License #: **673-14-012**
Organization Name: **Gateway Homes, Inc.**

Date of Inspection: **07-07-2026**
Program Type/Facility Name: **14-012 Summer Drive**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	Summer Drive This regulation was NOT MET as evidenced by: See OHR citations below.		8/14/2026
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	Summer Drive ""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. See § 37.2-100 of the Code of Virginia." This regulation was NOT MET as evidenced by: • Upon review of Provider's CHRIS report A#20250005 and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded allegation of Neglect on 4/6/26, when Employee #1, failed to ensure a safe environment, free of easily	PR) 07/31/2026 The Compliance/Training Department has completed a comprehensive review of its adolescent program to identify contributing factors and areas of improvement to implement and adhere to regulations noted in the description of non-compliance. This included reviewing and addressing strengthening clinical oversight for all direct care staff and ensuring person-centered interventions. As it relates to environmental safety and hazard elimination, the program director will review and provide training to all staff on the environmental safety procedures to ensure all areas accessible to residents are routinely inspected for potential hazards. This would include inspections of bedrooms, bathrooms, closets, common areas, and outdoor spaces. Additional training will be provided on documentation and reporting maintenance concerns or hazardous items during site inspections. Additional training will be completed to review regulations for implementing individualized supervision to include but not be limited to	7/31/2026

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		removable objects (re: nail in this incident) from the bathroom closet, which lead to Individual #1 eating the nail during a state of emotional distress. • Upon review of Provider's CHRIS report A#20250005 and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded allegation of Neglect on 4/7/26, when Employee #2, failed to maintain appropriate supervision of Individual #1, leading to Individual #1 reportedly being outside unsupervised and consuming cigarettes. • Upon review of Provider's CHRIS report A#20250005 and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded allegation of Neglect when the Agency failed to create and maintain a clear supervision plan for Individual #1 to meet their needs. • Upon review of Provider's CHRIS report A#20250005 and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded allegation of Neglect when the Agency failed to create and maintain a clear supervision plan for Individual #1 to meet their needs needs of PICA, OCD, Elopement Risk, monitoring and supervision needs in the bathroom or bedroom while individual was asleep.	required supervision level, community supervision expectations, elopement prevention strategies, staff intervention procedures, and high-risk behaviors. The Program Director or designee will review each supervision plan identified in established ISPs and make revisions. Training has been provided to the Program Director and designee on ensuring updates to the supervision plan and person-centered plan as the following incidents occur (e.g., after psychiatric hospitalization, following incidents of elopement or significant changes in behavioral presentation) or a clinical necessity has been determined. Assigned case manager and clinical reviewer will review individualized service plans (ISPs) and clinical documentation to reflect a comprehensive overview of individualized interventions to address risk factors, supervision requirements, and clinical/medical necessities monthly or as instances occur. In addition, qualified clinical staff will facilitate or participate in treatment team meetings to develop and review support plans to meet clinical needs. Gateway will review individualized supervision planning process for individuals identified as having evaluated behavioral or safety risks to include but not limited to supervision risk assessments upon admission, review of incidents related to risk concerns, review and make updates to person-centered documents after hospitalizations or crisis stabilization, review and update documentation to reflect change in diagnosis or behavior, and implement additional support plans (e.g., supervision checks, 1:1 support, etc.) as necessary.	

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		• Upon review of Provider's CHRIS report A#20250005 and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded allegation of Neglect when the Agency failed to create and maintain a clear supervision plan for Individual #1 to meet their need for a Behavior Support Plan, establishment of safety protocols, or a referral request for a Behavior Specialist or Therapeutic Consultation.	The program director and site leadership will collaborate with Quality Assurance Coordinators to reinforce systematic monitoring activities including chart audits, environmental audits, or additional monitoring activities on a monthly basis. Lastly, on July 28th, 2026, the Program Director and Assistant Program Director conducted a site meeting for staff to address clinical oversight by reviewing staff's daily, weekly, and monthly responsibilities. This meeting addressed: Ensuring staff review staffing assignments for supervision requirements, implementation of interventions identified in ISPs or support plans, and protocols for responding to and reporting incidents. Furthermore, the program director will immediately address any staff concerns through coaching, retraining, performance improvement plans, or disciplinary actions, as appropriate. OHR/OLR) Accepted 09/15/2026	
12VAC35-115-60. B. (5) - The provider's duties. 5. Providers shall not deliver any service to an individual without an ISP that is tailored specifically to the needs and expressed preferences of the individual and, in the case of a minor, the minor and the minor's parent or guardian or other	N	Summer Drive **This regulation was NOT MET as evidenced by:** • Upon review of Provider's CHRIS report **A#20250005** and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded complaint of Services 12VAC35-115-60 (B)(5) when the **Agency** failed to create an ISP that identified	PR) 07/31/2026 The most recent treatment plan for Individual #1 addresses a history of elopement, self-harm, and swallowing behaviors. A formal diagnosis of PICA is not included in historical documents; therefore, it was not included in clinical documentation. The agency failed to create an ISP that identified specific service needs related to the OCD diagnosis. To prevent reoccurrence, staff creating treatment plans will receive retraining to ensure all documented diagnoses are incorporated into treatment plans. Documentation reviewers will also be provided additional training to support this	8/14/2026

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person authorized to consent to treatment pursuant to § 54.1-2969 A of the Code of Virginia. Services provided in response to emergencies or crises shall be deemed part of the ISP and thereafter documented in the ISP.		specific services needs related to Individual's diagnoses of PICA and OCD. • Upon review of Provider's CHRIS report **A#20250005** and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded complaint of Services 12VAC35-115-60 (B)(5) when the **Agency** failed to create an ISP that identified specific services needs related to Individual's historical behavior of Elopement. • Upon review of Provider's CHRIS report **A#20250005** and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded complaint of Services 12VAC35-115-60 (B)(5) when the **Agency** failed to create an ISP goal or safety plan/protocol specific to Individual #1's specific need for 1:1 supervision in the bathroom and bedroom when asleep. There was no plan that identified how to ensure Individual's safety during these time or how to monitor Individual during these times. • Upon review of Provider's CHRIS report **A#20250005** and completion of a joint OHR/SIU investigative review of complaints, Advocate determined that there was a founded complaint of Services 12VAC35-115-60 (B)(5) when the **Agency** failed to create a Behavior Support Plan for	process. In addition, the program director and site leadership will collaborate with Quality Assurance Coordinators to reinforce this expectation through monthly chart audits. Any required or specialized supervision, including one-to-one supervision, will be documented in future treatment plans before admission to services and updated if monitoring frequency changes. Guidance will include specific needs for 1:1 and will include details regarding supervision in the bathroom and bedroom when the individual is asleep. Compliance will provide mandatory retraining for QMHP staff completing treatment plans. Retraining will be finalized by 8/14/26. Ongoing monitoring will be provided by program leadership and quality assurance, including documentation review and monthly audits to ensure compliance. LMHP and treatment team created a support plan for Individual #1. The support plan addressed risks such as elopement, swallowing objects, and self-harm. However, Individual #1 was hospitalized rapidly after admission, and the support plan was not signed before discharge. Staff have been retrained on the importance of reviewing support plans with the client and obtaining signatures promptly after creation. To ensure support plans are signed within required timelines, the assigned supervisor will track completion and provide the signed support plan to compliance. OHR/OLR) Accepted 09/15/2026	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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		Individual #1.		

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.

Hollie Carlisle, Human Rights | (Signature of Organization Representative) | Date

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