DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **2240-14-010**
Organization Name: **Center for Discovery**

Date of Inspection: **06-23-2026**
Program Type/Facility Name: **14-010 Burke Lake 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	Burke Lake Road This regulation was NOT MET as evidenced by: See OHR citations below.		

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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	Burke Lake Road 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. • Due to a preponderance of evidence, including witness statements, staff admissions, and witness credibility, the Provider identified a violation of neglect for A#20250023. • It was reported that Employee #1 believed Individual #1 was with another staff member but did not establish direct line of sight supervision. Employee #1 proceeded to retrieve a different patient for medication administration, leaving the medication room unlocked and accessible to Individual #1. Individual #1 ingested 36 tablets of Medication #1 due to Over-the-Counter medication being left on the desk. Individual #1 was given Medication #2 in response and required additional medical attention from the emergency room. • Individual #1's right to be free of neglect was violated.	PR) 07/15/2026 Issue that lead to non compliance: The nurse believed that individual #1 was with another staff member. The nurse went to retrieve another individual for med pass while leaving the med room open with medication on the desk and individual #1 ingested 36 tablets of medication. Plan of action to address systematic changes: Nurse was presented with a final written warning on 12/10/25. Training for all staff completed on 12/2/25 on proper med room security, handoff on line of sight, and communication when transitioning through the facility Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation: Executive Program Director and Director of Operations will monitor staff handoff, ensure line of sight is consistent, and the med room is secured appropriately. This will be an ongoing effort. OHR/OLR) Accepted 07/22/2026	12/10/2025

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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.

Diana Atcha, Human Rights	(Signature of Organization Representative)	Date

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