Licensing Specialists Yvonne Luster, RN, MHS; Rhonda Angel, M.Ed; Tammy Trestrail, LCSW; Veronica Davis, LCSW; Joslynn Perry, MSW, ACSW; and Regional Manager, Ralph Sroufe, LPC, LSATP. Office of Human Rights (OHR) Advocates Mark Seymour, M.Div. and Chuck Collins, JD, also participated in the investigations.

The factors contributing to this decision include multiple violations constituting neglect in resident care, beginning with the assault of resident [redacted] by several other residents on January 14, 2006. This assault led to a need for the provision of immediate medical treatment to [redacted] due to head trauma (concussion), possible strangulation, and bruising/contusions over several areas of his body. This incident was the direct result of inadequate staffing and supervision on the unit

where [redacted] was located. At the time of the assault, only two staff members were present for twelve boys. Sight and sound supervision was not provided for residents. This was in violation of Whisper Ridge's policy. In addition, in spite of the concerns nursing staff voiced about the severity of [redacted]s injuries, administrative staff directed nurses not to call emergency services (911). According to nursing staff, in a meeting held the day after the assault, administrative staff stated that they did not want 911 called because of concerns that the State might find out.

Since the assault on resident [redacted] on January 14, 2006, at least three serious assaults have occurred, including resident to resident assaults and a resident assault on staff. The most recent assault occurred on Tuesday, February 21, 2006, and resulted in injury to staff members and police intervention. In almost every case where OL or OHR staff has interviewed residents, the residents have reported feeling unsafe due to peer assaults and lack of staff intervention. Resident [redacted] told human rights advocates that he was being targeted by other residents and felt terrorized. Shortly after this conversation, he was attacked by other residents. Whisper Ridge staff was injured intervening to stop the attack. Resident [redacted] has aggression now listed as one of her problems in her service plan. She stated that she had to learn to "fight back" to defend herself against the aggression of others at Whisper Ridge. In interviews, her psychiatrist confirmed this. This indicates that the milieu at Whisper Ridge is an unsafe place, creating new problems for residents rather than solving them.

Residents have also not been protected from self-harm. Recently, resident [redacted] and resident [redacted] overdosed with medications that had reportedly been "cheeked," which resulted from nursing staff's failure to properly follow Whisper Ridge medication administration protocols. In at least one of these incidents, involving [redacted], there was a significant delay in accessing emergency medical care due to staff not immediately implementing emergency procedures. In both of these overdose incidents, residents required emergency room treatment, but were transported in facility or staff vehicles, which were not properly equipped to address a medical emergency should either of the residents have developed further complications.

There have been several recent resident suicide attempts involving [redacted], [redacted] and [redacted] In those three cases, neither nursing nor medical staff medically assessed the residents in a timely manner. In fact, OL staff has requested psychiatric re-evaluation of several residents to determine if they are still appropriately served at Whisper Ridge.

During the course of investigations, OL staff has discovered numerous allegations of Whisper Ridge staff sexual abuse of residents. These allegations remain under investigation and if such allegations are substantiated, citations will be made and forwarded to you and may also be included as a basis for the Department's decision to revoke your license.

In addition to Whisper Ridge's failure to protect its residents, medical care is not being provided properly. Since the investigation began, OL staff members have discovered over twenty medication errors, including some residents not receiving ordered medications for days or longer. Documentation discovered by OL staff found that there is a system in place to hide medication errors, by having nursing staff "correct" such errors, without indicating that such "corrections" are late entries. Interviews with your physicians indicate that administrative nursing staff has countermanded physician orders on at least two occasions.

The number of mental health direct care staff and nursing staff are inadequate to address current needs and number of residents. There have been reports from Whisper Ridge staff that medical appointments are not kept because not enough staff are on hand. Staffing has not been adequate to protect or supervise residents properly. Residents interviewed report not feeling safe. Licensing staff found that on February 3, 2006, two staff members were supervising eight residents, four of whom were on special precautions. Three residents, [redacted], [redacted], and [redacted] went Absent Without Leave (AWOL) recently due to inadequate staffing and supervision.

The required regulatory reporting of incidents and serious injuries has often not been followed, and when reports are made, they are often very vague and misleading, minimizing the seriousness of incidents that have occurred so that neither the OL nor the residents' guardians really know what is happening in the facility and cannot provide adequate oversight of residents. The reports on the [redacted] assault omitted some of the actual events and minimized his injuries. In addition, there have been multiple reports of resident "escorts" or physical holds that on review are actually restraints, in violation of the Human Rights Regulations.

Whisper Ridge has not assessed individuals appropriately prior to admission and has admitted individuals whom it cannot manage with existing staffing or does not have the expertise to treat.

On February 4, 2006, in an e-mail sent at midnight, the OL asked Whisper Ridge to develop a crisis stabilization plan by February 6, 2006 as a result of the multiple incidents that had occurred and the disturbing conditions the OL found in the facility. Whisper Ridge submitted a plan on February 6, 2006. See Attachment A-Crisis Stabilization Plan and Response. Incidents have continued to occur at an alarming rate. In the period between February 14, 2006 and February 22, 2006, a resident ([redacted]) under 1:1 observation managed to attempt suicide, two residents went AWOL, another resident ([redacted]) was assaulted and injured by other residents and climbed up on the roof allegedly to get away from his attackers or go AWOL, and at least two other residents ([redacted] and [redacted]) attacked staff resulting in police intervention.

It should also be noted that the Department previously entered into a Consent Agreement for continued operations with Whisper Ridge on November 29, 2004, through September 30, 2005, based upon similar violations and findings.

There is no evidence that Whisper Ridge is daily providing a structured program of therapeutic, educational or recreational care. Below is a summary of the most serious violations that have affected residents' health and safety. These violations and additional violations are attached in a corrective action plan that was sent to Whisper Ridge via fax on February 23, 2006. See Attachment B. The Department is basing the revocation of your license on the violations detailed in this letter and in the attachments.

REGULATIONS 12 VAC 35-45-30, 22 VAC 42-10-690.A.2 and 12 VAC 35-115-50.B.2:

Each Provider shall guarantee resident rights as outlined in § 37.1-84.1 (§ 37.2-400 as recodified) of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services (12 VAC 35-115).

There shall be evidence of a structured program of care designed to provide protection, guidance and supervision.

In receiving all services, each individual has the right to: (2) Be protected from harm including abuse, neglect, and exploitation.

1. Whisper Ridge staff failed to provide a structured program of care to protect and supervise residents on 500 Hall on January 14, 2006 when a male resident [redacted] was assaulted by other residents, sustaining serious injuries before staff intervened. Child Protective Services has made findings of neglect against the two staff members involved, due to their lack of supervision of residents on the 500 Hall on January 14, 2006, which allowed resident [redacted] to be seriously assaulted by other residents and suffer serious injuries, including a concussion, prior to staff intervention.

2. Staff neglect contributed to the hospitalization of resident [redacted] on January 27, 2006 for a Seroquel overdose, as well as a failure to provide a structured program of care to protect and supervise residents. Specifically, nursing staff members neglected to implement medication administration procedures in a manner to prevent and/or minimize resident [redacted]s ability to cheek prescribed medications and stockpile these medications, for a period of at least seven days.

3. Nursing staff neglected to implement medication administration procedures in a manner to prevent and/or minimize resident [redacted]'s ability to cheek prescribed medications and stockpile these medications for a number of days. This resident was able to hide the hoarded medications in her room and avoid detection by moving them when the "planned" twice-weekly room searches were to be conducted. She took an overdose of this medication in late January, 2006.

4. Whisper Ridge staff failed to provide a structured program of care to protect and supervise residents as shown in a January 4, 2006 incident report (7:05 pm) which states that a peer "walked up to resident MR and began hitting resident in the head with a stick causing injury. Resident guarded herself with her hands while screaming out." Nurse assessment by [redacted], LPN, at 8:40 pm notes "assessed resident hematoma Rt. occipital area, Rt. shoulder whelp mark, ring finger swollen, appears crooked. Applied ice to hand and head. Notified physician - Neuro checks q shift."

5. Whisper Ridge neglected to maintain the safety of resident [redacted]. [redacted] stated in an interview with OL staff on February 3, 2006, that he was "told to follow staff around" as his safety plan. According to the incident report form dated January 15, 2006 at 7:30 pm, [redacted] was at his room door when another resident approached him, pushed him, and hit him with a closed fist. A different peer also hit him in the face at least twice which resulted in the following based on nursing documentation: small abrasion noted on right eye at outer eyebrow area and swelling at orbital area. Based on this assault, [redacted] was placed on close observation, which according to Whisper Ridge's policy on Special Precautions Guidelines does not exist. Whisper Ridge does have a policy regarding

Continuous Observation which requires a resident to be in visual range of staff at all times. [redacted] was attacked for the second time in his bedroom while asleep. Another peer entered his bedroom, punched [redacted], and pushed him to the floor. Whisper Ridge failed to provide protection for this resident and to follow its own policy and procedures. A resident was able to enter [redacted]'s bedroom and assault him prior to staff intervention, while placed on special precautions. Whisper Ridge also failed to provide a structured program of care for the protection and safety of this resident. According to the therapist note written on January 17, 2006 by Megan Ice, she encouraged [redacted] "to use other methods of keeping himself safe, such as remaining close to staff and alerting staff to any threats". This method of intervention does not clearly define the staff's role in ensuring the protection and safety of residents. In fact, this method suggests that [redacted] is responsible for his own safety. In addition, there was no supporting documentation in his record to suggest that the treatment team had reviewed the issue of his safety or developed a safety plan. The provider's initial response to the first assault resulted in the "close observation" procedure, which failed to ensure his safety because he was again assaulted while sleeping in his bedroom.

6. Staff member FP reported to OL staff that she suspected a staff member [redacted] had sexually abused [redacted] on February 2, 2006. The resident stated in interviews with OL and OHR staff that he had a close relationship with [redacted] and believed that [redacted] "liked him in that way." On February 3, 2006 [redacted] turned in a "sick call" slip to his therapist, TF, stating that he had rectal bleeding. In subsequent interviews, QL denied any sexual abuse by the staff member. There was no nursing assessment of his complaint, and no documentation that Dr. C, the attending medical physician was made aware of the complaint.

7. Resident [redacted] who had experienced a very difficult week (aggression, positive drug screen, refusal of therapy, serious assault of peer), and was noted on January 11, 2006 by his therapist to be an AWOL risk, was not maintained in eyesight of staff at all times when in an outside courtyard between the cafeteria and the gym. Approximately two hours prior to the AWOL, the resident seriously assaulted a peer, who was taken to the hospital via ambulance. After that incident, the resident was visited by his pregnant girlfriend and her mother and was given money by the girlfriend's mother. He had also gone to the unit to change his shoes and coat just prior to going AWOL. Staff did not see him get onto the roof of the building to AWOL. He was allegedly (according to resident reports in the internal investigation submitted to the OL January 24, 2006) boosted onto the roof in the courtyard by another resident. Staff neglected to maintain adequate supervision of the resident who went absent without leave.

8. [redacted] did not receive treatment for a yeast infection. There was an order for Diflucan 150 mg for yeast infection on November 11, 2005 but there was no documentation showing that the medication had been administered. There was an order written for her to have a urine culture sent on January 2, 2006 for blistering on her labia, burning and discharge but there was no documentation showing that the culture had been done. There were orders written for visits to Teen Health

Clinic dated January 4, 2006 and January 31, 2006, but no documentation of clinic visits found in the record.

9. On February 03, 2006, four boys on 400 Hall were identified (documented) as needing "close observation" by staff. There were eight residents on the unit and two MHS staff assigned for second shift on that unit. This staffing renders constant observation of four residents extremely difficult, if not impossible.

10. [redacted] reported in interviews that residents who were on lower phase levels or on AWOL precautions were not taken for physician appointments because Whisper Ridge could not assign an adequate number of staff to accompany the resident to maintain his/her safety. Nursing staff have also reported to licensing staff that residents have not been sent out for timely medical care/treatment due to a lack of staffing.

11. Whisper Ridge nursing staff informed Licensing staff in interviews that administrators take residents off of close observation and 1:1 precautions because there are not enough staff members to provide the required level of monitoring while residents are on these precautions.

12. Several residents, including [redacted], [redacted] and [redacted], who are known to self-mutilate, have access to many sharp objects (including razors and screws) with which they have used to harm themselves on several occasions, as documented in resident records and on Incident Reports, and confirmed in interviews with these residents by OL staff.

REGULATION 22-VAC 42-10-700.A(1), (3), and (4) and 12 VAC 35-45-150.1:

The facility shall have and implement written procedures for promptly: (1) Providing or arranging for the provision of medical and dental services for health problems identified at admission; (3) Providing emergency services for each resident as provided by statute or by the agreement with the resident's legal guardian; and (4) Providing emergency services for any resident experiencing or showing signs of suicidal or homicidal thoughts, symptoms of mood or thought disorders, or other mental health problems.

The provider shall develop and implement written policies and procedures for a crisis or clinical emergency that shall include: (1) Procedures for crisis or clinical stabilization, and immediate access to appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services if on-call physician back-up or mental health clinical services are not available.

The facility failed to provide appropriate emergency and other healthcare services for residents. Whisper Ridge also failed to follow their internal policies and acceptable standards of practice in addressing medical emergencies.

1. On January 14, 2006, nursing staff were instructed to not call 911 by two Administrators on Call, although nurses on duty had assessed a male resident [redacted] to need emergency medical attention due to noting that he stopped breathing on two

occasions, had cyanosis of his lips and nail beds, experienced what appeared to be two seizures, and had highly elevated vital signs.

2. Documentation and staff reports substantiate a delay of at least 25 minutes in transporting [redacted] to the hospital emergency room. The delay in getting emergency medical care for resident [redacted] is significant because documentation and reports reveal a change in the resident's physical and mental functioning between the time he reported ingesting the medications and the time in which he is actually transported to the hospital emergency room. After the resident reported taking an overdose of Seroquel, nursing documentation at 1800 stated resident was alert and vitals were obtained. At 1815, nursing documentation stated a change in vital signs, change in affect from alert (at 1800) to "flat" and a change in his physical stamina (i.e. movement of extremities slow motion). Reports obtained from the nursing supervisor (VH) and the nurse on duty (LB) reveal that they determined the resident to be in a life-threatening situation. These reports and documentation of changes in the resident's level of functioning substantiated that this was a potentially life threatening situation which, according to the provider's emergency policy entitled, "Written Plan for Emergency Services", required staff members to call 911 for assistance. Staff reports and documentation did not demonstrate that staff members called 911 for immediate assistance. Dr. J was contacted and directed staff to call 911 immediately. However, the operations coordinator assigned two MHS (Mental Health Specialists) to transport JH to the University of Virginia Hospital (UVA) Emergency Room (ER) in a Whisper Ridge vehicle, which did not have emergency medical equipment in it to deal with more complicated medical problems in the event the resident's condition worsened. The RN was so concerned about [redacted] that she insisted on also riding with them. He was kept overnight at UVA and returned to Whisper Ridge the following day.

3. Resident [redacted] was able to cheek prescribed medications and stockpile these medications for a number of days. This resident was able to hide the hoarded medications in her room, and avoid detection by moving them when the "planned" twice-weekly room searches were to be conducted. Staff then neglected to facilitate and/or arrange for <u>immediate</u> access to appropriate external resources as required by 12 VAC 35-45-150.1 when [redacted] took the medications. Specifically, emergency medical attention was not appropriately accessed because the RN was advised not to call 911 for female resident [redacted]. The resident's transport to UVA for emergency medical attention was done without accessing appropriate emergency medical personnel/ ambulance, and endangered the resident by transporting her in a Whisper Ridge vehicle without emergency medical equipment and medical personnel.

4. Resident [redacted], who attempted suicide, did not receive any medical attention in response to the suicide attempt. An Incident Report written by MHS Tomika Young at 12:56 pm on January 2, 2006 stated that female resident [redacted] was found on "...the floor of her room with a belt tied around her neck and attached to the handle of her drawer. Resident was also turning purple in the face. Staff immediately began to remove the belt from the resident's neck." According to the Incident Report, assistance from alternate staff arrived (noted to be IS and LC, MHS staff) and staff removed the belt, stripped her room, and escorted her to the unit hallway. Staff was

noted to have put the resident on a "self-harm" protocol and "will continue to monitor her behaviors". Although the Incident Report documented that the RN was notified at 12:56 pm, there was no nurse's note in the record. A progress note, also written by TY, MHS, stated basically the same events. There was no indication the resident was medically evaluated at any time for this incident. There was no nurse's "medical review" written as required on the Incident Report. Nurses interviewed confirmed that they were not informed of the incident until the next day. However, despite a nursing assessment not being documented on the incident report and nursing staff statements that they were not informed about the incident until the next day, an e-mail from Melissa Sergeant, to Rhonda Angel, dated February 22, 2006, stated "the nurse who assessed AH assessed her as being alert and oriented with a patent airway in no acute distress." There was no indication this documentation in the e-mail was a late entry in the record.

5. Female resident [redacted] who experienced a 13-minute seizure on December 21, 2005 (from 6:05 am to 6:18 am), as reported by nursing notes and interviews, was not taken for immediate medical treatment, although the Whisper Ridge physician ordered her to be sent to the ER immediately. Based on nursing and physician interviews, and record documentation, Dr. J gave the order via phone to the nurse to send [redacted] to the ER immediately. When he and Dr. M came to the facility a few hours later, [redacted] still had not been sent. MF, RNCS, COO, had come to the facility after [redacted] had the seizure and determined that she did not need to go to the ER immediately. According to an interview with VH, Director of Nursing, MF had told her to "sit on it and re-evaluate later." MF overruled the physician's order. Upon discovering [redacted] had not been sent as of 12:30 pm, Dr. M ordered her to be sent immediately.

6. Female resident [redacted] made a suicide attempt on January 29, 2006 by placing a rope/cord from her sweatpants around her neck and attempting to hang herself, but was not seen by a physician until January 31, 2006. On February 2, 2006, [redacted] was observed by OL staff with a belt in her jeans. She reported feeling unsafe. The Office of Licensing staff requested that [redacted] be psychiatrically re-assessed as soon as possible to determine if she was still appropriate for continued treatment and could remain safe at Whisper Ridge. Upon psychiatric assessment by Dr. J on January 4, 2006, [redacted] was determined to no longer be appropriate for treatment at Whisper Ridge.

7. Male resident [redacted] wrapped a sheet around his neck in an apparent attempt to hang himself on January 31, 2006. He was not assessed by a nurse on that day. The provider also failed to adequately complete a suicide risk assessment on the resident. According to documentation dated January 31, 2006 by RJ, shift leader prior to the resident attempting suicide, [redacted] was in the hallway "joking" about doing self-harm. After the suicide attempt, there was no supporting documentation that the nurse or psychiatrist was contacted for evaluation/assessment. During the February 8, 2006 interview with Dr. J, he reported that staff did not inform him that [redacted] had attempted to hang himself. In addition, Dr. J reported that [redacted] told him on February 4, 2006 he tied a sheet around his neck, five days after the suicide attempt. The therapist's individual therapy session note dated February 1, 2006

written by TF, clearly states that the day after the suicide attempt "he displayed several cognitive distortions during the session and had a irritable mood. . ."

8. Whisper Ridge neglected to maintain the safety of male resident [redacted]. [redacted] was placed on special precaution "1:1" which means, according to Whisper Ridge policy, that "staff accompaniment is required at all times (at arm's length)" and "access to sharps, belts, cords, hair accessories, or other contraband items which may be a potential risk, is denied." According to the incident report form dated February 14, 2006 at 5:09 pm, [redacted] requested to use the bathroom. He went into his bathroom and tied a shoestring around his neck and attempted to choke himself. The provider failed to ensure that special precaution 1:1 was implemented appropriately and to secure any items that could pose a potential risk for the resident to harm himself such as his shoe string. In addition, a multidisciplinary note written by the nurse on February 14, 2006 at 1800 stated that the resident was found in the bathroom by staff with a shoe string around neck-short of breath-responded to stimulation. The shoestring had to be removed from resident's neck. Prior to this suicide attempt, at 5:10 pm, (Internal Incident Report form) [redacted] engaged in self-injurious behaviors such as scratching himself with his fingers and (multidisciplinary note dated February 14, 2006) tried to pick something up from the floor to choke himself.

REGULATION 22 VAC 42-10-720(F),(G), VAC 35-45-30, 12 VAC 35-115.50B2 and 12 VAC 115-60.B8

Medication prescribed by a licensed physician shall be administered as prescribed.

A daily log shall be maintained of all medicines received by each resident and shall identify the individual who administered the medication.

Each Provider shall guarantee resident rights as outlined in § 37.1-84.1 (§ 37.2-400 as recodified) of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services (12 VAC 35-115).

There are several documented instances of prescribed medication not being administered as prescribed. Nurses responsible for administering prescribed medications did not follow appropriate Whisper Ridge protocols. There were numerous prescription medication errors noted, confirmed by review of the Medication Administration Record (MAR), Incident Reports, and Nursing Interviews:

1. On November 25, 2005, resident [redacted] was given a urine drug screen that was positive for benzodiazepines. The resident had been admitted on November 8, 2005. No benzodiazepines were prescribed for the resident and there were no physician orders for passes outside the facility. VH reported to licensing staff that controlled substances had been reported missing to administrators. A review of incident reports also found instances where medications were found sitting atop medication carts in cups, making it possible for residents to obtain medications.

2. VH also reported that in December 2005, she reported to MS that 28 Adderall were missing that had been prescribed for resident [redacted]. She further reported that she had no knowledge that an internal investigation was conducted regarding the missing medications.

3. [redacted]'s medication administration record (MAR) was observed for the month of January 2006. There are three staff initials written for administering medications, however, there are no complete signatures written on the MAR, to account for these initials, as required by medication administration procedures.

4. Female resident [redacted] did not receive Seroquel as prescribed from February 1-3, 2006 due to having no medication.

5. Female resident [redacted] did not receive Risperdal as prescribed from February 1– 3, 2006 due to having no medication.

6. Female resident [redacted] did not receive Risperdal 1 mg BID for mood February 1-3, 2006 (it was noted that consent was not returned). She received Seroquel and Tripital for February 1, 2006 only. Clindamycin Phosphate Pledgetts 2x's daily 0800 dose were not given February 1, 2006 – February 2, 2006 am.

7. Female resident [redacted] was given Abilify until January 10, 2006, although the medication was discontinued on November 2, 2005 (consent to discontinue was also obtained on November 14, 2005). This was documented on an Incident Report written on January 10, 2006 at 1600 by VH, RN. RN VH notified Dr. J at that time. This medication error was also noted E.P.'s record (medication order and MAR), and acknowledged by RN LB in interview with several Licensing staff on February 2, 2006.

7. Resident [redacted] did not receive prescribed medications for several days. He was admitted January 26, 2006, assessed by Dr. J on February 1, 2006, and was prescribed Trazadone 100 mg and Lexapro 2 mg (per written orders). As of February 8, 2006, [redacted] had not received any medications because Whisper Ridge had not gotten consent from [redacted]'s social worker. During the investigation, Whisper Ridge was unable to produce any documentation showing that they had requested such consent, until February 15, 2006, which indicated the guardian had signed the consent on February 10, 2006.

8. On January 2, 2006, [redacted] was given Penicillin by the nurse. The medication was not scheduled to be given until her dental appointment on January 10, 2006 due to Mitral Valve insufficiency. The physician was informed and instructed to continue with the correct order.

9. On January 16, 2006, staff noted that an envelope was left in the nursing station window containing medication for a resident.

10. On January 22, 2006, [redacted]s Singulair, ordered to be given but never transcribed to the MAR on admission, was omitted December 14, 15, and 16, 2005.

11. On January 22, 2006, [redacted]'s Ortho Evra patch was omitted. The physician was aware, and continued the order.

12. On January 24, 2006, [redacted]'s 0800 medications were omitted.

13. On February 5, 2006, [redacted]'s (last name not documented) medication was found on the front desk. The medication was removed and given to the nurse. (Incident report completed by staff member TC).

14. On February 5, 2006, [redacted] did not get his 1300 dose of Medrol. The Nurse Manager was notified.

15. On February 6, 2006, [redacted]'s 1200 dose of Amphetamine Salt was not initialed in the MAR.

16. On February 7, 2006, [redacted] 0800 and 1200 dose of Lexapro, Tirnessa, Clindamycin, Valtrex and Amphetamine Salts were not signed off as administered in the MAR.

17. On February 7, 2006, [redacted]'s 0800 birth control medication was not signed off as administered on the MAR.

18. On February 7, 2006 [redacted]'s 0800 dose of Vitamin and Wellbutrin was not signed off as administered on the MAR.

19. On February 7, 2006, [redacted]'s 0800 doses of Zelnorm, Colace, Topamax, Effexor and Birth Control were not signed off as administered in the MAR.

20. On February 8, 2006, [redacted]'s 1200 dose of Augmentin was not signed off as administered on the MAR.

21. On February 8, 2006, [redacted]'s 1400 dose of Augmentin was not signed off as administered on the MAR.

22. On February 13, 2006, [redacted]'s 0800 and 1200 doses of Amphetamine Salts were not signed off as administered on the MAR.

23. A review of the December 2005 MAR of [redacted] found a taped note marked "Leslie", indicating the need to initial an empty space for December 31, 2005.

These medication errors were discovered by reviewing recent MARs, and found in a binder in the nurse's station by Joslynn Perry entitled "Nurses Medication Notes" containing notes from third shift nurses to other facility nurses, listing residents and dates when specific medications had not been signed off as administered, and reminding the nurses to fill these in. There was no documentation on MARs that any corrections made were "late entries."

REGULATION 22 VAC 42-10-200.B.3:

A person who assumes or is designated to assume the responsibilities of a position or any combination of positions described in these standards shall (3) demonstrate a working knowledge of the policies and procedures that are applicable to his specific position or positions.

1. Whisper Ridge nursing staff failed to follow or implement Whisper Ridge's Medication Administration policy by failing to adequately check for residents cheeking medications. This nursing staff neglect contributed to the hospitalization of resident [redacted] on January 27, 2006, for a Seroquel overdose. Specifically, nursing staff members neglected to implement medication administration procedures in a manner to prevent and/or minimize resident [redacted]'s ability to cheek prescribed medications and stockpile these medications for a period of at least seven days.

2. Whisper Ridge nursing staff failed to follow or implement Whisper Ridge's Medication Administration policy by failing to adequately check for residents cheeking medications. This nursing staff neglect failed to prevent and/or minimize resident [redacted]'s ability to cheek prescribed medications and stockpile these medications for a number of days. This resident was able to hide the hoarded medications in her room, and avoid detection by moving them when the "planned" twice-weekly room searches were to be conducted. The resident subsequently ingested the hoarded medication.

3. A review of incident reports found instances where medications were found sitting atop medication carts in cups, making it possible for residents to obtain medications.

REGULATION 22 VAC 42-10-740.E.1 and 12 VAC 35-45-80.B.3:

The facility shall develop and implement written policies and procedures which address staff supervision of children.

The provider shall have and implement written policies and procedures that address the provision of staffing appropriate to the needs and behaviors of the residents served.

Staffing on 500 Hall on 1/14/06 during the incident of residents assaulting resident SE who had just transferred to 500 Hall was not maintained according to Whisper Ridge policy (two staff were present for twelve boys) and sight and sound supervision was not provided for residents at the time the assault on the resident occurred at approximately 2:55 pm.

REGULATION 22 VAC 42-10-800.5:

The following actions are prohibited: (5) Any action which is humiliating, degrading, or abusive.

1. The actions of staff in removing female residents [redacted] and [redacted] by staff IS in November, 2005, out of their beds by lifting up the edges of their mattresses and "flipping or rolling" the residents out of bed are determined to be abusive. Office of Human Rights staff, Chuck Collins and Mark Seymour interviewed many male residents during various dates of these investigations. Male residents reported this practice continues.

2. On January 23, 2006, resident [redacted] was "...immediately placed...in a physical hold" because he "postured" at staff. There was no description of the posture given and no aggression to staff described until after the resident was put in a physical hold.

REGULATION 12 VAC 35-45-200.A:

Any serious incident, as defined by these regulations, unexplained absence or death of a resident shall be reported to the Office of Licensing within 24 hours. Such reports shall include:

1. The date and time the incident occurred;

2. A brief description of the incident;

3. The action taken as a result of the incident;

4. The name of the person who completed the report;

5. The name of the person who made the report to the placing agency, guardian, or other applicable authorities; and

6. The name of the person to whom the report was made.

There were several incidents, which should have been reported to OL and/or OHR, but were not reported. These include:

1. Suicide attempts: January 2, 2006- [redacted] attempted hanging; January 30, 2006 – [redacted] attempted hanging; January 31, 2006 – [redacted]. attempted hanging.

2. Report of peer-to-peer altercation January 8, 2006 – [redacted] was reported to have no injuries by Melissa Sergeant via email to OHR and OL, but [redacted]'s record includes a nurse's note (Fewell, LPN) written on January 8, 2006 stating that "Resident hit in face by another resident...Both cheeks sl swollen – sm. laceration lt. ear without bleeding – cleaned – pressure applied – Ice to face."

REGULATIONS 22 VAC 42-10-780.A and 22 VAC 42-10-820.A:

The facility shall have and implement written policies and procedures for behavior management and for documenting and monitoring the management of resident behavior.

The facility shall have and implement written policies and procedures governing use of physical restraint.

Numerous residents and Whisper Ridge staff reported to OL staff in interviews on February 2, 3, 8, 14, and 15, 2006 that staff incorrectly implements TOVA procedures, are often not acting to prevent fights among residents, and are not intervening immediately when residents do fight. Documentation in residents' records also indicates that staff restrained residents prior to attempting less restrictive interventions, and for insufficient reasons (one documented restraint for resident [redacted] for "refusing to remove her hood and leave the bathroom.") On October 5, 2005, this was also evidenced by progress notes describing incidents of resident fights and staff interventions.

REGULATIONS 22 VAC 42-10-580.B.6 and 22 VAC 42-10-580.B.7:

Facilities accepting routine admissions shall develop, and fully complete prior to acceptance for care, an application for admission which is designed to compile information necessary to determine: (6) the suitability of the prospective resident's admission; and (7) whether the prospective resident's admission would pose any significant risk to (i) the prospective resident or (ii) the facility's residents or staff.

1. Whisper Ridge failed to adequately assess male resident [redacted]'s suicidal risk and his appropriateness for admission into the program. This violation is based on documentation reviewed in [redacted]'s record, including [redacted]'s pre-placement form, admission application, and discharge summary from the Commonwealth Center for Children and Adolescents (where he was admitted prior to Whisper Ridge) and Whisper Ridge's Integrated Assessment. Whisper Ridge admission criteria includes the admission of adolescents with high-risk behaviors. These high-risk behaviors are specified in criteria 3.f of Whisper Ridge policy #201, which states, "applicant demonstrates an escalating pattern of self-injurious or assaultive behaviors." However, findings demonstrate that prior to admitting [redacted], Whisper Ridge failed to sufficiently assess the current status of this resident's high-risk behaviors, and to determine risks associated with admitting such a high risk resident. Whisper Ridge also failed to adequately assess if the current program of service could meet the needs of this individual. Prior to admission into the program and based on the application for admission, it was clearly documented that [redacted] would use objects to hurt himself and had a history of hanging himself. In addition, the reason for failure in previous placements was due to suicide attempts. This is also demonstrated through the special treatment plan document dated February 14, 2006 which reads "[redacted] is actively suicidal, and we do not have the intention or resources to keep him on 1:1 for a long period of time."

2. Whisper Ridge failed to adequately assess resident [redacted] for risk and appropriateness of placement. Review of [redacted]'s application for admission and pre-admission assessment reveals a lack of adequate information regarding this resident's multiple prior placements. The reason for failure at his many previous placements is not specified, and was only documented as "youth stated he had homicidal and suicidal ideation." There is also insufficient documentation demonstrating that the resident's current level of functioning was adequately assessed prior to acceptance for admission to Whisper Ridge on January 6, 2006. There was no psychiatric input on the admission of this resident with a complex history of failed psychiatric and residential placements. [redacted]'s psychiatric evaluation was not completed until January 11, 2006.

3. Whisper Ridge failed to adequately reassess [redacted] upon her readmission to Whisper Ridge on December 6, 2005, following an admission from November 23, 2005 until December 6, 2005 in an acute psychiatric facility. She had been admitted to Whisper Ridge initially January 20, 2005, and had remained there until the hospitalization for stabilization on November 23, 2005. Based on a review of [redacted]'s record, risks associated with this second admission to Whisper Ridge were not determined as required. No documented reassessment of CI's needs was completed prior to readmission, nor was [redacted]'s motivation for continued treatment at Whisper Ridge. Additionally, recommendations (from her acute hospitalization) for continued stabilization of psychiatric symptoms (particularly self-mutilating) were not integrated into Whisper Ridge's treatment plan upon her

readmission. Since this readmission, [redacted] has persistently displayed behaviors indicating that her treatment needs cannot be met at Whisper Ridge, including continued assaultive and self-injurious behaviors, and refusal of prescribed medications.

REGULATIONS 22 VAC 42-10-335.A; 22 VAC 42-10-470.B and REGULATION 22 VAC 42-10-380.F:

Heat shall be evenly distributed in all rooms occupied by the residents such that a temperature no less than 65° F is maintained, unless otherwise mandated by state or federal authorities.

The interior and exterior of all buildings shall be safe, properly maintained, clean and in good working order.

Each child shall have a separate, clean, comfortable bed equipped with mattress, pillow, blankets, bed linens, and, if needed, a waterproof mattress cover.

1. During a tour by Licensing staff Y. Luster and J. Perry on February 2, 2006, it was noted that the heating unit on 300 Hall in the room occupied by [redacted] was disconnected and the room was cold. Per staff report, maintenance was aware and would make the repair as soon as door alarm work was completed. Another resident on this unit commented that [redacted] had slept in her coat because the room was too cold. During a tour on February 3, 2006, it was noted that this room had been bolted shut, and the resident had been moved to another room. However, Licensing staff talked with the resident who had been moved and looked at her new room, noting that the front of the heating unit was falling off and the knobs did not appear to be working, so that the "heat" was not adjustable.

2. Licensing staff noted on February 2, 2006 that numerous ceiling tiles were broken/damaged, and floors were generally unclean in the dining room, bedrooms and hallways. Additionally, numerous chests of drawers were broken.

3. Licensing staff noted on a February 2, 2006 tour that numerous mattresses were sagging and lacking padding.

Under Virginia Code § 37.2-418, you are entitled to an informal conference before your license is revoked. Pursuant to Virginia Code § 2.2-4019, you have the right in an informal conference to have reasonable notice thereof, to appear in person or by counsel for the informal presentation of actual data, argument or proof, to have notice of any information in the possession of the Department which can be relied upon in making an adverse decision, to receive a prompt decision and to be informed in writing of the factual or procedural basis of any adverse decision. If an adverse decision is made following an informal conference, you may request a formal hearing, as provided in the *Administrative Process Act*.

You may request an informal conference within 10 days of your signature on the return receipt of this letter. Your request must be in writing and sent to: Ms. Leslie Anderson, Director, Office of Licensing, P.O. Box 1797, Richmond, Virginia 23218-1797. Should you decide to file a request for an informal conference, you will be notified by the Department of the time, place and date of the conference. If you fail to request the conference within the time period allowed, this letter will constitute the Department's final decision to revoke your license, which will

become effective thirty (30) days after your receipt of this letter. If you have any questions regarding this letter, please call Ms. Leslie Anderson, Director, Office of Licensing at (804) 371-6885.

The Department may continue to receive complaints regarding the health, safety, and welfare of residents receiving services in your program and therefore reserves the right under Virginia Code § 37.2-411 to inspect this service and take appropriate and necessary action while the service continues to operate. Whisper Ridge of Charlottesville is also obligated pursuant to §12 VAC 35-105-160 to make available any information required by the Office of Licensing to establish compliance with applicable statues and regulations. The service must continue to submit written plans of correction for any non-compliance noted during an inspection by the Office of Licensing. Findings of any such investigation may become a part of the record during an administrative proceeding.

Sincerely,

James Reinhard

James S. Reinhard, M.D.

Copy: Raymond Ratke, Chief Deputy Commissioner
Leslie Anderson, Director, Office of Licensing
Margaret Walsh, Director, Office of Human Rights
Ralph Sroufe, Regional Manager, Office of Licensing
Allyson Tysinger, Assistant Attorney General
James Bowser, Regional Advocate, Office of Human Rights
File 630-14-001