cumberland
hospital for children and adolescents

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

December 22, 2020

Ruthanne Risser
Director, Division of Acute Care Services
Commonwealth of Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233

Dear Ms. Risser,

Please find the attached revised CMS-2567 form submitted by Cumberland Hospital for Children and Adolescents to address the Immediate Jeopardy findings from the unannounced complaint survey conducted on December 1, 2020 by the Office of Licensure and Certification. We feel that the plan contained within addresses the identified deficiencies in a manner that resolves the issues with expediency as well as providing a framework to create sustainable change. In addition, we have now entered into a contract with Joint Commission Resources to provide an external review of the operations of Cumberland Hospital for Children and Adolescents. We remain 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 12/09/2020

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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
[signature]	Chief Executive Officer	12/22/2020

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 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	On 12/1/20 the following Corrective Actions were taken: • Day shift nurses were in-serviced 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 and following days were provided with the same training prior to beginning their next shifts to ensure that all nurses were trained. • 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 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 includes that unit medication carts were locked and properly secured upon observation.	

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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	• Occurrences of unlocked or improperly secured medication carts observed, require immediate action by the manager performing the observation. Actions may 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 observation. • As additional corrective action for observed noncompliance of a secured (locked) medication cart, the pharmacist is to 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 medication cart observed be performed by the pharmacist during their next in-person shift. 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 of the unit disruption and removed the staff member from the vicinity of the patient. The Unit Coordinator interviewed the patient in her room to determine the cause of the disruption. The patient alleged that a staff member had abused her by grabbing her, pushing her into a chair and yelling at her.	

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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 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 043	• 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. 12/2/20: The incident was reported to the Director of Risk Management who immediately reported the incident to the New Kent County Department of Social Services, and they reported the incident to the Virginia Department of Health. • On the morning of 12/2/2020, the Risk Manager completed an investigation and with other leadership members, determined actions to be taken. 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.	

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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		o The Assistant Director of Nursing initiated disciplinary action for the employee based on the substantiated findings noted by the Director of Risk Management. o 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 12/1/20 to her 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 and other patient care staff arriving for shifts subsequent to jeopardy notification were provided with the same training prior to beginning their shifts. 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 quality 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	

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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. Please refer to tags A0144 and A0145.		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 its 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:	
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: 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		1. **Intensive Staff Training:** On 12/7/2020, the facility's CEO contacted Corporate 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 determined. The facility had scheduled this education for all direct care staff commencing 12/11/2020 and to conclude not later than 12/31/2020. This training	

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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		plan has been modified for all staff to complete the training no later than 12/27/20. The intensive education plan further specifies that 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: ✓ Provides videos and a consistent message for staff, and includes waiting room and nursing station scenarios as examples. ✓ Focuses on Verbal De-escalation, Crisis Prevention and Workplace Violence Prevention. The Chief Executive Officer created a full time Staff Educator position which was posted internally and externally. The new employee orientation and education program, and the annual education and competency program are a priority for review and revision. The purpose of the position is to develop the hospital wide education and training program including New Employee Orientation. The Staff Educator assists department managers with the education and training needs of staff based on requirements of Joint Commission, OSHA, CDC, State and Federal Guidelines. Our patient population will be the central focus of the training for both new orientation and annual education. The Staff Educator collaborates with Risk Management, Employee Health and Clinical Disciplines to provide in-services for areas of risk.	

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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		The priority for this role on hire is to develop hospital wide education and training program including the New Employee Orientation Program. The Chief Nursing Officer developed and implemented a new nurse and technician preceptorship program. She selected staff to serve as preceptors for the upcoming January 4th orientation. These staff were provided education and training regarding expectations of a preceptor and how to complete an orientation checklist. Training was provided via a preceptor checklist. The Chief Nursing Officer met with each preceptor individually to do the training. The Chief Nursing Officer will be managing this orientation for the next upcoming orientation process starting January 4, 2021. She will meet with new staff for a daily check-in with preceptors during the week of unit based orientation. She will assure that the orientation is rigorous and that the checklist is completed appropriately. 2. **Dual Reporting of Incidents**: The quality improvement corrective action plan also includes 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 the facility by the core quality team discovered that on multiple occasions, the facility identified, investigated, managed and reported known incidents appropriately to the local social services agency but that the local agency was reporting to the state	

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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		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 has corrected 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 is responsible for reporting 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 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. **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 provides 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.	

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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		The members of the Performance Improvement Executive Committee are Cumberland's Chief Executive Officer, Chief Operating Officer, Director of Quality, Director of Risk Management, and Chief Nursing Officer. In addition, the Corporate Divisional Director of Clinical Services, Corporate Regional Vice President, Corporate Senior Regional Vice President, Corporate Risk Manager, and Corporate Divisional Director of Nursing on the committee provides external expertise on regulatory matters to include the facility's sustained compliance with CMS Conditions of Participation. The addition of the corporate members provides oversight of current systems, assists in the development/revision of processes and systems, and development of sustainable and robust systems that promote a culture of safety and to hold facility leadership accountable for the timely implementation of these processes and systems. The committee meets on a weekly basis. Meetings will be held for a minimum of 8 weeks or until the plan of correction is fully implemented and data shows sustained improvement. The meeting agenda includes: 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 further summarized and reported to the facility's	

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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,		Governing Board as an agenda item at the Board's monthly scheduled meeting. 4. **Focused External Surveys and Reviews** Cumberland Hospital and Corporate Leadership contacted with JCR Inc., an external consulting group to complete a review of hospital systems and provide external feedback. The contract was signed on 12/22/20. Results of the external review will be shared with Corporate Leadership and the Cumberland Hospital Executive Performance Improvement Team. The Executive Performance Improvement Committee will consider this a working document and issues identified in the report will be a main focus of the committee. Results of the consult will be reviewed by the Governing Board. 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 surveys of the CoP's at the facility for a period of one year. The surveys will specifically focus on assessing the facility's compliance with CMS Conditions of Participation, starting with the areas of concern. The first 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 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.	12/27/2020

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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	A115	Additional actions based on receipt of this report: The Governing Body directed the CEO and Leadership group to take all corrective actions needed to address findings. Please refer to the following: 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 Responsible: Chief Executive Officer Please refer to the following: A0144 and A0145.	

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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	A144	• The Chief Nursing Officer educated all nurses on safe storage of medication carts, keeping carts locked at all times, and reporting when a cart is found unlock or not secured. This education was completed in Health Stream via PowerPoint with competency testing. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked, not secured, or when there is a suspicion of medications missing. The current process has been enhanced as follows: 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 medication cart observed will be performed by the pharmacist during their next in-person shift. • The Chief Nursing Officer educated the nursing leadership team and the unit nurses on what to do when a cart was found unlocked, or a medication was missing. This education included securing and locking medication carts during a code or when not in use. Education included the current process as written above. Education was on a 1:1 basis with understanding of expectations verified by written attestation • Education regarding locking	12/27/2020

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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	medication carts, securing medication carts, and reconciling medications has been incorporated 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 if the medication carts are locked and secured. This is done once per shift by the Unit Coordinator and/or the Nursing Supervisors. Securing of temperature probes was added to this tool. Occurrences of unlocked or improperly secured medication carts 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 and including termination) for the staff responsible for the cart at the time of observation. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning corrective actions for staff responsible for the cart when policy is not followed. This education occurred 1:1 with understanding of expectations verified by signed attestation. • In order to address repeated incidents and complaint investigations, the Director of Risk Management reviews and reconciles incidents daily during, and after, flash. Specifically, the Chief Nursing Officer/designee reviews 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	Nursing Supervisor report in flash and reports incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in flash and the Midas (incident reporting system) report to assure that all incidents are entered and investigated. Incidents of abuse and neglect, and serious incidents, are then reported to Virginia Department of Health. • 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, reporting incidents, and development of plans to prevent future recurrences. The RM Director was also provided guidelines for timeliness of completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by signed attestation. • The Director of Risk Management reviews video on all incidents of patient abuse and other serious incidents. Results of the video review are reported to the appropriate Senior Leader and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. • Inappropriate staff behaviors reported or found on video review are reported to the staff member's manager and the Chief Executive officer. Staff suspected of abuse and neglect will be	

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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	suspended immediately pending final investigation. Person Responsible Chief Nursing Officer Monitoring The Leadership Team and Nursing Leaders audit the medication carts to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients, every shift. Audits are conducted via a tool that contains a check if medication carts are locked. This tool is then given the Director of Quality. The Pharmacist audits incidents of medication cart reconciliation via an audit tool that contains the number of times the reconciliation was completed. This data is then compared to the data reported by the Nursing Leaders concerning carts found to be unlocked, or concerns with missing medication. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Medical Staff, and in 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 Midas Report (incident tracking system) daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incident investigation is assessed. In the instance where the quality of the reports is lacking, the Director	

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A 144	Continued From page 16 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	A 144	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 Safety Committee, Medical Executive Committee monthly, and Governing Board.	

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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 The Chief Executive Officer collaborated	12/27/2020

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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	with the Corporate UHS Clinical Education Team to identify the appropriate education for all direct care staff. This training is a 1.5 hour long computer based learning system (Health Stream) module. Prevention First training is intended to extend staff's knowledge and expertise in managing challenging patient behaviors. The Prevention First Training includes the following: 1. A solution to deepen staff's awareness of risk and helps unify the organization by establishing a common language informed by shared values. A true culture of safety means everyone on staff has the skills to reduce workplace violence. 2. Provides videos and a consistent message for staff, and includes waiting room and nursing station scenarios as examples. 3. Focuses on Verbal De-escalation, Crisis Prevention and Workplace Violence Prevention. Specific objective for the course include the following: 1. Introduction to Crisis- Stages of Crisis 2. Responding to Someone in Distress- Communication in Crisis 3. Perceptions and Unknown Contributors to Crisis 4. Responding to Defensive Behavior 5. After the Crisis- Debriefing All current staff will complete the Prevention First training with competency assessed via post-test.	

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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	Prevention First training has be added to New Employee Orientation and annual training. After the training, the Director of Clinical Services and the Chief Nursing Officer held staff meetings for all direct care staff to discuss their comfort level, knowledge, and expertise in managing challenging patient behaviors. Staff requesting more help met individually with the Director of Clinical Services or Chief Nursing Officer to ask questions. • In order to address repeated incidents and complaint investigations, the Director of Risk Management manages incident reconciliation. Specifically, the Chief Nursing Officer/designee reviews the Nursing Supervisor report in Flash and reports incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in flash and the Midas (incident reporting system) report to assure that all incidents are entered and investigated. Incidents of abuse and neglect, and serious incidents, are then reported to Virginia Department of Health. • 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, reporting incidents, and development of plans to prevent future recurrences. The RM Director was also provided guidelines for timeliness of completion of investigations and corrective actions.	

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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	There was a strong focus on analysis of incidents based on the investigation, along with development of sustainable action plans to prevent repeated and/or further incidents. Understanding of expectations addressed in training was verified by signed attestation. • The Director of Risk Management reviews video on all incidents of patient abuse and other serious incidents. Results of the video review are reported to the appropriate Senior Leader and the Chief Executive Officer. The CEO ensures that the appropriate department heads take corrective actions to prevent recurrence of events. Inappropriate staff behaviors reported or found on video review are reported to the staff member's manager and the Chief Executive officer. Staff suspected of abuse and neglect is suspended immediately pending final investigation. On 12/17/20, the Chief Executive Officer implemented every 2 hour leadership rounds on all units during waking hours of the patients 7 days per week and assigned all senior leaders specific dates/times for rounding responsibilities. On any units with active COVID cases, rounds will be done via camera review. These rounds will be completed for the next 30 days, then reduced to each waking shift for an additional 90 days. The focus of these rounds is to provide oversight, support to staff, assess staffs' therapeutic interactions with patients, and model behavior for staff when interacting with one another and with patients. Rounds and observations are noted on the Leadership Rounds Form. Additionally, one of the senior leaders has	

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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	assigned each day to modify their hours of work and will be present at the facility from 12-9, providing additional support and leadership to the evening shift when there is less structure. Person Responsible Chief Executive Officer Monitoring Monitoring of effectiveness of training and appropriateness of staff interactions with patients is done through the leadership rounding process. Documentation will include 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 Executive PI Committee, MEC, 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 Midas Report (incident tracking system) daily to the Corporate Risk Manager and Corporate Director of Clinical Services for review. Timeliness and thoroughness of incidents are assessed. In the instance where the quality of the reports is lacking, the Director of Risk Manager is contacted to take further action. This process will continue for at least 4 months. Incidents of noncompliance with incident	

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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	reporting and investigated will be reported to the Chief Executive Officer, and the Corporate Regional Vice President. Data is aggregated and reported to the Safety Committee, Medical Executive Committee monthly, and Governing Board.	

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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

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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		

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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		

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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	Please refer to the following: A0286	

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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 • In order to address repeated incidents and complaint investigations, the Director of Risk Management reviews and reconciles incidents daily during, and after, flash. Specifically, the Chief Nursing Officer/designee reviews the Nursing Supervisor report in flash and	12/27/2020

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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	and reports incidents from the past 24 hours. The Director of Risk Management compares the incidents reported in flash and the Midas (incident reporting system) report to assure that all incidents are entered and investigated. Incidents of abuse and neglect, and serious incidents, are then reported to Virginia Department of Health. o 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, reporting incidents, and development of plans to prevent future recurrences. The RM Director was also provided guidelines for timeliness of completion of investigations and corrective actions. Understanding of expectations laid out in training was verified by signed attestation. o The Director of Risk Management reviews video on all incidents of patient abuse and other serious incidents. Results of the video review are reported to the appropriate Senior Leader and the Chief Executive Officer. Staff receive appropriate corrective action based on the results of the investigation. A monitoring plan to evaluate the investigation, analysis, and action planning related to incidents was developed by the Chief Executive Officer along with the Corporate Director of Risk and the Corporate Divisional Director of Clinical Services. The Corporate Director of Risk,	

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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	Corporate Divisional Director of Clinical Services, and the hospital Director of Risk are reviewing and evaluating the incident reporting and investigating process at Cumberland Hospital daily for a period of at least three months. The investigations are reviewed for timeliness, thoroughness, and quality. Rigorous investigation, comprehensive analysis, and sustainable action plans are the focus of this process. Noncompliance will be reported to the Chief Executive Officer and the Corporate Regional Vice President. Person Responsible Director of Risk Management Monitoring For a period of at least three months, the Corporate Director of Risk and the Corporate Director of Clinical Services are monitoring the incident reporting system for accuracy, timeliness, thoroughness, and quality with each incident. Monitoring is done daily with each incident and each investigation. . The Corporate Director of Risk reports noncompliance real time to the Chief Executive Officer, which will be addressed through additional training and/or disciplinary action as appropriate. Aggregated data is reported to the Hospital Safety Committee, Medical Staff, and the Governing Board monthly.	

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A 286	Continued From page 32	A 286		

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.

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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		

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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		

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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		
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	A 385	Please refer to A 0398	

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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 385		
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	A 398	Plan of Correction • The Chief Nursing Officer educated all nurses on safe storage of medication carts, keeping carts locked at all times, and reporting when a cart is found unlock or not secured. This education was completed in Health Stream via PowerPoint with competency testing. • The Chief Nursing Officer and Director of Pharmacy reviewed and revised the Policy and Procedure for reconciling medications when a cart is found unlocked, not secured, or when there is a suspicion of medications missing. The current process has been enhanced as follows: 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 medication cart observed will be performed by the pharmacist during	12/27/2020

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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	A 398	their next in-person shift. • The Chief Nursing Officer educated the nursing leadership team and the unit nurses on what to do when a cart was found unlocked, or a medication was missing. This education included securing and locking medication carts during a code or when not in use. Education included the current process as written above. Education was on a 1:1 basis with understanding of expectations verified by written attestation • Education regarding locking medication carts, securing medication carts, and reconciling medications has been incorporated 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 if the medication carts are locked and secured. This is done once per shift by the Unit Coordinator and/or the Nursing Supervisors. Securing of temperature probes was added to this tool. Occurrences of unlocked or improperly secured medication carts 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 and including termination) for the staff responsible for the cart at the time of observation.	

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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	A 398	• The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning corrective actions for staff responsible for the cart when policy is not followed. This education occurred 1:1 with understanding of expectations verified by signed attestation. Person Responsible Chief Nursing Officer Monitoring The Leadership Team and Nursing Leaders audit the medication carts to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients, every shift. Audits are conducted via a tool that contains a check if medication carts are locked. This tool is then given the Director of Quality. The Pharmacist audits incidents of medication cart reconciliation via an audit tool that contains the number of times the reconciliation was completed. This data is then compared to the data reported by the Nursing Leaders concerning carts found to be unlocked, or concerns with missing medication. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Medical Staff, and in Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate.	

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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.	A 398		
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.	A 405	Plan of Correction • The Chief Nursing Officer educated all nurses on safe storage of medication carts, keeping carts locked at all times, and reporting when a cart is found unlock or not secured. This education was completed in Health Stream via PowerPoint with competency testing.	12/27/2020

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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	A 405	• The Chief Nursing Officer and Director of Pharmacy reviewed the Policy and Procedure for reconciling medications when a cart is found unlocked, not secured, or when there is a suspicion of medications missing. The current process has been enhanced as follows: 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 medication cart observed will be performed by the pharmacist during their next in-person shift. • The Chief Nursing Officer educated the nursing leadership team and the unit nurses on what to do when a cart was found unlocked, or a medication was missing. This education included securing and locking medication carts during a code or when not in use. Education included the current process as written above. Education was on a 1:1 basis with understanding of expectations verified by written attestation. • Education regarding locking medication carts, securing medication carts, and reconciling medications has been incorporated into New Employee Orientation and annual nursing and pharmacy orientation.	

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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.	A 405	• On 12/1/20 the Chief Operating Officer revised the Observation Rounds Audit tool for Unit Coordinators (Nurse Managers) and Nursing Supervisors to check if the medication carts are locked and secured. This is done once per shift by the Unit Coordinator and/or the Nursing Supervisors. Securing of temperature probes was added to this tool. Occurrences of unlocked or improperly secured medication carts 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 and including termination) for the staff responsible for the cart at the time of observation. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning corrective actions for staff responsible for the cart when policy is not followed. This education occurred 1:1 with understanding of expectations verified by signed attestation. • The hospital Leadership Team, Unit Coordinators and Nursing Supervisors check the medication carts each shift. Instances of non-compliance result in reconciliation of medications. • The Chief Nursing Officer educated nurses via a Health Stream PowerPoint and test to secure temperature probes away from patient areas, including avoiding patient trash cans. Securing temperature probes was added to the Leadership Rounds form.	

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CUMBERLAND HOSPITAL LLC	9407 CUMBERLAND ROAD NEW KENT, VA 23124

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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	Person Responsible Chief Nursing Officer Monitoring The Leadership Team and Nursing Leaders audit the medication carts to assess if they are locked and located in a secure area, and temperature probes are secured and not accessible to the patients, every shift. Audits are conducted via a tool that contains a check if medication carts are locked. This tool is then given the Director of Quality. The Pharmacist audits incidents of medication cart reconciliation via an audit tool that contains the number of times the reconciliation was completed. This data is then compared to the data reported by the Nursing Leaders concerning carts found to be unlocked, or concerns with missing medication. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Medical Staff, and in Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate.	

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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.	A 405		
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	A 489	Please refer to the following: Please refer to, A502	

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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.	A 489		
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	A 502	Plan of Correction • The Chief Nursing Officer educated all nurses on safe storage of medication carts, keeping carts locked at all times, and reporting when a cart is found unlock or not secured. This education was completed in Health Stream via PowerPoint with competency testing.	12/27/2020

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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	A 502	• The Chief Nursing Officer and Director of Pharmacy reviewed the Policy and Procedure for reconciling medications when a cart is found unlocked, not secured, or when there is a suspicion of medications missing. The current process has been enhanced as follows: 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 medication cart observed will be performed by the pharmacist during their next in-person shift. • The Chief Nursing Officer educated the nursing leadership team and the unit nurses on what to do when a cart was found unlocked, or a medication was missing. This education included securing and locking medication carts during a code or when not in use. Education included the current process as written above. Education was on a 1:1 basis with understanding of expectations verified by written attestation. • Education regarding locking medication carts, securing medication carts, and reconciling medications has been incorporated 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	

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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	A 502	• Managers) and Nursing Supervisors to check if the medication carts are locked and secured. This is done once per shift by the Unit Coordinator and/or the Nursing Supervisors. Securing of temperature probes was added to this tool. Occurrences of unlocked or improperly secured medication carts 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 and including termination) for the staff responsible for the cart at the time of observation. • The Chief Nursing Officer educated the Unit Coordinators and Nursing Supervisors concerning corrective actions for staff responsible for the cart when policy is not followed. This education occurred 1:1 with understanding of expectations verified by signed attestation. • The hospital Leadership Team, Unit Coordinators and Nursing Supervisors check the medication carts and temperature probes each shift. Instances of non-compliance result in reconciliation of medications. Person Responsible Chief Nursing Officer Monitoring The Leadership Team and Nursing Leaders audit the medication carts to assess if they are locked and located in a secure area, and temperature probes are secured and	

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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,	A 502	not accessible to the patients, every shift. Audits are conducted via a tool that contains a check if medication carts are locked. This tool is then given the Director of Quality. The Pharmacist audits incidents of medication cart reconciliation via an audit tool that contains the number of times the reconciliation was completed. This data is then compared to the data reported by the Nursing Leaders concerning carts found to be unlocked, or concerns with missing medication. Data is reported daily in flash, and aggregated data is reported monthly in Performance Improvement Committee, Medical Staff, and in Governing Board. Any ongoing non-compliance will be addressed through additional training and/or disciplinary action as appropriate.	

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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	A 502		

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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.	A 502		