

9407 CUMBERLAND ROAD · NEW KENT, VIRGINIA 23124 (800) 368-3472

January 15, 2021

Douglas Middlebrooks, Ph.D.
Acute Care Supervisor
Commonwealth of Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233

Dear Dr. Middlebrooks,

Please find the three attached CMS-2567 forms submitted by Cumberland Hospital for Children and Adolescents. The three forms address the Condition Level Findings resulting from the unannounced complaint survey conducted on 12/29/20, the Condition Level Findings resulting from the Immediate Jeopardy abatement survey on 12/29/20, and the Condition Level Findings resulting from the unannounced complaint survey conducted on 12/9/20 by the Office of Licensure and Certification. We feel that the plans contained show a commitment to addressing the identified deficiencies with a combination of urgency and sustainability. Cumberland Hospital remains dedicated to providing quality, safe care for our patients, and we are committed to demonstrating continuous quality improvement. The corrective actions detailed within will show robust actions designed to ensure that our dedication and commitment are realized resulting in high level patient care.

Sincerely,

Garrett Hamilton
Chief Executive Officer

Cumberland Hospital for Children and Adolescents

RECEIVED
JAN 2 7 2021
VDHVOLC

PRINTED: 01/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		493300	B. WING		C 12/29/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9407 CUMBERLAND ROAD NEW KENT, VA 23124	12/20/2020	
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A 263	survey was conducted 12/29/2020 by two (2) Inspectors from Virgin Office of Licensure and Complaint #VA00050 found to be substantic compliance with 42 Compliance wit	dicare/Medicaid complaint d 12/28/2020 through) Medical Facilities hia Department of Health, hid Certification. 309 was investigated and lated. The facility was not in EFR Part 482: Conditions of hitals (last updated February ciency was cited: Participation: Quality formance Improvement velop, implement and language on the complete of the comp	A 26	regulations. The facility also reserves right to amend the Plan of Correction necessary and to contest the deficient findings, conclusions, and actions of the second seco	the sthe as cies, the all the architering the	
	The hospital must ma	aintain and demonstrate		VDHV	DLC	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	- Lo	TITLE	(X6) DATE	
	11 1			CEO	1/15/2021	

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.

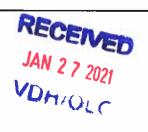
FORM CMS-2567(02-99) Previous Versions Obsolete

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A 263		program for review by CMS.	A 26	3	
A 286	Based on clinical recofacility document revice complaint investigation facility failed to ensure Performance Improve effectively monitoring concerns thus failing this condition. The findings include: The facility has an out deficiency related to the survey findings for converted to the survey findings fo	of for further information. (2), (e)(3) m Scope t include, but not be limited that shows measurable ators for which there is identify and reduce medical measure, analyze, and track ents covernent activities must track	A 28	Plan of Correction Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys Incident Investigation • A new Risk Manager with previou management experience in Virgin began employment on 11-30-202 • The Corporate Director of Risk Management and Corporate Divis Director of Clinical Services provieducation and training to the Hos Director of Risk Management on reviewing,	nia 20. sional ided
	adverse patient eve (c) Program Activities (2) Performance imp	ents		Director of Clinical Services provi education and training to the Hos Director of Risk Management on	ided

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NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EA	(X5) COMPLETION	
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TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
					reconciling, investigating, and reporting	ia	
A 286	Continued From page	2	A:	286	incidents, and on developing plans to	•	
	their causes, and imp	lement preventive actions			prevent future recurrences. The Direct	tor of	
		include feedback and			Risk Management was also provided	,	
	learning throughout th	ne hospital.			guidelines for timeliness of completion investigations and corrective actions.	1 OT	
		·			Understanding of expectations laid out	it in	
	(e) Executive Respon	sibilities, The hospital's			training was verified by question and	`'''	
	governing body (or or	ganized group or individual			answer and signed attestation.		
	who assumes full lega	al authority and responsibility			•		
	for operations of the h	nospital), medical staff, and			 In order to strengthen and standa 		
	administrative officials	s are responsible and			the investigation and improvement		
	accountable for ensu	ring the following:			process, the Chief Executive Office and the Director of Risk Manager	cer nont	
	(3) That clear expect	ations for safety are			in collaboration with the Director		
	established.				Human Resources, Corporate Di		
	This STANDARD is r	not met as evidenced by:			of Risk Management, and Corpor	ate	
	Based on interviews,	record reviews and during			Divisional Director of Clinical Sen		
	the course of a comp	laint investigation, it was			developed a new procedure for the	ie	
	determined the facility	y failed to thoroughly			management, reporting, and investigation of abuse/neglect		
	investigate and reviev	w an allegation they received			incidents. This process was adde	ed to	
	related to patient abu	se.			the Abuse and Neglect Reporting		
					and includes the following steps:		
	The findings include:				o Immediate placement of		
					involved on administrativ		
		urveyor received a document			teave pending results of investigation		
		ent Investigation 12/4/2020.			o Notification of the emplo	vee's	
		reference to a complaint			supervisor, Director of R		
	_	eyor was conducting. The			Management, and the		
		e allegation received by the			Administrator on Call		
	facility, the investigati				o Completion of thorough		
	· ·	ollow up action. Staff Member			investigation of allegatio the employee's supervis		
	(SM) #4 (Director of F	•			Director of Risk Manage		
		ncluded interviewing the			 Review of the investigat 		
		f the alleged abuse, two			results by the supervisor	r, [
		and a review of camera			Director of Risk Manage		
	_	nt read in part: "Conclusion:			Chief Executive Officer,		
		ce and statements above this			Director of Human Reso to determine the approp		
	allegation has been for	ound to be false."			actions to be taken, if ar		
	O= 42/20/2020 4b = -				assorts to be taken, if at	.J.	
	On 12/28/2020, the s	urveyor reviewed the clinical	1				

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A 286	record for Patient #2. progress note was wr Tech.) documenting to incident that occurred #8 (Registered Nurse) progress note was wr Nurse) documenting the incident that occu SM #8. On 12/2/2020 contained evidence th Pediatric Nurse Pract incident involving Pat Patient #2 that "a nur access [the nurse's] p has been escalated to [Chief Nursing Officer An interview was con SM #6 (Corporate rep #4 explained the inver reviewing the record occurred to the record of	on 12/1/2020 at 2200, a ritten by SM #11 (Behavioral heir eyewitness account of an between Patient #2 and SM e). On 12/1/2020 at 2240, a ritten by SM #9 (Registered their eyewitness account of their	A 28	The revised policy was approve the Medical Executive Committ the Governing Board. • Each department head or supe provided retraining to their emp on expectations for reporting of incidents through the appropria channels. For those not able to complete remote data entry into electronic system (only Nurses Nursing Supervisors), expectat reporting to their immediate sup and nursing leader on duty wer included. Education was provic group and individual sessions of opportunity for discussion and clarification to assure understat expectations, which was verifie signed attestation. • The Director of Risk Management provided education to the leade team in group and individual se on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator of (AOC) staff and Nursing Super- were also educated concerning management and reporting pro to follow when they are coverin shifts and weekends. Understat of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incident with the Chief Nursing Officer. Chief Nursing Officer/designee the Nursing Supervisor Report morning "flash" meeting and ide the supervisor Report morning "flash" meeting and ide	rvisor loyees te o the and ions for pervisor e ded in with ading of d by ent ership essions e on Call visors the cedure g off- anding d ent es daily The reviews in the	

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r v v s c c n F s c c 1 " r r r r r r r r r r r r r r r r r r	Additionally, a review had not been conduct eadership staff prior to 12/29/2020, the surve regarding the internal with SM #2 (Chief Op SM #2, SM #4, and Sconcerns and discuss making moving forward prior to the exit confers are to the exit confers are prior to the exit confers are provided document titled, "Risk 12/4/2020". The d	r additional information. of the investigation results ted by any member of the to 12/28/2020. On tryors discussed the concerns investigation of the allegation terating Officer), #4, and #6. M #6 acknowledged the ted the changes the facility is trd. Tence on 12/29/2020, the d an amended copy of the Management Investigation	A 286	incidents from the past 24 hours. Director of Risk Management compares the incidents reported i "flash" meeting with those submitt through the electronic incident reporting system by the nursing si assure that all incidents are enter investigation. The Director of Risk Management reviews video on all serious incide Results of the video review, includ any inappropriate staff behaviors, reported to the employee's manag appropriate Senior Leader, and the Chief Executive Officer. Staff rec appropriate corrective action base the results of the investigation. Incident Reporting Dual Reporting of Incidents: The Executive Officer is committed to frequent communication with the s (Virginia Department of Health or regarding incidents and results of investigations at Cumberland Hos The hospital's previous process followed the minimum requirement report such information to the local social services agency, which the turn was responsible for reporting VDH. In order to assure that VDH aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadershi implemented a new dual reporting process to notify both the local so services agency and VDH as the regulatory agency with deemed oversight of the facility's complian with CMS Conditions of Participat	n the sed taff to ed for tents. ding are ger, se seive ed on Chief more state VDH) spital. at to al n in to d is e ip grid is state ce ion.	



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		A 286	incidents to the local Social Servagency and to VDH as the Reguloversight agency, assuring that incident reporting is consistent, and contains evidence of a compinternal investigation with disposifindings (if any), evidence of state compliance, and corrective action taken, as applicable. The facility established this process during a planning meeting with the Direct Quality, Director of Risk Manage Chief Operating Officer and Chie Executive Officer on 12/8/2020. Ongoing Oversight The leadership team formed a Performance Improvement Executive Committee to provide oversight facility's internal quality improve initiatives, including but not limite the immediate improvement initiated the number of serious indirectly involving patient care statemployed by the facility. The initial members of the Perform Improvement Executive Committed Cumberland's Chief Executive Committed Cumberland's Chief Executive Composition of Policier, Director of Quality, Director of Quality, Director of Clinical Services. The addition of Divisional Director of Clinical Services. The addition of Divisional Director of Clinical Services on regulatory matters include the facility's sustained compliance with CMS Conditions Participation.	imely blete sition, andards ans / a cor of ament, af a cor of ament, af a cor of ament and to, attive to cidents aff armance are afficer, arating attor of a cor of a	

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			A 2		included review and discussion of compliance rates with direct care straining requirements, remedial traineeds, scheduling of external train resources if needed, the current strain of internal investigations, corrective actions taken as a result of substantiated investigations, monit of corrective action plans, and state external reporting requirements as applicable. The activities of the Performance Improvement Executive Committee summarized, and the Chief Opera Officer reports this summary to the facility's Governing Board as an agenda item at the Board's month scheduled meetings. This commit will be functional for a period of at four (4) months or longer, if neces until the QAPI process at Cumberl Hospital is well established and his functional. Focused Mock Surveys: As additing reinforcement of the core team's commitment to correcting repeated quality concerns within the facility, core team resolved to engage the Corporate Divisional Director of CI Services to perform quarterly modes surveys at the facility for a period one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting the areas of concern cited in this deficiency statement. The first mosurvey will be done in the 1st Quarcalendar year 2021. The Director's findings and observations will be communicated to the Performance Improvement Executive Committee	staff aining hing hing tatus re itoring tus of s re are ting re least sary, land ghly fonal d the linical k of g with bock ter of s	

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			A 286	an action-item report. The report be reviewed during the weekly me until the identified deficiencies are corrected. The facility will further include a plan for sustainability in response to corrective actions take. Additional Actions taken following to 12/29/20 survey: Oversight: The Corporate Director Nursing, and the Corporate Vice President and Senior Vice Preside Cumberland Hospital have been a to Performance Improvement Executive Committee. The ongoin agendas for this committee includ overall functioning of the QAPI property as well as ongoing review of the effectiveness of this plan of corrective External Review of Conditions of Participation: Cumberland Hospit underwent an external review in the form of a 4-day survey performed Joint Commission Resources Incorporated. The review took plat January 4-8, 2021. The focus of the survey was compliance with the composition of Participation. The review took plat January 4-8, 2021. The focus of the Sconditions of Participation. The review took plat January 4-8, 2021. The focus of the Survey was compliance with the composition of Participation. The review took plat January 4-8, 2021. The focus of the Survey was compliance with the composition of Participation. The review took plat January 4-8, 2021. The focus of the Survey was compliance with the composition of Participation. The review took plat January 4-8, 2021. The focus of the Performance Improvement Execution Committee, and an action plan to address any deficiencies noted with developed. The report and action will be a standing agenda item on Performance Improvement Execution Performance Improvement Execu	eeting een. the or of ent for added ng e the ogram ction. al ne by ace he ited Upon t ing tive ll be plan the tive view		

ı	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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			AZ	Executive Committee will in turn progress, variances, and compliate the Governing Board at its month meetings. Based on recurrent complaints we the hospital, it was determined the Quality Program should undergo revision. The Chief Operating Or and the Corporate Director of Cli Services consulted the Corporate President of Performance Improves to obtain and implement a new a more rigorous program that could implemented at Cumberland Hose The new program addresses the to identify, track, and monitor advection plan is implemented to show improvement in identified areas. new program incorporates previous action plan items that require atteand development of a robust and sustainable plan to correct identificate and development of a robust and sustainable plan to correct identificate and prevent repeated occurrences was implemented. The Corporate Vice President of Performance Improvement provious training to the Cumberland leade team concerning QAPI. The goal training was to improve the known base and competency of Cumberleadership regarding a rigorous a sustainable program. Training we conducted virtually over zoom, and training information was provided facility. Training was completed facility. Training was completed facility. Training was completed facility. Training Officer	ithin lat the	

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			A 2	Summary of Ongoing Naserious incidents such as diversions and incidents neglect. The Director of sends the report from the tracking system daily to the Manager and Corporate Services for review. Time thoroughness of incident investigation/action plant in the instance where the reports or action planning development, the Director Management is contacted action. This process will least 4 months. Incident with incident reporting ar will be reported to the Chrofficer and the Corporate President. Data is aggregate to the Performance Important Committee weekly, and in Medical Executive Committee Governing Board.	aggement tracks is medication of abuse and Risk Management is electronic incident the Corporate Risk Director of Clinical reliness and in ming is assessed and reported to take further or of Risk is of noncompliance and investigations hief Executive is Regional Vice gated and reported overment Executive monthly to the		

PRINTED: 12/15/2020 **FORM APPROVED** OMB NO. 0938-0391

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A 000	An unannounced Me survey was conducted 12/9/2020 by three (3) Inspectors (MFI's) fround Certification (OL Health (VDH). The fawith 42 CFR Part 48: Participation for Host During the investigat Jeopardy was identified Areas of concern ided 482.12 of Participation 482.13 Participation 482.13 Participation 482.13(c)(2) in a Safe setting 482.13(c)(3) from Abuse 482.21 Participation 482.21 Participation 482.23 of Participation 482.23 of Participation 482.23 (b)(6) -Adhere to Policies and 482.23(c)(1),(c)(1)(i) Medication Administration 482.25 Condition of Participation 482.25 Complaint #VA00050	edicare/Medicaid complaint ed 11/30/2020 through 3) Medical Facilities om the Office of Licensure C), Virginia Department of cellity was not in compliance 2 for the Conditions of pitals. ion a finding of Immediate ied at 482.13 Patient Rights. Intified included the following: Governing Body - Condition Patient Rights- Care Patient Rights-Care Patient Rights-Free QAPI - Condition of Nursing Services - Condition Nursing Services Ind Procedures Ind Condition Services Ind Procedures Ind Procedures Ind Procedures Ind Pharmaceutical Services Ind Pharmaceutical	AOC	By submitting this Plan of Correct does not admit that it violated the The facility also reserves the righ Plan of Correction as necessary at the deficiencies, findings, conclus actions of the agency.	regulations. t to amend the and to contest		
ABODATODY		NTIATED with deficient SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(VG) DATE	
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FORM CMS-2567(02-99) Previous Versions

Event ID:5F9P11

Facility ID: VA0528

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A 000	Continued From page practice at the conditi		A 000			
A 043	As of 12/9/2020, the f Immediate Jeopardy of acceptable plan of rei GOVERNING BODY	due to failure to present an	A 043			
A 043	CFR(s): 482.12 There must be an effelegally responsible for If a hospital does not governing body, the pfor the conduct of the functions specified in governing body This CONDITION is a Based on complaint summediate Jeopardy, did not provide oversithe protection of the sfailing to substantially. The findings include: A finding of Immediate 12/1/2020 regarding parafe setting and protection of the facility which could have resultant or death to the pfacility failed to follow for the investigation or reported, thus allowing the substantial patients of the facility failed to follow for the investigation or reported, thus allowing the substantial patients of the facility failed to follow for the investigation or reported, thus allowing the substantial patients of the facility failed to follow for the investigation or reported, thus allowing the substantial patients of the facility failed to follow for the investigation or reported, thus allowing the substantial patients of the facility failed to follow for the investigation or reported, thus allowing the substantial patients of the facility failed to follow for the investigation or reported, thus allowing the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients of the facility which could have result the substantial patients o	hospital must carry out the this part that pertain to the mot met as evidenced by: survey findings of the facility Governing Body ght of the hospital to ensure afety of all patients thus comply with this condition.	A 043	The Governing Board directed the CEO an Leadership group to take all corrective actineeded to address findings. The Governing Board is meeting on a monthly basis for at four months to receive reports of corrective actions and effectiveness of those actions I upon monitoring data. Please refer to the following for detailed actions and the following for detailed actions and the following for detailed actions are refer to the following for detailed action 40145- Patient Rights- Condition of Participation A0145- Patient Rights- Free from Abuse A0263- QAPI - Condition of Participation A0286- QAPI- Patient Safety A0385- Nursing Services- Condition of Participation A0398- Nursing Services- Nurses must additionally Policies and Procedures A0405- Nursing Services - Medication Administration - Basic Safe Practices A0489- Pharmaceutical Services Condition Participation A0502- Secure Storage of Medications Person Responsible Chief Executive Officer	ons ng least based tions: pation ng	01/29/2021

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND HOSPITAL LLC			STR 940	EET ADDRESS, CITY, STATE, ZIP CODE 7 CUMBERLAND ROAD W KENT, VA 23124	12/09/2020	
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A 043	unlocked medication put into place a plan promote patient safe. On 12/1/2020, a Starby the arms and "she and began yelling at investigated and and however the facility becomplaints concerning patients by staff. The although may have be by the facility, demorregarding systemic facility has failed to protection of patients facility in recognizing establish sustainable of these concerns. See the following tage A0115- Patient Right-finding of Immediate A0144- Patient Right-finding of Immediate A0145- Patient rights A0263- QAPI- Patient A0385- Nursing Sen Participation A0398- Nursing Sen Administration - Bas A0489- Pharmaceuti Participation A0502- Secure Store	is cart. The facility failed to to prevent recurrence and ty. If Member grabbed a patient oved" the patient into a chair the patient. The facility addressed the concern, has experienced multiple and allegations of abuse of ese allegations, which been identified and addressed a recurring concern allure of the facility regarding and ensuring the facility and ensuring the facility and ensuring the facility and ensuring the facility are plans to prevent recurrence as: Is- Condition of Participation as Safe Setting and Ensuring the facility are plans to prevent recurrence as: Is- Condition of Participation of Par	A 043	RECEIVED JAN 2 7 2021 VDHVOLC		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE: COMPI	
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A 115	Immediate Jeopardy 12:20 p.m. After revi Centers for Medicare the State Agency, the unacceptable and the Immediate Jeopardy p.m. The facility Lea 2, 3, 4, 8 and #13- Co Regulatory Director) the plan not being acc Jeopardy remaining in PATIENT RIGHTS CFR(s): 482.13 A hospital must prote patient's rights. This CONDITION is Based on complaint s Immediate Jeopardy, ensure the protection safe environment and abuse thus failing to s condition. The findings include: It was reported two punlocked medication Lamactil (Lamotrigine stabilizer medication) some of the medication 10/31/2020. It was reon 11/01/2020. The finivestigation and put reoccurrence. On 11 were again able to accept the stability of the medication and put reoccurrence. On 11 were again able to accept the stability of the stability o	findings on 12/9/2020 at ew and consideration by the e and Medicaid Services and e plan was determined to be a facility remained in as of 12/9/2020 at 3:00 adership (Staff Members #1, orporate Regional were notified at that time of cepted and the Immediate in effect. In the facility staff did not in of the patients rights to a did to be free from all forms of substantially comply with this eatients having access to an eart, taking the medication e/Lamactil is a mood and crushing and "snorting" on. This occurred on eported by Patient #1 and #2 facility failed to conduct a full a plan in place to prevent a /4/2020, Patient #1 and #2		115	Hospital leadership reviewed the incidents aprocesses cited in the CMS 2567, revised procedures and processes to address the incidents, educated staff, and implemented monitoring to verify ongoing compliance wit rules. Leadership reports audit results to the relevant hospital committees and the Board Please refer to the following for details: A0144 and A0145	h the	01/29/2021

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A 115	as was documented was no evidence the this issue until 11/6 investigation was conterviewed by the stregarding the allegation and stated the allegations are interviewed. It was reported a stream as the patient by the arms a chair and yelled a con 12/1/2020. The member immediate An investigation of and determined it to staff member was to presented the surveinservices conducted which the event occurs which the event occurs and 12/4/2020. Inservices were doon 12/4/2020.	d-[quetiapine] is an cine.) and crush the ing to "snort" the medication of in the clinical records. There is facility had begun to address /2020 and no formal/full conducted. Patient #1 was surveyor on 12/1/2020 ation of taking the medications gations were true. Patient #2 ding at the facility and could not aff member "grabbed" a sand "shoved" the patient into at the patient. This occurred facility suspended the staffely pending the investigation. The allegation was completed to be substantiated and the erminated. The facility ey team with evidence of ed with staff of the Unit on curred. The inservices were and Abuse and Neglect". Cumented as being conducted exices were then conducted estaff on 12/4, 12/5, 12/6, 12/7, 12.6. Secussed with facility staff of #3 through out the survey ding multiple complaints the agency of ongoing patient use. The survey team facility leadership these strate a systematic problem	A 115		
		n plans previously developed, and immediacy for the facility to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
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A 115	review their system and sustainable pla prevent recurrence. The facility present Immediate Jeopard 12:20 p.m. After recenters for Medicathe State Agency, the State Agency, the State Agency of Unacceptable and the Immediate Jeopard p.m The facility Let 2, 3, 4, 8 and #13-6 Regulatory Director	in order to develop robust ins to correct the concerns and and a plan of removal for the y findings on 12/9/2020 at view and consideration by the re and Medicaid Services and the plan was determined to be the facility remained in y as of 12/9/2020 at 3:00 readership (Staff Members #1, Corporate Regional) were notified at that time of accepted and the Immediate	A 115		
A 144	PATIENT RIGHTS: CFR(s): 482.13(c)(2) The patient has the setting. This STANDARD is Based on patient in clinical record revie and during the cour investigation, it was failed to ensure each safe setting. This is patient residing at the setting of	right to receive care in a safe s not met as evidenced by: nterview, staff interview, w, review of facility documents se of a complaint determined the facility staff ch patient received care in a had the potential to affect every he facility.	A 144	Initial Plan of Correction based on 11/and 12/9/20 surveys Medication Security The Chief Nursing Officer educated nurses on expectations for safe stored medication carts, keeping carts lock times, reporting when a cart is foun unlocked or not secured, securing the temperature probes, and securing the medication carts whenever codes a prior to responding to the code. Edwas provided via electronic training (Healthstream) with competency vertesting. The Chief Nursing Officer than different and verified that all nurses received training.	all rage of ked at all d f f f f re called ucation system wrified via cracked t the
	unlocked medication	n cart on two occasions		The Chief Nursing Officer and Direct Pharmacy reviewed and revised the	

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on 11/4/2020, crushin intent of "snorting" the self reported they had After the first report, to investigate and put a reoccurrence. There is put in place to protect future occurrence after Patient #1 was admitted the clinical record was Nurse) Assessment" "11/1/2020 2000 (8:00 snorting crushed med med cart on 10/21/20 (4:00 a.m.) it was does observed acting strancheck (every fifteen made was attempting to hid white substance that a became agitated whe eventually stated that med cart Supervisor situation" A "Medica 11/2/2020 evidenced, to staff yesterday that medications covertly to behavioral code was a along with another pathave crushed and inhis unclear what medications take place to claims" On 11/4/20 "Medical Progress No staff found (patient) we	in 10/31/2020 and Seroquel ing the medications with the elemedications. The patients of taken the medications. The patients in place to prevent was no investigation or plan at the patients and prevent er the second report as well. The de 8/24/2020. Contained in some a "Daily RN (Registered note which documented, D.p.m.) Patient admitted to als taken by peer from unit 20" On 11/4/2020 at 0400 cumented, "Patient was age during routine Q15 initute checks). Pt (patient) appeared crushed. Pt in staff confiscatedPt (patient) got Seroquel off of (name) aware of all Progress Note" dated in part: "(patient) reported	A 144	and Procedure for reconciling medic when a cart is found unlocked or no secured, or when there is a suspicion medications are missing. The proce enhanced as follows: The manager observing the issue through leaders rounds or random checks secures the medication cart, completes an incidereport, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. It observation of noncompliance is maduring off-hours, the nursing supervious notifies the pharmacist on call, and a pharmacist performs a reconciliation medication cart observed at the begetheir next in-person shift. The revised policy was approved by the I Executive Committee and Governing Boates and the cart in the cart with the cart is found unlocked or not set the cart is found unlocked or not set the cart is found unlocked or not set the cart is found unlocked on 1:1 basis opportunity for discussion and clarification is reported or otherwise determined to be missing. Education provided on a 1:1 basis with unders of expectations verified by question answer and written attestation. The Chief Nursing Officer incorporate ducation regarding expectations for medication carts, securing temperate probes, locking the carts prior to rest to codes, and the medication cart reconciliation process into New Emporentation and annual nursing and pharmacy orientation.	ton that ess was hip ne ent o f an ide isor a n of the inning of Medical ard. all ss for if the nenever cured. with cation to ns. the ess to d, or a n was tanding and ted the r locking ure ponding bloyee

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A 144	confiscated from (patitaking place" Patient #2 was admitt clinical record docume suicidal precautions. revealed a note dated p.m.) which document admitted taking crush-10/31/2020 and snorth Note" dated 11/2/2020 (patient) reported to simedications from a cate Afterwards (patient) clinhaled them with ano documentation provided on 11/6/2020 "the patitipossession of contrab (patient) turned in a portion of the interports. The survey team required documentation of the interports. On 11/30/2020 at appine Member #1 (Quality) sile that (Staff Member #4 Dabout this. (Staff Member #4 Dabout this. (Staff Member #4 With documentation with ad been filed and "Pl findings of investigation"	ent)an investigation is ed on 02/06/2020. The ented the Patient was on Review of the clinical record 11/1/2020 at 2000 (8:00 ted, "(Patient name) ed meds from cart ng" A "Medical Progress Devidenced, " Yesterday taff that (patient) stole at on 10/31/2020. aims to have crushed and ther peer" Further ed by the facility evidenced ent reported (patient) was in and (medication) and bowder substance to a small plastic bag with probes that appeared to empt to snort the ested the facility provide investigation into both these roximately 12:15 p.m., Staff stated, "We cannot find any aff- former Risk Manager) Director of Nursing) had aber #7) no longer works at provided the survey team nat evidenced the report an of action pending n". Staff Member #1 and efficer) also provided the	A 144	revised the Observation Rounds Audi for Unit Coordinators (Nurse Manager Nursing Supervisors to check that the medication carts are locked and secur including during code response, and temperature probes are secure. This is done once per shift by the Unit Coordinator (Nurse Manager) and/or thursing Supervisors. Occurrences of unlocked or improperly secured medic carts require immediate action by the manager performing the observation. Actions include securing the cart, identhe staff responsible for the error, initic corrective action for the staff responsithe cart at the time of observation, completing an incident report, and not the pharmacist that a prompt reconcilineds to be completed. The Chief Nursing Officer educated the Coordinators and Nursing Supervisors concerning the enhanced audits, their audit tool, corrective actions for staff responsible for the cart when policy is followed, and the incident reporting expectation to ensure a thorough investigation is completed. This educations cocurred 1:1 with understanding of expectations verified by question and answer and signed attestation. Incident Investigation A new Risk Manager with previous risk management experience in Virginia be employment on 11-30-2020. The Corporate Director of Risk Manager on reviewing, reconciling, investigating reporting incidents, and on developing to prevent future recurrences. The Director of Risk Manager on reviewing, reconciling, investigating reporting incidents, and on developing to prevent future recurrences. The Directors of Risk Manager on reviewing for timeliness of completion investigations and corrective actions. Understanding of expectations laid out training was verified by question and an additional developing to prevent future recurrences.	red, hat audit the cation attifying atting ble for ifying attion be Unit sevised not attion k egan ement dinical ing to nent g, and plans rector d of t in

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A 144	leadership staff which the October 31 repor Staff Member #7 wro "immediate action to nursing staff failing to procedure for locking carts" There was dethe facility had made "rounds sheet" on 11. Cart is secure" was a According to Staff Meround on the units at utilize this document According to these "a carts were found unkton 11/3, 11/4, 11/5, and documentation that the on 11/5, 11/9, 11/10, that "Medication Cart discussed. On 11/30/2020 at 2:3 interviewed Patient # patients therapist (St stated, "I know why y talked tothe person her name was (name about it" The surv had taken the medicasure did. I stole the pyes I did it twice. I to then another time I to a code going on the twatching and I took to med cart"stole" is a pills from my drawer. medicationsI was genot them" The survenced them" The survenced them" The survenced cart	in discussed the allegation for it. In one of the documents, ite on November 2 that be taken in regards to ofollow the established and securing medication ocumentation presented that an adjustment to their /3/2020 and that "Medication idded to this document. It is an adjustment in the discrete form of the first in the presence of the aff Member #1, Leadership staff least "once a shift" and during those rounds. It is an adjustment in the medication ocked on various units on 11/6/2020. There was mere were "Staff Meetings" and 11/11/2020 with a note is being locked" was 10 p.m., the surveyor in the presence of the aff Member #5). Patient #1 four here. I figured I'd be a from Social Services, I think in the presence of the aff Member #5). Patient #1 four here. Patient #1 if they ations. Patient #1 stated, "I oills Seroquel and Lamactil. There was not the seroquel. There was	A 14	 In order to strengthen and standardi investigation and improvement proce. Chief Executive Officer and the Dire Risk Management, in collaboration of Director of Human Resources, Corp Director of Risk Management, and Corporate Divisional Director of Clin Services, developed a new procedu the management, reporting, and investigation of abuse/neglect incide This process was added to the Abus Neglect Reporting policy and include following steps: Immediate placement of staff in on administrative leave pending of investigation Notification of the employee's supervisor, Director of Risk Management, and the Adminis Call Completion of thorough investigaligns by the employee's supervisor and Director of Risk Management Review of the investigation rest he supervisor, Director of Risk Management, Chief Executive and Director of Human Resour determine the appropriate action be taken, if any. The revised policy was approved by Medical Executive Committee and the Governing Board. Each department head or supervisor provided retraining to their employee expectations for reporting of incidenthrough the appropriate channels. If those not able to complete remote dentry into the electronic system (only Nurses and Nursing Supervisors), expectations for reporting to their im supervisor and nursing leader on duincluded. Education was provided in and individual sessions with opportudiscussion and clarification to assurunderstanding of expectations, which verified by signed attestation. 	ess, the ctor of with the orate ical re for ents. See and es the envolved gresults trator on gation of utts by Officer, ces to ons to the ene ene en

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A 144	(patient) about what and inquired as to wind Member #7- Risk Ma "Yes I know (name or no one talked to me operson and you now. Patient #2 if (the patiabout the report; and Ma'am. I am telling to the pills both times. It trying to do better. It was a fine to a level III and this review that did not show that did not show the timeline and finding and expressed concern the total expressed concer	(the patient) had admitted to nether Patient #2 knew (Staff nager). Patient #2 stated, if Staff Member #7) and No; except the social services" The surveyor asked ent) was telling the truth Patient #2 stated, "Yes he truth. I did indeed take wish I hadn't, but I did. I am know it was wrong" documentation provided by nat Staff Member #7 had not dated November 10, (from 11/4/2020) "did not rise was prior to the camera now the patient accessing the original powdery substance all dust" a.m., the surveyor reviewed ags with Staff Member #1 from regarding the lack of rvention for both reports of ken. The surveyor nat once reported on no plan put in place to eand on 11/4/2020 it was ee patient had gotten unlocked medication cart. Incussed the concerns that	A 144	The Director of Risk Management proeducation to the leadership team in gand individual sessions on the revise procedure for the management, reportant investigation of abuse/neglect allegations. The Administrator on Calstaff and Nursing Supervisors were a educated concerning the management reporting procedure to follow when the covering off-shifts and weekends. Understanding of expectations was viby question and answer and signed attestation. The Director of Risk Management revand reconciles incidents daily with the Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flameeting and identifies incidents from past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with the submitted through the electronic incidence reporting system by the nursing staff assure that all incidents are entered finestigation. The Director of Risk Management revolded on all serious incidents. Result video review, including any inappropriated behaviors, are reported to the employee's manager, appropriate Set Leader, and the Chief Executive Office Staff receive appropriate corrective activated to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is committed to more than the chief executive Officer is commit	roup d ring, I (AOC) lso nt and ey are erified riews e Chief sh" the ose ent to or liews s of the late into er. etion on.	
	the time of either report medications were mis substance was truly of medications.	oncile medication carts at ort to determine whether ssing and whether the lrywall dust or crushed a.m., the survey team, after		frequent communication with the state (Virginia Department of Health or VDH regarding incidents and results of investigations at Cumberland Hospita hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was response	l. The he	

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l .		ROVIDER OR SUPPLIER			9407	ET ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND ROAD V KENT, VA 23124	114	2/09/2020
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	A 144	reviewing Appendix C Supervisory Staff of the Immediate Jeopardy. Centers for Medicare (CMS). On 12/1/2020 Leadership (Staff Mem Member #1- Quality, and Staff Member #4 notified of the finding a plan of removal was At 12:30 p.m., on 12/c conducted a follow-up (Staff Member #5) of #5 stated, "(Patient#1 (patient) shared with a that was shared with another peer, and this of characterI can't should be possible for The survey team interpharmacist on 12/1/2 Member #6 stated, "T filled on Tuesday and report that tells us how in each cart for each (look at the contents of was a crushed substamedications, it had a ford drawer it came from, the drawers" When ask reconciled the cart at stated, "No. That's a to look through." Whe	notified the State Agency he findings/concerns for The SA consulted the and Medicaid Services of at 10:17 a.m., the facility mber #3- CEO, Staff Staff Member #2- COO, Chief Nursing Officer) were of Immediate Jeopardy and as requested. 1/2020, the surveyor of interview with the therapist Patient #1. Staff Member) is not very reliable, but me the same information you(patient) would protect ent) would take go it and not "snitch" on as behavior would not be out easy whether its true or not, ne thing you were and it	A		for reporting to VDH. In order to as VDH is aware of serious incidents a details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting to notify both the local social service agency and VDH as the state regul agency with deemed oversight of the facility's compliance with CMS Con Participation. The Director of Risk Management is responsible for reporting serious into the local Social Services agency and as the Regulatory Oversight agency assuring that incident reporting is continuously and contains evidence of a content investigation with disposition findings (if any), evidence of standard compliance, and corrective actions applicable. The facility established process during a planning meeting Director of Quality, Director of Risk Management, Chief Operating Office Chief Executive Officer on 12/8/2020 Ongoing Oversight The leadership team formed a Performational Improvement Executive Committee provide oversight of the facility's into quality improvement initiatives, including improvement initiatives, including the initial members of the Performational Improvement Executive Committee Cumberland's Chief Executive Officer Medical Officer, Chief Operating Officer Medical Officer, Chief Deprating Officer Divisional Director of Clinical Service addition of the Divisional Director of Services on the committee provides expertise on regulatory matters to in the facility's sustained compliance we Conditions of Participation.	and the process es atory he ditions of s cidents to hid to VDH y, onsistent, omplete hi, urds taken, as this with the her and commance to ernal uding but rement erious are staff ance are ser, Chief ficer, and eses. The control	RECE, JAN 27 2021

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A 144	the staff member staff look at the crushed signature of the facing as follows: A0115 Patient Rights Conditional Findingone or more federal his regulations. PLAN O Cumberland Hospital jeopardy finding in 12 actions as stated to confinding under CMS Conditional Finding in 12 actions as stated to confinding under CMS Conditional Finding in 12 actions as stated to confinding under CMS Conditional Finding in 12 actions as stated to confinding under CMS Conditional Finding in 12 actions as stated to confinding under CMS Conditional Finding in 12 actions as stated to confinding under CMS Conditional Finding in 12 actions as stated to confind the finding under CMS Conditional Finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as stated to confind the finding in 12 actions as follows:	ed they were only asked to ubstance on one occasion. ed, "The tech who fills the ny doses missing and we a patient missed a dose of p.m., a plan of removal was lity. The plan of removal was called to meet realth, safety and/or Quality of CORRECTION—will correct the immediate production of Participation tag sponsible DISCUSSION—IBLE: Chief Nursing Officer 12-1-20. A144 PATIENT SAFE SETTING—Observed: a unlocked on unit 6B less to medications. A unlocked cart on tow 0/31/2020 and 11/4/2020. In in place after becoming lent; this allowed lent shared medication with was on suicide precautions. It a serious adverse a serious adverse outcome the identified ows: the patients were put	A 14	 The committee meets on a week! The initial meeting agenda include and discussion of compliance rate direct care staff training requirement remedial training needs, scheduling external training resources if need current status of internal investigations, mon corrective actions taken as a resusubstantiated investigations, mon corrective action plans, and status external reporting requirements as applicable. The activities of the Performance Improvement Executive Committee summarized, and the Chief Opera Officer reports this summary to the Governing Board as an agenda its Board's monthly scheduled meeting committee will be functional for a at least four (4) months or longer, necessary, until the QAPI process Cumberland Hospital is well establishingly functional. Focused Mock Surveys: As additing reinforcement of the core team's commitment to correcting repeate concerns within the facility, the coresolved to engage the Corporate Director of Clinical Services to per quarterly mock surveys at the facility focus on assessing the compliance with CMS Conditions. Participation, starting with the area concern cited in this deficiency sta. The first mock survey will be done Quarter of calendar year 2021. The Director's findings and observation communicated to the Performance Improvement Executive Committe action-item report. The report will reviewed during the weekly meeting identified deficiencies are corrected facility will further include a plan for sustainability in response to corrected actions taken. 	d review s with some some some some some some some some		

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A 144	maintain safety and por death. PLAN OF Conurses were inserviced storage, safety and ket times by the Assistant immediately upon recipeopardy notification. for shifts this evening with the same training shiftsThe Assistant Chief Nursing Officer immediately upon recipeopardy notification to medication carts. All coproperly secured and time of these observations of the secured the Obfor Unit Coordinators include observations of shift by a nurse manainclude that unit medicand properly secured Occurrences of unlock medication carts observation. Actions of cart, identifying the stand corrective action (the staff responsible for observation An addition observed noncomplian medication cart, the plate observing manage reconciliation of the modification of the	correvent patient harm, injury correvent patient harm, injury corrections: -Day shift and on medication cart beging carts locked at all at Director of Nursing eiving the immediate. Further, all nurses arriving and night will be provided a prior to beginning their Director of Nursing and the completed unit rounds eipt of the immediate of assess the status of the carts were noted to be in the locked position at the tionsThe Chief Operating asservation Rounds Audit tool and Nursing Supervisors to of medication carts once per ager. Observation status will cation carts were locked upon observation. The correction is the eff responsible for the error, (up to disciplinary action) for or the cart at the time of the tional corrective action for noce of a secured (locked) tharmacist will be notified by art to perform an immediate edications contained in the nof noncompliance is made expectation is that the	A 144	Additional Actions taken following the 12/29/20 survey: Oversight: The Corporate Director of Nursing, and the Corporate Vice Press and Senior Vice President for Cumber Hospital have been added to Perform Improvement Executive Committee. Ongoing agendas for this committee in the overall functioning of the QAPI program swell as ongoing review of the effectiveness of this plan of corrections. External Review of Conditions of Participation: Cumberland Hospital underwent an external review in the fora 4-day survey performed by Joint Commission Resources Incorporated review took place January 4-8, 2021. focus of the survey was compliance we cited CMS Conditions of Participation. receipt, the survey results will be sharn with the leadership team at Cumberlant Hospital, the Governing Board, and members of the Performance Improve Executive Committee, and an action plant be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review progress with correcting deficiencies. Performance Improvement Executive Committee Well in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. Based on recurrent complaints within thospital, it was determined that the Querogram should undergo a revision. The Chief Operating Officer and the Corpo Director of Clinical Services consulted Corporate Vice President of Performal Improvement to obtain and implement and more rigorous program that could implemented at Cumberland Hospital, new program addresses the need to intrack, and monitor adverse patient occurrences and assure that a plan is	ident rland ance The clude ogram The The ith the Upon ed and ment clan to n will ref The erning the pality he rate the nce a new be The	

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A 144	after 12/1/2020 will be cart safety prior to rep scheduled shift until a training. PERSON RIDISCUSSION-PERS Nursing Officer. COM 12/1/2020. Quality Ass Improvement- The fact Compliance, Chief Opexecutive Officer, as a facility's Quality impro 12/7/2020 to discuss a findings identified by the retrospectively review corrective action plans numerous improvement terms of incident identified actions to date continuate to achieve a desired minimal properties of incident incidents involving Cultiple to achieve a desired minimal properties actions to solutions, the facility's expeditiously enhance patient safety amongs members. The team with initiatives to facility perspectives, behavious with the organization's patient care, reduction culture of patient safety comprehensive quality of staff accountability initiatives: 1. Intensive Staff Traifacility's CEO contacted.	Nurses arriving for shifts and educated on medication porting to the unit for their all staff nurses have received ESPONSIBLE ON RESPONSIBLE: Chief MPLETION DATE: Ressment and Performance cility's Director of Regulatory porating Officer and Chief core members of the exement committee, met on the immediate jeopardy the agency. The core team red recent and ongoing and determined that while ents have been made in this fication, incident united reporting, the facility's use to require focus in order reduction in occurrences of mberland staff members, that in order for it's be sustainable as long-term quality leaders need to a the culture of quality and at its direct care staff further agreed to proceed tate changes in staff's re, and actions to fully align a commitment to quality and at the plan for a improvement and culture	A 144	implemented to show improvement in identified areas. The new program incorporates previous action plan item require attention and development of robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. The Corporate Vice President of Performance Improvement provided to the Cumberland leadership team concerning QAPI. The goal of training to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virt over zoom, and training information we provided to the facility. Training was completed on 1/22/21. Person Responsible Chief Operating Officer Summary of Ongoing Monitoring: As described above, the Leadership Team Nursing Leaders audit the medication carts shift to assess if they are locked and locate secure area, and temperature probes are send not accessible to the patients. The Pharmacist audits incidents of medication creconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that comported daily in flash, and aggregated data reported monthly in Performance Improvement Execommittee, Performance Improvement Execommittee, Medical Staff, and Governing Execution and additional training and/or disciplina action as appropriate. The Director of Risk Management tracks se incidents such as medication diversions an incidents of abuse and neglect. The Direct Risk Management sends the report from the electronic incident tracking system daily to	and every d in a ecured cart s correct Data is a is ment ecutive locard. Seed ry

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A 144	scheduling of an outsintensive staff trainin patient care staff. Thincluded topics related managing power strumanagement, verbal and neglect recognition to extend staff's known managing challenging facility was assigned course content was scheduled this educated commencing 12/11/2 later than 12/31/2020 plan further specifies curriculum, entitled "lobe a required new-hidirect care staff as work training for existing staff development. A Program description training specifies the Training for non-direct and crisis awareness Immediate training staff during COVID-19. Provides-non classion of required to have in preventing and ma Provides videos and staff and includes was station scenarios as a Can be used as remeat any time. Focuses on de-escal workplace violence post effective and staff	side resource to provide g to Cumberland's direct he request for training and to preventing is intended where the provided and expertise in g patient behaviors. The a corporate educator and suggested. The facility has attion for all direct care staff to 20 and to conclude not to this custom-designed prevention First Training will be recorded annual to the "Prevention First" curriculum as follows: at care staff in de-escalation to the "Prevention First" curriculum as follows: at care staff in de-escalation to the staff who are BMS training, but need skills the provided and the provided and the staff to the staff who are the staff to the staff the sta	A 14	Corporate Risk Manager and Corporate Risk Manager and Corporation of Clinical Services for review. The thoroughness of incident investigation planning is assessed. In the instantial quality of the reports or action plantinther development, the Director Management is contacted to take This process will continue for at le Incidents of noncompliance with in reporting and investigations will be Chief Executive Officer and the Control Regional Vice President. Data is a reported to the Performance Impresecutive Committee weekly, and Medical Executive Committee and Board.	meliness and ation/action unce where the nning needs of Risk further action. east 4 months. nocident e reported to the orporate aggregated and overment I monthly to the	

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	, -	Incidents: The quality					
	improvement action						
		ocess for dual reporting of					
		he local social services					
		e state regulatory agency					
		ersight of the facility's					
		S Conditions of Participation.					
		ously investigated incidents					
		core quality team discovered					
	that on multiple occa	sions the facility identified,					
	investigated, manage	ed and reported known					
	incidents to the local	social services agency but					
	that the agency was	reporting to the state					
		hout the results of either their					
		nvestigations or corrective					
	actions, leading to a						
		teemed state agency which					
		osed as "substantiated"					
	complaints but with r facility.	o deficient practice at the					
	The facility will corre	ct the redundancy in					
	complaint investigati	ons by having the Director of			20		
	Quality and newly his						
		s the final results of internal					
	1 -	ortable serious incidents					2
		of risk Management will					
	l '	nts to the local Social					19
		to the regulatory Oversight					
	, -	t incident reporting is					
		d contains evidence of a					
		restigation, findings, evidence					1
		ince, and corrective actions					
		The facility established this					
		ig meeting with Director of			K.		
		isk Management, Chief					
	Operating Officer on						
		a Performance Improvement					10
		e: The core team further fied deficiency in quality			10000		

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A 144	assessment condir Performance Improvide internal quality cor limited to, the immreduce the numbe involving patient ca facility. The member Improvement exect Cumberland's CEC Director of clinical Division Director of committee will provengulatory matters sustained complia Participation. The weekly basis. The compliance rates were current status of in actions taken as a investigations, more plans, and status of requirements as a The activities of the executive Committ and reported to the an agenda item at scheduled meeting 4. Condition of Pa Surveys As additional reinforcommitment to cor concerns within the resolved to engage Director of Clinical	tions by establishing a covernent Executive Committee, explicit oversight of the facility's atrol initiatives, including but not rediate improvement initiative to rediate improvement initiative to rediate improvement directly are staff employed by the person of the performance autive Committee are D, COO, Director of Quality, magement, CNO, Division Services. The addition of the folinical Services on the vide external expertise on to include the facility's magement of CMS Conditions of committee will meet on a reagenda will include: with direct care training redial training needs, mal resources if needed, the aternal investigations, corrective result of substantiated mitoring of corrective action of external reporting opplicable. The provement are will further be summarized as facility's Governing Body as the Board's quarterly	A -	144		RECEIVED IN 27 2021

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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A 144	specifically focus on a compliance with CMS starting with the areas survey will be done be calendar year 2021. observations will be of Performance Improve via action-item report reviewed during the widentified deficiencies will further include a presponse to the correct On 12/1/2020 at 4:00 rounds on the hospital removal had been implead did not identify a were not secured and revealed they had red the facility policy/plan carts were locked and that patients were bei safety.	the mock surveys will assessing the facility's a Conditions of Participation, as of concern, The first mock beginning in 1st quarter of a Communicated to the sement executive Committee. The report will be are corrected. The facility blan for sustainability in ctive actions taken. In p.m., the survey team made all units to verify the plan of blemented. The survey any medication carts that a interviews with staff believed education regarding of ensuring medication as secured at all times, and any observed to ensure their	A 14	4	
	Medicare and Medica Agency, the plan was unacceptable and the Immediate Jeopardy a p.m The facility Lea 2, 3, 4, 8 and #13- Co Regulatory Director) of the plan not being acc Jeopardy remaining in	facility remained in as of 12/9/2020 at 3:00 dership (Staff Members #1, proporate Regional were notified at that time of cepted and the Immediate a effect.			01/29/2021
A 145	PATIENT RIGHTS: FF ABUSE/HARASSMEI CFR(s): 482.13(c)(3)		A 14	5 Plan of Correction Initial Plan of Correction based on 1 and 12/9/20 surveys	

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					Abuse/Neglect		
A 145	of abuse or harassment of abuse or harassment of the staff interview of facility docu course of a complaint determined the facility Patient #5 was free from abuse have the potent residing at the facility. The findings included On 12/1/2020, Patient Member #12 and puschair, as the staff mer Patient #5 was admitted.	ght to be free from all forms ent. not met as evidenced by: ew, clinical record review, ments and during the investigation, it was y staff failed to ensure om abuse. Allegations of tial to affect every patient t #5 was "grabbed" by Staff hed the patient down into a mber "yelled" at the patient.	A 1	45	The Chief Nursing Officer (CNO) implemented intensive staff training of providing patients with a safe setting. Training began on 12/11/20 and cond 12/31/20. With the support of the Collinical Training and Education depathospital leadership developed a curric entitled "Prevention First" for all direct staff, based on the CEO's request for additional training on the topics of preand managing power struggles with pmilieu management, verbal de-escala and abuse and neglect recognition. The training is intended to extend staff's knowledge and expertise in managing challenging patient behaviors. The curriculum completed via the Healths platform provides videos and a consist message for staff, and includes waiting and nursing station scenarios as examiting a focus on Verbal De-escalation, Prevention and Workplace Violence Prevention. The training includes postesting to ensure competency and staprovided opportunities for further discommendations.	eluded reporate tream stent groom mples Crisis st-ff are	
	"12/1/2020 2220 (10:2 incident w/a (with a) s not want to clean up (equipment after treatr Staff repeatedly prom PT got aggressive and hands on staff's chest over and physically sa explained to (patient) hands on staff and pu According to the invest Member #8 (Risk Mar evidenced: "While UC the unit, the milieu wa	nent in (patient's) room. pted PT to cooperate and d pushed staff w/ (with) both d/shoulders. Staff almost fell at patient down in chair and that (patient) should not put sh people over" stigation conducted by Staff hager) the following was (Unit Coordinator) was in s interrupted with a loud			 with the Nursing Leadership. This custom-designed curriculum, ent "Prevention First Training" will be a renew-hire orientation course for all dire staff as well as required annual training existing staff continuing education and development. Incident Investigation A new Risk Manager with previous rismanagement experience in Virginia bemployment on 11-30-2020. The Corporate Director of Risk Managand Corporate Divisional Director of Cervices provided education and trainthe Hospital Director of Risk Manager 	quired ect care ng for d staff ek egan gement Clinical ning to	
		ember standing over the nt. UC went over to inquire			on reviewing, reconciling, investigatin reporting incidents, and on developing		

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(patient's) room to tall had happened. Staff patient to room and content as (patient) at sent staff member aw Patient was tearful and by staff to pack up (patient) shad not packed it to spatient felt (they) were staff did not. (Patient to leave (patient's) root the staff from (patient staff grabbed the patient of the chair and begon into the chair and begon investigation." Further investigation." Further investigation revealed interviews with the UM Member #11) and Patient documentation reveal FMR (Facility Risk Macamera incident via the found that at 16:45 (4 visible in (patient's) rocan be seen at the document of the chair and shutting member grabs the patient what appears go of the patient which Next at 16:48 the patient	ening and took patient to k with (patient) as to what Member followed UC and ontinued to argue with tempted to talk with UC. UC ray from patient and room. In a stated (patient) was told attent's) breathing states (patient) apparently taff's expectations as a done packing it up and and admits to pushing the stated and "shoved (patient) and to yell at (patient)". In an to yell at (patient)". In the proof of M (Unit Manager Staff sient #5. Further and "Shoved the me camera system and the staff member was pulled at home pending further and cumentation of M (Unit Manager Staff sient #5. Further and "Camera Review: The mager) reviewed the me camera system and the staff member way of the Pt's room. At pt. can be seen pushing the door then the staff tient and forces (patient) to ket to the door. At the same mager/Coordinator) can be to be redirecting staff to let in the staff member does. The same and the staff member does. The same and the staff member does are to goes back into samera cannot see what	A 145	plans to prevent future recurrences. Director of Risk Management was als provided guidelines for timeliness of completion of investigations and cornactions. Understanding of expectation out in training was verified by question answer and signed attestation. In order to strengthen and standardizinvestigation and improvement proce Chief Executive Officer and the Direct Risk Management, in collaboration with Director of Human Resources, Corpo Director of Risk Management, and Corporate Divisional Director of Clinic Services, developed a new procedure management, reporting, and investigabuse/neglect incidents. This procest added to the Abuse and Neglect Reppolicy and includes the following step of Immediate placement of strinvolved on administrative pending results of investigation of the employer supervisor, Director of Risk Management, and the Administrator on Call Completion of thorough investigation of allegations employee's supervisor and Director of Risk Management, Chief Execution of the investigation by the supervisor, Director Management, Chief Execution of the complete actions to be to any. The revised policy was approved by the Medical Executive Committee and the Governing Board. Each department head or supervisor provided retraining to their employees expectations for reporting of incidents through the appropriate channels. For not able to complete remote data entithe electronic system (only Nurses ar Nursing Supervisors), expectations for the electronic system (only Nurses and Nursing Supervisors), expectations for the electronic system (only Nurses and Nursing Supervisors), expectations for the electronic system (only Nurses and Nursing Supervisors), expectations for the electronic system (only Nurses and Nursing Supervisors), expectations for the electronic system (only Nurses and Nursing Supervisors), expectations for the electronic system (only Nurses and Nursing Supervisors), expectations for the electronic system (only Nurses and Nursing Supervisors), expectations for the electronic system (onl	ective ons laid on and te the ss, the stor of ith the orate cal e for the attion of iss was orting is: aff leave ation e's by the ent results of Risk tive man e aken, if the e	

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A 145	(patient) in, the UM wredirect staff out of the with the patientCon and statements above found to be trueFoll Member involved in the immediately and then Techs (technicians) and Nurses) for that shift a struggles- the training 12/9/2020. The UM was management which we 12/9/2020." The statement of Patingst finished my breatt putting it up when I plus taff member #12) and and pushed me into that me" The survey team condinterview with Staff Member with the survey behind d the nurses a commotion that disrugand saw (Staff Member) to step with the survey to be	alks over and appears to e room and then verbalizes clusion: Due to the evidence e, this allegation has been ow-Up Action: The staff his incident was suspended terminated. Behavioral and RN's (Registered are being retrained on power will be completed by will be retrained on staff hill be completed by staff hill be completed by ent #5 evidenced, in part: "I ming treatment and was a staff hill be chair and started to yell ducted an follow-up ember #11 on 12/9/2020 at Member recounted the ors and stated, "I was tation and a heard a sted the milieu! looked up	A -	1145	reporting to their immediate supervison nursing leader on duty were included. Education was provided in group and individual sessions with opportunity for discussion and clarification to assure understanding of expectations, which verified by signed attestation. • The Director of Risk Management proveducation to the leadership team in ground individual sessions on the revised procedure for the management, report and investigation of abuse/neglect allegations. The Administrator on Call staff and Nursing Supervisors were alseducated concerning the management reporting procedure to follow when the covering off-shifts and weekends. Understanding of expectations was very by question and answer and signed attestation. • The Director of Risk Management revisand reconciles incidents daily with the Nursing Officer/designee reviews the Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flast meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with the submitted through the electronic incider reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management revisited on all serious incidents. Results video on all serious incidents. Results video review, including any inappropriation staff behaviors, are reported to the employee's manager, appropriate Sen Leader, and the Chief Executive Office Staff receive appropriate corrective actions of the investigation of th	r was vided oup ting, (AOC) so t and ey are rified ews Chief h" he ese ent or ews of the ate ior er. tion in.	

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A 145	(Patient admitted to proom and then said () the arms and shoved immediately notified to Member) was sent he investigation There a couple of the (patie #12) being rude and to, but it was not witnesspeak to (Staff Member), but it was not witnesspeak to (Staff Member). I was Member) had been ruknow that I was watch was watch the facility presented evidence of inservice. Unit on which the every were "Power Struggle Inservices were docu on 12/4/2020. Inserv with all direct care stated 12/8 and 12/9/2020.	oushing staff out of (patient's) Staff) grabbed (patient) by (patient) into the chairI the supervisor and (Staff	A 145	regarding incidents and result investigations at Cumberland hospital's previous process for minimum requirement to report information to the local social agency, which then in turn was for reporting to VDH. In order VDH is aware of serious incid details of Cumberland Hospital investigations, however, leader implemented a new dual report notify both the local social ser and VDH as the state regulated deemed oversight of the facility with CMS Conditions of Particular to the local Social Services agents as the Regulatory Oversight assuring that incident reporting timely and contains evidence internal investigation with dispindings (if any), evidence of scompliance, and corrective acapplicable. The facility establiprocess during a planning me Director of Quality, Director of Management, Chief Operating Chief Executive Officer on 12/1	h or VDH) ts of Hospital. The bllowed the out such services as responsible or to assure that lents and the al's ership orting process to rvices agency ory agency with ty's compliance cipation. ment is ous incidents to outly and to VDH agency, ag is consistent, of a complete outlion, standards ctions taken, as ished this eting with the firisk g Officer and	
	the concerns regardir received by the state care issues and abus discussed with the fact allegations demonstrated with regard to action pand the urgency and review their systems it and sustainable plans prevent recurrence. The facility presented	ng multiple complaints agency of ongoing patient e. The survey team		The leadership team formed a Improvement Executive Comprovide oversight of the facility quality improvement initiatives not limited to, the immediate in initiative to reduce the number incidents directly involving pat employed by the facility. The initial members of the Perlimprovement Executive Commount Cumberland's Chief Executive Medical Officer, Chief Operation Director of Quality, Director of	mittee to y's internal s, including but mprovement r of serious tient care staff rformance mittee are e Officer, Chief ng Officer,	JAN 27 2021 VDHOLC

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		TEMENT OF DEFICIENCIES	9 N	TREET ADDRESS, CITY, STATE, ZIP CODE 407 CUMBERLAND ROAD IEW KENT, VA 23124 PROVIDER'S PLAN OF CORRECTION (EAR	CH (X5)
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A 145	The Unit Coordinator the area and removed vicinity of the patient. interviewed the patient determine the cause of patient alleged that a (patient) by grabbing (into a chair and yelling Cumberland policy on Neglect of a Patient, the senior supervisor and suspended the er investigation of the all immediately left the far another shift at the fact physician and the patinotified of the incident was entered into the far reporting system for fainvestigation. In the morning of 12/2 Manager was notified Nursing of the allegations.	rland Hospital took vestigate the alleged to a patient as follows: - immediately responded to the staff member from the The Unit Coordinator it in (patient's) room to of the disruption. The staff member had abused (patient), pushing (patient) of at (patient) Per Suspected Abuse and the Unit Coordinator notified on duty of the occurrence inployee pending further regation. The employee cility and did not work cility The attending ent's legal guardian were . The associated allegation acility's internal incident inther follow-up and	A 145	Management, Chief Nursing Officer ar	. The linical xternal ude n CMS sis. eview th street and the conficer at the This ed of at essary, allity am sional n
	completed the investig the allegation of staff a substantiated. Elemen included the following incident. Interviews w coordinator and other the unit at the time of	pation and determined that abuse to a patient was ats of the investigation A camera review of the atient, unit staff members present on		period of one year. The mock surveys specifically focus on assessing the fac compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statem. The first mock survey will be done in the Quarter of calendar year 2021. The Director's findings and observations we communicated to the Performance Improvement Executive Committee via	s will ility's ent. ne 1 st

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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		493300	B. WING		12/09/2020	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 9407 CUMBERLAND ROAD NEW KENT, VA 23124		
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A 145	Risk Management. T Management notified Services of the incide abuse. On 12/4/2020 based of findings, the employed 12/2 to (employee) telemployee did not have Cumberland patients of the complaining patients of the complaining patients of immediately prever- patient abuse and to repatient abuse and to repatient abuse and Negled of Nursing upon receiven and "abuse and Negled of Nursing upon receiven otification. Further a subsequent to jeopard provided with the same their shifts. Quality Assessment as Improvement - The fact Compliance, Chief Op Executive Officer, as of facility's Quality impro- 12/7/2020 to discuss of findings identified by the retrospectively review corrective action plans numerous improvement terms of incident identifications to-date continu- to achieve a desired re-	ee based on the content by the Director of he Director of Risk New Kent County Social int of substantiated patient on the substantiated e was terminated. From remination on 12/4/2020, the ee any contact with following the incident with int. In the further occurrences of maintain patient safety on ening shift patient care staff 'Avoiding Power Struggles' ect' by the Assistant Director wing the immediate jeopardy It nurses arriving for shifts dy notification will be lee training prior to beginning and Performance contact with the immediate jeopardy the agency. The core team led recent and ongoing and determined that while introduced in the immediate jeopardy the agency. The core team led recent and ongoing and determined that while introduced in incident cuired reporting, the facility's use to require focus in order leduction in occurrences of mberland staff members.	A 145	action-item report. The report will I reviewed during the weekly meetin identified deficiencies are corrected facility will further include a plan for sustainability in response to correct actions taken. Additional Actions taken following the 12/29/20 survey: Oversight: The Corporate Director Nursing, and the Corporate Vice Prand Senior Vice President for Cum Hospital have been added to Perfolimprovement Executive Committee ongoing agendas for this committee ongoing agendas for this committee the overall functioning of the QAPI as well as ongoing review of the effectiveness of this plan of correct. External Review of Conditions of Participation: Cumberland Hospital underwent an external review in the a 4-day survey performed by Joint Commission Resources Incorporate review took place January 4-8, 202 focus of the survey was compliance cited CMS Conditions of Participations of Pa	of esident berland mance. The enclude program from of ed. The 1. The ewith the bon. Upon lared with Hospital, sof the reddress oped. Standing Meeting mance will in at its	

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A 145	solutions, the facility expeditiously enhand patient safety amon members. The team with initiatives to face perspectives, behave with the organization patient care, reducticulture of patient saccomprehensive qual of staff accountabilitinitiatives: 1. Intensive Staff Treacility's CEO contact President of Clinical scheduling of an outintensive staff training patient care staff. Tincluded topics relate managing power stream anagement, verbal and neglect recognite extend staff's known anaging challenging facility was assigned course content was scheduled this educ commencing 12/11/202 plan further specifies curriculum, entitled be a required new-hidrect care staff as we training for existing staff development. A Program description training specifies the	r's quality leaders need to ce the culture of quality and gst its direct care staff in further agreed to proceed cilitate changes in staff's riors, and actions to fully align in's commitment to quality on of serious incidents, and a fety. The plan for lity improvement and culture by includes the following raining: On 12/7/2020, the content of the co	A 145	Corporate Vice President of Per Improvement to obtain and imple and more rigorous program that implemented at Cumberland Ho new program addresses the nee track, and monitor adverse patie occurrences and assure that a p implemented to show improvemidentified areas. The new prograincorporates previous action pla require attention and developme robust and sustainable plan to cidentified areas and prevent reproccurrences was implemented. The Corporate Vice President of Performance Improvement provious to the Cumberland leadership to the Cumberland leadership te concerning QAPI. The goal of the to improve the knowledge base competency of Cumberland leadersgarding a rigorous and sustain program. Training was conducted over zoom, and training informat provided to the facility. Training completed on 1/22/21. The Corporate Risk Manager provided Director of Risk Management and the Leadership team a best practices "addregarding management of abuse and allegations. Topics of the advisory in a. Types of Abuse b. Strategies to deca allegations of ab c. Injury Reduction d. Samples of abuse neglect response. The leadership team is reviewing the practice recommendations and the hocurrent processes to develop an internaction to improve any identified hospi processes. The action plan will be suftle Performance Improvement Executed Committee and the Governing Board and implementation. Person Responsible Chief Executive Officer	ement a new could be spital. The spital. The spital to identify, and spital is ent in am in items that ent of a correct eated spital is eated spital is ent in am in items that ent of a correct eated spital is ent in am in items that ent of a correct eated spital is ent in am in items that ent of a correct eated spital is ent in items that ent of a correct eated spital is ent in items that ent of a correct eated spital is ent in items that ent of the could ent items that items tha	

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A 145	during COVID-19. Provides-non class not required to have in preventing and m. Provides videos and staff and includes we station scenarios as Can be used as remat any time. Focuses on de-esc workplace violence Cost effective and sentire organization reality of crisis. 2. Dual Reporting of improvement action development of a perious incidents to agency as well as the who has deemed organization compliance with CM. The analysis of prefat our facility by the that on multiple occinvestigated, manaincidents to the location that the agency we oversight agency we oversight agency wown or the facility's actions, leading to a investigation by the were frequently discomplaints but with facility. The facility will correcomplaint investiga Quality and newly here.	support to facilities and staff room training for staff who are e BMS training, but need skills nanaging crisis situations. d a consistent message for vaiting room and nursing s examples. needial training for employees alation, crisis prevention, and	A 14	Monitoring of effectiveness of train appropriateness of staff interaction is done through the leadership rou Documentation includes completic each unit (with video review allows units), observations of staff/patient and any coaching done with staff. are reviewed daily by the CEO, Ch Manager with any corrective action implemented immediately. Aggres compliance with rounds and approstaff/patient interactions is present the Performance Improvement Exc Committee, Medical Executive Corthe Governing Board. The Director of Risk Management incidents such as medication diverincidents of abuse and neglect. The Risk Management sends the report electronic incident tracking system Corporate Risk Manager and Risk Risk Risk Risk Risk Risk Risk Risk	ing and is with patients anding process. In of rounds to de for COVID interactions, Rounds forms NO, and Risk ins needed gated data on priateness of ead monthly to ecutive interactions and interaction and interaction and interaction incomplete incom		

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A 145	Continued From page	26	Α.	145	8		
	investigations on repo	ortable serious incidents					
	jointly. The Director of	of risk Management will					
	report serious inciden						i
		to the regulatory Oversight					
	agency ensuring that						
		contains evidence of a					
		estigation, findings, evidence					
		nce, and corrective actions					
		The facility established this					3
		meeting with Director of					
		k Management, Chief					
	Operating Officer on 1	Performance Improvement					
		The core team further					
		ed deficiency in quality					
	assessment condition						
		ment Executive Committee,					
		licit oversight of the facility's					
		initiatives, including but not					
		ate improvement initiative to					
	reduce the number of	serious incidents directly					1
į	involving patient care						
	facility. The members						
	Improvement executiv						
		OO, Director of Quality,				1	
Ì		ement, CNO, Division					
		rvices. The addition of the					
	Division Director of Cli						
		external expertise on					
	regulatory matters to i						· .
	Sustained compliance	with CMS Conditions of					
	Participation. The cor			100			
	weekly basis. The agreement compliance rates with	enda will include:					
	requirements, remedia						, I
		a training needs, resources if needed, the					
		resources if needed, the lal investigations, corrective					
	actions taken as a res			20			
		ring of corrective action					
	gations, monitor	any or corrective action					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9407 CUMBERLAND ROAD NEW KENT, VA 23124		
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A 145	executive Committee and reported to the an agenda item at it scheduled meeting. 4. Condition of Part Surveys As additional reinfor commitment to correconcerns within the resolved to engage Director of Clinical Smock survey's at the year. The purpose specifically focus on compliance with CM starting with the are survey will be done calendar year 2021. observations will be Performance Improvia action-item reporeviewed during the identified deficiencie will further include a response to the correction. After review and con Medicare and Medicare and Medicare and Medic Agency, the plan was unacceptable and the Immediate Jeopard p.m The facility Le 2, 3, 4, 8 and #13- C Regulatory Director.	external reporting plicable. Performance Improvement e will further be summarized facility's Governing Body as the Board's quarterly icipation: Focused Mock cement for the core team's facility, the core team the Corporate Divisional facility, the core team the Corporate Divisional facility for a period of one for the mock surveys will assessing the facility's assessing the facility's assessing the facility's assessing in 1st quarter of the Director's findings and communicated to the facility meeting until the easare corrected. The facility plan for sustainability in facility active actions taken. Insideration by the Centers for facility remained in the facility	A 145			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY
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CUMBERI	LAND HOSPITAL LLC			N	EW KENT, VA 23124		
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A 263	The hospital must demaintain an effective data-driven quality as improvement program. The hospital's govern the program reflects thospital's organizatio hospital departments those services furnish arrangement); and for to improved health or and reduction of med. The hospital must man evidence of its QAPI. This CONDITION is Based on findings of a complaint investigate ensure an effective quality developed and impled develop sustainable a continued patient carregarding patient right of patients residing at substantially comply with the findings include: Throughout the previous that multiple incidents patient rights and pat resulted in multiple unitiple	ing body must ensure that the complexity of the n and services; involves all and services (including ned under contract or cuses on indicators related atcomes and the prevention ical errors. Intain and demonstrate program for review by CMS. International demonstrate program was mented to track, monitor and action plans to prevent e and quality concerns ts and the health and safety the facility thus failing to with this condition.	A:	263	Hospital leadership reviewed and improve processes for documenting and reporting incidents internally, investigating incidents, action and reporting progress to internal committees, monitoring ongoing compliant reporting timely to external regulatory ager. Please refer to A0286 for details.	taking ce, and icies.	01/29/2021
	investigations, and fir	nannounced complaint adings of non-compliance in ation for Patient Rights and	5				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9407 CUMBERLAND ROAD NEW KENT, VA 23124	
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A 263	Quality Assurance an Improvement. Action facility have not been the current finding froinvestigation of 12/1/2 and associated non-Conditions of particip Governing Body, Nur Pharmaceutical Servi allegation of abuse to The facility presented identified Immediate 12/1/2020, however, Abuse was identified remaining in Immedia again presented a pla	d Performance Plans developed by the sustained as evidenced by m the complaint 2020 of Immediate Jeopardy compliance for the ation for Patient Rights, sing Services, and ices as well as the repeated o patients by staff. I a plan of removal for the Jeopardy findings on the additional concern of which resulted in the facility an of removal on 12/9/2020 lered an acceptable plan. facility remained in	A 26	3	
A 286	of allegations of abus in the previous month systematic failure by sustainable plan in or allegations of abuse. Please refer to A0286 PATIENT SAFETY CFR(s): 482.21(a), (c) (a) Standard: Program (1) The program musto, an ongoing program	m Scope t include, but not be limited im that shows measurable ators for which there is	A 28	6 Plan of Correction Initial Plan of Correction based on 11/30 and 12/9/20 surveys Medication Security The Chief Nursing Officer educated all nursexpectations for safe storage of medication keeping carts locked at all times, reporting cart is found unlocked or not secured, secured.	ees on carts, when a

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A 286	(2) The hospital mutrackadverse patitive (2) Performance imtrack medical errors analyze their cause actions and mechan and learning throug (e) Executive Responsive governing body (or who assumes full lefor operations of the administrative official accountable for ensity (3) That clear expensive established. This STANDARD is Based on staff inteclinical record reviet and during the cour investigation, it was failed to ensure the and tracked advers demonstrated plans these areas. The findings include Multiple areas of course the complaint investigation carts ar were not investigate. Also, multiple company the course immedication carts ar were not investigate.	st measure, analyze, and ent events es es provement activities must and adverse patient events, s, and implement preventive hisms that include feedback hout the hospital. consibilities, The hospital's organized group or individual egal authority and responsibility e hospital), medical staff, and als are responsible and suring the following: ectations for safety are s not met as evidenced by: rview, patient interview, w, review of facility documents as determined the facility staff Quality Program monitored e patient occurrences and as to show improvement in ed: concerns were identified during stigation resulting in an y finding. The facility had two accessing unlocked and talking medications which	A 2	medication carts whenever of prior to responding to the cowas provided via electronic (Healthstream) with compete testing. The Chief Nursing and verified that all nurses in training. The Chief Nursing Officer and Procedure for reconciling when a cart is found unlocked secured, or when there is a medications are missing. The enhanced as follows: The mobserving the issue through rounds or random checks as medication cart, completes report, and notifies the pharmaced perform a prompt reconcilial medications contained in the observation of noncompliant during off-hours, the nursing notifies the pharmacist on completes the pharmacist on complete their next in-person shift. The revised policy was appropriated to the pharmacy staff on the revised completing a prompt reconcilial medications contained in the cart is found unlocked of the cart	de. Education training system ency verified via Officer tracked eccived the end Director of ised the Policy of medications ed or not suspicion that he process was manager leadership ecures the an incident encist to tion of the e cart. If an ee is made g supervisor all, and a nciliation of the et he beginning of the et and enciliation of the et and enciliation of the ethe beginning of the ethe beginning of the ethe beginning of the ethe beginning of the ethe process for ciliation of the ethe process for enciliation of the ethe process to unlocked, or a therwise education was a understanding question and	

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NAME OF P	ROVIDER OR SUPPLIER	493300		STREET ADDRESS, CITY, STATE, ZIP CODE	12/09/2020
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A 286	This demonstrates a systematic failure of sustainable plan to patient #1 and #2 sable to access unlocations from 10/31/2020 and 11/40 occurrence, there waction developed to patient's again access medications. According to docume team, the CNO (Chi October 2020) state administration and smonth of November date on this docume written/submitted, a Staff Member #1 (Qa.m., the Staff Mem exactly when this wactly when this wattended by the facilocked was discuss Secured" was added Audit" sheet which, #1, is completed on on rounds. The find on November 3,202 After the addition of the rounds sheet, munlocked on 11/3, 1	ions by the state agency. In concern regarding a state facility to implement a prevent these concerns. In the facility to implement a prevent these concerns. In the facility to implement a prevent these concerns. In the cart of two occasions; 4/2020. After the first ras no investigation of plan of prevent reoccurrence and the ressed the cart and took In the cart of two occasions; 4/2020. After the first ras no investigation of plan of prevent reoccurrence and the ressed the cart and took In the servicing of medication recurity will be completed in refor all nurses"there was no rent to establish when it was although in an interview with reality) on 12/1/2020 at 8:45 restated, "I don't know as done but it is due to the form the medication carts being red. The "Medication carts being red. The "Medication cart is do to the "Leadership Rounds according to Staff Member rice a shift by Leadership staff all document was given for use	A 286	 The Chief Nursing Officer incorporate education regarding expectations for medication carts, securing temperature probes, locking the carts prior to responder to codes, and the medication cart reconciliation process into New Emplorientation and annual nursing and pharmacy orientation. On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audfor Unit Coordinators (Nurse Manage Nursing Supervisors to check that the medication carts are locked and secuncluding during code response, and temperature probes are secure. This is done once per shift by the Unit Coordinator (Nurse Manager) and/or Nursing Supervisors. Occurrences of unlocked or improperly secured medicarts require immediate action by the manager performing the observation. Actions include securing the cart, ide the staff responsible for the error, init corrective action for the staff responsible for the error, init corrective action for the staff responsible for the cart, and not the pharmacist that a prompt reconcineeds to be completed. The Chief Nursing Officer educated to Coordinators and Nursing Supervisor concerning the enhanced audits, the audit tool, corrective actions for staff responsible for the cart when policy if followed, and the incident reporting expectation to ensure a thorough investigation is completed. This educacurred 1:1 with understanding of expectations verified by question and answer and signed attestation. Incident Investigation A new Risk Manager with previous rimanagement experience in Virginia is employment on 11-30-2020. The Corporate Director of Risk Manager management experience in Virginia is employment on 11-30-2020. 	locking re onding oyee er it tool rs) and ered, that audit the cation eritifying liation he Unit rs revised s not cation

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A 286	monitoring were not showever there was or on 11/5/2020 and han copy of the agenda sheam was "*med carts. The survey team was evidence of robust insprogressive discipline nature of the reports of unlocked medication of the what occurred if leaded on rounds. Staff Members spoken to and the of When asked whether when staff were "spoken to and the of the what occurred if leaded on rounds. Staff Members spoken to and the of When asked whether when staff were "spoken to and the of the survey team discipline and hospital policy, stand that the inform "meetings" held with mobust education for the responsibilities of patient mon consequences for failuand procedures. The concerns were reteadership staff (Staff #8) on 12/1/2020 at 4:	cart safety and patient tarted until 11/9/2020, se unit which had a meeting dwritten in the corner of the neet presented to the survey clocked at all X's (times)". Inot provided with any servicing, training or regarding the serious of patients having access to carts and patient monitoring. 12/1/2020 at approximately ser #4 (CNO) was asked ship found carts unlocked sher #4 stated, "The nurse art immediately secured." there was documentation of sen to" in terms of initiating for failure to follow safety aff member #4 stated, "It ussed with Staff Member #1 ation provided for the sursing staff did not reflect a se staff regarding the ent safety, basic medication itoring, as well as potential are to follow hospital policy wiewed with the facility Members #1, 2, 3, 4, and 20 p.m. #5 was "grabbed" by Staff	A:	286	the Hospital Director of Risk Managemereviewing, reconciling, investigating, an reporting incidents, and on developing to prevent future recurrences. The Dire of Risk Management was also provided guidelines for timeliness of completion of investigations and corrective actions. Understanding of expectations laid out training was verified by question and an and signed attestation. In order to strengthen and standardize to investigation and improvement process. Chief Executive Officer and the Director Risk Management, in collaboration with Director of Human Resources, Corporat Director of Risk Management, and Corp. Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation abuse/neglect incidents. This process added to the Abuse and Neglect Report policy and includes the following steps: Immediate placement of staff involved on administrative lead pending results of investigation. Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call. Completion of thorough investigation of allegations by employee's supervisor and Director of Risk Management. Review of the investigation re by the supervisor, Director of Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be take any. The revised policy was approved by the Medical Executive Committee and the Governing Board. Each department head or supervisor.	ng to ent on id plans actor I of in inswer the the torate oon of was ting ave on the en, if	
		ed down into a chair, as			 Each department head or supervisor provided retraining to their employees o expectations for reporting of incidents 	'n	

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Ac Me ev the disparate parate	ember #8 (Risk Maidenced: "While UC e unit, the milieu was sruption of a staff mattent yelling at paties to what was happed atient's) room to tall and happened. Staff atient to room and contient as (patient) at the staff member awant at staff member awant at the to pack up (patient) at the staff to pack up (patient) at the total and packed it to see attent was tearful and a staff did not. (Patient) and not packed it to see the staff from (patient aff grabbed the paties of the chair and begindent was immediated and the staff of the chair and begindent was immediated at the staff and see the vestigation." Further westigation. Further westigation revealed the the unit of the chair and patient was immediated at the unit of the	stigation conducted by Staff nager) the following was a common (Unit Coordinator) was in as interrupted with a loud sember standing over the ent. UC went over to inquire ening and took patient to k with (patient) as to what Member followed UC and continued to argue with tempted to talk with UC. UC may from patient and room. In a stated (patient) was told stated (patient) was told states (patient) apparently staff's expectations as a done packing it up and and admits to pushing the staff member of and admits to pushing the staff member of and stated (patient). In and "shoved (patient) and to yell at (patient)". In the yell at (patient) and thome pending further of documentation of the following the staff member was pulled and thome pending further of documentation of the following the staff member was pulled and thome pending further of documentation of the following the staff member was pulled the following the staff member was pulled and thome pending further of documentation of the following the staff member was pulled the following the following the staff member was pulled the following the following the following the following the staff member was pulled the following t	A	286	through the appropriate channels. Fo not able to complete remote data entry the electronic system (only Nurses and Nursing Supervisors), expectations for reporting to their immediate supervison nursing leader on duty were included. Education was provided in group and individual sessions with opportunity for discussion and clarification to assure understanding of expectations, which verified by signed attestation. • The Director of Risk Management proveducation to the leadership team in grand individual sessions on the revised procedure for the management, report and investigation of abuse/neglect allegations. The Administrator on Call staff and Nursing Supervisors were alleducated concerning the management reporting procedure to follow when the covering off-shifts and weekends. Understanding of expectations was very guestion and answer and signed attestation. • The Director of Risk Management reviand reconciles incidents daily with the Nursing Officer/designee reviews the Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flast meeting and identifies incidents from past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with the submitted through the electronic incidereporting system by the nursing staff the assure that all incidents are entered for investigation. • The Director of Risk Management reviated on all serious incidents. Results video review, including any inappropriataff behaviors, are reported to the employee's manager, appropriate Ser Leader, and the Chief Executive Office Staff receive appropriate corrective activation and the results of the investigation.	y into d r r and r was vided oup ting, (AOC) so t and ey are erified desperator iews Chief che cor iews sof the ate	

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A 286	sit down in a chair netime the UM (Unit Maseen in what appears go of the patient which Next at 16:48 the pati (patient's) room (the compatient's) room (the compatient) in, the UM wore direct staff out of the with the patientCompand statements above found to be trueFoll Member involved in the immediately and then Techs (technicians) at Nurses) for that shift a struggles- the training 12/9/2020. The UM womanagement which wo	at to the door. At the same mager/Coordinator) can be to be redirecting staff to let the the staff member does. The staff member follows alks over and appears to be room and then verbalizes clusion: Due to the evidence be, this allegation has been ow-Up Action: The staff his incident was suspended terminated. Behavioral and RN's (Registered are being retrained on power will be completed by will be retrained on staff hill be completed by the survey team with a conducted with staff of the ant occurred. The inservices is and Abuse and Neglect". The inservices is and Abuse and Neglect and the survey team with the survey team with the survey team with the survey team with the survey team of the inservices and Abuse and Neglect. The inservices is and Abuse and Neglect and the survey team with the survey team with facility staff through out the survey in multiple complaints agency of ongoing patient entre the survey team.	A 28	 Dual Reporting of Incidents: The Chie Executive Officer is committed to more frequent communication with the state (Virginia Department of Health or VDH regarding incidents and results of investigations at Cumberland Hospital hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was respond for reporting to VDH. In order to assulv VDH is aware of serious incidents and details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting protonotify both the local social services agency and VDH as the state regulate agency with deemed oversight of the facility's compliance with CMS Conditional Participation. The Director of Risk Management is responsible for reporting serious incidents local Social Services agency and the local Social Services agency, assuring that incident reporting is contimely and contains evidence of a continternal investigation with disposition, findings (if any), evidence of standard compliance, and corrective actions taken applicable. The facility established the process during a planning meeting with Director of Quality, Director of Risk Management, Chief Operating Officer Chief Executive Officer on 12/8/2020. Ongoing Oversight The leadership team formed a Performant Improvement Executive Committee to provide oversight of the facility's interriquality improvement initiatives, including the initiative to reduce the number of serion incidents directly involving patient care employed by the facility. The initial members of the Performant Improvement Executive Committee and Cumberland's Chief Executive Officer. 	e distribution of the control of the	

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	and sustainable plar prevent recurrence. The facility presente Immediate Jeopardy 12:20 p.m. After rev Centers for Medicard the State Agency, the unacceptable and the Immediate Jeopardy p.m The facility Le 2, 3, 4, 8 and #13- OR Regulatory Director) the plan not being and Jeopardy remaining NURSING SERVICE CFR(s): 482.23 The hospital must has service that provides The nursing services supervised by a region of the plan service that provides the nursing services supervised by a region of the cours investigation, the fact Nursing care was provided that patients we supervision to prevent failing to substantial.	in order to develop robust as to correct the concerns and d a plan of removal for the findings on 12/9/2020 at iew and consideration by the e and Medicaid Services and e plan was determined to be a facility remained in as of 12/9/2020 at 3:00 addership (Staff Members #1, corporate Regional were notified at that time of ecepted and the Immediate in effect.	RECEN JAN 27 20 VDHVOLO	Management, Chief Nursing Officer a Divisional Director of Clinical Services addition of the Divisional Director of Services on the committee provides e expertise on regulatory matters to incit the facility's sustained compliance wit Conditions of Participation. The committee meets on a weekly ba The initial meeting agenda included reand discussion of compliance rates we direct care staff training requirements remedial training needs, scheduling of external training resources if needed, current status of internal investigations corrective actions taken as a result of substantiated investigations, monitoric corrective actions taken as a result of substantiated investigations, monitoric corrective action plans, and status of external reporting requirements as applicable. The activities of the Performance Improvement Executive Committee as summarized, and the Chief Operating reports this summary to the facility's Governing Board as an agenda item a Board's monthly scheduled meetings. committee will be functional for a perileast four (4) months or longer, if necuntil the QAPI process at Cumberland Hospital is well established and highly functional. Focused Mock Surveys: As additional reinforcement of the core team's commitment to correcting repeated quencerns within the facility, the core to resolved to engage the Corporate Dividence of Clinical Services to perform quarterly mock surveys at the facility period of one year. The mock survey specifically focus on assessing the facompliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency states.	Risk and b. The dinical sternal lude h CMS sis. eview ith f the s, ng of re Officer at the This bod of at essary, d vality	
		medication cart, thus taking		The first mock survey will be done in Quarter of calendar year 2021. The Director's findings and observations were supplied to the control of the control	vill be	

A 385 Continued From page 36 medications. Again on 11/4/2020, Patient #1 accessed an unlocked medication cart and took medications. The facility staff failed to follow policy and procedure and basic safe medication practices in keeping medication carts locked and patients under observation to ensure safety. This resulted in an Immediate Jeopardy finding under Patient Rights- Care in a safe setting. Please refer to: A0398, A0405, and A0144 further information. A 398 SUPERVISION OF CONTRACT STAFF Communicated to the Performance Improvement Executive Committee include Improvement Executive Committee include Improvement Executive Committee include Improvement Executive Committee include Improvement Executive Committee. The ongoing agendas for this committee include the overall functions of the APPROPRIATE Communicated to the Performance Improvement Executive Committee include Improvement Executive Committee include Improvement Executive Committee include the overall functions of the APPROPRIATE DEFICIENCY) Communicated to the Performance Improvement Executive Committee include Improvement Executive Committee include Improvement Executive Committee include The APPROPRIATE Communicated to the Performance Improvement Executive Committee include Improvement Executive Committee include The APPROPRIATE Communicated to the Performance Improvement Executive Committee include The APPROPRIATE Communicated to the Performance Improvement Executive Committee include The APPROPRIATE Communicated to the Performance Improvement Executive Committee include The APPROPRIATE Communicated to the Performance Improvement Executive Committee include The APPROPRIATE Communicated to the Performance Improvement Executive Committee include The APPROPRIATE Communicated to the Performance Improvement Executive Committee include The APPROPRIATE Communicate to the Performance Improvement Executive Committee include The APPROPRIATE Communication in the APPROPRIATE In A 388 SUPERVISION OF CONTRACT STAFF		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
A 385 Continued From page 36 medications. Again on 11/4/2020, Patient #1 accessed an unlocked medication cart and took medications. The facility staff failed to follow policy and procedure and basic safe medication practices in keeping medication carts locked and patients under observation to ensure safety. This resulted in an Immediate Jeopardy finding under Patient Rights- Care in a safe setting. PREFIX Tag STREET ADDRESS, CITY, STATE, ZIP CODE 9407 CUMBERLAND ROAD NEW KENT, VA 23124 PREFIX CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Communicated to the Performance Improvement Executive Committee via an action-item report. The report will be reviewed during the weekly meeting until the identified deficiencies are corrected. The facility will further include a plan for sustainability in response to corrective actions taken. Additional Actions taken following the 12/29/20 survey: *Oversight: The Corporate Director of Nursing, and the Corporate Director of Nursing, and the Corporate Vice President and Senior Vice President for Cumberland Hospital have been added to Performance A0398, A0405, and A0144 further information. A 398 SUPERVISION OF CONTRACT STAFF			40000					С
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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE A 385 Continued From page 36 medications. Again on 11/4/2020, Patient #1 accessed an unlocked medication cart and took medications. The facility staff failed to follow policy and procedure and basic safe medication practices in keeping medication carts locked and patients under observation to ensure safety. Additional Actions taken following the 12/29/20 survey: This resulted in an Immediate Jeopardy finding under Patient Rights- Care in a safe setting. Oversight: The Corporate Director of Nursing, and the Corporate Vice President and Senior Vice President for Cumberland Hospital have been added to Performance Improvement Executive Committee. The ongoing agendas for this committee include the overall functioning of the OAPI program.					94	07 CUMBERLAND ROAD		
A 385 Continued From page 36 medications. Again on 11/4/2020, Patient #1 accessed an unlocked medication cart and took medications. The facility staff failed to follow policy and procedure and basic safe medication practices in keeping medication carts locked and patients under observation to ensure safety. This resulted in an Immediate Jeopardy finding under Patient Rights- Care in a safe setting. A 398 SUPERVISION OF CONTRACT STAFF CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DATE COMPLETI DATE COM		1			N	EW KENI, VA 23124		
A 385 Continued From page 36 medications. Again on 11/4/2020, Patient #1 accessed an unlocked medication cart and took medications. The facility staff failed to follow policy and procedure and basic safe medication practices in keeping medication carts locked and patients under observation to ensure safety. This resulted in an Immediate Jeopardy finding under Patient Rights- Care in a safe setting. Please refer to: A0398, A0405, and A0144 further information. A 398 SUPERVISION OF CONTRACT STAFF Improvement Executive Committee via an action-item report. The report will be reviewed during the everall function and action-item report. The report will be reviewed during the everall function action to an action-item report. The report will be reviewed during the everall function action to an action-item report. The report will be reviewed during the everall function action to an action-item report. The report will be reviewed during the everall function action to	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE	SS-	COMPLETION DATE
All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on staff interview, patient interview, clinical record review, review of facility documents and during the course of a complaint investigation, it was determined the facility staff failed to ensure nursing staff adhered to hospital policies and procedures for the safe storage of medications and the monitoring of patients. The findings included: On 10/31/2020 Patient #1 and #2 gained access to un unsecured medication cart during what was		medications. Again of accessed an unlocked medications. The fact policy and procedure practices in keeping in patients under observations. This resulted in an Immunder Patient Rights-Please refer to: A0398, A0405, and A SUPERVISION OF CCFR(s): 482.23(b)(6) All licensed nurses whospital must adhere procedures of the hospital must adhere the nursing service, in through which those parvices (that is, hospitalse, other agreement This STANDARD is in Based on staff intervictinical record review and during the course investigation, it was of failed to ensure nursi policies and procedure medications and the interviction of the findings included On 10/31/2020 Patient The findings in Cluded On 10/31/2020 Patient The findings in Cluded On 10/	on 11/4/2020, Patient #1 d medication cart and took cility staff failed to follow and basic safe medication medication carts locked and vation to ensure safety. Immediate Jeopardy finding Care in a safe setting. O144 further information. ONTRACT STAFF The provide services in the to the policies and spital. The director of provide for the adequate uation of all nursing ur within the responsibility of regardless of the mechanism personnel are providing pital employee, contract, int, or volunteer). The patient interview, the review of facility documents are of a complaint letermined the facility staff mg staff adhered to hospital res for the safe storage of monitoring of patients.			Improvement Executive Committee v action-item report. The report will be reviewed during the weekly meeting of identified deficiencies are corrected. facility will further include a plan for sustainability in response to corrective actions taken. Additional Actions taken following the 12/29/20 survey: Oversight: The Corporate Director of Nursing, and the Corporate Vice Pres and Senior Vice President for Cumber Hospital have been added to Perform Improvement Executive Committee ongoing agendas for this committee in the overall functioning of the QAPI proas well as ongoing review of the effectiveness of this plan of correction. External Review of Conditions of Participation: Cumberland Hospital underwent an external review in the factory at a 4-day survey performed by Joint Commission Resources Incorporated review took place January 4-8, 2021. focus of the survey was compliance vieted CMS Conditions of Participation receipt, the survey results will be shat the leadership team at Cumberland Hospital the Governing Board, and members of Performance Improvement Executive Committee, and an action plan to add any deficiencies noted will be develop. The report and action plan will be a singenda item on the Performance Improvement Executive Committee Magenda for review of progress with correcting deficiencies. The Perform Improvement Executive Committee we turn report progress, variances, and compliance to the Governing Board a monthly meetings.	until the The The e sident orande The nclude ogram oran oran of . The The with the . Upon red with lospital, of the lress bed. tanding leeting ance rill in t its the uality The	

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A 398	described as a "beha patient without staff k 11/4/2020, a medicati and Patient #1 again and take medications Patient #1 was admitthe clinical record wa. Nurse) Assessment" "11/1/2020 2000 (8:00 snorting crushed medications carting stranched cart on 10/21/20 (4:00 a.m.) it was doo observed acting strancheck (every fifteen niwas attempting to hid white substance that became agitated wheeventually stated that medications" A "Medical 11/2/2020 evidenced to staff yesterday that medications covertly behavioral code was along with another pathave crushed and inhis unclear what medications covertly behavioral code was along with another pathave crushed and inhis unclear what medications covertly "Medical Progress No staff found (patient) with that appear to be crustonfiscated from (patient) with the patient #2 was admitted." Patient #2 was admitted.	vioral outburst" by another nowledge Again, on on cart was left unsecured was able to access the cart without staff knowledge. Ited 8/24/2020. Contained in as a "Daily RN (Registered note which documented, D.p.m.) Patient admitted to its taken by peer from unit 20" On 11/4/2020 at 0400 sumented, "Patient was ige during routine Q15 initute checks). Pt (patient) is a med cup /c (with) a appeared crushed. Pt in staff confiscatedPt (patient) got Seroquel off in (name) aware of al Progress Note" dated in part: "(patient) reported		Director of Clinical Services consul Corporate Vice President of Perfor Improvement to obtain and implem and more rigorous program that co implemented at Cumberland Hospi new program addresses the need to track, and monitor adverse patient occurrences and assure that a plan implemented to show improvement identified areas. The new program incorporates previous action plan it require attention and development robust and sustainable plan to cornidentified areas and prevent repeat occurrences was implemented. The Corporate Vice President of Performance Improvement provide to the Cumberland leadership team concerning QAPI. The goal of train to improve the knowledge base and competency of Cumberland leaders regarding a rigorous and sustainab program. Training was conducted over zoom, and training information provided to the facility. Training was completed on 1/22/21. Person Responsible Chief Executive Officer Summary of Ongoing Monitoring: As described above, the Leadership Tea Nursing Leaders audit the medication cashift to assess if they are locked and loc secure area, and temperature probes and not accessible to the patients. The Pharmacist audits incidents of medication compared to assure that carts are not or locked/secured consistently but also that medication cart reconciliation is occurring is reported daily in flash, and aggregated reported monthly in Performance Improvement I Committee, Medical Staff, and Governing Any ongoing non-compliance will be added to the patients.	mance ent a new uld be al. The o identify, is in ems that of a ect ed d training ing was l thip ee virtually was s m and rts every ated in a e secured in cart e is ely c correct g. Data d data is ement executive g. Board.		

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A 398	revealed a note date p.m.) which docume admitted taking crus 10/31/2020 and snot Note" dated 11/2/2020 (patient) reported to medications from a conference of Afterwards (patient) inhaled them with an documentation provition 11/6/2020 "the papossession of contra (patient) turned in a (patients) therapist in broken thermometer have been used to a medication"	Review of the clinical record and 11/1/2020 at 2000 (8:00 nted, "(Patient name) hed meds from cart ring" A "Medical Progress 20 evidenced, " Yesterday staff that (patient) stole cart on 10/31/2020. claims to have crushed and nother peer" Further ded by the facility evidenced attent reported (patient) was in aband (medication) and powder substance to a small plastic bag with probes that appeared to ttempt to snort the		through additional training and/or discipaction as appropriate. The Director of Risk Management track incidents such as medication diversions incidents of abuse and neglect. The Director of Risk Management sends the report for electronic incident tracking system daily Corporate Risk Manager and Corporate of Clinical Services for review. Timeling thoroughness of incident investigation/oplanning is assessed. In the instance of quality of the reports or action planning further development, the Director of Risk Management is contacted to take further This process will continue for at least 4 Incidents of noncompliance with incider and investigations will be reported to the Executive Officer and the Corporate Revice President. Data is aggregated and to the Performance Improvement Execution Committee weekly, and monthly to the Executive Committee and Governing B	as serious and rector of m the y to the e Director ess and action where the needs sk er action. months. nt reporting e Chief egional reported utive Medical oard.
	was reviewed and en 19. All medications medication cart or lo medication cart/room times when not in us "Milieu Management observation rounds repatients every 15 mistuations someone patient safety, espect the current situation. On 11/30/2020 at 2:3 interviewed Patient patients therapist (S stated, "I know why talked tothe person	cked cabinet22. The n will be kept locked AT ALL ie by the nurse" Under ""15 (fifteen) minute must be completed on all nutesduring CODE must be assigned to monitor cially of those not involved in	A 3	Hospital leadership review and revised procedures for securing and locking me carts, educated nursing staff, and imple monitoring to confirm ongoing compliar Please refer to A0398 for details. Plan of Correction Medication Security The Chief Nursing Officer educate nurses on expectations for safe st medication carts, keeping carts lot times, reporting when a cart is fou unlocked or not secured, securing temperature probes, and securing medication carts whenever codes prior to responding to the code. E was provided via electronic trainin (Healthstream) with competency we testing. The Chief Nursing Officer and verified that all nurses received	d all orage of cked at all of are called ducation g system erified via tracked

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	sure did. I stole the antipsychotic) and L Yes I did it twice. It then another time I to a code going on the watching and I took med cart "stole" is pills from my drawe medications I was snort them " The si (the patient) was tel and Patient #2 state the truth. I did inderwish I hadn't, but I do know it was wrong In an interview with Registered Nurse of staff member stated locked at all times a patients are to be of but staff are responsare at all times" Concerns were add Leadership (Staff M 8:45 a.m. and again Members #1,2,3,4, and ADMINISTRATION CFR(s): 482.23(c)(1) (1) Drugs and biologiadministered in acceptable staff are responsated and state laws, the order practitioners responsated in acceptable staff and biological state laws, the order practitioners responsate and state laws, the order practitioners responsate in acceptable staff and biological state laws, the order practitioners responsate in acceptable staff and biological staff and b	cations. Patient #1 stated, "I pills Seroquel (an amactil (a mood stabilizer). ook the lamactil once and took the Seroquel. There was unit and nobody was them out of the unlocked a relative term, I took my own r. 1 didn't take anybody else's going to crush them and urveyor asked Patient #2 if ling the truth about the report; ed, "Yes Ma'am. I am telling ed take the pills both times. I lid. I am trying to do better. I ." Staff Member #9, a n. 12/1/2020 at 3:20 p.m., the I, "Medication carts are to be and never left unattendedall necked every fifteen minutes sible for knowing where they ressed with Facility ember#1) on 12/1/2020 at at 4:20 p.m. with Staff and 8. OF DRUGS I), (c)(1)(i) & (c)(2) gicals must be prepared and ordance with Federal and ers of the practitioner or isible for the patient's care as 2.12(c), and accepted		 The Chief Nursing Officer and Di Pharmacy reviewed and revised and Procedure for reconciling me when a cart is found unlocked or secured, or when there is a susp medications are missing. The prenhanced as follows: The manal observing the issue through lead rounds or random checks secure medication cart, completes an interport, and notifies the pharmacia a prompt reconciliation of the me contained in the cart. If an obsernoncompliance is made during or nursing supervisor notifies the phemacial, and a pharmacist performs a reconciliation of the medication cobserved at the beginning of their person shift. The revised policy was approved Medical Executive Committee and Board. The Director of Pharmacy educal pharmacy staff on the revised procompleting a prompt reconciliation medications contained in the cart the cart is found unlocked or not Training was provided on 1:1 bas opportunity for discussion and classure understanding of expectations understanding of expectations is reported or otherwide determined to be missing. Education is reported or otherwide termined to be missing. Educations verified by quest answer and written attestation. The Chief Nursing Officer incorpeducation regarding expectations medication carts, securing temper probes, locking the carts prior to to codes, and the medication car reconciliation process into New Incommedication can be seen the medication car reconciliation process into New Incommedication can be seen the medication can reconciliation process into New Incommedication can be seen the medication can reconciliation process into New Incommedication can be seen the medication can reconciliation process into New Incommedication can be seen the medication can reconciliation process into New Incommedication can be seen the seen t	the Policy dications not cion that occess was ger ership s the cident st to perform dications vation of ff-hours, the narmacist on a first open of the dications with a first open of the dispersion of the disper	

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A 405	administered on the onot specified under § practitioners are activated law, including scope policies, and medical regulations. (2) All drugs and bioliadministered by, or user or other personnel in and State laws and rapplicable licensing raccordance with the policies and procedu. This STANDARD is Based on staff intervollinical record review and during the cours investigation, it was failed to ensure staff for medication admirfailed to ensure med all times to prevent useffected two patients the potential to affect The findings included Patient #1 and #2 we medication cart which separate occasions in the service of	cals may be prepared and orders of other practitioners (482.12(c) only if suching in accordance with State of practice laws, hospital I staff bylaws, rules, and ogicals must be under supervision of, nursing accordance with Federal egulations, including requirements, and in approved medical staffures. In the series of a complaint determined the facility staff followed basic safe practices histration. The Nursing staff ication carts were locked at unauthorized access. This is, Patient #1 and #2, but had it all patients at the facility.		Orientation and annual nursing pharmacy orientation. On 12/1/20 the Chief Operating revised the Observation Round for Unit Coordinators (Nurse Nursing Supervisors to check medication carts are locked a including during code responsemperature probes are secundone once per shift by the Urr (Nurse Manager) and/or the Supervisors. Occurrences of improperly secured medication immediate action by the man the observation. Actions include the cart, identifying the staff of the error, initiating corrective staff responsible for the cart observation, completing an information and notifying the pharmacist reconciliation needs to be concerning the enhanced auraudit tool, corrective actions responsible for the cart when followed, and the incident repexpectation to ensure a thore investigation is completed. To occurred 1:1 with understance expectations verified by questanswer and signed attestation. Person Responsible Chief Nursing Officer Summary of Ongoing Monitoring Leaders audit the medical shift to assess if they are locked as a shift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to assess if they are locked as a sift to a signed at the signed at the signed as a sift to a session and a signed at the signed as a sift to a session and a signed at the signed as a sift to a session and a signed at the signed as a sift to a session and a signed at the signed as a sift to a session and a signed at the signed as a sift to a session and a signed at the signed as a signed at the signed as a signed at the signed as a signed at the signed at the signed as a signed at the signed as a signed at the signed at the signed as a signed at the signed at	ang Officer ands Audit tool Managers) and that the ind secured, se, and that re. This audit is alt Coordinator Nursing unlocked or on carts require ager performing ude securing esponsible for action for the at the time of actiont report, that a prompt inpleted. ucated the Unit inpervisors didits, the revised for staff policy is not porting ugh this education ling of stion and in. g pip Team and tion carts every		
	medication Seroque Patient #1 was admi	and on 11/4/2020, the I was taken. itted 8/24/2020. Contained in as a "Daily RN (Registered		secure area, and temperature pro and not accessible to the patients Pharmacist audits incidents of me reconciliation. The data from each compared to assure that carts are locked/secured consistently but a	. The dication cart a source is a not only		

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A 405	Nurse) Assessment" "11/1/2020 2000 (8:00 snorting crushed med med cart on 10/21/20 (4:00 a.m.) it was doo observed acting strar check (every fifteen in was attempting to hid white substance that became agitated whe eventually stated that med cartSupervisor situation" A "Medica 11/2/2020 evidenced to staff yesterday that medications covertly behavioral code was along with another pahave crushed and inhis unclear what medications covertly behavioral code was along with another pahave crushed and inhis event actually too going to take place to claims" On 11/4/20 "Medical Progress No staff found (patient) with that appear to be crushed from (patient) with the place" Patient #2 was admitticlinical record docum suicidal precautions. revealed a note dated p.m.) which document admitted taking crush 10/31/2020 and snort Note" dated 11/2/202	note which documented, 0 p.m.) Patient admitted to its taken by peer from unit (20" On 11/4/2020 at 0400 cumented, "Patient was age during routine Q15 minute checks). Pt (patient) a appeared crushed. Pt in staff confiscatedPt (patient) got Seroquel off (name) aware of al Progress Note" dated in part: "(patient) reported (patient) obtained from the med cart while a taking place on the unit stient. (Patient) claims to alled those medications. It cations were obtained and of ok placean investigation is review the validity of these 20 it was documented in the ote: "yesterday evening with presumed medications shed. This was immediately ient)an investigation is red on 02/06/2020. The ented the Patient was on Review of the clinical record of 11/1/2020 at 2000 (8:00 tted, "(Patient name) ed meds from cart ing" A "Medical Progress 0 evidenced, "Yesterday staff that (patient) stole	A 40	medication cart reconciliation is occurri reported daily in flash, and aggregat reported monthly in Performance Im Committee, Performance Improvement Committee, Medical Staff, and Govern Any ongoing non-compliance will be through additional training and/or action as appropriate. The Director of Risk Management tracincidents such as medication diverincidents of abuse and neglect. The Risk Management sends the report electronic incident tracking system of Corporate Risk Manager and Corporate Clinical Services for review. Time thoroughness of incident investigation planning is assessed. In the instance quality of the reports or action plant further development, the Director Management is contacted to take furt This process will continue for at least Incidents of noncompliance with incider and investigations will be reported to Executive Officer and the Corporate Re President. Data is aggregated and reporteromance Improvement Executive weekly, and monthly to the Medical Committee and Governing Board. Plan of Correction Medication Security The Chief Nursing Officer educate nurses on expectations for safe stomedication carts, keeping carts locations, reporting when a cart is four unlocked or not secured, securing temperature probes, and securing medication carts whenever codes prior to responding to the code. En was provided via electronic training (Healthstream) with competency vitesting. The Chief Nursing Officer and verified that all nurses receive training. The Chief Nursing Officer and Directoric Training of the Chief Nursing Officer and Verified that all nurses receive training.	ed data is provement Executive ing Board, addressed disciplinary eks serious sions and Director of from the aily to the Director of iness and intion/action where the ing needs of Risk her action. 4 months, at reporting the Chief gional Vice inted to the Committee Executive executive did all in age of ked at all interaction in a system erified via tracked in the chief gional vice interaction in a system erified via tracked in the chief gional vice in the chief gional	01/29/2021

A93300 B. WING 12/09/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9407 CUMBERLAND ROAD	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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A 405 Continued From page 42 Afterwards (patient) claims to have crushed and inhaled them with another peer" Further documentation provided by the facility evidenced on 11/8/2020 "the patient reported (patient) was in possession of contraband (medication) and (patient) turned in a powder substance to (patient) therapist in a small plastic bag with broken thermometer probes that appeared to have been used to attempt to snort the medication" The facility policy for "Medication Administration" was reviewed and evidenced, in part. "Slorage: 19. All medications will be stored in the medication card or locked cabinet22. The medication card rolocked cabinet22. The medication card rolocked cabinet22. The medication card work must be completed on all patients every 15 minutesduring CODE situations someone must be assigned to monitor patient safety, especially of those not involved in the current situation" According to "audit documents" which were performed by facility leadership, medication cards were found unlocked on various units on 11/3, 11/4, 11/5, and 11/8/2020. On 11/30/2020 at 2:30 p.m., the surveyor interviewed Patient #1 in the presence of the patients therapist (Staff Member #5). Patient #1 stated, "I know why you're here. I figured I'd be talked to the person from Social Services, I think her name was (name), came and talked to me about it" The surveyor asked Patient #1 if they had taken the medications. Patient #1 if they had taken the medications and talked to me about it It has the process to folicity and provided on a not prov	A 405	Afterwards (patient) of inhaled them with and documentation provide on 11/6/2020 "the parpossession of contrait (patient) turned in a propossession of contrait (patients) therapist in broken thermometer have been used to at medication" The facility policy for was reviewed and everage and e	claims to have crushed and other peer" Further ded by the facility evidenced tient reported (patient) was in band (medication) and bowder substance to a small plastic bag with probes that appeared to tempt to snort the "Medication Administration" idenced, In part: "Storage: will be stored in the exed cabinet22. The will be kept locked AT ALL exe by the nurse" Under "15 (fifteen) minute must be completed on all nutesduring CODE must be assigned to monitor fally of those not involved in "According to "audit ere performed by facility on carts were found unlocked 1/3, 11/4, 11/5, and O p.m., the surveyor 1 in the presence of the aff Member #5). Patient #1 ou're here. I figured I'd be from Social Services, I think), came and talked to me eyor asked Patient #1 if they ations. Patient #1 stated, "I wills Seroquel (an mactil (a mood stabilizer).	A 4	and Procedure for reconciling method a cart is found unlocked or secured, or when there is a susp medications are missing. The penhanced as follows: The mana observing the issue through lead rounds or random checks secure medication cart, completes an in report, and notifies the pharmaci perform a prompt reconciliation of medications contained in the car observation of noncompliance is during off-hours, the nursing sup notifies the pharmacist on call, a pharmacist performs a reconcilia medication cart observed at the their next in-person shift. The revised policy was approved by the Executive Committee and Governing The Director of Pharmacy educal pharmacy staff on the revised prompleting a prompt reconciliation medications contained in the cart the cart is found unlocked or not Training was provided on 1:1 bare opportunity for discussion and cleasure understanding of expectations assure understanding of expectation is reported or otherwind determined to be missing. Education is reported or otherwind determined to be missing. Education is reported or otherwind to expectations verified by quest answer and written attestation. The Chief Nursing Officer incorpeducation regarding expectations medication carts, securing temper probes, locking the carts prior to to codes, and the medication car reconciliation process into New Eorientation and annual nursing a pharmacy orientation.	edications not icion that ocess was ger ership is the cident st to of the cident st to of the deprisor and a common of the deprisor and a common of the comm		

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A 405	a code going on the use watching and I took the med cart"stole" is a pills from my drawer. medicationsI was generated the truth. I did indeed wish I hadn't, but I did know it was wrong" In an interview with Stregistered Nurse on staff member stated, locked at all times and patients are to be chebut staff are responsible are at all times" Concerns were addre Leadership (Staff Mer 8:45 a.m. and again a Members #1,2,3,4, and members #1,2,3,4, and members #1,2,3,4, and states is a patients and again a Members #1,2,3,4, and members #1	ok the Seroquel. There was init and nobody was nem out of the unlocked relative term, I took my own I didn't take anybody else's loing to crush them and veyor asked Patient #2 if ng the truth about the report; "Yes Ma'am. I am telling I take the pills both times. I l. I am trying to do better. I lam trying to do bett		revised the Observation Rounds Audit for Unit Coordinators (Nurse Manager Nursing Supervisors to check that the medication carts are locked and secur including during code response, and it temperature probes are secure. This done once per shift by the Unit Coordi (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked improperly secured medication carts reimmediate action by the manager perf the observation. Actions include secur the cart, identifying the staff responsible the error, initiating corrective action for staff responsible for the cart at the time observation, completing an incident reand notifying the pharmacist that a progreconciliation needs to be completed. The Chief Nursing Officer educated the Coordinators and Nursing Supervisors concerning the enhanced audits, the maudit tool, corrective actions for staff responsible for the cart when policy is followed, and the incident reporting expectation to ensure a thorough investigation is completed. This education occurred 1:1 with understanding of expectations verified by question and answer and signed attestation. Incident Investigation A new Risk Manager with previous risk management experience in Virginia be employment on 11-30-2020. The Corporate Director of Risk Managent Corporate Divisional Director of C	ed, nat audit is audit is nator or equire orming ring le for the e of port, mpt e Unit evised not ation	
	The hospital must have that meet the needs of the institution must have registered pharmacistorage area under comedical staff is response.	re pharmaceutical services f the patients. ave a pharmacy directed by ist or a drug pmpetent supervision. The		Services provided education and training the Hospital Director of Risk Managem reviewing, reconciling, investigating, at reporting incidents, and on developing to prevent future recurrences. The Director of Risk Management was also provide guidelines for timeliness of completion investigations and corrective actions. Understanding of expectations laid out training was verified by question and a and signed attestation.	ng to nent on nd plans ector d of	

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A 489	drug errors. This fund be delegated to the h pharmaceutical service. This CONDITION is Based on staff intervice clinical record review, and during the course investigation, the faci services were provide all patients thus failing with this condition. The findings include: On 10/31/2020 and 1 were left unlocked an (Patient #1 and #2). of medications by the to determine the actus whether other medical missing. This resulted in a find for the rights of patier setting. Please refer to A0115 A405 and A502 for fur SECURE STORAGE CFR(s): 482.25(b)(2)(i) - All Cobe kept in a secure and locked when app This STANDARD is reason as setting.	cospital's organized ce. Inot met as evidenced by: ew, patient interview, facility document review of a complaint lity did not ensure Pharmacy ed that ensured the safety of g to substantially comply 1/4/2020 medication carts d accessed by two patients There was no reconciliation facility pharmacy services al medications taken and ations could potentially be ling of Immediate Jeopardy hats to receive care in a safe 1, A0144, A0345, A0398, hather information. (i) Irugs and biologicals must rea, ropriate. Inot met as evidenced by: ew, patient interview, facility document review		In order to strengthen and standardiz investigation and improvement proce Chief Executive Officer and the Direct Risk Management, in collaboration w Director of Human Resources, Corpo Director of Risk Management, and Corporate Divisional Director of Clinic Services, developed a new procedure the management, reporting, and investigation of abuse/neglect incider This process was added to the Abuse Neglect Reporting policy and include following steps: Immediate placement of standardized involved on administrative pending results of investigation of the employe supervisor, Director of Risk Management, and the Administrator on Call Completion of thorough investigation of allegations employee's supervisor and Director of Risk Management. Chief Executory of the investigation by the supervisor, Director Management, Chief Executory of the investigation of the investigation by the supervisor, Director Management, Chief Executory of the investigation of the investigation by the supervisor of Humagement actions to be to any. The revised policy was approved by the Medical Executive Committee and the Governing Board. Each department head or supervisor provided retraining to their employee expectations for reporting of incidents through the appropriate channels. For not able to complete remote data entitle electronic system (only Nurses and Nursing Supervisors), expectations for reporting to their immediate supervisor nursing leader on duty were included Education was provided in group and individual sessions with opportunity for discussion and clarification to assure understanding of expectations, which verified by signed attestation.	ss, the stor of ith the crate cal er for ints. er and is the laff leave attion er's cal er for its sof Risk stive man er eaken, if the er for those cy into indicator and cor

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A 502	failed to ensure the sand when a reported occurred, the facility twere reconciled to demedications that were medications were portacility failed to ensur were found to be unknot been removed. The findings included Patient #1 and #2 regundocked medication again on 11/4/2020 rewas no reconciliation report was received to medications were mismedications were mismedi	letermined the facility staff afe storage of medications unauthorized access failed to ensure medications etermine the actual etaken, and whether other tentially missing. Also the etaken medication carts ocked, that medications had emoving medications. There of medications when the other determine whether esing and the actual there were also other ication carts were found ck was done to see if any saing. Ited 8/24/2020. Contained in a "Daily RN (Registered note which documented, 0 p.m.) Patient admitted to its taken by peer from unit 1/20" On 11/4/2020 at 0400 cumented, "Patient was nige during routine Q15 ninute checks). Pt (patient) the a med cup /c (with) a pappeared crushed. Pt en staff confiscatedPt is (patient) got Seroquel off		The Director of Risk Management and reconciles incidents daily with Nursing Officer. The Chief Nursing Officer/designee reviews the Nursi Supervisor Report in the morning meeting and identifies incidents from past 24 hours. The Director of Risk Management compares the incider reported in the "flash" meeting with submitted through the electronic in reporting system by the nursing state assure that all incidents are entered investigation. Person Responsible Chief Nursing Officer Summary of Ongoling Monitoring As described above, the Leadership Te Nursing Leaders audit the medication of shift to assess if they are locked and lost secure area, and temperature probes a and not accessible to the patients. The Pharmacist audits incidents of medication reconciliation. The data from each sour compared to assure that carts are not olocked/secured consistently but also the medication cart reconciliation is occurring is reported daily in flash, and aggregate reported monthly in Performance Improcement Committee, Performance Improcement Committee, Performance Improcement Committee, Medical Staff, and Governing Any ongoing non-compliance will be addithrough additional training and/or disciplantion as appropriate. The Director of Risk Management track incidents such as medication diversions Director of Risk Management sends the from the electronic incident tracking systo the Corporate Risk Management sends the from the electronic incident tracking systo the Corporate Risk Management sends the from the electronic incident tracking systo the Corporate Risk Management sends the from the electronic incident tracking systo the Corporate Risk Management track incidents and thoroughness of incider investigation/action planning is assessed instance where the quality of the reports action. This process will continue for at action. This process will continue for at action. This process will continue for at action.	the Chief Ing Ilash" In the Icc Ints Ithose Iccident Iff to Inf	

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A 502	to staff yesterday that medications covertly behavioral code was along with another pathave crushed and inlies unclear what medicathis event actually togoing to take place to claims" On 11/4/20 "Medical Progress No staff found (patient) withat appear to be cru	, in part: "(patient) reported	A489	months. Incidents of noncompliance with reporting and investigations will be report Chief Executive Officer and the Corporat Regional Vice President. Data is aggregate reported to the Performance Improvemer Executive Committee weekly, and month Medical Executive Committee and Gover Board. Hospital leadership reviewed and revised procedures for reconciling medications in event that a medication cart is left unlock unsecured, or there is suspected or alleg diversion of medications. Leadership proceducation to nursing and pharmacy staff improvements and implemented monitors ongoing compliance. Please refer to the responses to A405 and for details.	ted to the elected and out lay to the ning 01/29/2021 the elected or elected on the elected on the elected to vided on the elected on the ele
	clinical record docum suicidal precautions. revealed a note date p.m.) which documer admitted taking crush 10/31/2020 and snor Note" dated 11/2/202 (patient) reported to smedications from a captient of the papers of contra (patient) turned in a possession of contra (patient) turned	ned meds from cart ting" A "Medical Progress t0 evidenced, " Yesterday staff that (patient) stole art on 10/31/2020. claims to have crushed and other peer" Further ded by the facility evidenced tient reported (patient) was in band (medication) and bowder substance to a small plastic bag with probes that appeared to	A502	Plan of Correction Initial Plan of Correction based on 11/2 and 12/9/20 surveys Medication Security The Chief Nursing Officer educated nurses on expectations for safe stor medication carts, keeping carts lock times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes a prior to responding to the code. Edit was provided via electronic training (Healthstream) with competency vetesting. The Chief Nursing Officer to and verified that all nurses received training. The Chief Nursing Officer and Direct Pharmacy reviewed and revised the and Procedure for reconciling medication acart is found unlocked or not secured, or when there is a suspicite.	all age of ed at all if f f re called ucation system rified via racked the tor of Policy cations t

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A 502	reports. On 11/30/2020 at app Member #1 (Quality) file that (Staff Member #4-about this. (Staff Mehere." There was doo the facility had made "rounds sheet" on 11/Cart is secure" was a According to Staff Meround on the units at utilize this document According to these "a carts were found units 11/3, 11/4, 11/5, and 11/4, 11/	proximately 12:15 p.m., Staff stated, "We cannot find any r #7- former Risk Manager) Director of Nursing) had mber #7) no longer works umentation presented that an adjustment to their 3/2020 and that "Medication dded to this document. mber #1, Leadership staff least "once a shift" and during those rounds. udit documents medication cked on various units on 11/6/2020.		medications are missing. The proce enhanced as follows: The manager observing the issue through leaders! rounds or random checks secures the medication cart, completes an incide report, and notifies the pharmacist to a prompt reconciliation of the medication contained in the cart. If an observation noncompliance is made during off-hemory of the pharmacist performs a reconciliation of the medication cart at the beginning of their next in-personal three	perform tions on of ours, the eacist on observed on shift. dedical rd. all as for the enever ored. with eation to	
	patients therapist (Stastated, "I know why you talked tothe person her name was (name about it" The survey had taken the medical sure did. I stole the pyes I did it twice. I to then another time I to a code going on the uwatching and I took the medicationsI was goills from my drawer. medicationsI was gont them" The survey whether anyone from (patient) about what (and inquired as to whether survey is to the state of the state	I in the presence of the aff Member #5). Patient #1 pu're here. I figured I'd be from Social Services, I think of the asked Patient #1 if they stions. Patient #1 stated, "I ills Seroquel and Lamactil ok the lamactil once and ok the Seroquel. There was smit and nobody was nem out of the unlocked relative term, I took my own I didn't take anybody else's spoing to crush them and		 The Chief Nursing Officer educated nursing leadership team on the processing follow when a cart is found unlocked medication is reported or otherwise determined to be missing. Education provided on a 1:1 basis with underst of expectations verified by question answer and written attestation. The Chief Nursing Officer incorporate education regarding expectations for medication carts, securing temperate probes, locking the carts prior to rest to codes, and the medication cart reconciliation process into New Emporientation and annual nursing and pharmacy orientation. On 12/1/20 the Chief Operating Officer unit Coordinators (Nurse Manage Nursing Supervisors to check that the medication carts are locked and sec 	ess to or a was anding and ed the locking are bonding doyee er ait tool ers) and e	

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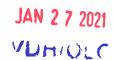
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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CHMDED	I AND HOODITAL LLC			9407 CUMBERLAND ROAD		
CUMBER	LAND HOSPITAL LLC			NEW KENT, VA 23124		
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A 502	"Yes I know (name of no one talked to me of person and you now. Patient #2 if (the patie about the report; and Ma'am. I am telling the pills both times. I trying to do better. I have the facility revealed the stated in the documer 2020, that the report to a level III and this was review that did not she medication cart. The in question was dryward on 12/1/2020 at 8:45 the timeline and finding and expressed concernivestigation and intermedications being talk expressed concern the 11/1/2020, there was prevent reoccurrence again reported that the medications from an intermedications were missingly and the person of the person	Staff Member #7) and No; except the social services" The surveyor asked ent) was telling the truth Patient #2 stated, "Yes he truth. I did indeed take wish I hadn't, but I did. I am know it was wrong" documentation provided by hat Staff Member #7 had not dated November 10, (from 11/4/2020) "did not rise was prior to the carnera ow the patient accessing the original powdery substance all dust" a.m., the surveyor reviewed high with Staff Member #1 arm regarding the lack of rivention for both reports of ten. The surveyor hat once reported on no plan put in place to and on 11/4/2020 it was		including during code response, and temperature probes are secure. This is done once per shift by the Unit Coordinator (Nurse Manager) and/or Nursing Supervisors. Occurrences of unlocked or improperly secured medicarts require immediate action by the manager performing the observation. Actions include securing the cart, ider the staff responsible for the error, initic corrective action for the staff responsis the cart at the time of observation, completing an incident report, and not the pharmacist that a prompt reconcil needs to be completed. The Chief Nursing Officer educated the Coordinators and Nursing Supervisors concerning the enhanced audits, the audit tool, corrective actions for staff responsible for the cart when policy is followed, and the incident reporting expectation to ensure a thorough investigation is completed. This educ occurred 1:1 with understanding of expectations verified by question and answer and signed attestation. Incident Investigation A new Risk Manager with previous rismanagement experience in Virginia be employment on 11-30-2020. The Corporate Director of Risk Managand Corporate Divisional Director of Cervices provided education and train the Hospital Director of Risk Manager on reviewing, reconciling, investigatin reporting incidents, and on developing to prevent future recurrences. The Diof Risk Management was also provide guidelines for timeliness of completion investigations and corrective actions.	audit the cation atifying ating ble for difying ation ation be Unit s revised ation k egan gement clinical ing to nent g, and g plans rector ed	
	Pharmacist on 12/1/2 Member #6 stated, "T	rviewed Staff Member #6, 020 T 1:20 p.m Staff 'he medication carts are Fridays. We do a cart fill		Understanding of expectations laid outraining was verified by question and a and signed attestation.		

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Facility ID:

If continuation sheet Page 49 of 50



AND DI AN OF CORRECTION IDENTIFICATION NUMBER		A, BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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A 502	report that tells us how in each cart for each clook at the contents of was a crushed substant medications, it had a drawer it came from, drawers" When ast reconciled the cart at stated, "No. That's a to look through." Whe #6) had been notified the staff member state look at the crushed substaff Member #6 state cart never reported at were never informed amedication" The survey team disc facility Leadership on (Staff Member #1) an	w many (medications) to put (patient)I was asked to f the medication cup and it unce, but did not look like tint to itI wasn't told what there are a lot of medication ked if Staff Member #6 had that time, the Staff Member lot of medications drawers in asked if (Staff Member that there were two reports, ed they were only asked to ubstance on one occasion. Ed, "The tech who fills the my doses missing and we a patient missed a dose of ussed the concerns with 12/1/2020 at 8:45 a.m. d at 10:17 a.m. (Staff d 4.) The concerns were		In order to strengthen and standardize investigation and improvement proces Chief Executive Officer and the Director Risk Management, in collaboration wit Director of Risk Management, and Corporate Divisional Director of Clinica Services, developed a new procedure management, reporting, and investigat abuse/neglect incidents. This process added to the Abuse and Neglect Repopolicy and includes the following steps of immediate placement of staff invoon administrative leave pending of investigation. Notification of the employee's supervisor, Director of Risk Management, and the Administrative Call. Completion of thorough investigation allegations by the employee's supervisor and Director of Risk Management. Review of the investigation result the supervisor, Director of Risk Management. Chief Executive Of and Director of Human Resource determine the appropriate actions taken, if any. The revised policy was approved by the Me Executive Committee and the Governing Best Executive Committee and the Governing Best Each department head or supervisor provided retraining to their employees expectations for reporting of incidents through the appropriate channels. For not able to complete remote data entry the electronic system (only Nurses and Nursing Supervisors), expectations for reporting to their immediate supervison nursing leader on duty were included. Education was provided in group and individual sessions with opportunity for discussion and clarification to assure understanding of expectations, which werified by signed attestation. The Director of Risk Management proveducation to the leadership team in group and individual sessions with opportunity for discussion to the leadership team in group and individual sessions with opportunity for discussion and clarification to assure understanding of expectations, which werified by signed attestation.	s, the or of h the ate at for the tion of swas witting stolet or on tion of stolet or on tion of stolet or on tion of stolet or on the tion of stolet or on the tion of stolet or on or those y into dor or or and or

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND HOSPITAL LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9407 CUMBERLAND ROAD NEW KENT, VA 23124	12/03/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS- COMPLÉTION	
				and individual sessions on the revise procedure for the management, repo and investigation of abuse/neglect allegations. The Administrator on Cal staff and Nursing Supervisors were a educated concerning the manageme reporting procedure to follow when the covering off-shifts and weekends. Understanding of expectations was v by question and answer and signed attestation. The Director of Risk Management revand reconciles incidents daily with the Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flameeting and identifies incidents from past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with the submitted through the electronic incidence reporting system by the nursing staff assure that all incidents are entered finvestigation. The Director of Risk Management revideo on all serious incidents. Result video review, including any inapproprist flowering and the Chief Executive Offices manager, appropriate Seleader, and the Chief Executive Offices abased on the results of the investigation. Incident Reporting Dual Reporting of Incidents: The Chief Executive Officer is committed to mo frequent communication with the state (Virginia Department of Health or VD regarding incidents and results of investigations at Cumberland Hospita hospital's previous process followed minimum requirement to report such information to the local social service agency, which then in turn was resport or reporting to VDH. In order to assist VDH is aware of serious incidents and	rting, I (AOC) iso nt and ey are erified riews e Chief sh" the lose lent to for riews s of the iate nior eer. ction ion. ef re e H) al. The the s insible ure that	

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				details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting protonotify both the local social services agency and VDH as the state regulat agency with deemed oversight of the facility's compliance with CMS Condit Participation. The Director of Risk Management is responsible for reporting serious incic the local Social Services agency and as the Regulatory Oversight agency, assuring that incident reporting is contimely and contains evidence of a coninternal investigation with disposition, findings (if any), evidence of standard compliance, and corrective actions to applicable. The facility established the process during a planning meeting Director of Quality, Director of Risk Management, Chief Operating Office Chief Executive Officer on 12/8/2020 Ongoing Oversight The leadership team formed a Perfor Improvement Executive Committee to provide oversight of the facility's international timited to, the immediate improve initiative to reduce the number of serincidents directly involving patient catemployed by the facility. The initial members of the Performant Improvement Executive Committee and Cumberland's Chief Executive Office Medical Officer, Chief Operating Officer and Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Service addition of the Divisional Director of Clinical Service addition of the Divisional Director of Clinical Service and Executive Services on the committee provides expertise on regulatory matters to induct the facility's sustained compliance with Conditions of Participation.	dents to to VDH desistent, implete dis liken, as his ith the rand ding but ment ious re staff decer, cand s. The Clinical external clude th CMS
				The committee meets on a weekly be The initial meeting agenda included in	

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				and discussion of compliance rates will direct care staff training requirements, remedial training needs, scheduling of external training resources if needed, the current status of internal investigations corrective actions taken as a result of substantiated investigations, monitoring corrective action plans, and status of external reporting requirements as applicable. The activities of the Performance Improvement Executive Committee are summarized, and the Chief Operating reports this summary to the facility's Governing Board as an agenda item at Board's monthly scheduled meetings. committee will be functional for a periol least four (4) months or longer, if neceuntil the QAPI process at Cumberland Hospital is well established and highly functional. Focused Mock Surveys: As additional reinforcement of the core team's commitment to correcting repeated quaconcerns within the facility, the core teresolved to engage the Corporate Divit Director of Clinical Services to perform quarterly mock surveys at the facility for period of one year. The mock surveys specifically focus on assessing the facility for period of one year. The mock surveys specifically focus on assessing the facility for compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statem. The first mock survey will be done in the Quarter of calendar year 2021. The Director's findings and observations with communicated to the Performance Improvement Executive Committee via action-item report. The report will be reviewed during the weekly meeting ur identified deficiencies are corrected. The facility will further include a plan for sustainability in response to corrective actions taken.	g of Officer It the This d of at ssary, allity am sional or a will ility's ent. he 1st Il be an htill the ihe	
				Additional Actions taken following the 12/29/20 survey:		

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				Oversight: The Corporate Director of Nursing, and the Corporate Vice Present Senior Vice President for Cumber Hospital have been added to Perform Improvement Executive Committee, ongoing agendas for this committee the overall functioning of the QAPI present as well as ongoing review of the effectiveness of this plan of correction. External Review of Conditions of Participation: Cumberland Hospital underwent an external review in the a 4-day survey performed by Joint Commission Resources Incorporated review took place January 4-8, 2021 focus of the survey was complianced cited CMS Conditions of Participation receipt, the survey results will be shat the leadership team at Cumberland I the Governing Board, and members Performance Improvement Executive Committee, and an action plan to add any deficiencies noted will be develod The report and action plan will be a sagenda item on the Performance Improvement Executive Committee Magenda for review of progress with correcting deficiencies. The Perform Improvement Executive Committee was turn report progress, variances, and compliance to the Governing Board amonthly meetings.	sident erland nance The include rogram of I. The With the n. Upon red with dospital, of the erlanding fleeting ance will in		
		RECEIVED JAN 2 7 2021 VDHVOLC		Based on recurrent complaints withir hospital, it was determined that the C Program should undergo a revision. Chief Operating Officer and the Corp Director of Clinical Services consulte Corporate Vice President of Perform Improvement to obtain and implement and more rigorous program that coul implemented at Cumberland Hospitanew program addresses the need to track, and monitor adverse patient occurrences and assure that a plan is implemented to show improvement in identified areas. The new program incorporates previous action plan iter.	Quality The orate d the ance at a new d be I. The identify,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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				robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. The Corporate Vice President of Performance Improvement provided to the Cumberland leadership team concerning QAPI. The goal of training to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virture over zoom, and training information with provided to the facility. Training was completed on 1/22/21. Person Responsible Chief Operating Officer Summary of Ongoing Monitoring: As described above, the Leadership Team Nursing Leaders audit the medication carts shift to assess if they are locked and locate secure area, and temperature probes are and not accessible to the patients. The Pharmacist audits incidents of medication or reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that comedication cart reconciliation is occurring, is reported daily in flash, and aggregated direported monthly in Performance Improvement Execommittee, Performance Improvement Execommittee, Performance Improvement Execommittee, Medical Staff, and Governing Exported Monitorial training and/or disciplina action as appropriate. The Director of Risk Management tracks se incidents such as medication diversions an incident of abuse and neglect. The Direct Risk Management sends the report from the electronic incident tracking system daily to Corporate Risk Manager and Corporate Direct Clinical Services for review. Timeliness thoroughness of incident investigation/actio planning is assessed. In the instance when	and every d in a ecured cart s correct Data ata is eent ecutive Board. ssed ry erious d or of e the the thector and on	

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				quality of the reports or action planning ne further development, the Director of Risk Management is contacted to take further at This process will continue for at least 4 millioridents of noncompliance with incident reporting and investigations will be reported Chief Executive Officer and the Corporate Regional Vice President. Data is aggregat reported to the Performance Improvement Executive Committee weekly, and monthly Medical Executive Committee and Govern Board.	oction. onths. Id to the ed and	

PRINTED: 01/06/2021 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND HOSPITAL LLC		94	TREET ADDRESS, CITY, STATE, ZIP CODE 407 CUMBERLAND ROAD IEW KENT, VA 23124		
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(A 000)	survey was conducted through December 2: facilities inspectors from and Certification, Virgonal The revisit was condigeopardy findings identification survey continuity of the revisit survey dentification of Participation 482.12 of Participation 482.13 (c) (2) in a Safe setting 482.13 (c) (2) in a Safe setting 482.13 (c) (3) from Abuse 482.21 (a), (c) (2), (e) (3) 482.23 of Participation 482.23 (b) (6) -Adhere to Policies and 482.23 (c) (1), (c) (1) (i), Medication Administration 482.25 (b) (2) (i) Services- Secure Storial Securic Secure Secure Storial Securic Secure Se	edicare/medicaid revisit ad December 28, 2020 9, 2020 by two (2) medical om the Office of Licensure ginia Department of Health. ucted based on immediate intified during a complaint ducted November 30, 2020 , 2020. Itermined the facility ABATED by but ALL DEFICIENCIES implaint validation survey cies include condition and ins. Governing Body - Condition Patient Rights- Care Patient Rights- Care Patient Rights- Free QAPI - Condition of UAPI- Patient Safety Nursing Services and Procedures (c)(2) Nursing Services- ation Pharmaceutical Services- ation Pharmaceutical	{A 000}	By submitting this Plan of Correction, facility does not admit that it violated the regulations. The facility also reserves right to amend the Plan of Correction anecessary and to contest the deficient findings, conclusions, and actions of the agency.	ne the as cies, ne
- DUIWIUKT L	JINEDI OK S OK PROVIDERS	outplier representative 3 signature		CGO	(X8) DATE 1/15/2001

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.

FORM CMS-2567(02-99) Previous Versions

Event ID: 5F9P12

Facility ID: VA0528

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED	
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{A 043}	GOVERNING BODY CFR(s): 482.12		{A 043	The Governing Board directed the CE Leadership group to take all corrective actions needed to address findings. Governing Board is meeting on a mon basis for at least four months to receive	r Γhe thly
	legally responsible for If a hospital does not governing body, the p	ersons legally responsible		reports of corrective actions and effectiveness of those actions based a monitoring data.	
		hospital must carry out the this part that pertain to the		Please refer to the following for details actions:	⊦d
	This CONDITION is a	not met as evidenced by:		A0115- Patient Rights- Condition of Participation A0144- Patient Rights Care in a Safe	
{A 115}	PATIENT RIGHTS CFR(s): 482.13			Setting A0145- Patient rights- Free from Abus A0263- QAPI -Condition of Participation	
	A hospital must protect patient's rights.	ct and promote each		A0286- QAPI- Patient Safety A0385- Nursing Services- Condition o Participation A0398- Nursing Services- Nurses mus	
	This CONDITION is	not met as evidenced by:		adhere to facility Policies and Procedures	
{A 144}	PATIENT RIGHTS: C. CFR(s): 482.13(c)(2)	ARE IN SAFE SETTING	=	A0405- Nursing Services - Medication Administration - Basic Safe Practices A0489- Pharmaceutical Services Cond	
	setting.	ght to receive care in a safe not met as evidenced by:		of Participation A0502- Secure Storage of Medications	s
{A 145}	PATIENT RIGHTS: FI ABUSE/HARASSME CFR(s): 482.13(c)(3)			Person Responsible Chief Executive Officer	
	The patient has the rigor of abuse or harassme	ght to be free from all forms ent.	{A 115	Hospital leadership reviewed the incid and processes cited in the CMS 2567 revised procedures and processes to	
	This STANDARD is r	not met as evidenced by:		address the incidents, educated staff, implemented monitoring to verify ongo	ping
{A 263}	QAPI CFR(s): 482.21			compliance with the rules. Leadership reports audit results to the relevant ho committees and the Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{A 263}	Continued From page	÷ 2			Please refer to the following for details A0144 and A0145	:		
	maintain an effective	velop, implement and , ongoing, hospital-wide, sessment and performance	{A 1	44}	Plan of Correction		01/29/2021	
	improvement program	n.		,	Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys		:	
	the program reflects thospital's organization hospital departments those services furnish arrangement); and for to improved health out and reduction of med. The hospital must material evidence of its QAPI	n and services; involves all and services (including ned under contract or cuses on indicators related utcomes and the prevention			The Chief Nursing Officer educate nurses on expectations for safe stof medication carts, keeping carts locked at all times, reporting where cart is found unlocked or not secure securing of temperature probes, a securing of medication carts where codes are called prior to responding the code. Education was provide electronic training system (Healthstream) with competency verified via testing. The Chief Nu Officer tracked and verified that a nurses received the training.	orage in a ired, ind never ing to d via		
{A 286}	to, an ongoing progra improvement in indical evidence that it will a medical errors. (2) The hospital must trackadverse patie (c) Program Activities (2) Performance implied track medical errors a analyze their causes,	m Scope t include, but not be limited im that shows measurable ators for which there is identify and reduce measure, analyze, and int events			The Chief Nursing Officer and Dir of Pharmacy reviewed and revise Policy and Procedure for reconcil medications when a cart is found unlocked or not secured, or when is a suspicion that medications ar missing. The process was enhan as follows: The manager observit issue through leadership rounds or random checks secures the medicart, completes an incident report notifies the pharmacist to perform prompt reconciliation of the medications contained in the cart observation of noncompliance is a during off-hours, the nursing supernotifies the pharmacist on call, an pharmacist performs a reconciliat the medication cart observed at the	there e ced ng the or cation , and a lf an made ervisor d a ion of		

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CUMBER	LAND HOSPITAL LLC			9407 CUMBERLAND ROAD	
				NEW KENT, VA 23124	
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	and learning throughout (e) Executive Respont governing body (or or who assumes full legat for operations of the hadministrative officials accountable for ensur (3) That clear expect established. This STANDARD is not service that provides and service that provides are supervised by a regist The hospital must have service that provides are supervised by a regist This CONDITION is not supervised nurses who spital must adhere the procedures of the hos nursing service must procedures of the hos nursing service must procedure of the hospital must adhere the procedure of t	sibilities, The hospital's ganized group or individual al authority and responsibility rospital), medical staff, and are responsible and ing the following: ations for safety are not met as evidenced by: See an organized nursing 24-hour nursing services. In the furnished or tered nurse. Second met as evidenced by: ONTRACT STAFF To provide services in the to the policies and pital. The director of provide for the adequate ation of all nursing responsibility of egardless of the mechanism personnel are providing		beginning of their next in-person shift. revised policy was approved by the M Executive Committee and Governing The Director of Pharmacy educated a pharmacy staff on the revised process completing a prompt reconciliation of medications contained in the cart when the cart is found unlocked or not secun Training was provided on 1:1 basis with opportunity for discussion and clarificates assure understanding of expectations The Chief Nursing Officer educated the nursing leadership team on the process follow when a cart is found unlocked, medication is reported or otherwise determined to be missing. Education a provided on a 1:1 basis with understate of expectations verified by question are answer and written attestation. The Chief Nursing Officer incorporate education regarding expectations for I medication carts, securing temperature probes, locking the carts prior to respect to codes, and the medication cart reconciliation process into New Emplot Orientation and annual nursing and pharmacy orientation. On 12/1/20 the Chief Operating Office revised the Observation Rounds Audit for Unit Coordinators (Nurse Manager Nursing Supervisors to check that the medication carts are locked and secur including during code response, and the medication carts are locked and secur including during code response, and the medication carts are locked and secur including during code response, and the medication carts are locked and secur including during code response, and the medication carts are locked and secur including during code response, and the medication carts require immediate action by the manager performing the observation.	edical Board. Il s for the never red. th ation to se ss to or a was nding nd d the ocking e ponding e ponding e or i tool s) and red, hat audit he
	services (that is, hosp lease, other agreemen	ital employee, contract,		Actions include securing the cart, iden the staff responsible for the error, initial corrective action for the staff responsible the cart at the time	ating
{A 405}	ADMINISTRATION OF	FDRUGS			

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{A 405}	CFR(s): 482.23(c)(1),	(c)(1)(i) & (c)(2)		of observation, completing an in- report, and notifying the pharma that a prompt reconciliation need completed.	cist
	administered in according State laws, the orders practitioners responsing specified under §482. standards of practice. (i) Drugs and biological administered on the order §4 practitioners are acting law, including scope of	ble for the patient's care as 12(c), and accepted als may be prepared and rders of other practitioners		The Chief Nursing Officer education Unit Coordinators and Nursing Supervisors concerning the enhancement of	enced rective he cart the ensure leted.
	(2) All drugs and biolo administered by, or un or other personnel in a and State laws and re applicable licensing reaccordance with the a policies and procedure. This STANDARD is n. Condition of Participat CFR(s): 482.25 §482.25 Condition of Pharmaceutical Service. The hospital must have that meet the needs of The institution must have a registered pharmaceutical process.	ader supervision of, nursing accordance with Federal gulations, including equirements, and in pproved medical staff es. ot met as evidenced by: ion: Pharmaceutical Se Participation: es. e pharmaceutical services of the patients. es a pharmacy directed by st or a drug mpetent supervision. The		 A new Risk Manager with previor management experience in Virging began employment on 11-30-20. The Corporate Director of Risk Management and Corporate Divibility Director of Clinical Services provied ucation and training to the Host Director of Risk Management on reviewing, reconciling, investigat and reporting incidents, and on developing plans to prevent future recurrences. The Director of Risk Management was also provided guidelines for timeliness of comporting investigations and corrective a Understanding of expectations lating training was verified by question and signed attestation. In order to strengthen and standating the investigation and improveme process, the Chief Executive Offiand the Director of Risk Manager 	nia 20. sional ided spital ing, e k letion ctions. id out on and

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2021 FORM APPROVED OMB NO. 0938-0391

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{A 502}	developing policies and drug errors. This function be delegated to the higher pharmaceutical service. This CONDITION is a SECURE STORAGE CFR(s): 482.25(b)(2)(i) - All of the kept in a secure and locked when apprint of the developing policies.	nd procedures that minimize tion may ospital's organized se. not met as evidenced by: (i) trugs and biologicals must rea,		in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corpor Divisional Director of Clinical Sendeveloped a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added the Abuse and Neglect Reporting policy and includes the following: Immediate placement of staff involved on administrative less pending results of investigation. Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call. Completion of thorough investigation of allegations by employee's supervisor and Director of Risk Management. Review of the investigation reby the supervisor, Director of Management, Chief Executive Officer, and Director of Huma Resources to determine the appropriate actions to be taken. The revised policy was approved the Medical Executive Committee the Governing Board. Each department head or superviprovided retraining to their employ on expectations for reporting of incidents through the appropriate channels. For those not able to complete remote data entry into the electronic system (only Nurses an Nursing Supervisors), expectation reporting to their immediate super and nursing leader on duty were included. Education was provided.	rector rate vices, ne ed to steps: fave on s y the t esults Risk e an en, if by and sor yees

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				group and individual sessions with opportunity for discussion and clarification to assure understand expectations, which was verified I signed attestation. The Director of Risk Management provided education to the leaders team in group and individual session the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on (AOC) staff and Nursing Supervis were also educated concerning the management and reporting proces to follow when they are covering of shifts and weekends. Understand expectations was verified by questand answer and signed attestation. The Director of Risk Management reviews and reconciles incidents with the Chief Nursing Officer. The Chief Nursing Officer/designee rest the Nursing Supervisor Report in morning "flash" meeting and identincidents from the past 24 hours. Director of Risk Management compares the incidents reported in "flash" meeting with those submitt through the electronic incident reporting system by the nursing stassure that all incidents are entered investigation. The Director of Risk Management reviews video on all serious incident Results of the video review, including any inappropriate staff behaviors, reported to the employee's management propriate Senior Leader, and the Chief Executive Officer. Staff recappropriate Corrective action base	ing of by t hip sions Call ors ne dure off- ding of stion n. t daily e views the diffes The n the sed taff to sed for the sed ger, se seive the sed the sed server the sed the sed server the sed the sed server the sed sed server the sed sed server the sed sed sed sed sed sed sed sed sed se

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				the results of the investigation.		
				 Incident Reporting Dual Reporting of Incidents: The Executive Officer is committed to frequent communication with the (Virginia Department of Health or regarding incidents and results or investigations at Cumberland How The hospital's previous process followed the minimum requireme report such information to the local social services agency, which the turn was responsible for reporting VDH. In order to assure that VDD aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadersh implemented a new dual reporting process to notify both the local services agency and VDH as the regulatory agency with deemed oversight of the facility's compliant with CMS Conditions of Participal with CMS Conditions of Participal Oversight agency, assuring that incident reporting is consistent, till and contains evidence of a compliance of tancompliance, and corrective action taken, as applicable. The facility established this process during a 	more state VDH) f spital. Int to all en in g to H is e lip g pocial state ace tion. It is ces atory mely lete tion, dards as	
		RECEIVED		planning meeting with the Director Quality, Director of Risk Manage		
		JAN 2 7 2021		Chief Operating Officer and Chie Executive Officer on 12/8/2020.		
		8008		Ongoing Oversight		
		VDHVOLC				

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				 The leadership team formed a Performance Improvement Exect Committee to provide oversight of facility's internal quality improvement initiatives, including but not limite the immediate improvement initiated reduce the number of serious incidirectly involving patient care statemployed by the facility. The initial members of the Perfor Improvement Executive Committe Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Oper Officer, Director of Quality, Direct Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of Divisional Director of Clinical Services on regulatory matters to include the facility's sustained compliance with CMS Conditions Participation. The committee meets on a weekl basis. The initial meeting agendal included review and discussion of compliance rates with direct care training requirements, remedial transplances if needed, the current sof internal investigations, corrective actions taken as a result of substantiated investigations, more of corrective action plans, and state external reporting requirements a applicable. The activities of the Performance Improvement Executive Committee Summarized, and the Chief Opera Officer reports this summary to the facility's Governing Board as an 	of the ment do to, attive to idents of the mance see are of the vices and the v

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				agenda item at the Board's mont scheduled meetings. This comm will be functional for a period of a four (4) months or longer, if neces until the QAPI process at Cumber Hospital is well established and I functional. • Focused Mock Surveys: As add reinforcement of the core team's commitment to correcting repeat quality concerns within the facility core team resolved to engage the Corporate Divisional Director of Services to perform quarterly mosurveys at the facility for a period one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, startiful the areas of concern cited in this deficiency statement. The first mean survey will be done in the 1st Quacalendar year 2021. The Director findings and observations will be communicated to the Performance Improvement Executive Committed an action-item report. The report be reviewed during the weekly mentil the identified deficiencies and corrected. The facility will further include a plan for sustainability in response to corrective actions tall Additional Actions taken following 12/29/20 survey: • Oversight: The Corporate Director Nursing, and the Corporate Vice President and Senior Vice President and Senior Vice President Cumberland Hospital have been to Performance Improvement Executive Committee. The ongoing 12/29/20 survey:	nittee at least essary, erland highly itional ed y, the e Clinical ck l of ne ng with eck arter of r's ee ee via ewill eeting e ken. the or of ent for added
				agendas for this committee include	

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			overall functioning of the QAPI proas well as ongoing review of the effectiveness of this plan of correct effectiveness of this plan of correct underwent an external review in the form of a 4-day survey performed Joint Commission Resources Incorporated. The review took planuary 4-8, 2021. The focus of the survey was compliance with the composition of Participation. The review took planuary 4-8, 2021. The focus of the Survey was compliance with the composition of Participation. The receipt, the survey results will be shared with the leadership team and Cumberland Hospital, the Governing Board, and members of the Performance Improvement Execut Committee, and an action plan to address any deficiencies noted with developed. The report and action will be a standing agenda item on Performance Improvement Execut Committee Meeting Agenda for resulting to progress with correcting deficient The Performance Improvement Executive Committee will in turn reprogress, variances, and compliar the Governing Board at its monthly meetings. Based on recurrent complaints with the hospital, it was determined the Quality Program should undergo a revision. The Chief Operating Officend the Corporate Director of Clim Services consulted the Corporate President of Performance Improve to obtain and implement a new and more rigorous program that could implemented at Cumberland Hosp The new program addresses the resident occurrences and assure the to identify, track, and monitor adversariance.	ction. al ne by nce he ited Upon to the plan the tive view ncies. eport nce to y hin at the icer ical Vice ement do be ital. need erse

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				plan is implemented to show improvement in identified areas. new program incorporates previous action plan items that require attered and development of a robust and sustainable plan to correct identificareas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provide training to the Cumberland leader team concerning QAPI. The goal training was to improve the knowlease and competency of Cumber leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was provided facility. Training was completed of 1/22/21. Person Responsible Chief Operating Officer Summary of Ongoing Monitoring: As described above, the Leadership Trand Nursing Leaders audit the medical carts every shift to assess if they are leaded to a secure area, and temperature probes are secured and naccessible to the patients. The Pharmaudits incidents of medication cart reconciliation. The data from each sour compared to assure that carts are not locked/secured consistently but also the correct medication cart reconciliation is occurring. Data is reported daily in flat and aggregated data is reported montil Performance Improvement Committee Performance Improvement Executive Executive Committee, Medical Staff, a	ed ed ed ship of edge and nd as d to the on eam tion ocked not nacist ree is only nat s sh, nly in

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				Governing Board. Any ongoing non- compliance will be addressed through additional training and/or disciplinary a as appropriate.		
				The Director of Risk Management trac serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Manage sends the report from the electronic in tracking system daily to the Corporate Manager and Corporate Director of Cl Services for review. Timeliness and thoroughness of incident investigation/action planning is assess in the instance where the quality of the reports or action planning needs furthed development, the Director of Risk Management is contacted to take furth action. This process will continue for a least 4 months. Incidents of noncomp with incident reporting and investigation will be reported to the Chief Executive Officer and the Corporate Regional Vic President. Data is aggregated and rep to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	ment cident Risk inical sed. e er ner at diance ons	
			{A 14	Initial Plan of Correction based on	01/29/2021	
				11/30/20 and 12/9/20 surveys Abuse/Neglect		
				The Chief Nursing Officer (CNO) implemented intensive staff training or providing patients with a safe setting. Training began on 12/11/20 and concluding 12/31/20. With the support of the Corp Clinical Training and Education depart led "Prevention First" for all direct care	uded porate ment,	

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				based on the CEO's request for additional training on the topics of preventing and managing power struggles with patients, milieu management, verbal de-escalatio and abuse and neglect recognition. The training is intended to extend staff's knowledge and expertise in managing challenging patient behaviors. The curriculum comple via the Healthstream platform provideos and a consistent message staff, and includes waiting room a nursing station scenarios as exam with a focus on Verbal De-escalat Crisis Prevention and Workplace Violence Prevention. The training includes post-testing to ensure competency and staff are provide opportunities for further discussion the Nursing Leadership. This custom-designed curriculum, entitled "Prevention First Training' be a required new-hire orientation course for all direct care staff as we required annual training for existing staff continuing education and standevelopment. Incident Investigation A new Risk Manager with previous management experience in Virgin began employment on 11-30-2026. The Corporate Director of Risk Management and Corporate Divist Director of Clinical Services provided ucation and training to the Hosp Director of Risk Management on reviewing, reconciling, investigating and reporting incidents, and on developing plans to prevent future.	n, n. eted vides for ind aples tion, g d n with vell as ag ff s risk ia 0. sional ded pital

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				recurrences. The Director of Risk Management was also provided guidelines for timeliness of comple of investigations and corrective ac Understanding of expectations laid in training was verified by question answer and signed attestation. In order to strengthen and standar the investigation and improvemen process, the Chief Executive Office and the Director of Risk Managemin collaboration with the Director of Risk Management, and Corpora Divisional Director of Clinical Service developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added the Abuse and Neglect Reporting policy and includes the followings of Immediate placement of involved on administrative leave pending results of investigation. Notification of the employ supervisor, Director of Risk Management, and the Administrator on Call. Completion of thorough investigation of allegation the employee's supervisor and Director of Risk Management. Review of the investigation results by the supervisor. Director of Risk Management. Review of the investigation results by the supervisor. Director of Risk Management. Review of the investigation of the Executive Officer, and Director of Risk Management. Review of the investigation results by the supervisor Director of Risk Management. The revised policy was approved the Medical Executive Committee the Governing Board.	etion ctions. d out n and rdize t eer nent, of ector ate rices, e d to steps: staff e yee's sk as by or on ment, and urces iate y, by

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				 Each department head or super provided retraining to their emploon expectations for reporting of incidents through the appropriate channels. For those not able to complete remote data entry into electronic system (only Nurses a Nursing Supervisors), expectation reporting to their immediate super and nursing leader on duty were included. Education was provided group and individual sessions we opportunity for discussion and clarification to assure understane expectations, which was verified signed attestation. The Director of Risk Management provided education to the leaded team in group and individual session the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator of (AOC) staff and Nursing Superviver also educated concerning management and reporting process to follow when they are covering shifts and weekends. Understate expectations was verified by quand answer and signed attestation. The Director of Risk Management eviews and reconciles incidents with the Chief Nursing Officer. To Chief Nursing Officer/designed the Nursing Supervisor Report in morning "flash" meeting and ide incidents from the past 24 hours Director of Risk Management compares the incidents reported "flash" meeting with those submathrough the electronic incident 	the and ons for ervisor ed in ith ding of by the ssions on Call isors the edure of festion on. Int s daily the reviews on the ontifies on the

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				reporting system by the nursing sassure that all incidents are enter investigation. The Director of Risk Managemen reviews video on all serious incide Results of the video review, including any inappropriate staff behaviors, reported to the employee's manasappropriate Senior Leader, and the Chief Executive Officer. Staff recappropriate corrective action bases the results of the investigation. Incident Reporting Dual Reporting of Incidents: The Executive Officer is committed to frequent communication with the (Virginia Department of Health or regarding incidents and results of investigations at Cumberland Hos The hospital's previous process followed the minimum requirement report such information to the local social services agency, which the turn was responsible for reporting VDH. In order to assure that VDH aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadersh implemented a new dual reporting process to notify both the local so services agency and VDH as the regulatory agency with deemed oversight of the facility's compliant	t ents. ding are ger, ne ceive ed on Chief more state VDH) spital. nt to al n in to d is e ip cial state	
				The Director of Risk Management responsible for reporting serious incidents to the local Social Service agency and to VDH as the Regular Oversight agency, assuring that incident reporting is consistent, times to the local service agency and to VDH as the Regular Coversight agency, assuring that incident reporting is consistent, times to the local service agency.	t is ces atory	

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				and contains evidence of a comp internal investigation with disposi findings (if any), evidence of stan compliance, and corrective action taken, as applicable. The facility established this process during a planning meeting with the Directo Quality, Director of Risk Manager Chief Operating Officer and Chier Executive Officer on 12/8/2020. Ongoing Oversight The leadership team formed a Performance Improvement Execution Committee to provide oversight of facility's internal quality improvement initiatives, including but not limite the immediate improvement initiative the number of serious incompliance of the Performance of the Perfor	tion, dards as or of ment, f tive f the ment d to, tive to idents f mance ee are ficer, ating or of f the vices al of y f staff aining	

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			resources if needed, the current sof internal investigations, correctivactions taken as a result of substantiated investigations, monor of corrective action plans, and state external reporting requirements a applicable. The activities of the Performance Improvement Executive Committed summarized, and the Chief Opera Officer reports this summary to the facility's Governing Board as an agenda item at the Board's month scheduled meetings. This commit will be functional for a period of at four (4) months or longer, if neces until the QAPI process at Cumber Hospital is well established and he functional. Focused Mock Surveys: As additive reinforcement of the core team's commitment to correcting repeated quality concerns within the facility core team resolved to engage the Corporate Divisional Director of Concerns at the facility for a period one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting the areas of concern cited in this deficiency statement. The first mesurvey will be done in the 1st Quality calendar year 2021. The Director findings and observations will be communicated to the Performance Improvement Executive Committed an action-item report. The report be reviewed during the weekly me until the identified deficiencies are corrected. The facility will further	itoring atus of s ee are ating ee ally eittee at least ssarry, cland ighly eitinical ck of ee ag with ock rter of t's ee ee via will eeting ee eeting ee

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					include a plan for sustainability in response to corrective actions taken Additional Actions taken following 12/29/20 survey: Oversight: The Corporate Director Nursing, and the Corporate Vice President and Senior Vice President and Senior Vice President and Hospital have been to Performance Improvement Executive Committee. The ongoing agendas for this committee include overall functioning of the QAPI president as well as ongoing review of the effectiveness of this plan of correctiveness of the Participation: Cumberland Hospital review in the form of a 4-day survey performed Joint Commission Resources Incorporated. The review took plantany 4-8, 2021. The focus of survey was compliance with the CMS Conditions of Participation. receipt, the survey results will be shared with the leadership team and Cumberland Hospital, the Govern Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted with developed. The report and action will be a standing agenda item on Performance Improvement Executive Meeting Agenda for recommittee Meeting Agenda	the or of ent for added ng le the ogram ction. tal he by ace the sited Upon at ing tive ill be o plan o the ctive eview encies.	

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					termined that the Id undergo a perating Officer ector of Clinical e Corporate Vice ince Improvement ent a new and in that could be perland Hospital. It is seen that a person of the ince Improvement ent a new and in that could be perland Hospital. It is seen that a person of the ince Improvement ent assure that a person of the ince Improvement enter identified person of the ince Improvided enter the knowledge of Cumberland enter identified person of the ince Improvided enter ince	

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				c. Injury Reduction Strategies d. Samples of about neglect responsible recommendations and thospital's current processes to dinternal plan of action to improve identified hospital's processes. In plan will be submitted to the Performent Executive Committed Governing Board for approval an implementation. Person Responsible Chief Executive Officer Summary of Ongoing Monitori Monitoring of effectiveness of train appropriateness of staff interaction patients is done through the lead rounding process. Documentation completion of rounds to each univideo review allowed for COVID observations of staff/patient internand any coaching done with staff forms are reviewed daily by the Cand Risk Manager with any correlactions needed implemented implem	nuse and nee plan at the best nee evelop an any The action formance ee and the description of the action of the action of the action of the actions at (with units), actions, actions, actions, actions, actions, actions and the action of the	

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			{A 26:	Clinical Services for review. Timelines thoroughness of incident investigation/action planning is assess In the instance where the quality of the reports or action planning needs furthed evelopment, the Director of Risk Management is contacted to take furth action. This process will continue for least 4 months. Incidents of noncomp with incident reporting and investigation will be reported to the Chief Executive Officer and the Corporate Regional View President. Data is aggregated and repto the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board. Hospital leadership reviewed and importing incidents internally, investigating incidents, taking action and reporting progress to internal committees, monitiongoing compliance, and reporting time external regulatory agencies. Please refer to A0286 for details.	sed. eer at liance ons ce orted cutive	01/29/2021
			{A 286			01/29/2021
				Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys		
				Medication Security		
		at .		 The Chief Nursing Officer educate nurses on expectations for safe st of medication carts, keeping carts locked at all times, reporting when cart is found unlocked or not secu securing of temperature probes, a securing of medication carts when 	orage a red,	

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				codes are called prior to respondithe code. Education was provide electronic training system (Healthstream) with competency verified via testing. The Chief Nu Officer tracked and verified that a nurses received the training. The Chief Nursing Officer and Dir of Pharmacy reviewed and revise Policy and Procedure for reconcil medications when a cart is found unlocked or not secured, or when is a suspicion that medications ar missing. The process was enhan as follows: The manager observi issue through leadership rounds or random checks secures the medicart, completes an incident report notifies the pharmacist to perform prompt reconciliation of the medications contained in the cart observation of noncompliance is a during off-hours, the nursing supernotifies the pharmacist on call, an pharmacist performs a reconciliate the medication cart observed at the beginning of their next in-person of the medical Executive Committee Governing Board. The Director of Pharmacy educate pharmacy staff on the revised profor completing a prompt reconciliate of the medications contained in the whenever the cart is found unlock not secured. Training was provided 1:1 basis with opportunity for discussion and clarification to assunderstanding of expectations. The Chief Nursing Officer educate nursing leadership team on the process.	rsing II rector d the ing there e leced ing the or cation i, and ia If an made ervisor id a ion of ine shift. by and ed all cess ation ie cart ied or ed on ure	

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				to follow when a cart is found unloor a medication is reported or otherwise determined to be missir Education was provided on a 1:1 with understanding of expectation verified by question and answer a written attestation. The Chief Nursing Officer incorpo the education regarding expectating for locking medication carts, secur temperature probes, locking the coprior to responding to codes, and medication cart reconciliation provinto New Employee Orientation are annual nursing and pharmacy orientation. On 12/1/20 the Chief Operating O revised the Observation Rounds A tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors check that the medication carts are locked and secured, including dure code response, and that temperate probes are secure. This audit is donce per shift by the Unit Coordina (Nurse Manager) and/or the Nursi Supervisors. Occurrences of unlow or improperly secured medication require immediate action by the manager performing the observation Actions include securing the cart, identifying the staff responsible for error, initiating corrective action for staff responsible for the cart at the of observation, completing an incireport, and notifying the pharmacithat a prompt reconciliation needs completed.	rated cons ring carts the cess and fficer Audit carts to re ing carts to re in re the cart the c
60 B				The Chief Nursing Officer educate Unit Coordinators and Nursing Supervisors concerning the enhance	

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				audits, the revised audit tool, cor actions for staff responsible for the when policy is not followed, and incident reporting expectation to a thorough investigation is compound investigation occurred 1:1 with understanding of expectations we by question and answer and signattestation. Incident Investigation A new Risk Manager with previous management experience in Virgit began employment on 11-30-202 The Corporate Director of Risk Management and Corporate Divit Director of Clinical Services proveducation and training to the Host Director of Risk Management on reviewing, reconciling, investigat and reporting incidents, and on developing plans to prevent future recurrences. The Director of Risk Management was also provided guidelines for timeliness of compof investigations and corrective a Understanding of expectations lain training was verified by question answer and signed attestation. In order to strengthen and stands the investigation and improveme process, the Chief Executive Off and the Director of Risk Manage in collaboration with the Director Human Resources, Corporate Diof Risk Management, and Corpo Divisional Director of Clinical Sedeveloped a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was additional process.	ne cart the ensure leted. erified us risk nia 20. sional ided spital ing, re k eletion actions. aid out on and ardize nt icer ment, of irector rate rvices, he	

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				the Abuse and Neglect Reportin policy and includes the following olimediate placement of involved on administrate leave pending results of investigation. Notification of the emplous supervisor, Director of Management, and the Administrator on Call. Completion of thorough investigation of allegating the employee's supervisor. Director of Risk Management. Review of the investigation results by the supervisor. Director of Risk Management. Review of the investigation results by the supervisor. Director of Human Restoner to determine the appropriate of the appropriate of the determine of th	steps: of staff ive f oyee's Risk ons by sor tion or, ement, , and ources oriate ny. the e the ons for ervisor		
	F	RECEIVED		clarification to assure understand expectations, which was verified	-		
		JAN 2 7 2021		signed attestation.	Jy		
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			 The Director of Risk Managemen provided education to the leaders team in group and individual sess on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on (AOC) staff and Nursing Supervis were also educated concerning the management and reporting proces to follow when they are covering of shifts and weekends. Understand expectations was verified by questand answer and signed attestation. The Director of Risk Management reviews and reconciles incidents with the Chief Nursing Officer. The Chief Nursing Officer/designee rest the Nursing Supervisor Report in morning "flash" meeting and identincidents from the past 24 hours. Director of Risk Management compares the incidents reported in "flash" meeting with those submitted through the electronic incident reporting system by the nursing stassure that all incidents are entered investigation. The Director of Risk Management reviews video on all serious incided Results of the video review, including any inappropriate staff behaviors, reported to the employee's manage appropriate Senior Leader, and the Chief Executive Officer. Staff recappropriate corrective action bases the results of the investigation. Incident Reporting Dual Reporting of Incidents: The Executive Officer is committed to the executive Off	call cors ne dure off- stion n. daily e views the iffies The n the ed taff to ed for ents. ling are ger, e eive d on Chief	

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				frequent communication with the (Virginia Department of Health or regarding incidents and results or investigations at Cumberland How The hospital's previous process followed the minimum requirement report such information to the local social services agency, which the turn was responsible for reportin VDH. In order to assure that VD aware of serious incidents and the details of Cumberland Hospital's investigations, however, leaders implemented a new dual reporting process to notify both the local services agency and VDH as the regulatory agency with deemed oversight of the facility's complial with CMS Conditions of Participal with CMS Conditions of Participal incidents to the local Social Service agency and to VDH as the Regulatory agency, assuring that incident reporting is consistent, the and contains evidence of a compliance, and corrective action taken, as applicable. The facility established this process during a planning meeting with the Director Quality, Director of Risk Manage Chief Operating Officer and Chied Executive Officer on 12/8/2020. **Ongoing Oversight** The leadership team formed a Performance Improvement Executive Officer on 12/8/2020. **Ongoing Oversight** The leadership team formed a Performance Improvement Executive Officer on 12/8/2020.	r VDH) f spital. Int to cal cen in g to H is ce hip g cocial cstate nce tion. Int is ices catory mely clete tion, dards ns or of ment, f	

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				the immediate improvement initial reduce the number of serious incidirectly involving patient care staff employed by the facility. The initial members of the Perform Improvement Executive Committe Cumberland's Chief Executive Off Chief Medical Officer, Chief Opera Officer, Director of Quality, Director Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of Divisional Director of Clinical Services on the committee provides externs expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions Participation. The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with direct care straining requirements, remedial traineeds, scheduling of external train resources if needed, the current sof internal investigations, corrective actions taken as a result of substantiated investigations, moni of corrective action plans, and staff external reporting requirements as applicable. The activities of the Performance Improvement Executive Committe summarized, and the Chief Opera Officer reports this summary to the facility's Governing Board as an agenda item at the Board's month scheduled meetings. This commit will be functional for a period of at four (4) months or longer, if neces until the QAPI process at Cumberl	dents f nance he are ficer, ficer, ficer, fices fices fices ficer fices ficer fices ficer fices ficer fices ficer fices fices ficer fices ficer fices ficer fices ficer	

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			 Focused Mock Surveys: As additive reinforcement of the core team's commitment to correcting repeated quality concerns within the facility core team resolved to engage the Corporate Divisional Director of Corporate Director one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting the areas of concern cited in this deficiency statement. The first measurvey will be done in the 1st Qualical Calendar year 2021. The Director findings and observations will be communicated to the Performance Improvement Executive Committee an action-item report. The report be reviewed during the weekly mean the identified deficiencies are corrected. The facility will further include a plan for sustainability in response to corrective actions taken and the identified deficiencies are corrected. The facility will further include a plan for sustainability in response to corrective actions taken and the Corporate Vice President and Senior Vice President and Senior Vice President and Senior Vice President and Senior Vice President Cumberland Hospital have been a to Performance Improvement Executive Committee. The ongoin agendas for this committee include overall functioning of the QAPI proas well as ongoing review of the effectiveness of this plan of corrective effectiveness of this plan	tional ed to the ed to the ed	

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				 External Review of Conditions of Participation: Cumberland Hospi underwent an external review in the form of a 4-day survey performed Joint Commission Resources Incorporated. The review took planuary 4-8, 2021. The focus of survey was compliance with the CMS Conditions of Participation. receipt, the survey results will be shared with the leadership team a Cumberland Hospital, the Govern Board, and members of the Performance Improvement Execut Committee, and an action plan to address any deficiencies noted will be a standing agenda item on Performance Improvement Execut Committee Meeting Agenda for recomplianted the Governing Board at its monthly meetings. Based on recurrent complaints with the hospital, it was determined the Quality Program should undergo a revision. The Chief Operating Officiand the Corporate Director of Clin Services consulted the Corporate President of Performance Improve to obtain and implement a new an more rigorous program that could implemented at Cumberland Hosp The new program addresses the reto identify, track, and monitor advepatient occurrences and assure the plan is implemented to show improvement in identified areas. New program incorporates previous action plan items that require atternations. 	he by ace the ited Upon at ing tive ill be plan the tive view ncies. eport nce to y thin at the a icer ical Vice ement d be bital. need erse at a The us

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				and development of a robust and sustainable plan to correct identicareas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provict training to the Cumberland leaded team concerning QAPI. The goat training was to improve the known base and competency of Cumberleadership regarding a rigorous a sustainable program. Training we conducted virtually over zoom, attraining information was provided facility. Training was completed 1/22/21. Person Responsible Chief Executive Officer Summary of Ongoing Monitoring: As described above, the Leadership and Nursing Leaders audit the medicaters every shift to assess if they are and located in a secure area, and temperature probes are secured and accessible to the patients. The Pharma udits incidents of medication cart reconciliation. The data from each so compared to assure that carts are not locked/secured consistently but also the correct medication cart reconciliation occurring. Data is reported daily in fland aggregated data is reported month Performance Improvement Committee Performance Improvement Executive Committee, Medical Staff, and Govern Board. Any ongoing non-compliance addressed through additional training and/or disciplinary action as appropria	ded ership al of eledge rland and eas end d to the on Team ation locked not macist urce is d only that is esh, thly in e, ning will be	

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				seriodive negl seno tracl Man Serv thord inve In th repo deve Man actic leas with will t Offic Pres to th	Director of Risk Management tractous incidents such as medication resions and incidents of abuse and lect. The Director of Risk Manage dist the report from the electronic inking system daily to the Corporate lager and Corporate Director of Clivices for review. Timeliness and oughness of incident stigation/action planning is assess the instance where the quality of the lorts or action planning needs further elopment, the Director of Risk lagement is contacted to take further. This process will continue for at 4 months. Incidents of noncompincident reporting and investigation be reported to the Chief Executive cer and the Corporate Regional Visident. Data is aggregated and reported to the Performance Improvement Executive Weekly, and monthly to the lical Executive Committee and erning Board.	ment cident Risk nical ed. er er at liance ns		
			{A 3i	proc med and ongo	pital leadership review and revised sedures for securing and locking lication carts, educated nursing statemented monitoring to confirmation compliance. The property of the security is a security of the se	off,	01/29/2021	
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				securing of medication carts when codes are called prior to responding the code. Education was provide electronic training system (Healthstream) with competency verified via testing. The Chief Nu Officer tracked and verified that a nurses received the training. The Chief Nursing Officer and Dir of Pharmacy reviewed and revise Policy and Procedure for reconcili medications when a cart is found unlocked or not secured, or when is a suspicion that medications armissing. The process was enhan as follows: The manager observing issue through leadership rounds or random checks secures the medicatr, completes an incident report notifies the pharmacist to perform prompt reconciliation of the medications contained in the cart. observation of noncompliance is reduring off-hours, the nursing supernotifies the pharmacist on call, and pharmacist performs a reconciliation the medication cart observed at the beginning of their next in-person some The revised policy was approved the Medical Executive Committee Governing Board. The Director of Pharmacy educate pharmacy staff on the revised profor completing a prompt reconciliation the medications contained in the whenever the cart is found unlocked not secured. Training was provided 1:1 basis with opportunity for discussion and clarification to assunderstanding of expectations. The Chief Nursing Officer educated	rsing il ector d the ing there e ced ng the or cation , and a lf an made rvisor d a on of he shift. by and ed all cess tion e cart ed or ed on ure

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				nursing leadership team on the proto follow when a cart is found unlour or a medication is reported or otherwise determined to be missin Education was provided on a 1:11 with understanding of expectations verified by question and answer at written attestation. The Chief Nursing Officer incorporate education regarding expectation for locking medication carts, secur temperature probes, locking the caprior to responding to codes, and it medication cart reconciliation production into New Employee Orientation an annual nursing and pharmacy orientation. On 12/1/20 the Chief Operating Officer evised the Observation Rounds A tool for Unit Coordinators (Nurse Managers) and Nursing Supervisos check that the medication carts are locked and secured, including duric code response, and that temperate probes are secure. This audit is donce per shift by the Unit Coordina (Nurse Manager) and/or the Nursin Supervisors. Occurrences of unloc or improperly secured medication require immediate action by the manager performing the observation Actions include securing the cart, identifying the staff responsible for error, initiating corrective action for staff responsible for the cart at the of observation, completing an incidereport, and notifying the pharmacis that a prompt reconciliation needs completed. The Chief Nursing Officer educated Unit Coordinators and Nursing	rated ons ing arts the tess ad ficer audit was to be ng ure one ator ng cked carts on. the time tent at to be	

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				process into New Employee Orier and annual nursing and pha orientation. On 12/1/20 the Chief Operating Orevised the Observation Rounds / tool for Unit Coordinators (Nurse Managers) and Nursing Supervise check that the medication carts an locked and secured, including dur code response, and that temperat probes are secure. This audit is conce per shift by the Unit Coordin (Nurse Manager) and/or the Nursi Supervisors. Occurrences of unlo or improperly secured medication require immediate action by the manager performing the observati Actions include securing the cart, identifying the staff responsible for error, initiating corrective action for staff responsible for the cart at the of observation, completing an inci report, and notifying the pharmaci that a prompt reconciliation needs completed. The Chief Nursing Officer educated Unit Coordinators and Nursing Supervisors concerning the enharm audits, the revised audit tool, correactions for staff responsible for the when policy is not followed, and the incident reporting expectation to eat horough investigation is completed. This education occurred 1:1 with understanding of expectations ver by question and answer and signed attestation. Incident Investigation A new Risk Manager with previous management experience in Virginians.	officer Audit ors to re ring ture done ator ing cked carts ion. r the or the etime dent st to be ed the inced ective e cart ne insure eted. diffied ed

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				 The Corporate Director of Risk Management and Corporate Division Director of Clinical Services provied education and training to the Hos Director of Risk Management on reviewing, reconciling, investigating and reporting incidents, and on developing plans to prevent future recurrences. The Director of Risk Management was also provided guidelines for timeliness of comploof investigations and corrective act Understanding of expectations laid in training was verified by question answer and signed attestation. In order to strengthen and standate the investigation and improvement process, the Chief Executive Officiand the Director of Risk Management in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Service developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added the Abuse and Neglect Reporting policy and includes the following solimited placement of involved on administrative leave pending results of investigation Notification of the employ supervisor, Director of Risk Management, and the Administrator on Call Completion of thorough investigation of allegation the employee's supervisor and Director of Risk 	sional ded pital ng, e cetion ctions. d out n and rdize t cer nent, of ector ate ices, e d to tteps: staff e vee's sk	

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				compares the incidents reported "flash" meeting with those substhrough the electronic incident repsystem by the nursing staff to a that all incidents are entered investigation. Person Responsible Chief Nursing Officer Summary of Ongoing Monitoring As described above, the Leadership Teand Nursing Leaders audit the medicat carts every shift to assess if they are leand located in a secure area, and temperature probes are secured and naccessible to the patients. The Pharmaudits incidents of medication cart reconciliation. The data from each sour compared to assure that carts are not a locked/secured consistently but also the correct medication cart reconciliation is occurring. Data is reported daily in flast and aggregated data is reported month Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governi Board. Any ongoing non-compliance wand addressed through additional training and/or disciplinary action as appropriated. The Director of Risk Management to serious incidents such as medical diversions. The Director of Management sends the report from electronic incident tracking system dathe Corporate Risk Manager and Corp Director of Clinical Services for real Timeliness and thoroughness of incinvestigation/action planning is assessed the instance where the quality of the record action planning needs further	eam tion tion tion tion tion tion tion tion		

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			{A48	development, the Director of Risk Management is contacted to take furth action. This process will continue for a least 4 months. Incidents of noncomp with incident reporting and investigation will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reput to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board. Hospital leadership reviewed and revision the event that a medication cart is lead unlocked or unsecured, or there is suspected or alleged diversion of medications. Leadership provided education to nursing and pharmacy state improvements and implemented monitors to verify ongoing compliance. Please refer to the responses to A40 A502 for details.	at liance ns ce orted cutive	01/29/2021
			(A502	Plan of Correction Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys		01/29/2021
				Medication Security		
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			or a medication is reported or otherwise determined to be missin Education was provided on a 1:1 with understanding of expectation verified by question and answer a written attestation. The Chief Nursing Officer incorporate education regarding expectation for locking medication carts, secund temperature probes, locking the compiler to responding to codes, and medication cart reconciliation production into New Employee Orientation are annual nursing and pharmacy orientation. On 12/1/20 the Chief Operating Orientation. In the Chief Observation Rounds Are tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors check that the medication carts and locked and secured, including duricode response, and that temperate probes are secure. This audit is donce per shift by the Unit Coordinator (Nurse Manager) and/or the Nursi Supervisors. Occurrences of unlocor improperly secured medication require immediate action by the manager performing the observation Actions include securing the cart, identifying the staff responsible for error, initiating corrective action for staff responsible for the cart at the of observation, completing an incide report, and notifying the pharmacis that a prompt reconciliation needs completed. The Chief Nursing Officer educates	basis is and rated ons ring arts the cess and ficer Audit ors to e ing ure cone cator ang cked carts on. The rine dent ime dent is to be ed the ursing anced anced in the cars on the cator and the ca	

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				actions for staff responsible for when policy is not followed, and incident reporting expectation to a thorough investigation is com. This education occurred 1:1 wit understanding of expectations by question and answer and significant attestation. Incident Investigation A new Risk Manager with previous began employment on 11-30-20 The Corporate Director of Risk Management and Corporate Director of Clinical Services producation and training to the House Director of Risk Management or reviewing, reconciling, investigation and reporting incidents, and on developing plans to prevent futtor recurrences. The Director of Risk Management was also provided guidelines for timeliness of como finvestigations and corrective Understanding of expectations in training was verified by quest answer and signed attestation. In order to strengthen and start the investigation and improprocess, the Chief Executive Off the Director of Risk Manager collaboration with the Director of Resources, Corporate Director Management, and Corporate Director of Clinical Services, de a new procedure for the manareporting, and investigation abuse/neglect incidents. This was added to the Abuse and Reporting	the pensure pleted. h verified ined visional vided pspital nations. aid out ion and iderdize prement icer and nent, in Fluman of Risk ivisional veloped gement, on of process	

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			policy and includes the following Immediate placement of staff involved on administrative lea pending results of investigatio Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call Completion of thorough investigation of allegations by employee's supervisor and Director of Risk Management Review of the investigation re by the supervisor, Director of Management, Chief Executive Officer, and Director of Huma Resources to determine the appropriate actions to be take any. The revised policy was approved the Medical Executive Committee the Governing Board. Each department head or supervis provided retraining to their employ on expectations for reporting of incidents through the appropriate channels. For those not able to complete remote data entry into th electronic system (only Nurses an Nursing Supervisors), expectation reporting to their immediate super and nursing leader on duty were included. Education was provided group and individual sessions with opportunity for discussion and clarification to assure understandil expectations, which was verified b signed attestation. The Director of Risk Manage provided education to the leade team in group and individual sessi	ave on s y the sults Risk e en en, if by and sor yees ne dd is for visor d in en	

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				on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator of (AOC) staff and Nursing Superviwere also educated concerning management and reporting process to follow when they are covering shifts and weekends. Understare expectations was verified by quee and answer and signed attestations. The Director of Risk Management reviews and reconciles incidents with the Chief Nursing Officer. The Chief Nursing Officer/designeer the Nursing Supervisor Report in morning "flash" meeting and ideincidents from the past 24 hours Director of Risk Management compares the incidents reported "flash" meeting with those submit through the electronic incident reporting system by the nursing assure that all incidents are enterinvestigation. The Director of Risk Management reviews video on all serious incidents reported to the employee's management reviews video on all serious incidents and inappropriate Senior Leader, and Chief Executive Officer. Staff reappropriate corrective action batthe results of the investigation. Incident Reporting Dual Reporting of Incidents: The Executive Officer is committed frequent communication with the (Virginia Department of Health or regarding incidents and results of the entry and results of the regarding incidents and results of the resul	n Call isors the edure off- nding of estion on. Int is daily he eviews in the ntifies in the itted staff to ered for Int dents. uding s, are ager, the ecceive sed on The Chief to more ne state or VDH)

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				investigations at Cumberland Hos The hospital's previous process followed the minimum requirement report such information to the loc social services agency, which the turn was responsible for reporting VDH. In order to assure that VDI aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadersh implemented a new dual reporting process to notify both the local so services agency and VDH as the regulatory agency with deemed oversight of the facility's compliant with CMS Conditions of Participa. The Director of Risk Management responsible for reporting serious incidents to the local Social Servit agency and to VDH as the Regul Oversight agency, assuring that incident reporting is consistent, tit and contains evidence of a compliant investigation with dispositindings (if any), evidence of stant compliance, and corrective action taken, as applicable. The facility established this process during a planning meeting with the Director Quality, Director of Risk Manager Chief Operating Officer and Chief Executive Officer on 12/8/2020. Ongoing Oversight The leadership team formed a Performance Improvement Executive Officer on 12/8/2020. Ongoing Oversight The leadership team formed a Performance Improvement finitial reduce the number of serious incidirectly involving patient care stated directly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidirectly involving patient care stated in the province of serious incidents in the province of serious incidents in the province of serious incid	nt to all en in growth to all en in

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				 employed by the facility. The initial members of the Perforn Improvement Executive Committe Cumberland's Chief Executive Of Chief Medical Officer, Chief Open Officer, Director of Quality, Direct Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of Divisional Director of Clinical Services on the committee provides extern expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions Participation. The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with direct care training requirements, remedial traneeds, scheduling of external train resources if needed, the current sof internal investigations, corrective actions taken as a result of substantiated investigations, mon of corrective action plans, and state external reporting requirements as applicable. The activities of the Performance Improvement Executive Committee summarized, and the Chief Opera Officer reports this summary to the facility's Governing Board as an agenda item at the Board's month scheduled meetings. This commit will be functional for a period of at four (4) months or longer, if neces until the QAPI process at Cumber Hospital is well established and his functional. 	ee are ficer, ating or of the vices al of staff aining ning tatus ve itoring tus of s ee are eting e least ssary, land	

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				Focused Mock Surveys: As additional Actions to deficiency survey: Surveys and the actions taken following to describe a plan for sustainability in response to corrective actions taken following to deficiency surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting the areas of concern cited in this deficiency statement. The first measurvey will be done in the 1st Qualicalendar year 2021. The Director findings and observations will be communicated to the Performance Improvement Executive Committed an action-item report. The reporting the identified deficiencies are corrected. The facility will further include a plan for sustainability in response to corrective actions taken Additional Actions taken following to take the province of the plan for sustainability in response to corrective actions taken Additional Actions taken following to take the province of the plan for sustainability in response to corrective actions taken Additional Actions taken following to take the province of the province taken following to take the province of the province taken following to take the province taken for the province taken for the province taken for the province taken for the province taken fo	ed y, the elinical ck of e g with ock rter of 's e ee via will eeting en. the
				 Oversight: The Corporate Directo Nursing, and the Corporate Vice President and Senior Vice Preside Cumberland Hospital have been a to Performance Improvement Executive Committee. The ongoin agendas for this committee include overall functioning of the QAPI pro as well as ongoing review of the effectiveness of this plan of correct 	ent for odded ng e the ogram
	i.			External Review of Conditions of Participation: Cumberland Hospita underwent an external review in the	al

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		RECEIV JAN 2 7 7 VDH/O	2021	form of a 4-day survey performed Joint Commission Resources Incorporated. The review took plat January 4-8, 2021. The focus of the survey was compliance with the commission of Participation. Receipt, the survey results will be shared with the leadership team and Cumberland Hospital, the Governing Board, and members of the Performance Improvement Execution Committee, and an action plan to address any deficiencies noted with developed. The report and action will be a standing agenda item on Performance Improvement Execution Committee Meeting Agenda for resulting of progress with correcting deficient. The Performance Improvement Executive Committee will in turn resulting progress, variances, and compliant the Governing Board at its monthly meetings. Based on recurrent complaints with the hospital, it was determined that Quality Program should undergo a revision. The Chief Operating Officand the Corporate Director of Clinic Services consulted the Corporate President of Performance Improve to obtain and implement a new and more rigorous program that could implemented at Cumberland Hosp. The new program addresses the note identify, track, and monitor adversation plan items that require attention and development of a robust and sustainable plan to correct identification and prevent repeated	ace the ited Upon at ing tive II be plan the tive view ncies. eport nce to y thin at the a icer ical Vice ement d be ital heed erse at a The is ntion	

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				diversions and incidents of abuse and neglect. The Director of Risk Manage sends the report from the electronic in tracking system daily to the Corporate Manager and Corporate Director of C Services for review. Timeliness and thoroughness of incident investigation/action planning is asses in the instance where the quality of the reports or action planning needs furth development, the Director of Risk Management is contacted to take furth action. This process will continue for least 4 months. Incidents of noncomp with incident reporting and investigation will be reported to the Chief Executive Officer and the Corporate Regional V President. Data is aggregated and reported to the Performance Improvement Execommittee weekly, and monthly to the Medical Executive Committee and Governing Board.	ement ncident e Risk linical sed. e er her at bliance bns c cce corted cutive		