License #: **1746-14-008**
Organization Name: **Gateway Counseling Center**

Date of Inspection: **09-08-2026**
Program Type/Facility Name: **14-008 Belvedere Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-180. - Responsibilities of the provider. The provider shall develop and implement written policies and procedures to monitor and evaluate service quality and effectiveness on a systematic and on-going ongoing basis. The provider shall implement improvements when indicated.	N	Belvedere Drive This regulation was NOT MET as evidenced by: Given the repeat violations and extent of the violations issued in this CAP the provider is not effectively evaluating service quality and effectiveness on a systematic and on-going basis. During the 12/29/2025 exit interview and corresponding CAP the Licensing specialist noted the Provider needs to review all policies and procedures to ensure they align with current processes. Provider should also review the depth of clinical documentation to ensure it is clear the elements of ISPs are being implemented in progress notes and reviewed in both individual and group therapy sessions. There was no indication this was done.	PR) 09/16/2026 Root Cause: Insufficient systematic quality-assurance and supervisory process for identifying, tracking and monitoring compliance deficiencies, which resulted in recurring issues not being consistently identified and addressed before they were cited during licensing reviews. Corrective Action: Complete a review of all Policies and Procedures including the Quality Improvement Program. Preventative Action: Newly appointed Program Director will follow through on all aspects of identifying, tracking and monitoring all compliance requirements to ensure that they align with current processes. Clinical Director will review all clinical documentation to ensure elements of ISPs are being implemented in progress notes and individual and group therapy. OLR) Accepted 10/02/2026	10/1/2026
12VAC35-46-270. B. (1) - A person who assumes or is designated to assume the responsibilities of a position or any combination of positions described in this chapter shall: 1. Meet the qualifications of the position	N	Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training.	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-270. B. (2) - A person who assumes or is designated to assume the responsibilities of a position or any combination of positions described in this chapter shall: 2. Fully comply with all applicable regulations for each function;	N	Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-270. B. (3) - A person who assumes or is designated to assume the responsibilities of a position or any combination of positions described in this chapter shall: 3. Demonstrate a working knowledge of the policies and procedures that are applicable to the person's specific position.	N	Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-300. B. (6) - The records of each employee shall include: 6. Documentation of compliance with requirements of Virginia laws regarding child protective services and criminal history background investigations;	NS	Belvedere Drive This regulation was NOT MET as evidenced by: E#10 start date 7/10/2026 has no documentation of required FBI background check.	PR) 09/16/2026 Root Cause: Inadequate personnel file compliance and quality assurance process for verifying and documenting required CPS and criminal history background investigations. Although background screening requirements were part of the hiring process, there was not a systematic final verification process to ensure that all required documentation was appropriately placed in the employee personnel file and subsequently the file verified for completeness. Corrective Action: The criminal background for employee 10 was immediately obtained and placed in her file. Preventative Action: Newly appointed Program Director will utilize appropriate check sheets and conduct complete audit of each new hire before the new hire begins working with children to ensure that all required documents have been completed, received, and properly filed. PD will conduct complete monthly audits of all files and document on employee file index that audits have been completed. PD will also review, revise P&P as needed to improve process of onboarding new staff. OLR) Accepted 10/02/2026	9/9/2026
12VAC35-46-300. B. (8) - The records of each employee shall include: 8. Documentation of all training required by these regulations this chapter and any other	N	Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification	9/30/2026

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training employee development received by individual staff;		have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each	

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			medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-310. A. (8) - Required initial training: 8. Before administering medication, all staff responsible for medication administration shall have successfully completed a medication training program	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications.		by a certified trainer.	hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-310. A. (9) - Required initial training: 9.The provider shall carry out targeted staff training in any area of quality improvement as identified from the results of the quality improvement plan.	N	Belvedere Drive This regulation was NOT MET as evidenced by: There was no documentation of this training or a valid quality improvement plan.	PR) 09/16/2026 Gateway utilizes a check sheet to ensure all initial and annual training is completed. Gateway also has a comprehensive Quality Improvement Plan. Both documents will be reviewed by new Program Director within the next (15) days to evaluate for effectiveness and make necessary revisions. OLR) Accepted 10/02/2026	9/30/2026
12VAC35-46-310. B. (2) - Required annual retraining: 2. All staff	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive	PR) 09/17/2026 Root Cause: System Failure. Training not	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
who administer medication shall complete annual refresher medication training.		This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-500. B. - Windows in bathrooms, sleeping areas, and dressing areas shall provide for privacy.	N	Belvedere Drive This regulation was NOT MET as evidenced by: The upstairs bedroom requires curtains to provide privacy, and it appears the children in multiple rooms have improvised by covering windows with clothes and towels2340 Belvedere.	PR) 09/16/2026 Root Cause: Failure by previous management to conduct or delegate frequent physical plant inspections to identify needed repairs and regular maintenance Corrective Action: Effective immediately, curtains will be replaced to ensure the privacy of residents. Completed repairs will be photographed or otherwise documented and retained for Licensing review. Preventative Action: A full-time maintenance person is now on staff 40+ hours per week and will do a minimum of weekly walk throughs to inspect all rooms and exterior areas for damages or needed repairs. House managers will also do daily walk throughs to identify concerns, and have an inspection sheet that will be maintained and handed in weekly to maintenance and newly hired Program Director OLR) Accepted 10/02/2026	10/1/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-590. B. - The interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. This includes, but is not limited to, required locks, mechanical devices, indoor and outdoor equipment, and furnishings.	N	Belvedere Drive This regulation was NOT MET as evidenced by:The double doors immediately adjacent to the basement bedroom require significant repair to stabilize them and keep out insects and reported reptiles. 2340 Belvedere.	PR) 09/16/2026 During the inspection of 12/29/2025, the specific physical plant concerns that were identified were corrected. Additional physical plant deficiencies were identified on 9/8/2026. Root Cause: Failure by previous management to conduct or delegate for frequent physical plant inspections to identify needed repairs and regular maintenance Corrective Action: Effective immediately, all items presenting an issue of safety will receive priority for repair. Damaged floors will be repaired or replaced; damaged doors will be replaced; newly drywalled spots will be sanded and painted; and all worn/torn furniture will be replaced, including hard wood furniture that is worn /scratched prohibiting proper disinfectant cleaning. Curtains will be replaced to ensure the privacy of residents. Completed repairs will be photographed or otherwise documented and retained for Licensing review. Preventative Action: A full-time maintenance person is now on staff 40+ hours per week and will do a minimum of weekly walk throughs to inspect all rooms and exterior areas for damages or needed repairs. House managers will also do daily walk throughs to identify concerns and have an inspection sheet that will be maintained and handed in weekly to maintenance and newly hired Program Director. OLR) Accepted 10/02/2026	10/1/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-600. A. - All furnishings and equipment shall be safe, clean, and suitable to the ages and number of residents.	N	Belvedere Drive This regulation was NOT MET as evidenced by: The basement bedroom drywall is in disrepair including unsanded and unpainted drywall. Door to the basement bedroom is broken and needs to be replaced. The door threshold to the same room requires repair or replacement. The carpet is also frayed and detached from the floor and requires repair, cleaning or replacement. The upstairs bedroom requires curtains to provide privacy, and it appears the children in multiple rooms have improvised by covering windows with clothes and towels. All the drywall requires painting and cleaning. Couches have ripped cushions and require replacement or repair. Multiple furnishings including the kitchen table, chairs, dressers and tables have worn finishes that prohibit disincentive cleaning. Physical plant is very rough to support a therapeutic environment.	PR) 09/16/2026 During the inspection of 12/29/2025, the specific physical plant concerns that were identified were corrected. Additional physical plant deficiencies were identified on 9/8/2026. Root Cause: Failure by previous management to conduct or delegate for frequent physical plant inspections to identify needed repairs and regular maintenance Corrective Action: Effective immediately, all items presenting an issue of safety will receive priority for repair. Damaged floors will be repaired or replaced; damaged doors will be replaced; newly drywalled spots will be sanded and painted; and all worn/torn furniture will be replaced, including hard wood furniture that is worn /scratched prohibiting proper disinfectant cleaning. Curtains will be replaced to ensure the privacy of residents. Completed repairs will be photographed or otherwise documented and retained for Licensing review. Preventative Action: A full-time maintenance person is now on staff 40+ hours per week and will do a minimum of weekly walk throughs to inspect all rooms and exterior areas for damages or needed repairs. House managers will also do daily walk throughs to identify concerns and have an inspection sheet that will be maintained and handed in weekly to maintenance and newly hired Program Director. OLR) Accepted 10/02/2026	10/1/2026
12VAC35-46-625. A.	N	**HEALTH AND SAFETY VIOLATION**	PR) 09/17/2026	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
(5) - The provider shall have and implement written policies and procedures for the on-site provision of a structured program of care or treatment of residents with mental illness, mental retardation, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, mental retardation, substance abuse, or brain injury interventions shall be based on the assessed needs of the resident. These interventions, applicable to the population served, shall include, but are not limited to: 5. Assistance with activities of daily living (ADL's);		Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified.	

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			In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-625. A. (7) - The provider shall have and implement	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and	PR) 09/17/2026 Root Cause: Misinterpretation of wording in	9/20/2026

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written policies and procedures for the on-site provision of a structured program of care or treatment of residents with mental illness, mental retardation, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, mental retardation, substance abuse, or brain injury interventions shall be based on the assessed needs of the resident. These interventions, applicable to the population served, shall include, but are not limited to: 7. Providing positive behavior supports;		individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physical restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be	

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			conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	
12VAC35-46-625. C. (3) - The provider shall have and implement written policies and procedures that address the provision of: 3. Staffing appropriate to the needs and behaviors of the residents served.	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physical restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a	9/20/2026

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			new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	
12VAC35-46-650. - Each resident shall be placed in the least	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive	PR) 09/17/2026 Root Cause: Misinterpretation of wording in	9/20/2026

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restrictive level of programming appropriate to individual functioning and available services.		This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be	

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			conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	
12VAC35-46-660. H. - Entries in a resident's record shall be current, dated, and authenticated by the person making the entry. Errors shall be corrected by striking through and initialing.	N	Belvedere Drive This regulation was NOT MET as evidenced by: Record reviews of both individual and employee records found the use of white out.		
12VAC35-46-660. H. - Entries in a resident's record shall be current, dated, and authenticated by the person making the entry. Errors shall be corrected by striking through and initialing.	NS	Belvedere Drive This regulation was NOT MET as evidenced by: Record reviews of both individual and employee records found the use of white out.	PR) 09/16/2026 A memo has been sent to all staff from the Clinical Director reminding them about the 'no white out' regulation. All documents will be reviewed daily by house supervisors to ensure that regulation is followed. Program Director will ensure compliance upon routine inspections. Any further use of white out will result in staff disciplinary action. OLR) Accepted 10/02/2026	9/16/2026
12VAC35-46-670. - Complete written policies and procedures for record reviews shall be developed and implemented that shall evaluate records for completeness, accuracy, and timeliness of	NS	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Multiple/Most MARs do not have signatures of staff administering just initials. Do not have effect of PRN medications. Do not explain why medication where missed. Multiple MARs do not have the year included and white out used throughout the records.	PR) 09/16/2026 Root Cause: System Failure. Training not verified prior to medication administration as a result of inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32-hour prior certification before	9/30/2026

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documentation. Such policies shall include provisions for ongoing review to determine whether records contain all required service documentation, and release of information documents required by the provider.			registering for 6-hour refresher, which had always been done in the past. All staff had previously had 32-hour training, although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32-hour medication certification, immediately ceased administering medications. Only staff who have current 32-hour medication certification are administering medications. Eight staff are currently enrolled in the 32-hour course and expect to receive full certification by 9/20/2026. Preventative Action: Newly appointed Program Director will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employee's required initial medication training and subsequent recertification prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will include the Program Director doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The Program Director will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials and all other pertinent information,	

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			and immediately address any identified deficiencies and provide additional training or corrective action as needed. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR, for Program Director review and approval. OLR) Accepted 10/02/2026	
12VAC35-46-710. B. (4) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 4. The protection needs of the prospective resident;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing	9/20/2026

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			agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	
12VAC35-46-710. D. (1) - Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 1. The needs of the prospective resident	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home".	PR) 09/16/2026 Root Cause: System Failure. Training not verified prior to medication administration as a result of inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32-hour prior certification before	9/30/2026

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can be addressed by the facility's services;		A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	registering for 6-hour refresher, which had always been done in the past. All staff had previously had 32-hour training, although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32-hour medication certification, immediately ceased administering medications. Only staff who have current 32-hour medication certification are administering medications. Eight staff are currently enrolled in the 32-hour course and expect to receive full certification by 9/20/2026. Preventative Action: Newly appointed Program Director will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employee's required initial medication training and subsequent recertification prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will include the Program Director doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The Program Director will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials and all other pertinent information,	

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			and immediately address any identified deficiencies and provide additional training or corrective action as needed. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR, for Program Director review and approval. OLR) Accepted 10/02/2026	
12VAC35-46-710. D. (2) - Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 2. The facility's staff is trained to meet the prospective resident's needs;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home". A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a	9/30/2026

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			new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	
12VAC35-46-710. D. (3) - Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 3. The admission of the prospective resident would not pose any	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home". A review of all active employee records E#1 through E#13,	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of	9/30/2026

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significant risk to (i) the prospective resident or (ii) the facility's residents or staff.		found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	

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12VAC35-46-750. D. (1) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 1. Resident's progress toward meeting the plan's objectives;	N	Belvedere Drive This regulation was NOT MET as evidenced by: Progress notes need to be directly tied to "individual ISP for every identified goal". During the 12/29/2025 exit interview and corresponding CAP the Licensing specialist noted the Provider needs to review all policies and procedures to ensure they align with current processes. During the 12/29/2025 exit interview and corresponding CAP the Licensing specialist noted the Provider needs to review all policies and procedures to ensure they align with current processes. Provider should also review the depth of clinical documentation to ensure it is clear the elements of ISPs are being implemented in progress notes and reviewed in both individual and group therapy sessions. There was no indication this was done.	PR) 09/16/2026 Root Cause: Insufficient systematic quality-assurance and supervisory process for identifying, tracking and monitoring compliance deficiencies, which resulted in recurring issues not being consistently identified and addressed before they were cited during licensing reviews. Corrective Action: Complete a review of all Policies and Procedures including the Quality Improvement Program. Preventative Action: Newly appointed Program Director will follow through on all aspects of identifying, tracking and monitoring all compliance requirements to ensure that they align with current processes. Clinical Director will review all clinical documentation to ensure elements of ISPs are being implemented in progress notes and individual and group therapy. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-750. H. (1) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 1. The resident;	N	Belvedere Drive This regulation was NOT MET as evidenced by: There was no documentation to support this was done for any individuals.	PR) 09/16/2026 Root Cause: Inconsistent review of signatures to ensure that all parties are participating in the development and updating of the individualized service plan. Although the documents were being developed with the participation of all parties, the process did not include a reliable method for ensuring that signature sheets were returned to facility from various participants. Corrective Action: PD and Case Manager will work together to immediately review the records to determine which files do not have documentation of all parties participation. For any missing documentation the required document will be completed and placed in resident file. Preventative Action: Prior to filing service plans, Case Manager will ensure completion of documentation and signatures verifying that all relevant parties participated. PD will conduct a monthly audit of resident records to verify participation, signatures and distribution of plans as required. OLR) Accepted 10/02/2026	9/30/2026

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12VAC35-46-750. H. (2) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 2. The resident's family, if appropriate, and legal guardian;	N	Belvedere Drive This regulation was NOT MET as evidenced by: There was no documentation to support this was done any individuals.	PR) 09/16/2026 Root Cause: Inconsistent review of signatures to ensure that all parties are participating in the development and updating of the individualized service plan. Although the documents were being developed with the participation of all parties, the process did not include a reliable method for ensuring that signature sheets were returned to facility from various participants. Corrective Action: PD and Case Manager will work together to immediately review the records to determine which files do not have documentation of all parties participation. For any missing documentation the required document will be completed and placed in resident file. Preventative Action: Prior to filing service plans, Case Manager will ensure completion of documentation and signatures verifying that all relevant parties (residents family, if appropriate and legal guardian) participated. PD will conduct a monthly audit of resident records to verify participation, signatures and distribution of plans as required. OLR) Accepted 10/02/2026	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-750. H. (2) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 2. The resident's family, if appropriate, and legal guardian;	N	Belvedere Drive This regulation was NOT MET as evidenced by: There was no documentation to support this was done for any individuals.		
12VAC35-46-750. H. (3) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 3. The placing agency;	N	Belvedere Drive This regulation was NOT MET as evidenced by: There was no documentation to support this was done any individuals.		

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-750. H. (3) - There shall be documentation showing the involvement of the following parties unless clearly inappropriate, in developing and updating the individualized service plan and in developing the quarterly progress report: 3. The placing agency;	N	Belvedere Drive This regulation was NOT MET as evidenced by: There was no documentation to support this was done for any individuals.	Root Cause: Inconsistent review of signatures to ensure that all parties are participating in the development and updating of the individualized service plan. Although the documents were being developed with the participation of all parties, the process did not include a reliable method for ensuring that signature sheets were returned to facility from various participants. Corrective Action: PD and Case Manager will work together to immediately review the records to determine which files do not have documentation of all parties participation. For any missing documentation the required document will be completed and placed in resident file. Preventative Action: Prior to filing service plans, Case Manager will ensure completion of documentation and signatures verifying that all relevant parties (residents family, if appropriate, placing agency and legal guardian) participated. PD will conduct a monthly audit of resident records to verify participation, signatures and distribution of plans as required.	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-760. A. (1) - Except when transfer is ordered by a court of competent jurisdiction, the provider's receiving service or facility shall document receipt of the following at the time of the resident's transfer: 1. Documentation of advance notification to the family, if appropriate;, the resident, the placement agency, and the legal guardian;	N	Belvedere Drive This regulation was NOT MET as evidenced by: No evidence of this occurring for individual #4 as confirmed by OHR interview of the child and staff on 9/8/2026 at Rock Hill when he was moved without notice to include staff on duty. Individuals' belongings and medications were not moved when he returned from school at the Rock Hill location instead of his home at the Belvedere location. This is in violation of multiple OHR regulations.	PR) 09/16/2026 Root Cause: Resident and his older brother had been having difficulties that were affecting the mental health of Resident. The legal guardian/placing agency was aware of the issues and at 11a on Sept 8, requested an emergency move to Rock Hill. Therefore, he was transported at that time. Corrective Action: By the afternoon of Sept 8, the receiving house documented the situation that had caused the sudden move (request from legal guardian for health and safety reasons); notification to placing agency that the move had been completed, as requested; receipt from Belvedere with current service plan, progress of resident that included strengths and needs, medications, and personal belongings. Preventative Action: PD and Case Manager will review all regulation regarding the movement of youth from one facility to another and explain to placing agencies what the facility is required to do when a move is requested. PD and Case Manager will abide fully by stated regulations of 12VAC35-46-760.A.1 OLR) Accepted 10/02/2026	9/9/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-760. A. (2) - Except when transfer is ordered by a court of competent jurisdiction, the provider's receiving service or facility shall document receipt of the following at the time of the resident's transfer: 2. A written summary of the resident's progress while at the transferring facility, justification for the transfer, and the resident's current strengths and needs;	N	Belvedere Drive This regulation was NOT MET as evidenced by: No evidence of this occurring for individual #4 as confirmed by OHR interview of the child and staff on 9/8/2026 at Rock Hill when he was moved without notice to include staff on duty. Individuals' belongings and medications were not moved when he returned from school at the Rock Hill location instead of his home at the Belvedere location. This is in violation of multiple OHR regulations.	PR) 09/16/2026 Root Cause: Resident and his older brother had been having difficulties that were affecting the mental health of Resident. The legal guardian/placing agency was aware of the issues and at 11a on Sept 8, requested an emergency move to Rock Hill. Therefore, he was transported at that time. Corrective Action: By the afternoon of Sept 8, the receiving house documented the situation that had caused the sudden move (request from legal guardian for health and safety reasons); notification to placing agency that the move had been completed, as requested; receipt from Belvedere with current service plan, progress of resident that included strengths and needs, medications, and personal belongings. Preventative Action: PD and Case Manager will review all regulation regarding the movement of youth from one facility to another and explain to placing agencies what the facility is required to do when a move is requested. PD and Case Manager will abide fully by stated regulations of 12VAC35-46-760.A.2 OLR) Accepted 10/02/2026	9/9/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-760. A. (3) - Except when transfer is ordered by a court of competent jurisdiction, the provider's receiving service or facility shall document receipt of the following at the time of the resident's transfer: 3. A copy of the resident's record.	N	Belvedere Drive This regulation was NOT MET as evidenced by: No evidence of this occurring for individual #4 as confirmed by OHR interview of the child and staff on 9/8/2026 at Rock Hill when he was moved without notice to include staff on duty. Individuals' belongings and medications were not moved when he returned from school at the Rock Hill location instead of his home at the Belvedere location. This is in violation of multiple OHR regulations.	PR) 09/16/2026 Root Cause: Resident and his older brother had been having difficulties that were affecting the mental health of Resident. The legal guardian/placing agency was aware of the issues and at 11a on Sept 8, requested an emergency move to Rock Hill. Therefore, he was transported at that time. Corrective Action: By the afternoon of Sept 8, the receiving house documented the situation that had caused the sudden move (request from legal guardian for health and safety reasons); notification to placing agency that the move had been completed, as requested; receipt from Belvedere with current service plan, progress of resident that included strengths and needs, medications, and personal belongings. Preventative Action: PD and Case Manager will review all regulation regarding the movement of youth from one facility to another and explain to placing agencies what the facility is required to do when a move is requested. PD and Case Manager will abide fully by stated regulations of 12VAC35-46-760.A.3 OLR) Accepted 10/02/2026	9/9/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-760. B. - The transferring service or facility shall document the date of transfer and the name of the receiving service or facility to which the resident was transferred.	N	Belvedere Drive This regulation was NOT MET as evidenced by: No evidence of this occurring for individual #4 as confirmed by OHR interview of the child and staff on 9/8/2026 at Rock Hill when he was moved without notice to include staff on duty. Individuals' belongings and medications were not moved when he returned from school at the Rock Hill location instead of his home at the Belvedere location. This is in violation of multiple OHR regulations.	PR) 09/16/2026 Root Cause: Resident and his older brother had been having difficulties that were affecting the mental health of Resident. The legal guardian/placing agency was aware of the issues and at 11a on Sept 8, requested an emergency move to Rock Hill. Therefore, he was transported at that time. Corrective Action: By the afternoon of Sept 8, the receiving house documented the situation that had caused the sudden move (request from legal guardian for health and safety reasons); notification to placing agency that the move had been completed, as requested; receipt from Belvedere with current service plan, progress of resident that included strengths and needs, medications, and personal belongings. Preventative Action: PD and Case Manager will review all regulation regarding the movement of youth from one facility to another and explain to placing agencies what the facility is required to do when a move is requested. PD and Case Manager will abide fully by stated regulations of 12VAC35-46-760.B OLR) Accepted 10/02/2026	9/9/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-80. E. - Upon receipt of the corrective action plan, the department shall review the plan and determine whether the plan is approved or not approved. The provider shall have an additional 10 business days to submit a revised corrective action plan after receiving a notice that the plan submitted has not been approved.	N	Belvedere Drive This regulation was NOT MET as evidenced by: Failure to implement an approved corrective action plan issued 12/29/2025, repeat violations 300B.6, 660 H, & 670.	PR) 09/16/2026 600.A During the inspection of 12/29/2025, the specific physical plant concerns that were identified were corrected. Additional physical plant deficiencies were identified on 9/8/2026. 300.B During the inspection of 12/29/2025 the CAP regarding the identified staff missing the criminal background report was implemented. The 9/8/2026 review identified a missing report of a fairly new employee. 660.H and 670 Corrective action plan of 12/29/2025 was reviewed with all staff. Failure to implement plan completely was the result of previous Program Director having initially unrecognized cognitive deficiencies which eventually resulted in a stroke. Management has now been delegated to new PD. Preventative Action: A full-time maintenance person is now on staff 40+ hours per week and will do a minimum of weekly walk throughs to inspect all rooms and exterior areas for damages or needed repairs. House managers will also do daily walk throughs to identify concerns and have an inspection sheet that will be maintained and handed in weekly to maintenance and newly hired Program Director. OLR) Accepted 10/02/2026	10/15/2026
12VAC35-46-800. A. (1) - There shall be evidence of a structured program of care designed to: 1. Meet each resident's	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
physical and emotional needs;		physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home". A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	
12VAC35-46-800. A. (2) - There shall be evidence of a structured program of care designed to: 2. Provide protection, guidance, and supervision;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive **Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home".** **A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.**	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	
12VAC35-46-800. A. (3) - There shall be evidence of a structured program of care designed to: 3. Meet the objectives of any required individualized service plan.	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive **Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home".** **A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.**	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-800. C. - The provider shall maintain a daily communication log to share information with staff about significant happenings or problems experienced by residents, with the identity of the person making each entry in the log recorded.	N	Belvedere Drive This regulation was NOT MET as evidenced by: The identify of the individual making entry in the daily log shall be recorded, multiple daily communication log entries not signed off by staff as witness by E#1 and E#2 when reviewed by OL and OHR.	PR) 09/16/2026 Root Cause: Systemic failure of quality assurance reviews of staff documentation (communication log) Corrective Action: The Program Director will immediately ensure compliance with communication log policy and procedures to ensure significant happenings or problems experienced by residents are clearly documented and the name of the staff member making the entry is clearly identified. All direct-care staff will receive verbal retraining on the requirements of correct documentation in the communication log. Preventative Action: PD will review notes weekly and any identified gaps will be corrected immediately. Staff who fail to consistently implement or document according to policy and procedure will receive additional supervision and training. OLR) Accepted 10/02/2026	9/20/2026
12VAC35-46-850. A. (1) - The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by residents. At a minimum these policies will address: 1. Identification of the	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records found only one of the active 13 staff have completed the 32 hour State approved Medication Administration Training and none of the 5 staff who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
staff member responsible for routinely communicating to the prescribing physician			to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-850. A. (2) - The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by residents. At a minimum these policies will address: 2. Storage of controlled substances;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records found only one of the active 13 staff have completed the 32 hour State approved Medication Administration Training and none of the 5 staff who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have	9/30/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-850. A. (3) - The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by residents. At a minimum these policies will address: 3. Documentation of medication errors and drug reactions;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records found only one of the active 13 staff have completed the 32 hour State approved Medication Administration Training and none of the 5 staff who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer. A review of MARs for the past 12 months for all individuals in service found staff repeatedly failed to include the date of prescription for medications and staff failed to identify their initials repeatedly.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those	9/30/2026

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			staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will	

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			ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-850. A. (4) - The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by residents. At a minimum these policies will address: 4. Documentation of any medications prescribed and administered following admission;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records found only one of the active 13 staff have completed the 32 hour State approved Medication Administration Training and none of the 5 staff who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer. A review of MARs for the past 12 months for all individuals in service found staff repeatedly failed to include the date of prescription for medications and staff failed to identify their initials repeatedly.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight	9/30/2026

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			staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-850. A. (6) - The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by residents. At a minimum these policies will address: 6. Distribution of medication off campus.	N	Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records found only one of the active 13 staff have completed the 32 hour State approved Medication Administration Training and none of the 5 staff who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer. A review of MARs for the past 12 months for all individuals in service found staff repeatedly failed to include the date of prescription for medications and staff failed to identify their initials repeatedly.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration as a result of inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32-hour prior certification before registering for 6-hour refresher, which had always been done in the past. All staff had previously had 32-hour training, although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32-hour medication certification, immediately ceased administering medications. Only staff who have current 32-hour medication certification are administering medications. Eight staff are currently enrolled in the 32-hour course	9/30/2026

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			and expect to receive full certification by 9/20/2026. Preventative Action: Newly appointed Program Director will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employee's required initial medication training and subsequent recertification prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will include the Program Director doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The Program Director will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials and all other pertinent information, and immediately address any identified deficiencies and provide additional training or corrective action as needed. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been	

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			completed each day on the back of each MAR, for Program Director review and approval. There is currently a policy for 'distribution of medication off campus'. Policy and Procedure/Medication Administration Policy/paragraph 'F'. OLR) Accepted 10/02/2026	
12VAC35-46-850. C. - Policies shall include training requirements necessary for employees or contractors who are authorized to administer medications. Medications shall be administered only by persons authorized to do so by the Drug Control Act (§ 54.13400 et seq. of the Code of Virginia).	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records found only one of the active 13 staff have completed the 32 hour State approved Medication Administration Training and none of the 5 staff who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer. A review of MARs for the past 12 months for all individuals in service found staff repeatedly failed to include the date of prescription for medications and staff failed to identify their initials repeatedly.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each	9/30/2026

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			employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends.	

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			To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-850. G. (1) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 1. Date the medication was prescribed;	N	Belvedere Drive This regulation was NOT MET as evidenced by: A review of MARs for the past 12 months for all individuals found staff repeatedly failed to include the date of prescription for medications	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and	9/30/2026

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			subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-850. G. (6) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 6. Identity of the individual who administered the medication;	N	Belvedere Drive This regulation was NOT MET as evidenced by: A review of MARs for the past 12 months for all individuals in service found staff failed to identify their initials repeatedly.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with	9/30/2026

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			supervisory review conducted monthly and documentation maintained in each employee's training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been	

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			completed each day on the back of each MAR. OLR) Accepted 10/02/2026	
12VAC35-46-850. G. (7) - A medication administration record shall be maintained of all medicines received by each resident and shall include: 7. Dates the medication was discontinued or changed.	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: A review of all active employee records E#1 through E#13, found only one of the active 13 employees, employee #13, completed the 32 hour State approved Medication Administration Training and none of the 5 employees who have been employed for over a year have had the required Annual State approved Medication Administration Training by a certified trainer. A review of MARs for the past 12 months for all individuals in service found staff failed to identify their initials repeatedly.	PR) 09/17/2026 Root Cause: System Failure. Training not verified prior to medication administration due to inadequate internal process for verifying, tracking and routinely auditing staff medication training credentials, including distinguishing initial medication training from recertification requirements, due to assuming medication administration training staff would have verified 32 hour prior certification before registering for 6 hour refresher, which had always been done in the past. All staff had previously had 32 hour training although there was no documentation to verify previous training. Corrective Action: Staff who do not have documented 32 hour medication immediately ceased administering medications. Only those staff who have current 32 hour medication training will be administering medications. Eight staff are currently enrolled in the 32 hour course and expect to receive full certification by 9/20/2026 Preventative Action: Newly appointed PD will implement a comprehensive medication-administration monitoring process to include a centralized medication-training credential tracking and auditing process that verifies each employees required initial medication training (approved by the Board of Nursing) and subsequent recertification (by a certified trainer) prior to medication administration, with supervisory review conducted monthly and documentation maintained in each employee's	9/30/2026

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			training record. Any identified deficiency will be immediately addressed, and staff will not administer medications until all required training and credentials have been verified. In addition, the comprehensive process will provide for PD doing routine, weekly audits of medication administration records to ensure that all medications administered are accurately, completely and timely documented. The PD or designated supervisor will conduct and document weekly audits to ensure that each medication is accurately documented, including the required date, time, route, signature and initials, storage of controlled substances, staff member routinely assigned to communicate with prescribing physician, documentation of meds prescribed following admission, distribution of meds when off campus and all other pertinent information, and immediately address and identified deficiencies and provide additional training or corrective action as needed. PD will ensure that residents are assisted with ADLs as needed, that the needs of the prospective client can be addressed by facility services, and the prospective resident would not pose any significant risk the prospective resident, current residents or staff. Audit findings will be reviewed as part of the providers ongoing quality improvement process to ensure that corrective measures are effective and prevent recurrence and to monitor for trends. To ensure the corrective action is effective with no room for error, for the first 30 days, each house supervisor will do a 100% MARs review daily and document that a review has been completed each day on the back of each MAR. OLR) Accepted 10/02/2026	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-900. A. (3) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 3. Identification of successful intervention strategies for problem behavior;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. The application for admission is designed to compile information necessary to determine the protection needs of the prospective resident; ensure that all needs can be addressed by facility services (physical, emotional, protection, guidance, supervision); meet objectives of ISP; and ensure that the prospective resident would not pose a significant risk to current residents or staff. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will	9/20/2026

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			be reviewed with PD at staff meetings, in addition to the full annual reviews to determine appropriateness for the population served. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions and to ensure that the needs of the resident can be addressed by the facilities services. OLR) Accepted 10/02/2026	

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12VAC35-46-900. D. - Each provider shall develop and implement written policies and procedures concerning behavior support plans and other behavioral interventions that are directed toward maximizing the growth and development of the resident consistent with the requirements of 12VAC35-115-105.	N	Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. A. - The provider shall develop and implement written policies and procedures for behavioral interventions and consistent with the requirements of 12VAC35-115. Minimum provisions shall include rules of conduct and methods for documenting and monitoring the management of resident behavior.	N	Belvedere Drive	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. B. (1) - Written information concerning the provider's behavioral support and intervention policies and procedures shall be provided prior to admission to prospective residents, legal guardians, and placing agencies. For court-ordered and emergency admissions, this information shall be provided to: 1. Residents within 12 hours following admission;	N	Belvedere Drive This regulation was NOT MET as evidenced by:	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. B. (2) - Written information concerning the provider's behavioral support and intervention policies and procedures shall be provided prior to admission to prospective residents, legal guardians, and placing agencies. For court-ordered and emergency admissions, this information shall be provided to: 2. Placing agencies within 72 hours following the resident's admission;	N	Belvedere Drive This regulation was NOT MET as evidenced by:	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. B. (3) - Written information concerning the provider's behavioral support and intervention policies and procedures shall be provided prior to admission to prospective residents, legal guardians, and placing agencies. For court-ordered and emergency admissions, this information shall be provided to: 3. Legal guardians within 72 hours following the resident's admission. The requirements of this subsection do not apply when a state psychiatric hospital is evaluating a child's treatment needs as provided by the Code of Virginia.	N	Belvedere Drive This regulation was NOT MET as evidenced by:	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. D. - The provider shall develop and implement written policies and procedures governing use of physical restraint that shall complay with the requirements of 12VAC35-115.	N	Belvedere Drive	PR) 09/17/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal review and audit of all policies and restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. E. - All physical restraints shall be reviewed and evaluated to plan for continued staff development for performance improvement.	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Program Type/Facility Name: **14-008 Belvedere Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. F. - Use of physical restraint shall be limited to that which is minimally necessary to protect the resident or others as required by 12VAC35-115.	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

License #: **1746-14-008**
Organization Name: **Gateway Counseling Center**

Date of Inspection: **09-08-2026**
Program Type/Facility Name: **14-008 Belvedere Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. G. - Trained staff members may physically restrain a resident only after less restrictive interventions.	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Program Type/Facility Name: **14-008 Belvedere Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. I. (5) - Each application of physical restraint shall be fully documented in the resident's record including: 5. Less restrictive interventions that were unsuccessfully attempted prior to using physical restraint;	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-940. K. - The provider shall review the facility's behavior intervention techniques and policies and procedures at least annually to determine appropriateness for the population served.	N	**HEALTH AND SAFETY VIOLATION** Belvedere Drive This regulation was NOT MET as evidenced by: Staff and individual interviews verified inappropriate behavioral intervention strategies found written in the Resident Handbook and supported by the providers' policies and procedures. Current Resident Handbook states "staff may physically restrain youth who are refusing to follow directives which are required to maintain structure and safety in the home"	PR) 09/16/2026 Root Cause: Misinterpretation of wording in Resident Handbook. Corrective Action: The terminology utilized in the Resident Handbook has been modified to ensure compliance with regulatory standards and inclusion of rules of conduct, and provision of methods for documenting and monitoring resident behavior. All staff were sent a copy of the correction and acknowledged receipt of memo. All staff will be re-educated on proper behavioral intervention techniques and minimally necessary interventions. Due to the inappropriate behavioral intervention strategies utilized by staff, a mandatory full 'Safe Crisis Management' class is being conducted at 9am on Sept 17, 2026. Program Director will ensure all residents are provided with written information regarding behavior interventions within 12 hours of admission and legal guardians/placing agencies within 72 hours of admission utilizing a new admission checklist. Additionally, Clinical Director will update all resident individual behavioral support plans monthly. Preventative Action: Safe Crisis Management strategies that are effective and therapeutic will be reviewed with PD at staff meetings, in addition to the full annual reviews. Complete internal audit of all restraints will be conducted by PD to ensure proper staff training, accurate documentation and appropriate use of less restrictive interventions. OLR) Accepted 10/02/2026	9/20/2026

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **1746-14-008**
Organization Name: **Gateway Counseling Center**

Date of Inspection: **09-08-2026**
Program Type/Facility Name: **14-008 Belvedere Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
Provider has 5 business days to respond to this violation notice given the serious of the violations. Provider is required to review the complete STANDARDS FOR THE REGULATION OF CHILDREN'S RESIDENTIAL FACILITIES OFFICE OF LICENSING VA Department of Behavioral Health and Developmental Services 12VAV35-46-10 ET SEQ in preparation for a follow up review by DBHDS and relevant agencies. Provider needs to be prepared to present proof of compliance in chronological order from the beginning of STANDARDS FOR THE REGULATION OF CHILDREN'S RESIDENTIAL FACILITIES OFFICE OF LICENSING to the end. Additionally, the provider needs to present one set of printed copies of all the documents, policies, procedures, inspections, verifications and approvals to demonstrate compliance with all regulations contained within STANDARDS FOR THE REGULATION OF CHILDREN'S RESIDENTIAL FACILITIES OFFICE OF LICENSING. Copies of individual and employee records do not require copies and will be reviewed individually and scanned by reviewers as needed. This review will occur at the providers' main office and will occur promptly after the provider responds to this violation notice. cpc

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.

Christopher Cart, Licensing Specialist	(Signature of Organization Representative)	Date

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