DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **1217-14-011**
Organization Name: **ELK HILL FARM, INC.**

Date of Inspection: **02-21-2024**
Program Type/Facility Name: **14-011 Duncan Cottage**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115).	N	Duncan Cottage This regulation was NOT MET as evidenced by: See OHR citation.		3/5/2024

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12VAC35-115-110. C. (4) - The provider's duties. 4. Providers shall not use seclusion, restraint, or time out as a punishment or reprisal or for the convenience of staff.	N	Duncan Cottage This regulation was NOT MET as evidenced by: Upon review of CHRIS entry, A-20240011, the provider's investigation included video review and a review of internal policy which revealed: • Employee #1 closed a door on individual #1's foot when Individual #1 refused to move away from a peer's door; and • Employee #1 tackled Individual #1 to restrain Individual #1 holding the individual down on the floor using his hands and knees, after Individual #1 directly spray from a spray bottle towards Employee #1. Based on the provider's investigative findings, Employee #1 failed to support the individual per the provider's policy and behavioral management protocol.	PR) 03/05/2024 PR: Elk Hill aggress with these finding. Employee #1 was Mandt recertified during the time of the incident. However, after reviewing the video it was determined that Employee #1 did not follow the Mandt protocol. The physical restraint that occurred was not a Mandt approved restraint. Employee #1 was sent home during his shift, and immediately suspended the next day until the investigation was completed. As a result of the investigation by the Program Director and Residential Director it was determined that Employee #1 would be terminated from Elk Hill. The Chief Human Resources Officer will ensure that Employee #1 is not rehired at Elk Hill. OHR/OLR) Accepted 03/06/2024	3/5/2024

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12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	Duncan Cottage This regulation was NOT MET as evidenced by: "Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Examples of abuse include acts such as Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies; professionally accepted standards of practice; or the person's individualized services plan. Upon the review of CHRIS entry, A-20240011, the provider's investigation included a review of the provider's policy and video recording which revealed: • Per the review of video footage, Employee #1 was observed closing the door on Individual #1's foot. Employee #1 was also observed tackling Individual #1 to restrain them. Employee held Individual #1 down on the floor with Individual #1's hands and knees. Based on the provider's investigative finding, there is a preponderance of evidence to support the provider's substantiated finding of abuse.	PR) 03/05/2024 PR: Immediately after the incident Employee #1 was sent home by the Program Director and the Residential Director. The Program Director, Residential Director, lead Mandt instructor, and the Chief Human Resource Officer reviewed the video of the incident, and it was determined that Employee #1 did not use Mandt techniques to physical restraint the youth. As a result of the video evidence Employee #1 was terminated from his position. The Residential Director informed Employee #1 that his position was terminated, and he was not eligible for rehire. The Chief Human Resource Officer will oversee this process. OHR/OLR) Accepted 03/06/2024	3/5/2024

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General Comments / Recommendations:

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.

Andrea Milhouse, Human Rights	(Signature of Organization Representative)	Date

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