Behavioral Health Centers provide a continuum of services for the treatment of some of the most vulnerable individuals in our state who are at risk of, or suffering from, mental, behavioral, or addictive disorders. These facilities treat individuals who require a higher level of care than many other facility types, including one-on-one care and daily nursing care. In recent years, the number and severity of incidents and other issues related to care of the consumer have arisen leading to a crisis level. Additional protections for the vulnerable population served by Behavioral Health Centers is needed to maintain their safety, and in some instances their lives. Outlined within are sampling of incidents and other issues that have occurred and been discovered as a result of regulatory activity at Behavioral Health Centers in West Virginia. This list is not exhaustive but representative. Facility and consumer names have been removed.

INCIDENTS

- A 19-year-old consumer consumed unsecured antifreeze and did not receive outside medical attention for upwards of 12 hours after which he was life-flighted to Charleston. The consumer repeatedly notified staff that he was not feeling well and even told them that he drank the antifreeze. The consumer spent several days in the ICU and several additional weeks being hospitalized for recovery. The consumer needed dialysis as a result. **Greenbrier County**

- A consumer was repeatedly sprayed with a water hose outside of his residence and in full view of his neighbors as punishment for noncompliance of staff directives. A concerned neighbor filmed this severe abuse and contacted OHFLAC out of concern for the consumer's well-being. **Marion County**

- A consumer, who was a child, with required supervision, was able to obtain the keys to a facility-owned vehicle. He died in a fiery crash. **Kanawha County**

- Facility admitted a consumer, who was a known child molester and had served time in prison for child molestation, to a licensed residential site. The consumer molested a housemate shortly after admission, due to staff's neglect to provide supervision consistent with his behavior plan, and he was arrested. **Greenbrier County**

- A non-verbal consumer was swaddled tightly in blankets with pillows and a heavy bean bag lying on and against her to restrict movement as the consumer tried desperately to free herself. **Cabell County**

- One consumer had her shirtsleeves tied in a knot so that she could not use her hands. She was restrained 24 hours per day, except in the shower. Surveyors watched this consumer attempt to eat dinner in this de facto mechanical restraint. **Kanawha County**

- The provider was renovating a consumer's bathroom. Supplies, including an open bag of cement tools, including a working drill and a saw; and other dangerous equipment was piled in the hallway, right outside of the bedroom of multiple consumers and blocking the emergency exit. Construction was done for the week; however, supplies were left unattended and within reach of consumers. **Wood County**

- A consumer was restrained on many occasions with heavy blankets piled on top of him, even covering his head. Multiple staff sat on him, even sleeping on top of him, for long periods of time while playing on their phones. **Kanawha County**

- A consumer was physically assaulted by staff. Staff was upset because the consumer was having a behavior on another staff which happened to be the staff's wife. **Greenbrier County**

- Consumer overdosed on staff's medication (Subutex) and died. Hospital records confirmed the overdose. **Mineral County**

- Consumer sustained a third degree burn and did not receive medical attention for upwards of six hours. **Greenbrier County**

- Another consumer suffered burns and was treated with mustard by direct care staff because they were unable to locate the first aid kit with burn cream. Consumer was not assessed by the registered nurse. **Mercer County**

- A consumer ingested a battery while she was on suicide protocol, resulting in the need for emergency surgery. **Greenbrier County**

- A consumer was not provided a shower for a period of months, only periodic bedside "sink baths." Her hygiene was so poor that staff took it upon themselves to give her a tight military hair cut to irradicate the problem of the matted hair and odor which resulted. An immediate jeopardy (IJ) was identified nine months prior for failure to provide adaptive equipment (shower chair). **Cabell County**

- Consumer sustained a fractured nose of unknown origin and the provider neglected to follow its abuse and neglect policy to protect consumers pending the outcome of an investigation. **Cabell County**

- Consumer spent approximately two hours in a facility vehicle unsupervised resulting in heat exhaustion and a body temperature of 104°F for which he received no outside medical attention. **Greenbrier County**

- A facility neglected to provide consumer with medical evaluation and follow-up for four days after he suffered physical abuse by his direct care staff. Staff pulled consumer's hair to pull his head back until his neck was "extended" then poured his whole cup of honey thickened liquids into his mouth quickly and did not give consumer a chance to swallow. **Ohio County**

- Agencies are failing to adequately train staff, often having staff just sign a sheet claiming they were trained. One instance of a facility training staff on a consumer's programs and safety protocols **AFTER THE CONSUMER HAD DIED**. **Cabell County**

- Video surveillance footage revealed an unsupervised consumer brandishing large kitchen knives while walking and balancing himself on kitchen counters. Staff and management had been in the practice of hiding kitchen cutlery rather than locking it up, as required by program protocol. **Marion County**

- Consumer was administered by staff and overdosed on a different consumer's prescription medication of seizure medication. **Mercer County**

- Three staff withheld CPR from consumer when required. The consumer died. **Ohio County**

- Staff and management repeatedly sleeping on duty at a time when they were assigned consumer care responsibilities and management repeatedly not acting when aware that staff were sleeping on duty. **Cabell County**

- Multiple decubitus ulcers not being reported and no internal investigations: severity levels ranging up to Stage IV. **Statewide**

- A staff withheld water from a consumer for several hours because he didn't want the consumer to urinate in her pants. **Cabell County**

- Consumer overdosed on Digoxin. No assessment of the consumer or lab work completed after discovery of medication error to rule out digoxin toxicity and arrhythmias. **Mercer County**

- Multiple choking incidents. A consumer choked and died as a result of being provided food that was contrary to her diet orders. OHFLAC discovered that facility management attempted to conceal the facility's culpability by telling first responders, hospital staff, and state regulators that the consumer had choked on crayons, in a first time PICA type behavior. **Cabell County**

- Multiple examples of unsupervised consumers eloping and being retrieved by law enforcement. **Kanawha and Cabell Counties and multiple other counties**

- Drug use by staff. One incident involved an overnight staff removing two consumers from their home in the middle of the night while in a paranoid state, leaving one low-functioning consumer alone on a dark country road, and leaving the other consumer at the home of a person who was unaffiliated with the facility and untrained and unapproved to care for the consumer. **Greenbrier County**

- Multiple incidents of consumers not being provided required, adaptive equipment. One man was required to urinate and defecate in a brief because he did not have a handicap accessible bathroom and lacked sufficient staff to assist him with toileting. It was easier and cheaper for facility staff to change his diaper than to provide the required staff and handicap accommodations. **Berkeley County**

- Consumer going for over a year needing dental extractions requiring pain medications. **Cabell County**

- Multiple examples of community storage of toileting and personal hygiene supplies, e.g. several consumer's toothbrushes, razors, etc. stored in the same box, etc. **Statewide**

- Multiple incidents of consumers living in deplorable conditions, including, but not limited to, no blankets, broken down mattresses and furniture, filth, roaches and bed bugs and broken toilets. **Kanawha, Mercer, and Berkeley Counties**

CHEMICAL STORAGE

- Chemicals maintained in an unlocked condition and assessable to consumers. Multiple incidents of consumers ingesting chemicals. **Greenbrier and Cabell Counties**

MEDICATION ISSUES

- LPNs giving medications outside the ordered time and then falsifying Medication Administration Records (MARs), extra medications found (generally given to reduce anxiety), and the facility unable to explain 30 extra pills. **Cabell and Upshur Counties, as well as similar issues statewide**

- Significant false documentation on Medication Administration Records. **Mercer and Upshur Counties, as well as similar issues in multiple counties**

- No medical evaluations conducted after discovery of improper distribution of medications. **Mercer and Berkeley Counties as well as statewide**

- Facility could not produce physician orders for medications documented "being withheld" per physician orders. **Statewide**

- Numerous medications listed as "medication not in home." **Mercer and Logan Counties as well as statewide**

- No medication variance reports completed. **Upshur and Wood Counties as well as statewide**

- No accountability for narcotics. **Upshur and Wood Counties**

- No record of missed medications. **Kanawha, Upshur, and Berkeley Counties with similar issues statewide**

- Medications not administered in compliance with the physician's order and state law. **Kanawha, Mercer, and Upshur Counties with similar issues statewide**

- Drugs not stored under proper conditions of security. **Wood and Berkeley Counties**

- Failure to secure medications, i.e., medication combinations the same as other locks in the home and already preset with the combination so anyone could access. **Wood County**

- Failure to administer over 1,000 medications including benzodiazepines and other crucial medications. **Mercer County**

- Physician orders not followed. 0ver 3,700 medications missed in a three-month period which included critical medications. In that three-month period, one consumer did not receive 1,094 doses of blood pressure medications. **Kanawha County**

- One consumer missed 51 doses of Klonopin and 29 doses of mood stabilizer (Olanzapine) from November 2 through November 15, 2019, because she missed a doctor's appointment. Despite the pharmacy also calling and letting them know it needed refills, she still did not get seen by doctor until February 15, 2020. The pharmacy gave her 15 pills in November hoping they would get her to the doctor. The consumer had serious increases in behaviors. Overall, this consumer missed 873 doses of medications. In addition, there were 106 peg tube feedings not given to her and no weights taken. The most current weight was 73 pounds from the hospital in January. **Kanawha County**

- Consumer was not given Patch for nausea as prescribed. The Patch should have been administered every 72 hours but went as long as 144 hours apart. **Kanawha County**

- Depo-Provera shot for birth control not given for a consumer on multiple occasions because the facility did not have it available. Then she received the wrong dosage. **Logan County**

- There are issues with physicians' orders not being signed and dated. **Statewide**

- Pharmacy review indicated problems and still no follow-up from the facility. **Kanawha County**

- Blood pressures and pulses not taken prior to the administration of antihypertensive medications. **Kanawha County and similar issues statewide**

ELOPEMENT ISSUES

- Elopement protocols not implemented for the stated reason that the consumer was "too fat to elope." **Wood County**

- Elopement consumers found by the police (this has occurred in several areas). **Cabell, Greenbrier, and Kanawha Counties**

- Multiple IJs for failing to follow consumer elopement protocols and for having monitoring systems that were absent or inadequate. Door alarms were not in working condition or not being activated. **Statewide**

ABUSE, NEGLECT AND INVESTIGATION ISSUES

- Multiple instances of failure to follow their own abuse and neglect policies designed to protect consumers from alleged perpetrators during the course of abuse and neglect investigations, including failure to remove perpetrators to protect consumers during investigations. **Statewide**

- Multiple occurrences of abuse and neglect not reported to OHFLAC. **Statewide**

- Multiple occurrences of the provider failing to conduct required internal investigations for allegations of abuse and neglect. **Statewide**

- Incident tracking system did not accurately reflect critical incidents that occurred and were not being used to enhance care and service; many critical incidents went undocumented. **Statewide**

- Provider lacked documented evidence of consumer care and supervision, i.e., sleep charts, progress note documentation, consumer case load assignments. This is a normal occurrence. **Statewide**

- Provider could not produce documented evidence of completed investigations upon request of OHFLAC surveyors. **Cabell and Kanawha Counties and Statewide**

- Consumer did not have Abnormal Involuntary Movements (AIMs) completed per policy for consumers on medications for behaviors. **Kanawha County with similar issues statewide**

- Even after IJs were identified, the facility failed to effectively complete their immediate plan of correction. They pulled old training, rather than providing additional training and instruction. **Kanawha County**

- Reporting of critical incidents to OHFLAC not completed. **Statewide**

STAFF ISSUES

- Program manager sleeping on shift on multiple occasions and encouraging others to sleep on shift. The program manager stated he would cover for them. This employee reported directly to the facility's Executive Director. **Cabell County**

- Provider lacked evidence of staff training on consumer care. **Statewide**

- Multiple consumers not being provided their required staffing ratios. **Statewide**

- Had no staffing ratios identified for the individual needs of the consumers or based on their behavioral support protocol. Staffing needs were not being determined based on consumer needs. **Statewide**

- All individual program plans (IPPs) contain provisions for staff to take smoke breaks, even staff providing 1:1 level of care may leave the consumer unattended to go outside and smoke. Note: Consumer programs are not permitted to be designed for staff convenience. **Wood County**

- Staff substance abuse issues endangered consumer's health and safety. **Raleigh County**

- Unqualified registered nurse supervising approved medication assistive personnel (AMAPs). **Harrison County**

- AMAP observations and recertifications were not conducted and completed by the AMAP registered nurse as required. **Statewide**

- Consumer weights, vital statistics, and other ordered procedures were not being done as ordered because individuals were "unable to come to the office because of COVID." **Statewide**

- Provider utilized AMAPs and failed to comply with the AMAP training requirements. **Mercer County**

- Provider failed to verify references for employees. **Statewide**
- The provider failed to ensure the initial assessment reviewed the consumer's history. **Statewide**
- Nursing staff has expired WV Nursing license (prior to COVID exceptions). **Berkeley County**
- Provider failed to ensure they prohibited employment of individuals with a conviction or prior employment history of child or consumer abuse, neglect, or mistreatment. **Multiple counties**
- The provider failed to obtain permission from the consumers' designated legal representative(s) prior to treatment, except in emergent conditions. **Statewide**
- The provider failed to obtain monthly vital signs or weights as ordered by the physician. **Statewide**
- Failure to obtain consumers' daily weight as ordered by physician because the home had no scale. **Kanawha and Mercer Counties**
- Development of decubitus ulcers not reported or treated appropriately. **Statewide**
- The facility failed to ensure consumers were not subjected to physical, verbal, sexual, or psychological abuse or punishment. **Statewide**
- After an internal investigation on July 14, 2020, the facility had no documented evidence of staff being retrained on mandated reporting or abuse and neglect after substantiating physical abuse of a consumer by staff. **Statewide issue with retraining**
- Facility neglected to provide consumer care and supervision in accordance with their individual program plans and needs. **Statewide**
- Insufficient staffing to consumer ratios. Five consumers present in the group home with only one staff. Some consumers require use of adaptive equipment, including but not limited to Hoyer lift and wheelchair with safety belt, and wheelchair. Staffing ratios per Individual Program Plans revealed consumers with staffing ratio's ranging from 1:1 to 1:3 (no staffing levels noted of 1:5). Physician orders listed consumer diagnoses including but not limited to PICA, legally blind, physically aggressive behaviors, Autism, Epilepsy, Cerebral Palsy, and Seizures. **Ohio County**
- Provider had no way to measure weights on consumers in wheelchairs. **Kanawha County**
- Insufficient staff to provide protective oversight to all consumers on multiple occasions. **Statewide**

BUILDING MAINTENANCE ISSUES

- Consumers' bedroom doors equipped with a peephole allowing one-way visual access into the rooms from the outside. This compromises the consumer's privacy during personal hygiene activities and during medical and nursing treatments that require exposure of one's body. This allows any person, including other consumers, to view the consumers during private activities in their bedrooms. **Ohio County**

- Sanitary conditions (mice and ants) discovered and frozen hamburger laying on the kitchen counter. **Greenbrier County**

- Food not served in a form consistent with the developmental level of the consumers. **Statewide**

- Consumers without functional furniture. **Statewide**

- Main consumer bathroom gutted and completely unusable for a period of upwards of ten months. Provider failed to make the bathroom operational even though it was brought to the provider's attention over the course of several surveys. **Greenbrier County**

- Homes belonging to several consumers had doors equipped with locking mechanisms that required the use of a key to unlock the door from the inside of the home. Staff who were on shift were responsible for keeping the keys that unlock the door in their possession. The locking mechanism on the doors created a high-risk concern which hinders the escape route for consumers if an emergency should arise along with impacting the health and safety of the consumer. **Mercer County**

- Unsafe stove exhaust fan in kitchen, broken toilet with sharp porcelain edges, and old refrigerator laying outside. **Berkeley County**

COVID-19

- There have been repeated violations of COVID-19 protocol and CDC guidelines in the presence of consumers despite being issued numerous IJs for the same. This includes failure to wear masks, improper wearing of masks, inaccurate assessment tool to determine if staff are safe to work and use of dirty oral thermometer with no probe protectors. **Statewide**

- COVID-19 screening tool identified by OHFLAC to be erroneous was not corrected immediately and found a second time at the same site by OHFLAC surveyors. **Statewide**