License #: **6251-14-008**
Organization Name: **Teen Titans Youth Services LLC**

Date of Inspection: **05-30-2025**
Program Type/Facility Name: **14-008 Teen Titan Youth Home College Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-270. B. (1) - A person who assumes or is designated to assume the responsibilities of a position or any combination of positions described in these regulations after December 28, 2007, shall: 1. Meet the qualifications of the position or positions;	N	This regulation was NOT MET as evidenced by: Employee #1's job description for the position of LMHP requires the employee to hold a LPC or LCSW license. The employee does not meet the requirement of the job description as the employee is not licensed. Employee #2's job description for the position of DSP requires the employee to hold a food handler's card. The employee's personnel record did not document a food handler's card as required by the job description.	PR) 07/06/2025 Cited Standard: 12VAC35-46-270 – Staff qualifications must be consistent with the job description requirements. Date of Citation: 6/25/2025 **Statement of Issue** During the residential licensing inspection, it was identified that Employee #1 was assigned to the role of a Licensed Mental Health Professional (LMHP) per their job description. This position, by regulation and facility policy, requires the individual to hold an active LPC (Licensed Professional Counselor) or LCSW (Licensed Clinical Social Worker) license. At the time of inspection, the employee file did not contain verification of the required license. **Immediate Corrective Actions Taken** The employee's professional credentials were reviewed and verified. It was confirmed that Employee #1 does in fact hold the appropriate licensure required for the LMHP position. The valid LPC license documentation was added to Employee #1’s personnel file immediately upon discovery. The employee file was re-reviewed to ensure completeness and compliance with other documentation standards. **Process and Protocols to Ensure Compliance** • Personnel File Audit: A full audit of all clinical staff files is being conducted to ensure that all required licensure and credentialing documentation is up to date	7/18/2025

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			and accurately reflects each employee's assigned role. **Process and Protocols to Remain in Compliance** • Updated Hiring and File Maintenance Protocol: A checklist has been implemented for HR and program leadership to ensure that, prior to onboarding and role assignment, all credential requirements (e.g., licenses, degrees, certifications) are verified and documented in the employee's file. • Job Description and Credential Alignment Review: All clinical position descriptions (including LMHP, and other credentialed roles) are being reviewed and updated to ensure clarity on credential requirements. Cross-referencing of actual staff credentials with job descriptions is now required quarterly. **Responsible Party:** Owner and CAO **Monitoring and Oversight** Ongoing oversight will be provided by the owner and CAO, who will jointly ensure compliance with all personnel documentation requirements. Quarterly audits of clinical staff files will be documented and maintained for DBHDS review. **Second Statement of Issue** During a residential licensing inspection, it was identified that Employee #2's job description for the Direct Support Professional (DSP) position	

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			required the possession of a valid food handler's card. However, the employee's personnel file did not contain documentation of this certification, resulting in noncompliance with the stated job qualifications. Immediate Corrective Actions Taken The facility conducted an immediate review of the DSP job description and determined that the food handler's card was not essential to the actual job duties or regulatory responsibilities of DSP staff. The requirement for a food handler's card was formally removed from the DSP job description and the revised job description was made mirror the requirements of the DBHDS responsibilities. The revised job description has been approved by program leadership and added to all current DSP employee files, including Employee #2's. Process and Protocols to Ensure Compliance To prevent future discrepancies between job descriptions and personnel files, the following measures have been implemented: • Comprehensive Review of All Job Descriptions: All job descriptions are being reviewed to ensure that all listed requirements are aligned with actual job responsibilities and current regulatory standards. **Process and Protocols to Remain in Compliance** • HR Documentation Alignment Audit: A full audit of all personnel files is being	

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			conducted to ensure that each file contains documentation supporting every requirement listed in the employee's current job description. Updated HR Procedures: A policy has been implemented requiring HR and supervisory staff to review and confirm that any job requirement listed in a job description is: (1) justified by job duties and (2) verifiable through documentation in the personnel file prior to employee onboarding or role changes. Document Version Control: All outdated or superseded job descriptions have been archived. Going forward, only the most current, approved versions will be used for staff onboarding and HR compliance. **Responsible Party:** Owner and CAO Monitoring and Oversight The Owner and CAO will jointly monitor for consistency between job descriptions and personnel documentation. An initial audit of personnel files and job descriptions will be conducted to ensure continued compliance with DBHDS regulations. All staff will be notified of the updated job description and expectations at the next annual training. OLR) Partially Accepted 09/16/2025Please remove all staff names from the original CAP response.	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-300. B. (7) - The records of each employee shall include: 7. Documentation of compliance with requirements of Virginia laws regarding child protective services and criminal history background investigations;	N	This regulation was NOT MET as evidenced by: Employee #1's personnel record did not contain a completed disclosure statement as required by the regulation.	PR) 07/06/2025 Corrective Action Plan DBHDS Residential Licensing Inspection Cited Standard: 12VAC35-46-300.B(7) – Personnel records shall contain a completed disclosure statement. Date of Citation: 6/25/2025 **Statement of Issue** During the DBHDS residential licensing inspection, it was identified that Employee #1's personnel record did not contain a completed disclosure statement, as required by 12VAC35-46-300.B(7). This document is a regulatory requirement used to confirm whether an employee has been convicted of any barrier crimes that would disqualify them from working in a licensed residential setting. **Immediate Corrective Actions Taken** Upon being notified of the violation, a full audit of all current employee personnel files was immediately conducted. Disclosure statements were collected and completed by all employees, including Employee #1, and were appropriately filed in each respective personnel record as of 7/18/2025. The Owner verified that every current employee now has a completed disclosure statement on file. **Process and Protocols to Ensure Compliance** • Quarterly Personnel File Audits: The	7/18/2025

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			facility will implement quarterly audits of personnel files to verify the presence of all required documentation, including disclosure statements. **Process and Protocols to Remain in Compliance** To ensure ongoing compliance with DBHDS personnel documentation requirements: • Revised Onboarding Checklist: The employee onboarding checklist has been updated to include mandatory completion and verification of the disclosure statement prior to the employee's start date. • Administrative Staff Training: All administrative personnel and supervisors have been retrained on regulatory hiring and documentation standards, with special emphasis on 12VAC35-46-300 requirements. **Responsible Party:** Owner and CAO **Monitoring and Oversight** Ongoing oversight will be provided by the Owner and CAO, who will jointly ensure compliance with all personnel documentation requirements. Quarterly audits of staff files will be documented and maintained for DBHDS review. OLR) Partially Accepted 09/16/2025Please remove all staff names from CAP response	
12VAC35-46-300. C. - Personnel records,	N		PR) 07/06/2025	7/18/2025

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including separate health records, shall be retained in their entirety for at least three years after separation from employment, contractual service, student/intern, or volunteer service.		This regulation was NOT MET as evidenced by: Employee #1 and #2's personnel record contained health records. The health records were not filed separately as required by the regulation.	Corrective Action Plan DBHDS Residential Licensing Inspection Cited Standard: 12VAC35-46-300.C – All health and medical information shall be maintained separately from the employee's general personnel record. Date of Citation: 6/25/2025 **Statement of Issue** During the DBHDS residential licensing inspection, it was found that employee personnel records contained health and/or medical information (e.g., physical exams, TB test results, vaccination records), which is non-compliant with 12VAC35-46-300.C. This regulation requires that such documentation be maintained in a separate, confidential health file. **Immediate Corrective Actions Taken** All health and medical documents were immediately removed from the general personnel/employment files. A separate, confidential medical file was created for each employee. These files are stored in a secure, locked cabinet accessible only to authorized administrative staff. Each employee's general personnel file was reviewed to ensure no remaining medical information was left in violation of the regulation. **Process and Protocols to Ensure Compliance** To ensure ongoing compliance with 12VAC35-46-300.C: • Updated File Management Protocol: A revised file management system has been	

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			implemented. All health-related documentation will be stored exclusively in the separate medical file. **Process and Protocols to Remain in Compliance** • Staff Training: Administrative staff have been trained on the proper handling and separation of personnel and health/medical records, in accordance with DBHDS and HIPAA confidentiality standards. • File Audit Schedule: The facility has instituted quarterly audits to verify that no medical information is retained in employee personnel files. **Responsible Party**: Owner and CAO **Monitoring and Oversight** Ongoing oversight will be provided by the owner and CAO, who will jointly ensure compliance with all personnel documentation requirements. Quarterly audits of clinical staff files will be documented and maintained for DBHDS review. OLR) Partially Accepted 09/16/2025Please remove all staff names from CAP response	
12VAC35-46-310. A. (3c) - Required initial training: 3. Within 14 days following their begin date, new employees, employees transferring from other	N	This regulation was non-compliant systemic as evidenced by: Employee #2's personnel record did not document evidence of initial training regarding the decision-making	PR) 07/16/2025 **Corrective Action Plan** **DBHDS Residential Licensing Inspection** **Cited Standard:** 12VAC35-46-310. A. (3c)-Required initial training: 3. Within 14 days following their begin date, new employees, employees transferring from other facilities	7/18/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
facilities operated by the same provider, relief staff, volunteers, and students and interns shall be given orientation and training regarding: 3c. The decision-making plan;		plan.	operated by the same provider, relief staff, volunteers, and students and interns shall be given orientation and training regarding: 3c. The decision-making plan **Date of Citation**: 6/25/2025 **Facility Name:** TTYS **Statement of Issue:** During the residential licensing inspection, it was identified that employee #2's personnel record did not document evidence of initial training regarding the decision-making plan as required by 12VAC35-46-310. A. (3c) **Immediate Corrective Actions Taken:** All identified staff were made aware of the missing required training immediately. Certificates of completion and updated training logs were added to each personnel file to ensure documentation was up-to-date. **Process and Protocols to Ensure Compliance:** • The CAO reviewed and updated the staff training curriculum to ensure it includes all required topics, such as behavior intervention, emergency preparedness, medication administration (if applicable), and person-centered practices. • All staff were re-trained on critical safety and intervention topics as needed and signed new training acknowledgment forms. • A master training tracker was developed to record each employee's completed trainings, due dates for annual refreshers, and topics covered.	

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			Process and Protocols to Remain in Compliance: • New staff will receive required training during orientation before they begin working with residents, and training completion will be verified and documented in their personnel file within 14 days of hire date. • The CAO will maintain and regularly update the training tracker, ensuring no required training lapses occur. • Quarterly internal audits of training records will be conducted to verify ongoing compliance and address gaps immediately. **Responsible Party:** Owner and CAO **Monitoring and Oversight:** • Quarterly internal audits of all staff training records by the CAO. • Monthly administrative review meetings with the Owner and CAO to discuss compliance status. OLR) Partially Accepted 09/16/2025Please remove all staff names from CAP response	
12VAC35-46-310. A. (4) - Required initial training: 4. Within 30 days following their begin date, all staff working with residents shall be enrolled in a standard first aid class and in a cardiopulmonary	N	This regulation was NOT MET as evidenced by: Employee #2 did not complete a standard first aid/cpr class as the training did not include hands on, in person training.	PR) 07/13/2025 **Corrective Action Plan** **DBHDS Residential Licensing Inspection** **Cited Standard:** 12VAC35-46-310. A. (4) Required initial training, First Aid/CPR **Date of Citation**: 6/25/2025	7/18/2025

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resuscitation class facilitated by the American Red Cross or other recognized authority, unless the individual is currently certified in first aid and cardiopulmonary resuscitation.			**Statement of Issue:** During a recent compliance review by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), it was identified that employee #2 did not complete a standard first aid/CPR class as the training did not include hands-on, in-person training. The absence of this documentation resulted in non-compliance with 12VAC35-46-310.A.(4), which requires within 30 days following their begin date, all staff working with residents shall be enrolled in a standard first aid class and in a cardiopulmonary resuscitation class facilitated by the American Red Cross or other recognized authority, unless the individual is currently certified in first aid and cardiopulmonary resuscitation. **Immediate Corrective Actions Taken:** Employee #2 was immediately scheduled for and completed training covering all required topics: standard first aid class and a cardiopulmonary resuscitation class facilitated by the American Red Cross or other recognized authority. Documentation of these trainings, including certificates of completion and signed training acknowledgments, was immediately added to employee #2's personnel file. **Process and Protocols to Ensure Compliance:** • Training Checklist: The CAO reviewed and updated the training checklist to include a detailed list of all required training topics per 12VAC35-46-310.A.(4) • Personnel File Audit: Personnel files for all current employees were audited to ensure all mandatory training	

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			documentation is complete and up to date. Any additional gaps identified were corrected immediately through training and documentation updates. **Process and Protocols to Remain in Compliance:** • All new staff will be required to complete mandatory trainings within 30 days of hire date, including those identified above, during orientation and before any direct resident contact. Completion will be verified and documented in each personnel file. • A master training tracker has been established and will be maintained by the CAO to ensure all required training is scheduled and completed annually. • The CAO will conduct quarterly audits of personnel files to confirm that all training documentation is current and complete. • Annual refresher training will be scheduled proactively, with reminders sent to staff at least 30 days in advance of expiration deadlines **Responsible Party:** Owner and CAO **Monitoring and Oversight:** Quarterly internal audits of all staff training records by the CAO. OLR) Partially Accepted 09/16/2025Please remove all staff names from CAP response	
12VAC35-46-310. A. (5) - Required initial	N		PR) 07/13/2025	7/18/2025

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training: 5. Within 30 days following their begin date, all staff working with residents shall be trained in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention.		This regulation was NOT MET as evidenced by: Employee #2's personnel record did not document evidence that the employee was trained in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention.	**Corrective Action Plan** **DBHDS Residential Licensing Inspection** **Cited Standard:** 12VAC35-46-310. A. (5) Required initial training: Child Abuse and Neglect, Mandatory Reporting, Maintaining Appropriate Professional Relationships, Interaction Among Staff and Residents, and Suicide Prevention. **Date of Citation:** 6/25/2025 **Statement of Issue:** During a recent compliance review by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), it was identified that employee #2's personnel record did not document evidence that the employee was trained in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention. The absence of this documentation resulted in non-compliance with 12VAC35-46-310.A.(5), which requires within 30 days following their begin date, all staff working with residents shall be trained in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention. **Immediate Corrective Actions Taken:** Employee #2 was immediately scheduled for and completed training covering all required topics: child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships and interactions, and	

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			suicide prevention. Documentation of these trainings, including certificates of completion and signed training acknowledgments, was immediately added to employee #2's personnel file. **Process and Protocols to Ensure Compliance:** • Checklist: The CAO reviewed and updated the training checklist to include a detailed list of all required training topics per 12VAC35-46-310.A.(5). • Personnel File Audit: Personnel files for all current employees were audited to ensure all mandatory training documentation is complete and up to date. Any additional gaps identified were corrected immediately through training and documentation updates. **Process and Protocols to Remain in Compliance:** • All new staff will be required to complete mandatory trainings, including those identified above, during orientation and prior to any direct resident contact. Completion will be verified and documented in each personnel file. • A master training tracker has been established and will be maintained by the CAO to ensure all required training is scheduled and completed annually. • The CAO will conduct quarterly audits of personnel files to confirm all training documentation is current and complete. • Annual refresher training will be scheduled proactively, with reminders	

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			sent to staff at least 30 days in advance of expiration deadlines. **Responsible Party:** Owner and CAO **Monitoring and Oversight:** Quarterly internal audits of all staff training records by the CAO. OLR) Partially Accepted 09/16/2025Please remove all staff names from CAP response	
12VAC35-46-310. A. (7) - Required initial training: 7. Within 30 days following their begin date, all staff shall be trained on appropriate siting of children's residential facilities, and good neighbor policies and community relations.	N	This regulation was NOT MET as evidenced by: Employee #1 and #2's personnel record did not document that the employee was trained on appropriate siting of children's residential facilities, and good neighbor policies and community relations.	PR) 07/13/2025 **Corrective Action Plan** **DBHDS Residential Licensing Inspection** **Cited Standard:**12VAC35-46-310. A. (7): Required initial training: 7. Within 30 days following their begin date, all staff shall be trained on appropriate siting of children's residential facilities, and good neighbor policies and community relations. **Date of Citation**: 6/25/2025 **Statement of Issue:** During a recent compliance review by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), it was identified that Employees #1 and #2's personnel records did not contain documentation confirming completion of training on the appropriate siting of children's residential facilities, good neighbor policies, and community relations. This resulted in non-compliance with 12VAC35-46-310.A.(7), which requires training on fostering positive relationships with the surrounding community and understanding siting requirements. **Immediate Corrective Actions Taken:**	7/18/2025

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			Employees #1 and #2 were immediately scheduled for and successfully completed comprehensive training on the appropriate siting of children's residential facilities, good neighbor policies, and community relations. Certificates of completion and signed training acknowledgments were immediately filed in each employee's personnel record to ensure compliance. **Process and Protocols to Ensure Compliance:** • The staff training checklist has been updated to explicitly include "siting of children's residential facilities, good neighbor policies, and community relations" as a required component during both initial orientation and annual refresher training • A full audit of all personnel files was conducted to ensure no other gaps exist in training documentation for this or any other required topics. **Process and Protocols to Remain in Compliance:** • All new staff will be required to complete mandatory trainings, including those identified above, during orientation and prior to any direct resident contact. Completion will be verified and documented in each personnel file. • A master training tracker has been established and will be maintained by the CAO to ensure all required training is scheduled and completed annually. • The CAO will conduct quarterly audits of	

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			personnel files to confirm all training documentation is current and complete. • Annual refresher training on good neighbor policies and community engagement will be scheduled and tracked to reinforce staff understanding and compliance. **Responsible Party:** Owner and CAO **Monitoring and Oversight:** Quarterly internal audits of all staff training records by the CAO. OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-310. A. (9) - Required initial training: 9.The provider shall carry out targeted staff training in any area of quality improvement as identified from the results of the quality improvement plan.	N	This regulation was NOT MET as evidenced by: Employee #1 and #2's personnel record did not document that the provider carried out targeted staff training in any area of quality improvement as identified from the results of the quality improvement plan.	PR) 07/13/2025 **Corrective Action Plan** **DBHDS Residential Licensing Inspection** **Cited Standard**:12VAC35-46-310. A. (9) Required initial training: The provider shall carry out targeted staff training in any area of quality improvement as identified from the results of the quality improvement plan **Date of Citation:** 6/25/2025 **Statement of Issue:** During a compliance review by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), it was identified that Employees #1 and #2's personnel records did not contain documentation verifying that they had received targeted staff training in areas identified through the organization's quality improvement plan. This	7/18/2025

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			omission resulted in non-compliance with 12VAC35-46-310.A.(9), which requires providers to offer staff development that addresses quality improvement findings to strengthen service delivery. **Immediate Corrective Actions Taken:** Employees #1 and #2 were immediately scheduled for and completed targeted training sessions addressing the areas for improvement identified in the most recent quality improvement plan. Training topics included documentation accuracy, person-centered planning, and communication protocols. Certificates of completion and signed acknowledgments were promptly filed in each employee's personnel record. **Process and Protocols to Ensure Compliance:** • Checklist: The CAO reviewed and updated the training checklist to include a detailed list of all required training topics per 12VAC35-46-310. A. (9) • Personnel File Audit: Personnel files for all current employees were audited to ensure all mandatory training documentation is complete and up to date. Any additional gaps identified were corrected immediately through training and documentation updates. **Process and Protocols to Remain in Compliance:** • All new staff will be required to complete	

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			mandatory trainings, including those identified above, during orientation and prior to any direct resident contact. Completion will be verified and documented in each personnel file. • A master training tracker has been established and will be maintained by the CAO to ensure all required training is scheduled and completed annually. • The CAO will conduct quarterly audits of personnel files to confirm all training documentation is current and complete. • Annual refresher training will be scheduled proactively, with reminders sent to staff at least 30 days in advance of expiration deadlines. **Responsible Party:** Owner and CAO **Monitoring and Oversight:** Quarterly internal audits of all staff training records by the CAO. OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-380. B. (1) - A child care worker and a relief child care worker shall: 1. Have a baccalaureate degree in human services;	N	This regulation was NOT MET as evidenced by: At the time of hire, employee #2 did not hold a baccalaureate degree in human services as required by	PR) 07/12/2025 Date: 7/1/2026 Statement of Issue:	7/18/2025

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		the regulation.	The DBHDS licensing standard initially required direct care staff to hold a baccalaureate degree in human services or a related field. During inspection, it was cited that Employee #2 did not meet this requirement at the time of hire. 12VAC35-46-380 This regulation was NOT MET as evidenced by: At the time of hire, Employee #2 did not hold a baccalaureate degree in human services as required by the regulation B. (1). **Immediate Corrective Actions Taken:** A review of the regulation was completed, and it was confirmed that the degree in Human Services is not a DBHDS requirement for this position and has since been removed from the job description. TTYS updated all job descriptions and internal hiring documents to reflect the current DBHDS standards, ensuring alignment with the revised education requirements. Employee #2's qualifications were reviewed and found acceptable under the current regulatory expectations. **Process and Protocols to Ensure Compliance:** Staff Hiring Checklists: HR has updated all hiring checklists to remove references to outdated degree requirements and to reflect the current qualifications based on the most recent DBHDS guidance. Personnel File Audit: A full audit of all personnel files is being	

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			conducted to verify that documentation and qualifications for each role are up to date and consistent with the current DBHDS licensing regulations. This ensures no reliance on outdated requirements when evaluating new or current staff. Responsible Party: Owner and Chief Administrative Officer (CAO) **Monitoring and Oversight:** The CAO or owner will conduct quarterly audits to ensure all hiring practices remain aligned with the most current version of DBHDS standards. OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-710. B. (11a) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 11. Medication and drug use profile, which shall include: 11a. History of prescription, nonprescription, and illicit drugs that were taken over the six	N	This regulation was NOT MET as evidenced by: Individual #1's application did not document a history of nonprescription, and illicit drugs that were taken over the six months prior to admission.	PR) 07/11/2025 **Corrective Action Plan** Date: 7/1/2025 **Statement of Issue** During a recent residential licensing inspection, it was noted that Group Home did not meet the standard outlined in 12VAC35-46-710. B. (11a). This regulation requires that an individual's application for admission document any history of nonprescription and illicit drug use over the six months prior to admission. The file for Individual #1 did not include this specific documentation at the time of review. **Immediate Corrective Actions Taken**	7/18/2025

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months prior to admission;			The application for Individual #1 was immediately updated to reflect a complete and accurate history of nonprescription and illicit drug use for the six months prior to admission. The application for admission was updated to reflect a space to collect nonprescription and illicit drug use six months prior to admission. **Process and Protocols to Ensure Compliance** Admissions Packet Update: The admissions application has been revised to include a clearly marked and mandatory section titled "Substance Use History: Past 6 Months". Staff cannot proceed with admission documentation without completing this section. Admission Staff Training: Ongoing training for all staff responsible for admissions will be held quarterly, with immediate retraining already completed. Training will emphasize the importance of compliance with all DBHDS documentation standards. Personnel File Audit A audit of all clinical staff files is being conducted while working on correcting CAP's received. Our goal is to ensure that all required licensure and credentialing documentation is up to date and accurately reflects each employee’s assigned role. Responsible parties: Owner and Chief Administrative Officer (CAO) **Monitoring and Oversight** A quarterly quality assurance review will be	

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			conducted by the CAO to evaluate ongoing compliance with 12VAC35-46-710. B. (11a). OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-710. B. (4) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 4. The protection needs of the prospective resident;	N	This regulation was NOT MET as evidenced by: Individual #1's application did not document the protection needs of the prospective resident. The application only addressed the protection needs of others.	PR) 07/12/2025 Date: 7/1/12025 **Statement of Issue** During a recent inspection by DBHDS Residential Licensing, TTYS Residential Group Home was found to be non-compliant with 12VAC35-46-710. B. The regulation requires that the application for admission include information concerning both the protection needs of the prospective resident as well as their potential impact on others. It was determined that Individual #1's application only included documentation related to the protection needs of others from the resident, and did not adequately address the protection needs of the resident herself. **Immediate Corrective Actions Taken** The admission application form was revised to include distinct and separate fields that capture the protection needs of the prospective resident in addition to the impact they may have on others. Individual #1's application was updated	7/18/2025

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			immediately upon discovery of this oversight to reflect the resident's specific protection needs, including trauma history, vulnerability level, and supervision requirements. **Process and Protocols to Ensure Compliance** Revised Admission Application: The application now requires documentation of: The resident's specific protection needs (e.g., history of victimization, need for supervision, physical or cognitive limitations). Any known triggers or safety risks that require staff awareness. The potential impact the resident may have on others in the program. **Staff Training:** All staff involved in the intake process received refresher training on the updated application and the importance of accurately documenting both dimensions of protection needs. The training emphasizes trauma-informed practices, safety planning, and individualized assessments during admission. Responsible Party: Owner and Chief Administrative Officer (CAO) Monitoring and Oversight The CAO or their owner will conduct a quarterly audit of all new resident admissions to ensure that protection needs for both the resident and others are documented.	

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			OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-710. B. (7) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 7. Family history and relationships;	N	This regulation was NOT MET as evidenced by: Individual #1's application did not document the family history and relationships.	PR) 07/11/2025 Date: 7/1/2025 **Statement of Issue** During a recent DBHDS residential licensing inspection, TTYS Residential Group Home was cited for non-compliance with 12VAC35-46-710. B. (7). This regulation requires that the resident's application include documentation of the individual's family history and relationships. The application for Individual #1 was found to be incomplete and did not include this required information at the time of file review. **Immediate Corrective Actions Taken** The admissions application was immediately revised to include a designated section titled "Family History and Relationships" to ensure this information is collected and documented during intake. Individual #1's application was updated with available family information, including the youth's sibling, who had already been listed on the form. It was confirmed that the parental rights had been terminated, and the referring social worker did not provide mother or father contact details due to their lack of legal involvement. However, the original application did include a section to document both mother and father's contact information should it have been available.	7/18/2025

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			Process and Protocols to Ensure Compliance Application Enhancement: The application for admission now includes a mandatory field requiring detailed information regarding the resident's family history, legal guardianship status, past placements, and significant relationships. If parental rights are terminated, this must be clearly documented with justification from the referring agency. Personnel File Audit A full audit of all clinical staff files is being conducted to ensure that all required licensure and credentialing documentation is up to date and accurately reflects each employee's assigned role. Any gaps in training related to admission documentation standards will be addressed during this audit process. Responsible Party: Owner and Chief Administrative Officer (CAO) **Monitoring and Oversight** The CAO will conduct monthly reviews of all newly admitted client files to ensure compliance with intake documentation standards. . OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-710. B. (8) - Providers shall develop, and fully complete prior to	N	This regulation was NOT MET as evidenced by:	PR) 07/11/2025 Date: 7/1/2025	7/18/2025

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acceptance for care, an application for admission that is designed to compile information necessary to determine: 8. Social and development history;		Individual #1's application did not document the social and development history.	**Statement of Issue** During a recent DBHDS residential licensing inspection, TTYS Residential Group Home was found to be out of compliance with 12VAC35-46-710. B. (8) Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 8. Social and development history; **Immediate Corrective Actions Taken** The admission application for Individual #1 was immediately updated to include documentation of the resident's social and development history. The admissions form was revised to add a designated section specifically titled "social and development history" to ensure this information is documented during the intake process for all new residents. All current resident files were reviewed for the presence of this information. Any files missing this information were corrected and updated immediately. **Process and Protocols to Ensure Compliance** Application Revision: The admissions application form has been updated to include a structured section where staff must document the resident's social and development history at intake. This information will be collected via direct observation, initial assessments, and consultation with referral sources.	

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			Personnel File Audit A full audit of all clinical staff files is being conducted to ensure that all required licensure and credentialing documentation is up to date and accurately reflects each employee's assigned role. Clinical and admissions staff involved in collecting or reviewing admission documentation are also being audited for training compliance on DBHDS standards. Responsible Party: Owner and Chief Administrative Officer (CAO) **Monitoring and Oversight** The CAO will perform a quarterly quality assurance review of the intake process to ensure adherence to the updated protocols OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-710. B. (9) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 9. Current behavioral functioning and social competence;	N	This regulation was NOT MET as evidenced by: Individual #1's application did not document the current behavioral functioning and social competence.	PR) 07/11/2025 **Corrective Action Plan** Date: 7/1/2025 **Statement of Issue** During a recent DBHDS residential licensing inspection, TTYS Residential Group Home was found to be out of compliance with 12VAC35-46-710. B. (9). This regulation requires that each resident's application include documentation of the individual's current behavioral functioning and social competence. Individual #1's application did not include this required information at the time of file review.	7/18/2025

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			Immediate Corrective Actions Taken The admission application for Individual #1 was immediately updated to include documentation of the resident's current behavioral functioning and social competence. The admissions form was revised to add a designated section specifically titled "Current Behavioral Functioning and Social Competence" to ensure this information is documented during the intake process for all new residents. All current resident files were reviewed for the presence of this information. Any files missing this information were corrected and updated immediately. **Process and Protocols to Ensure Compliance** Application Revision: The admissions application form has been updated to include a structured section where staff must document the resident's observed behavioral functioning and social competence at intake. This information will be collected via direct observation, initial assessments, and consultation with referral sources. Personnel File Audit A full audit of all clinical staff files is being conducted to ensure that all required licensure and credentialing documentation is up to date and accurately reflects each employee's assigned role. Clinical and admissions staff involved in collecting or reviewing admission documentation are also being audited for training compliance on DBHDS standards.	

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			Responsible Party: Owner and Chief Administrative Officer (CAO) **Monitoring and Oversight** The CAO will perform a quarterly quality assurance review of the intake process to ensure adherence to the updated protocols. OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-765. H. (1a) - Discharge summaries: 1. No later than 30 days after discharge, a comprehensive discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: 1a. Services provided to the resident;	N	This regulation was NOT MET as evidenced by: Individual #'s discharge summary did not document services provided to the resident.	PR) 07/11/2025 **Corrective Action Plan** Date: 7/1/2025 **Statement of Issue** During a recent DBHDS Residential Licensing inspection, the facility was cited under 12VAC35-46-765. H. (1a). The citation stated that the discharge summary for Individual # [Insert #] did not document the services provided to the resident during their placement. Response to Finding TTYS Residential Group Home respectfully disagrees with this finding. Upon review of the cited discharge summary, it was determined that the document did contain a clear record of services provided to the resident, including the types of services and the names of the service providers. We believe the summary met the intent of the regulation.	7/18/2025

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			Immediate Corrective Actions Taken The discharge summary template has been updated to include a clearly labeled section titled "Summary of Services Provided During Placement" to ensure clarity for all reviewers. Clinical and case management staff have been advised of this new section and instructed to use it when preparing all future discharge summaries. A review was conducted to ensure the same level of detail exists in recent discharge summaries. **Process and Protocols to Ensure Compliance** Template Revision: The discharge summary now includes a distinct section summarizing services, therapeutic interventions, and support provided throughout placement. Quality Review: Discharge summaries will be reviewed and approved by the Program Director or CAO before being filed to ensure all elements are complete. Responsible Party Owner and Chief Administrative Officer (CAO) **Monitoring and Oversight** The CAO and owner will conduct routine audits of discharge summaries to ensure compliance with formatting updates and regulatory expectations.	

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12VAC35-46-765. H. (1f) - Discharge summaries: 1. No later than 30 days after discharge, a comprehensive discharge summary shall be placed in the resident's record and sent to the persons or agency that made the placement. The discharge summary shall review: 1f. Date the discharge summary was prepared and the signature of the person preparing it.	N	This regulation was NOT MET as evidenced by: Individual #2's discharge summary did not document the date the discharge summary was prepared and the signature of the person preparing it.	PR) 07/11/2025 **Corrective Action Plan** Date:7/1/2025 **Statement of Issue** During a recent DBHDS Residential Licensing inspection, the facility was cited for non-compliance with 12VAC35-46-765. H. (1f). The regulation requires that all discharge summaries include the date the summary was prepared and the signature of the person preparing the document. For Individual #2, the discharge summary lacked both the preparation date and preparer’s signature, resulting in an incomplete clinical record. **Immediate Corrective Actions Taken** The missing information for Individual #2 was immediately corrected. The discharge summary was reviewed and amended to include the accurate preparation date and the signature of the preparer. **Process and Protocols to Ensure Compliance** Discharge Summary Template Revision: All discharge summary templates have been updated to include required fields for "Date Prepared" and "Signature of Preparer" to eliminate the risk of omission. Staff Training: Clinical and administrative staff responsible for preparing discharge	7/18/2025

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			documentation will receive ongoing training on DBHDS regulatory standards for client discharge. Quality Review Protocol: All discharge summaries will be reviewed and approved by the Program Director or Owner prior to being filed in the resident's record. **Monitoring and Oversight** The Owner and CAO will conduct quarterly audits of all discharge documentation to ensure compliance with 12VAC35-46-765. H. (1f) and other related standards. Spot audits will be conducted on a monthly basis, and any identified discrepancies will be corrected within 24 hours. OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-810. B. (1) - The following written information concerning each resident shall be readily accessible to staff who may have to respond to a medical or dental emergency: 1. Name, address, and telephone number of the physician and dentist to be notified;	N	This regulation was NOT MET as evidenced by: The name, address, and telephone number of Individual #1's physician and dentist to be notified was not readily accessible to staff who may have to respond to a medical or dental emergency.	PR) 07/11/2025 **Corrective Action Plan** Date: 7/1/2025 **Statement of Issue** During the recent residential licensing inspection, the facility was found to be non-compliant with 12VAC35-46-810. B. (1). The regulation requires that the name, address, and telephone number of an individual's physician and dentist be readily accessible to staff who may have to respond to a	7/18/2025

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			medical or dental emergency. It was determined that for Individual #1, this information was not immediately available to staff during the time of inspection. **Immediate Corrective Actions Taken** Upon notification of the deficiency, TTYS staff immediately reviewed and updated the face sheet for Individual #1 to include the complete contact information for both their primary care physician and dentist. This information has been placed at the front of the physical client file and uploaded into the secure digital record system for quick and direct access by staff in the event of an emergency. All on-duty staff were informed of the change and instructed on how to quickly locate this information within both formats. **Process and Protocols to Ensure Compliance** Face Sheet Standardization: All resident binders will now include a designated section listing the full name, address, and contact information for the assigned physician and dentist. Staff Training: Staff will receive refresher training on emergency protocol procedures, including how to access and utilize client health information in the event of a medical or dental emergency. **Responsible Party:** Owner and Chief Administrative Officer (CAO) **Monitoring and Oversight**	

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			The Owner and CAO will conduct quarterly audits of client records to ensure all emergency contact information-including medical and dental providers-is current and accessible. OLR) Partially Accepted 09/23/2025Please remove all staff names from the original CAP response.	
12VAC35-46-810. B. (2) - The following written information concerning each resident shall be readily accessible to staff who may have to respond to a medical or dental emergency: 2. Name, address, and telephone number of a relative or other person to be notified;	N	This regulation was NOT MET as evidenced by: The name, address, and telephone number of Individual #1's relative or other person to be notified was not readily accessible to staff who may have to respond to a medical or dental emergency.	PR) 07/10/2025 **Corrective Action Plan** DBHDS Licensing Standard Cited: 12VAC35-46-810. B. (2) Citation: The name, address, and telephone number of Individual #1's relative or other person to be notified was not readily accessible to staff who may have to respond to a medical or dental emergency. **Statement of Issue:** The licensing inspector cited that the contact information of a relative or other emergency contact for Individual #1 was not readily accessible to staff in the event of a medical or dental emergency. We respectfully submit that this youth's parental rights have been terminated, and at the time of admission, there were no relatives or approved emergency contacts designated aside from the assigned social worker and their supervisor. As such, there was no family member to list for emergency contact purposes.	7/18/2025

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			However, the Face Sheet in Individual #1's file does include the full name, agency address, office phone number, and email contact for both the assigned social worker and her supervisor, who legally hold decision-making authority for this youth. **Immediate Corrective Action:** Enhanced Labeling on Face Sheet: The social worker and supervisor will be clearly labeled as Primary Emergency Contact / Guardian on the face sheet going forward. An added note will clarify that no biological family or additional contacts are listed due to TPR (Termination of Parental Rights). Process and Protocol to remain in compliance Emergency Contact Reference Sheet: A one-page emergency contact summary will be added to the front of the resident's file for immediate visibility. This sheet will include: Youth's legal guardian (social worker) Supervisor's contact Any relevant legal notes (e.g., TPR status) Emergency numbers for DSS after-hours contact **Monitoring and Oversight:** Responsible Party: Owner and CAO OLR) Accepted 09/23/2025	

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12VAC35-46-810. B. (4a) - The following written information concerning each resident shall be readily accessible to staff who may have to respond to a medical or dental emergency: 4. Information concerning: 4a. Use of medication;	N	This regulation was NOT MET as evidenced by: Information concerning the use of medication regarding Individual #1 was not readily accessible.	PR) 07/10/2025 **Corrective Action Plan** DBHDS Residential Licensing Inspection 12VAC35-46-810. B. (4a) Citation: Information concerning the use of medication regarding Individual #1 was not readily accessible. Date of Citation:5/30/2025 Facility Name: TTYS Prepared By: Owner and CAO **Statement of the Issue** During the facility inspection, it was noted that information regarding the use of medication for Individual #1 was not readily accessible as required by standard 12VAC35-46-810.B.(4a). At the time of admission, the youth was not prescribed or using any medications. However, prescription medications were initiated after admission, and the updated information had not yet been clearly documented in the readily accessible portion of the individual's file. **Immediate Corrective Action Taken:** The lack of documentation was the result of a breakdown in communication between clinical and residential staff regarding the need to update the individual's accessible health records after the initiation of medication. Additionally, the intake documentation did not include a placeholder or statement for "no medications at this time," which contributed to the oversight when medications were later prescribed. Immediate Update to File: Individual #1's file has been updated to include a	7/18/2025

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			current medication list, clearly marked and stored in the readily accessible health section of the resident's file. All prescribed medications, dosages, schedules, and prescribing provider information have been entered into the Medication Administration Record (MAR) and cross-referenced in the health documentation section. **Process and Protocols to remain in compliance:** Revised Intake Procedure: The intake application and initial health summary now include a dedicated section for medication history. If no medications are currently prescribed, "None" will be clearly indicated to avoid ambiguity. All updates regarding medication initiation after admission will be recorded within 24 hours in both the MAR and medical section of the individual's file. Staff Training: All direct care and administrative staff will complete a mandatory refresher training by August 15,2025 on documentation standards and compliance with DBHDS 12VAC35-46-810 requirements. Training will emphasize timely updates to health records when there are changes in a youth's medical or psychiatric status. Monitoring and oversight responsible party: Owner and CAO	

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			OLR) Accepted 09/23/2025	
12VAC35-46-810. B. (4b) - The following written information concerning each resident shall be readily accessible to staff who may have to respond to a medical or dental emergency: 4. Information concerning: 4b. All allergies, including medication allergies;	N	This regulation was NOT MET as evidenced by: Information concerning all allergies, including medication allergies regarding Individual #1 was not readily accessible.	PR) 07/07/2025 **Corrective Action Plan** DBHDS Residential Licensing Inspection Cited Standard: 12VAC35-46-810.B(4b) – Information concerning all allergies, including medication allergies, shall be readily accessible to staff and shall be kept current. Date of Citation: 5/30/2025 Facility Name: TTYS Prepared By: Owner/CAO **Statement of Issue** During the DBHDS Residential Licensing inspection, it was found that Individual #1's allergy section on the intake application was left blank. While the application contains a designated section to record allergies, it was not completed. This made allergy information not readily accessible, in violation of 12VAC35-46-810.B(4b). Even in cases where the individual has no known allergies, this field must be clearly documented to ensure staff are informed and to prevent any ambiguity. **Immediate Corrective Action Taken** A full audit of all resident files was conducted to ensure that allergy sections are fully completed. The intake application for Individual #1 was immediately updated to reflect "None" in the allergy section, confirming that there are no known allergies.	7/18/2025

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			Staff were verbally notified and reminded of the importance of confirming and documenting allergy status for each individual. **Process and Procedures to Ensure Compliance** **Revised Intake Protocol:** Intake paperwork has been updated to require that allergy fields cannot be left blank. Staff must enter either specific allergy details or write "None" if no allergies are reported. All administrative and direct care staff have been retrained on the importance of documenting allergy information accurately. **Monitoring and Oversight** File Monitoring and Audits quarterly Any omissions will be corrected immediately, and documentation audits will be logged for internal tracking and DBHDS review. Accessible Allergy Documentation: A summary of all resident allergies (including "None" where applicable) will be placed in the Emergency Medical Binder for quick staff reference. Allergy information will also be included on the Resident Fact Sheet posted in the staff office and updated regularly. Responsible Party: CAO and Owner	

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12VAC35-46-810. B. (4c) - The following written information concerning each resident shall be readily accessible to staff who may have to respond to a medical or dental emergency: 4. Information concerning: 4c. Substance abuse and use;	N	This regulation was NOT MET as evidenced by: Information concerning substance abuse and use regarding Individual #1 was not readily accessible.	PR) 07/07/2025 **Corrective Action Plan** DBHDS Residential Licensing Inspection Cited Standard: 12VAC35-46-810.B(4c) – "Information concerning substance abuse and use shall be readily accessible." Date of Citation: [Insert date of inspection] Facility Name: TTYS Prepared By: Owner/CAO **Statement of Issue** During the DBHDS Residential Licensing inspection, it was cited that Individual #1's file did not include readily accessible documentation of substance use or abuse history, as required under 12VAC35-46-810.B(4c). Readily accessible substance use information is critical for clinical decision-making, risk assessment, treatment planning, and the safety of both the individual and others in the home. **Immediate Corrective Actions Taken** A full review of Individual #1's record was conducted immediately. Relevant documentation from intake assessments, clinical evaluations, and substance abuse screenings were gathered and placed in a newly created Substance Use Summary Sheet located in the front of the individual's clinical file. A copy of the summary was also placed in the Emergency Medical Binder for use by staff or	7/18/2025

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			medical professionals during emergencies or off-site appointments. **Monitoring/Oversight** Revised Intake Process: A Substance Use History Form has been incorporated into the intake packet for all new residents. This form will be completed during intake interviews and updated during quarterly reviews or upon any significant behavioral incidents related to substance use. Clinical File Organization: Each clinical file will now include a clearly labeled "Substance Use History" section that will include: The completed Substance Use History Form Clinical notes Drug screening results Referrals and participation records from any substance use treatment or counseling Responsible parties: Owner/CAO OLR) Accepted 09/23/2025	
12VAC35-46-810. B. (4d) - The following written information concerning each resident shall be readily accessible to staff who	N	This regulation was NOT MET as evidenced by: Information concerning significant past and present	PR) 07/07/2025 **Corrective Action Plan** DBHDS Residential Licensing Inspection Cited Standard: 12VAC35-46-810.B(4d) – "Information concerning significant past and	7/18/2025

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may have to respond to a medical or dental emergency: 4. Information concerning: 4d. Significant past and present medical problems;		medical problems regarding Individual #1 was not readily accessible.	present medical problems shall be readily accessible." Date of Citation: 5/30/2025 Facility Name: TTYS Prepared By: Owner/CAO **Summary of Issue** During the DBHDS licensing inspection, it was identified that Individual #1's file did not have readily accessible documentation of significant past and present medical conditions. This omission poses a risk to the individual's safety and continuity of care, especially in emergency situations or when care is being transitioned between staff. **Immediate Corrective Actions Taken** A complete review of Individual #1's records was conducted immediately following the inspection. A medical history summary page has been developed and added to the front of each individual's clinical file for quick reference. Individual #1's medical history, including past and current diagnoses, allergies, hospitalizations, and relevant medical providers, has been documented and placed in both the primary clinical record and an emergency grab-and-go folder. Process and Protocols to Ensure Compliance A Medical History Intake Form has been developed and will be completed during all new intakes. This form includes:	

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Program Type/Facility Name: **14-008 Teen Titan Youth Home College Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Past and current medical diagnoses Medication and allergy history Hospitalizations and surgeries Primary care and specialist provider information All medical documentation will also be copied and filed in the resident's emergency binder, kept in a secure but easily accessible location in the event of an evacuation or emergency transport. **Monitoring and Oversight** Responsible Party: Owner and CAO Quarterly File Audits will be performed by the CAO, with results reviewed during internal quality improvement meetings. OLR) Accepted 09/23/2025	

License #: **6251-14-008**
Organization Name: **Teen Titans Youth Services LLC**

Date of Inspection: **05-30-2025**
Program Type/Facility Name: **14-008 Teen Titan Youth Home College Drive**

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

General Comments / Recommendations:
The LS recommends that the provider organizes employee records and ensures that items are organized and filed.
The LS recommends that the provider revises its application to ensure that all requirements are contained on the application.
The LS recommends that the provider ensures that employees are trained regarding all regulatory required training areas.

Please include the following in your response:
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.
2. Include a plan of action to address systematic changes (process/protocols, etc) that have been or will be implemented to ensure you remain in compliance of the regulation.
3. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist).

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.

Anisha Walker, Licensing Specialist	(Signature of Organization Representative)	Date

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