License #: **5908-14-008**
Organization Name: **Pathway to Success, LLC**

Date of Inspection: **10-28-2025**
Program Type/Facility Name: **14-008 Pathway House**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-300. A. - Separate up-to-date personnel records shall be maintained for each employee, student or intern, volunteer, and contractual service provider for whom background investigations are required by Virginia statute. Content of personnel records of volunteers, students or interns, and contractual service providers may be limited to documentation of compliance with requirements of Virginia laws regarding child protective services and criminal history background investigations.	N	Pathway House This regulation was NOT MET as evidenced by: In review of Employee's #1 and #2 Personnel Records, the provider failed to separate the Employee's child protective services and criminal history background investigations, from the remainder of their Employee's personnel documents required, per the Office of Licensing regulations.	PR) 12/16/2025 Please see attached. OLR) Partially Accepted 12/16/2025The provider will need to insert their corrective action plan response inside the box labeled "Provider Response". This includes their step-by-step plan of action on how they will ensure that they are not cited for the same regulation again and the title of the person responsible for ensuring that the step-by-step plan of action is implemented. PR) 12/16/2025 Step-by-Step Corrective Action Plan Regulation: 12VAC35-46-300.A Responsible Party: Program Manager, Pathway to Success LLC Step 1: Identify and Acknowledge the Issue Action: The Program Manager reviewed the citation and confirmed that Employee #1 and Employee #2’s child protective services and criminal history background investigation documents were incorrectly stored within their general personnel files instead of being maintained separately as required by 12VAC35-46-300.A. Outcome: Root cause identified as improper file organization rather than missing documentation. Step 2: Immediate Correction of the Issue Action: The Program Manager immediately removed all	11/19/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			background investigation documents for Employee #1 and Employee #2 from their general personnel files. Action Completed: Documents were transferred to a secure, designated background-check folder Folder is maintained separately from all personnel files Access restricted to authorized administrative staff only Completion Date: 11/1/2025 Step 3: Update Personnel Records Policy Action: The Program Manager ensured the Personnel Records Policy (12VAC35-46-300) was formally updated to clearly require: All CPS and criminal background investigations be filed separately Background check documentation must never be stored within general personnel files Outcome: Revised policy implemented agency-wide. Completion Date: 11/1/2025 Step 4: Revise Staff File Checklist Action: The Program Manager updated the Staff File Checklist to include a mandatory verification step confirming:	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Background investigations are filed in the correct, separate location Personnel files are not considered "complete" without this verification Outcome: Checklist finalized and implemented for all current and future staff files. Completion Date: 10/31/2025 Step 5: Implement Ongoing Monitoring and Audit Process Action: The Program Manager established a monthly internal audit process to ensure continued compliance with 12VAC35-46-300.A. Audit Process Includes: Monthly review of all active personnel files Verification that background investigations remain separate Immediate correction of any discrepancies Documentation of findings and corrections in an audit log Responsible Staff: Program Director or designee, with oversight by the Program Manager Step 6: Conduct First Monthly Audit Action: The Program Manager scheduled the first audit	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			under the new procedure to confirm full implementation and sustainability of corrective actions. Scheduled Date: 12/1/2025 Step 7: Ensure Sustainability and Accountability Action: The Program Manager will: Review audit results monthly Address trends or recurring issues immediately Provide refresher guidance to administrative staff as needed Maintain documentation for DBHDS review and compliance tracking Final Planned Completion Date: Correction of Employee #1 and Employee #2 files: Completed on 11/1/25 Implementation of new filing protocol: Completed on 11/1/25 Updated Checklist finalized: Completed on 10/31/25 First monthly audit under new procedure: Scheduled for 12/1/25 Final Planned Completion Date: 11/1/2025 OLR) Accepted 12/17/2025	
12VAC35-46-730. A. - At the time of	N	Pathway House	PR) 12/16/2025	11/19/2025

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Date of Inspection: **10-28-2025**
Program Type/Facility Name: **14-008 Pathway House**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
admission, each resident's record shall include a completed face sheet that contains (i) the resident's full name, last known residence, birth date, birthplace, gender, race, social security number or other unique identifier, religious preference, and admission date; and (ii) names, addresses, and telephone numbers of the resident's legal guardians, placing agency, emergency contacts, and parents, if appropriate.		This regulation was NOT MET as evidenced by: In review of Individual #2 Service Record, the provider failed to include the Individual's gender, birthplace, and religious preference, on their face-sheet.	Please see attached. OLR) Partially Accepted 12/16/2025The provider will need to insert their corrective action plan response inside the box labeled "Provider Response". This includes their step-by-step plan of action on how they will ensure that they are not cited for the same regulation again and the title of the person responsible for ensuring that the step-by-step plan of action is implemented. PR) 12/16/2025 Step-by-Step Corrective Action Plan Regulation: 12VAC35-46-730.A Responsible Party: Program Administrator, Pathway to Success LLC Step 1: Identification of the Issue Action: The Program Administrator reviewed the regulatory citation and identified that Individual #2’s face sheet was incomplete and missing required information related to the individual’s gender, birthplace, and religious preference, as required under 12VAC35-46-730.A. Outcome: The deficiency was confirmed as a documentation oversight during the intake/admission process. Step 2: Immediate Correction of the Deficiency Action: The Program Administrator ensured the Program Manager updated Individual #2’s face sheet to include all required missing information.	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Verification: Face sheet reviewed for completeness All required fields confirmed present and accurate Completion Date: 11/1/2025 Step 3: Update Resident Records Policy Action: The Program Administrator revised the Resident Records Policy to specifically require routine auditing of resident face sheets to ensure compliance with 12VAC35-46-730.A. Outcome: Policy now clearly identifies face sheet completeness as a compliance requirement and ongoing monitoring responsibility. Completion Date: 11/19/2025 OLR) Accepted 12/17/2025	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **5908-14-008**
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Program Type/Facility Name: **14-008 Pathway House**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
It is recommended that the provider submit their corrective action plan by the due date indicated in their Licensing Report.

Please make sure to include the following in your Corrective Action Plan response:
1. Please identify the root cause(s) of the violation;
2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again;
3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist).
4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP.
5. Include a date of completion for each corrective action.

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.

Jessika Bennett, Licensing Specialist	(Signature of Organization Representative)	Date

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