DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **673-14-008**
Organization Name: **Gateway Homes, Inc.**

Date of Inspection: **09-11-2023**
Program Type/Facility Name: **14-008 Gateway Adolescent Program**

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	Gateway Adolescent Program This regulation was NOT MET as evidenced by: See OHR citation.		
12VAC35-115-110. C. (10) - The provider's duties. 10. Providers shall ensure that only staff who have been trained in the proper and safe use of seclusion, restraint, and time out techniques may initiate, monitor, and discontinue their use.	N	Gateway Adolescent Program This regulation was NOT MET as evidenced by: *Providers shall ensure that only staff who have been trained in the proper and safe use of seclusion, restraint, and time out techniques may initiate, monitor, and discontinue their use.* Upon the review of CHRIS entry A-20230010, the provider's investigation was substantiated for restraint not in compliance with standards based on the following: • Employee #1 failed to follow the provider's policy which revealed unauthorized use of restraint techniques: • Employee #1 intervened and have indicated they utilized Entity #1 approved methods to address the situation. Individual #1 visited the emergency room to receive assessment for scratches to her forehead	PR) 09/18/2023 The staff on site during the incident were trained and there is evidence of this in their employee files. Gateway was in compliance as much as is humanly possible at the time of the event. Gateway did everything in their power to provide a safe environment for the individual; however, Gateway does not have the ability to control a staff person's choices and decision making at the time of an incident.	8/14/2023

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		and shoulder. • Individual #1 obtain some bruising on their shoulder and four distinct marks that appear to be from fingernails on a forearm. Based on the provider's investigative finding, there is a preponderance of evidence to support the provider's substantiated finding for the use of restraint not in compliance with standards.	The identified former employee chose not to follow the training and, in response: Gateway removed this individual from staffing immediately to protect the individuals in the program, contacted Child Protective Services to report the incident, conducted a thorough investigation, determined the staff person's liability for the incident, terminated this staff person as a result of their actions, and reported all of this to DBHDS and OHR through Serious Incident Reporting in CHRIS in accordance with all regulations. OHR/OLR) Accepted 09/20/2023	

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.

Andrea Milhouse, Human Rights | (Signature of Organization Representative) | Date

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