

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

PRINTED: 01/27/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>493300</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/10/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CUMBERLAND HOSPITAL LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9407 CUMBERLAND ROAD</b> <b>NEW KENT, VA 23124</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced Medicare/Medicaid Hospital Complaint survey was conducted April 8 through 10, 2019 by two (2) Medical Facilities Inspectors from the Virginia Department of Health's Office of Licensure and Certification.</p> <p>The survey process included: a review of the facility's Patient Rights; Quality; Medical Staff; and Nursing Services. Interviews were conducted, medical records and policies and procedures were reviewed.</p> <p>Complaints #VA00045883 and #VA00045824 were investigated during the survey. Both complaints were substantiated; no deficiencies were sited.</p> <p>The facility was determined to be in substantial compliance with the Federal regulations as stated in 42 CFR Part §482. Conditions of Participation for Hospitals.</p>	A 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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