cumberland
hospital for children and adolescents

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	493300	A. BUILDING _____ B. WING _____	C 12/29/2020

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

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A 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted 12/28/2020 through 12/29/2020 by two (2) Medical Facilities Inspectors from Virginia Department of Health, Office of Licensure and Certification. Complaint #VA00050309 was investigated and found to be substantiated. The facility was not in compliance with 42 CFR Part 482: Conditions of Participation for Hospitals (last updated February 2020). A condition level deficiency was cited: §482.21 Condition of Participation: Quality Assessment and Performance Improvement Program	A 000	By submitting this Plan of Correction, the facility does not admit that it violated the regulations. The facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the	
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate	A 263	Hospital leadership reviewed, revised, and enhanced the quality assurance performance improvement system; educated relevant staff on the improvements; and implemented monitoring to confirm ongoing effectiveness of the program. Please refer to A0286 for details.	1/29/2021

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

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A 263	Continued From page 1 evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on clinical record review, staff interview, facility document review and during the course of a complaint investigation, it was determined the facility failed to ensure the Quality Assessment of Performance Improvement (QAPI) program was effectively monitoring and reviewing patient care concerns thus failing to substantially comply with this condition. The findings include: The facility has an outstanding condition level deficiency related to the QAPI program based on survey findings for complaints #VA00050091 and VA00050244. This complaint survey revealed an additional QAPI related deficiency. Please refer to A0286 for further information.	A 263		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze	A 286	**Plan of Correction** **<u>Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys</u>** *Incident Investigation* • A new Risk Manager with previous risk management experience in Virginia began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital Director of Risk Management on reviewing,	1/29/2021

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A 286	Continued From page 2 their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on interviews, record reviews and during the course of a complaint investigation, it was determined the facility failed to thoroughly investigate and review an allegation they received related to patient abuse. The findings include: On 12/28/2020, the surveyor received a document titled, Risk Management Investigation 12/4/2020. This document was in reference to a complaint investigation the surveyor was conducting. The document outlined the allegation received by the facility, the investigation conducted, the conclusion, and the follow up action. Staff Member (SM) #4 (Director of Risk) conducted the investigation, which included interviewing the patient (Patient #2) of the alleged abuse, two peers of the patient, and a review of camera footage. The document read in part: "Conclusion: Due to lack of evidence and statements above this allegation has been found to be false." On 12/28/2020, the surveyor reviewed the clinical	A 286	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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if any.	

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A 286	Continued From page 3 record for Patient #2. On 12/1/2020 at 2200, a progress note was written by SM #11 (Behavioral Tech.) documenting their eyewitness account of an incident that occurred between Patient #2 and SM #8 (Registered Nurse). On 12/1/2020 at 2240, a progress note was written by SM #9 (Registered Nurse) documenting their eyewitness account of the incident that occurred between Patient #2 and SM #8. On 12/2/2020, a medical progress note contained evidence that SM #12 (Certified Pediatric Nurse Practitioner) was aware of the incident involving Patient #2 and a concern from Patient #2 that "a nurse was allowing patients to access [the nurse's] phone" and that the "concern has been escalated to the Risk Manager and CNO [Chief Nursing Officer] for further investigation. An interview was conducted on 12/28/2020 with SM #6 (Corporate representative) and SM #4. SM #4 explained the investigation was conducted by reviewing the record and video footage and conducting interviews with the patient and peers. SM #4 stated, "I was not able to conduct interviews with the nurses." SM #4 did not provide further explanation as to why the interviews could not be conducted. SM #6 stated, "This is the first I am seeing of this report. We are in the process of changing wording and will no longer be using the word false. The word false gives the wrong impression like none of the allegation happened." The investigation documentation presented to the surveyors revealed a failure to thoroughly conduct a complete investigation. There was no documentation that an attempt was made to interview the nurses involved, the behavioral technician involved, or any follow-up conducted	A 286	The revised policy was approved by the Medical Executive Committee and the Governing Board. • Each department head or supervisor provided retraining to their employees 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation. • The Director of Risk Management provided education to the leadership team in group and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies	

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A 286	Continued From page 4 with SM #12 to gather additional information. Additionally, a review of the investigation results had not been conducted by any member of the leadership staff prior to 12/28/2020. On 12/29/2020, the surveyors discussed the concerns regarding the internal investigation of the allegation with SM #2 (Chief Operating Officer), #4, and #6. SM #2, SM #4, and SM #6 acknowledged the concerns and discussed the changes the facility is making moving forward. Prior to the exit conference on 12/29/2020, the surveyor was provided an amended copy of the document titled, "Risk Management Investigation 12/4/2020". The document reads in part: "Conclusion: Based on this investigation it was reviewed that the patient's behavior/actions of pouring the shampoo on the RN [Registered Nurse] was substantiated. The act of the RN pushing the pt. [patient] was unsubstantiated due to lack of witnesses, and no video footage due to the incident occurring outside of camera view."	A 286	incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief 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. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious	

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		A 286	incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda	

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		A 286	included review and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until 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 quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be communicated to the Performance Improvement Executive Committee via	

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		A 286	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 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 QAPI program 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 form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement	

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		A 286	Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, 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 items that require attention and development of a robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was provided to the facility. Training was completed on 1/22/21. • **Person Responsible** Chief Operating Officer	

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		A 286	**Summary of Ongoing Monitoring:** The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	

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A 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted 11/30/2020 through 12/9/2020 by three (3) Medical Facilities Inspectors (MFI's) from the Office of Licensure and Certification (OLC), Virginia Department of Health (VDH). The facility was not in compliance with 42 CFR Part 482 for the Conditions of Participation for Hospitals. During the investigation a finding of Immediate Jeopardy was identified at 482.13 Patient Rights. Areas of concern identified included the following: 482.12 Governing Body - Condition of Participation 482.13 Patient Rights- Condition of Participation 482.13(c)(2) Patient Rights-Care in a Safe setting 482.13(c)(3) Patient Rights- Free from Abuse 482.21 QAPI - Condition of Participation 482.21(a),(c)(2),(e)(3) QAPI- Patient Safety 482.23 Nursing Services - Condition of Participation 482.23(b)(6) Nursing Services -Adhere to Policies and Procedures 482.23(c)(1),(c)(1)(i),(c)(2) Nursing Services- Medication Administration 482.25 Pharmaceutical Services- Condition of Participation 482.25(b)(2)(i) Pharmaceutical Services- Secure Storage Complaint #VA00050091 and VA00050244 were found to be SUBSTANTIATED with deficient	A 000	By submitting this Plan of Correction, the facility does not admit that it violated the regulations. The facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CEO	1/15/2021

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A 000	Continued From page 1 practice at the condition level. As of 12/9/2020, the facility remained in Immediate Jeopardy due to failure to present an acceptable plan of removal.	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on complaint survey findings of Immediate Jeopardy, the facility Governing Body did not provide oversight of the hospital to ensure the protection of the safety of all patients thus failing to substantially comply with this condition. The findings include: A finding of Immediate Jeopardy was identified on 12/1/2020 regarding patient rights for care in a safe setting and protection of patients from Abuse. An unlocked medication cart was accessed by patients of the facility and drugs were removed which could have resulted in injury, permanent harm or death to the patients involved. The facility failed to follow its policy and procedures for the investigation of the first allegation when reported, thus allowing a recurrence of a second report of patients removing medications from an	A 043	The Governing Board directed the CEO and Leadership group to take all corrective actions needed to address findings. The Governing Board is meeting on a monthly basis for at least four months to receive reports of corrective actions and effectiveness of those actions based upon monitoring data. Please refer to the following for detailed actions: A0115- Patient Rights- Condition of Participation A0144- Patient Rights Care in a Safe Setting 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 adhere to facility Policies and Procedures A0405- Nursing Services - Medication Administration - Basic Safe Practices A0489- Pharmaceutical Services Condition of Participation A0502- Secure Storage of Medications **Person Responsible** Chief Executive Officer	01/29/2021

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A 043	Continued From page 2 unlocked medication cart. The facility failed to put into place a plan to prevent recurrence and promote patient safety. On 12/1/2020, a Staff Member grabbed a patient by the arms and "shoved" the patient into a chair and began yelling at the patient. The facility investigated and and addressed the concern, however the facility has experienced multiple complaints concerning allegations of abuse of patients by staff. These allegations, which although may have been identified and addressed by the facility, demonstrated a recurring concern regarding systemic failure of the facility regarding protection of patients. The Governing Body of the facility has failed to provide oversight to the facility in recognizing and ensuring the facility establish sustainable plans to prevent recurrence of these concerns. See the following tags: A0115- Patient Rights- Condition of Participation -finding of Immediate Jeopardy A0144- Patient Rights Care in a Safe Setting 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 adhere to facility Policies and Procedures A0405- Nursing Services - Medication Administration - Basic Safe Practices A0489- Pharmaceutical Services Condition of Participation A0502- Secure Storage of Medications The facility presented a plan of removal for the	A 043		

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A 043	Continued From page 3 Immediate Jeopardy findings on 12/9/2020 at 12:20 p.m. After review and consideration by the Centers for Medicare and Medicaid Services and the State Agency, the plan was determined to be unacceptable and the facility remained in Immediate Jeopardy as of 12/9/2020 at 3:00 p.m.. The facility Leadership (Staff Members #1, 2, 3, 4, 8 and #13- Corporate Regional Regulatory Director) were notified at that time of the plan not being accepted and the Immediate Jeopardy remaining in effect.	A 043		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on complaint survey findings of Immediate Jeopardy, the facility staff did not ensure the protection of the patients rights to a safe environment and to be free from all forms of abuse thus failing to substantially comply with this condition. The findings include: It was reported two patients having access to an unlocked medication cart, taking the medication Lamactil (Lamotrigine/Lamactil is a mood stabilizer medication) and crushing and "snorting" some of the medication. This occurred on 10/31/2020. It was reported by Patient #1 and #2 on 11/01/2020. The facility failed to conduct a full investigation and put a plan in place to prevent a reoccurrence. On 11/4/2020, Patient #1 and #2 were again able to access an unlocked medication cart and obtain the medication	A 115	Hospital leadership reviewed the incidents and processes cited in the CMS 2567, revised procedures and processes to address the incidents, educated staff, and implemented monitoring to verify ongoing compliance with the rules. Leadership reports audit results to the relevant hospital committees and the Board. Please refer to the following for details: A0144 and A0145	01/29/2021

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A 115	Continued From page 4 Seroquel (Seroquel- [quetiapine] is an antipsychotic medicine.) and crush the medications intending to "snort" the medication as was documented in the clinical records. There was no evidence the facility had begun to address this issue until 11/6/2020 and no formal/full investigation was conducted. Patient #1 was interviewed by the surveyor on 12/1/2020 regarding the allegation of taking the medications and stated the allegations were true. Patient #2 was no longer residing at the facility and could not be interviewed. It was reported a staff member "grabbed" a patient by the arms and "shoved" the patient into a chair and yelled at the patient. This occurred on 12/1/2020. The facility suspended the staff member immediately pending the investigation. An investigation of the allegation was completed and determined it to be substantiated and the staff member was terminated. The facility presented the survey team with evidence of inservices conducted with staff of the Unit on which the event occurred. The inservices were "Power Struggles and Abuse and Neglect". Inservices were documented as being conducted on 12/4/2020. Inservices were then conducted with all direct care staff on 12/4, 12/5, 12/6, 12/7, 12/8 and 12/9/2020. The survey team discussed with facility staff Members #1, 2, and #3 through out the survey the concerns regarding multiple complaints received by the state agency of ongoing patient care issues and abuse. The survey team discussed with the facility leadership these allegations demonstrate a systematic problem with regard to action plans previously developed, and the urgency and immediacy for the facility to	A 115		

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A 115	Continued From page 5 review their systems in order to develop robust and sustainable plans to correct the concerns and prevent recurrence. The facility presented a plan of removal for the Immediate Jeopardy findings on 12/9/2020 at 12:20 p.m. After review and consideration by the Centers for Medicare and Medicaid Services and the State Agency, the plan was determined to be unacceptable and the facility remained in Immediate Jeopardy as of 12/9/2020 at 3:00 p.m.. The facility Leadership (Staff Members #1, 2, 3, 4, 8 and #13- Corporate Regional Regulatory Director) were notified at that time of the plan not being accepted and the Immediate Jeopardy remaining in effect.	A 115		
A 144	Please refer to tags A0144 and A0145. PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on patient interview, staff 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 each patient received care in a safe setting. This had the potential to affect every patient residing at the facility. The findings include: Patient #1 and #2 were able to access an unlocked medication cart on two occasions	A 144	**Plan of Correction** **Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy	01/29/2021

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A 144	Continued From page 6 removing Lamactil on 10/31/2020 and Seroquel on 11/4/2020, crushing the medications with the intent of "snorting" the medications. The patients self reported they had taken the medications. After the first report, the facility failed to investigate and put a plan in place to prevent reoccurrence. There was no investigation or plan put in place to protect the patients and prevent future occurrence after the second report as well. Patient #1 was admitted 8/24/2020. Contained in the clinical record was a "Daily RN (Registered Nurse) Assessment" note which documented, "11/1/2020 2000 (8:00 p.m.) Patient admitted to snorting crushed meds taken by peer from unit med cart on 10/21/2020..." On 11/4/2020 at 0400 (4:00 a.m.) it was documented, "Patient was observed acting strange during routine Q15 check (every fifteen minute checks). Pt (patient) was attempting to hide a med cup /c (with) a white substance that appeared crushed. Pt became agitated when staff confiscated ...Pt eventually stated that (patient) got Seroquel off med cart...Supervisor (name) aware of situation..." A "Medical Progress Note" dated 11/2/2020 evidenced, in part: "...(patient) reported to staff yesterday that (patient) obtained medications covertly from the med cart while a behavioral code was taking place on the unit along with another patient. (Patient) claims to have crushed and inhaled those medications. It is unclear what medications were obtained and of this event actually took place...an investigation is going to take place to review the validity of these claims..." On 11/4/2020 it was documented in the "Medical Progress Note: "...yesterday evening staff found (patient) with presumed medications that appear to be crushed. This was immediately	A 144	and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer	

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A 144	Continued From page 7 confiscated from (patient)...an investigation is taking place..." Patient #2 was admitted on 02/06/2020. The clinical record documented the Patient was on suicidal precautions. Review of the clinical record revealed a note dated 11/1/2020 at 2000 (8:00 p.m.) which documented, "(Patient name) admitted taking crushed meds from cart 10/31/2020 and snorting..." A "Medical Progress Note" dated 11/2/2020 evidenced, "...Yesterday (patient) reported to staff that (patient) stole medications from a cart on 10/31/2020. Afterwards (patient) claims to have crushed and inhaled them with another peer..." Further documentation provided by the facility evidenced on 11/6/2020 "the patient reported (patient) was in possession of contraband (medication) and (patient) turned in a powder substance to (patients) therapist in a small plastic bag with broken thermometer probes that appeared to have been used to attempt to snort the medication..." The survey team requested the facility provide documentation of the investigation into both these reports. On 11/30/2020 at approximately 12:15 p.m., Staff Member #1 (Quality) stated, "We cannot find any file that (Staff Member #7- former Risk Manager) or (Staff Member #4- Director of Nursing) had about this. (Staff Member #7) no longer works here." Staff Member #1 provided the survey team with documentation what evidenced the report had been filed and "Plan of action pending findings of investigation". Staff Member #1 and #2 (Chief Operating Officer) also provided the survey team with communication between	A 144	revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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 began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer	

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A 144	Continued From page 8 leadership staff which discussed the allegation for the October 31 report. In one of the documents, Staff Member #7 wrote on November 2 that "immediate action to be taken in regards to nursing staff failing to follow the established procedure for locking and securing medication carts..." There was documentation presented that the facility had made an adjustment to their "rounds sheet" on 11/3/2020 and that "Medication Cart is secure" was added to this document. According to Staff Member #1, Leadership staff round on the units at least "once a shift" and utilize this document during those rounds. According to these "audit documents medication carts were found unlocked on various units on 11/3, 11/4, 11/5, and 11/6/2020. There was documentation that there were "Staff Meetings" on 11/5, 11/9, 11/10, and 11/11/2020 with a note that "Medication Carts being locked" was discussed. 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 stated, "I sure did. I stole the pills Seroquel and Lamactil. Yes I did it twice. I took the lamactil once and then another time I took the Seroquel. There was a code going on the unit and nobody was watching and I took them out of the unlocked med cart..."stole" is a relative term, I took my own pills from my drawer. I didn't take anybody else's medications....I was going to crush them and snort them..." The surveyor inquired as to whether anyone from the facility had interviewed	A 144	and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation.	

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A 144	Continued From page 9 (patient) about what (the patient) had admitted to and inquired as to whether Patient #2 knew (Staff Member #7- Risk Manager). Patient #2 stated, "Yes I know (name of Staff Member #7) and No; no one talked to me except the social services person and you now..." The surveyor asked Patient #2 if (the patient) was telling the truth about the report; and Patient #2 stated, "Yes Ma'am. I am telling the truth. I did indeed take the pills both times. I wish I hadn't, but I did. I am trying to do better. I know it was wrong..." Further review of the documentation provided by the facility revealed that Staff Member #7 had stated in the document dated November 10, 2020, that the report (from 11/4/2020) "did not rise to a level III and this was prior to the camera review that did not show the patient accessing the medication cart. The original powdery substance in question was drywall dust..." On 12/1/2020 at 8:45 a.m., the surveyor reviewed the timeline and findings with Staff Member #1 and expressed concern regarding the lack of investigation and intervention for both reports of medications being taken. The surveyor expressed concern that once reported on 11/1/2020, there was no plan put in place to prevent reoccurrence and on 11/4/2020 it was again reported that the patient had gotten medications from an unlocked medication cart. The surveyor also discussed the concerns that the facility did not reconcile medication carts at the time of either report to determine whether medications were missing and whether the substance was truly drywall dust or crushed medications. On 12/1/2020 at 9:00 a.m., the survey team, after	A 144	• The Director of Risk Management provided education to the leadership team in group and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief 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. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible	

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A 144	Continued From page 10 reviewing Appendix Q notified the State Agency Supervisory Staff of the findings/concerns for Immediate Jeopardy. The SA consulted the Centers for Medicare and Medicaid Services (CMS). On 12/1/2020 at 10:17 a.m., the facility Leadership (Staff Member #3- CEO, Staff Member #1- Quality, Staff Member #2- COO, and Staff Member #4 Chief Nursing Officer) were notified of the finding of Immediate Jeopardy and a plan of removal was requested. At 12:30 p.m., on 12/1/2020, the surveyor conducted a follow-up interview with the therapist (Staff Member #5) of Patient #1. Staff Member #5 stated, "(Patient#1) is not very reliable, but (patient) shared with me the same information that was shared with you...(patient) would protect another peer, so (patient) would take responsibility for doing it and not "snitch" on another peer, and this behavior would not be out of character....I can't say whether its true or not, but I was told the same thing you were and it would be possible for (patient) to do that..." The survey team interviewed Staff Member #6, Pharmacist on 12/1/2020 T 1:20 p.m.. Staff Member #6 stated, "The medication carts are filled on Tuesday and Fridays. We do a cart fill report that tells us how many (medications) to put in each cart for each (patient)....I was asked to look at the contents of the medication cup and it was a crushed substance, but did not look like medications, it had a tint to it...I wasn't told what drawer it came from, there are a lot of medication drawers..." When asked if Staff Member #6 had reconciled the cart at that time, the Staff Member stated, "No. That's a lot of medications drawers to look through." When asked if (Staff Member #6) had been notified that there were two reports,	A 144	for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation.	

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A 144	Continued From page 11 the staff member stated they were only asked to look at the crushed substance on one occasion. Staff Member #6 stated, "The tech who fills the cart never reported any doses missing and we were never informed a patient missed a dose of medication..." On 12/1/2020 at 3:06 p.m., a plan of removal was presented by the facility. The plan of removal was as follows: A0115 Patient Rights: Immediate Jeopardy Conditional Finding- The facility failed to meet one or more federal health, safety and/or Quality regulations. PLAN OF CORRECTION- Cumberland Hospital will correct the immediate jeopardy finding in 12/2/2020 with the corrective actions as stated to correct the conditional level finding under CMS Condition of Participation tag A144. PERSON RESPONSIBLE DISCUSSION- PERSON RESPONSIBLE: Chief Nursing Officer COMPLETION DATE 12-1-20. A144 PATIENT RIGHTS: CARE IN A SAFE SETTING- Observed: a medication cart was unlocked on unit 6B allowing a patient access to medications. A Patient accessed the unlocked cart on tow separate occasions, 10/31/2020 and 11/4/2020. Staff did not put a plan in place after becoming aware of the first incident; this allowed recurrence. The patient shared medication with another patient who was on suicide precautions. There is evidence that a serious adverse outcome occurred, or a serious adverse outcome is likely as a result of the identified noncompliance as follows: the patients were put at risk for adverse drug reaction, overdose, aggravation of underlying conditions, and/or death. There is a need for immediate action to include prevention of further occurrences, to	A 144	• The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until 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 quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be 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.	

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A 144	Continued From page 12 maintain safety and prevent patient harm, injury or death. PLAN OF CORRECTION: -Day shift nurses were inserviced on medication cart storage, safety and keeping carts locked at all times by the Assistant Director of Nursing immediately upon receiving the immediate jeopardy notification. Further, all nurses arriving for shifts this evening and night will be provided with the same training prior to beginning their shifts. -The Assistant Director of Nursing and the Chief Nursing Officer completed unit rounds immediately upon receipt of the immediate jeopardy notification to assess the status of the medication carts. All carts were noted to be properly secured and in the locked position at the time of these observations. -The Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators and Nursing Supervisors to include observations of medication carts once per shift by a nurse manager. Observation status will include that unit medication carts were locked and properly secured upon observation. Occurrences of unlocked or improperly secured medication carts observed, will require immediate action by the manager performing the observation. Actions will include securing the cart, identifying the staff responsible for the error, and corrective action (up to disciplinary action) for the staff responsible for the cart at the time of the observation. - An additional corrective action for observed noncompliance of a secured (locked) medication cart. the pharmacist will be notified by the observing manager to perform an immediate reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the expectation is that the pharmacist on call is notified by the nursing supervisor and a reconciliation of the cart will be performed by the pharmacist during the next	A 144	**Additional Actions taken following the 12/29/20 survey**: • 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 QAPI program 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 form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, track, and monitor adverse patient occurrences and assure that a plan is	

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A 144	Continued From page 13 in-person shift. -Staff Nurses arriving for shifts after 12/1/2020 will be educated on medication cart safety prior to reporting to the unit for their scheduled shift until all staff nurses have received training. PERSON RESPONSIBLE DISCUSSION- PERSON RESPONSIBLE: Chief Nursing Officer. COMPLETION DATE: 12/1/2020.Quality Assessment and Performance Improvement- The facility's Director of Regulatory Compliance, Chief Operating Officer and Chief Executive Officer, as core members of the facility's Quality improvement committee, met on 12/7/2020 to discuss the immediate jeopardy findings identified by the agency. The core team retrospectively reviewed recent and ongoing corrective action plans and determined that while numerous improvements have been made in terms of incident identification, incident management and required reporting, the facility's actions to-date continue to require focus in order to achieve a desired reduction in occurrences of incidents involving Cumberland staff members. The team determined that in order for it's cumulative actions to be sustainable as long-term solutions, the facility's quality leaders need to expeditiously enhance the culture of quality and patient safety amongst its direct care staff members. The team further agreed to proceed with initiatives to facilitate changes in staff's perspectives, behaviors, and actions to fully align with the organization's commitment to quality patient care, reduction of serious incidents, and a culture of patient safety. The plan for comprehensive quality improvement and culture of staff accountability includes the following initiatives: 1. Intensive Staff Training: On 12/7/2020, the facility's CEO contacted UHS's Assistant Vice President of Clinical Training and Education for	A 144	implemented to show improvement in identified areas. The new program incorporates previous action plan items that require attention and development of a robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was 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 and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the	

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A 144	Continued From page 14 scheduling of an outside resource to provide intensive staff training to Cumberland's direct patient care staff. The request for training included topics related to preventing and managing power struggles with patients, milieu management, verbal de-escalation, and abuse and neglect recognition. The training is intended to extend staff's knowledge and expertise in managing challenging patient behaviors. The facility was assigned a corporate educator and course content was suggested. The facility has scheduled this education for all direct care staff commencing 12/11/2020 and to conclude not later than 12/31/2020. The intensive education plan further specifies this custom-designed curriculum, entitled "Prevention First Training" will be a required new-hire orientation course for all direct care staff as well as required annual training for existing staff continuing education and staff development. A Program description of the "Prevention First" training specifies the curriculum as follows: Training for non-direct care staff in de-escalation and crisis awareness. Immediate training support to facilities and staff during COVID-19. Provides-non classroom training for staff who are not required to have BMS training, but need skills in preventing and managing crisis situations. Provides videos and a consistent message for staff and includes waiting room and nursing station scenarios as examples. Can be used as remedial training for employees at any time. Focuses on de-escalation, crisis prevention, and workplace violence prevention. Cost effective and streamlined to prepare your entire organization to deal with the unpredictable reality of crisis.	A 144	Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	

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A 144	Continued From page 15 2. Dual Reporting of Incidents: The quality improvement action plan will also include development of a process for dual reporting of serious incidents to the local social services agency as well as the state regulatory agency who has deemed oversight of the facility's compliance with CMS Conditions of Participation. The analysis of previously investigated incidents at our facility by the core quality team discovered that on multiple occasions the facility identified, investigated, managed and reported known incidents to the local social services agency but that the agency was reporting to the state oversight agency without the results of either their own or the facility's investigations or corrective actions, leading to a second regulatory investigation by the deemed state agency which were frequently disposed as "substantiated" complaints but with no deficient practice at the facility. The facility will correct the redundancy in complaint investigations by having the Director of Quality and newly hired Director of Risk Management process the final results of internal investigations on reportable serious incidents jointly. The Director of risk Management will report serious incidents to the local Social Services Agency and to the regulatory Oversight agency ensuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation, findings, evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process by a planning meeting with Director of Quality, Director of risk Management, Chief Operating Officer on 12/8/2020. 3. Establishment of a Performance Improvement Executive Committee: The core team further addressed the identified deficiency in quality	A 144		

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A 144	Continued From page 16	A 144		

assessment conditions by establishing a Performance Improvement Executive Committee, which will provide explicit oversight of the facility's internal quality control initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. The members of the performance Improvement executive Committee are Cumberland's CEO, COO, Director of Quality, Director of risk Management, CNO, Division Director of Clinical Services. The addition of the Division Director of Clinical Services on the committee will provide external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. The committee will meet on a weekly basis. The agenda will include: compliance rates with direct care training requirements, remedial training needs, scheduling of external resources if needed, the current status of internal investigations, corrective actions taken as a result of substantiated investigations, monitoring of corrective action plans, and status of external reporting requirements as applicable.

The activities of the Performance Improvement executive Committee will further be summarized and reported to the facility's Governing Body as an agenda item at the Board's quarterly scheduled meeting.

4. Condition of Participation: Focused Mock Surveys

As additional reinforcement for the core team's commitment to correcting repeated quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock survey's at the facility for a period of one

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A 144	Continued From page 17 year. The purpose of the mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern, The first mock survey will be done beginning in 1st quarter of calendar year 2021. The Director's findings and observations will be communicated to the Performance Improvement executive Committee via 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 the corrective actions taken. On 12/1/2020 at 4:00 p.m., the survey team made rounds on the hospital units to verify the plan of removal had been implemented. The survey team did not identify any medication carts that were not secured and interviews with staff revealed they had received education regarding the facility policy/plan of ensuring medication carts were locked and secured at all times, and that patients were being observed to ensure their safety. After review and consideration by the Centers for Medicare and Medicaid Services and the State Agency, the plan was determined to be unacceptable and the facility remained in Immediate Jeopardy as of 12/9/2020 at 3:00 p.m.. The facility Leadership (Staff Members #1, 2, 3, 4, 8 and #13- Corporate Regional Regulatory Director) were notified at that time of the plan not being accepted and the Immediate Jeopardy remaining in effect.	A 144		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3)	A 145	**Plan of Correction** **Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys**	01/29/2021

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A 145	Continued From page 18 The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on staff 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 Patient #5 was free from abuse. Allegations of abuse have the potential to affect every patient residing at the facility. The findings included: On 12/1/2020, Patient #5 was "grabbed" by Staff Member #12 and pushed the patient down into a chair, as the staff member "yelled" at the patient. Patient #5 was admitted to the facility on 8/28/2020. According to documentation in the clinical record, the following was evidenced: "12/1/2020 2220 (10:22 p.m.) PT (patient) had an incident w/a (with a) staff member when PT did not want to clean up (patient's) medical equipment after treatment in (patient's) room. Staff repeatedly prompted PT to cooperate and PT got aggressive and pushed staff w/ (with) both hands on staff's chest/shoulders. Staff almost fell over and physically sat patient down in chair and explained to (patient) that (patient) should not put hands on staff and push people over..." According to the investigation conducted by Staff Member #8 (Risk Manager) the following was evidenced: "While UC (Unit Coordinator) was in the unit, the milieu was interrupted with a loud disruption of a staff member standing over the patient yelling at patient. UC went over to inquire	A 145	*Abuse/Neglect* • The Chief Nursing Officer (CNO) implemented intensive staff training on providing patients with a safe setting. Training began on 12/11/20 and concluded 12/31/20. With the support of the Corporate Clinical Training and Education department, hospital leadership developed a curriculum entitled "Prevention First" for all direct care staff, based on the CEO's request for additional training on the topics of preventing and managing power struggles with patients, milieu management, verbal de-escalation, 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 Healthstream platform provides videos and a consistent message for staff, and includes waiting room and nursing station scenarios as examples with a focus on Verbal De-escalation, Crisis Prevention and Workplace Violence Prevention. The training includes post-testing to ensure competency and staff are provided opportunities for further discussion with the Nursing Leadership. • This custom-designed curriculum, entitled "Prevention First Training" will be a required new-hire orientation course for all direct care staff as well as required annual training for existing staff continuing education and staff development. *Incident Investigation* • A new Risk Manager with previous risk management experience in Virginia began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital Director of Risk Management on reviewing, reconciling, investigating, and reporting incidents, and on developing	

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A 145	Continued From page 19 as to what was happening and took patient to (patient's) room to talk with (patient) as to what had happened. Staff Member followed UC and patient to room and continued to argue with patient as (patient) attempted to talk with UC. UC sent staff member away from patient and room. Patient was tearful and stated (patient) was told by staff to pack up (patient's) breathing equipment. (Patient) states (patient) apparently had not packed it to staff's expectations as patient felt (they) were done packing it up and staff did not. (Patient) wanted the staff member to leave (patient's) room and admits to pushing the staff from (patient's) room. Patient stated staff grabbed the patient and "shoved (patient) into the chair and began to yell at (patient)". Incident was immediately reported to immediate senior supervisors. Staff member was pulled from the floor and sent home pending further investigation." Further documentation from the investigation revealed documentation of interviews with the UM (Unit Manager Staff Member #11) and Patient #5. Further documentation revealed: "Camera Review: The FMR (Facility Risk Manager) reviewed the camera incident via the camera system and found that at 16:45 (4:45 p.m.) the patient is not visible in (patient's) room but the staff member can be seen at the door way of the Pt's room. At 16:47 (4:47 p.m.) the pt. can be seen pushing the staff and shutting the door then the staff member grabs the patient and forces (patient) to sit down in a chair next to the door. At the same time the UM (Unit Manager/Coordinator) can be seen in what appears to be redirecting staff to let go of the patient which the staff member does. Next at 16:48 the patient goes back into (patient's) room (the camera cannot see what [patient] is doing) the staff member follows	A 145	plans to prevent future recurrences. The Director of Risk Management was also provided guidelines for timeliness of completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for	

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A 145	Continued From page 20 (patient) in, the UM walks over and appears to redirect staff out of the room and then verbalizes with the patient...Conclusion: Due to the evidence and statements above, this allegation has been found to be true...Follow-Up Action: The staff Member involved in this incident was suspended immediately and then terminated. Behavioral Techs (technicians) and RN's (Registered Nurses) for that shift are being retrained on power struggles- the training will be completed by 12/9/2020. The UM will be retrained on staff management which will be completed by 12/9/2020." The statement of Patient #5 evidenced, in part: "I just finished my breathing treatment and was putting it up when I playfully pushed (name of staff member #12) and (staff member) got upset and pushed me into the chair and started to yell at me...." The survey team conducted an follow-up interview with Staff Member #11 on 12/9/2020 at 10:00 a.m. The Staff Member recounted the event with the surveyors and stated, "I was behind d the nurses station and a heard a commotion that disrupted the milieu...I looked up and saw (Staff Member #12) standing over (Patient #5) yelling. I immediately walked over and I heard (Staff Member #12) say "Don't put your hands on me, I don't play like that"...I told (Staff Member) to step back and asked (Patient #5) to come with me so I could talk with (patient) privately in (patient's room). The (Staff Member) followed us into the room and was interrupting and I told (Staff Member) to leave. (Patient) was crying and I asked what happened...(patient said apparently (patient) had not done well putting up the equipment and that it had irritated (Staff).	A 145	reporting to their immediate supervisor and 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 was verified by signed attestation. • The Director of Risk Management provided education to the leadership team in group and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief Executive Officer is committed to more	

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A 145	Continued From page 21 (Patient admitted to pushing staff out of (patient's) room and then said (Staff) grabbed (patient) by the arms and shoved (patient) into the chair...I immediately notified the supervisor and (Staff Member) was sent home pending an investigation....There have been grievances from a couple of the (patients) about (Staff Member #12) being rude and using inappropriate language , but it was not witnessed by anyone else. I did speak to (Staff Member #12) about the concerns and let (Staff Member) know that I was watching (Staff Member). I was not able to prove (Staff Member) had been rude, but I let (Staff Member) know that I was watching (Staff Member)...." The facility presented the survey team with evidence of inservices conducted with staff of the Unit on which the event occurred. The inservices were "Power Struggles and Abuse and Neglect". Inservices were documented as being conducted on 12/4/2020. Inservices were then conducted with all direct care staff on 12/4, 12/5, 12/6, 12/7, 12/8 and 12/9/2020. The survey team discussed with facility staff Members #1, 2, and #3 through out the survey the concerns regarding multiple complaints received by the state agency of ongoing patient care issues and abuse. The survey team discussed with the facility leadership these allegations demonstrate a systematic problem with regard to action plans previously developed, and the urgency and immediacy for the facility to review their systems in order to develop robust and sustainable plans to correct the concerns and prevent recurrence. The facility presented a plan of removal for the Immediate Jeopardy findings on 12/9/2020 at	A 145	frequent communication with the state (Virginia Department of Health or VDH) regarding incidents and results of investigations at Cumberland Hospital. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk	

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A 145	Continued From page 22 12:20 p.m. The plan included the following: On 12/1/2020 Cumberland Hospital took immediate action to investigate the alleged incident of staff abuse to a patient as follows: - The Unit Coordinator immediately responded to the area and removed the staff member from the vicinity of the patient. The Unit Coordinator interviewed the patient in (patient's) room to determine the cause of the disruption. The patient alleged that a staff member had abused (patient) by grabbing (patient), pushing (patient) into a chair and yelling at (patient). - Per Cumberland policy on Suspected Abuse and Neglect of a Patient, the Unit Coordinator notified the senior supervisor on duty of the occurrence and suspended the employee pending further investigation of the allegation. The employee immediately left the facility and did not work another shift at the facility. - The attending physician and the patient's legal guardian were notified of the incident. The associated allegation was entered into the facility's internal incident reporting system for further follow-up and investigation. In the morning of 12/2/2020, the facility's risk Manager was notified by the Assistant Director of Nursing of the allegation of abuse and suspension of the employee. The Risk Manager completed the investigation and determined that the allegation of staff abuse to a patient was substantiated. Elements of the investigation included the following: A camera review of the incident. Interviews with the patient, unit coordinator and other staff members present on the unit at the time of the occurrence. The Assistant Director of Nursing initiated disciplinary	A 145	Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until 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 quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be communicated to the Performance Improvement Executive Committee via an	

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A 145	Continued From page 23 action for the employee based on the substantiated findings noted by the Director of Risk Management. The Director of Risk Management notified New Kent County Social Services of the incident of substantiated patient abuse. On 12/4/2020 based on the substantiated findings, the employee was terminated. From 12/2 to (employee) termination on 12/4/2020, the employee did not have any contact with Cumberland patients following the incident with the complaining patient. To immediately prevent further occurrences of patient abuse and to maintain patient safety on patient care units, evening shift patient care staff were re-educated on "Avoiding Power Struggles" and "abuse and Neglect" by the Assistant Director of Nursing upon receiving the immediate jeopardy notification. Further all nurses arriving for shifts subsequent to jeopardy notification will be provided with the same training prior to beginning their shifts. Quality Assessment and Performance Improvement- The facility's Director of Regulatory Compliance, Chief Operating Officer and Chief Executive Officer, as core members of the facility's Quality improvement committee, met on 12/7/2020 to discuss the immediate jeopardy findings identified by the agency. The core team retrospectively reviewed recent and ongoing corrective action plans and determined that while numerous improvements have been made in terms of incident identification, incident management and required reporting, the facility's actions to-date continue to require focus in order to achieve a desired reduction in occurrences of incidents involving Cumberland staff members. The team determined that in order for it's cumulative actions to be sustainable as long-term	A 145	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 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 QAPI program 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 form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the	

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A 145	Continued From page 24 solutions, the facility's quality leaders need to expeditiously enhance the culture of quality and patient safety amongst its direct care staff members. The team further agreed to proceed with initiatives to facilitate changes in staff's perspectives, behaviors, and actions to fully align with the organization's commitment to quality patient care, reduction of serious incidents, and a culture of patient safety. The plan for comprehensive quality improvement and culture of staff accountability includes the following initiatives: 1. Intensive Staff Training: On 12/7/2020, the facility's CEO contacted UHS's Assistant Vice President of Clinical Training and Education for scheduling of an outside resource to provide intensive staff training to Cumberland's direct patient care staff. The request for training included topics related to preventing and managing power struggles with patients, milieu management, verbal de-escalation, and abuse and neglect recognition. The training is intended to extend staff's knowledge and expertise in managing challenging patient behaviors. The facility was assigned a corporate educator and course content was suggested. The facility has scheduled this education for all direct care staff commencing 12/11/2020 and to conclude not later than 12/31/2020. The intensive education plan further specifies this custom-designed curriculum, entitled "Prevention First Training" will be a required new-hire orientation course for all direct care staff as well as required annual training for existing staff continuing education and staff development. A Program description of the "Prevention First" training specifies the curriculum as follows: Training for non-direct care staff in de-escalation and crisis awareness.	A 145	Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, 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 items that require attention and development of a robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was provided to the facility. Training was completed on 1/22/21. The Corporate Risk Manager provided the facility Director of Risk Management and the rest of the Leadership team a best practices "advisory" regarding management of abuse and neglect allegations. Topics of the advisory included: a. Types of Abuse b. Strategies to decrease allegations of abuse c. Injury Reduction Strategies d. Samples of abuse and neglect response plan The leadership team is reviewing the best practice recommendations and the hospital's current processes to develop an internal plan of action to improve any identified hospital's processes. The action plan will be submitted to the Performance Improvement Executive Committee and the Governing Board for approval and implementation. **Person Responsible** Chief Executive Officer	

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A 145	Continued From page 25 Immediate training support to facilities and staff during COVID-19. Provides-non classroom training for staff who are not required to have BMS training, but need skills in preventing and managing crisis situations. Provides videos and a consistent message for staff and includes waiting room and nursing station scenarios as examples. Can be used as remedial training for employees at any time. Focuses on de-escalation, crisis prevention, and workplace violence prevention. Cost effective and streamlined to prepare your entire organization to deal with the unpredictable reality of crisis. 2. Dual Reporting of Incidents: The quality improvement action plan will also include development of a process for dual reporting of serious incidents to the local social services agency as well as the state regulatory agency who has deemed oversight of the facility's compliance with CMS Conditions of Participation. The analysis of previously investigated incidents at our facility by the core quality team discovered that on multiple occasions the facility identified, investigated, managed and reported known incidents to the local social services agency but that the agency was reporting to the state oversight agency without the results of either their own or the facility's investigations or corrective actions, leading to a second regulatory investigation by the deemed state agency which were frequently disposed as "substantiated" complaints but with no deficient practice at the facility. The facility will correct the redundancy in complaint investigations by having the Director of Quality and newly hired Director of Risk Management process the final results of internal	A 145	**Summary of Ongoing Monitoring** Monitoring of effectiveness of training and appropriateness of staff interactions with patients is done through the leadership rounding process. Documentation includes completion of rounds to each unit (with video review allowed for COVID units), observations of staff/patient interactions, and any coaching done with staff. Rounds forms are reviewed daily by the CEO, CNO, and Risk Manager with any corrective actions needed implemented immediately. Aggregated data on compliance with rounds and appropriateness of staff/patient interactions is presented monthly to the Performance Improvement Executive Committee, Medical Executive Committee, and the Governing Board. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	

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A 145	Continued From page 26	A 145		

investigations on reportable serious incidents jointly. The Director of risk Management will report serious incidents to the local Social Services Agency and to the regulatory Oversight agency ensuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation, findings, evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process by a planning meeting with Director of Quality, Director of risk Management, Chief Operating Officer on 12/8/2020.

3. Establishment of a Performance Improvement Executive Committee: The core team further addressed the identified deficiency in quality assessment conditions by establishing a Performance Improvement Executive Committee, which will provide explicit oversight of the facility's internal quality control initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. The members of the performance Improvement executive Committee are Cumberland's CEO, COO, Director of Quality, Director of risk Management, CNO, Division Director of Clinical Services. The addition of the Division Director of Clinical Services on the committee will provide external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. The committee will meet on a weekly basis. The agenda will include: compliance rates with direct care training requirements, remedial training needs, scheduling of external resources if needed, the current status of internal investigations, corrective actions taken as a result of substantiated investigations, monitoring of corrective action

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A 145	Continued From page 27 plans, and status of external reporting requirements as applicable. The activities of the Performance Improvement executive Committee will further be summarized and reported to the facility's Governing Body as an agenda item at the Board's quarterly scheduled meeting. 4. Condition of Participation: Focused Mock Surveys As additional reinforcement for the core team's commitment to correcting repeated quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock survey's at the facility for a period of one year. The purpose of the mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern, The first mock survey will be done beginning in 1st quarter of calendar year 2021. The Director's findings and observations will be communicated to the Performance Improvement executive Committee via 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 the corrective actions taken. After review and consideration by the Centers for Medicare and Medicaid Services and the State Agency, the plan was determined to be unacceptable and the facility remained in Immediate Jeopardy as of 12/9/2020 at 3:00 p.m.. The facility Leadership (Staff Members #1, 2, 3, 4, 8 and #13- Corporate Regional Regulatory Director) were notified at that time of the plan not being accepted and the Immediate Jeopardy remaining in effect.	A 145		

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A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on findings of Immediate Jeopardy during a complaint investigation, the facility staff did not ensure an effective quality program was developed and implemented to track, monitor and develop sustainable action plans to prevent continued patient care and quality concerns regarding patient rights and the health and safety of patients residing at the facility thus failing to substantially comply with this condition. The findings include: Throughout the previous months, the facility has had multiple incidents of concerns involving patient rights and patient care issues which have resulted in multiple unannounced complaint investigations, and findings of non-compliance in Conditions of Participation for Patient Rights and	A 263	Hospital leadership reviewed and improved the processes for documenting and reporting incidents internally, investigating incidents, taking action and reporting progress to internal committees, monitoring ongoing compliance, and reporting timely to external regulatory agencies. Please refer to A0286 for details.	01/29/2021

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A 263	Continued From page 29 Quality Assurance and Performance Improvement. Action Plans developed by the facility have not been sustained as evidenced by the current finding from the complaint investigation of 12/1/2020 of Immediate Jeopardy and associated non-compliance for the Conditions of participation for Patient Rights, Governing Body, Nursing Services, and Pharmaceutical Services as well as the repeated allegation of abuse to patients by staff. The facility presented a plan of removal for the identified Immediate Jeopardy findings on 12/1/2020, however, the additional concern of Abuse was identified which resulted in the facility remaining in Immediate Jeopardy. The facility again presented a plan of removal on 12/9/2020 which was not considered an acceptable plan. As of 12/9/2020, the facility remained in Immediate Jeopardy. The facility has experienced multiple complaints of allegations of abuse by employees to patients in the previous months which demonstrated a systematic failure by the facility to implement a sustainable plan in order to prevent the recurrent allegations of abuse. Please refer to A0286 for further information.	A 263		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors.	A 286	**Plan of Correction** **Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys** *Medication Security* The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of	01/29/2021

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A 286	Continued From page 30 (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities. The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on 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 the Quality Program monitored and tracked adverse patient occurrences and demonstrated plans to show improvement in these areas. The findings included: Multiple areas of concerns were identified during the complaint investigation resulting in an immediate jeopardy finding. The facility had two reports of patients accessing unlocked medication carts and talking medications which were not investigated. Also, multiple complaints have been received over the past months requiring numerous	A 286	medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation.	

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A 286	Continued From page 31 complaint investigations by the state agency. This demonstrates an concern regarding a systematic failure of the facility to implement a sustainable plan to prevent these concerns. Patient #1 and #2 self reported they had been able to access unlocked medication carts and take medications from the cart of two occasions; 10/31/2020 and 11/4/2020. After the first occurrence, there was no investigation of plan of action developed to prevent reoccurrence and the patient's again accessed the cart and took medications. According to documents presented to the survey team, the CNO (Chief Nursing Officer Report October 2020) stated, "inservicing on medication administration and security will be completed in month of November for all nurses"...there was no date on this document to establish when it was written/submitted, although in an interview with Staff Member #1 (Quality) on 12/1/2020 at 8:45 a.m., the Staff Member stated, "I don't know exactly when this was done but it is due to the CEO by the tenth of November..." On November 2, 2020 per an email document provided by the facility, the medication carts being locked was discussed. The "Medication cart is Secured" was added to the "Leadership Rounds Audit" sheet which, according to Staff Member #1, is completed once a shift by Leadership staff on rounds. The final document was given for use on November 3,2020. After the addition of the medication cart check to the rounds sheet, medication carts were found unlocked on 11/3, 11/4, 11/5, and 11/6/2020 during the rounds. Meetings for nursing staff	A 286	• The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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 began employment on 11-30-2020. • The Corporate Director of Risk Management	

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A 286	Continued From page 32 regarding medication cart safety and patient monitoring were not started until 11/9/2020, however there was one unit which had a meeting on 11/5/2020 and handwritten in the corner of the copy of the agenda sheet presented to the survey team was "*med carts locked at all X's (times)". The survey team was not provided with any evidence of robust inservicing, training or progressive discipline regarding the serious nature of the reports of patients having access to unlocked medication carts and patient monitoring. When interviewed on 12/1/2020 at approximately 2:00 p.m., Staff Member #4 (CNO) was asked what occurred if leadership found carts unlocked on rounds. Staff Member #4 stated, "The nurse is spoken to and the cart immediately secured." When asked whether there was documentation of when staff were "spoken to" in terms of initiating progressive discipline for failure to follow safety and hospital policy, staff member #4 stated, "It should be done." The survey team discussed with Staff Member #1 and #4 that the information provided for the "meetings" held with nursing staff did not reflect a robust education for the staff regarding the responsibilities of patient safety, basic medication practices, patient monitoring, as well as potential consequences for failure to follow hospital policy and procedures. The concerns were reviewed with the facility Leadership staff (Staff Members #1, 2, 3, 4, and #8) on 12/1/2020 at 4:20 p.m. On 12/1/2020, Patient #5 was "grabbed" by Staff Member #12 and pushed down into a chair, as the staff member "yelled" at the patient.	A 286	and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 on expectations for reporting of incidents	

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A 286	Continued From page 33 According to the investigation conducted by Staff Member #8 (Risk Manager) the following was evidenced: "While UC (Unit Coordinator) was in the unit, the milieu was interrupted with a loud disruption of a staff member standing over the patient yelling at patient. UC went over to inquire as to what was happening and took patient to (patient's) room to talk with (patient) as to what had happened. Staff Member followed UC and patient to room and continued to argue with patient as (patient) attempted to talk with UC. UC sent staff member away from patient and room. Patient was tearful and stated (patient) was told by staff to pack up (patient's) breathing equipment. (Patient) states (patient) apparently had not packed it to staff's expectations as patient felt (they) were done packing it up and staff did not. (Patient) wanted the staff member to leave (patient's) room and admits to pushing the staff from (patient's) room. Patient stated staff grabbed the patient and "shoved (patient) into the chair and began to yell at (patient)". Incident was immediately reported to immediate senior supervisors. Staff member was pulled from the floor and sent home pending further investigation." Further documentation from the investigation revealed documentation of interviews with the UM (Unit Manager Staff Member #11) and Patient #5. Further documentation revealed: "Camera Review: The FMR (Facility Risk Manager) reviewed the camera incident via the camera system and found that at 16:45 (4:45 p.m.) the patient is not visible in (patient's) room but the staff member can be seen at the door way of the Pt's room. At 16:47 (4:47 p.m.) the pt. can be seen pushing the staff and shutting the door then the staff member grabs the patient and forces (patient) to	A 286	through the appropriate channels. For those not able to complete remote data entry into the electronic system (only Nurses and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation. • The Director of Risk Management provided education to the leadership team in group and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting*	

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A 286	Continued From page 34 sit down in a chair next to the door. At the same time the UM (Unit Manager/Coordinator) can be seen in what appears to be redirecting staff to let go of the patient which the staff member does. Next at 16:48 the patient goes back into (patient's) room (the camera cannot see what [patient] is doing) the staff member follows (patient) in, the UM walks over and appears to redirect staff out of the room and then verbalizes with the patient...Conclusion: Due to the evidence and statements above, this allegation has been found to be true...Follow-Up Action: The staff Member involved in this incident was suspended immediately and then terminated. Behavioral Techs (technicians) and RN's (Registered Nurses) for that shift are being retrained on power struggles- the training will be completed by 12/9/2020. The UM will be retrained on staff management which will be completed by 12/9/2020." The facility presented the survey team with evidence of inservices conducted with staff of the Unit on which the event occurred. The inservices were "Power Struggles and Abuse and Neglect". Inservices were documented as being conducted on 12/4/2020. Inservices were then conducted with all direct care staff on 12/4, 12/5, 12/6, 12/7, 12/8 and 12/9/2020. The survey team discussed with facility staff Members #1, 2, and #3 through out the survey the concerns regarding multiple complaints received by the state agency of ongoing patient care issues and abuse. The survey team discussed with the facility leadership these allegations demonstrate a systematic problem with regard to action plans previously developed, and the urgency and immediacy for the facility to	A 286	• Dual Reporting of Incidents: The Chief 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. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer.	

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A 286	Continued From page 35 review their systems in order to develop robust and sustainable plans to correct the concerns and prevent recurrence. The facility presented a plan of removal for the Immediate Jeopardy findings on 12/9/2020 at 12:20 p.m. After review and consideration by the Centers for Medicare and Medicaid Services and the State Agency, the plan was determined to be unacceptable and the facility remained in Immediate Jeopardy as of 12/9/2020 at 3:00 p.m.. The facility Leadership (Staff Members #1, 2, 3, 4, 8 and #13- Corporate Regional Regulatory Director) were notified at that time of the plan not being accepted and the Immediate Jeopardy remaining in effect.	A 286	Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until 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 quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be	
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION 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, the facility staff did not ensure Nursing care was provided in a safe environment and that patients were provided adequate supervision to prevent harm/potential harm thus failing to substantially comply with this condition. The findings include: On 10/31/2020 Patient #1 and #2 were able to access an unlocked medication cart, thus taking			

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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 CFR(s): 482.23(b)(6) 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		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 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 QAPI program 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 form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate	

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A 398	Continued From page 37 described as a "behavioral outburst" by another patient without staff knowledge Again, on 11/4/2020, a medication cart was left unsecured and Patient #1 again was able to access the cart and take medications without staff knowledge. Patient #1 was admitted 8/24/2020. Contained in the clinical record was a "Daily RN (Registered Nurse) Assessment" note which documented, "11/1/2020 2000 (8:00 p.m.) Patient admitted to snorting crushed meds taken by peer from unit med cart on 10/21/2020..." On 11/4/2020 at 0400 (4:00 a.m.) it was documented, "Patient was observed acting strange during routine Q15 check (every fifteen minute checks). Pt (patient) was attempting to hide a med cup /c (with) a white substance that appeared crushed. Pt became agitated when staff confiscated ...Pt eventually stated that (patient) got Seroquel off med cart...Supervisor (name) aware of situation..." A "Medical Progress Note" dated 11/2/2020 evidenced, in part: "...(patient) reported to staff yesterday that (patient) obtained medications covertly from the med cart while a behavioral code was taking place on the unit along with another patient. (Patient) claims to have crushed and inhaled those medications. It is unclear what medications were obtained and of this event actually took place...an investigation is going to take place to review the validity of these claims..." On 11/4/2020 it was documented in the "Medical Progress Note: "...yesterday evening staff found (patient) with presumed medications that appear to be crushed. This was immediately confiscated from (patient)...an investigation is taking place..." Patient #2 was admitted on 02/06/2020. The clinical record documented the Patient was on		Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, 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 items that require attention and development of a robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was 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 Team and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed	

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A 398	Continued From page 38 suicidal precautions. Review of the clinical record revealed a note dated 11/1/2020 at 2000 (8:00 p.m.) which documented, "(Patient name) admitted taking crushed meds from cart 10/31/2020 and snorting..." A "Medical Progress Note" dated 11/2/2020 evidenced, "...Yesterday (patient) reported to staff that (patient) stole medications from a cart on 10/31/2020. Afterwards (patient) claims to have crushed and inhaled them with another peer..." Further documentation provided by the facility evidenced on 11/6/2020 "the patient reported (patient) was in possession of contraband (medication) and (patient) turned in a powder substance to (patients) 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: "Storage: 19. All medications will be stored in the medication cart or locked cabinet...22. The medication cart/room will be kept locked AT ALL times when not in use by the nurse..." Under "Milieu Management" "15 (fifteen) minute observation rounds must be completed on all patients every 15 minutes...during CODE situations someone must be assigned to monitor patient safety, especially of those not involved in the current situation..." 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		through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	
		A 385	Hospital leadership review and revised the procedures for securing and locking medication carts, educated nursing staff, and implemented monitoring to confirm ongoing compliance. Please refer to A0398 for details.	01/29/2021
		A 398	**Plan of Correction** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the	01/29/2021

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A 398	Continued From page 39 had taken the medications. Patient #1 stated, "I sure did. I stole the pills Seroquel (an antipsychotic) and Lamactil (a mood stabilizer). Yes I did it twice. I took the lamactil once and then another time I took the Seroquel. There was a code going on the unit and nobody was watching and I took them out of the unlocked med cart..."stole" is a relative term, I took my own pills from my drawer. I didn't take anybody else's medications....I was going to crush them and snort them..." The surveyor asked Patient #2 if (the patient) was telling the truth about the report; and Patient #2 stated, "Yes Ma'am. I am telling the truth. I did indeed take the pills both times. I wish I hadn't, but I did. I am trying to do better. I know it was wrong..." In an interview with Staff Member #9, a Registered Nurse on 12/1/2020 at 3:20 p.m., the staff member stated, "Medication carts are to be locked at all times and never left unattended...all patients are to be checked every fifteen minutes but staff are responsible for knowing where they are at all times..." Concerns were addressed with Facility Leadership (Staff Member#1) on 12/1/2020 at 8:45 a.m. and again at 4:20 p.m. with Staff Members #1,2,3,4, and 8.		training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee	
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.			

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A 405	Continued From page 40 (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. 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 staff followed basic safe practices for medication administration. The Nursing staff failed to ensure medication carts were locked at all times to prevent unauthorized access. This affected two patients, Patient #1 and #2, but had the potential to affect all patients at the facility. The findings included: Patient #1 and #2 were able to access the medication cart which was left unlocked on two separate occasions taking two different medications. On 10/31/2020 the medication Lamactil was taken, and on 11/4/2020, the medication Seroquel was taken. Patient #1 was admitted 8/24/2020. Contained in the clinical record was a "Daily RN (Registered		Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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. **Person Responsible** Chief Nursing Officer **Summary of Ongoing Monitoring** As described above, the Leadership Team and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct	

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A 405	Continued From page 41 Nurse) Assessment" note which documented, "11/1/2020 2000 (8:00 p.m.) Patient admitted to snorting crushed meds taken by peer from unit med cart on 10/21/2020..." On 11/4/2020 at 0400 (4:00 a.m.) it was documented, "Patient was observed acting strange during routine Q15 check (every fifteen minute checks). Pt (patient) was attempting to hide a med cup /c (with) a white substance that appeared crushed. Pt became agitated when staff confiscated ...Pt eventually stated that (patient) got Seroquel off med cart...Supervisor (name) aware of situation..." A "Medical Progress Note" dated 11/2/2020 evidenced, in part: "...(patient) reported to staff yesterday that (patient) obtained medications covertly from the med cart while a behavioral code was taking place on the unit along with another patient. (Patient) claims to have crushed and inhaled those medications. It is unclear what medications were obtained and of this event actually took place...an investigation is going to take place to review the validity of these claims..." On 11/4/2020 it was documented in the "Medical Progress Note: "...yesterday evening staff found (patient) with presumed medications that appear to be crushed. This was immediately confiscated from (patient)...an investigation is taking place..." Patient #2 was admitted on 02/06/2020. The clinical record documented the Patient was on suicidal precautions. Review of the clinical record revealed a note dated 11/1/2020 at 2000 (8:00 p.m.) which documented, "(Patient name) admitted taking crushed meds from cart 10/31/2020 and snorting..." A "Medical Progress Note" dated 11/2/2020 evidenced, "...Yesterday (patient) reported to staff that (patient) stole medications from a cart on 10/31/2020.		medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board. **Plan of Correction** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of	A 405 01/29/2021

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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 11/6/2020 "the patient reported (patient) was in possession of contraband (medication) and (patient) turned in a powder substance to (patients) 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: "Storage: 19. All medications will be stored in the medication cart or locked cabinet...22. The medication cart/room will be kept locked AT ALL times when not in use by the nurse..." Under "Milieu Management" "15 (fifteen) minute observation rounds must be completed on all patients every 15 minutes...during 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 carts were found unlocked on various units on 11/3, 11/4, 11/5, and 11/6/2020. 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 stated, "I sure did. I stole the pills Seroquel (an antipsychotic) and Lamactil (a mood stabilizer). Yes I did it twice. I took the lamactil once and	A 405	Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer	

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A 405	Continued From page 43 then another time I took the Seroquel. There was a code going on the unit and nobody was watching and I took them out of the unlocked med cart..."stole" is a relative term, I took my own pills from my drawer. I didn't take anybody else's medications....I was going to crush them and snort them..." The surveyor asked Patient #2 if (the patient) was telling the truth about the report; and Patient #2 stated, "Yes Ma'am. I am telling the truth. I did indeed take the pills both times. I wish I hadn't, but I did. I am trying to do better. I know it was wrong..." In an interview with Staff Member #9, a Registered Nurse on 12/1/2020 at 3:20 p.m., the staff member stated, "Medication carts are to be locked at all times and never left unattended...all patients are to be checked every fifteen minutes but staff are responsible for knowing where they are at all times..." Concerns were addressed with Facility Leadership (Staff Member#1) on 12/1/2020 at 8:45 a.m. and again at 4:20 p.m. with Staff Members #1,2,3,4, and 8.		revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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 began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation.	
A 489	Condition of Participation: Pharmaceutical Se CFR(s): 482.25 §482.25 Condition of Participation: Pharmaceutical Services. The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize			

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A 489	Continued From page 44 drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on staff interview, patient interview, clinical record review, facility document review and during the course of a complaint investigation, the facility did not ensure Pharmacy services were provided that ensured the safety of all patients thus failing to substantially comply with this condition. The findings include: On 10/31/2020 and 11/4/2020 medication carts were left unlocked and accessed by two patients (Patient #1 and #2). There was no reconciliation of medications by the facility pharmacy services to determine the actual medications taken and whether other medications could potentially be missing. This resulted in a finding of Immediate Jeopardy for the rights of patients to receive care in a safe setting. Please refer to A0115, A0144, A0345, A0398, A405 and A502 for further information.		• In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation.	
A 502	SECURE STORAGE CFR(s): 482.25(b)(2)(i) §482.25(b)(2)(i) - All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on staff interview, patient interview, clinical record review, facility document review and during the course of a complaint			

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A 502	Continued From page 45 investigation, it was determined the facility staff failed to ensure the safe storage of medications and when a reported unauthorized access occurred, the facility failed to ensure medications were reconciled to determine the actual medications that were taken, and whether other medications were potentially missing. Also the facility failed to ensure when medication carts were found to be unlocked, that medications had not been removed. The findings included: Patient #1 and #2 reportedly accessed an unlocked medication cart on 10/31/2020 and again on 11/4/2020 removing medications. There was no reconciliation of medications when the report was received to determine whether medications were missing and the actual medications taken. There were also other occasions when medication carts were found unlocked and no check was done to see if any medications were missing. Patient #1 was admitted 8/24/2020. Contained in the clinical record was a "Daily RN (Registered Nurse) Assessment" note which documented, "11/1/2020 2000 (8:00 p.m.) Patient admitted to snorting crushed meds taken by peer from unit med cart on 10/21/2020..." On 11/4/2020 at 0400 (4:00 a.m.) it was documented, "Patient was observed acting strange during routine Q15 check (every fifteen minute checks). Pt (patient) was attempting to hide a med cup /c (with) a white substance that appeared crushed. Pt became agitated when staff confiscated ...Pt eventually stated that (patient) got Seroquel off med cart...Supervisor (name) aware of situation..." A "Medical Progress Note" dated		• The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. **Person Responsible** Chief Nursing Officer **Summary of Ongoing Monitoring** As described above, the Leadership Team and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4	

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A 502	Continued From page 46 11/2/2020 evidenced, in part: "...(patient) reported to staff yesterday that (patient) obtained medications covertly from the med cart while a behavioral code was taking place on the unit along with another patient. (Patient) claims to have crushed and inhaled those medications. It is unclear what medications were obtained and of this event actually took place...an investigation is going to take place to review the validity of these claims..." On 11/4/2020 it was documented in the "Medical Progress Note: "...yesterday evening staff found (patient) with presumed medications that appear to be crushed. This was immediately confiscated from (patient)...an investigation is taking place..." Patient #2 was admitted on 02/06/2020. The clinical record documented the Patient was on suicidal precautions. Review of the clinical record revealed a note dated 11/1/2020 at 2000 (8:00 p.m.) which documented, "(Patient name) admitted taking crushed meds from cart 10/31/2020 and snorting..." A "Medical Progress Note" dated 11/2/2020 evidenced, "...Yesterday (patient) reported to staff that (patient) stole medications from a cart on 10/31/2020. Afterwards (patient) claims to have crushed and inhaled them with another peer..." Further documentation provided by the facility evidenced on 11/6/2020 "the patient reported (patient) was in possession of contraband (medication) and (patient) turned in a powder substance to (patients) therapist in a small plastic bag with broken thermometer probes that appeared to have been used to attempt to snort the medication..." The survey team requested the facility provide documentation of the investigation into both these		months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	
		A489	Hospital leadership reviewed and revised the procedures for reconciling medications in the event that a medication cart is left unlocked or unsecured, or there is suspected or alleged diversion of medications. Leadership provided education to nursing and pharmacy staff on the improvements and implemented monitors to verify ongoing compliance. Please refer to the responses to A405 and A502 for details.	01/29/2021
		A502	**Plan of Correction** **Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured. or when there is a suspicion that	01/29/2021

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A 502	Continued From page 47 reports. On 11/30/2020 at approximately 12:15 p.m., Staff Member #1 (Quality) stated, "We cannot find any file that (Staff Member #7- former Risk Manager) or (Staff Member #4- Director of Nursing) had about this. (Staff Member #7) no longer works here." There was documentation presented that the facility had made an adjustment to their "rounds sheet" on 11/3/2020 and that "Medication Cart is secure" was added to this document. According to Staff Member #1, Leadership staff round on the units at least "once a shift" and utilize this document during those rounds. According to these "audit documents medication carts were found unlocked on various units on 11/3, 11/4, 11/5, and 11/6/2020. 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 stated, "I sure did. I stole the pills Seroquel and Lamactil. Yes I did it twice. I took the lamactil once and then another time I took the Seroquel. There was a code going on the unit and nobody was watching and I took them out of the unlocked med cart..."stole" is a relative term, I took my own pills from my drawer. I didn't take anybody else's medications....I was going to crush them and snort them..." The surveyor inquired as to whether anyone from the facility had interviewed (patient) about what (the patient) had admitted to and inquired as to whether Patient #2 knew (Staff Member #7- Risk Manager). Patient #2 stated,		medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured,	

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A 502	Continued From page 48 "Yes I know (name of Staff Member #7) and No; no one talked to me except the social services person and you now..." The surveyor asked Patient #2 if (the patient) was telling the truth about the report; and Patient #2 stated, "Yes Ma'am. I am telling the truth. I did indeed take the pills both times. I wish I hadn't, but I did. I am trying to do better. I know it was wrong..." Further review of the documentation provided by the facility revealed that Staff Member #7 had stated in the document dated November 10, 2020, that the report (from 11/4/2020) "did not rise to a level III and this was prior to the camera review that did not show the patient accessing the medication cart. The original powdery substance in question was drywall dust..." On 12/1/2020 at 8:45 a.m., the surveyor reviewed the timeline and findings with Staff Member #1 and expressed concern regarding the lack of investigation and intervention for both reports of medications being taken. The surveyor expressed concern that once reported on 11/1/2020, there was no plan put in place to prevent reoccurrence and on 11/4/2020 it was again reported that the patient had gotten medications from an unlocked medication cart. The surveyor also discussed the concerns that the facility did not reconcile medication carts at the time of either report to determine whether medications were missing and whether the substance was truly drywall dust or crushed medications. The survey team interviewed Staff Member #6, Pharmacist on 12/1/2020 T 1:20 p.m.. Staff Member #6 stated, "The medication carts are filled on Tuesday and Fridays. We do a cart fill		including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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 began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation.	

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A 502	Continued From page 49 report that tells us how many (medications) to put in each cart for each (patient)....I was asked to look at the contents of the medication cup and it was a crushed substance, but did not look like medications, it had a tint to it...I wasn't told what drawer it came from, there are a lot of medication drawers..." When asked if Staff Member #6 had reconciled the cart at that time, the Staff Member stated, "No. That's a lot of medications drawers to look through." When asked if (Staff Member #6) had been notified that there were two reports, the staff member stated they were only asked to look at the crushed substance on one occasion. Staff Member #6 stated, "The tech who fills the cart never reported any doses missing and we were never informed a patient missed a dose of medication..." The survey team discussed the concerns with facility Leadership on 12/1/2020 at 8:45 a.m. (Staff Member #1) and at 10:17 a.m. (Staff Members #1, 2, 3, and 4.) The concerns were again reviewed on 12/1/2020 qt 4:20 p.m.		• In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation. • The Director of Risk Management provided education to the leadership team in group	

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			and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief 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. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the	

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			details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda included review	

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			and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until 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 quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be 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**:	

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			• 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 QAPI program 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 form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, 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 items that require attention and development of a	

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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 training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was 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 and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the	

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			quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	

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{A 000}	INITIAL COMMENTS An unannounced medicare/medicaid revisit survey was conducted December 28, 2020 through December 29, 2020 by two (2) medical facilities inspectors from the Office of Licensure and Certification, Virginia Department of Health. The revisit was conducted based on immediate jeopardy findings identified during a complaint validation survey conducted November 30, 2020 through December 9, 2020. The revisit survey determined the facility ABATED the immediate jeopardy but ALL DEFICIENCIES CITED during the complaint validation survey remain. The deficiencies include condition and standard level citations. 482.12 Governing Body - Condition of Participation 482.13 Patient Rights- Condition of Participation 482.13(c)(2) Patient Rights-Care in a Safe setting 482.13(c)(3) Patient Rights- Free from Abuse 482.21 QAPI - Condition of Participation 482.21(a),(c)(2),(e)(3) QAPI- Patient Safety 482.23 Nursing Services - Condition of Participation 482.23(b)(6) Nursing Services -Adhere to Policies and Procedures 482.23(c)(1),(c)(1)(i),(c)(2) Nursing Services-Medication Administration 482.25 Pharmaceutical Services-Condition of Participation 482.25(b)(2)(i) Pharmaceutical Services- Secure Storage	{A 000}	By submitting this Plan of Correction, the facility does not admit that it violated the regulations. The facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency.	

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

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{A 043}	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by:	{A 043}	The Governing Board directed the CEO and Leadership group to take all corrective actions needed to address findings. The Governing Board is meeting on a monthly basis for at least four months to receive reports of corrective actions and effectiveness of those actions based upon monitoring data. Please refer to the following for detailed actions: A0115- Patient Rights- Condition of Participation A0144- Patient Rights Care in a Safe Setting 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 adhere to facility Policies and Procedures A0405- Nursing Services - Medication Administration - Basic Safe Practices A0489- Pharmaceutical Services Condition of Participation A0502- Secure Storage of Medications **Person Responsible** Chief Executive Officer	1/29/2021
{A 115}	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by:	{A 115}	Hospital leadership reviewed the incidents and processes cited in the CMS 2567, revised procedures and processes to address the incidents, educated staff, and implemented monitoring to verify ongoing compliance with the rules. Leadership reports audit results to the relevant hospital committees and the Board.	1/29/2021
{A 144}	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by:			
{A 145}	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by:			
{A 263}	QAPI CFR(s): 482.21			

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{A 263}	Continued From page 2 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: {A 286} PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback	{A 144}	Please refer to the following for details: A0144 and A0145 **Plan of Correction** **Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the	01/29/2021

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{A 286}	Continued From page 3 and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: {A 385} NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: {A 398} SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) 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: {A 405} ADMINISTRATION OF DRUGS		beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time	

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{A 405}	Continued From page 4 CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by:			
{A 489}	Condition of Participation: Pharmaceutical Se CFR(s): 482.25 §482.25 Condition of Participation: Pharmaceutical Services. The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for		of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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 began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management,	

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{A 489}	Continued From page 5 developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by:			
{A 502}	SECURE STORAGE CFR(s): 482.25(b)(2)(i) §482.25(b)(2)(i) - All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by:		in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and nursing leader on duty were included. Education was provided in	

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			group and individual sessions with opportunity for discussion and clarification to assure understanding of expectations, which was verified by signed attestation. • The Director of Risk Management provided education to the leadership team in group and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on	

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			the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief 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. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight*	

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			• The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an	

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			agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until 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 quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be 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 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	

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			overall functioning of the QAPI program 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 form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, track, and monitor adverse patient occurrences and assure that a	

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			plan is implemented to show improvement in identified areas. The new program incorporates previous action plan items that require attention and development of a robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was 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 and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Executive Committee, Medical Staff, and	

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			Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	
		{A 145}	**Plan of Correction** **<u>Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys</u>** *Abuse/Neglect* The Chief Nursing Officer (CNO) implemented intensive staff training on providing patients with a safe setting. Training began on 12/11/20 and concluded 12/31/20. With the support of the Corporate Clinical Training and Education department, led "Prevention First" for all direct care staff,	01/29/2021

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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-escalation, 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 Healthstream platform provides videos and a consistent message for staff, and includes waiting room and nursing station scenarios as examples with a focus on Verbal De-escalation, Crisis Prevention and Workplace Violence Prevention. The training includes post-testing to ensure competency and staff are provided opportunities for further discussion with the Nursing Leadership. • This custom-designed curriculum, entitled "Prevention First Training" will be a required new-hire orientation course for all direct care staff as well as required annual training for existing staff continuing education and staff development. *Incident Investigation* • A new Risk Manager with previous risk management experience in Virginia began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital Director of Risk Management on reviewing, reconciling, investigating, and reporting incidents, and on developing plans to prevent future	

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			recurrences. The Director of Risk Management was also provided guidelines for timeliness of completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if any. The revised policy was approved by the Medical Executive Committee and the Governing Board.	

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			• Each department head or supervisor provided retraining to their employees 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation. • The Director of Risk Management provided education to the leadership team in group and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident	

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			reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief 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. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely	

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			and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with direct care staff training requirements, remedial training needs, scheduling of external training	

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			resources if needed, the current status of internal investigations, corrective actions taken as a result of substantiated investigations, monitoring of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until 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 quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be 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	

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			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 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 QAPI program 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 form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings.	

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			• Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, 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 items that require attention and development of a robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was provided to the facility. Training was completed on 1/22/21. The Corporate Risk Manager provided the facility Director of Risk Management and the rest of the Leadership team a best practices "advisory" regarding management of abuse and neglect allegations. Topics of the advisory included: a. Types of Abuse b. Strategies to decrease allegations of abuse	

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			c. Injury Reduction Strategies d. Samples of abuse and neglect response plan The leadership team is reviewing the best practice recommendations and the hospital's current processes to develop an internal plan of action to improve any identified hospital's processes. The action plan will be submitted to the Performance Improvement Executive Committee and the Governing Board for approval and implementation. **Person Responsible** Chief Executive Officer **Summary of Ongoing Monitoring** Monitoring of effectiveness of training and appropriateness of staff interactions with patients is done through the leadership rounding process. Documentation includes completion of rounds to each unit (with video review allowed for COVID units), observations of staff/patient interactions, and any coaching done with staff. Rounds forms are reviewed daily by the CEO, CNO, and Risk Manager with any corrective actions needed implemented immediately. Aggregated data on compliance with rounds and appropriateness of staff/patient interactions is presented monthly to the Performance Improvement Executive Committee, Medical Executive Committee, and the Governing Board. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of	

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			Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	
		{A 263}	Hospital leadership reviewed and improved the processes for documenting and reporting incidents internally, investigating incidents, taking action and reporting progress to internal committees, monitoring ongoing compliance, and reporting timely to external regulatory agencies. Please refer to A0286 for details.	01/29/2021
		{A 286}	**Plan of Correction** **Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever	01/29/2021

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			codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. The Chief Nursing Officer educated the nursing leadership team on the process	

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			to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced	

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			audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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 began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to	

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			the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation.	

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			• The Director of Risk Management provided education to the leadership team in group and individual sessions on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief Executive Officer is committed to more	

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			frequent communication with the state (Virginia Department of Health or VDH) regarding incidents and results of investigations at Cumberland Hospital. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to,	

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			the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until the QAPI process at Cumberland	

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			Hospital is well established and highly functional. • Focused Mock Surveys: As additional reinforcement of the core team's commitment to correcting repeated quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be 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 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 QAPI program as well as ongoing review of the effectiveness of this plan of correction.	

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			• External Review of Conditions of Participation: Cumberland Hospital underwent an external review in the form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, 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 items that require attention	

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			and development of a robust and sustainable plan to correct identified areas and prevent repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was 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 Team and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate.	

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			The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	
		{A 385}	Hospital leadership review and revised the procedures for securing and locking medication carts, educated nursing staff, and implemented monitoring to confirm ongoing compliance. Please refer to A0398 for details.	01/29/2021
		{A 398}	**Plan of Correction** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and	01/29/2021

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			securing of medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the	

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			nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing	

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			Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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. **Person Responsible** Chief Nursing Officer **Summary of Ongoing Monitoring** As described above, the Leadership Team and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical	

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			Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	
		{A 405}	**Plan of Correction** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes are called prior to responding to the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are	01/29/2021

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			• missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked, or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process	

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			process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective actions for staff responsible for the cart when policy is not 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	

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			began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk	

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			Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management	

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			compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. **Person Responsible** Chief Nursing Officer **Summary of Ongoing Monitoring** As described above, the Leadership Team and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication diversions. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further	

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			development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	
		{A489}	Hospital leadership reviewed and revised the procedures for reconciling medications in the event that a medication cart is left unlocked or unsecured, or there is suspected or alleged diversion of medications. Leadership provided education to nursing and pharmacy staff on the improvements and implemented monitors to verify ongoing compliance. Please refer to the responses to A405 and A502 for details.	01/29/2021
		{A502}	**Plan of Correction** **<u>Initial Plan of Correction based on 11/30/20 and 12/9/20 surveys</u>** *Medication Security* • The Chief Nursing Officer educated all nurses on expectations for safe storage of medication carts, keeping carts locked at all times, reporting when a cart is found unlocked or not secured, securing of temperature probes, and securing of medication carts whenever codes are called prior to responding to	01/29/2021

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			the code. Education was provided via electronic training system (Healthstream) with competency verified via testing. The Chief Nursing Officer tracked and verified that all nurses received the training. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked or not secured, or when there is a suspicion that medications are missing. The process was enhanced as follows: The manager observing the issue through leadership rounds or random checks secures the medication cart, completes an incident report, and notifies the pharmacist to perform a prompt reconciliation of the medications contained in the cart. If an observation of noncompliance is made during off-hours, the nursing supervisor notifies the pharmacist on call, and a pharmacist performs a reconciliation of the medication cart observed at the beginning of their next in-person shift. The revised policy was approved by the Medical Executive Committee and Governing Board. • The Director of Pharmacy educated all pharmacy staff on the revised process for completing a prompt reconciliation of the medications contained in the cart whenever the cart is found unlocked or not secured. Training was provided on 1:1 basis with opportunity for discussion and clarification to assure understanding of expectations. • The Chief Nursing Officer educated the nursing leadership team on the process to follow when a cart is found unlocked,	

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			or a medication is reported or otherwise determined to be missing. Education was provided on a 1:1 basis with understanding of expectations verified by question and answer and written attestation. • The Chief Nursing Officer incorporated the education regarding expectations for locking medication carts, securing temperature probes, locking the carts prior to responding to codes, and the medication cart reconciliation process into New Employee Orientation and annual nursing and pharmacy orientation. • On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check that the medication carts are locked and secured, including during code response, and that temperature probes are secure. This audit is done once per shift by the Unit Coordinator (Nurse Manager) and/or the Nursing Supervisors. Occurrences of unlocked or improperly secured medication carts require immediate action by the manager performing the observation. Actions include securing the cart, identifying the staff responsible for the error, initiating corrective action for the staff responsible for the cart at the time of observation, completing an incident report, and notifying the pharmacist that a prompt reconciliation needs to be completed. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning the enhanced audits, the revised audit tool, corrective	

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			actions for staff responsible for the cart when policy is not 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 began employment on 11-30-2020. • The Corporate Director of Risk Management and Corporate Divisional Director of Clinical Services provided education and training to the Hospital 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 completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by question and answer and signed attestation. • In order to strengthen and standardize the investigation and improvement process, the Chief Executive Officer and the Director of Risk Management, in collaboration with the Director of Human Resources, Corporate Director of Risk Management, and Corporate Divisional Director of Clinical Services, developed a new procedure for the management, reporting, and investigation of abuse/neglect incidents. This process was added to the Abuse and Neglect Reporting	

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			policy and includes the following steps: o Immediate placement of staff involved on administrative leave pending results of investigation o Notification of the employee's supervisor, Director of Risk Management, and the Administrator on Call o Completion of thorough investigation of allegations by the employee's supervisor and Director of Risk Management o Review of the investigation results by the supervisor, Director of Risk Management, Chief Executive Officer, and Director of Human Resources to determine the appropriate actions to be taken, if 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 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 and Nursing Supervisors), expectations for reporting to their immediate supervisor and 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 was verified by signed attestation. • The Director of Risk Management provided education to the leadership team in group and individual sessions	

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CUMBERLAND HOSPITAL LLC	9407 CUMBERLAND ROAD NEW KENT, VA 23124

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			on the revised procedure for the management, reporting, and investigation of abuse/neglect allegations. The Administrator on Call (AOC) staff and Nursing Supervisors were also educated concerning the management and reporting procedure to follow when they are covering off-shifts and weekends. Understanding of expectations was verified by question and answer and signed attestation. • The Director of Risk Management reviews and reconciles incidents daily with the Chief Nursing Officer. The Chief Nursing Officer/designee reviews the Nursing Supervisor Report in the morning "flash" meeting and identifies incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in the "flash" meeting with those submitted through the electronic incident reporting system by the nursing staff to assure that all incidents are entered for investigation. • The Director of Risk Management reviews video on all serious incidents. Results of the video review, including any inappropriate staff behaviors, are reported to the employee's manager, appropriate Senior Leader, and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. *Incident Reporting* • Dual Reporting of Incidents: The Chief Executive Officer is committed to more frequent communication with the state (Virginia Department of Health or VDH) regarding incidents and results of	

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			investigations at Cumberland Hospital. The hospital's previous process followed the minimum requirement to report such information to the local social services agency, which then in turn was responsible for reporting to VDH. In order to assure that VDH is aware of serious incidents and the details of Cumberland Hospital's investigations, however, leadership implemented a new dual reporting process to notify both the local social services agency and VDH as the state regulatory agency with deemed oversight of the facility's compliance with CMS Conditions of Participation. • The Director of Risk Management is responsible for reporting serious incidents to the local Social Services agency and to VDH as the Regulatory Oversight agency, assuring that incident reporting is consistent, timely and contains evidence of a complete internal investigation with disposition, findings (if any), evidence of standards compliance, and corrective actions taken, as applicable. The facility established this process during a planning meeting with the Director of Quality, Director of Risk Management, Chief Operating Officer and Chief Executive Officer on 12/8/2020. *Ongoing Oversight* • The leadership team formed a Performance Improvement Executive Committee to provide oversight of the facility's internal quality improvement initiatives, including but not limited to, the immediate improvement initiative to reduce the number of serious incidents directly involving patient care staff	

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			employed by the facility. • The initial members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, Chief Nursing Officer and Divisional Director of Clinical Services. The addition of the Divisional Director of Clinical Services on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. • The committee meets on a weekly basis. The initial meeting agenda included review and discussion of compliance rates with 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 of 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 Officer reports this summary to the facility's Governing Board as an agenda item at the Board's monthly scheduled meetings. This committee will be functional for a period of at least four (4) months or longer, if necessary, until the QAPI process at Cumberland Hospital is well established and highly functional.	

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			• Focused Mock Surveys: As additional reinforcement of the core team's commitment to correcting repeated quality concerns within the facility, the core team resolved to engage the Corporate Divisional Director of Clinical Services to perform quarterly mock surveys at the facility for a period of one year. The mock surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern cited in this deficiency statement. The first mock survey will be done in the 1st Quarter of calendar year 2021. The Director's findings and observations will be 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 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 QAPI program 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	

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			form of a 4-day survey performed by Joint Commission Resources Incorporated. The review took place January 4-8, 2021. The focus of the survey was compliance with the cited CMS Conditions of Participation. Upon receipt, the survey results will be shared with the leadership team at Cumberland Hospital, the Governing Board, and members of the Performance Improvement Executive Committee, and an action plan to address any deficiencies noted will be developed. The report and action plan will be a standing agenda item on the Performance Improvement Executive Committee Meeting Agenda for review of progress with correcting deficiencies. The Performance Improvement Executive Committee will in turn report progress, variances, and compliance to the Governing Board at its monthly meetings. • Based on recurrent complaints within the hospital, it was determined that the Quality Program should undergo a revision. The Chief Operating Officer and the Corporate Director of Clinical Services consulted the Corporate Vice President of Performance Improvement to obtain and implement a new and more rigorous program that could be implemented at Cumberland Hospital. The new program addresses the need to identify, 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 items that require attention and development of a robust and sustainable plan to correct identified areas and prevent repeated	

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			repeated occurrences was implemented. • The Corporate Vice President of Performance Improvement provided training to the Cumberland leadership team concerning QAPI. The goal of training was to improve the knowledge base and competency of Cumberland leadership regarding a rigorous and sustainable program. Training was conducted virtually over zoom, and training information was 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 and Nursing Leaders audit the medication carts every shift to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients. The Pharmacist audits incidents of medication cart reconciliation. The data from each source is compared to assure that carts are not only locked/secured consistently but also that correct medication cart reconciliation is occurring. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Performance Improvement Executive Committee, Medical Staff, and Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate. The Director of Risk Management tracks serious incidents such as medication	

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			diversions and incidents of abuse and neglect. The Director of Risk Management sends the report from the electronic incident tracking system daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation/action planning is assessed. In the instance where the quality of the reports or action planning needs further development, the Director of Risk Management is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident reporting and investigations will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Data is aggregated and reported to the Performance Improvement Executive Committee weekly, and monthly to the Medical Executive Committee and Governing Board.	