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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454108	A. BUILDING _____ B. WING _____	C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS CREEK HOSPITAL	17750 CALI DRIVE HOUSTON, TX 77090

(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 Note: The CMS-2567 is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. If information is inadvertently changed by the provider, you should notify the state Survey Agency. If the SA notices any discrepancy in the information related to scope and severity assigned or the deficiency citation (s), the SA will report this occurrence to the Dallas Regional Office. The Regional Office will make a referral of possible fraud to the Office of the Inspector General (OIG). Complaint # TX 00188756 was Substantiated. An unannounced visit was made to conduct complaint investigations per Sections 5040, 5130 and 5210F of the State Operations Manual (SOM). Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals was utilized to determined hospital's compliance with 42 CFR 482 Conditions of Participation (CoP) for Hospitals regarding: Patient Rights, Admission/Transfer/ Discharge Rights, Quality of Care and Treatment, Nursing Services, and Physician Services. An entrance conference was held on the morning of 01-30-14 with key administrative personnel. The purpose, scope and process of the complaint investigation was explained and an opportunity for questions and discussion was provided. [redacted] An exit conference was held on the afternoon of	A 000	The creation and submission of this plan of correction does not constitute an admission by the facility of any allegations or conclusions set forth in this statement of deficiencies. In accordance with regulation, the facility provides this plan of correction and documents actions taken by the facility to address cited deficiencies. Recv'd FEB 20 2014 HFC - Houston REVIEWED FEB 20 2014 by: [redacted]	

LABORA[redacted] 'S SIGNATURE | TITLE CEO | (X6) DATE 02-19-14

Any def[redacted]cy which the institution may be excused from correcting providing it is determined that other sa[redacted]uctions.) Except for nursing homes, the findings stated above are disclosable 90 days following [redacted] 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 01-30-14 with key administrative personnel. Findings of the investigation were discussed and again, an opportunity for questions and discussion was provided.	A 000	The CEO, Medical Director, CNO, and PI Director met and reviewed the Nursing Documentation policy. Recommendations were made for revisions to the policy. The Medical Executive Committee and the Governing Body approved the revised policy and Discharge Nursing Note.	2/18/14
A 130	482.13(b)(1) PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to uphold the right of one (1) of 4 sampled discharged patients (Patient ID # 7) to participate in his/her plan of care. Facility therapist (Staff ID # 7) failed to inform physician of Patient # 7 ' s expression of vulnerability & possible harm to self on date of discharge Findings include: TX # 00188756 Record review on 01-30-14 of intake TX 00188756 revealed allegation by complainant that Patient # 7 was discharged too soon " in the midst of a severely depressed Bipolar 2 episode and suicidal state... " Record review of the clinical record of Patient # 7 revealed she was s 49 years old and admitted involuntarily to the facility on 10-07-12 via law enforcement transport. Patient # 7 voiced Suicidal ideation with plans to have a motor vehicle accident.	A 130	The CNO and Clinical Service Director will re-educate the staff on patient rights in participating in care planning and the treatment planning process to ensure that patients participate in the development and implementation of their plan of care in accordance with 482.13 (b) (1). Patients' Master Treatment Plan (MTP) will reflect active participation in their plan of care as evidenced by a signature and date of the MTP review and update.	2/26/14 2/26/14

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A 130	Continued From page 2 Record review of physician orders, dated 10-12-12 (7 a.m.) " Discharge patient home after Family Therapy ... handwritten discharge summary completed... " (Physician /ID #4) Record review of Patient ID # 7 Family Therapy notes dated 10-12-12 (2:30 p.m.) by Therapist ID # 7 read: " ...labile affect and mood, tearful, poor insight and judgment; anxious; disheveled ... " Record review of Patient # 7 ' s Group Therapy Notes, dated 10-12-12 (1230) read: " ...Pt. says ' I ' m too vulnerable to go home. ' Pt. said she thinks that if she goes home today she will probably harm herself before the flight on Monday... " This note was co-signed by therapist ID # 7 at 1:00 p.m. Further review of the Patient # 7 ' s record, including all progress notes, failed to reveal evidence the physician was notified of Patient # 7 ' s expression of being " too vulnerable for discharge and voicing possible harm to self ... " Facility Therapist ID # 8 was unable to locate documentation in the medical record the physician was informed. Telephone interview on 01-31-14 at 11:45 a.m. with facility therapist ID # 7 she could not recall Patient # 7. She went on to say that if a patient voiced concerns of harming self immediately after discharge, she would either call the doctor herself or make sure the charge nurse called him. This notification would be documented in the progress notes. Telephone interview with Physician ID # 4 on 01-30-14 at 3:20 p.m. he stated if he had been	A 130	MONITORING: The Clinical Service Director will review monthly 30% of all records to ensure a compliance rate of 97% in patient participation in their plan of care and treatment. Monthly data will be collected, analyzed, and reported to the Performance Improvement Committee Monthly. Staff re-education will be provided as identified by the chart reviews. The CNO and Clinical Service Director will retrain all license nursing staff and clinical service staff on documentation of notifications to the physician for changes in condition and report of significant patient information.	2/26/14 2/21/14

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A 130	Continued From page 3 informed of Patient # 7 ' s expression of vulnerability and possible harm to self-next day, he would have postponed the discharge. H went on to say he would have re-evaluated the patient prior to discharge. He said often he wrote discharge orders in the early morning, but he expected to be informed of any significant patient changes prior to actual discharge. The facility did not have a policy that addressed informing physician of significant patient information.	A 130		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview and record review, an RN failed to supervise and evaluate the care of one (1) of 4 sampled discharged patients (Patient ID # 7). RN failed to document an assessment or condition status of Patient # 7 upon discharge. Findings include: TX # 00188756 Record review on 01-30-14 of intake TX 00188756 revealed allegation by complainant that Patient # 7 was discharged too soon " in the midst of a severely depressed Bipolar 2 episode and suicidal state... " Record review of the clinical record of Patient # 7	A 395	The CNO will provide training to all registered nurses in accordance with 482.23(b)(3) on RN supervision of nursing care. The CNO will provide re-education to all registered nurses on documentation of assessment and condition status with special emphasis on accuracy of documentation and medical record entries. The CNO will introduce and train registered nurses on the use of the Discharge Nursing Note. The registered nurse will document an assessment and condition status of the patient at the time of discharge, and will include the time the patient discharges from the unit.	2/19/14 2/26/14

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A 395	Continued From page 4 revealed she was s 49 years old and admitted involuntarily to the facility on 10-07-12 via law enforcement transport. Patient # 7 voiced Suicidal ideation with plans to have a motor vehicle accident. Record review of physician orders, dated 10-12-12 (7 a.m.) " Discharge patient home after Family Therapy ... handwritten discharge summary completed... " (Physician /ID #4) Record review of Patient # 7 ' s Group Therapy Notes, dated 10-12-12 (1230) read: " ...Pt. says ' I ' m too vulnerable to go home. ' Pt. said she thinks that if she goes home today she will probably harm herself before the flight on Monday... " This note was co-signed by therapist ID # 7 at 1:00 p.m. Record review of Patient ID # 7 family therapy notes dated 10-12-12 (2:30 p.m.) by Therapist ID # 7 read: " ...labile affect and mood, tearful, poor insight and judgment; anxious; disheveled ... " Record review of nursing notes for Patient # 7 dated 10-12-13 revealed the last nurses ' note was timed at 7:30 p.m.,: " observation in day room ...D/C (discharge) today.. Ambulating out with tech. verbalizes understanding of orders ... " Interview on 01-30-14 at 2:15 p.m. with Chief Nursing Officer (CNO/ID # 2) she was unable to locate documentation of the actual time of discharge or nursing assessment of Patient # 7 upon discharge. Record review of the every 15 minute monitoring record for Patient ID #7 revealed the last observation on the unit was recorded on 10-12-13	A 395	The CNO and PI Director reviewed patient medical record and concluded that the registered nurse failed to document the condition status of the patient in accordance with the established Nursing Documentation policy. Necessary corrective action was taken with employee. MONITORING: The CNO will direct, monitor, and evaluate the nursing services provided. The CNO and/or designee will review 100% of the Discharge Nursing Notes daily for 90 days to ensure compliance. Monthly monitoring will continue once compliance is achieved at a review rate of 30%. The senior management team will review the data and compliance rate daily. The data and compliance rate will be reported monthly to the Performance improvement Committee. The CNO/designee will take immediate action and provide re-education to any registered nurse that on review does not comply with the policy.	2/14/14

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A 395	Continued From page 5 at 3:45 p.m. Record Review of the facility Discharge Census Summary for 10-12-12 revealed Patient # 7 was removed from the facility computer system at 4: 51 p.m. The CNO stated she " would expect a discharge note and assessment to be documented by nursing on Patient # 7, especially considering the circumstances ... " The CNO acknowledged the time documented on the 10-12-12 nursing notes for Patient # 7 was in error. Patient # 7 was discharged from the hospital around 4:30 p.m.; the nurse ' s note was timed at 7:30 p.m., which was after the patient had left. Record review of facility policy titled " Nursing Documentation, " revised date 2/2013, read: " ...8. The patient ' s status is documented upon transfer or discharge from the hospital... "	A 395		