Investigation ID: **6**
License #: **1802-14-009**
Organization Name: **Pathways Youth Services III**

Date of Inspection: **05-16-2024**
Program Type/Facility Name: **14-009 Pathways Youth Services**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-750. B. (1) - Individualized service plans shall describe in measurable terms the: 1. Strengths and needs of the resident;	N	Pathways Youth Services This regulation was NOT MET as evidenced by: During a record review of Individual #1 on 5/16/24, current treatment plan for Individual #1 did not reflect current, identified behavioral support needs for elopement.	PR) 07/04/2024 **I"m disputing this violation:** The violation issued for not updating service plans and behavioral plans appears to be a matter of differing opinions. There is no specific regulation that states elopements must be included in Individualized Service Plans (ISPs) and behavioral plans. It is important to focus on identifying triggers and antecedents that precede problematic behavior. There was no need to update the plans specifically to address elopement. Several reasons support this: 1. The elopement incident seemed to be more influenced by peer pressure. Out of the four children involved, two had been at the facility for over a year without any previous elopement attempts. One of them was turning 18 soon, one was transitioning to a foster home, and the other was a new admission. Three out of the four children expressed remorse for their actions and admitted to acting impulsively. One even stated that they would repeat the behavior because they did not want to be in the facility anymore. As a result, a discharge notice was given to the legal guardian and placing agency, and a discharge date was set. Given these circumstances, there was no need to update any service plans. 2. As a board certified professional, it is important to question how a licensing specialist can dictate what takes priority. From a clinical perspective, the focus should be on working towards preventing similar incidents from	7/15/2024

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			happening again by addressing the underlying behaviors. 3. The licensing specialist in question does not ask pertinent questions when reviewing charts. When asked about the progress, she simply states that everything looks good. This lack of inquiry raises concerns about her transparency and thoroughness. In the past, all inspectors have provided feedback and highlighted any overlooked issues. However, she does not request any additional information or clarification. 4. The licensing specialist was informed that her visit felt like an investigation due to previous disagreements. She denied this and stated that it was standard protocol. However, it is difficult to understand why this incident was treated as an investigation when the children returned within an hour, and no injuries were reported. Approximately two weeks later, the licensing specialist requested information, which was promptly provided. From the facility's perspective, it seems that she is determined to find fault. It is worth noting that elopement incidents are not uncommon among children in care, and some have even gone missing for extended periods or engaged in more serious behaviors such as stealing vehicles. Therefore, it is perplexing why this particular incident warranted an "investigation." 5. The delay in issuing the violation is another concern. It has taken well over 30 days for the licensing specialist to send any notification, which is unacceptable. This prolonged timeframe is unprecedented, as previous inspectors have never taken this long. Additionally, the facility is requesting to be assigned a different licensing specialist, as it is unclear why they were	

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			assigned this particular individual when no other facilities in the area have her as their specialist. In conclusion, the facility questions the validity and fairness of the violation given the circumstances surrounding the elopement incident. The facility emphasizes the importance of focusing on preventing future incidents and requests a more timely and unbiased approach from the licensing agency. OLR) Partially Accepted 07/16/2024 Per discussion on 7/16/24, please provide a corrective action plan for this citation. PR) 07/29/2024 1. Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. The elopement incident seemed to be more influenced by peer pressure. Out of the four children involved, two had been at the facility for over a year without any previous elopement attempts. One of them was turning 18 soon, one was transitioning to a foster home, and the other was a new admission. Three out of the four children expressed remorse for their actions and admitted to acting impulsively. One even stated that they would repeat the behavior because they did not want to be in the facility anymore. As a result, a discharge	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			notice was given to the legal guardian and placing agency, and a discharge date was set. 2. Include a plan of action to address systematic changes. This may require updating policies, procedures, forms or conducting any needed training or retraining for staff, or other steps that could alleviate the problem in order to minimize the possibility that the violation will occur in the future. This provider's plan of action is as follows: Provider will update service plans and behavioral plans to focus on identifying triggers and antecedents that precede problematic behavior such as elopements. 3. Indicate the frequency for monitoring the plan including how it will be monitored (EX: monthly audits, weekly chart reviews, daily checklist, etc). This provider will ensure this process is done once an elopement happens within 48 hours of the incident. This process will be monitored quarterly. 4. Include the position of the person responsible for monitoring the plan of action. Do not include staff/employee names. Program Director will ensure this process is monitored on a quarterly basis by using	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			a quarterly audit form. OLR) Accepted 07/30/2024	
12VAC35-46-750. C. - The initial individualized service plan shall be reviewed within 60 days of the initial plan and within each 90-day period thereafter and revised as necessary.	N	Pathways Youth Services This regulation was NOT MET as evidenced by: During an unannounced inspection on 5/16/24 for the purpose of investigating the incident of elopement on 4/4/24, Individual #1 record does not contain evidence that their treatment plan was updated to include elopement concerns after the initial elopement incident on 10/8/23.	PR) 07/04/2024 **I"m disputing this violation:** The violation issued for not updating service plans and behavioral plans appears to be a matter of differing opinions. There is no specific regulation that states elopements must be included in Individualized Service Plans (ISPs) and behavioral plans. It is important to focus on identifying triggers and antecedents that precede problematic behavior. There was no need to update the plans specifically to address elopement. Several reasons support this: 1. The elopement incident seemed to be more influenced by peer pressure. Out of the four children involved, two had been at the facility for over a year without any previous elopement attempts. One of them was turning 18 soon, one was transitioning to a foster home, and the other was a new admission. Three out of the four children expressed remorse for their actions and admitted to acting impulsively. One even stated that they would repeat the behavior because they did not want to be in the facility anymore. As a result, a discharge notice was given to the legal guardian and placing agency, and a discharge date was set. Given these circumstances, there was no need to update any service plans. 2. As a board certified professional, it is important to question how a licensing specialist	7/15/2024

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			can dictate what takes priority. From a clinical perspective, the focus should be on working towards preventing similar incidents from happening again by addressing the underlying behaviors. 3. The licensing specialist in question does not ask pertinent questions when reviewing charts. When asked about the progress, she simply states that everything looks good. This lack of inquiry raises concerns about her transparency and thoroughness. In the past, all inspectors have provided feedback and highlighted any overlooked issues. However, she does not request any additional information or clarification. 4. The licensing specialist was informed that her visit felt like an investigation due to previous disagreements. She denied this and stated that it was standard protocol. However, it is difficult to understand why this incident was treated as an investigation when the children returned within an hour, and no injuries were reported. Approximately two weeks later, the licensing specialist requested information, which was promptly provided. From the facility's perspective, it seems that she is determined to find fault. It is worth noting that elopement incidents are not uncommon among children in care, and some have even gone missing for extended periods or engaged in more serious behaviors such as stealing vehicles. Therefore, it is perplexing why this particular incident warranted an "investigation." 5. The delay in issuing the violation is another concern. It has taken well over 30 days for the licensing specialist to send any notification, which is unacceptable. This prolonged timeframe is unprecedented, as previous inspectors have	

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			never taken this long. Additionally, the facility is requesting to be assigned a different licensing specialist, as it is unclear why they were assigned this particular individual when no other facilities in the area have her as their specialist. In conclusion, the facility questions the validity and fairness of the violation given the circumstances surrounding the elopement incident. The facility emphasizes the importance of focusing on preventing future incidents and requests a more timely and unbiased approach from the licensing agency. OLR) Partially Accepted 07/16/2024 Per discussion on 7/16/24, please provide a corrective action plan for this citation. PR) 07/29/2024 1. Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. The elopement incident seemed to be more influenced by peer pressure. Out of the four children involved, two had been at the facility for over a year without any previous elopement attempts. One of them was turning 18 soon, one was transitioning to a foster home, and the other was a new admission. Three out of the four children expressed remorse for their actions and admitted to acting impulsively. One even	

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			Program Director will ensure this process is monitored on a quarterly basis by using a quarterly audit form. OLR) Accepted 07/30/2024	

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.

Breanna Goad, Licensing Specialist | (Signature of Organization Representative) | Date

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