DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **1746-14-010**
Organization Name: **Gateway Counseling Center**

Date of Inspection: **04-11-2024**
Program Type/Facility Name: **14-010 Rock Hill Church Rd**

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	Rock Hill Church Rd This regulation was NOT MET as evidenced by: See OHR citations below.		4/13/2024

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12VAC35-115-230. A. (2) - Providers shall collect, maintain, and report the following information concerning abuse, neglect, and exploitation: 2. The director of a service licensed or funded by the department shall report each allegation of abuse or neglect via the department's web-based reporting application within 24 hours of receipt of the allegation (see 12VAC35-115-175).	N	Rock Hill Church Rd This regulation was NOT MET as evidenced by: CHRIS Abuse #20240001, #20240002, #20240003, #20240004, #20240005/Incident Date: April 3, 2024 • Director was notified on April 3, 2024, at 9:30 am of allegations of neglect. • Allegations of neglect were not entered into the department's web-based reporting system until April 7, 2024, at 1:18 pm, which was not within the required 24 hours. Failing to report allegations of abuse or neglect via the department's web-based reporting application within 24 hours of receipt of the allegation is a violation of 12VAC35-115-230(A)(2).	PR) 04/13/2024 When situations of abuse or neglect occur there is generally so much going on and various steps to take that ensure that all youth are safe and back on track and that the house is running smoothly. It is very easy to overlook the step of notifying the office of licensing within the 24 hour time line. Moving forward, the Clinical Director has included a line on incident reports under 'Persons Notified' that will remind CD that the incident must also go in CHRIS and OHR within 24 hours.. See uploaded document. OHR/OLR) Accepted 04/15/2024	4/13/2024
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	Rock Hill Church Rd This regulation was NOT MET as evidenced by: "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. CHRIS Abuse #20240001, #20240002, #20240003, #20240004, #20240005/Incident Date: April 3, 2024 Provider has substantiated for neglect based on the	PR) 04/13/2024 Upon receiving the report from employee #2 that employee #1 failed to supervise properly (asleep during shift and leaving kids alone) and failing to provide adequate nutrition, and that this had occurred previously, employee #1 was immediately terminated with no opportunity for rehire. Clinical Director notified CPS of the incidents. Clinical Director then notified all staff of the incident and reviewed policy and procedure with all staff regarding proper supervision, ie.....awake during night shift; no resident ever left alone for any period of time, for any reason; and ensuring that all youth receive breakfast before leaving for school.	4/13/2024

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		following: • On April 3, 2024, Employee #2 arrived to the group home and noticed that Employee #1 was pulling back into the group home with no individuals. • Employee #2 then went into the group home and discovered that Employee #1 had left Individual #1, Individual #2, and Individual #3 alone in the group home for a period of time. • Provider's internal investigation additionally revealed the following: ◦ On the morning of April 3, 2024, Employee #1 was asleep and had to be awakened by an individual, so that Individual #4 and Individual #5 did not miss the bus for school. ◦ While Employee #1 drove Individual #4 and Individual #5 to the bus stop, Employee #1 left Individual #1, Individual #2, and Individual #3 alone and unsupervised at the group home for approximately 15 minutes, which is against provider's supervision protocols. ◦ Employee #1 failed to provide breakfast to Individual #4 and Individual #5 before taking them to the bus stop. ◦ Employee #1 had left individual's alone, unsupervised on other occasions. Leaving individuals alone and unsupervised/not following supervision protocols and failing to provide a meal to individuals is failing to provide services, including nourishment, necessary to the health, safety, or welfare of individuals and is a violation of 12VAC35-115-50(B)(2).	Clinical Director will review this policy and procedure at all staff meetings, moving forward, so that all staff will realize the importance of complying with all policies and procedures. OHR/OLR) Accepted 04/15/2024	

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General Comments / Recommendations:

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

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

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