

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

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License #: **780-14-001**

Organization Name: **Liberty Point Behavioral Healthcare, LLC**

Date of Inspection: **12-22-2025**

Program Type/Facility Name: **14-001 Liberty Point Academy**

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
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	Liberty Point Academy This regulation was NOT MET as evidenced by: See OHR citations below.		1/12/2026

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12VAC35-115-110. C. (6) - The provider's duties. 6. Providers shall not use a restraint that places the individual's body in a prone (face down) position.	N	Liberty Point Academy This regulation was NOT MET as evidenced by: CHRIS A#20250033 Providers shall not use a restraint that places the individual's body in a prone (face down) position. - While Individual #1 was experiencing a behavioral crisis, Employee #1 and Individual #1 fell to the floor causing Individual #1 to land on Individual #1's stomach and Employee #1 to fall on top of Individual #1. - Employee #2 and Employee #3 both observed Employee #1 remain on top of Individual #1 while Individual #1 was on Individual #1's stomach in a prone position, and then proceed to perform a headlock/choke hold on Individual #1. - Employee #3 then immediately pulled Employee #1 off Individual #1 and removed Employee #1 from the area and away from Individual #1. Employee #1 remaining on top of Individual #1 while Individual #1 was on Individual #1's stomach and performing a headlock/choke hold move was using a restraint that placed Individual #1's body in a prone (face down) position and, therefore, is a violation of 12VAC35-115-110(C)(6).	PR) 01/12/2026 Employee #1 resigning from his position on November 30, 2025. A High Alert was sent out by the Director of Milieu Management the week of December 8th. This High Alert addressed Power Struggles as well as Tap Out procedures for staff. High Alert emphasized the importance of working as a team and managing your emotions when feeling overwhelmed. We organized supplementary training sessions for MHS staff to enhance their knowledge and skills regarding Primary Restraint Techniques, emphasizing the correct application of these techniques and the potential consequences of improper implementation. Director of Quality Management discussed proximity and arm and hand placement. Director of Quality Management will continue to review camera footage and assess training gaps with new and existing staff. OHR/OLR) Accepted 01/12/2026	1/12/2026
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse,	N	Liberty Point Academy This regulation was NOT MET as evidenced by: CHRIS A#20250033	PR) 01/12/2026 Employee #1 resigned from his position November 30, 2025. On December 8th, the Director of Milieu Management initiated a High Alert to address Power Struggles and outlined Tap-Out Procedures for MHS staff.	1/12/2026

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neglect, and exploitation.		"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, intellectual disability, or substance abuse. Provider substantiated for physical abuse based on the following: - Individual #1 alleged that, on November 30, 2025, Employee #1 choked Individual #1 and hit Individual #1 several times. - Individual #1 was in the cafeteria with Employee #1 when Individual #1 experienced a behavioral crisis. - Employee #1 reported that Individual #1 hit Employee #1 in the face several times causing visible injuries to Employee #1's face. - Employee #3 arrived first to assist Employee #1 with Individual #1. - Employee #3 reported that Employee #3 thought that Employee #1 was attempting to initiate a restraint with Individual #1 when Employee #3 observed Employee #1 and Individual #1 fall to the floor with Individual #1 landing on Individual #1's stomach and Employee #1 landing on top of Individual #1. - Employee #2 reported that Employee #2 arrived to see Employee #1 on top of Individual #1 and Individual #1 was lying on Individual #1's stomach in	Furthermore, we conducted training and re-education on the risks associated with placing patients in the prone position. Patient safety concerning primary restraint techniques was also a focal point on our discussions and the importance of using the right techniques. OHR/OLR) Accepted 01/12/2026	

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		a prone position. - Both Employee #2 and Employee #3 reported that while Employee #1 was on top of Individual #1, who was lying on the stomach in a prone position, Employee #1 placed Employee #1's arm around Individual #1's neck and performed, what appeared to be, a headlock/choke hold on Individual #1. - Employee #3 then immediately pulled Employee #1 off Individual #1 and removed Employee #1 from the area and away from Individual #1. Employee #1 lying on top of Individual #1 while Individual #1 is on Individual #1's stomach and performing a headlock/choke hold on Individual #1 is an act that was performed knowingly, recklessly, or intentionally and that might have caused physical or psychological harm, injury, or death to Individual #1 and is a violation of 12VAC35-115-50(B)(2).		

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.

Heather Hilleary, Human Rights

(Signature of Organization Representative)

Date

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