License #: **909-14-003**
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **01-27-2025**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-310. B. (1a) - Required annual retraining: 1. All employees, contractors, students/interns, and volunteers shall complete an annual refresher emergency preparedness and response training that shall include: 1a. Alerting emergency personnel and sounding alarms;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the personnel record for Employee #1 did not contain documentation of emergency preparedness and response training.	PR) 03/13/2025 Regarding Employee #1's annual training in Emergency Preparedness, we have uploaded his certificate of completion and the credit granted, thus demonstrating compliance with the standard cited. This training was listed on Employee #1's training transcript and in his file at that time of the Surveyor's visit. However, the certificate itself was not in Employee #1's file at the time of the Surveyor's visit. OLR) Not Accepted 04/04/2025 Regional Manager notified the provider at the time of the inspection that Emergency Preparedness training was not evidenced in Employee #1's personnel record. The provider was not able to provide documentation of training at the time of the inspection. Please provide a corrective action plan for the citation to ensure that all trainings are completed on time and available at the time of inspections. PR) 08/13/2025 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. The required training was listed on Employee #1’s training transcript, but the certificate itself was not in employee #1’s file at the time of the inspection. The facility shall observe practices to ensure that required trainings are completed, documented, and documentation is available	9/1/2025

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			upon request for inspection. 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. Evidence of course completion may include graded tests, certificates, or attestations. The above shall be stored in printed or electronic forms by the Human Resource Department, and are to be made available upon request. 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). Director of Human Resources. 100% of incoming training documentation reviewed for completeness and filed, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-310. B. (1b) - Required annual retraining: 1. All employees, contractors, students/interns, and volunteers shall complete an annual refresher emergency	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the personnel record for Employee #1 did not contain documentation of emergency preparedness and response training.	PR) 03/13/2025 Regarding Employee #1's annual training in Emergency Preparedness, we have uploaded his certificate of completion and the credit granted, thus demonstrating compliance with the standard cited. This training was listed on Employee #1's training transcript and in his file at that time of the Surveyor's visit. However, the	9/1/2025

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preparedness and response training that shall include: 1b. Implementing evacuation procedures, including evacuation of residents with special needs (i.e., deaf, blind, nonambulatory);			certificate itself was not in Employee #1's file at the time of the Surveyor's visit. OLR) Not Accepted 04/04/2025 Regional Manager notified the provider at the time of the inspection that Emergency Preparedness training was not evidenced in Employee #1's personnel record. The provider was not able to provide documentation of training at the time of the inspection. Please provide a corrective action plan for the citation to ensure that all trainings are completed on time and available at the time of inspections. PR) 08/13/2025 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. The required training was listed on Employee #1’s training transcript, but the certificate itself was not in employee #1’s file at the time of the inspection. The facility shall observe practices to ensure that required trainings are completed, documented, and documentation is available upon request for inspection. 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. Evidence of course completion may include graded tests, certificates, or attestations. The above shall be stored in printed or electronic	

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			forms by the Human Resource Department, and are to be made available upon request. 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). Director of Human Resources. 100% of incoming training documentation reviewed for completeness and filed, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-310. B. (1c) - Required annual retraining: 1. All employees, contractors, students/interns, and volunteers shall complete an annual refresher emergency preparedness and response training that shall include: 1c. Using, maintaining, and operating emergency equipment;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the personnel record for Employee #1 did not contain documentation of emergency preparedness and response training.	PR) 03/13/2025 Regarding Employee #1's annual training in Emergency Preparedness, we have uploaded his certificate of completion and the credit granted, thus demonstrating compliance with the standard cited. This training was listed on Employee #1's training transcript and in his file at that time of the Surveyor's visit. However, the certificate itself was not in Employee #1's file at the time of the Surveyor's visit. OLR) Not Accepted 04/04/2025 Regional Manager notified the provider at the time of the inspection that Emergency Preparedness training was not evidenced in Employee #1's personnel record. The provider was not able to provide documentation of	9/1/2025

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			training at the time of the inspection. Please provide a corrective action plan for the citation to ensure that all trainings are completed on time and available at the time of inspections. PR) 08/13/2025 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. The required training was listed on Employee #1's training transcript, but the certificate itself was not in employee #1's file at the time of the inspection. The facility shall observe practices to ensure that required trainings are completed, documented, and documentation is available upon request for inspection. 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. Evidence of course completion may include graded tests, certificates, or attestations. The above shall be stored in printed or electronic forms by the Human Resource Department, and are to be made available upon request. 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).	

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			Director of Human Resources. 100% of incoming training documentation reviewed for completeness and filed, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-310. B. (1d) - Required annual retraining: 1. All employees, contractors, students/interns, and volunteers shall complete an annual refresher emergency preparedness and response training that shall include: 1d. Accessing emergency information for residents including medical information;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the personnel record for Employee #1 did not contain documentation of emergency preparedness and response training.	PR) 03/13/2025 Regarding Employee #1's annual training in Emergency Preparedness, we have uploaded his certificate of completion and the credit granted, thus demonstrating compliance with the standard cited. This training was listed on Employee #1's training transcript and in his file at that time of the Surveyor's visit. However, the certificate itself was not in Employee #1's file at the time of the Surveyor's visit. OLR) Not Accepted 04/04/2025 Regional Manager notified the provider at the time of the inspection that Emergency Preparedness training was not evidenced in Employee #1's personnel record. The provider was not able to provide documentation of training at the time of the inspection. Please provide a corrective action plan for the citation to ensure that all trainings are completed on time and available at the time of inspections. PR) 08/13/2025 1. Provide a statement of the issue that led to	9/1/2025

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			non-compliance and state how you corrected/will correct the deficient practice in this specific violation. The required training was listed on Employee #1's training transcript, but the certificate itself was not in employee #1's file at the time of the inspection. The facility shall observe practices to ensure that required trainings are completed, documented, and documentation is available upon request for inspection. 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. Evidence of course completion may include graded tests, certificates, or attestations. The above shall be stored in printed or electronic forms by the Human Resource Department, and are to be made available upon request. 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). Director of Human Resources. 100% of incoming training documentation reviewed for completeness and filed, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25	

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			OLR) Accepted 09/12/2025	
12VAC35-46-310. B. (1e) - Required annual retraining: 1. All employees, contractors, students/interns, and volunteers shall complete an annual refresher emergency preparedness and response training that shall include: 1e. Utilizing community support services.	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the personnel record for Employee #1 did not contain documentation of emergency preparedness and response training.	PR) 03/13/2025 Regarding Employee #1's annual training in Emergency Preparedness, we have uploaded his certificate of completion and the credit granted, thus demonstrating compliance with the standard cited. This training was listed on Employee #1's training transcript and in his file at that time of the Surveyor's visit. However, the certificate itself was not in Employee #1's file at the time of the Surveyor's visit. OLR) Not Accepted 04/04/2025 Regional Manager notified the provider at the time of the inspection that Emergency Preparedness training was not evidenced in Employee #1's personnel record. The provider was not able to provide documentation of training at the time of the inspection. Please provide a corrective action plan for the citation to ensure that all trainings are completed on time and available at the time of inspections. PR) 08/13/2025 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. The required training was listed on Employee #1’s training transcript, but the certificate itself was not in employee #1’s file at the time of the inspection. The facility shall observe practices to ensure that required trainings are completed,	9/1/2025

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			documented, and documentation is available upon request for inspection. 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. Evidence of course completion may include graded tests, certificates, or attestations. The above shall be stored in printed or electronic forms by the Human Resource Department, and are to be made available upon request. 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). Director of Human Resources. 100% of incoming training documentation reviewed for completeness and filed, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-310. B. (4) - Required annual retraining: 4. All staff working with residents shall receive annual retraining in child abuse and neglect, mandatory reporting, maintaining	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the personnel record for Employee #1 did not contain documentation of annual training in child abuse and neglect, mandatory reporting,	PR) 03/13/2025 Regarding Employee #1's annual training in Child Abuse and Neglect, we have uploaded his certificate of completion and the credit granted, thus demonstrating compliance with the standard cited. This training was listed on Employee #1's training transcript and in his file at that time of	9/1/2025

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appropriate professional relationships, and interaction among staff and residents, and suicide prevention.		maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention.	the Surveyor's visit. However, the certificate itself was not in Employee #1's file at the time of the Surveyor's visit. OLR) Not Accepted 04/04/2025 Regional Manager notified the provider at the time of the inspection that Child Abuse and Neglect training was not evidenced in Employee #1's personnel record. The provider was not able to provide documentation of training at the time of the inspection. Please provide a corrective action plan for the citation to ensure that all trainings are completed on time and available at the time of inspections. PR) 08/13/2025 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. The required training was listed on Employee #1’s training transcript, but the certificate itself was not in employee #1’s file at the time of the inspection. The facility shall observe practices to ensure that required trainings are completed, documented, and documentation is available upon request for inspection. 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.	

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			Evidence of course completion may include graded tests, certificates, or attestations. The above shall be stored in printed or electronic forms by the Human Resource Department, and are to be made available upon request. 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). Director of Human Resources. 100% of incoming training documentation reviewed for completeness and filed, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-310. B. (5) - Required annual retraining: 5. All staff shall receive annual retraining on the provider's policies and procedures regarding standard precautions.	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the personnel record for Employee #1 did not contain documentation of annual training in the provider's policies and procedures regarding standard precautions.	PR) 03/13/2025 Regarding Employee #1's annual training in standard precautions, we have uploaded his certificate of completion in CPR and First-Aid. The CPR and First-Aid course content, offered by the American Heart Association (AHA) covers standard precautions. Although AHA recommends renewal in 2026, the facility's policy requires this training annually; Employee #1 is due to retake the training in July 2025. OLR) Not Accepted 04/24/2025Regional Manager notified the provider at the time of the inspection that annual training in standard	9/1/2025

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			precautions was not evidenced in Employee #1's personnel record. The provider was not able to provide documentation of training at the time of the inspection. Please provide a corrective action plan for the citation to ensure that all trainings are completed on time and available at the time of inspections. PR) 08/13/2025 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. The required training was listed on Employee #1’s training transcript, but the certificate itself was not in employee #1’s file at the time of the inspection. The facility shall observe practices to ensure that required trainings are completed, documented, and documentation is available upon request for inspection. 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. Evidence of course completion may include graded tests, certificates, or attestations. The above shall be stored in printed or electronic forms by the Human Resource Department, and are to be made available upon request. 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).	

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			Director of Human Resources. 100% of incoming training documentation reviewed for completeness and filed, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-420. D. (1) - At the time of the original application and at least annually thereafter the buildings shall be inspected and approved by state or local health authorities, whose inspection and approval shall include: 1. General sanitation;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the provider did not have documentation of a completed general sanitation inspection.	PR) 03/13/2025 The Director of Plant Operations provided the Surveyor a copy of the sanitation report, and the Survey indicated to the Director of Plant Operations that the facility was in compliance with regulation at the time of the survey. Harbor Point therefore requests the annulment of this citation. OLR) Not Accepted 05/28/2025Provider agreed to submit a copy of the general sanitation report rather than requesting dismissal of the citation. PR) 08/13/2025 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. The facility shall ensure that an annual general sanitation inspection is conducted by a state or local health authority, and documentation to evidence compliance is available upon request. 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	9/1/2025

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			compliance of the regulation. The facility shall schedule required inspections within the timeframe specified in the standard, and retain documentation of the inspection. 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). Director of Plant Operations. Compliance with required inspections to be reviewed monthly, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 9/1/25 OLR) Partially Accepted 09/12/2025Please include copy of sanitation report with CAP response. PR) 09/16/2025 9-16-25 Report attached OLR) Accepted 10/07/2025	
12VAC35-46-500. C. - Every sleeping area shall have a door that may be closed for privacy or quiet and this door shall be readily	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, Location #1 did not have a	PR) 03/13/2025 On the day of the survey, a patient's bedroom was observed to be without a door due the patient destroying the door the previous day. Upon advice from the Surveyor, the patient was	8/13/2025

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opened in case of fire or other emergency.		door that may be closed for privacy or quiet.	moved to a bedroom with a functioning door. On January 28, 2028, the patient's door was replaced and they were moved back to their room. OLR) Not Accepted 04/24/2025At the time of the inspection, the door to Location #1 did not have a door that may be closed for quiet or privacy. Please provide a corrective action plan for the citation to ensure that this issue does not occur in the future. PR) 08/13/2025 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. At the time of the inspection, Location #1 did not have a door that may be closed for privacy or quiet. The facility shall have protocols to ensure that sleeping areas have doors, or that temporary arrangements are made to meet the standard. 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. In the event that timely repair/replacement of a sleeping area door is not possible, the Milieu Manager or appropriate Administrator shall make appropriate temporary arrangements. 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	

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			chart reviews, daily checklist). Milieu Manager or appropriate Administrator. Alternative sleeping arrangements to be reviewed every shift via internal communication. Any milieu staff with knowledge of an inoperable door shall use the facility Maintenance Request form. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 8/13/25 OLR) Partially Accepted 09/12/2025This response does not include confirmation that the door related to the citation was repaired to ensure privacy. Please provide evidence that this correction has been made. PR) 09/16/2025 Photo attached OLR) Accepted 10/07/2025	
12VAC35-46-590. B. - The interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. This includes, but is not limited to, required locks, mechanical devices, indoor and outdoor equipment, and furnishings.	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, walls and doors in Location #2 were in need of painting and repair for cracks.	PR) 03/13/2025 On the day of the survey, Location #2 was in need of painting and repair. Plant Operation staff were actively painting the unit and replacing the door during the survey; all related work was completed the same day (January 27, 2025). The Surveyor was notified accordingly, and they noted that the facility was in compliance with the regulation. OLR) Not Accepted 04/24/2025At the time of the inspection, walls and doors in Location #2 were in need of painting and repair for cracks.	8/13/2025

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			Regional Manager indicate that the provider was in compliance and did not view repair of cracks. Please provide a corrective action for ensuring that the facility is in compliance with interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. PR) 08/13/2025 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. At the time of the inspection, walls and doors in Location #2 were in need of painting and repair for cracks. The facility shall have protocols to identify areas in need or painting and repairs and notify the Plant Operations Department. 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. Any milieu staff member with knowledge of an area in need of paint or repairs shall use the facility Maintenance Request slip. The Director of Plant Operations shall track requests and ensure timely completion. The status of pending repairs shall be made available to regulatory bodies who wish to inspect. 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). Director of Plant Operations. Requests shall be	

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			tracked in real time, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 8/13/25 OLR) Partially Accepted 09/12/2025This response does not include evidence that the repairs were made. Please submit evidence of repairs. PR) 09/16/2025 Photos attached OLR) Accepted 10/07/2025	
12VAC35-46-710. B. (2) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 2. The mental health, emotional, and psychological needs of the prospective resident;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the applications for admission for Individual #1 and #2 contained some information related to the mental health, emotional, and psychological needs of the prospective resident but the information was not adequate to fully determine the individuals needs in these areas.	PR) 03/13/2025 At the time of the survey, the Surveyor noted that some portions of the admission form were not fully completed; some sections that were not applicable were not indicated as such. Per the Surveyor's advice, the Director of Admissions sent an email to her team at 1140hrs on the day of the survey, instructing them to complete all sections of the application forms and indicate where "non-applicable" applies. The Surveyor agreed that such practice would be in compliance with regulation. OLR) Not Accepted 04/24/2025Regional Manager did not advise the provider as it is the provider's responsibility to implement and monitor a corrective action plan which will not only correct any systemic issues that led to non-compliance but also avoid the same deficiency in the future. Please submit a corrective action plan that will avoid this citation in the future.	1/27/2025

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			PR) 08/13/2025 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. It was noted that some portions of the admission form were not fully completed; some sections that were not-applicable (N/A) were not indicated as such. Forms administered at admission shall be complete, with fields that are "N/A" noted. 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. The Director of Admissions was made aware of the issue during the site visit, and directed her team to observe the above on the same date of the inspection, 1/27/25. 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). Director of Admissions. Monitoring to be completed by the staff administering the forms on an ongoing basis. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 1/27/25	

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			OLR) Accepted 09/12/2025	
12VAC35-46-710. B. (3) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 3. The physical health needs, including the immunization needs, of the prospective resident;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the applications for admission for Individual #1 and #2 contained a place to enter the physical health needs, including the immunization needs, of the prospective resident, however the sections were blank.	PR) 03/13/2025 At the time of the survey, the Surveyor noted that some portions of the admission form were not fully completed; some sections that were not applicable were not indicated as such. Per the Surveyor's advice, the Director of Admissions sent an email to her team at 1140hrs on the day of the survey, instructing them to complete all sections of the application forms and indicate where "non-applicable" applies. The Surveyor agreed that such practice would be in compliance with regulation. OLR) Not Accepted 04/24/2025Regional Manager did not advise the provider as it is the providers responsibility to implement and monitor a corrective action plan which will not only correct any systemic issues that led to non-compliance but also avoid the same deficiency in the future. Please submit a corrective action plan that will avoid this citation in the future. PR) 08/13/2025 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. It was noted that some portions of the admission form were not fully completed; some sections that were not-applicable (N/A) were not indicated as such. Forms administered at admission shall be complete, with fields that are "N/A" noted. 2. Include a plan of action to address systematic changes (process/protocols, etc) that have been	1/27/2025

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			or will be implemented to ensure you remain in compliance of the regulation. The Director of Admissions was made aware of the issue during the site visit, and directed her team to observe the above on the same date of the inspection, 1/27/25. 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). Director of Admissions. Monitoring to be completed by the staff administering the forms on an ongoing basis. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 1/27/25 OLR) Accepted 09/12/2025	
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	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the applications for admission for Individual #1 and #2 did not include the protection needs of the prospective resident.	PR) 03/13/2025 At the time of the survey, the Surveyor noted that some portions of the admission application were not fully completed; some sections that were not applicable were not indicated as such. Per the Surveyor's advice, the Director of Admissions sent an email to her team at 1140hrs on the day of the survey, instructing them to complete all sections of the application and indicate where "non-applicable" applies. The Surveyor agreed that such practice would be in compliance with regulation.	1/27/2025

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			OLR) Not Accepted 04/24/2025Regional Manager did not advise the provider as it is the providers responsibility to implement and monitor a corrective action plan which will not only correct any systemic issues that led to non-compliance but also avoid the same deficiency in the future. Please submit a corrective action plan that will avoid this citation in the future. PR) 08/13/2025 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. It was noted that some portions of the admission form were not fully completed; some sections that were not-applicable (N/A) were not indicated as such. Forms administered at admission shall be complete, with fields that are "N/A" noted. 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. The Director of Admissions was made aware of the issue during the site visit, and directed her team to observe the above on the same date of the inspection, 1/27/25. 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). Director of Admissions. Monitoring to be	

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			completed by the staff administering the forms on an ongoing basis. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 1/27/25 OLR) Accepted 09/12/2025	
12VAC35-46-710. B. (6) - Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 6. The behavior support needs of the prospective resident;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the applications for admission for Individual #1 and #2 did not include the behavior support needs of the prospective resident.	PR) 03/13/2025 At the time of the survey, the Surveyor noted that some portions of the admission application were not fully completed; some sections that were not applicable were not indicated as such. Per the Surveyor's advice, the Director of Admissions sent an email to her team at 1140hrs on the day of the survey, instructing them to complete all sections of the application and indicate where "non-applicable" applies. The Surveyor agreed that such practice would be in compliance with regulation. OLR) Not Accepted 04/24/2025Regional Manager did not advise the provider as it is the providers responsibility to implement and monitor a corrective action plan which will not only correct any systemic issues that led to non-compliance but also avoid the same deficiency in the future. Please submit a corrective action plan that will avoid this citation in the future. PR) 08/13/2025 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.	1/27/2025

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			It was noted that some portions of the admission form were not fully completed; some sections that were not-applicable (N/A) were not indicated as such. Forms administered at admission shall be complete, with fields that are "N/A" noted. 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. The Director of Admissions was made aware of the issue during the site visit, and directed her team to observe the above on the same date of the inspection, 1/27/25. 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). Director of Admissions. Monitoring to be completed by the staff administering the forms on an ongoing basis. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 1/27/25 OLR) Accepted 09/12/2025	
12VAC35-46-710. B. (9) - Providers shall develop, and fully complete prior to acceptance for care, an application for	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the applications for admission	PR) 03/13/2025 At the time of the survey, the Surveyor noted that some portions of the admission application were not fully completed; some sections that were not applicable were not indicated as such. Per the	1/27/2025

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admission that is designed to compile information necessary to determine: 9. Current behavioral functioning and social competence;		for Individual #1 and #2 did not include current behavioral functioning and social competence.	Surveyor's advice, the Director of Admissions sent an email to her team at 1140hrs on the day of the survey, instructing them to complete all sections of the application and indicate where "non-applicable" applies. The Surveyor agreed that such practice would be in compliance with regulation. OLR) Not Accepted 04/24/2025Regional Manager did not advise the provider as it is the providers responsibility to implement and monitor a corrective action plan which will not only correct any systemic issues that led to non-compliance but also avoid the same deficiency in the future. Please submit a corrective action plan that will avoid this citation in the future. PR) 08/13/2025 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. It was noted that some portions of the admission form were not fully completed; some sections that were not-applicable (N/A) were not indicated as such. Forms administered at admission shall be complete, with fields that are "N/A" noted. 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. The Director of Admissions was made aware of the issue during the site visit, and directed her team to observe the above on the same date of the inspection, 1/27/25.	

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			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). Director of Admissions. Monitoring to be completed by the staff administering the forms on an ongoing basis. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 1/27/25 OLR) Accepted 09/12/2025	
12VAC35-46-750. B. (3) - Individualized service plans shall describe in measurable terms the: 3. Goals, objectives, and strategies established for the resident;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the ISP's for Individual #1 and #2 contained objective and strategies which were measurable, however the goals were not measurable.	PR) 03/13/2025 The Surveyor had a lengthy meeting with the Director of the Assessment and Diagnostic (A&D) program concerning the ISPs for Individuals #s 1 and 2. The A&D Director clarified to the Surveyor that the goals were measurable because they are SMART goals with timelines. The Surveyor requested that case management notes be placed in the patients' charts. However, a preamble document at the beginning of patient charts indicate and reference that ISPs and case management notes are available electronically in iCANotes and WPC. The Surveyor was shown these protected electronic repositories of patient information and she indicated that it satisfied regulator compliance. OLR) Not Accepted 05/28/2025Provider agreed to submit copies of Individual #1 and #2 ISP's.	9/1/2025

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			PR) 08/13/2025 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. At the time of the inspection, the ISPs for Individual #1 and #2 contained objectives and strategies which were measurable, however the goals were not measurable. The Director of Clinical Services shall communicate the requirement to the staff responsible for creating the document. 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. The goals, objectives, and strategies listed on an individual's service plan shall be described in measurable terms. 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). Director of Clinical Services or designee. Audit one (1) record per Therapist per month to ensure compliance with the standard and report to the Performance Improvement Committee. Audit to be discontinued after six (6) months at 100% compliance. 4. By what date you will have each planned	

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			corrective action completed (Ex. Date training completed or Date protocol implemented). Start date for monthly audit, 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-840. B. - Within seven days of placement, each resident shall have had a screening assessment for tuberculosis as evidenced by the completion of a screening form containing, at a minimum, the elements found on the Report of Tuberculosis Screening form published by the Virginia Department of Health. The screening assessment may be no older than 30 days.	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection the individual records for Individual #2 did not contain documentation of a screening assessment for tuberculosis as evidenced by the completion of a screening form containing, at a minimum, the elements found on the Report of Tuberculosis Screening form published by the Virginia Department of Health. The record did contain documentation of individual's refusal to receive a PPD test but there was no documented plan in place to resolve this issue.	PR) 03/13/2025 As stated in the citation, Individual #2's refusal information was documented by the nurse, and this was available to the surveyor during the site visit. The facility maintains that refusal of treatment is a human right, and therefore no plan was developed to resolve the issue. The facility requests that the citation be annulled. OLR) Not Accepted 05/28/2025Provider agreed to respond to the citation rather than request dismissal. PR) 08/13/2025 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. At the time of the inspection, the individual records for Individual #2 did not contain documentation of a screening assessment for tuberculosis. The record did contain documentation of individual's refusal to receive a PPD test. The facility refers to 12VAC35-115-70 regarding this citation, and shall honor individual refusals for services. 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.	1/27/2025

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			The staff member who is assigned to administer a PPD shall document any refusal by the individual and file in the medical record to be made available upon request. 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). Assigned Nursing staff or designee. 100% of refusals for PPD testing to be documented, ongoing. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). 8/13/25 OLR) Accepted 09/12/2025	
12VAC35-46-900. A. (1) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 1. Identification of positive and problem behavior;	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the Behavior Support Plans for Individual #1 and #2 did not document identification of positive behaviors.	PR) 03/13/2025 The state cites that BSPs for Individuals #1 and #2 did not contain positive behaviors. However, the A&D Director indicated to the Surveyor the gradual development of ISPs, with 24-48 hours after admission, with monthly updates. Positive behaviors would be in the ISPs as Individuals #1 and #2 progressed through the A&D program This was explained to the Surveyor and accepted as compliant with regulation. OLR) Not Accepted 04/24/2025The regulation requires that the written BSP containing identification of positive and problem behavior be developed and implemented within 30 days of	1/27/2025

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			admission. The admission date for Individual #1 was 06/04/2024 and the admission date for Individual #2 was 12/2/2024. At the time of the inspection on 1/27/2025 both individuals had been admitted for over 30 days. Regional Manager did not accept as compliant at the time of the inspection. Please submit a corrective action plan to correct and prevent this deficiency in the future. PR) 08/13/2025 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. At the time of the inspection, the Behavior Support Plans for Individual #1 and #2 did not document identification of positive behaviors. The facility confirmed that this section was on the Behavior Support Plan template, but was omitted in the inspected document. 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. Staff completing the Behavior Support Plan shall use a current version of the template with the sections required by the standard. 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).	

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			Director of Clinical Services or designee. Audit one (1) record per Therapist per month to ensure compliance with the standard and report to the Performance Improvement Committee. Audit to be discontinued after three (3) months at 100% compliance. 4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). Start date for audit, 9/1/25 OLR) Accepted 09/12/2025	
12VAC35-46-900. A. (5) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 5. Identification of interventions that may escalate inappropriate behaviors.	N	Harbor Point Behavioral Health This regulation was NOT MET as evidenced by: At the time of the inspection, the Behavior Support Plan for Individual #2 did not document interventions that may escalate inappropriate behavior.	PR) 03/13/2025 The state cites that BSPs for Individual #2 did not document interventions that may escalate inappropriate behavior. However, the A&D Director indicated to the Surveyor the gradual development of BSPs, with 24-48 hours after admission, with monthly updates. Positive behaviors would be in the ISPs as Individuals #2 progressed through the A&D program This was explained to the Surveyor and accepted as compliant with regulation. OLR) Not Accepted 04/24/2025The regulation requires that the written BSP containing interventions that may escalate inappropriate behavior be developed and implemented within 30 days of admission. The admission date for Individual #1 was 06/04/2024 and the admission date for Individual #2 was 12/2/2024. At the time of the inspection on 1/27/2025 both individuals had been admitted for over 30 days. Regional Manager did not accept as compliant at the time of the inspection. Please submit a corrective action plan to correct and	1/27/2025

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			prevent this deficiency in the future. PR) 08/13/2025 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. At the time of the inspection, the Behavior Support Plans for Individual #1 and #2 did not document identification of interventions that may escalate inappropriate behaviors. The facility confirmed that this section was on the Behavior Support Plan template, but was omitted in the inspected document. 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. Staff completing the Behavior Support Plan shall use a current version of the template with the sections required by the standard. 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). Director of Clinical Services or designee. Audit one (1) record per Therapist per month to ensure compliance with the standard and report to the Performance Improvement Committee. Audit to be discontinued after three (3) months at 100% compliance.	

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			4. By what date you will have each planned corrective action completed (Ex. Date training completed or Date protocol implemented). Start date for audit, 9/1/25 OLR) Accepted 09/12/2025	

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.

Carrie Craddock	(Signature of Organization Representative)	Date

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