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

PRINTED: 02/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	493300		C 01/29/2015

NAME OF PROVIDER OR SUPPLIER: CUMBERLAND HOSPITAL LLC

STREET ADDRESS, CITY, STATE, ZIP CODE: 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) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Complaint survey was conducted January 28, 2015 through January 29, 2015. Three Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health conducted the survey. Five complaints were investigated (VA 00031230, VA 00031220, VA 00031221, VA 00031076 and VA 00030935). The complaint investigation outcomes are as follows: VA 00031230-Substantiated, with deficient practice cited; VA 00031220-Unsubstantiated-due to a lack of evidence; VA 00031221-Unsubstantiated-due to a lack of evidence, but remains an open investigation by the facility and the county sheriff's office; VA 00031076-Substantiated, with deficient practice cited; and VA 00030935- was Substantiated, with deficient practice cited. The survey team did not conduct a review of the PSI quality workbook due to the facility's report that no quality meetings had been performed since the validation survey conducted December 1-3, 2014. The facility was not in compliance with 42 CFR Part 482: Conditions of Participation for Hospitals (Rev. 122 September 26, 2014).	A 000	RECEIVED MAR 09 2015 VDH/OLC	
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care.	A 131	Chief Nursing Officer reviewed policies and procedures immediately to make the appropriate modification that will ensure that the rights of patients' representative to make informed decisions about care is protected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patrice Gay Brooks | TITLE: CEO | (X6) DATE: 3/5/2015

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 131	Continued From page 1 The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure the right of the representative of the patient (a minor) to make informed decisions regarding the care of one (1) patient out of ten (10) patients included in the survey sample. (Patient #4) The Findings Included: Patient #4 was admitted to the facility on April 25, 2014, for uncontrolled diabetes and obesity. Patient #4 was discharged on December 12, 2014. Patient #6 was admitted to the facility on November 17, 2014 for diabetes, PTSD (Post Traumatic Stress Disorder), and dysthemia (chronic depression). During an interview on January 28, 2014, at approximately 12:30 PM, Staff #6 stated the allegation that Patient #4 and #6 were not monitored on December 11, 2014, was received on December 18, 2014. Staff #6 stated that an investigation was conducted on December 18, 2014, after Patient #4 was discharged. The investigation concluded that Patient #4 and #6 were not monitored from 9:51 PM to 11:26 PM on December 11, 2014, in Unit 7 B. Staff #6 stated that numerous attempts have been made to report the incident to the legal	A 131	The policy on Abuse and Neglect Reporting was modified to include (p. 3 inserted after #8) "Every effort will be made to notify parent/guardian as soon as possible following the event. Staff will attempt 2 calls per shift to reach the parent/guardian and notify the CNO and Risk Manager of unsuccessful attempts. Each attempt to notify will be documented in the medical record. If attempts to reach the parent/guardian by telephone are unsuccessful after 72 hours, a certified letter detailing the event will be sent by the Risk Manager to the last known address on file." The entire process will be documented on the Reporting Patient/Resident Abuse or Neglect Checklist. This revised policy was used to in-service physicians and unit staff on Friday, March 6, 2015. Monitoring: 100% of the Patient/Resident Abuse or Neglect checklist will be audited to ensure that appropriate documentation is is in the medical record, notification was delivered, and if not, certified letters was sent. Results will be reported in monthly Performance Improvement Committee. Responsible Party: Chief Nursing Officer/ Director of Risk Management RECEIVED VDH/OLC	3/6/15

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A 131	Continued From page 2 guardian of Patient #4, including voice messages left on January 6, 2015 and January 7, 2015. The legal guardian has not acknowledged any messages left on the voice mail. Staff #1 stated that it was also difficult to reach the legal guardian during the hospitalization of Patient #4.	A 131		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, document review and interview, it was determined that the facility failed to protect the rights of patients to receive care in a safe setting in three (3) out of the ten (10) patients included in the survey sample.(Patients #4, #6 and #8) The Findings Included: Patient #4 was admitted to the facility on April 25, 2014, for uncontrolled diabetes and obesity. Patient #6 was admitted to the facility on November 17, 2014 for diabetes, PTSD (Post Traumatic Stress Disorder), and dysthemia (chronic depression). At approximately 2:45 PM, on January 28, 2015, review of documentation, based on the video of Unit 7B on December 11, 2014, between 9:51 PM and 11: 26 PM, revealed Patient #4 enters, exits, and re-enters the room of Patient #6 as follows: Enters the room at 9:51 PM and exits at 11:15 PM Re-enters the room at 11:18 PM and exits at 11:27 PM	A 144	The Chief Nursing Officer immediately reviewed policies and procedures to make the appropriate modifications to ensure that the facility will protect the rights of patients to receive care in a safe setting. The policy on Hospital Admissions was modified (p. 8 #29), to indicate that A high risk notification alert form is initiated by the Admissions Office. This form will be given to the admitting physician for further completion during the admission meeting and for physician assessment/review. Areas identified as high risk by history will be noted on the form. Areas deemed as potential continued risk during hospitalization will be written as precaution orders by the admitting physician. This form will be used as hand-off to the unit staff receiving the patient following the admission meeting". This revised policy was used to in-service physicians and unit staff on Friday, March 6, 2015. A re-in-service of the Levels of Observation Sexual Victimization/Sexual Aggression policies was completed by physicians and unit staff on Friday, March 6, 2015. Monitoring: On a monthly basis, 100% of all admissions medical record will be audited to ensure that all high risk notification form has been completed. Results will be reported in monthly Performance Improvement Committee. Responsible Party: Chief Nursing Officer	3/6/15

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A 144	Continued From page 3 Re-enters the room briefly at 11:28 PM Patient #6 exits and re-enters her own room multiple times during the period of 9:51 PM to 11:26 PM At approximately 3:00 PM, the surveyor with Staff 6 and #7, viewed the video taken on Unit 7B, December 11, 2014, during the hours of 9:51 PM to 11:26 PM. The video confirmed the written statement of events as listed above. It was observed that Staff #11 and #12 did not make rounds during this time period. Facility policy for "Patient Observation Rounds: Expectations and Acknowledgement" requires that staff acknowledge: 1. Every 15 minutes visually account for each patient assigned 2. Document concurrently carrying the clipboard in hand the patient's location and activity During an interview at approximately 3:30 PM on January 28, 2015, Staff #6 and #7 acknowledged that Patient #4 entered the room of Patient #6 multiple times and that no rounds were made by Staff #11 and #12 from 9:51 PM to 11:29 PM. 3. Patient #8 was admitted to the facility on 11/10/2014 for new onset of human immunodeficiency virus and post traumatic stress disorder related to sexual trauma. Review of Patient #8's medical record documented an extensive history of sexual abuse and assault by others. Review of the facility's policy titled "Sexual Aggression/Sexual Victimization Precautions" in	A 144	RECEIVED VDH/OLC	

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A 144	Continued From page 4 part read: "Purpose: 1. To provide continuous interventions aimed at providing a safe environment for patients identified with a history of sexual abuse, initiation of sexual conduct, sexually aggressive, sexually provocative behaviors or lowered impulse control related to sexual issues. Policy: 2. Emphasize to all patients and staff that the hospital is a sexually safe culture, where it is clear to all, that sexual activity and sexual relationships are never appropriate to the treatment setting ...4. Establishment of the appropriate observation level will be based on patient's past and current behaviors [Sic]. This may include line of sight or one to one observation status ..." An interview and review of Patient #8's medical record was conducted on 01/28/2015 at approximately 2:00 p.m., with Staff #6. Staff #6 acknowledged that Patient #8 had an extensive history of sexual abuse and sexual trauma. Staff #6 reported that Patient #8 was initially housed on a unit with single patient rooms. Staff #6 reported Patient #8 was transferred to another unit "just prior to the Thanksgiving holiday." Staff #6 reviewed Patient #8's medical record and reported that Patient #8 had not initially been placed on Sexual Aggression/Sexual Victimization Precautions. Staff #6 stated, "After the report on January 19th of an alleged sexual incident involving [him/her] and three other patients. [Staff #16's name] placed [Patient #8's name] on "Sexual Aggression/Sexual Victimization Precautions" and moved [him/her] back to the unit with private rooms." An interview was conducted on 01/28/2015 at 2:46 p.m., with Staff #16. Staff #16 verified Patient #8's history of sexual, abuse, "sexual	A 144		

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A 144	Continued From page 5 acting out", and sexual trauma. Staff #16 reported that "Sexual Aggression/Sexual Victimization Precautions are very restrictive." Staff #16 reported that Sexual Aggression/Sexual Victimization Precautions are not created until the patient displays some action, which "could be as simple as passing an inappropriate note to another patient." Staff #16 stated, "I initiated the Sexual Aggression/Sexual Victimization Precautions after the incident was reported months after it was alleged to occur. The reporter of the incident had a vendetta against [Patient #8's name]. I think [Patient #8's name] admitted to the allegation because it made [him/her] more important, a notoriety as a bad kid. I don't think it happened." Staff #16 verified related to the length of time between the alleged incident "sometime over the Thanksgiving weekend" and it being reported 01/16/2015 limited the investigation, which is on-going.	A 144	RECEIVED VDH/OLC	
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT 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 observation of video tape, document review and interview it ws determined that the facility failed to ensure patients were free from physical abuse by staff for two (2) of ten (10) patients included in the survey sample. (Patients #2 and #10) The findings included: Patient #10 was admitted to the facility on 11/10/2014 for management of his/her Diabetes	A 145	Chief Nursing Officer immediately reviewed policy and procedure for revisions and update to ensure that patients are free from physical abuse by staff. The policy on Remedial Education was updated to include (p. 2, # 6, a) events of abuse or neglect as a qualifying event. Before revision, Remedial Education policy did not have any mention of Abuse and Neglect being a qualifying event. The policy outline the time frame of 48 hours to educate staff on any qualifying event that have taken place. Remedial education for qualifying events will be added as a standing agenda item in the Patient Care Committee. The revised policy was used to in-service clinical management staff on Friday, March 6, 2015.	3/6/15 3/4/15

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A 145	Continued From page 6 Type I and adjustment reaction. The facility documented on video the actions of Staff #10. Staff #10 utilized a two-handed push; to push Patient #10 into the seclusion room on 12/18/2014. An interview was conducted on 01/29/2015 at 1:33 p.m., with Staff #6. Staff #6 stated, "[Name of Staff #2] was at home and was scanning the video system and observed the incident and immediately brought it to the attention of the ADON (Assistant Director of Nursing). It was a blatant push." Staff #6 stated, [Staff #2's name] was watching in real time." Staff #6 reported that information collected from the facility's investigation revealed Patient #10 had been "yelling threats and threw a chair." Staff #6 stated, "After about three to five minutes of that behavior a staff from another unit came over and was able to calm [Patient #10's name] down." Staff #6 reported Patient #10 and that staff walked to the time out room calmly. Staff #6 stated, "[Patient #10's name] was just standing in the doorway to the room sorta leaning against the door way. And [Staff #10's name] approached and pushed [Patient #10's name] into the room and used [his/her] foot to block the door." Staff #6 stated, "Besides pushing the patient, when [Staff #10's name] closed the door and blocked it with [his/her] foot that equaled seclusion. There is a call system available, if a patient needs to be secluded, you let the other staff on the unit know, and you call for help." Staff #6 reported Staff #10 did not call for help and did not inform the charge nurse [he/she] had blocked the door. Staff #6 reported since Staff #2 was watching the video in real time the charge nurse was informed that Staff #10 had blocked the door to the time out	A 145	Monitoring 100% of all qualifying events will be audited to ensure the appropriate remedial education has been provided and will be reported at the weekly Patient Safety Council Committee and monthly to the Performance Improvement Committee. Responsible Party: Chief Nursing Officer RECEIVED VDH/OLC	

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A 145	Continued From page 7 room and placed Patient #10 in seclusion. Staff #6 stated, "When the charge nurse became aware, the door was opened, [Staff #10] was relieved of [his/her] assignment and a seclusion pack was started." The surveyor requested any documentation of staff inservices or re-education related to the prevention of abuse that may have occurred after the incident. Staff #6 reported he/she would find out from Staff #1 if staff had been provided re-education/inservices. An interview was conducted on 01/29/2015 at approximately 10:00 a.m., with Staff #1. Staff #1 reviewed the facility's investigation with the surveyor. Staff #1 confirmed the findings that Patient #10's right to be free from any form of abuse had been violated. Staff #1 reported the staff were all trained in crisis prevention and instructed to "block and move not pushing patients." Staff #1 reported the facility did not perform a facility wide staff inservice or re-education. Staff #1 reported he/she would check to see if an inservice had been performed for the staff on the unit, which housed Patient #10. An interview was conducted on 01/29/2015 at approximately 1:10 p.m., with Staff #1, Staff #2 and Staff #6. Staff #1 offered an agenda for a unit meeting, but reported there was no documentation that staff had been provided inservices or re-education to protect patients from staff abuse or staff mistreatment. Staff #1 and Staff #2 agreed that a second incident of staff to patient abuse was documented approximately thirty (30) days after the above incident involving Patient #10. 2. Ten medical records (Medical Records #1-#10)	A 145	RECEIVED VDH/OLC	

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A 145	Continued From page 8	A 145		

were reviewed during the complaint survey conducted on January 28, 2015 and January 29, 2015. Patient #1's and Patient #2's medical records were reviewed on January 28, 2015 from 10:30 am to 12:00 p.m..

The findings included:

Patient #1 is a sixteen (16) year old admitted to the above named facility on 10/08/2014 for Type II diabetes (the body either resists the effects of insulin or does not produce enough insulin), obesity, and a depressive disorder.

Patient #2 is a fifteen (15) year old who was admitted to the above named facility on 12/03/2013. Patient #2's diagnosis is Type I diabetes (pancreas produces little or no insulin), asthma, hypertension, and behavior disturbance.

Documentation titled Patient/Guardian Grievance Report (written by Patient #2) was provided to the surveyor by Staff #4 on January 28, 2015 at approximately 11:30 am. The statement "I tried to resolve the issue with staff before writing this" was checked "yes" by Patient #2. Patient #2's documentation states [Name of Staff #15] "started grabbing on me and I pushed [him/her] off. [She/he] pulled my hair, scratched me and pushed me on the floor." Patient #2 signed and dated the grievance report on 01/22/2015.

Documentation in Patient #2's medical record dated 1/22/2015 by Staff #15 states Patient #2 "was asked to turn roommate's radio down during a behavioral code situation on the unit." The note further states Patient #2 was pushed and fell to the floor while Staff #15 was attempting to get the patient off of him/her. Documentation by Staff

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A 145	Continued From page 9 #15 states "patient also received a scratch to left upper side. Area was examined by the charge nurse and supervisor on duty." Staff #4 was interviewed on January 28, 2015 at approximately 11:00 am. Staff #4 verified the facility was aware of the incident involving Staff #15 and Patient #2. Staff #4 stated the facility did not have the incident on video tape because it occurred in Patient #1's and Patient #2's rooms. Staff #4 stated Patient #1 (the roommate of Patient #2) was an eyewitness to the incident which occurred on January 22, 2015 at approximately 6:30 p.m. between Staff #15 and Patient #2. Staff #4 stated Patient #1 spoke to Staff #5 regarding the incident. Staff #4 stated Patient #1 had written what he/she observed during the incident. Staff #4 stated to the surveyor during interview Staff #15 had resigned the morning of entrance on 01/28/2015. Staff #4 stated he/she had told Staff #15 "things did not look good" after reading Patient #1's documentation of the altercation between Staff #15 and Patient #2. Staff #4 confirmed the facility's staff are taught to block and not push patients. Staff #4 verified the facility is investigating the complaint. Staff #5 was interviewed on January 28, 2015 at 11:30 am. Staff #5 confirmed he/she has been working with Patient #1 since admission during counseling sessions. Staff #5 stated Patient #1 had no history of not telling the truth. Staff #5 stated he/she felt Patient #1 was telling the truth about his/her account of the physical altercation between Staff #15 and Patient #2. Staff #5 confirmed he/she asked Patient #2 to document what he/she had witnessed during the struggle.	A 145		

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A 145	Continued From page 10 Staff #4 was asked and provided a copy to the surveyor of the documentation of Patient #1's account of the altercation between Staff #15 and Patient #2. The letter was provided to the surveyor on 01/28/2015 at approximately 1:20 p.m.. A hand written document was provided to the surveyor with no date, time, or signature on the document. Staff #4 stated the document was written by Patient #1. The letter stated in part "staff came back in and told [him/her] to turn it down again and searched for the radio. [Patient #2's name] grabbed [his/her] hand and told [him/her] not to touch it. Staff pushed [him/her] away. [He/she] did it again and staff pushed [him/her] again and [Patient #2's name] said not to touch [him/her] and pushed the staff's hand away. It happened again and then staff grabbed [Patient #2's name] by [his/her] side/arm making scratches pushing [him/her] to the middle of the room and threw [him/her] on the floor and raised [his/her] hand like [he/she] was going to hit [Patient #2's name]. I [Patient #1] don't swear to this but I thought I heard [him/her] say [reference to Staff #15] have you lost your [expletive] mind." Patient #1 further states in the letter Staff #15 "takes the radio and walks out leaving [Patient #2's name] on the floor with slightly bleeding welts on [his/her] side and arm." Staff #15's employee file (Employee file #1) was reviewed on January 28, 2015 at approximately 1:40 p.m.. Staff #4 was present during the review of the personnel file. Staff #15 had a documented hire date of 02/06/2006. Staff #15 had a current performance evaluation dated 12/16/2014. Documentation indicates Staff #15 did not meet the performance standard related to "performs delegated functions as appropriate to the position to include medication administration	A 145	RECEIVED MAR 09 2015 VDH/OLC	

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A 145	Continued From page 11 and treatments as prescribed by the physician." Further documentation found pertaining to Staff #15's performance evaluation states "received a final written warning related to not counting narcotics in August." The form states in part "on the evening shift 09/02/2014 it was discovered that 19 Vimpat (anti seizure medication) 50 mg tablets were missing from the 6 A medication cart. The last documented count was 09/02/2014 at 0700. This employee [Staff #15] was assigned to the Unit 6 A at 1700 by the Chief Nursing Officer (CNO). [She/he] accepted the medication keys from the off going nurse and assumed the care of the patients and oversight of the narcotics without counting controlled drugs." The form was signed and dated on 09/05/2014 by Staff #15. According to the Food and Drug Administration "Vimpat is a federally controlled substance because it can be abused or lead to drug dependence." Staff #1 was interviewed on January 28, 2015 at approximately 2:30 p.m.. Staff #1 stated the day of 09/02/2014 there were three missed narcotic counts. Staff #1 stated another staff nurse was terminated due to possible medication diversion. Staff #1 provided a copy of the Report of Theft Or Loss of Controlled Substances submitted to the Drug Enforcement Agency (DEA) dated 09/05/2014. Documentation in Staff #15's personnel file indicated he/she was up to date on all the facility's competencies for the nursing staff. A current CPI (Crisis Prevention Institute) blue card indicated Staff #15 had completed the Nonviolent Crisis Intervention training program yearly. According to CPI "the Nonviolent Crisis Intervention program is a safe, nonharmful behavior management system designed to help human service professionals provide for the best possible Care, Welfare,	A 145		

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	493300		C 01/29/2015

NAME OF PROVIDER OR SUPPLIER: CUMBERLAND HOSPITAL LLC

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A 145	Continued From page 12 Safety, and Security of disruptive, assaultive, and out of control individuals." A copy of "Addressing Challenging Behavior" part of the above named facility's Manual of Hospital Based Behavioral Management Practices and Guidelines was obtained from Staff #4 on January 28, 2015 at approximately 12:45 p.m.. Under the section titled Purpose states in part "the best treatment for challenging behavior is being proactive and not reactive." It further states "this means working with patients to help them find ways to succeed, being fair, open and consistent with patients; finding ways to engage patients in productive activities that each person values; and mutual respect and communication between each staff member and each patient according to ethical and professional standards. The balancing of care and welfare with safety and security of all people is our top priority." A copy of the facility's Patient/Resident Rights was received on January 28, 2015 at approximately 1:30 p.m.. The facility's Patient/Resident Rights #2 states in part "You have the right to be treated with dignity and respect." Documentation found in the medical record of Patient #2 indicated he/she received patient rights. Staff #4 was present during the medical record reviews on January 28, 2015 and was aware of all the findings. Staff #1 and Staff #2 were aware of the findings on January 28, 2015 at approximately 4:00 p.m..	A 145	RECEIVED MAR 09 2015 VDH/OLC	
A 438	482.24(b) FORM AND RETENTION OF RECORDS	A 438	The Chief Nursing Officer immediately reviewed policies and procedures to make the appropriate modifications to ensure that medical records are accurately documented and completed.	

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A 438	Continued From page 13 The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on observation, document review and interview, it was determined that the facility failed to ensure medical records were accurately documented and promptly completed for five (5) out of ten (10) included in the survey sample. (Patients #4, #6, #8, #9 and #10) Findings included: Patient #4 was admitted to the facility on April 25, 2014, for uncontrolled diabetes and obesity. Patient #6 was admitted to the facility on November 17, 2014 for diabetes, PTSD (Post Traumatic Stress Disorder), and dysthemia (chronic depression). On January 28, 2015, at approximately 11:45 AM, the medical records for Patient #4 and #6 were reviewed. The medical records for Patient #4 and #6 revealed that on December 11, 2014, Staff #11 and #12 had initialed the patient observation rounds sheets every 15 minutes from 9:51 PM to 11:29 PM. At approximately 3:00 PM, the surveyor with Staff #6 and #7, viewed the video taken on Unit 7 B, the evening of December 11, 2014, during the hours of 9:51 PM to 11:26 PM. It was observed that Staff #11 and #12 did not make rounds during this time period.	A 438	The policy on Levels of Observation was modified (p. 2 #7 – 8) to include: In the event that a precaution is ordered by the physician, the Observation Rounds Sheet will be immediately marked to indicate the initiation of the precaution and a "red dot" sticker placed on the sheet to indicate the risk as part of the order notation. The corresponding precaution information sheet will be attached to the Patient Observation Rounds Sheet. When Patient Observation Rounds Sheets are prepared for a new day, the staff will review the Kardex and previous sheet for notation of precautions and ensure all precautions are noted on the form. A "red dot" sticker will be applied to indicate the high risk precaution order. The corresponding precaution information sheet will be attached to the Patient Observation Rounds Sheet. The Charge RN on the night shift will verify all precautions are marked as ordered on the Patient Observation Rounds Sheets. This revised policy was used to in-service clinical management staff on Friday, March 6, 2015. Monitoring: On a monthly basis, 100% audit of the Night Shift Charge Nurse Checklist to ensure that precautions are appropriately labeled on the Observation Sheets. Responsible Party: Chief Nursing Officer RECEIVED MAR 09 2015 VDH/OLC	3/6/15

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A 438	Continued From page 14 Facility policy for "Patient Observation Rounds: Expectations and Acknowledgement" requires that staff acknowledge: 1. Every 15 minutes visually account for each patient assigned 2. Document concurrently carrying the clipboard in hand the patient's location and activity During an interview at approximately 3:30 PM on January 28, 2015, Staff #6 and #7 acknowledged that Staff #11 and #12 had not made observation rounds during this time period and had falsified medical records by initialing that they had made 15 minute rounds. 3. Patient #8 was admitted to the facility on 11/10/2014 for new onset of human immunodeficiency virus and post traumatic stress disorder related to sexual trauma. Review of Patient #8's medical record indicated a physician's order to place the patient on sexual victimization precautions and sexual aggressive precaution. The order was documented as received and noted at 10:00 a.m., on 01/20/2015. Review of Patient #8's "Patient Observation Rounds" for 01/20/2015 did not indicate the patient had been placed on "Sexual Aggression" and "Sexual Victimization" precautions. Review of the facility's policy titled "Sexual Aggression/Sexual Victimization Precautions" in part read: "Policy: 2. Emphasize to all patients and staff that the hospital is a sexually safe culture, where it is clear to all, that sexual activity and sexual relationships are never appropriate to the treatment setting ... 7. Patients on Sexual Aggression/Sexual Victimization Precautions may	A 438		

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A 438	Continued From page 15 not have their bedroom doors closed. 8. Patients on Sexual Aggression/Sexual Victimization Precautions may not be in the bathroom with other patients, even if accompanied by staff ..." An interview and review of Patient #8's medical record was conducted on 01/28/2015 at approximately 2:00 p.m., with Staff #6. Staff #6 acknowledged the medical record documented a physician's order to place Patient #8 on precautions for "Sexual Aggression" and "Sexual Victimization." Staff #6 verified Patient #8's "Patient Observation Rounds" for 01/20/2015 did not indicate the patient had been placed on "Sexual Aggression" and "Sexual Victimization" precautions. Staff #6 stated, "Staff failed to document the new precautions on the rounding sheet." Staff #6 verified the check off boxes on the "Patient Observation Rounds" for Sexual Aggression and Sexual Victimization for Patient #8 on 12/20/2014 were blank. Staff #6 verified the only checked precaution was "Medical Risk." Staff #6 acknowledged without the documentation of the instituted "Sexual Aggression" and "Sexual Victimization" precautions; Patient #8 was free to enter other patient's bedroom and use the unit bathroom with other patients. 4. Patient #10 was admitted to the facility on 11/10/2014 and had a physician's order dated 11/24/2014 for "Sexual Victimization" precautions. Review of Patient #10's "Patient Observation Rounds" for 11/27/2014 through 11/30/2014 did not document the patient was on "Sexual Victimization" precautions. Patient #10's "Patient Observation Rounds" forms indicated the patient was on a "Behavioral Support Plan" for bullying. An interview and review of Patient #10's medical	A 438		

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A 438	Continued From page 16 record was conducted on 01/28/2015 at approximately 2:17 p.m., with Staff #6. Staff #6 verified that Patient #10 had been placed on "SVP ("Sexual Victimization" precautions)." Staff #6 reviewed Patient #10's "Patient Observation Rounds" for 11/27/2014 through 11/30/2014. Staff #6 verified that staff had failed to document Patient #10's was on "Sexual Victimization" precautions. Staff #6 acknowledged if a staff was covering and not familiar with Patient #10's precautions; Patient #10 would have been free to enter other patient's bedroom and use the unit bathroom with other patients. Review of Patient #10's "Patient Observation Rounds" for 11/27/2014 through 11/30/2014 did not document the patient had utilized the bathroom for twenty-four hours on 11/29/2014. Review of Patient #10's "Patient Care Flow Sheet" for 11/29/2014 had voided four (4) times and had one (1) bowel movement. Staff #6 verified Patient #10's "Patient Observation Rounds" did not match his/her "Patient Care Flow Sheet." 5. Patient #9 was admitted to the facility on 12/8/2014 and was not on the unit during the time of the alleged incident over the Thanksgiving weekend. Review of Patient #9's medical record revealed the patient was placed on "Sexual Victimization" precautions physician's order dated 01/02/2015. Review of Patient #9's "Patient Observation Rounds" revealed staff failed to document the patient was on "Sexual Victimization" precautions for the following dates: 01/02/2015, 01/21/2015, 01/22/2015, 01/23/2015, and 01/24/2015. Review of Patient #9's "Patient Care Flow Sheet(s)" revealed staff failed to document the patient's "Sexual Victimization"	A 438		

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A 438	Continued From page 17 precautions for the following dates: 01/04/2015, 01/16/2015, 01/17/2015, 01/18/2015, 01/22/2015 and 01/23/2015. Without the documentation of sexual precautions Patient #9 would have been free to enter other patient's bedrooms and use the unit bathroom with other patients. An interview and review of Patient #9's medical record was performed on 01/28/2015 at approximately 2:30 p.m., with Staff #6. Staff #6 verified the staff had failed to document Patient #9's "Sexual Victimization" precautions on the patient's "Patient Care Flow Sheet(s)" and "Patient Observation Rounds" on the above noted dates. Staff #6 acknowledged that each "Patient Observation Rounds" document had been signed by at least six staff (two staff per shift) and the "Patient Care Flow Sheet(s)" had been signed by at least three staff one for each shift. Staff #6 verified this finding related to staff failing to document sexual aggression and/or victimization precautions for Patients #8, #9 and #10.	A 438		