



COMMONWEALTH OF VIRGINIA

Office of the State Inspector General

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January 11, 2017

Dr. Jack Barber, Interim Commissioner
Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23219

SUBJECT: OSIG 2016-BHDS-004 FY 2016 Unannounced Inspections of Training Centers

Dear Dr. Barber:

The Office of the State Inspector General (OSIG) performed unannounced inspections at four facilities operated by the Department of Behavioral Health and Developmental Services, including three training centers serving individuals with intellectual or developmental disabilities and Hiram Davis Medical Center (HDMC) that serves individuals with comorbid behavioral health, intellectual or developmental disabilities, and primary health disorders requiring hospitalization. These inspections were performed pursuant to the *Code of Virginia* § [2.2-309.1\[B\]\(1\)](#). The overall goal of unannounced inspections is to review the quality of services provided and make policy and operational recommendations in order to prevent problems, abuses, and deficiencies and improve the effectiveness of programs and services. For fiscal year (FY) 2016, the unannounced inspections focused specifically on the content and implementation of [Departmental Instruction 201 \(RTS\)03 Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities \(DI201\)](#).

These inspections covered the three training centers and one medical center operated by DBHDS in the Commonwealth, including:

- Central Virginia Training Center — 321 beds, located in Lynchburg, providing intermediate care and skilled nursing to adults and elder adults with intellectual or developmental disabilities (IDs/DDs);
- Southeastern Virginia Training Center — 75 beds, located in Chesapeake, providing intermediate care services to adults with IDs/DDs;
- Southwestern Virginia Training Center — 186 beds, located in Hillsville, providing intermediate care services for adults and elder adults with IDs/DDs; and
- Hiram Davis Medical Center — 84 beds, located in Petersburg, providing integrated behavioral health and acute medical/surgical services for residents of all DBHDS-operated facilities as well as individuals with IDs/DDs who do not have community-level access to additional medical, skilled, and rehabilitation services required upon discharge from training centers.

These inspections were conducted in the same manner as those conducted for the behavioral health facilities and the background, scope and methodology for these inspections was consistent with the inspections of the behavioral health facilities. In order to avoid repeating all of the background information, this letter serves to summarize those observations and recommendations that were not previously communicated in the behavioral health inspection report.

All of the findings and recommendations in the FY 2016 Unannounced Inspections of Behavioral Health Facilities, Report No. 2016-BHDS-003 apply to the training centers and the Hiram Davis Medical Center. As a result, we are not repeating those findings and recommendations but do request agency management to implement those recommendations for the training centers and Hiram Davis Medical Center.

In addition to those observations and recommendations, OSIG identified the following additional observation and recommendation.

OBSERVATION NO. 1 — ALL FACILITIES REVIEWED AS PART OF THESE INSPECTIONS ARE PERFORMING POST-INVESTIGATION BRIEFINGS, WHICH ARE DESIGNED TO IMPROVE THE INVESTIGATION PROCESS AND DRIVE PERFORMANCE IMPROVEMENT FACILITY-WIDE.

DI201 states that at the conclusion of an investigation, the investigator “...shall brief the facility director and human rights advocate in order to provide additional information or comments and obtain feedback regarding [their] preliminary determination.” In speaking with administrators and investigators at facilities covered in this report, OSIG found that all of them perform post-investigation briefings where the investigator discussed their findings with the facility director, human rights advocate, and other staff as appropriate. OSIG commends these four facilities for performing this important step in the investigation process. These briefings provide the facilities opportunities for quality management and performance improvement and the investigators an opportunity to receive feedback about their report and the investigation process. This practice was not in place at the behavioral health facilities during those inspections.

OBSERVATION NO. 1 RECOMMENDATION

DBHDS should ensure that all 14 facilities operated by DHBDS perform briefings at the conclusion of abuse and neglect investigations as this is required by DI201 and would be considered a best practice.

By copy of this letter, OSIG is requesting that agency management provide a corrective action plan within 30 days to address this recommendation.

On behalf of OSIG, I would like to express our appreciation for the assistance provided by facility directors and their staff during these inspections.

If you have any questions, please call me at (804)625-3255 or email me at june.jennings@osig.virginia.gov. I am also available to meet with you in person to discuss this report.

Sincerely,

June W. Jennings, CPA
State Inspector General

CC: Paul J. Reagan, Chief of Staff to Governor McAuliffe
Suzette P. Denslow, Deputy Chief of Staff to Governor McAuliffe
William A. Hazel Jr., MD, Secretary of Health & Human Resources