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

Date of Inspection: **04-10-2025**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-1070. C. - The provider shall notify the department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; 6. The name of the person to whom the report was made.	NS	Harbor Point Behavioral Health This regulation was NOT MET (SYSTEMIC) as evidenced by: CHRIS Number: 20250020 Date/Time of Discover: 02/25/2025 7:45PM Enter Date/Time: 03/21/2025 1:59PM Reporting Delay: 546:14:00 Location Name: Harbor Point Behavioral Health CHRIS Number: 20250024 Date/Time of Discover: 03/23/2025 7:30PM Enter Date/Time: 03/27/2025 6:57PM Reporting Delay: 71:27:00 Location Name: Harbor Point Behavioral Health Note: As this is provider's second step in the Progressive Citation Cycle for the same regulation within a one-year period, measured on a rolling basis, provider has demonstrated systemic noncompliance. Provider was previously cited for late reporting • The first citation was issued on 10/16/24 and is now non-compliant.	PR) 04/17/2025 20250020- A review of this entry indicated that the case was not entered timely. The issue was traced back to miscommunication regarding a checkbox in the incident paperwork. The Director of Nursing was notified and advised to complete a re-education with nursing staff regarding completing the paperwork. The miscommunication did not cause any delay in services rendered to the individual and only affected the notification to DBHDS. 20250024- A review of this entry indicated that the case was not entered timely due to late reporting by the nurse who committed the medication error. The issue was found to be isolated to one occurrence by one nurse, and no systematic or policy changes are being made at this time. The Director of Nursing completed an investigation per policy and issued written corrective action. The Director also completed two monitoring sessions for return demonstration of the training topics. These corrective steps were completed prior to the submission of this CAP and are attached. OLR) Partially Accepted 05/14/2025 In addition to the above, the provider response needs to include the following: 1. Staff by title responsible for monitoring process implemented to ensure timely data entry of Level II and Level III incidents into CHRIS. This role should be someone other than the person who is	3/30/2025

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			responsible for entering the data in CHRIS where possible. 2. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: daily checks, monthly audits, weekly chart reviews, quarterly checklist). PR) 05/29/2025 20250020- A review of this entry indicated that the case was not entered timely. The issue was traced back to miscommunication regarding a checkbox in the incident paperwork. The Director of Nursing was notified and advised to complete a re-education with nursing staff regarding completing the paperwork. The miscommunication did not cause any delay in services rendered to the individual and only affected the notification to DBHDS. 20250024- A review of this entry indicated that the case was not entered timely due to late reporting by the nurse who committed the medication error. The issue was found to be isolated to one occurrence by one nurse, and no systematic or policy changes are being made at this time. The Director of Nursing completed an investigation per policy and issued written corrective action. The Director also completed two monitoring sessions for return demonstration of the training topics. These corrective steps were completed prior to the submission of this CAP and are attached. Plan of Correction: Update 5-29-25 20250020- A review of this entry indicated that	

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			the case was not entered timely. The issue was traced back to miscommunication regarding a checkbox in the incident paperwork. The Director of Nursing was notified and advised to complete a re-education with nursing staff regarding completing the paperwork. The miscommunication did not cause any delay in services rendered to the individual and only affected the notification to DBHDS. The issue was found to be isolated to one occurrence and no adjustments were made to existing processes or protocols. The facility shall follow the current policy for compliance monitoring including a review of all incident reports by the Director of Risk Management or designee trained in entering incidents into the CHRIS system within 24 hours. The corrective steps shall be in place by 3-30-25. 20250024- A review of this entry indicated that the case was not entered timely due to late reporting by the nurse who committed the medication error. The issue was found to be isolated to one occurrence by one nurse, and no systematic or policy changes are being made at this time. The Director of Nursing completed an investigation per policy and issued written corrective action. The Director also completed a monitoring session for return demonstration of the training topics. The facility shall follow the current policy for compliance monitoring with Nurse-led quality checks of the Medication Administration Record occurring every 24 hours. This is expected to "catch" medication variances and make the information available to the staff trained in entering incidents into the CHRIS system under the current reporting policy. These corrective steps were completed prior to the submission of this CAP and are attached	

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			OLR) Accepted 06/18/2025	

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.

Lakesha Steele, Incident Management Unit	(Signature of Organization Representative)	Date

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