DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **291-14-008**
Organization Name: **Second Story**

Date of Inspection: **05-13-2026**
Program Type/Facility Name: **14-008 Second Story**

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	Second Story 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	Second Story 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 staff admissions and failure to follow policy, the Provider identified a violation of 12VAC35-115-50(B)(2) for neglect related to CHRIS Report A#20250008. • It was reported that Employee #1 went to wake up Individual #1 in their room, but did not find them in their room or in the group home. Employee #1 filed a missing person's report and contacted Individual #1's family members. Upon investigation, it was determined that bed checks were not completed throughout the night, violating program policy. • Individual #1's right to be free from neglect was violated.	PR) 06/02/2026 This incident occurred due to a staff member reporting that they misremembered program policy, thus failing to conduct bed checks following the start of their shift at 7:45am. During the weekly staff meeting held on 1/7/26, this staff member was retrained (alongside other counselors) by the Compliance and Training Manager (CTM) on correct program policy regarding overnight bed checks: *"Staff should… perform bed checks for each resident every 15-30 minutes (or in shorter time periods when required due to extenuating circumstances – e.g. safety concerns) until residents are woken up the next morning."* CTM will continue to train staff on this policy during their individual onboarding training. Refresher trainings will also be provided as needed or more frequently if outlined in the Quality Improvement Plan, which is updated annually. OHR/OLR) Accepted 06/15/2026	1/7/2026

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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