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Plan of correction attached. Hard copy to follow by mail.
September 28, 2020
Ruthanne Risser, Director
Division of Acute Care Services
Commonwealth of Virginia, Department of Health
Office of Licensure and Certification
9960 Mayland Drive – Suite 401
Henrico, Virginia 23233

RE: Cumberland Hospital, 49-3300
Hospital Medicare/Medicaid Complaint Investigation Survey

Dear Ms. Risser,

Please accept the attached CMS-2567 form from Cumberland Hospital for Children and Adolescents with included response and Plan of Correction to the Code Federal Regulations conditional and standard level deficiencies which were cited in our final report from the VDH’s unannounced complaint survey conducted at our facility on August 17 – 20th, 2020.

Sincerely,

Leslie D. Bowery, Director, Standards and Regulatory Compliance
Cumberland Hospital for Children and Adolescents
Unannounced Medicare/Medicaid Hospital Complaint Investigation surveys were conducted February 13, 2020 through March 4, 2020, by two (2) Medical Facilities Inspectors (MFIs) from the Virginia Department of Health's (VDH) Office of Licensure and Certification (OLC) and August 17, 2020 through August 20, 2020 by six (6) MFIs from the VDH, OLC.

In addition to investigating the complaints, the following Conditions of Participation for Acute Care Hospitals were also surveyed for compliance: §482.12 Governing Body, §482.13 Patient Rights, §482.21 Quality Assessment and Performance Improvement Program, §482.23 Nursing Services, and §482.25 Pharmaceutical Services. The surveys were conducted during the COVID-19 pandemic. The facility COVID-19 plan was reviewed.

The survey process included observations, interviews, review of clinical records, facility documents and applicable policies and procedures. The complaints investigated included:

Complaints:
VA0048286 - Substantiated with deficiency
VA0049472 - Substantiated with deficiency
VA0049443 - Substantiated with deficiency
VA0048935 - Substantiated with deficiency
VA0048318 - Unsubstantiated
VA0049542 - Unsubstantiated
VA0049442 - Unsubstantiated
VA0049282 - Unsubstantiated

Based on the findings from the two (2) surveys,
A000 Continued From page 1
the facility was not in compliance with the Conditions for Participation for Hospitals with the following Condition level citations:

§482.13 Patient Rights
§482.21 Quality Assessment and Performance Improvement Program

Standard level deficiencies were also cited.

A115 PATIENT RIGHTS
CFR(s): 482.13

A hospital must protect and promote each patient’s rights.

This CONDITION is not met as evidenced by:
Based on video surveillance review, interviews, and facility document review, it was determined that the facility staff did not substantially comply with this condition of participation by:

1. Failing to Immediately provide protection for the patient’s health and safety while failing to adhere to standards of care, policy and procedure, law and regulation. (TAG A144)

2. Failing to ensure the patient was free of all forms of abuse, neglect, or harassment while failing to adhere to standards of care, policy and procedure, law and regulation. (TAG 145)

3. Failing to conduct restraint procedures in adherence with safe and approved restraint and seclusion training techniques that adheres to policies and procedures, law and regulation. (TAG 167)

The findings include:

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<td>• Please refer to A 344, A 143, and A 167</td>
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### Statement of Deficiencies and Plan of Correction

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID** A 115

<table>
<thead>
<tr>
<th>ID</th>
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<td>A. BUILDING:</td>
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**NAME OF PROVIDER OR SUPPLIER**

CUMBERLAND HOSPITAL LLC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

9487 CUMBERLAND ROAD

NEW KENY, VA 23124

** SUMMARY STATEMENT OF DEFICIENCIES**

**ID** A 115

**PREVIOUS STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

1. On February 13, 2020 at 11:00 a.m., Staff Member #1 reported to a surveyor that the facility had an incident of abuse on February 12, 2020.

   Upon review of the video surveillance the surveyor observed a staff member touch, hit and drag a patient on the floor. Other staff members who were present or working at the time verified the actions observed on the video. Staff present failed to follow the facility's policy and procedure to immediately ensure patient safety, including direction related to staff members. Please see A-0144 & A-0145 for additional information.

2. Staff interview and review of facility policy and procedure revealed staff used a towel to protect themselves when a patient spit. Interviews revealed this action was taught in staff training, but was inconsistent with the facility policy and procedure. Please see A-0167 for additional information.

**PATIENT RIGHTS: CARE IN SAFE SETTING**

**CFR(s):** 482.13(g)(2)

The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by:

The facility's failed to immediately provide protection for the patient's emotional health and safety as well as his/her physical safety by not immediately placing an employee on leave in adherence to policy and appropriate patient safety standards of practice for (1) of one (1) patients (Patient #2).

On February 20, 2020 at 12:00 p.m. an interview with Staff Member #1 revealed "The Nursing

**PLAN OF CORRECTION:**

- The facility CEO and Risk Manager reviewed and affirmed that the hospital's policy "Reporting of Abuse and Neglect" provided direction for immediate suspension of any employee following an allegation of abuse/neglect.

- Nursing Supervisors, Unit Coordinators, and all other managers/supervisors received retraining on immediately placing staff on administrative leave pending investigation. This training was completed by the Chief Operating Officer in the form of in-person training. Understanding of expectation was verified by signed attestation.

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A 144. Continued From page 3

Supervisor was notified of the Incident at 8:25 p.m. [Staff Member #11] continued to work on Unit 8 until the end of the scheduled shift. [Staff Members #1 and #2] (Administrative Staff) were notified of the incident on February 13, 2020 at 5:00 a.m. [Staff Member #11] was terminated on February 13, 2020 at 3:00 p.m."

A review of the facility policy provided by Staff Member #2 on February 19, 2020 at 3:30 p.m. titled "Hospital Policy on Reporting Patient/Resident abuse or neglect" read in part, "Immediate reporting of an actual, alleged or suspected incident of abuse or neglect to a patient while in the direct care of [Name of facility] to the nursing Supervisor/Unit Coordinator on duty at the time of the occurrence and respective supervisor. The Department Supervisor/Nursing Supervisor shall immediately take steps/actions to protect the patient/resident until investigation is complete by placing the employee on administrative leave."

The facility failed to follow their policy by not taking immediate action and allowing Staff Member #11 to continue to work until the end of the shift.

A 145. PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

The patient has the right to be free from all forms of abuse or harassment.

This STANDARD is not met as evidenced by: Based on video surveillance review, interviews, and facility document review, it was determined that the facility staff failed to ensure the patient

A 145. PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

- Nursing Supervisors, Unit Coordinators and other manager/supervisors were retrained to immediately notify the Chief Nursing Officer or the appropriate department head during day shift hours and the Administrator on Call for occurrences on weekends, or off shifts, of suspected incidents of patient abuse or neglect. Understanding of expectations was verified by signed attestation.
- The Administrator on Call policy was revised to incorporate the process for notification of staff suspension for suspected abuse or neglect of a patient. The policy was approved by the Medical Executive Committee and Governing Body.
- The staff that serve as Administrator on Call were retrained on the policy. The Chief Operating Officer completed this training in the form of in-person instruction. Understanding was verified by signed attestation.

PERSON RESPONSIBLE: Chief Operating Officer

MONITORING:
- The Director of Human Resources is tracking 100% of Incident of alleged staff abuse/neglect including appropriate removal of staff from duty, and reports data monthly to the Performance Improvement Committee and Medical Staff, and quarterly to Governing Board. Any failure to report allegations of abuse/neglect will be addressed through additional retraining and/or corrective action.
A.145 Continued From page 4

was free of all forms of abuse, neglect, or harassment, for (1) of one (1) patients (Patient # 2).

The findings include:

On February 13, 2020 at 11:00 a.m., Staff Member #1 reported that the facility had an incident of abuse on February 12, 2020, that the facility would be self-reporting that day to the applicable state agencies and law enforcement.

On February 18, 2020, Staff Member #1 and the surveyor reviewed the video recording of the events of February 12, 2020. The following was observed:

At approximately 6:14 p.m., Patient #2 was seated on the couch with another patient when Staff Member #11 approached the couch and took a seat between the two patients.

At approximately 6:15 p.m., Patient #2 placed their left hand in front of Staff Member #11’s face and appeared to be conversing (there was no sound to the video) with Staff Member #11.

Patient #2 did this several times over the next minute.

At 6:16 p.m., Patient #2 placed their left arm on Staff Member #11’s right shoulder. Staff Member #11 appeared to be engaged in conversation with the second patient sitting on the couch, and was not observed to respond to Patient #2.

At 6:17 p.m., Patient #2 again put their left hand in front of Staff Member #11’s face with the left pointer finger extended, and Staff Member #11
A145  Continued From page 5

shrugged off the patient’s arm and hand while appearing to be redirecting the patient’s actions. Patient #2 turned towards Staff Member #11 and appeared to spit at Staff Member #11’s face.

At that time, Staff Member #11 stood and put a hand on Patient #2 at the necklive, and attempted to pull the patient up to a standing position as the patient was resisting with the left arm extended out to Staff Member #11’s right shoulder. Patient #2, in an attempt to free self from Staff Member #11, kicked with the left leg into Staff Member #11’s abdominal area. Staff Member #11 released the hold on Patient #2, grabbed the patient’s ankles and pulled the patient to the floor, Patient #2's head and back was observed to strike the floor.

While Patient #2 was on the floor, Staff Member #11 was seen striking Patient #2 in the chest and abdomen with a closed fist approximately 4 times. Another Staff Member then separated Staff Member #11 and Patient #2. Staff Member #11 grabbed Patient #2’s ankles again and drug Patient #2 approximately 15 feet across the floor.

Documentation by Staff Member #9, Registered Nurse (RN), in the Nursing Notes on February 12, 2020 at 8:00 p.m. read in part "Pt (Patient) complained of stomach pain. Pt stated that [pt] targeted and spit in face of staff and then the staff punched [pt] in the stomach. Pt changed story to nothing-happened back to original story. No bruises noted to abdominal or stomach. No bruises noted to frontal trunk area. [Pt] requested to call [parent]. Pt stated that [pt] was punched in dayroom area. Pt’s [parent] notified at 7:25 p.m. and verbalized understanding. Nursing Supervisor notified at 7:24 p.m. [Patient #2’s
Continued from page 6

name talked on phone with [parent] without incident. Oncoming nurse give report.”

Documentation by Staff Member # 16, RN Nursing Supervisor, in the Nursing Supervisor Notes on February 12, 2020 read in part “[Patient # 2’s name] sitting on couch, split at staff, reported to [parent] that staff hit them in abdomen. Please review camera at 6:00 p.m. to 8:30 p.m. Staff reported that she witnessed punches. [Parent] to call to find out if [Patient # 2’s name] was punched.” According to Staff Member # 2, it was not unusual for the parent to call as they usually calls multiple times.

On February 17, 2020 at 1:40 p.m., an interview with Staff member # 9 revealed, “I was at the nurse’s station. I know [Patient #2] was being aggressive prior to this and staff had to intervene to keep [Patient #2] away from a female patient. I did not see what took place but [Patient #2] told me [Staff member #11] punched [Patient #2] in the stomach and then told me it didn’t happen and then changed story and said it did happen. I did not see [Staff member #11] put hands on [Patient #2]. I wasn’t out there. I did report what [Patient #2] told me the supervisor.”

On February 17, 2020 at 4:00 p.m., an interview with Staff Member # 8 revealed, “I usually don’t work on Unit 6. I am assigned to 7 B or A, but I can work on any unit. I started hearing it first. I could hear [Staff Member #11] say “get on the floor. Get on the floor” or something like that. Myself and the other BT (behavioral tech) ran to the commotion and [Staff Member #11] had [Patient #2] on the floor and [Patient #2] pants were half down and I was trying to get in there to help [Patient #2] and I saw [Staff Member #11]
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punch [Patient #2] in the stomach. I tried to separate them but [Staff Member #2] told me to get back and I was so shocked I stepped back. I saw [Staff Member #11] punch [Patient #2] 5 or 6 times. [Staff Member #11] was connecting with those punches. [Staff Member #11] grabbed [Patient #2] by the ankles and drug [Patient #2] out in the floor by the cabinets. I was in total shock. I look at the other BT and [other BT] went to [Staff Member #11] and I went to [Patient #2]. [Other BT] moved [Staff Member #11] out of the way. Other BTs swooped in to [Patient #2]. I didn't know what to do. I've never witnessed anything like that before. I saw the Nursing Supervisor on 8 and told [Nursing Supervisor] I needed to talk to [Nursing Supervisor]. I was sent back to 7 and when the Supervisor came over there I talked to [Nursing Supervisor] about it in the kitchen and reported what I'd seen. I don't know what made [Staff Member #11] do that. I can't understand why [Staff Member #11] would do that. This obviously isn't the job for [Staff Member #11]. I have never had a bad experience with any staff here that I have worked with. [Staff member #11] sounded agitated and one thing that I did notice was after it was over and [Staff Member #11] was pushed away by the other BT, [Staff Member #11] walked away and had a smile on face. I am upset with myself. I look back and I know I should have handled this differently. In the future I certainly will handle this differently if it ever happened again. I just hope it never happens again.

On February 17, 2020 at 4:30 p.m., an interview with Staff Member #10 revealed, "I was not familiar with [Name of Staff Member #11], this was the first time I worked with [staff member]. Staff Member got here late that day at about 5:10.
A145  Continued From page 8

p.m. [Staff Member] went to the kitchen, and got
drink, and came to us (other techs) to see what
we were doing on the unit (activities, groups). We
explained that things were fine. We were in the
midst of eating, sitting at a table in the big room. I
heard what sounded like “Oh my (epithet) god”
or “Oh the (adjective) not”. When I jumped up to
see what was going on [Staff Member #1’s
name] and [Patient #2’s name] were in the floor
and [Staff Member #11] was punching [Patient
#2]. I was trying to get to [Patient #2], but [Patient
#2] was kicking [Staff Member #11] and [Staff
Member #11] grabbed [Patient #2] out of the
floor. I put my arm out and told [Staff Member
#11] to get back that [Staff Member #11] need to
go “tap out” with [Name of another Staff Member].
I heard [Staff Member #11] say when [Staff
Member #11] came in that “everything that could
go wrong today has”. I think [Staff Member #11]
was late waiting for [Staff Member #11] car to get
fixed. After that happened with [Patient #2] I told
[Staff Member #11], I pulled [Staff Member #11] to
the side and said “Nothing you can say can
explain, what you’ve done”. I do believe I reported
to the nurse but all my days run together and it’s
hard to remember. I know if this ever happened
again I’d call the supervisor immediately myself.”

On February 20, 2020 at 12:00 p.m. an interview
with Staff Member #1 revealed “The Nursing
Supervisor was notified of the incident at 6:25
p.m. [Staff Member #11] continued to work on
Unit 8 until the end of the scheduled shift. [Staff
Members #1 and #2] (Administrative Staff) were
notified of the incident on February 13, 2020 at
5:00 a.m. [Staff Member #1] was terminated on
February 13, 2020 at 3:00 p.m.”

A review of the facility policy provided by Staff
**A145** Continued From page 9

Member #2 on February 19, 2020 at 3:30 p.m. titled "Hospital Policy on Reporting Patient/Resident abuse or neglect" read in part, "Immediate reporting of any actual, alleged or suspected incident of abuse or neglect to a patient while in the direct care of [Name of facility] to the Nursing Supervisor/Unit Coordinator on duty at the time of the occurrence and respective supervisor. The Department Supervisor/Nursing Supervisor shall immediately take steps/actions to protect the patient/resident until investigation is complete by placing the employee on administrative leave."

The facility failed to follow their policy by not taking immediate action and allowing Staff Member #11 to continue to work until the end of the shift.

**A187** PATIENT RIGHTS: RESTRAINT OR SECLUSION

CFR(s): 482.13(a)(4)(i)

[The use of restraint or seclusion must be—]

(i) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

This STANDARD is not met as evidenced by:

Based on interviews and document review, it was determined the facility failed to ensure their practice of placing a towel four (4) to six (6) inches in front of a patient's face during restraint was a part of a safe and appropriate restraint and seclusion techniques in their policies and procedures and an approved CPI (Crisis Prevention Institute) technique in accordance with CPI training.

**PLAN OF CORRECTION:**

- The Director of Risk Management revised the Seclusion/Restraint Policy to include mitigation for spitting. This mitigation includes the proper and safe use of face shields to prevent a patient from spitting on another person.
- The Seclusion/Restraint Policy and Training Curriculum was revised to include mitigation for spitting, by implementing use of face shields rather than towels to protect from patients who are spitting during restraint events.
- The CPI instructors were restrained by the Chief Operating Officer and Risk Manager on acceptable methods of managing spitting behavior (face shields) and never to teach any process involving towels. Expectations were verified by signed attestation.

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A.167 Continued from page 10

The findings include:

The Policy titled Restrictive Procedures #303.25 was provided by Staff Member #7 and reviewed on 8/17/2020. The policy did not include the procedures for the use of a towel being held four (4) to six (6) inches above a patient's face who is spitting.

Staff Member #7 was interviewed several times on 8/17 and 19/2020 and stated, "Before a staff member can assist with a patient who is combative or trying to harm themselves or someone else they must have attended and passed the CPI course."

Staff Member #12 was interviewed on 8/17/2020 at 3:00 P.M. and stated, "We are taught in CPI to use a towel above a patient's head if they are spitting. The towel should be held about six (6) inches above the patient's face."

Staff Member #8 was interviewed on 8/17/2020 at 4:02 P.M. and stated, "If a patient is spitting we hold a towel above the patient's face to protect the staff."

Staff Member #2 was interviewed on 8/19/2020 at approximately 2:20 P.M. and stated, "I am a CPI instructor. We teach the staff to use a towel to protect the staff when a patient is spitting. The towel is held four (4) to six (6) inches above the patient's head. Spitting is considered a strike and the towel is used to block the strike."

The CPI handbook was reviewed on 8/17/2020 and does not address the use of a towel above a patient's face when they are spitting. The
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

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<td>handbook does not address spitting.</td>
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<td>Staff Member #3 was interviewed at various times on both 8/17 and 19/2020 and stated, &quot;Our trainer is going away in October to be re-certified in CPI. We will have them address this issue with their staff in the meantime we will update our policy to include a spit barrier.&quot;</td>
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<tr>
<th>A 283</th>
<th>QAPI</th>
<th>CFR(s): 482.21</th>
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<td>The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.</td>
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<td>The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.</td>
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<td>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</td>
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<td>This CONDITION is not met as evidenced by: Based on medical record review, staff interview, facility document review and facility regulatory complaint history, it was determined the facility did not substantially comply with this condition by:</td>
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<td>Failing to ensure the Quality Assessment and Performance Improvement (QAPI) program considered the incidences, prevalence, and</td>
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severity of complaints and to develop a plan of action to mitigate and prevent reoccurrences of issues,

Failing to report events involving potential patient harm to the QAPI program (see tag A-0286), and;

Failing to ensure all staff members have the ability to report incidents in order to enable accurate and immediate reporting and investigation of incidents and concerns. (See tag A-0286)

The findings include:

The facility’s regulatory compliance history was reviewed and evidenced a concerning number of complaints and reoccurring events. Specifically, the surveyor identified 27 complaints since January, 2018 that involved allegations of patient abuse or harm.

Furthermore, the survey team investigated six (6) additional complaints during the August 2020 survey. The current complaints provided evidence that incidents were continuing/reoccurring and the QAPI program failed to prevent reoccurrences and find long-term solutions.

The surveyor discussed these concerns with staff during the survey. The facility staff stated the issues are taken to QAPI, however, there is evidence by the facility history that actions implemented are not sustained or are ineffective in decreasing complaints. The facility staff discussed the development of new interventions consisting of personnel changes, addition of a full time Patient Advocate, and the formation of committees to work on concerns, however the
A 263 | Continued From page 13  
facility stated the interventions were still "in the development stages".

(See tag A-0285)

A 268 | PATIENT SAFETY  
CFR(s): 482.21(a), (c)(2), (e)(3)

(a) Standard: Program Scope  
(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors.  
(2) The hospital must measure, analyze, and track ... adverse patient events ...

(c) Program Activities .....  
(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...  
(3) That clear expectations for safety are established.

This STANDARD is not met as evidenced by: Based on clinical record review, staff interview and a review of facility documents, it was determined the facility failed to ensure the timely reporting of two (2) incidents involving potential harm to patients to the Quality Assessment and Performance Improvement Plan.

### PLAN OF CORRECTION:
- The Director of Risk Management ensures that all facility employees have the ability to report incidents via use of the facility paper-based Patient Event Report.
- Training was provided to all employees on completion of the Patient Event Report form via in-person instruction. Competency was verified by skills assessment test and signed acknowledgement of the training material.
- All incidents will be logged into the Midas Incident Reporting Log by the Risk Manager.

**PERSON RESPONSIBLE:** Director of Risk Management

### MONITORING:
- The Director of Risk Management is using the nursing supervisor report, which includes all incidents that occurred during the shift, to compare and contrast reported incidents. Incidents that were not documented via the facility Patient Event Report will be rectified the same day.
- The Director of Risk Management reports all incidents daily to the leadership team in the daily Flash meeting.
- The Director of Risk Management tracks and trends incident reports and incident types that occur, including data on accuracy of reporting incidents.
- Data is reported monthly in the Patient Care Committee and Medical Staff monthly, and quarterly in Governing Board. Any non-compliance with reporting will result in retraining and/or disciplinary action as appropriate.
Continued From page 14

(QAPI) program (Patient #2 and Patient #4).

The findings included:

Patient #2 experienced a seizure with a fall that was not reported as per the facility policy for reporting and tracking of adverse events.

The clinical record for Patient #2 was reviewed and evidenced that on 8/5/2020 at approximately 9:14 a.m., it was documented in the "Patient Care Flow Sheet": .."Hed seizure, fell hit head-checked by nurse...checked by doctor..."

On 8/17/2020 at 3:00 p.m., the surveyor interviewed Staff Member #16 (Behavioral Tech (BT)). Staff member #18 stated, "I was with another BT and the patient (Patient #2) was standing in between us... (Patient #2) suddenly fell and hit (their) head on the door and began to jerk, having a seizure in the floor...I got on the floor by the patient and asked the nurse to get a pillow. The pillow was put under (Patient #2) head...when the seizure ended (the patient) was snoring...the patient was not able to walk, so I scooped (them) up and carried (Patient #2) to their room..."

On 8/10/2020 at approximately 9:30 a.m., the surveyor reviewed the video footage of the incident above which occurred on 8/5/2020 at 9:14 a.m. From the video footage the surveyor was able to see the patient fall, hit (their) head on the door facing and land on the floor experiencing jerking body movements. The surveyor observed the RN to place a pillow under the patient's head, obtain a blood pressure cuff and obtain vital signs once the jerking stopped. The surveyor could also observe two other staff members standing by
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the patient. One staff member bent down and
began rubbing the patient's back. The RN was
observed to go to the desk and use the
telephone, while the two other staff members
remained with the patient. The patient was then
observed to be picked up by a staff member and
carried to (the patient's) room.

The surveyor reviewed the facility policy and
procedure for "Incident Reporting". The
document revealed the following, in part:
"...Definitions ...7. Serious Injuries/Events
constitute any of the following outcomes as a
result of healthcare intervention but may not be
limited to this list: a. Accidents such as falls
...Procedure: 18. Any facility employee or staff
member who discovers, is directly involved in or
is responding to an event/incident is to complete
or direct the completion of a Healthcare Peer
Review (HPR) incident report into MIDAS
(electronic reporting system) by RDE. a. This
report is to be entered through RDE into the
MIDAS system prior to the end of the staff
members scheduled shift ...b. Healthcare Peer
Review (HPR) Incident reports are to be signed
by the individual preparing the report. c. The
Nurse Charge of Shift (identified by Staff Member
#3 as the House Supervisor) on duty at time of
event is notified of any HPR Incident, reviews
HPR for completeness, making suggestions or
eadditions as necessary from nursing perspective
...h. The completed form is forwarded to the Risk
Manager within 72 hours ..."

On 8/19/2020 at 2:00 p.m., the surveyor reviewed
the adverse event/incident reporting log. The
concern related to Patient #2's incident (seizure
with fall) was not listed on the log. The surveyor
requested further information on the reporting of
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the incident. At 2:40 p.m., Staff Member #3 (Safety/Risk) stated there was no incident form completed for this event but "The expectation is, there should have been a report filled out ..."

On 8/20/2020 at 8:40 a.m., the surveyor discussed the incident with Staff Member #6 (Quality). Staff Member #6 stated, "(Risk) was on vacation during that time and I am the back-up. I cannot enter falls into the system myself. I don't have access and have not had the training to be able to put them in ... there was a step missed in the documentation process and no incident report was filed ... it was on my morning meeting notes for that day and I told (Staff Member 7) that there was no incident report and it should have been put in. Every nurse has access to put in the reports ..." The surveyor also discussed the concern regarding reporting. Staff Member #6 stated, "There is no policy that staff cannot report to any agency they feel they need to. We just ask that they report to us first, because if the allegation or concern has to do with abuse or neglect we need to know immediately so that we can keep the patient safe..."

The surveyor discussed the concerns throughout the investigation process and during a review of the Quality Program on 8/20/20. The surveyor also discussed the concerns with Staff Members #1 (CEO), #9 (Quality) and #7 (COO) on 8/20/20 at 11:15 a.m.

Patient #4 purposely ingested medication not intended for them and the incident was not reported as per the facility policy for reporting and tracking of adverse events.

A medical record review for Patient #4 on August
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<th>A.286</th>
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<td>17, 2020 at 12:32 p.m. revealed a note entered by Staff Member #19 (Behavioral Tech) on April 17, 2020 that advised Patient #4 admitted to taking medication not intended for them. The note further added the patient took the medication from the nurse’s station while the patient experienced a panic attack. Staff Member #19 advised they reported the incident to the charge nurse, Staff Member #18.</td>
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During an interview with Staff Member #7 on August 17, 2020 at 1:23 p.m., Staff Member #7 advised that Patient #4 did take and ingest medication not intended for them from the nurse’s station. This occurred when Staff Member #18 left the medication sitting on the counter while the staff member left the area to use the phone. Staff Member #19 did report the incident to Staff Member #18 when Patient #4 advised them of the event. Staff Member #19 did not report the event as required. The incident was not reported to the OAPI program until August 29, 2020, or namely twelve (12) days later, when the patient advised another staff member of the incident.

During an interview with Staff Member #6 on August 17, 2020 at 3:00 p.m., Staff Member #6 advised that only charge nurses have the ability to enter incidents into the reporting system. Behavioral techs do not have that ability and instead are supposed to report events to a charge nurse. Behavioral techs do have the option to report incidents anonymously through the employee compliance hotline.