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

PRINTED: 06/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454063	A. BUILDING ______ B. WING ______	C 06/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS CREEK HOSPITAL INC	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-2567L 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). TX-000-80104 - Substantiated An unannounced visit was made to the facility to conduct a complaint investigation. The survey was conducted per State Operations Manual (SOM) to determine compliance with 42 CFR Part 482, Conditions of Participation for Hospitals. An entrance conference was held on 6/13/2007 at 9:00 AM with administrative personnel #50, Chief Executive Officer, at which time the nature and scope of the investigation was discussed and an opportunity for questions was provided. An exit conference was held on 6/14/2007 at 5:00 PM with administrative personnel #50 at which time the findings of the investigation were discussed. An opportunity for questions and discussion was provided.	A 000	**A038 482.13 Patient's Rights** The hospital now ensures the protection and promotion of the rights of all patients by vigilantly observng patients with specific risk factors, monitoring the treatment milieu to ensure that any safety issues are corrected, and ensuring speedy access to emergency services should these become necessary. • Communication systems have been improved to ensure that staff understands their specific and individual responsibilities to provide and maintain a safe setting. The assignment sheets reflect more detail and the Supervisor's report was created to supplement the verbal report between shifts. • Staff re-training was provided on June 24, 25, 29 and 30 for suicide risk assessment and Patient Rounds. These rounds include direct visual observation of the patient; for sleeping patients, staff must be within an arm's length to clearly identify the patient and confirm that the patient is breathing normally. • Completion of 15 minute checks and monitoring of patients per policy is essential to patient safety, and failure to provide these results in appropriate disciplinary action. • The "Patient Use of Potential Dangerous Items" policy has been implemented; there is now a process for ensuring that potentially dangerous items provided to patients for their personal use are tracked and that items are secured to prevent patient self-harm. • The "Sharps Sign-Out Log" and Nursing Assignment sheet are used in hand-off communication at shift change to verify the location and return of all potentially dangerous items. • To further ensure optimal patient safety and staff communication, CCH formalized the House Supervisor rounds process with a 2-Hour Rounds Sheet to verify that staff are providing a safe milieu, that Q 15-minute and special precautions checks are performed as ordered, and that patient rights are being protected.	1
A 038	482.13 PATIENTS' RIGHTS A hospital must protect and promote the rights of each patient.	A 038		

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.

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A 038	Continued From page 1	A 038		

This CONDITION is not met as evidenced by:
TX-000-80104 - Substantiated

Based on record review, an interview with staff #55, RN, BSN, and review of the facility's internal investigation, the facility failed to provide patient #1 a safe treatment environment, thus violating his rights. Based on record review, policy review and interview, the facility also failed to provide safety for the other 14 patients on the unit (patient # 2- #15).

Findings include:

A review of policy titled "Level of Observation" states:

#6. Q 15 Minute Observations
*Minimum level of observation for all patients.
*Staff will observe patient and document on the Patient Observation Record q 15 minutes.
*Assigned staff will make direct visual contact with patients and confirm they are in no danger or distress.
*Staff will be vigilant for potential risk factors identified for specific patients (levels of precautions).
*Sleeping patients will be observed at close enough proximity to confirm they are in no physical distress. Staff will observe the patient at a minimum arm's length distance to ensure the ability to clearly see the patient's identity and respiration.

Citing patient #1, a 30 year old male, admitted to the facility on 4/28/07, who "became acutely suicidal after wife threatened to leave him over

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Provider's Plan of Correction (A 038):

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- To facilitate after-hours EMS access to patients in emergency situation, Nursing Supervisors established that House Supervisors will assign a specified staff to go to the lobby to meet and escort EMS to the appropriate destination while the Supervisor remains on the unit to render assistance with the emergency.
- EMS will be given contact numbers for the Admissions Department at 281-586-5956 and the House Supervisor at 281-586-5939 to ensure immediate communication.

Monitoring:
- Completion of orientation checklists; annual competence, performance reviews and training logs in employee files for evidence of training and, when needed, corrective disciplinary action, for maintaining patient and milieu safety.
- Patient Rounds Sheets for evidence of rounds completion (concurrently and retrospectively).
- Sharps Sign-Out Log for evidence of return of all potentially dangerous items.
- House Supervisor 2-Hour Rounds Sheets for evidence that rounds are being conducted.

Person Responsible:

Implementation Date: July 1, 2007

42 CFR 401

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A 038	Continued From page 2 this past week." Per Incident Report Form, dated 5/7/07, written by staff #53 "time of incident 0200. Client stated he was in the shower when he cut his Left wrist with a small razor blade, which was found in the shower. Stated incident occurred at 9:00 PM, but in reality, another peer came to (staff #52) and reported to staff #52 that at 11:00 PM the patient was taking a shower. Assessed affected area. Cleansed with water and applied a pressure dressing to stop the bleeding. Findings, severe, deep laceration on left wrist, self inflicted....notified Dr. Lucas and called 911 to transport to ER." A statement written as part of an internal investigation by patient #1 on 5/9/07 reveals the following: on 5/6/07 at approximately 9:30 PM, patient #1, who had been admitted for suicidal ideation on 4/28/07, and was supposed to be physically viewed by staff every 15 minutes, took a razor he had checked out 3 days previously, went into his shower, turned it on, and slit his left wrist. He stated that he passed out and regained consciousness approximately 5-6 hours later. His room had flooded and he walked to the nurses station to report it. They saw his wrist, decided he needed stitches, and called 911 for an ambulance around 2:30 AM. A review of rounds sheets for that evening reveals that no rounds were performed from on 5/6/07 10:00 PM until 5/7/07 7:00 AM. A review of the internal investigation reveals that staff members #52, Psychiatric Technician, and #53, Agency RN, stated that each thought the other was responsible for rounds. Staff #54, RN, Supervisor, was in charge of 5 units on that shift.	A 038		

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A 038	Continued From page 3 She was made aware of the situation around 2:30 AM when the patient came to the nurses station, but she did not stay on the unit and resolve the situation, instead going to another unit to perform other duties. An interview was conducted on 6/7/07 at 12:30 PM in the administrative conference room, with staff #55, RN, BSN, who conducted the internal investigation. She stated that when the Emergency Medical Services (EMS) personnel arrived to take patient #1 no one was waiting to let them into the facility, resulting in a further 10-15 minute delay in the patient's treatment. Review of the facility "Administrative Policy on Code Blue" reveals that "The Nurse Manager/Nursing Supervisor/designee shall assign a staff member to direct and escort the EMS team." This policy was not followed. A review of 15 of 15 medical records (patients #1-#15) revealed that no rounds were completed on 5/6/07 from 10:00 PM through 5/7/07 at 7:00 AM. Cypress Creek EMS (the ambulance company that transported the patient to the Houston Northwest Medical Center Emergency Room) document reads: Call received: 02:37 Scene: 02:40 Patient Side: 02:54 Pt Released: 03:23 Primary Diagnosis: Attempted Suicide " Upon EMS arrival found 30 year old male sitting	A 038		

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A 038	Continued From page 4 in a chair at a local mental hospital. Staff of the facility called EMS this date due to pt cutting his wrist on 5/6/07 with a shaving razor that he brought from home. Pt stated that he did not want to harm himself or others, pt stated that he was ' pissed off that his insurance company was paying $600 a day for him to be there. ' Pt has a 4cm induration partial thickness lacerating to the left wrist. No active bleeding noted, staff of the facility had bandaged pt ' s wrist with a kling type dressing. Pt transported to the hospital where he was left in the care of the triage nurse and full PT report without incident. " The Houston Northwest Medical Center Registration Record reads: Patient # 073932402 admit time: 03:25 admit diagnosis: open wound of wrist Seq/Episode Procedure: Skin closure NEC, Repair superficial wound Psych note at 04:50 reads: Intervention: Searched patient and belongings for dangerous items. Moved to a secure room. Staff member from Cypress Creek hospital at bedside with pt. Procedure: 04:48 Assist provider w/laceration repair of left wrist using sutures.	A 038	1	
A 057	482.13(c)(2) RECEIVE CARE IN A SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview with staff #50, #51 and #55,	A 057		

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A 057	Continued From page 5 record review of 15 of 15 patients (#1-#15), and review of policy and procedure, the facility failed to provide 15 of 15 patients on unit 1 with a safe setting. Findings include: Citing patient #1, a 30 year old male, admitted to the facility on 4/28/07, who "became acutely suicidal after wife threatened to leave him over this past week." Per Incident Report Form, dated 5/7/07, written by staff #53 "time of incident 0200. Client stated he was in the shower when he cut his Left wrist with a small razor blade, which was found in the shower. Stated incident occurred at 9:00 PM, but in reality, another peer came to (staff #52) and reported to staff #52 that at 11:00 PM the patient was taking a shower. Assessed affected area. Cleansed with water and applied a pressure dressing to stop the bleeding. Findings, severe, deep laceration on left wrist, self inflicted....notified ind called 911 to transport to ER." This statement conflicts with facts found in other documentation, and conflicts with the patient's written statement concerning the incident. A statement written as part of an internal investigation by patient #1 on 5/9/07 reveals the following: on 5/6/07 at approximately 9:30 PM, patient #1, who had been admitted for suicidal ideation on 4/28/07, and was supposed to be physically viewed by staff every 15 minutes, took a razor he had checked out 3 days previously, went into his shower, turned it on, and slit his left wrist. He stated that he passed out and regained consciousness approximately 5-6 hours later. His	A 057	**A057 482.13 (c) (2) Receive care in a safe setting** The Hospital now ensures the rights of all patients to receive care in a safe setting, particularly to protect patients from harming themselves. Policies and practices have been reviewed and improved to enhance protections for suicidal patients. • Changes have been made in staff training, assessment and re-assessment of suicidal risk, oversight of safety precautions, better control of access to harmful objects, staff patient care assignments, patient and environmental monitoring, and communication among and between the treatment team. A new form was created. A new policy was created. A new logging sheet was created and more detail was added to the logging sheet. • To re-educate staff on suicidal risk and prevention, meetings were conducted on June 24, 25, 29 & 30 to review, question by question, the "Inpatient Suicide/Self-Harm Assessment" and the new process for risk assessment was implemented on July 1, 2007. • Pre-admission and nursing assessments include specific queries for suicidal ideation, plans, history, etc. If the patient is not suicidal upon admission but becomes suicidal or expresses suicidal ideations during the hospital stay, a suicide assessment is completed by any RN, Therapist or MD. • All patients with an identified suicide risk are placed on suicide precautions and the concern is addressed in the treatment plan. • Once suicide precautions are initiated, the physician must complete a suicide assessment tool to determine that it is safe to order the discontinuation of suicide precautions.	1

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A 057	Continued From page 6 room had flooded and he walked to the nurses station to report it. They saw his wrist, decided he needed stitches, and called 911 for an ambulance around 2:30 AM. Interviews were conducted with staff #50, #51 and #55. They could not offer any explanation of why the patient was given a razor when he was on suicide precautions, or why no one noticed that he hadn ' t turned it back in. A review of the " Administrative Policy on Patient ' s Use of Personal Possessions " reads: " 10. Patients specifically shall not be allowed to keep in their possession: j. Safety razors, electric razors with cords, or disposable razors " There is a sharps sign out list, but staff #51, Director of Nursing, stated that they are discarded so there is no record of the patient checking out the razor. During interviews with staff #50, #51 and #55, the surveyor asked for any policy regarding the procedure for checking out and returning sharps. None of the above named staff was able to produce such a policy, and staff #50 stated that no such policy exists.	A 057	• To ensure that staffing is adequate to protect patients from opportunities for self-harm, a staffing matrix and acuity indicators are used. • The Nursing Assignment Sheet is used to assign named staff to suicide precautions monitoring for specific patients; staff initial their areas of responsibility to verify assignments. • The "Patients Use of Potential Dangerous Items" policy was implemented to track the safe use and timely return of these items to secured storage. • The "Sharps Sign-Out Log" and Nursing Assignment sheet are used in hand-off communication at shift change to verify the location and return of all potentially dangerous items. • Patients who are on suicide precautions are not allowed unsupervised use of any sharps, including safety razors for shaving. • CCH formalized the House Supervisor rounds process with a 2-Hour Rounds Sheet to verify that staff are providing a safe milieu, and that Q 15-minute and special precautions checks are performed as ordered. These rounds require direct visual observation of the patient; for sleeping patients, staff must be within an arm's length to clearly identify the patient and confirm that the patient is breathing normally. Completion of 15 minute checks and monitoring of patients per policy is essential to patient safety, and failure to provide these results in appropriate disciplinary action. **Monitoring:** • Completion of orientation checklists; annual competence, performance reviews and training logs in employee files for evidence of training and, when needed, corrective disciplinary action, for maintaining patient and milieu safety. • Nursing Assignment Sheet for evidence of patients on suicide precautions. • Patient Rounds Sheets for evidence of rounds completion (concurrently and retrospectively). • Sharps Sign-out Log for evidence of return of all potentially dangerous items. • House Supervisor 2-Hour Rounds Sheets for evidence that rounds are being conducted. • Staffing Variance Report **Person Responsible:** **Implementation Date:** 6/21,24,25,29,30; 7/1/2007	1
A 204	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 interviews with staff #50, #51, and #55,	A 204		

42CFR401

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A 204	Continued From page 7 medical record review of 15 of 15 patients on unit 1, and review of the facility's internal investigation, no registered nurse supervised or evaluated patients #1-#15 from 10:00 PM on 5/6/07 through 7:00 AM on 5/7/07. Findings include: A review of policy titled "Level of Observation" states: #6. Q 15 Minute Observations *Minimum level of observation for all patients. *Staff will observe patient and document on the Patient Observation Record q 15 minutes. *Assigned staff will make direct visual contact with patients and confirm they are in no danger or distress. *Staff will be vigilant for potential risk factors identified for specific patients (levels of precautions). *Sleeping patients will be observed at close enough proximity to confirm they are in no physical distress. Staff will observe the patient at a minimum arm's length distance to ensure the ability to clearly see the patient's identity and respiration. Citing patient #1, a 30 year old male, admitted to the facility on 4/28/07, who "became acutely suicidal after wife threatened to leave him over this past week." Per Incident Report Form, dated 5/7/07, written by staff #53 "time of incident 0200. Client stated he was in the shower when he cut his Left wrist with a small razor blade, which was found in the shower. Stated incident occurred at 9:00 PM, but in reality, another peer came to (staff #52) and	A 204	**A204 482.23 (b)(3) RN Supervision of Nursing care** • The hospital now ensures that patients are assigned to RNs who are responsible to provide patient assessment/re-assessment, active treatment interventions, and oversight/direction of nursing staff, based on the patient's needs and treatment plan. • Assignments are written and include critical information such as assigned levels of observation, alerts to any medical or clinical issues, and other information needed to assure a safe and secure therapeutic environment and care of assigned patients. • The Nursing Supervisor is the RN who has the ultimate responsibility under the Director of Nursing, for delegation of patient assignment and supervision of care. • Each unit has an RN who is responsible for the provision of a safe treatment environment and care of the patients on each unit. The Unit RN delegates to the LVN and Psychiatric Technician the aspects of care within their scope of practice. • On 6-24,25,29 and 30 staff meetings were held to review Patient Rounds, Suicide Assessment, Abuse and Neglect Reporting Process and the updated Suicide Policy. • Staff meetings on 6-24, 25, 29 & 30 covered staff responsibilities and procedures during codes. • A staffing matrix and acuity indicators are now used to ensure that staffing is sufficient to protect patients from opportunities for self-harm. • On 6-8-07, to provide an additional layer of documented oversight to the units, the hospital initiated a House Supervisor two (2) hour rounds process. The House Supervisor provides and documents rounds a minimum of every two hours. The purpose of this is to ensure that the Unit Staff are providing and documenting their levels of observation (15 min checks, etc.) and special precautions in accordance with MD orders and patient needs.	1

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A 204	Continued From page 8 reported to staff #52 that at 11:00 PM the patient was taking a shower. Assessed affected area. Cleansed with water and applied a pressure dressing to stop the bleeding. Findings, severe, deep laceration on left wrist, self inflicted....notified and called 911 to transport to ER." This statement conflicts with facts found in rounding sheets, and in the patient's written statement regarding the incident. A statement written as part of an internal investigation by patient #1 on 5/9/07 reveals the following: on 5/6/07 at approximately 9:30 PM, patient #1, who had been admitted for suicidal ideation on 4/28/07, and was supposed to be physically viewed by staff every 15 minutes, took a razor he had checked out 3 days previously, went into his shower, turned it on, and slit his left wrist. He stated that he passed out and regained consciousness approximately 5-6 hours later. His room had flooded and he walked to the nurses station to report it. They saw his wrist, decided he needed stitches, and called 911 for an ambulance around 2:30 AM. A review of rounds sheets for that evening reveals that no rounds were performed from on 5/6/07 10:00 PM until 5/7/07 7:00 AM. A review of the internal investigation reveals that staff members #52, Psychiatric Technician, and #53, Agency RN, stated that each thought the other was responsible for rounds. Staff #54, RN, Supervisor, was in charge of 5 units on that shift. She was made aware of the situation around 2:30 AM when the patient came to the nurses station, but she did not stay on the unit and resolve the situation, instead going to another unit to perform other duties.	A 204	• To facilitate after-hours EMS access to patients in emergency situations, Nursing Supervisors established that House Supervisors will assign a specified staff to go to the lobby to meet and escort EMS to the appropriate destination while the Supervisor remains on the unit to render assistance with the emergency. • EMS will be given contact numbers for the Admissions Department at 281-586-5956 and the House Supervisor at 281-586-5939 to ensure immediate communication. **Monitoring:** • Patient Rounds Sheets for evidence of rounds completion (concurrently and retrospectively) • Nursing Assignment Sheet for evidence of patients on suicide precautions. • House Supervisor 2-Hour Rounds Sheets for evidence that rounds are being conducted. **Person Responsible:** **Implementation Date:** June 8 and 25, 2007 42CFR481	1

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A 204	Continued From page 9 An interview was conducted on 6/7/07 at 12:30 PM in the administrative conference room, with staff #55, RN, BSN, who conducted the internal investigation. She stated that when the Emergency Medical Services (EMS) personnel arrived to take patient #1 no one was waiting to let them into the facility, resulting in a further 10-15 minute delay in the patient's treatment. Review of the facility "Administrative Policy on Code Blue" reveals that "The Nurse Manager/Nursing Supervisor/designee shall assign a staff member to direct and escort the EMS team." This policy was not followed. A review of 15 of 15 medical records (patients #1-#15) revealed that no rounds were completed on 5/6/07 from 10:00 PM through 5/7/07 at 7:00 AM. Cypress Creek EMS (the ambulance company that transported the patient to the Houston Northwest Medical Center Emergency Room) document reads: Call received: 02:37 Scene: 02:40 Patient Side: 02:54 Pt Released: 03:23 Primary Diagnosis: Attempted Suicide " Upon EMS arrival found 30 year old male sitting in a chair at a local mental hospital. Staff of the facility called EMS this date due to pt cutting his wrist on 5/6/07 with a shaving razor that he brought from home. Pt stated that he did not want to harm himself or others, pt stated that he was ' pissed off that his insurance company was	A 204		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS CREEK HOSPITAL INC	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 204	Continued From page 10 paying $600 a day for him to be there. ' Pt has a 4cm induration partial thickness lacerating to the left wrist. No active bleeding noted, staff of the facility had bandaged pt ' s wrist with a kling type dressing. Pt transported to the hospital where he was left in the care of the triage nurse and full PT report without incident. " The Houston Northwest Medical Center Registration Record reads: Patient # admit time: 03:25 admit diagnosis: open wound of wrist Seq/Episode Procedure: Skin closure NEC, Repair superficial wound Psych note at 04:50 reads: Intervention: Searched patient and belongings for dangerous items. Moved to a secure room. Staff member from Cypress Creek hospital at bedside with pt. Procedure: 04:48 Assist provider w/laceration repair of left wrist using sutures.	A 204	42CFR401	