STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	493300	A. BUILDING ______ B. WING ______	C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HOSPITAL LLC	**9407 CUMBERLAND ROAD NEW KENT, VA 23124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Hospital Complaint Investigation survey was conducted May 30, 2017 through June 1, 2017 by two Medical Facilities Inspectors with the Virginia Department of Health's Office of Licensure and Certification. The survey process included: a review of Patient's Rights . Interviews were conducted . A review was conducted of closed and open records for a total sample of 6 patients (Patients #1-#6). Complaint #VA00037980, was investigated during the survey. The facility was found not not be in compliance with the requirements of 42 CFR 489, The Responsibilities of Medicare Participating Hospitals in Emergency Cases. The Complaint was substantiated with deficient practice.	A 000		
A 169	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on document review and interview it was determined the facility staff followed a PRN order to restrain one of six patients, Patient #3. The findings include:	A 169		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 169	Continued From page 1	A 169		

Continued From page 1

The medical record of Patient #3 was reviewed on May 30, 31 and June 1, 2017. A review of Patient #3's medical record revealed the following information:
Patient #3 was a 12 year old admitted on April 11, 2017 with the diagnoses of morbid obesity with pre-diabetes, asthma, edema both legs and mood disorder.

At approximately 22:16 (10:16 P.M.) on 5/5/17 Patient #3 removed personal belongings from his/her room and placed them in the community dayroom. Patient #3 pulled 2 chairs together to make a place to sleep and demanded the lights be turned out. When Patient #3's demands were not met Patient #3 attempted to turn the dayroom lights off. The staff intervened; Patient #3 became aggressive and threw a large trash can at a staff member. As staff members began to approach Patient #3, Patient #3 became more aggressive and was physically restrained. The physician was notified and a order was obtained to give Benadryl 50 mg (milligrams) IM (Intra muscularly). The physician also gave an order if the medication was not effective to use the stretcher and transport (Patient #3) to time out room.

At 10:38 P.M. Patient #3 was administered 50 mg of Benadryl IM. Patient #3 continued to struggle.

Patient #3 continued to be aggressive and at 11:01 P.M. and was placed on a stretcher.

On 5/31/17 at 10:30 a.m. and at 11:20 a.m. on 6/1/17 Staff Member #2 was interviewed. Staff Member #2 provided the following information:
"I was the acting supervisor and respond to

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A 169	Continued From page 2 codes. I contacted the physician and got the order for the medication and the physician gave an order to transport to time out if the medication was not effective. We (5 to 6 staff) used a sheet to place (Name of Patient #3) on the stretcher. We placed a strap across his/her chest like a child's car seat and one possibly across the thighs. I can't remember how many straps were on the stretcher. We don't use it very often. The staff still were holding him/her as we placed him/her on the stretcher with a person at each arm and each leg." On May 30 and 31, 2017 Staff Member #3 was interviewed and stated, "I reviewed the tape of the incident (tape was on a continuous loop and was automatically deleted at the end of 24 days (which was May 30, 2017), we thought it was kept for at least 30 days) but I could not see the patient's head to see if a towel was held above their head or not. It is our protocol that if a patient begins to spit we hold a towel above their head to block the spit but do not place it on their face. I was not able to see how his/her lip was injured. I could not see where he/she was taken after they left the unit. Initially he/she was standing but was taken to the floor and held by the staff. He/She was wrapped in a sheet and placed on the stretcher where there was a harness type strap placed across his/her chest, a strap across his/her thighs and one across their lower legs. The staff still place and keep their hands on the patient at all times when a patient is on the stretcher." Staff Member #1 was interviewed on 5/30, 31 and 6/1/17 several times and stated, "Unit #7 where he/she (Patient #3) resided does not have a seclusion room but it does have a time out room.	A 169		

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A 169	Continued From page 3 He/She never went to another unit because during the escort he/she calmed down and was able to comply with the staff request. He/She was never placed in time out or seclusion room and at 11:16 P.M. returned to Unit #7 and was no longer restrained."	A 169		