DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **1217-14-012**
Organization Name: **ELK HILL FARM, INC.**

Date of Inspection: **08-06-2025**
Program Type/Facility Name: **14-012 Massie Cottage**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Massie Cottage This regulation was NOT MET as evidenced by: See OHR citation.		
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	Massie Cottage This regulation was NOT MET as evidenced by: *"Neglect" means failure by a person, program, or facility operated, licensed, or funded by the* *department, excluding those operated by the Department of Corrections, responsible for providing* *services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse.* Upon review of CHRIS entry, **A-20250031,** the provider's investigation included the review of video footage, witness statements, and staff admissions, which revealed: • Employee #1 and Employee #2 failed to lock the door after retrieving medications, leaving the door ajar. Furthermore, over-the-counter medication	PR) 08/28/2025 PR: Employee #1 and Employee #2 did not properly secure the office closet door, which raised concerns about the potential theft of medication stored inside. Although there was no video evidence to confirm that any medication was taken, Elk Hill has implemented new expectations to enhance security. All staff members are now required to keep the closet door when not in use, avoid the medication aisle while grocery shopping with youth, and ensure that medications are kept separate from food items when shopping without residents. The Program Director has addressed these issues with Employee #1 and Employee #2 during their supervision, and the Residential Director will oversee this process. OHR/OLR) Accepted 09/05/2025	08/28/2025 00:00:00

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		while out in the community with individuals present. Consequently, Individual #1 was able to access Medication #1 from the office and give the pills to another individual. • Employees #1 and #2 failed to provide support necessary to the health, safety, and welfare of Individual #1, which meets the regulatory definition of neglect. Based on the provider's investigative findings, there is a preponderance of evidence to support the provider's substantiated finding of neglect.		

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