Investigation Findings Report

License #	Investigation ID	Date Investigation Received:	01/17/2006
630-14-001	39	Date Investigation Closed:	03/16/2006

Investigated by: Rhonda Angel

Investigation Description:
Cville CPS called to report an allegation by a former resident of WR that he had been "set up" by a staff member to be assaulted by his peers on 1/14/06. On this date, a male resident was assaulted by peers, resulting in his need for emergency room treatment for head trauma (concussion), possible strangulation, and bruising/contusions over several areas of his body. WR PI Mgr. reported via email on 1/16/05 that she was advised of this boy's allegation by Albemarle Co. DSS. WR also reported via email on 1/16/05 that this boy had been involved in an altercation with a peer on 1/14/06, was struck several times, and had bruises and swelling to his head and back and was sent to UVA via rescue squad for further assessment.

Inspection Date	Inspection Summary Description
01/19/2006	Met at temporary foster care home of boy who was assaulted by peers to interview him. Also interviewing were the Cville CPS Worker, Police Detective, and Human Rights Advocate. The boy described the events of 1/14/06. He stated that he had been acting out on his unit (400) and broken a plexiglass window and hit staff with the broken piece. He had been restrained without incident and then let up, becoming aggressive again towards staff, and was restrained again. The Shift Leader informed the boy that he was going to be sent to the 500 Hall. The child alleges that this same staff, who was also restraining him (Shift Leader), whispered to him that he was going to get jumped when he got to 500 Hall. After he calmed and was let up, he went to his room. He was informed he was being moved to 500 Hall now and stated that he refused to go. He stated that he knew he would get "jumped" on 500 because he had been jumped previously when sent to that hall. He fought staff who came to physically remove him from his room to go to 500 Hall. He was physically "escorted" by being picked up by his arms and legs by four male staff. As the staff were carrying the boy out of the door to the unit, another male resident approached and hit the restrained boy on the head and kicked him. The staff continued to transport the resident to the 500 Hall. When they got inside the doors and let the resident go, he went after the Shift Leader again. He was restrained again and quickly calmed. Then most of the staff left the unit and the boy was interacting with other boys. Another boy asked him to come to his room to write down the address of a girl they knew. The boy went inside the room and saw one other boy sitting on the bed. He was suddenly jumped by the two boys he was talking to and "several" others who had been hidden out of his sight. At some point (unclear how long) he was thrown out of the room into the hallway, where additional boys joined in the attack on him. He thinks he was hit by a desk, he was curled up trying to protect himself. A male staff came down the hall and told the boys to back off, which they did. A female staff was also present. Other staff arrived on the unit. Shortly, a nurse came to assess him. He tried to walk and fell down, thinks he passed out. He was assisted to the nurses station and thinks he had a seizure. Other nurses were there, as well as staff, to assess him. He is somewhat unclear about what happened after the attack in the room. He recalls being taken out of the facility on a stretcher to an ambulance and to UVA ER. A staff was sent to stay with him there. He was not returned to WR, but transferred to the local detention group home until an emergency foster family could be found for him, at the request of the social worker at UVA, due to questionable safety at WR for him. He is currently with a foster family, awaiting transfer to another treatment program. Talked with the CPS worker and Detective, who will be interviewing staff and residents at WR this week and next. They will allow Licensing and Human Rights to sit in on these interviews. The accused will be interviewed separately at the police station. RA
01/20/2006	Sat in on CPS and Detective interviews of staff present during the incident on 1/14/06. Staff deny knowledge of a the kids on 500 hall planning to jump the resident. All state that the resident was out of control and not cooperative on the other unit, and supervisors made the decision to move him. Staff who were on the unit at the time of the attack deny hearing anything going on in the bedroom, and state they did not know the residents were in there. They first heard fighting in the hallway and went around the corner (from the day room where they were sitting, doing paperwork) to see several boys fighting, but all ran away when staff approached except the resident who was

injured, but seemed to have trouble standing. That was when the nurse was called. It is notable that staff could not see down the hallway, nor on most of the unit if sitting in the dayroom doing paperwork together.

Also began review of records of residents involved. Notes written by nurses present describe a resident who was having trouble staying alert, having apparent seizures, and with difficulty taking his blood pressure. Also, nurses all wrote that they had to call administrators (not present at the facility) for "permission" to call 911 for emergency medical care and that administrators did not want them to do so. RNs did so anyway, and the police arrived first to respond to the assault call. Talked with PI Mgr. about concerns of lack of info. in incident report we received on the 1/14/06 incident. I discussed with her that this report minimized what occurred in this incident and that we had previously discussed this issue of not wanting to find out how serious an incident was from an outside source, such as the police. Also questioned on why the RN was not told to call 911, given the apparent condition of the resident (temp. loss of consciousness and seizure). PI Mrg. stated that the RN was upset on the phone and she could hear the resident speaking in the background, so she asked the RN to re-take the vitals, but the RN hung up.

Also received a copy of the police report on response to the facility on 1/14/06. The police describe a situation in which staff did not want to let them into the facility. When the police insisted on responding to the call regarding an assault, they observed the resident in the nurses' station with "several bruises and marks on his face, scalp and arms and appeared to be incoherent. He did not response to [my] voice." The police further wrote in the report that the "[RN] told me that he [resident] had stopped breathing due to a restriced airway and that they could only get a blood pressure by palpation. [The resident's] pupils were ractive, but slow to respond to light stimulus." The police report also stated that the resident alleged to police that a staff had organized a bunch of residents to jump him when he was transferred to the 500 unit. The resident also told police that he had been jumped before on the 500 unit. The police report also includes description of a conversation with the ER physician, who was very concerned about the resident returning to WR, for his safety. He apparently suffered a concussion, hemorrhage behind one eye, and severe bruising over his head, neck and torso.
Investigation continues. RA

01/23/2006 Interviewed boys who witnessed the incident on 1/14/06 with CPS and Detective. Reviewed info. CPS and Detective got from interviews on 1/21/06 with boys at WR. The boys did not hear staff tell the boy he would get jumped on the 500 hall. However, a few boys stated that it was common knowledge that this resident was jumped by boys on the 500 hall previously, and that he did not want to return to that hall because it would happen again. Some of the boys involved denied involvement, but some admit participation while blaming the planning and majority of the attack on the resident who AWOL'ed later that same day. He has not been located. It is apparent from interviews with staff and residents that the staff on 500 hall were not within sight and sound supervision of the residents just prior to, nor during most of the assault. It was only when they "fell" out into the hall that the staff responded. Investigation continues. RA

01/27/2006 Reviewed residents' records and personnel records in relation to this incident. Also received a copy of the UVA ER record for the resident. Injuries described include a concussion, a left eye hemorrhage, several contusions over the neck, face and torso. The physician and social worker at UVA did not believe the boys' safety could be maintained at WR, and worked with social services to send him to the detention home temporarily until an emergency foster family could be arranged. RA

01/30/2006 Met with new CEO and Interim CEO to review our preliminary findings. Reviewed personnel records and resident records. Discussed case with CPS Worker and Human Rights. It is unlikely a finding will be made by CPS against the staff member accused of "planning" the attack on the resident. The staff denies and no other staff heard or was aware of such a "plan". However, CPS may make a finding against the two staff who were on the unit at the time of the attack for neglect. This is not official as of this date. RA

Investigation Findings Report

Regulations Cited

690.A.2	Provide protection, guidance and supervision
740.E.1	P & P's for supervision, emergencies, off-campus, preferences
M30	Guaranteed Human Rights
M80.B.3	Staffing appropriate to the needs & behaviors of residents

Investigation Findings

Both the resident attacked and other residents describe an assault occurring on the 500 hall that was violent and ended only when the fight/assault moved from the bedroom of one boy into the hallway. Only then did staff respond and break it up. Staff admit sitting in an area to do "paperwork" that was not within sight and sound supervision of the most of the unit. It was immediately apparent to staff, from staff interviews and notes, that the resident was seriously injured. They describe him as having difficulty walking, standing, and suffering a seizure. Nurses describe a situation in which they had to ask permission to call 911 and then met with resistance from the administration. Once police arrived, the administrators did not want them to enter the building. Police reports also describe the attacked resident as having several bruises/marks and not responding well. The injuries were confirmed by UVA ER records as a concussion, hemorrhage of the eye and several severe contusions on the head, neck and torso. Police note that the boy alleged he was jumped by several peers in a bedroom, and had been told by the shift supervisor that he would get jumped when he moved him to the 500 unit. He states that the staff was upset with him for fighting with them, spitting, etc. It is unlikely a finding will be made by CPS against the staff member accused of "planning" the attack on the resident. The staff denies and no other staff heard or was aware of such a "plan". However, CPS may make a finding against the two staff who were on the unit at the time of the attack for neglect. This is not official as of this date. At this time, a number of violations were noted and the facility has submitted an acceptable plan of correction. This facility continues to be monitored closely and several investigations are ongoing. RA

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES
CORRECTIVE ACTION PLAN

Investigation ID:39
License #: **630-14-001**
Organization Name: **Psychiatric Solutions of Virginia, Inc.**

Date of Inspection: **01-30-2006**
Program Type/Facility Name: **Psychiatric Solutions of Va**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
690.A.2 - Provide protection, guidance and supervision	N	Whisper Ridge staff failed to provide a structured program of care to protect and supervise residents on 500 Hall on 1/14/06 when a male resident was assaulted by other residents, sustaining serious injuries before staff intervened.	Mental Health Specialists will be retrained on the Supervision of Residents policy. Planned Completion Date: March 17, 2006 Shift Leaders will assess supervision as part of their review of incidents occurring during their shift. Planned Completion Date: February 28, 2006. 100% of incidents will be reviewed in Operations Meeting and identified for training and/or disciplinary action as indicated. A summary report will be submitted to Quality Council each month. Planned Completion Date: February 27, 2006. Supervision occurs by a staff member checking the environment and location of residents every 15 minutes and document the results of rounds using a rounds checklist. Current practice. 3/02/06 - PARTIALLY ACCEPTED - PLEASE ANSWER THE FOLLOWING QUESTIONS: Is there a plan for training new staff in these areas? Is there a plan for regularly scheduled ongoing training of current staff? Who will conduct the training and how will training occur? Who will monitor MHS staff for compliance? How will this occur, and how will the info. be utilized? Will these plans be incorporated into the ongoing quality/performance improvement plan? R. ANGEL, OFFICE OF LICENSING REPLY f/ WR 3/16/06 - There is a plan for training new staff and will continue to be documented as part of orientation. The new policy is implemented and trainings are designed to address the policy standards and additions. Resident supervision has been a yearly required training. The changes made are currently being given in training sessions for all active direct care staff. Training days have been set up for all direct care staff to rotate through for 16 hrs. of weekly training classes. This will continue weekly until all direct care staff have been trained in all topics. The training will also now be required quarterly for one year, and then re-evaluation of the necessity of quarterly trainings made. The Director of Staff Development will ensure trainings are provided and will monitor selected trainers from among our therapists and other administrators.	02/28/2006
740.E.1 - P & P's for	N	Staffing on 500 Hall on 1/14/06 during the incident of	Whisper Ridge will maintain a staff to resident ration of 1:4	01/31/2006

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supervision, emergencies, off-campus, preferences		residents assaulting a resident just transferred to 500 Hall was not according to WR policy (two staff were present for twelve boys) and sight and sound supervision was not provided for residents at the time the assault on a resident occurred (approx. 2:55 p.m.).	when awake and 1:6 when asleep. Staff will be assigned by unit. Additional staff will be determined in accordance with Resident Supervision Policy. Whisper Ridge is altering its designation of staff obligated to respond to calls for assistance to avoid a reduction in staff below applicable ratio levels whenever possible and is instituting a policy requiring units temporarily having a higher staff ratio to keep all residents within sight. Planned Completion Date: January 31, 2006 ACCEPTED 3/02/06. R. ANGEL, OL	
M30 - Guaranteed Human Rights	N	Systemic Deficieny - Human Rights Violations: 1. Staff on 500 Hall neglected to provide a safe environment on 1/14/06 when a male resident was assaulted by other residents within an hour after his transfer to 500 Hall from 400 Hall. Two staff were not providing adequate supervision of residents. This assault resulted in the resident being treated at UVA Hospital and having the following injuries per CPS report - concussion, multiple contusions and abrasions on several areas of his body and head, and possible strangulation as described by ER physicians; 2. Whisper Ridge Staff did not provide a safe, therapeutic environment for a resident who was transferred to 500 Hall although he expressed fear of assault on that hall to staff when he was told he would be transferred there, and had been assaulted on 500 Hall previously (Dec. 2005); 3. Nursing staff were instructed to not call 911 by two Administrators on Call, although nurses on duty had assessed a male resident 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. 4. Also, Whisper Ridge did not report the 1/14/06 incident within the timeframe required by Human Rights Regulations.	1) Mental Health Specialists will be retrained on the Supervision of Residents policy which includes the Human Rights Policy on Resident Safety and the Rights to a Safe Environment. Shift Leaders will assess supervision as part of their review of incidents occurring during their shift. Planned Completion Date: March 17, 2006. 2) 100% of incidents will be reviewed in Operations Meeting and identified for training and/or disciplinary action as indicated. Planned Completion Date: February 27, 2006. 3) Residents needing to be removed from their units for safety reasons will be moved to a neutral location within the facility. All residents being moved from their units will be reviewed by the AOC prior to the move. If a neutral location is not available, the resident will be placed on one on one supervision. Planned Completion Date: January 31, 2006. 4) The Written Plan for Emergency Services will be revised to give full authority for medical emergency decisions to nursing and medical staff. Nursing and AOC staff will be trained on the policy. The facility will review the decision making process for all serious injuries. Planned Completion Date: February 28, 2006. 5) The Administrator On Call policy will be revised to state explicitly that 24 hour reportable incidents are reported to the Department via phone call on Saturdays, Sundays and holidays. Facility leadership serving in the AOC role will be trained on the policy. Reporting time frames will be monitored on the first business day following a weekend or holiday and reported in Operations Meeting. A reporting policy has been developed to provide clear direction as to the requirements for reporting to the Department of Mental Health, Mental Retardation, and Substance Abuse. Planned Completion Date: February 28, 2006 3/02/06 - PARTIALLY ACCEPTED. PLEASE ANSWER	03/17/2006

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			THE FOLLOWING QUESTIONS: Is there a plan for training new staff in these areas? Is there a plan for regularly scheduled ongoing training of current staff? Who will conduct the training and how will training occur? Who will monitor MHS staff for compliance (re: # 1 & 3)? How will this occur, and how will the info. be utilized? Will these plans be incorporated into the ongoing quality/performance improvement plan? In regards to #4, ALL staff need to be educated about this policy (esp. Shift Leaders & Lead MHS). R. ANGEL, OFFICE OF LICENSING RESPONSE f/ WR - 3/16/06 - See responses under 690.A.2; also Compliance of training attendance will be monitored by the Dir. of Staff Development. 100% of incidents are reviewed each morning and a retro monitoring process is and has been in place to verify procedure is followed and staff involved are counseled, trained and/or retrained when noncompliance arises. Ongoing supervision and adherence to the policy will be monitored by the Dir. of Clinical Services and Unit Coordinators. Supervision will occur through continuous monitoring of units by shift leaders and documented on the admin. report 6 times per shift and initialed by the shift leader. This will be verified each morning at operations meeting. When this procedure is not followed, shift leaders will immediately address the situation with staff and reported to the Operations Coordinator/Dir. of Clinical Services. If noncompliance continues, more formal means of disciplinary action up to and incl. termination will be enforced. Also, a training calendar with topice and trainers will be added to the Quality/Performance Improvement plan. This will be updated annually, and updated quarterly for TOVA updates. All polilcy changes and training compliance will be monitored in Quality Council. ACCEPTED 3/17/06.	
M80.B.3 - Staffing appropriate to the needs & behaviors of residents	N	Staffing on 500 Hall on 1/14/06 during the incident of residents assaulting a resident just transferred to 500 Hall was not according to WR policy (two staff were present for twelve boys) and sight and sound supervision was not provided for residents at the time the assault on a resident occurred.	See responses to 690.A.2 and 740.E.1 above. Planned Completion Date: March 17, 2006. 3/02/06 - PLEASE SEE RESPONSE ABOVE REGARDING PARTIAL ACCEPTANCE. R. ANGEL, OFFICE OF LICENSING 3/16/06 Response f/ WR - Please see response to citations above.	03/17/2006

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			3/17/06 ACCEPTED. R.Angel -	

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General Comments / Recommendations:
Mr. Davis,
Please indicate plans of correction, including quality improvement plans and actions already taken to address the violations noted.

This is investigation is not closed, and additional violations may be cited.

Please contact me if you have questions.

Thanks,
Rhonda Angel
Senior Licensing Specialist
DMH/MR/SAS

ADDENDUM 3/02/06 - Please note the corrective action plans were partially accepted, as described above. Please submit additional corrective action plans ASAP, but no later than 3/16/06.
Rhonda Angel, Senior Licensing Specialist

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Rhonda Angel, Specialist _____ (Signature of Organization Representative) _____ Date

Mail to: WSH - Licensure Office
PO Box 2500
Staunton. VA 24401

Due Date: 02-22-2006

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