STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454121	A. BUILDING _____ B. WING _____	C 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUSTIN OAKS HOSPITAL	1407 WEST STASSNEY LANE AUSTIN, TX 78745

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A 000	INITIAL COMMENTS The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An entrance conference was held with the facility Director of Performance Improvement and Risk Management the morning of 8-12-14. The purpose and process of the complaint survey were discussed, and an opportunity given for questions. Complaint TX00199457 was unsubstantiated with no related or unrelated Federal deficiencies cited. Complaint TX00198945 was substantiated with related Federal deficiencies cited. An exit conference was held with the facility Chief Executive Officer, Director of Performance Improvement and Risk Management and other administrative staff on the afternoon of 8-12-14. Preliminary findings of the survey were discussed, and an opportunity given for questions.	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. REVIEWED SEP 03 2014 by: [redacted]	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION [redacted]	A 123	A 123 §482.13(a)(2)(iii) – The hospital's administrative team review compliance with	9/01/14

[redacted]E TITLE CEO (X6) DATE 9-2-2014

institution may be excused from correcting providing it is determined that
cept for nursing homes, the findings stated above are disclosable 90 days
days following the date these documents are made available to the facility. If nursing homes, the above findings and plans of correction are disclosable 14
program participation.

42 CFR 401.126 and 401.133

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A 123	Continued From page 1 At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on a review of hospital policies and staff interviews the hospital failed to provide a written response to a patient grievance. Findings included: Review of hospital policy, "Patient Advocacy / Grievance and Conflict Resolution", Policy Number RI-17, effective 6/10/13, stated, in part, "A patient grievance would also include situations where patients or the patient's representative call or write to the hospital about concerns related to care or services that were not resolved during their stay or who did not wish to address their issue during their stay ... 9. Time frame for completion of the investigation is 72 hours after the receipt of the complaint, with written response within 7 days ... 11. Once the issue has been resolved, the staff person responsible for investigating and resolving the grievance will provide a written response within seven (7) days of the grievance/complaint being received. The response will include: a) The name of the contact person, b) The steps taken to investigate the grievance on behalf of the patient, c) The results of the grievance process, how the grievance was resolved; d) The date of completion of the investigation.	A 123	policies titled "Patient Advocacy / Grievances and Conflict Resolution" and "Patient Observations" during daily operations meeting, attended by the CEO, Executive Medical Director and Directors of Nursing, Clinical Services and Performance Improvement. Documentation of follow-up shall be added to the meeting's standing agenda / minutes. The Patient Advocate was re-trained by the Director of Performance Improvement, to ensure prompt notification and follow-up on documentation specific to grievances, to include written response to complainants as described in said policy. Patient Advocate shall report grievance activity, monthly to the PI Committee and Medical Executive Committee. Report will be forwarded to the Board quarterly. All staff shall be retrained on the policy and procedure associated with the policy titled "Patient Advocacy / Grievances and Conflict Resolution" by the Patient Advocate and Director of Performance Improvement.	9/02/14 9/15/14

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A 123	Continued From page 2 e) The process to follow if the patient/complainant is not satisfied with the response." Review of facility documentation provided to the surveyor revealed a complaint call was received by the facility on 5/20/14 from the father of Patient #1, with documentation by Staff #13 stating that he called the complainant on 5/21/14. There was also documentation that Staff #6 called the complainant on 5/21/14. In an interview with Staff #13, Director of Clinical Services the afternoon of 8/12/14 in the facility conference room, Staff #13 stated that he received a complaint from the father of Patient #1, after Patient #1 was discharged. The complaint involved nutrition, lost personal belongings, and patient phone calls. Staff #13 stated that he called the complainant and discussed the complaint with the father and stated that, "I spoke to the dad; when I was done, he didn't say anything else." In an interview with Staff #6, hospital administrator the afternoon of 8/12/14 in the facility conference room, she stated that she spoke with the father of Patient #1 (complainant) about the complaint after Staff #13 spoke to him and she felt that everything was resolved by the end of the conversation. In an interview with Staff#2, Risk Manager and Staff #13, Director of Clinical Services the afternoon of 8/12/14, Staff #2 and Staff #13 each stated that that there was no written response was provided to the complainant, the father of Patient #1, per hospital policy in response to his complaint/grievance to the hospital. Staff #2 stated that a written response was not provided if	A 123		

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A 123	Continued From page 3 they felt the complaint was resolved. The above findings were confirmed in an interview the afternoon of 8/12/14 in the facility conference room in an interview with the hospital administrator, risk manager, and shift supervisor.	A 123		
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 a review of medical records, staff interviews, and hospital policy, the hospital failed to ensure that nursing standards were met as evidenced by: patient dietary intake and needs were not addressed, meal intake was not documented for patients and a dietary consult was not ordered for a patient with appetite concerns. Interview and documentation revealed patient belongings were not secured and returned at patient discharge. Findings included: Review of the medical record for Patient #1 revealed the following: Daily Provider Progress notes were as follows: 5/7/14 Staff #7 MD: "Appetite: Remains poor." 5/8/14 Staff #7 MD: "Appetite: Good" 5/9/14 Staff #8 APRN: "Appetite: Good" 5/10/14 Staff #8 APRN: "Appetite: Good" 5/11/14 Staff #8 APRN: "Appetite: Good" Patient Observation/ MHT Progress Notes documentation for percentage of meals	A 395	A 395 §482.23(b)(3) – With the change in Nursing Administration, the CEO tasked the newly hired Director of Nursing with evaluating and re-structuring nursing services to ensure compliance with policies and standards, and ensures on-going monitoring and direction. The Director of Nursing shall retrain all nursing staff on the proper documentation of client status in accordance with the policy titled "Documentation Guidelines," "Nursing Assessment," "Multi-disciplinary Approach to Generating Order for Nutritional Assessments/Consults," and "Patient Observations." The Director of Nursing or designee conducts random chart audits for documentation of dietary consults and food intake. Audits shall continue until 95% success is sustained for 60 days.	9/30/14

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A 395	Continued From page 4	A 395		

consumed was incomplete as the percentage was not documented/left blank for 16 out of 26 meals as follows:

Date	Bkfast	Lunch	Dinner	Snack
5/6/14	2	2	blank	blank
5/7/14	blank	blank	blank	blank
5/8/14	20	5	75	blank
5/9/14	blank	blank	blank	blank
5/10/14	2	blank	blank	blank
5/11/14	50	blank	50	100
5/12/14	0	blank	discharged	discharged

12 Hour Nursing Assessment/Progress Note documentation for percentage of meals consumed was incomplete as the percentage was not documented/left blank for 16 out of 26 meals as follows:

Date	Bkfast	Lunch	Dinner	Snack
5/6/14	100	100	blank	100
5/7/14	30	blank	blank	blank
5/8/14	50	100	blank	100
5/9/14	blank	blank	blank	blank
5/10/14	75	blank	blank	blank
5/11/14	100	blank	blank	blank
5/12/14	75	blank	discharged	discharged

There was only one nursing shift narrative note which mentioned the consumption of meals for Patient #1; on 5/7/14, nursing documentation stated, "states did not sleep well Appetite [decreased as indicated by arrow drawn pointing down]." There was no documented evidence of any intervention or dietary consultation. Progress notes from the therapists included the following entry:
5/7/14 at 2:45 pm "Therapist spoke [with] [father] via phone - reviewed current progress in groups, medications & appetite."

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A 395	Continued From page 5 There was no documented evidence in the medical record that Patient #1 received a dietary or nutrition consult, despite physician, nursing, and therapy documentation about the patient's appetite. In addition to the record for Patient #1, review of an additional 4 out of 5 medical records (Patients #6, 8, 9, 10) revealed that dietary intake was not documented consistently by nursing staff. Review of the medical record for Patient #6 revealed no documentation for 2 meals on 8/10/14 and 4 meals on 8/9/14. Review of the medical record for Patient #8 revealed no documentation for 4 meals on 8/9/14 and 1 meal on 8/10/14. Review of the medical record for Patient #9 revealed no documentation for 4 meals on 8/9/14 and 1 meal on 8/10/14. Review of the medical record for Patient #10 revealed no documentation of 2 meals on 8/3/14 and 1 meal on 8/10/14. In an interview with Staff #2, Risk Manager, the afternoon of 8/12/14, she confirmed that the nurses and the MHTs are required to document the percentage of meals consumed for each patient and confirmed the above findings in the patient records. Review of hospital policy, "Documentation Guidelines", Policy Number PC-T-8, effective 6/10/13, stated, in part, "Documentation of care and other therapeutic services will occur in a systematic manner, reflecting patient needs, current status, special occurrences and on-going progress ... 2. Each discipline or modality shall document in the indicated medical record form, utilizing	A 395		

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A 395	Continued From page 6 standard medical record guidelines ..." Review of hospital policy, "Multidisciplinary Approach to Generating Order for Nutritional Assessments - Consults", Policy Number PC-N-13, effective 6/10/13, stated, in part, "4. The nursing staff will continually monitor the patients' food intake and complete weight checks as established per policy and request consult by dietitian if there are appetite or weight status concerns." Review of the Texas Nurse Practice Act §217.11. Standards of Nursing Practice, stated, in part, "(1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: ... (D) Accurately and completely report and document: (i) the client ' s status including signs and symptoms; (ii) nursing care rendered; ... (v) client response(s); and (vi) contacts with other health care team members concerning significant events regarding client ' s status;" Review of the medical record for Patient #1 revealed that the Patient Belongings Inventory form revealed a list of items were documented that Patient #1 brought with her to the hospital; Patient #1 signed the form on 5/5/14 and the form was witnessed by staff on 5/5/14. Patient #1 again signed the form on 5/12/14 which stated "Upon Discharge, all items have been returned to me." The checkboxes for "Yes" or "No" were left blank. The signature was witnessed by Staff #10 on 5/12/14.	A 395	The Interim Director of Nursing reviewed with staff the procedure for processing patient belongings. Additionally, as demonstrated to surveyors, a Process Improvement Team had convened and developed a new procedure for processing patient belongings. Staff is currently being trained on the procedure.	9/30/14 9/01/14

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A 395	Continued From page 7 In an interview with Staff #2, Risk Manager the afternoon of 8/12/14, she stated that patients complete a patient belongings inventory form when they are admitted to the hospital and they sign the form at discharge after the patient receives their belongings. Review of the Austin Oaks Hospital Patient Feedback and Complaint dated 5/20/14, revealed that the father of Patient #1 called after the discharge of Patient #1 to state that Patient #1 didn't receiving clothing /toiletries on multiple drop offs, and that clothes taken from drop off were lost, but were found 10 minutes later. Staff #13, Director of Clinical Services documented on 5/21/14 that he spoke to the father of Patient #1 and he was "greatful (sic) for our efforts to address his concerns ...He denied any further actions to be taken on our behalf." On 5/21/14, a note was made and signed by Staff #6, Hospital Administrator, which stated, "I talked [with] father and he was very satisfied based on the conversations [with] therapists." In an interview with Staff #13, Director of Clinical Services the afternoon of 8/12/14 in the facility conference room, Staff #13 stated that he received a complaint from the father of Patient #1 after her discharge, he reviewed the complaint and called the complainant. Per Staff #13, the father of Patient #1 stated that he had concerns that his daughter's clothes were lost, but Staff #13 was "pretty sure that the dad came back and got the clothes" when they were found after the patient was discharged. Staff #13 stated that, "I spoke to the dad; when I was done, he didn't say anything else."	A 395	The Director of Nursing or designee conducts random chart audits for documentation of receipt and return of patient belongings. Audits shall continue until 95% success is sustained for 60 days.	9/30/14

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A 395	Continued From page 8 Review of facility policy "Patient Valuables and Belongings", Policy Number RI-23, effective 6/10/13, stated, in part, "Patient's belongings that are placed in the custody of the hospital will be logged in and secured and returned to the patient on discharge ... 6. The patient and staff then return to the unit, the staff inventories all items that will not be kept in custody by the patient during their stay ... 10. The patient or /parent / guardian will review the inventory list and sign it; staff member doing the inventory will sign and date it ... 16. At the time of discharge the following steps will be taken: a. Unit staff will retrieve the Personal Belongings ...Patient and staff will sign and date form confirming receipt of items." The above findings were confirmed in an interview the afternoon of 8/12/14 in the facility conference room with the Hospital Administrator, the Risk Manager, and the RN Shift Supervisor.	A 395		