cumberland
hospital for children and adolescents

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

September 8, 2019

Debra Hopkins, Supervisor

Division of Acute Care Services

Commonwealth of Virginia Department of Health

Office of Licensure and Certification

9960 Mayland Drive - Suite 401

Henrico, VA 23233

RE: Cumberland Hospital, VA0528

State of Virginia Hospital Complaint Survey: #VA00046938

Dear Ms. Hopkins,

Please accept the attached SOV611 form from Cumberland Hospital for Children and Adolescents with included response and plan of correction to the State regulation standard level deficiency which was cited in our final report from the VDH's unannounced complaint survey that was conducted at our facility on August 12-13th, 2019.

Sincerely,

Leslie D. Bowery, Director, Standards and Regulatory Compliance

Cumberland Hospital for Children and Adolescents

Leslie D. Bowery 9/8/2019

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Please accept the following response with corrective action plan from Cumberland Hospital for Children and Adolescents related to a quality of care concern that was investigated by your agency on 8/12 – 8/13/19. 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.

The deficiencies cited in the report and our plan of corrective action are as follows:

Standard Level Finding - Patient Care Management - 12 VAC 5-410-230

- "The facility staff failed to ensure they followed a physician's signed ordered treatment for patient #5."

Patient #5 was a Cumberland Hospital patient from 2/25 – 7/12/2019. The complaint, as read by the surveyors at the on-site visit, included a statement from the complainant that the patient was discharged from the facility to his home and transported via ambulance not wearing his protective helmet. The facility agrees that the patient was discharged and loaded into the transport vehicle not wearing his protective helmet. These findings are based on staff interviews from the patient's day of discharge as well as previous observations of the patient not wearing a helmet at other times during his stay at Cumberland Hospital.

Cumberland Hospital utilizes an electronic medical record system for entry and acknowledgement of physicians' orders. We believe that the above cited deficiency was caused by an error in how the order was entered into the electronic medical record. The order was issued/entered on 2/25/19 by Dr. Daniel Davidow for a Medical Risk Precaution and contained instructions in the "notes" section of the precaution which stated "keep helmet in place unless bathing." The patient was not issued a stand-alone Medical Order to wear a helmet at all times. In Cumberland's electronic order administration system Medical Orders populate, with associated notes, directly to the electronic medication administration record however, Precaution Orders do not similarly populate when individual user settings in the e-MAR system are set to view "scheduled" administrations only. Therefore, the nursing staff at the facility was not prompted on a shift-to-shift basis that continual use of the helmet was required for the patient. Had the order been entered into the electronic system in the correct manner as a Medical Order, the nursing staff would be held accountable for following the order.

Corrective action for this deficiency will include re-education to the medical staff on entry of Medical Orders versus entry of Precaution Orders for any patients admitted to the facility with similar medical risks. We will also provide re-education to the nursing staff to ensure that individual default settings in

the medication administration record be set to show "all" orders instead of just "scheduled" orders. The training will include appropriate entry of instruction into the "notes" sections of orders for the medical staff. Nurse education will include reminder to review the MAR each shift for all orders including any ancillary notes/instruction embedded within orders.

The Chief Nursing Officer is the responsible party for the corrective action. Re-education on accurate medical order entry and review of orders for both the nursing staff and the medical staff will be completed by October 1, 2019. Evidence of re-education will include a signed acknowledgement from each staff member who received the training.

Person Responsible: Chief Nursing Officer

Monitoring: To ensure ongoing compliance with the plan of correction, the facility will audit all new Medical Risk Precaution orders for a minimum of 90 days of 100% sustained compliance to determine if the orders have been categorized appropriately in the electronic order entry system.

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0528	A. BUILDING: _____ B. WING _____	C 08/13/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments An unannounced Hospital Licensure Inspection was conducted 8/12/19 through 8/13/19 by three (3) Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. The facility was found to not be in compliance with the Regulations for the Licensure of Hospitals in Virginia 12 VAC 5-410, last revised November 14, 2018. One complaint, VA 00046938, was investigated during the survey. The complaint was substantiated with deficient practice.	E 000		
E 029	12 VAC 5-410-230 Patient care management D. No medication or treatment shall be given except on the signed order of a person lawfully authorized by state statutes. 1. Hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, may accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians and other persons lawfully authorized by state statute to give patient orders. 3. As specified in the hospital's medical staff bylaws, rules and regulations, or hospital policies and procedures, emergency telephone and other verbal orders shall be signed within a reasonable period of time not to exceed 72 hours, by the person giving the order, or, when such person is not available, cosigned by another physician or other person authorized to give the order.	E 029	RECEIVED SEP 11 2019 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patrice Gay Brooks — TITLE: CEO — (X6) DATE: 9/5/19

State of Virainia

STATEMENT OF DEFICIENCIES AND MN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION**NUMBER:**	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0528	A. BUILDNG - - - - - - - - - B. WING	C 08/13/2019

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

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 029	Continued From page 1 This RULE: is not met as evidenced by: Based on document review and interview, the facility staff failed to ensure they followed a physician's signed ordered treatment for one (1) of five (5) Patients (Patient #5). The findings include: On 8/13/19, the medical record of Patient #5 was reviewed and the following was noted: Patient #5 was admitted to the facility on 2/25/19 with a history of seizures, dysphagia, brain surgery requiring a helmet to be worn to protect the brain, aggression, fully dependent in all Activities of Daily Living (ADLS) and limited communication. In an interview on 8/13/19 at 9:35 **A M.,** Staff Member #9 (Occupational Therapist) stated, "I worked with (him/her] on a weekly basis. [He/She] didn't always have the helmet on. When [he/she] would get excited, (he/she] would move around a lot. I would say it would be extremely critical for (him/her] to have the helmet on during transport." Staff Member #10 (Registered Nurse) stated, "I was on duty when (he/she) was being discharged but I was passing medications to other patients. I **believe** their [Patient #5} helmet was on. I gave report to the EMTs (emergency medical technicians) and told them [he/she) had a history of seizures, so {he/she) would have had their helmet on. But I did not see them leave." On 8/13/19 at 11:20 P.M. Staff Member #13 was interviewed via telephone. Staff Member #13 stated, "We packed up four (4) large bags of belongings including medical supplies for [his/her] G-tube (gastrostomy tube) and diapers for a	E029	See attached document which includes the facility's response and plan for corrective action. Expected complete date for actions taken is 10/1/2019.	

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E 029	Continued From page 2 week. I walked [him/her] and the EMTs who transported [him/her) to the door of the unit. [He/She] didnot have a helmet on. [He/She) was not required to wear it because there had not been any incidents of them hitting themselves.." The Case Manager (Staff Member #11) was interviewed on 8/13/19 at 2:30 P.M. and stated, "[He/She} didn't have their helmet on that morning (when they were discharged)." On 2/25/19the Attending Physician (Staff Member#12) placed an order at 5:13 **P.M.** for Patient #5 to "Keep helmet in place unless bathing." An interview with the Attending Physician (Staff Member #12) was conducted on 8/13/19 at approximately 2:00 P.M. Staff Member #12 stated, "Yes, [he/she] should have had the helmet on at all times other than bathing and haircuts. [He/She] had a plate in their head from a surgery. The plate didn't fit quite well and if they had had a seizure or banged their head, it could have been dangerous. I would not have discontinued the order for the helmet" The findings were shared with the physician (Staff Member#12) on 8/13/19 at.approximately 2:00 P M., and with the Chief Executive Officer (CEO) and Chief Nursing Officer (CNO) at 3:00P M. on 8/13/19.	E 029		