



FAIRFAX - FALLS CHURCH

**Community  
Services Board**

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## **FAIRFAX-FALLS CHURCH COMMUNITY SERVICES BOARD COMPLIANCE COMMITTEE MEETING**

**Dan Sherrange, Chair**

**Wednesday, December 12, 2024, 4:00 PM**

Sharon Bulova Center for Community Health  
8221 Willow Oaks Corporate Drive, Level 3, Room 3-314, West  
Fairfax, VA 22031

### **MEETING AGENDA**

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| <b>1. Meeting Called to Order</b>                          | <b>Dan Sherrange</b> |
| <b>2. Roll Call, Audibility and Preliminary Motions</b>    | <b>Dan Sherrange</b> |
| <b>3. Matters of the Public</b>                            | <b>Dan Sherrange</b> |
| <b>4. Amendments to the Meeting Agenda</b>                 | <b>Dan Sherrange</b> |
| <b>5. Approval of the August 17, 2024, Meeting Minutes</b> | <b>Dan Sherrange</b> |
| <b>6. Follow up items from the August Meeting</b>          | <b>Joan Rodgers</b>  |
| <b>7. Updates</b>  | <b>Joan Rodgers</b>  |
| A. ComplyTrack Reports                                     |                      |
| B. CSB Serious Incident (Level III) Report                 |                      |
| <b>8. Open Discussion</b>                                  | <b>Dan Sherrange</b> |
| <b>9. Adjournment</b>                                      |                      |

Meeting materials are posted online at [Community Services Board | Community Services Board \(fairfaxcounty.gov\)](#) or may be requested by contacting Shayla Coleman at 703-324-7000 or at [CSBBoardClerk@fairfaxcounty.gov](mailto:CSBBoardClerk@fairfaxcounty.gov).

**FAIRFAX FALLS-CHURCH COMMUNITY SERVICES BOARD  
COMPLIANCE COMMITTEE MEETING MINUTES  
AUGUST 21, 2024**

The CSB Compliance Committee met in regular session at the Sharon Bulova Center at the 8221 Willow Oaks Corporate Drive, Room 3-314 West, Fairfax, VA 22031.

**1. Meeting Called to Order**

Committee Chair Dan Sherrange called the meeting to order at 4:00 PM.

**2. Roll Call, Audibility, and Preliminary Motions**

**PRESENT:**           **BOARD MEMBERS:** COMMITTEE CHAIR DAN SHERRANGE; BETTINA LAWTON;  
EVAN JONES

**ABSENT:**           **BOARD MEMBERS:** ANDREW SCALISE

**Also present:** Executive Director Daryl Washington; Deputy Director of Clinical Operations Barbara Wadley-Young; Deputy Director of Clinical Operations Abbey May; Division Director of BHOP Eileen Bryceland; Director of Administration & Policy Shweta Adyanthaya; Director of Quality Improvement and Compliance Joan Rodgers and Board Clerk Sameera Awan.

**3. Matters of the Public**

None were presented.

**4. Amendments to the Meeting Agenda**

The meeting agenda was presented for review, and no amendments were made by the consensus of the Committee. The meeting agenda was adopted unanimously.

**5. Approval of Minutes**

August 21, 2024, Compliance Committee minutes were distributed for review.

**MOTION TO ADOPT AUGUST 21, 2024, MEETING MINUTES WAS MOVED BY COMMITTEE MEMBER EVAN JONES, JIM GILLESPIE AND DAN SHERRANGE.**

**6. Follow up Items**

**Director of Quality Improvement and Compliance Joan Rodgers** presented the Audit Action Plan and Corrective Action Plan (CAP) Report, beginning with an overview of the audit findings. Seven internal audits were conducted and completed as part of a quality review, which is part of the preventative, general auditing activity for July 2024. These audits included 47 clinical records across seven different program areas and will close out the 2024 fiscal year. The areas audited in July were support coordination services, assisted community residential services, intensive case management at Gartland, behavioral health outpatient services at the Sharon Bulova Center, assisted community treatment at Gartland, and residential treatment services at Crossroads.

For the corrective action plan report, one corrective action was identified as related to a late series of incidents reported in the behavioral health adult case management area. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) accepted this corrective action plan. Additionally, a peer-to-peer issue was reported from an incident at the Assisted Community Residential Services group home, where a staff member briefly stepped out, leading to a minor conflict between two clients.

The team continues to assist programs in developing their quality improvement plans. Currently, 20 specific improvement plans are in place, covering all licensed services. All 20 plans have been completed and are scheduled for implementation.

**7. Updates**

**A. Comply Track Reports**

- **Director of Quality Improvement Joan Rodgers** provided the CSB Board Audit Report, and the CSB Board CAP Report.

**B. CSB Serious Incident (Level III) Report**

- **Director of Quality Improvement Joan Rodgers** provided the Serious Incident Report (SIR) for July 2024, noting six Level 3 serious incidents, with no related systemic issues identified.

**8. Open Discussion**

No matters were raised.

**9. Adjournment**

A motion to adjourn the meeting was made by Committee Member Evan Jones and seconded by Committee Chair Dan Sherrange. The motion was approved unanimously, and the meeting was adjourned at 4:26 PM.

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Date Approved

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Clerk to the Board

**Audit Report CSB Board for November 2024**

Item Custom ID	Audit Start Date	Entity	Audit Scope	Department	Audit Type	Sample Size	CSB Board Reporting	Audit Action Plan	Additional Information
6193	11/7/2024	Support Coordination (Gartlan)	CSB Internal Review	DD Case Management	Clinical Records	6	Standard Business Risk	Quality Review	Completed: 12/6/2024
6194	11/7/2024	Assisted Community Residential Services (Pennino)	CSB Internal Review	ID Group Homes (ACRS)	Clinical Records	6	Standard Business Risk	Quality Review	Completed: 12/6/2024
6196	11/8/2024	Behavioral Health Outpatient Services (Northwest Center/ Reston)	CSB Internal Review	MH Case Management - Adult	Clinical Records	4	Standard Business Risk	Quality Review	Completed: 12/6/2024
6197	11/8/2024	Behavioral Health Outpatient Services (Gartlan)	CSB Internal Review	MH Outpatient - Adult	Clinical Records	4	Standard Business Risk	Quality Review	Completed: 12/6/2024
6198	11/8/2024	Intensive Community Treatment Services (Gartlan)	CSB Internal Review	Intensive Case Management (ICM)	Clinical Records	8	Standard Business Risk	Quality Review	Completed: 12/6/2024
6199	11/8/2024	Supportive Community Residential Services (Merrifield)	CSB Internal Review	MH Supervised Living Program (RIC)	Clinical Records	8	Standard Business Risk	Quality Review	Completed: 12/6/2024
6200	11/8/2024	Intensive Community Treatment Services (Gartlan)	CSB Internal Review	Assertive Community Treatment (ACT) - Medium	Clinical Records	4	Standard Business Risk	Quality Review	Completed: 12/6/2024
6201	11/8/2024	Youth & Family Services (Merrifield)	CSB Internal Review	SA Outpatient - Youth	Clinical Records	4	Standard Business Risk	Quality Review	Completed: 12/6/2024
6202	11/8/2024	Behavioral Health Outpatient Services (Merrifield)	CSB Internal Review	MH Case Management - Adult	Clinical Records	8	Standard Business Risk	Quality Review	Completed: 12/6/2024

FY2025	Total of unduplicated audits for service areas reviewed in the current month	Total of duplicated audits for service areas reviewed in FY25	Total audits completed in the current month	Total Audits completed in FY25
	8	40	52	257

AUDIT LEGEND	
Item Custom ID	Item Custom ID Numbers will be entered on 12/8/2023, a day after the CSB Board Compliance Committee data is required for submission for the Board package
Audit Start Date	Date the audit was initiated
Entity	Location where the audited service was provided
Audit Scope	The agency conducting the audit and the scope of the audit
Department	Service Area
Audit Type	Description of audit, e.g., record review only, onsite audit
Sample Size	Number of charts reviewed
CSB Board Reporting	Level of business risk associated with audit findings
Audit Action Plan	Description of actions taken in response to the audit

## CSB Board CAP Report For November 2024

Item Custom Id	Start Date	Entity	Reviewing Agency	Corrective Action (Narrative)	CAP Status	Additional Information
6112	10/29/24	Youth & Family (Outpatient Services)	DBHDS	The Corrective Action Plan was accepted by the DBHDS Office of Licensing (OL).	Closed	Late Serious Incident Report
6118	11/1/24	Support Coordination	DBHDS	The Corrective Action Plan was accepted by the DBHDS Office of Licensing (OL).	Closed	Staffing procedure
6177	11/25/24	Residential Treatment & Detox Services (SA Residential Treatment - Crossroads)	DBHDS	The Corrective Action Plan is in development for review by the DBHDS Office of Licensing (OL).	Pending	Telephone procedure

<b>CAP LEGEND</b>	
Item CustomId	Identification number automatically assigned by Comply Tracker
Audit No.	References the audit number in the Audit Report
Start Date	Date the CSB was notified of the need for a CAP
Entity	Location where the audited service was provided
Reviewing	Agency requesting and reviewing the CAP
CAP	Description of the reason for the CAP
Date CAP	Date the reviewing agency approved the CAP