DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **1746-14-009**
Organization Name: **Gateway Counseling Center**

Date of Inspection: **07-12-2023**
Program Type/Facility Name: **14-009 Hope Road**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-70. - Each provider shall guarantee resident rights as outlined in § 37.2-400 of the Code of Virginia and in the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (12VAC35-115).	N	Hope Road This regulation was NOT MET as evidenced by: See OHR citation below:		7/1/2023

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12VAC35-115-230. A. (3a) - Providers shall collect, maintain, and report the following information concerning abuse, neglect, and exploitation: 3. The investigating authority shall provide a written report of the results of the investigation of abuse or neglect to the director and human rights advocate via the department's web-based reporting application within 10 working days from the date the investigation began unless an extension has been granted (see 12VAC35-115-175). This report shall include: 3a. Whether abuse, neglect, or exploitation occurred;	N	Hope Road This regulation was NOT MET as evidenced by: CHRIS A#20230004/Incident Date 5.18.23 • Investigative findings were due for completion in the investigation tab in CHRIS on 6/02/23; however, the findings were not completed in CHRIS until 6/08/23. • Provider failed to complete investigative findings in CHRIS within 10 working days from the date the investigation began which is a violation of 12VAC35-115-230(A)(3)(a).	PR) 07/13/2023 Director will ensure that when required, investigative findings are entered into CHRIS within 10 working days. Director will provide oversight to Program Coordinator, who is responsible for entering into CHRIS, as a means of ensuring that findings are entered in a timely manner. OHR/OLR) Accepted 07/13/2023	7/1/2023
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse,	N	Hope Road This regulation was NOT MET as evidenced by: CHRIS A#20230004/Incident Date 5.18.23	PR) 07/13/2023 Upon returning from vacation and hearing bits and pieces of the incident that occurred, Clinical Director read the notes that were available and interviewed the employees that were involved. Based on the information obtained, Director	7/1/2023

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neglect, and exploitation.		"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. • During an onsite visit, Employee #2 reported that on 5/18/23, Employee #2 was in the kitchen with other individuals and overheard Employee #1 tell Individual #1 "You hit me, you're not supposed to hit," followed by a commotion. • Employee #2 reported that they went to check on Employee #1 and Individual #1, and saw Employee #1 on top of Individual #1, who was face down on the floor in a prone restraint. During this time, Employee #1 was observed to be holding Individual #1's arms behind their back. • Individual #1 had a bump on Individual #1's head immediately following the incident. • Entity #1 reported that Individual #1 had petechiae all over face, neck, and ears and a headache for several days after the incident. • Photos of injuries taken the day after the incident of Individual #1 revealed the following: ◦ Bruising and swelling on left eye and face; ◦ Petechiae on face; ◦ Bruising just below right elbow; ◦ Red mark on left elbow; and, ◦ 2 red marks on right arm just below elbow; one was on the forearm and one was just above the wrist. • When Employee #1 placed and held Individual #1 in a prone restraint, Employee #1 knowingly,	believed that proper protocol had been followed. After the Human Rights complaint being received and additional information being obtained, employee number 1 was placed on leave pending outcome of investigation (employee #1 was not permitted to return). Employee number 2 was being closely monitored as there was concern regarding employee #2 demeanor with youth as well as concerns regarding honesty in reporting the chain of events that had occurred during the reported incident. Director held an emergency staff meeting to discuss the incident and provide supervision and instruction on what had occurred VS what should have occurred. The definition of abuse and neglect were reviewed and the policy and procedure regarding what protocol is to be followed; and how to safely and therapeutically handle oppositional and aggressive behavior in youth. Staff were instructed that in the event of an injury, in addition to applying or administering appropriate First Aid, if there are visible injuries of any kind, medical attention should be mandatory and if the child refuses, call 911, let first responders come to house and conduct a professional assessment. All staff are aware of the proper techniques involved with maintaining safety. Any staff violating policy and procedure will immediately be terminated. No child will be subjected to abuse or neglect at RYS. At no time will staff recklessly and intentionally cause physical or psychological harm to a child. OHR/OLR) Partially Accepted 07/13/2023	

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		recklessly, and intentionally caused physical harm, and might have caused psychological harm to Individual #1. This is a violation of 12VAC35-115-50 (B)(2). "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. • Interviews conducted on 6/1/23 during an onsite visit with Employee #2 and Employee #3 revealed the following: ◦ Employee #2 and Employee #3 reported that, immediately following the incident, Individual #1 had a red bump on forehead indicating a head injury; and, ◦ Employee #2 and Employee #3 reported that they offered to take Individual #1 to seek outside medical treatment, but Individual #1 refused and Employee #2 and Employee #3 gave Individual #1 ice for the bump on their head. • As reported by Individual #1's case worker, Individual #1 had a headache for several days after the incident. • Entity #1 reported that Individual #1 had petechiae the following day all over face, neck, and ears. • Photos of injuries revealed bruising, redness and swelling on the left side of face, to include left eye. • Employee #1, Employee #2, and Employee #3's failure to seek outside medical treatment for Individual #1's injuries following the incident meets the regulatory definition for neglect, and is a violation of 12VAC35-115-50(B)(2).	OHR Response: Partially accepted. Please remove any gender identifying pronouns and use only gender neutral pronouns. PR) 07/28/2023 07/13/2023 Upon returning from vacation and hearing bits and pieces of the incident that occurred, Clinical Director read the notes that were available and interviewed the employees that were involved. Based on the information obtained, Director believed that proper protocol had been followed. After the Human Rights complaint being received and additional information being obtained, employee number 1 was placed on leave pending outcome of investigation (employee #1 was not permitted to return). Employee number 2 was being closely monitored as there was concern regarding employee #2 demeanor with youth as well as concerns regarding honesty in reporting the chain of events that had occurred during the reported incident. Director held an emergency staff meeting to discuss the incident and provide supervision and instruction on what had occurred VS what should have occurred. The definition of abuse and neglect were reviewed and the policy and procedure regarding what protocol is to be followed; and how to safely and therapeutically handle oppositional and aggressive behavior in youth. Staff were instructed that in the event of an injury, in addition to applying or administering appropriate First Aid, if there are visible injuries	

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			of any kind, medical attention should be mandatory and if the child refuses, call 911, let first responders come to house and conduct a professional assessment. All staff are aware of the proper techniques involved with maintaining safety. Any staff violating policy and procedure will immediately be terminated. No child will be subjected to abuse or neglect at RYS. At no time will staff recklessly and intentionally cause physical or psychological harm to a child. OHR/OLR) Accepted 07/28/2023	

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12VAC35-115-60. B. (8) - The provider's duties. 8. Providers shall ensure that the entries in an individual's services record are at all times authentic, accurate, complete, timely, and pertinent.	N	Hope Road This regulation was NOT MET as evidenced by: CHRIS A#20230004/Incident Date: 5.18.23 • Interview with Employee #2 and review of documentation (Serious Incident Report) determined that documentation of incident did not match the statement provided by Employee #2 during an interview that was conducted on 6/1/23 during an onsite visit with the Human Rights Advocate. ◦ Serious incident report documented that restraint occurred as a result of Employee #1 attempting to prevent Individual #1 from getting into altercation with peers and for pushing staff. ◦ During an interview as part of an onsite visit on 6/1/23 with Human Rights Advocate, Employee #2 stated that Employee #2 overheard Employee #1 redirect Individual #1 to leave the activity room because Individual #1 did not ask for permission to go in there. Employee #2 stated that Employee #2 then overheard Employee #1 tell Individual #1 "You hit me, you're not supposed to hit," followed by a commotion. Employee #2 walked into the activity room and observed Employee #1 on top of Individual #1 who was face down and Employee #1 was holding Individual #1's arms behind their back. • Failing to accurately and authentically document a serious incident is violation of 12VAC35-115-60(B)(8).	PR) 07/13/2023 Per policy and procedure all incidents of behavior, both positive and negative are to be accurately documented in the resident daily log in a timely manner (before end of day). Incident reports should be a reflection and detailed report of what actually occurred during a situation requiring the report. All Incident Reports are reviewed by the Director and staff are interviewed for clarity, as needed. The documentation of this incident was not carefully reviewed as Director was out of the country. Director will continue to review all documentation and Incident reports to assure compliance with regulations as well as ensuring that reporting is timely and accurate/authentic. In the absence of the Director, the oversight of compliance with documentation requirements will be delegated to fully qualified staff. Employee number 2 was monitored and terminated due to concerns regarding authenticity of verbal and written reporting, along with other concerns. OHR/OLR) Accepted 07/13/2023	7/1/2023

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General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Cassie Purtlebaugh, Human Rights	(Signature of Organization Representative)	Date

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