Inspections Report

Cypress Creek Rehabilitation and Healthcare Center

Nursing Facility Abuse, Neglect, Exploitation, and Misappropriation

March 20, 2025
OIG Report No. INS-25-008

Inspector General

Texas Health and Human Services

Cypress Creek Rehabilitation and Healthcare Center

Nursing Facility Abuse, Neglect, Exploitation, and Misappropriation

Results in Brief

Why OIG Conducted This Inspection

In 2020 and 2021, the U.S. Department of Health and Human Services Office of Inspector General conducted audits of nursing facilities that reported allegations of potential abuse or neglect of Medicaid beneficiaries. The audits determined California, Florida, and New Jersey did not comply with federal requirements to report potential abuse or neglect of Medicaid beneficiaries. The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) initiated this inspection to determine whether the issues found in the 2020 and 2021 reports were present in Texas Medicaid nursing facilities.

Summary of Review

The inspection objective was to determine whether Cypress Creek Rehabilitation and Healthcare Center (Cypress Creek) has processes and procedures to document and report abuse, neglect, exploitation, and misappropriation incidents as required by state law. The inspection scope covered the period from September 1, 2022, through August 31, 2023.

For more information, contact:
OIGInspectionsReports@hhs.texas.gov

Key Results

Cypress Creek has policies and procedures that describe how to identify and report abuse, neglect, exploitation, and misappropriation. Cypress Creek did typically comply with state requirements regarding provider investigation reports, employment checks, and orientation related to abuse, neglect, exploitation, and misappropriation. Specifically:

- All tested incidents were reported timely.
- All provider investigation reports were submitted timely and maintained at least two years, as required.
- All tested employee files contained records of attendance at orientation training.
- Of 19 provider investigation reports tested, 18 (94.7 percent) contained all required information.
- Of 15 employee records tested:
  - All 15 criminal history checks were performed accurately.
  - 14 (93.3 percent) Employee Misconduct Registry and Nurse Aide Registry checks were conducted before the employee's date of hire.

Recommendations

Cypress Creek should:

- Improve controls over its processes to ensure all provider investigation reports contain all required information.
- Create and implement controls over its processes to perform timely Employee Misconduct Registry and Nurse Aide Registry checks.

Management Response

Cypress Creek declined the opportunity to respond to the findings and recommendations in this report.

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Inspection Overview

Overall Results

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) conducted an inspection to determine whether Cypress Creek Rehabilitation and Healthcare Center (Cypress Creek) protects residents by screening employees and training them to identify, report, and document abuse, neglect, exploitation, and misappropriation, as required.

Other than two low percentage exceptions, Cypress Creek typically met requirements on incident reporting, provider investigation reports, employment checks, and training during orientation. To correct the exceptions, Cypress Creek should:

- Submit provider incident reports containing all required information.
- Conduct Employee Misconduct Registry and Nurse Aid Registry checks timely.

OIG Inspections offered recommendations to Cypress Creek, which, if implemented, will improve compliance.

This report is considered written education in accordance with Texas Administrative Code.[1] Inspection findings identified in this report (a) may be referred to the Texas Health and Human Services Commission (HHSC) for potential pursuit of enforcement remedies or (b) may be subject to OIG administrative enforcement measures,[2] including administrative penalties.[3] This report does not address compliance beyond the scope and objective of this inspection.

OIG Inspections presented preliminary inspection results, observations, and recommendations to Cypress Creek in a draft report dated March 11, 2025. Cypress Creek declined the opportunity to respond to the findings and recommendations in this report. OIG Inspections thanks the management and staff at Cypress Creek for their cooperation and assistance during this inspection. Unless otherwise

[1] 1 Tex. Admin. Code § 371.1701 (May 1, 2016).

[2] 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

[3] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

Objective

The inspection objective was to determine whether Cypress Creek has processes and procedures to document and report abuse, neglect, exploitation, and misappropriation incidents as required by state law.

Scope

The inspection scope covered the period from September 1, 2022, through August 31, 2023.

Background

Cypress Creek is a skilled nursing facility licensed for 122 beds located in Cypress, Texas, in Harris County, as shown in Figure 1. The facility provides skilled nursing, rehabilitation services, long-term care, and post-acute care nursing.

Figure 1: Cypress Creek Location

Source: Google Maps

What Prompted This Inspection

In 2020 and 2021, the U.S. Department of Health and Human Services Office of Inspector General conducted audits of nursing facilities that reported allegations of potential abuse or neglect of Medicaid beneficiaries. The audits determined California, Florida, and New Jersey did not comply with federal requirements to report potential abuse or neglect of Medicaid beneficiaries.[4,5,6]

OIG Inspections initiated this inspection to determine whether the issues found in the 2020 and 2021 reports were present in Texas Medicaid nursing facilities.

[4] U.S. Department of Health and Human Services Office of Inspector General, "California Did Not Ensure That Nursing Facilities Always Reported Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Properly," A-09-19-02005 (June 9, 2021).

[5] U.S. Department of Health and Human Services Office of Inspector General, "Florida Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Assess, Prioritize, or Investigate Reported Incidents," A-04-17-08058 (Mar. 4, 2021).

[6] U.S. Department of Health and Human Services Office of Inspector General, "New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported," A-02-18-01006 (Aug. 19, 2020).

Detailed Results

Nursing facilities must develop and implement written policies and procedures that prohibit and prevent the mistreatment, abuse, neglect, exploitation of a resident, and misappropriation of a resident's property.[7] OIG Inspections tested records of incident reports, employment checks, and orientation training to determine whether Cypress Creek follows its policies and complies with state requirements.

Cypress Creek has policies and procedures that describe how to identify and report abuse, neglect, exploitation, and misappropriation. Cypress Creek did typically comply with state requirements regarding provider investigation reports, employment checks, and orientation related to abuse, neglect, exploitation, and misappropriation. Specifically:

- All tested incidents were reported timely.
- All provider investigation reports tested were submitted timely and maintained at least two years, as required.
- All tested employee files contained records of attendance at orientation training.
- Of 19 provider investigation reports tested, 18 (94.7 percent) contained all required information.
- Of 15 employee records tested:
    - All 15 criminal history checks were performed accurately.
    - 14 (93.3 percent) Employee Misconduct Registry and Nurse Aide Registry checks were conducted before the employee's date of hire.

The following sections of this report provide additional detail about the findings of noncompliance observed by OIG Inspections.

[7] 26 Tex. Admin. Code § 554.601(c) (Jan. 15, 2021).

Chapter 1: Cypress Creek Reported Incidents Timely and With Required Information in Most Cases

Of the 19 tested incidents of suspected abuse, neglect, exploitation, and misappropriation during the inspection scope, Cypress Creek:

- Reported all incidents to HHSC Complaint and Incident Intake within 24 hours, as required.
- Submitted provider investigation reports to HHSC Complaint and Incident Intake within five business days, as required.
- Included all required information in 18 of the 19 provider investigation reports.
- Maintained the provider investigation reports at least two years, as required.

The report that did not contain all required information lacked the date the incident occurred, and the date and time the resident's post-incident health condition was noted.

Nursing facilities must report specific details of the incidents of suspected abuse, neglect, exploitation, and misappropriation within certain timeframes and retain the records of the incidents.

Allegations must be reported to HHSC Complaint and Incident Intake: [8]

- No later than two hours if they involve abuse or result in serious bodily injury.
- No later than 24 hours for all other allegations that do not involve abuse and do not result in serious bodily injury.

[8] 26 Tex. Admin. Code § 554.602(a)(1) (Jan. 15, 2021).

The facility must conduct an investigation of the reported acts and:[9]

- Have evidence that all alleged violations were thoroughly investigated.
- Submit the results of the investigation to HHSC Complaint and Incident Intake within five working days of the incident.
- If the alleged violation is verified, take appropriate corrective action.

Nursing facilities must also maintain incident reports for two years after occurrence. These reports must include the name of the resident, witnesses, date and time of the incident, description of the incident, and resident's health status after the incident, including vital signs and date and time of entry.[10]

The provider investigation report should document all required information to provide clarity, key details, and transparency of an incident that has occurred.

Recommendation 1

Cypress Creek should improve controls over its processes to ensure all provider investigation reports contain all required information.

[9] 26 Tex. Admin. Code §§ 554.602(a)(2) and 554.602(a)(4) (Jan. 15, 2021).

[10] 26 Tex. Admin. Code § 554.1923 (c)(1) (Jan. 15, 2021).

Chapter 2: Cypress Creek Conducted Most Employee Misconduct Registry and Nurse Aide Registry Checks Timely and Accurately

Cypress Creek accurately performed searches of the Employee Misconduct Registry and Nurse Aide Registry prior to employees' hired dates, as required, in 14 of 15 employee records tested.

Nursing facilities must search the Employee Misconduct Registry and Nurse Aide Registry through the Employability Status Check Search website,[11] provided by HHSC, before an employee is hired and annually thereafter to determine if the person applying for employment is listed as unemployable on either registry.[12] In addition, nursing facilities must perform criminal history checks to determine if an individual has a conviction that bars them from employment before the individual has direct contact with a resident.[13] Cypress Creek performed criminal history checks accurately. Additionally, the annual Employee Misconduct Registry and Nurse Aide Registry checks were conducted timely and accurately in accordance with requirements.

Of 15 employee records tested, Cypress Creek performed one (6.7 percent) initial Employee Misconduct Registry and Nurse Aide Registry check four days after the date of hire.

Recommendation 2

Cypress Creek should create and implement controls over its processes to perform timely Employee Misconduct Registry and Nurse Aide Registry checks.

[11] HHSC requires nursing facilities and agencies to conduct Employee Misconduct Registry and Nurse Aide Registry checks through the Employability Status Check Search website.

[12] 26 Tex. Admin. Code § 561.3 (Apr. 21, 2022).

[13] Tex. Health & Safety Code § 250.003 (Jan. 1, 2014).

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

OIG Inspections selected Cypress Creek because it was among the facilities in Texas that reported an increased number of reported incidents related to abuse, neglect, exploitation, or misappropriation in the scope period compared to the previous year.

To achieve its objective, OIG Inspections collected information through (a) interviews with Cypress Creek's administrator and HHSC Long-term Care Regulation staff and (b) a review of reported incidents and complaints of abuse, neglect, exploitation, and misappropriation for 2023. OIG Inspections also reviewed information provided by Cypress Creek including:

- Policies and processes
- Provider investigation reports
- Orientation program documents
- Employee records

OIG Inspections reviewed a sample of personnel records for 15 Cypress Creek employees hired between September 1, 2022, through August 31, 2023, as well as 19 sampled provider investigation reports for the same period. OIG Inspections compared employee personnel records and provider investigation reports to state requirements to determine whether Cypress Creek (a) timely reported incidents and submitted Provider Investigation Reports that contain required information, (b) conducted accurate criminal history, Employment Misconduct Registry and Nurse Aide Registry checks, (c) conducted Employment Misconduct Registry and Nurse Aide Registry checks prior to the date of hire and annually, and (d) provided orientation instruction on identifying, reporting, and documenting abuse, neglect, exploitation, and misappropriation.

Standards

OIG Inspections conducts inspections of Texas HHS programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into

specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspection reports present factual data accurately, fairly, and objectively, and present findings, conclusions, and recommendations in a persuasive manner to strengthen program effectiveness and efficiency. OIG Inspections conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Criteria

OIG Inspections used the following criteria to evaluate the information provided:

- Tex. Health & Safety Code § 250.003 (2014)
- 26 Tex. Admin. Code §§ 554.601 (2021), 554.602 (2021), 554.1923 (2021), 554.1929 (2021), and 561.3 (2022)

Appendix B: Resources for Additional Information

The following resources provide additional information about the topics covered in this report.

For more information on Long-term Care

"Long-term Care Providers," HHSC https://www.hhs.texas.gov/providers/long-term-care-providers (accessed December 17, 2024)

"Nursing Facilities (NF)," HHSC https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf (accessed December 17, 2024)

For more information on Cypress Creek

Cypress Creek, https://cypresscreekrehab.com/ (accessed December 17, 2024)

Appendix C: Related Reports

- Paradigm at Faith Memorial: Nursing Facility Abuse, Neglect, Exploitation, and Misappropriation, INS-25-007, March 18, 2025
- Midtowne Meadows Health and Rehab: Nursing Facility Abuse, Neglect, Exploitation, and Misappropriation, INS-25-002, October 28, 2024

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this inspection report include:

- Anton Dutchover, CPA, Deputy Inspector General of Audit and Inspections
- Bruce Andrews, CPA, CISA, Director of Inspections
- James Aldridge, CFE, Manager of Inspections
- Bridney Jones, Lead Inspector
- Kenin Weeks, Senior Inspector
- Tiana Clayton, Senior Inspector
- Gabriel Moreno, Senior Inspector
- Mo Brantley, Senior Audit Operations Analyst

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Texas Health and Human Services Commission

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- Jose Garcia, Deputy Director of Compliance Division
- Stephen Pahl, Deputy Executive Commissioner for Regulatory Services

- Michelle Dionne-Vahalik, Associate Commissioner for Long-term Care Regulation

Cypress Creek Rehabilitation and Healthcare Center

- Brad Dorer, Owner and Interim Administrator, Cypress Creek Rehabilitation and Healthcare Center
- Christine Romo, Director of Nursing, Cypress Creek Rehabilitation and Healthcare Center

Appendix E: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Raymond Charles Winter, Inspector General
- Susan Biles, Principal Deputy Inspector General
- Kacy J. VerColen, Chief of Audit and Inspections
- Eugenia Krieg, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Diane Salisbury, Chief of Data Reviews
- Matt Chaplin, Chief of Operations
- Steve Johnson, Chief of Investigations and Utilization Reviews

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- OIG website: ReportTexasFraud.com

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: https://oig.hhs.texas.gov/report-fraud-waste-or-abuse
- Phone: 1-800-436-6184

To Contact OIG

- Email: oig.generalinquiries@hhs.texas.gov
- Mail: Texas Health and Human Services
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000