DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **20815-14-008**
Organization Name: **Jax Pathways, LLC**

Date of Inspection: **08-26-2026**
Program Type/Facility Name: **14-008 Jax Pathways**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-450. C. - Precautions shall be taken to prevent scalding from running water. Water temperatures shall be maintained between 100°F and 120°F.	N	Jax Pathways This regulation was NOT MET as evidenced by: In review of the physical environment, there failed to be evidence that the hot water temperature was maintained within a range of 100-120°F. The hot water temperature in the kitchen was 121.1°F. The provider is required to upload evidence of the hot water temperature maintained within a range of 100-120°F with the CAP.	PR) 09/01/2026 During the DBHDS walkthrough, the kitchen hot water temperature was recorded at 121.1°F, exceeding the required 100°F–120°F range due to thermostat drift. To correct this specific violation, the water heater setting was adjusted, the water was re-tested with a calibrated digital thermometer to confirm compliance, and photo evidence of the compliant reading was uploaded with this CAP. To ensure systemic compliance, we have implemented a routine water temperature monitoring protocol, equipped the home with a calibrated digital thermometer, and placed a warning tag on the thermostat dial. All Direct Care Staff and PRN Support Staff were trained on regulatory temperature limits, proper testing procedures, and immediate corrective actions if temperatures drift out of range. Systemic oversight is structured as follows: Direct Care Staff and PRN Support Staff test and log water temperatures weekly; the Program Director conducts monthly log reviews to confirm ongoing compliance; and the Chief Executive Officer (CEO) conducts quarterly quality assurance reviews to ensure overall administrative compliance. Actions were completed in sequence: water heater adjustment and photo documentation occurred on August 28, 2026; staff training and weekly log implementation occurred on August 31, 2026; and ongoing supervisory and QA monitoring became fully operational on September 1, 2026. The Final Planned Completion Date is September 1, 2026.	9/1/2026

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			OLR) Accepted 09/01/2026	
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	Jax Pathways This regulation was NOT MET as evidenced by: In review of the physical environment, there failed to be evidence that the physical environment and furnishings were well-maintained. The door to the closet in room #3 was off track. The outlet cover by the window in the living room was loose and the outlet cover over the back deck was broken. The provider is required to upload documented evidence of repairs/replacements of the closet door in room #3 and outlet covers in the living room and over the back deck with the CAP.	PR) 09/01/2026 During the DBHDS walkthrough, the physical environment and furnishings were noted as not well-maintained due to a closet door off track in room #3, a loose outlet cover near the living room window, and a broken outlet cover on the back deck. To correct these specific violations, the closet door in room #3 was re-hung and secured on its track, the living room outlet cover was tightened, and the broken back deck outlet cover was replaced with a new exterior-grade cover. Documented photo evidence showing each completed repair and replacement was uploaded with this CAP. To ensure systemic compliance, we have implemented a routine physical environment maintenance protocol to proactively identify and repair minor structural and fixture damages. All Direct Care Staff and PRN Support Staff were trained on performing routine environmental safety sweeps and reporting physical plant repairs immediately. Systemic oversight is structured as follows: Direct Care Staff and PRN Support Staff complete and document weekly physical environment walkthrough checklists; the Program Director conducts monthly facility audits to verify all repairs are completed promptly; and the Chief Executive Officer (CEO) conducts quarterly administrative reviews to ensure ongoing physical plant maintenance and compliance. Actions were completed in sequence: physical repairs were completed and photo	9/1/2026

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			documentation was secured on or before August 28, 2026; staff training and weekly checklist implementation occurred on August 31, 2026; and ongoing supervisory and QA monitoring was fully operational by September 1, 2026. The Final Planned Completion Date is September 1, 2026. OLR) Accepted 09/01/2026	
12VAC35-46-840. K. - A well-stocked first aid kit shall be maintained and readily accessible for minor injuries and medical emergencies.	N	Jax Pathways This regulation was NOT MET as evidenced by: In review of the physical environment, there failed to be evidence of a well-stocked first aid kit. The first aid kit failed to contain saline solution and antiseptic soap. The provider is required to upload evidence of saline solution and antiseptic soap with the CAP.	PR) 09/01/2026 During the DBHDS walkthrough, the physical environment inspection identified that the facility's first aid kit was missing saline solution and antiseptic soap. To correct this specific violation, saline solution and antiseptic soap were purchased, stored with the first aid kit to ensure it is well-stocked, and photo evidence showing both required items have been uploaded with this CAP. To ensure systemic compliance, we have implemented a routine first aid kit inventory protocol to verify all required medical supply levels are continuously maintained. All Direct Care Staff and PRN Support Staff were trained on the required inventory checklist, proper usage guidelines, and immediate restocking procedures when supplies run low. Systemic oversight is structured as follows: Direct Care Staff and PRN Support Staff inspect and log first aid kit supplies weekly; the Program Director conducts monthly inventory audits to confirm ongoing compliance; and the Chief Executive Officer (CEO) conducts quarterly administrative reviews to ensure facility readiness and regulatory compliance.	9/1/2026

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			Actions were completed in sequence: required supplies were purchased, restocked, and photo documented on or before August 28, 2026; staff training and weekly inventory log implementation occurred on August 31, 2026; and ongoing supervisory and QA monitoring became fully operational on September 1, 2026. The Final Planned Completion Date is September 1, 2026. OLR) Accepted 09/01/2026	

General Comments / Recommendations:
The Licensing Specialist recommends the provider review regulations 12VAC35-46-450, 12VAC35-46-590, and 12VAC35-46-840 for compliance. The Licensing Specialist recommends the provider move the fire extinguisher to a more accessible area in the kitchen and contact the Office of Human Rights for approval of video surveillance cameras.

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.

Melonie Beatty, Licensing Specialist | (Signature of Organization Representative) | Date

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