CERTIFICATE OF NEED/ CONVERSION APPLICATION

LATE FILES

Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by

Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486

Attorney General Docket Number: 15-486-01

April 20, 2016

WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Melinda A. Agsten
203.498.4362
magsten@wiggin.com

Rebecca A. Matthews
203.498.4502
rmatthews@wiggin.com

April 20, 2016

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: ***Eastern Connecticut Health Network, Inc.***
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

On behalf of Eastern Connecticut Health Network, Inc. ("***ECHN***") and Prospect Medical Holdings, Inc. ("***PMH***" and, together with ECHN, the "***Applicants***"), we thank you for your time at the hearings on March 29-30, 2016, and careful consideration of this important proposal.

Enclosed with this letter are the various late file exhibits requested of the Applicants by the Office of Health Care Access and the Office of the Attorney General. As with previous filings, one (1) hard copy and one (1) electronic copy of this submission have been provided to each Office.

Please note that Hearing Officer Kevin Hansted granted an extension to submit Late File #19, Revised/Updated Exhibit W – EBITA, Working Capital and Stockholders' Equity of PMH Hospitals (Prior to and Post Acquisition), until April 26, 2016.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn-Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

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1. **Timeline of ECHN's Review of PMH's Immediate Jeopardy Citations/Deficiencies in California**

Please see attached.

ECHN Review of PMH Immediate Jeopardy Issues

Timeline February 1, 2016 through March 28, 2016

Disclosure of Issues to ECHN:

- **February 1, 2016**: PMH representatives contact ECHN to advise ECHN that PMH had recently received additional information on Immediate Jeopardy citations at two of its California Hospitals and to provide some history and facts around this development. ECHN is also informed at the same time that PMH has asked the OAG and OHCA for an extension to file its responses to the January 12, 2016 completeness questions in the Waterbury/PMH CON proceeding in order to provide a detailed response regarding notices of CMS deficiencies and Immediate Jeopardy findings that PMH has received relating to certain of its California hospitals.

- **February 16-17, 2016**: PMH files a response to the Waterbury CON completeness questions with a summary that describes how its California regulatory issues arose and outlines the manner in which the issues are being remedied. PMH provides a copy of the filing to ECHN representatives and starts providing additional information around the latest developments. PMH explains that the initially identified deficiencies have been resolved, but discloses additional regulatory issues and provides excerpts from the following CMS Forms 2567:

    - A report detailing the results of a survey completed on September 25, 2015 (the "**September 25 Survey**") at two hospitals, Southern California Hospital at Hollywood and Culver City; and

    - A report detailing the results of a survey completed on November 10, 2015 (the "**November 10 Survey**") at Los Angeles Community Hospital.

- **February 17, 2016**: As a follow-up to the **November 10 Survey** CMS begins a re-survey at Los Angeles Community Hospital on February 15, 2016 which it completes on February 17, 2016 (the "**February 17 Survey**"). During the exit conference, CMS notifies PMH that there are no new Immediate Jeopardy findings but that there will be some deficiency findings relating to infection control and other matters. The formal results of the survey are provided on March 24, 2016 (see below).

- **February 18, 2016**: PMH SVP Corporate Development Von Crockett conducts a conference call with Peter Karl and other ECHN representatives Dennis McConville and Joyce Tichy in which he describes the outstanding deficiencies being addressed by PMH. Other PMH participants on the call are Thomas Reardon and Frank Saidara. Von Crockett provides background to the recent deficiency findings:

    - **Los Angeles Community Hospital**. Von Crockett reports that this review process began when surveyors responded to a patient's complaint of physician misconduct that PMH had self-reported and as to which it had instituted corrective actions. Surveyors found that PMH had not fully implemented its corrective actions, and as a result issued an Immediate Jeopardy finding. PMH then took further corrective action by suspending the physician and putting additional precautions into place. However, in a subsequent

follow-up survey (the **November 10 Survey**) surveyors identified other issues. As a result, CMS issued a 90 day termination letter for the three hospitals under the Los Angeles Community Hospital license (Los Angeles Community, Norwalk and Bellflower). The letter notified PMH that the Medicare provider agreement would be terminated April 13, 2016 unless deficiencies were satisfactorily corrected. Credible documentation evidencing correction of the issues and compliance with Medicare conditions was to be submitted by January 25, 2016. PMH submitted timely its corrective action plan and was resurveyed (the **February 17 Survey**) and was awaiting further regulatory response.

- **Hollywood/Culver City**: Von Crockett reports that this started with a fire on the roof at Culver City during construction to remediate an aging facility (previously in bankruptcy) in January 2015, in which an air handler pushed smoke into the building which required an evacuation. This led to a series of follow-up regulatory surveys, including the **September 25 Survey**, which found prior issues abated but then identified other issues and issued Immediate Jeopardies. Subsequently CMS conducted a 10-day "Validation Survey" in the third week of December (the "**December 22 Survey**"). The written survey report had not yet been received at the time of the conference call, although PMH had been informed orally that it would receive a 90 day letter notifying it of potential termination as a Medicare participating hospital.

Von Crockett describes various corrective actions taken which include replacement of the local administrative team including the CEO, CNO and Director of Quality Management and the resignation of the Chief of Staff and appointment of a new Chief of Staff; the hiring of consultant Greely and Company and the law firm Hooper Lundy & Bookman to assist in PMH's responses, and the appointment of a new corporate administrative team; i.e., Chief Quality Officer, Chief Clinical Officer, Vice President of Regulatory Affairs and Patient Safety, and the recruitment of a Chief Corporate Nursing Officer.

- **February 19, 2016**: ECHN's CEO Peter Karl meets with Board Chair Dr. O'Neill and Vice Chair Joy Dorin regarding PMH's disclosure of regulatory issues in California. It is determined that this information should be disclosed to the Board at its next meeting, and that a Board-level process should be established to look into the matter further.

- **February 23, 2016**: CMS issues a 90 day termination letter in connection with the **December 22 Survey** for the three hospitals under the Southern California Hospital license. The letter notifies PMH that the Medicare provider agreement will be terminated May 24, 2016 unless deficiencies are satisfactorily corrected; credible documentation evidencing correction of the issues and compliance with Medicare conditions are required to be submitted by March 4, 2016 (later extended to March 22, 2016).

ECHN Board Outlines a Deliberative Process and Begins Work:

- **February 24, 2016**: At a meeting of ECHN's Board of Trustees, Board Chair Dr. O'Neill advises the Board that PMH regulatory issues have come to light and that more information and investigation are needed to determine their scope and any impact on the ECHN/PMH transaction. Dr. O'Neill appoints Board Vice Chair Joy Dorin and Performance Assessment and Quality Committee Chair Dr. Michele Conlon to perform an in-depth review, with support from

Linda Quirici, ECHN Vice President for Quality and Safety, and her appropriate designees in the ECHN Quality Department (together, the "**Quality Evaluation Team**").

- **February 24, 2016**: PMH opens its data room containing regulatory surveys to ECHN. ECHN team begins reviewing the materials.

- **February 25, 2016**: PMH receives two written reports bearing survey dates December 18, 2016 and December 22, 2016 which together comprise the **December 22 Survey**, and releases them to ECHN.

- **February 29, 2016**: PMH representative Von Crockett leads a conference call with the ECHN **Quality Evaluation Team** and other representatives of ECHN. Mr. Crockett outlines the issues in the three hospitals that led to regulatory findings. ECHN's **Quality Evaluation Team** requests additional detail which is furnished. The parties go over next steps regarding exchange of further information, the review process to be conducted, and timeline.

- **March 2, 2016**: ECHN and PMH agree that a brief postponement of the public hearings scheduled for March 15-16 may be appropriate in order that ECHN may look further into the PMH regulatory matters.

- **March 4, 2016**: Members of the ECHN **Quality Evaluation Team** visit PMH's two Rhode Island hospitals, Our Lady of Fatima and Roger Williams, to learn about their quality programs, the experience since PMH acquisition, and the manner in which those programs have been allowed to progress under PMH.

- **March 4, 2016**: ECHN Transaction Committee meets to review the status of information regarding the Immediate Jeopardies and to consider next steps.

- **March 7, 2016**: The ECHN **Quality Evaluation Team** meets on current status and next steps for reviewing PMH regulatory issues in order to make recommendations to the full Board regarding PMH as an appropriate purchaser. ECHN proposes to PMH an agreement pursuant to which PMH will commit to support of ECHN's current quality programs (the "**Quality Commitment Letter**"), which PMH agrees to consider.

- **March 11, 2016:** ECHN Transaction Committee meets to discuss information learned to date including results of **Quality Evaluation Team** trip to Rhode Island, reviews proposed **Quality Commitment Letter**, and outlines further steps/deliverables.

- **March 18, 2016:** PMH provides draft Plan of Correction with summary for **December 22 Survey** to ECHN for review, along with quality performance indicators for its owned hospitals. PMH provides comments to the proposed **Quality Commitment Letter**.

- **March 21, 2016**: Peter Karl and members of the ECHN **Quality Evaluation Team** participate in a conference call with Von Crockett and a number of other PMH representatives to discuss the corrective actions and ECHN's follow-up questions resulting from its review of the **December 22 Survey** response.

- **March 22, 2016**: The ECHN **Quality Evaluation Team** reports back to the Transaction Committee the results of the review of PMH regulatory documents and the March 21, 2016 phone conference with PMH representatives. The Transaction Committee reviews PMH's comments to the **Quality Commitment Letter** and discusses responsive comments for ECHN. The Transaction Committee recommends that the Board approve proposal to proceed with the **Quality Commitment Letter** and to continue with the transaction with PMH.

ECHN Board Resolves to Proceed with the Transaction and Quality Commitment Letter:

- **March 23, 2016**: At a Special Meeting the Board receives a written report from the **Quality Evaluation Team** on the visit to PMH's Rhode Island hospitals and an oral report on PMH's regulatory issues. The Board considers the Transaction Committee recommendation and after deliberation resolves to proceed with the **Quality Commitment Letter** and the PMH transaction.

- **March 24, 2016:** PMH notifies ECHN that it has received the written CMS Forms 2567 from the **February 17 Survey** at Los Angeles Community Hospital, and provides a copy to ECHN. (The CMS cover letter is dated March 23, 2016). As CMS had indicated during the exit conference, there are no new Immediate Jeopardy findings, but there are additional findings relating to nursing services and infection control. The new plan of correction is due April 4, 2016 and the proposed date for terminating the Medicare provider agreement unless corrective actions are taken is extended from April 13, 2016 to June 21, 2016.

- **March 28, 2016: Quality Commitment Letter** finalized and executed by ECHN and PMH.

2. Quality Improvement Plans Adopted at Los Angeles Community Hospital and Southern California Hospital at Culver City.

Attached hereto as Exhibit 2(a) is the Quality and Performance Improvement Plan for Los Angeles Community Hospital.

Attached hereto as Exhibit 2(b) is the Quality and Performance Improvement Plan for Southern California Hospital at Culver City.

EXHIBIT 2(a)

ECHN Proposed Asset Purchase by PMH
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Los Angeles Community Hospital
2016 Performance Improvement Plan

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Behavioral Health Unit										
BHU - Nursing										
1. AMA			•	2%	1,2,5,7	AMA/AWOL	# AMA/AWOL / #DC	AMA/DC Log	UR/QC, MEC, GB	Data by month – Reported minimum of Quarterly
2. Restraints			•	20%	1,2,3,5,7	Providing alternate intervention before restraint application	# Restraint/month	Restraint Log monthly	UR, QC, MEC, GB	Data by month – Reported minimum of Quarterly
3. Falls			•	0%	1,3,4,7	Prevention of fall, fall assessment, fall with and without injury	# Fall	Incident reports	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
4. Crash Cart			•	100%	1,7	Crash Carts equipment checked nt and availability of non-expired medical supplies	# of crash cart checks/ # days in a month	Crash carts monthly check log	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
5. Hand Hygiene			•	100%	1,3,4,7	Hand Hygiene by hand washing and or alcohol	/ # of complaints / # HH observed	HH monitoring tools monthly	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
6. Effectiveness of Pain Management			•	100%	1,2,3,4,5,6,7	Pre and post pain assessment documentation	• Pre Pain assessment/ # pain meds • Effectiveness of pain management / # pain medication administered	Medical Record Review	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
Dietary										
1. RD timeless	•	•	•	98	7	Providing practitioner specific data	#initial assessments, follow ups, calorie counts, consults done by deadline/# total patients due	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
2. PO intake of meals recorded	•	•	•	90	5	Providing practitioner	#patients with recorded PO intake in EMR/#	RD productivity	QC	Data by Month – Reported Minimum of

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						specific data	total patients with oral diet	log/EMR		Quarterly
3. Correct diet order	•	•	•	100	1, 5	Providing practitioner specific data	# diets ordered correctly (diets ordered from approved list, diets discontinued, etc.)/total # of patients seen	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
4. RD recommendations taken within 48 hrs. – (LACH/NCH)	•	•		70	1, 5, 7	Providing practitioner specific data	#nutrition recommendations taken within 48 hours/total # of recommendations made	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
5. Actual weight obtained at admit – (LACH/NCH)	•	•		75	1, 5	Quality assurance	#accurate weights obtained at admit/total # of patients seen	RD productivity log/EMR	QC, CNO	Data by Month – Reported Minimum of Quarterly
6. Test Trays (include visual presentation, temperature, taste, timeliness)	•	•	•	95	1, 5, 6	Quality assurance	Total points scored/total possible points	Test Tray evaluation log	QC	Data by Month – Reported Minimum of Quarterly
7. Tray Accuracy Analysis – (LACHB)			•	90	1, 5, 6	Quality assurance	# of accurate trays/total # of tray observed	Tray Accuracy Log	QC	Data by Month – Reported Minimum of Quarterly
Health Information Mgmt.										
1. Medical Records Delinquency				50%	7	EHR System Monthly Delinquent Numbers	Total Number of Incomplete Medical Records Over 14 days from discharge/visit / Total Number of Inpatient Discharges, Total Number of Outpatient Surgeries, Total Number of ED Visits	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
2. Inpatient H&P completed within 24 hours of admission				100%	1, 2, 5, 7	Check every inpatient chart	Total number of H&P not completed within 24 hrs / Total number of admissions	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
3. Valid H&P completed within 24 hours prior to surgery.				100%	1, 2, 5, 7	Check every OPS chart	Total number of H&P not completed prior to surgery / Total number of OPS	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
4. Psychiatric Evaluation completed within 24 hours of admission				100%	1, 2, 5, 7	Check every inpatient chart	Total number of PE not completed within 24 hrs / Total number of admissions	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
Human Resources										
1. Licensure/Certification	•	•	•	100%	1,7	Provide Mgmt. with specific data	#of lic/cert compliance/#of lic/cert due for the month	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
2. Performance Evaluations	•	•	•	90%	5,7	Provide Mgmt. with specific data	#of evals completed/#of evals due	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
3. General Orientation Compliance	•	•	•	100%	7	Provide Mgmt. with specific data	#of attendees/#of new hires for the month	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
4. Annual Competency	•	•	•	90%	1,7	Provide Mgmt. with specific data	#of competency completed/#of competencies due	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
5. Annual Health Questionnaire	•	•	•	95%	1,7	Provide Mgmt with specific data	# of questionnaire due/#of questionnaire completed	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
Infection Control										
1. Invasive Devices	•	•		100%	3,5,7	Central line blood stream infections	**Numerator:** All CLBSI cases in all ICU,s in the organization. **Denominator:** # of central line days in all ICU,s	ICU Log book	P&T,QC, MEC.	Data by Month – Reported Minimum of Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
2. Hospital acquired MRSA laboratory confirmed blood stream infections.	•	•		100%	3,5,7	Positive blood culture after 48 hours of admission	**Numerator:** # of hospital acquired MRSA laboratory confirmed **Denominator:** Total number of patient days	Daily laboratory results	P&T,QC, MEC,	Data by Month – Reported Minimum of Quarterly
3. C.difficile	•	•		100%	3,5,7	All positive cultures after 48 hour of admission	**Numerator:** Laboratory confirmed positive cultures. **Denominator:** Total number of patients days	Daily laboratory results	P&T,QC, MEC	Data by Month- Reported Minimum of Quarterly
4. Prevalence Rate	•	•		100%	3,5,7	Final Surveillance	**Numerator:#** of hospital acquired infections. **Denominator:** # of patient days	Daily surveillance activities	P&T, QC MEC	Data by Month- Reported Minimum of Quarterly
5. Reportable Conditions	•	•		100%	1,3,5,7	Daily surveillance	Numerator: # of patients admitted with reportable conditions	Daily surveillance	P&T,QC, MEC	Data by Month- Reported Minimum of Quarterly
Laboratory	•	•								
1. Turn Around Time Urgent Care- Troponin	•	•		100%	1	2	# test meets criteria/ total test	Lab Data	QA	Q
2. Critical Read back Documentation	•	•		100%	1,3	3	# meets criteria/ # total criticals (days)	Lab Data	QA	Q
3. % Blood Cultures Not Contaminated	•	•		>97%	1,3,5	5	# non-contaminated blood cultures/ blood cultures drawn	Lab Data	QA	Q
4. Transfusion Services	•	•		Various	1,7	6,7	NA	Lab Data	QA	Q
5. Phlebotomy- Proper Identified or Labeled Specimens	•	•		100%	1	1	# properly identified/ labeled/# specimens	Lab Data	QA	Q
6. Lab Quality Control- Problems Resolved	•	•		100%	1,7	6,9	# days meeting criteria/ # days	Lab Data	QA	Q
7. Proficiency Testing- Transfusion	•	•		100%	1,7	6,10	# meets criteria/ # events	CAP Data	QA	Q
8. Proficiency Testing- Other Lab Test	•	•		>80%	1,7	1,6	# meets criteria/ #events	CAP Data	QA	Q
9. No Significant Variations Between Pathological Findings and Clinical Diagnosis for Surgical	•	•		100%	1,7	2,4	# that correlate/ # cases	Pathology	QA	Q

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Cases										
10. No Pathological Diagnostic Discrepancies	•	•		100%	1,7	4	# cases that meet/ cases reviewed	Pathology	QA	Q
11. Glucose Meter: Documentation of steps taken for Criticals as entered on meter	•	•		95%	1	3	Totals that meet criteria/ total of critical results	Lab Data Rals	QA	Q
Medical Staff										
1. Proctoring Evaluation completed within 3 months of practitioners' provisional appointment	•	•	•	100%	2 (NEW)	Practitioner Proctoring Completion	# Reports Submitted/ # Practitioners due for evaluation	Provisional Appointments Report	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
2. Ongoing Professional Practice Evaluation at Time of Reappointment/Bi-Annual Evaluation Reports Provided by: • Case Management • Infection Control • Laboratory • Medical Records • Pharmacy • Quality Management PI	•	•	•	100%	5	Obtaining Practitioner – Specific Data	# Reports Submitted/ # Practitioners due for evaluation	Reports received by various departments	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
Nursing										
ER										
1. Patient Throughput	•			10% decrease	Patient Satisfaction	Door to disposition time	Current time/2015 time	ED Logs	QC	Monthly
2. EMTALA	•			100%	Patient/ Organizational Safety	EMTALA Audit Elements	# Elements Achieved/Possible	Patient Chart	QC	Monthly
3. Triage time by RN was 15 minutes after arrival.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
4. MSE Completed by ER Physician 30 minutes after registration.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
5. Patient should be in bed 1 hour after ER MD makes a decision to admit as inpatient.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
ICU										
1. Pain Management	•			100%	Patient Safety	Pain Assessment/	# audit elements achieved/ # possible	30 Patient Records/Mont	QC	Monthly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						reassessment/ documentation		h		
2. Moderate Sedation	•			100%	Patient Safety	Propofol sedation vacation	# daily "sedation vacations"/# days sedated	Patient chart	QC	Reported daily and to Quality Council monthly and to P&T monthly
3. Restraints - physical	•			0%	Patient Safety/Patient Rights	Absence of physical restraints	# physical restraints/# patients	Patient Chart and ICU Log	QC	Daily and to Quality Council monthly
4. Care Plan documented with pre-existing condition i.e. Dialysis patient		•		100%	2,7,1	Chart audit	30/30	Medical Record	QC	Monthly
5. Consent signed for Hemodialysis Prior to treatment		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
6. For Septicemia Core Measure patient, Lactic Acid is drawn		•		100%	7, 1	Chart audit	Per # of Septicemia admitted 100%	Medical Record	QC	Monthly
7. For Septicemia Core Measure patient, Blood Culture is obtained prior to administration of IV antibiotics		•		100%	7, 1	1:1 Observation	Per # of Septicemia admitted 100%	Direct Observation	QC	Monthly
Med/Surg/Tele										
1. Medication Administration	•			100%	Patient Safety	Timely administration – 1 hour before/after scheduled	# doses given as scheduled/ #doses	Patient Chart	QC	Weekly with report to Quality Council monthly
2. Assessment	•			100%	Patient Safety	Assessment completed/documented/policy	# completed/# patients	Patient Chart	QC	Weekly with report to Quality Council monthly
3. Care Plans	•			100%	Patient Safety	Care Plan initiated/policy	# initiated/ # patients	Patient Chart	QC	Weekly with report to Quality Council monthly
4. Restraints - Physical	•			100%	Patient Rights	Monitoring elements/policy	# elements achieved/ # possible elements	Patient Chart	QC	Daily with report to Quality Council monthly
5. Skin Integrity	•			0%	Patient	Development/p	# adverse alteration	Patient	QC	Weekly with report

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					Safety	rogression of adverse alteration in skin integrity	in skin integrity/ # patients with Braden Scale 18 or higher	Assessment/ Chart		to Quality council monthly
6. Care plan documented with pre-existing condition i.e., Dialysis patient		•		100%	2, 7, 1	Chart audit	30/30	Medical Record	QC	Monthly
7. Consent signed for Hemodialysis prior to treatment		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
8. Pain re-assessment after pain medication administration		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
9. Medication Pass		•		100%	2, 7, 1	1:1 observation	20/20	Direct Observation	QC	Monthly
Nursing Admin (LACH/NCH/LACHB)										
1 Current Evaluations	•	•	•	90%	Currently less than 20% are completed on time.	Completed and sent to HR by due date.	# on time completed/number to be done	HR evaluation list with due dates.	QC	Monthly
2. Registry Files	•	•	•	100%	Patient safety/regulatory risk	Registry files current/complete for each nurse who works in the hospital	#files completed/standard # staff assigned during2016	Registry sign-in log in Nursing Administration	QC	Quarterly
3. RN Recruitment/ Retention	•	•	•	18%	Patient safety from critical shortages	New Hires and turnover	# Terminations/# of RNs	HR	QC	Quarterly
4. Policy/Procedures Current	•	•	•	100%	Patient Safety	Current date and content	# Nursing departments with current date for review/revision/# of Nursing departments	P&P data base	QC	Quarterly
Pediatrics										
1. Age specific care	•			100%	Patient Safety/Right	Care matched to developmental	# Developmental age specific care	Patient Chart/Observ	QC	Weekly with report to Quality Council

Indicator(s)	LACH	NCH	LAGHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					s	stage	plan/interventions/ # patients	ation/Pediatric unit log		monthly
2. IV infusion Safe Guards	•			100%	Patient Safety	IV order/administration size appropriate	# accurate order/administered IVs/# IVs	Patient Chart/Observation	QC	Weekly with report to Quality council monthly
Patient Access										
1. EMTALA Log	•	•		100%	1, 2	LD, PI	Numerator: Total number of patients listed on EMTALA log/Denominator: Total number of patients listed on EMTALA log	EMTALA log	QC	Quarterly
2. Language Line	•	•		100%	1, 2	RI, PI	Numerator: Total Number of Completed Consent Forms in Patient Preferred Language Denominator: Total Inpatient Registrations	Optimum Registration System	QC	Quarterly
3. IMM: Signed, timed and dated			•	100%	2	RI, PI	Numerator: Correctly completed IMM Forms Denominator: 50 patients	Important Message from Medicate	QC	Monthly
4. Preferred Language Log			•	100%	2	RI, PI	Numerator: Preferred language on the face sheets and consent matching Denominator: 50 patients	Face sheet and Consent forms	QC	Monthly
Pharmacy										
1. Medication Errors	•	•		<3.8%	Indicator for patient safety measure by pharmacy	Error reporting by pharmacy/ Nursing	Number of reported errors/total # discharges	Pharmacy reports and Nursing reports	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
2. Adverse Reaction	•	•		<0.25%	Indicator for patient safety	Error reporting based on rescue	Number of ADRs/Total discharges	Pharmacy reports and Nursing	Director of pharmacy,	Daily of Director of Pharmacy, Monthly to QC and CNO

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					measure by pharmacy	medication dispensed		reports	QC, CNO	
3. End Point Sterility Test	•	•		0%	Compliant to Board of Policy	Steriquot	# test failed/Total # of Test		Director of Pharmacy	Monthly
4. 30 min medication administration	•	•		>95%	Compliant to CMS	Random Chart Review	Specified med given within 30 min of the time due/Total number audited	Daily audit	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
5. Controlled Substances documentation in ED	•	•		100%	Compliant to CMS	Weekly Omincell report	# narcotic medications taken from omnicell that have matching entered orders for that patient/# audited	Weekly audit	QC, CNO	Weekly to Director of Pharmacy, Monthly to QC and CNO
6. ED drug dispensing for Pediatric patients	•	•		100%	Compliant to CMS	Daily Monitoring	Inappropriate orders/Total pediatric orders	Daily	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
7. Omnicell Override	•	•		100%	Compliant to CMS	Daily Monitoring	Complete orders/Total override	Daily audit	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
Physical Environment (EOC)										
1. Sixty (60) second response time for fire response personnel for false alarms and fire drills	•	•		85%	1,5	Staff Response	N- Fire Responses < 60 seconds D- Fire Responses	Drill Reports	EOC, QC, MEC	Quarterly
2. Reduce the number of recordable injuries by 5% from 2015	•	•		NCH: 12 LACH: 35	5	Safety	N- Number of Injuries D- Number of Days	HR	EOC, QC, MEC	Quarterly
3. Maintain level of patient falls at or below 2.8 benchmark fall rate per 1000 patient days	•	•		2.8	1, 6	Patient Handling	N- # of Patient Falls D- # of Patient Days	Quality Management	EOC, QC, MEC	Quarterly
4. Identified deficiencies on EOC rounds are corrected and documented as completed within 45 days	•	•		85%	5,1,6	Work Order Process	N- Deficiencies Identified D- Deficiencies Completed	EOC Rounds Survey Report	EOC, QC, MEC	Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerater / Denominator	Data Source	Reported to	Reporting Frequency
5. Reduce the number of theft types at Alta Los Angeles Hospitals by 10% from the total thefts reported in 2015.	•	•		LACH: 13 NCH: 13	1,6	Security	N- Thefts reported D- Thirteen	Security Reports	EOC, QC, MEC	Quarterly
6. 15% reduction in number of linen pounds per patient day from 2015.	•	•		LACH: 11.1 NCH:1 1.75	4	Allocation	N- Soiled Linen llb D- Adj Patient Days	Angelica Satisfactory Report	EOC, QC, MEC	Quarterly
7. Conduct Patient Safety Drills Quarterly in Non-Common Areas.	•	•		100%	1	Staff Response	N- Drills Completed D- Drills Scheduled	Drill Report	EOC, QC, MEC	Quarterly
8. Safety check completion rates for vendor life support equipment devices.	•	•		100%	5	Staff Training	N- Equip. Checked D- Equip. Received	Vendor Equipment Log Book	EOC, QC, MEC	Quarterly
9. Safety check completion rates each month for vendor non-life support equipment devices.	•	•		95%	5	Staff Training	N- Equip. Checked D- Equip. Received	Vendor Equipment Log Book	EOC, QC, MEC	Quarterly
10. Completion Rate for Submitted Work Orders	•	•		90%	5,1,6	Work Order Process	N- W.O. Completed D- W.O. Submitted	Work Order System	EOC, QC, MEC	Quarterly
Quality/Risk Management										
LACH/NCH										
1. Response to Grievances within 7 Days	•	•		100%	2,5,6	Grievance Response	# Responses with 7 Days/Grievances	Grievance Log	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
2. All OPPE to Medical Staff by Deadline	•	•		100%	2,5	Providing Practitioner Specific Data	#OPPE Reports Submitted by Deadline/#OPPE Reports Due	List of Reports Completed/Med Staff List of Reports Due	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
3. #AMA OPPE to Medical Staff by Deadline	•	•		2%	1,3,5	Patients leaving AMA	# AMAs per admission	AMA Report from IT/Clarity	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
4. # Falls blow national benchmark	•	•		2.5%	1,3,5	Patients falls by unit/shift	# falls per admission	Fall Report from Clarity	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
5. Overall Mortality Rate below national benchmark	•	•		2.5%	3,5,7	Total number of deaths	# of deaths per 100 discharges	Mortality Report from IT	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
6. Core Measures	•	•		100%	3,5,7	AMI, STK, VTE continued; Add Sepsis	Meet CMS Standard requirement for # reviewed	Data from IT	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
7. Readmissions	•	•		<10%	3,5,7	Patient readmitted within 30 days for same diagnosis	Number readmissions for same Diagnosis	Data from IT; Input from DUI and CM	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
Radiology										
1. Radiologist required procedures performed in a timely manner	•	•		100%	2,5	Time procedure performed	# of timely procedures/ # of procedures	EMR/PACS	QC	Quarterly
2. Critical result documentation	•	•		100%	1,7	Document in report	# of critical results reported/ # of critical results	Transcribed reports	QC	Quarterly
3. Marker Use	•	•		95%	1,4	Marker use	# of radiographs with marker/ # of radiographs	Image Review	QC	Quarterly
4. Discrepancy in the ED physician and radiologist interpretation	•	•		95%	4,7	Reading Accuracy	# of interpretations with no discrepancies/ # of interpretations by the ED physician	Radiologist	QC	Quarterly
5. Radiation Exposure	•	•		100%	3,7	Exposure	# of staff without exposure issue/ # of staff monitored	Dosimetry reports	QC, EOC	Quarterly
6. Computerized Tomography Dose Reporting	•	•		100%	1,7	Dose	# of CT scans missing dose/ # of CT scans	PACS images	QC	Quarterly
7. Appropriateness of Nuclear Medicine Procedures	•	•		100%	1,7	Reason for Procedure	# of appropriate NM procedures/ # of NM procedures	Contracted Service Manager	QC	Quarterly
Rehabilitation Services										
Wound Care Therapy										
1. Identification, intervention, and documentation of pain during Rehab/WC encounter.	•	•		100%	1,2,5,6,7	Completion of pain parameter entry in all daily encounters including documentation of pain level, applicable treatment, and/or pt's rights to proceed or not.	#of complete pain parameter documentation entries/10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool ☐ ongoing ☑new	QC Medicine	Quarterly
2. Prevention of pressure	•	•		LACH	1,2,5,6,7	Utilization of	#of hospital acquired	HAPU incident	QC,	Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
ulcers during hospital stay.				1.2% SA 0.1% NCH 0.8%		Braden Screening tool to identify patient with community PU. Monitoring of new pressure ulcer wounds not identified at admission. Tracking of HAPU using internal process.	pressure ulcers/1000 patient days.	reports. ☑ongoing ☐ new	Medicine	
3. Pressure Ulcer Prevention Program (PUPP) provided within 24 hrs upon admission, readmission, or transfer.	•	•		100%	1,2,5,6	Validation of Braden Screening tool compliance. Initiation of protocol supported with documentation.	#of PUPP provided within 24 hrs. upon admission, readmission, or transfer/ 10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool. ☑ongoing ☐ new	QC, Medicine	Quarterly
Rehab Services										
4. Speech Therapy evaluation provided (within 48hrs) when ordered by MD.	•	•		100%	1,2,6,7	Gathering all new consults and checking if patient was seen within the timeframe.	# of Speech Therapy evaluations provided within 48 hours/#of total Speech Therapy orders.	HER, QI data gathering tool. ☑ongoing ☐ new	QC, Medicine	Quarterly
5. Physical Therapy evaluation provided within 24 hrs. when ordered by MD to include a complete documentation such as: ✓ PT evaluation documentation ✓ PT goals ✓ Plan of Care ✓ Clarification of PT orders, if needed, with frequency, duration, and interventions.	•	•		100%	2,6,7	Gathering all new consults and checking if patient was seen within the timeframe with complete entries of documentation parameters.	# of Physical Therapy evaluations provided within 24 hrs. with complete documentation/10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool. ☑ongoing ☐ new	QC, Medicine	Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
6. Rehabilitation (Recreation) Therapy Assessment completed by Therapy team within 72 hours of patient admission			•	100%	4,6,7	Patient's Rights and Provision of Care issues	Total # compliance/total # of medical records reviewed.	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
7. Rehabilitation Therapy Discharge Summaries completed within 72 hours of patient discharge.			•	100%	4,6,7	Patient's Rights and Provision of Care issues	Total # compliance/total # of medical records reviewed	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
8. Rehabilitation Services			•	100%	4,6,7	Patient's Right and provision of Care issues	Total # compliance/total # of medical records reviewed.	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
Respiratory										
LACH/NCH	•	•								
1. Ventilator Protocol	•	•		65%	1,6,7		# weaned/total monitored	Log	QC	Quarterly
2. Trach Changed within 30 days	•	•		95%	1,3,5,7		# done/total trach pts	Charting	QC	Quarterly
3. Assessments/Reassessments	•	•		95%	1,5,7		# done/total measured	Charting	QC	Quarterly
4. Trach Ties	•	•		95%	1,5,6,7		#done/Total	Charting	QC	Quarterly
5. Equipment Changes	•	•		95%	1,5,6,7		# changed/Total	Charting	QC	Quarterly
6. Crash Carts	•	•		95%	1,3,5,7		# done/total	Log Book	QC	Quarterly
7. Oral Care	•	•		95%	1,3,4,5,6,7		#documented/total	Observatio	QC	Quarterly
8. Charges checked and submitted	•	•		95%	4,5,7		# checked/total	Charting	QC	Quarterly
9. Tardiness	•	•		95%	1,7		Days tardy/total	JBDEV	QC	Quarterly
10. Attendance	•	•		95%	1,7		Days absent/total	Schedule	QC	Quarterly
11. Continuous Pulse Oximeters for Vents	•	•		100%	1,3,4,5,7		# on pts/total	Observatio	QC	Quarterly
12. Medications ordered for SAU	•	•		100%	1,4,6,7		Not ordered/Total	Log Book	QC	Quarterly
13. Bedside Reporting for Patients	•	•		95%	1,5,6,7		#RTs not compl/total	Observatio	QC	Quarterly
14. Temperature Log (Norwalk Hospital)	•	•		100%	1,2,5		# out of range/total	Log	QC	Quarterly
15. Critical Values Reported in a timely manner	•	•		95%	1,5,7		# out of range/total	Log	QC	Quarterly

ECHN Proposed Asset Purchase by PMH
Late Files

Indicator(s)	LACH	NGH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Social Services										
1. Patients will be informed of their right to self-determination specifically their right to formulate an advance directive. Any patient that wants advance directive will be given information and will be followed up within 48 hours.	•	•		100%	5, 6, 7	2, 5	N: # of pts followed up within 48 hours of requesting info D: # of pts requesting information on advance directives	Advance Directives Log	QC	Q
2. All homeless patients will receive social work intervention to aid in placement. Documentation of intervention and final disposition will be reviewed for appropriateness.	•	•		100%	1.3	1,4	N: # of homeless pts seen by social services D: # of of homeless pts admitted	Admission screening	QC	Q
3. Homeless patients completing the informed consent form.	•	•		100%	1,3,5	1,5	N: # of homeless pts admitted to the hospital D: # of patients completing the form	Review of the medical record and forms	QC	Q
4. Psycho-Social Assessments completed with 72 hours of admission			•	100%	4, 6, 7	Social Services timely assessment of their patients	# Psycho-socials completed/Total # Psycho-socials for the sample	Medical Record	UR, QC, MEC, GB	Data by month – reported minimally quarterly
5. Important Message from Medi-Care-signatures obtained at time of admission and prior to discharge			•	100%	3, 4, 7	Timely notification of Medi-Care recipients of their rights.	# of signed IM message forms/Total # of IM messages for the sample	Medical Record	UR, QC, MEC, GB	Data by month reported minimally quarterly
6. Information provided to Care Giver when identified by the patient as part of the Aftercare Plan			•	100%	1, 2, 6, 7	Inclusion of patient Care Giver in the patient's aftercare	# of aftercare forms where Care Giver Identified with information provided/Total # of aftercare forms where Care Giver is identified.	Medical Record	UR, QC MEC, GB	Data by month – reported minimally quarterly
Sub-Acute										

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
1. MDS	•			100%	Patient Safety/Regulatory	Completion by required date	MDS forms completed on time/# patients	Patient Charts	Director of SA	Weekly with report to Quality Council Monthly
2. Care Plans	•			100%	Patient Safety/Regulatory	Care Plan initiated within specified time frame	# Completed by due date	Patient Charts	Director of SA	Weekly with report to Quality Council Monthly
3. Medication Administration	•			100%	Patient Safety/Regulatory	Timely administration – 1 hour before/after scheduled time	# doses given "on time"/ # doses	Patient Charts	Director of Pharmacy/Director of SA	Weekly with report to Quality Council Monthly
4. Infection Control	•			100%	Patient Safety/Regulatory	Handwashing	# washings/# required washings	20/week observations	Director of IC and Director of SA	Weekly with report to Quality Council Monthly
5.Care Plan/MDS congruence	•			100%	Patient Safety/Regulatory	Content congruence	# MDS/Care Plans congruent/# patients	Patient Charts	Director of SA	Monthly to Quality Council
6. Consent for Psych. Meds	•			100%	2	Documentation of obtained consent	# of Psych. Meds (last 30 days) /# of Consent Obtained	Chart	QC	Monthly
7. Side Effects Monitoring for Psych. Meds	•			100%	2	Side effects (S/E) monitoringevery shift	#shifts in the last 30 days of patients with Psych. Meds / # of S/E monitoring for Psych. Meds Q shift	Paper MAR	QC	Monthly
8. Foley Catheter (FC) with Indication for use	•			100%	2	Documentation of indication for FC use	# of FC in use (last 30 days)/ # of FC with indication	Chart	QC	Monthly
9. Use of Less Restrictive Measures Prior to Restraint use	•			100%	2	Documentation of less restrictive measures	# of restraints in use (last 30 days)/ # of documented less restrictive measures prior to use of restraint	Chart	QC	Monthly
10.Patency of Hemodialysis access	•			100%	2	Checking of bruit and thrill/	# of shifts requiring patency checks of	Chart	QC	Monthly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						Patency of HD access site every shift	HD access requiring (last 30 days)/ # of actual Q shift monitoring of HD patient access			
11. PICC Line Consent Form	•			100%	2	Consent form obtained prior to PICC line insertion	# of residents with PICC lines (last 30 days) / # of PICC lines with consent form prior to insertion	Chart	QC	Monthly
12. Post Fall Assessment	•			100%	2	Documen-tation of post fall assessment after a fall	# of Fall in the last 30 days/ # of post fall assessments documented after a fall in the last 30 days	Chart	QC	Monthly
13. Matching of Range of Motion MD Orders on orders in the RNA treatment record	•			100%	2	RNA MD orders matches the tx orders on RNA sheets	# of RNA MD orders in the chart in the last 30 days/ # of RNA orders wherein MD orders matches the RNA orders on tx sheets	Chart	QC	Monthly
14. Treatment (Tx) orders are applied to patients with skin problems	•			100%	2	Skin problems with Tx orders	# of patients having Skin problems with treatment orders (every week in the last 30days)/# of patients with skin problems that received txs as ordered (every week in the last 30 days)	Chart	QC	Monthly
15. MDS Location of Assessment per CAA (Care of Assessment Area)	•			100%	2	CAA indicates location where assessment can be found	# of CAA in the last 30 days / # CAA with indication of the location where the documented assessment can be found	Chart	QC	Monthly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
16. Triggered CAA in the MDS with Corresponding Care Plans	•			100%	2	CAA triggered in the MDS are with Care Plans	# of CAA in the last 30 days/ # of CAA with complete care plans in the last 30 days	Chart	QC	Monthly
Utilization Review										
1. Initial Discharge Assessments are completed within 48 clock hours of patients' admission	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)	Allscripts Care Mgmt MCG/SS Discharge notes	URC and Quality /PI Committee	Q
2. Admission reviews are completed within 24 clock hours of admission and include required review elements.	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)	Allscripts Care Mgmt / Milliman Care EMR for scanned copy.	URC and Quality /PI Committee	Q
3. Patient Choice: The CM dept will provide the patient / patient representative with choices pertaining to their post hospital provider choices. This will be prior to DC and includes ,but not limited to acute inpt rehab ,home health, infusion therapy ,hospice care, skilled nursing care , custodial care,etc.. . Evidence of patient choice is documented in the DC plan.(The organization must respect the choice of the patient or authorized representative except in unusual circumstances.)	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)		URC and Quality /PI Committee	Q
4. Daily concurrent reviews are completed each calendar day and include the	•	•		95%	5	PC	N: # patients screened D: # cases reviewed	Allscripts Care Mgmt / Milliman	Allscripts Care Mgmt /	Q

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
essential elements of the review.							(30 cases / month)	Care Guidelines (MCG	Milliman Care Guidelines (MCG	
5..Important Message from Medicare is re-issued to all Medicare and Medicare eligible patients within 48 hours of discharge.	•	•		100%	2	RI	N: # IMMs re issued D: # (ALL Mcare / Mcare Mged care discharges / month)	Medical record audit(Original copy maintained in the patient's MR)	UMC and Quality Council	Q
1. Medi-Cal Denial Rate Acute/Administrative Days			•	<5%	7	PI	N: Total # of Medi-Cal days Denied D: Total # of Medi-Cal Days processed	Processed TARS	UMC, QC	Quarterly
2. Inpatient Length of Stay (Over Utilization)			•	<5%	7	PI	N: Total # of patients with LOS of>14 days D: Total # of discharges	Chart Review	UMC, QC	Quarterly
3. 1st Level Medi-Cal Appeals			•	Trend	7	PI	N: Total Days approved D: Total days Processed	Processed Appeals	UMC, QC	Quarterly

RATIONALE FOR INDICATOR SELECTION:

1. **Patient Safety Issue**
2. **Survey Finding**
3. **High Risk Process**
4. **High Volume Process**
5. **Problem Prone**
6. **Patient Satisfaction Issue**
7. **Required Measure**

There may be more than one rationale for a single indicator. Survey findings should be first priority.

Exhibit 2(b)

Quality Assessment and Performance Improvement Indicators for 2016 (revised as of 3/23/2016)

Note: *Indicators are to be selected from this list. All indicators are not meant to be monitored at all times*

No	Name	Definition	Target*	Accountability	Prioritization Criteria**	Reporting	Comment
			Significant Adverse Occurrences				
1	Sentinel Event (Never Events)	Event leading to death or significant impairment (per Sentinel Event Policy) includes Near Misses (may be reported under significant events on scorecard)	0%	Risk Manager	XX, R, P, C	Quality Steering Committee (QSC) Medical Executive Committee (MEC) Board of Trustees (Board) [Monthly until resolution]	Each sentinel event is reported. The root cause analysis and prevention interventions are also reported.
2	Event Reporting Frequency (RCA)	Number of events reported of the following types: Medication-Related; Other significant	0%	Risk Manager	XX, R, P	QSC, MEC, BOARD [Monthly]	The focus will be to increase reporting of issues
3	Regulatory Citations	Issues identified in this category are monitored until sustained improvement is shown for a minimum of 3 months	TBD	TBD	TBD	TBD	TBD
			Patient Safety				
4	Inpatient Falls per 1000 patient days	**Numerator**: Number of inpatient falls reported during the month. **Denominator**: number of inpatient days per month X 1000.	0.36	Risk Manager	XX, R, P, V	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
5	Patient falls leading to injury requiring treatment	Number and brief description of the circumstances surrounding any inpatient or outpatient fall that required medical treatment	N/A	Risk Manager	XX, R, P, V	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee the effectiveness of corrective actions
			Infection Prevention				
6	MDRO Infection Rate	**Numerator:** Number of cases (HAI) **Denominator:** 1000 pt days	TBD	Infection Control Practitioner	R, P, C.	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
7	Surgical Site HAI rate	**Numerator**: Number SSI **Denominator:** per 1000 clean cases (targeted/specific cases only)	TBD	Infection Control Practitioner	R, C, P, S	QSC, MEC, BOARD [Quarterly]	Surgical procedures for review should be rotated to capture the spectrum of clinical services and operative areas
8	Ventilator Associated Event Rate	**Numerator:** Number of ventilator associated event infections **Denominator:** Number of ventilator patient days X 1000	TBD	Infection Control Practitioner	R, P, C.	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

9	Central Line/Catheter Related Sepsis Rate	**Numerator:** Number of CLABSI **Denominator:** Number of line insertion patient days X 1000	TBD	Infection Control Practitioner	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
10	MRSA Rate	**Numerator:** Number of cases (HAI) **Denominator:** 1000 pt days ❖	TBD	Infection Control Practitioner	R, P, C, S	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
11	C. difficile Rate	**Numerator:** Number of cases **Denominator:** 1000 pt days ❖	TBD	Infection Control Practitioner	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
12	Rate of Compliance CDC Hand Hygiene Requirements	**Numerator**: Number of observations when the caregiver performed hand hygiene per CDC guidelines. **Denominator**: number of observations (opportunities)	100%	Infection Control Practitioner	XX, R, P, V	At least ten observations per month QSC, MEC, BOARD and Infection Control [Quarterly]	Observations should be rotated to cover all settings and all disciplines.
Organ / Tissue Donation							
13	Notification of OPO of imminent patient death/actual death	**Numerator:**# of OPO contacts within time frames per policy **Denominator:** # of deaths per month	75%	Risk Manager	XX, E	QSC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
Environment of Care							
14	Emergency Generator Testing 12 tests required per year with intervals of not less than 20 days and not more than 40 days	**Numerator:** # of tests conducted at required load **Denominator:** # of tests required	TBD	Plant Operations	XX, R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
15	Preventative Maintenance on High Risk Equipment	**Numerator:** # of PM equipment checks per program **Denominator:** # of PM equipment observations conducted	95%	Biomed	R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
16	Emergency Management Activation	2 per year	TBD	Plant Operations	XX, R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

17	Emergency Management Employee Education	**Numerator:** # of employees correctly describing their role in the event of an internal/external disaster **Denominator:** # of employees interviewed	>90%	Plant Operations	R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
18	Fire Drills	**Numerator:** 1 fire drill per quarter per shift conducted **Denominator:** 12	100%	Plant Operations	XX, R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
19	Staff knowledge of fire plan	**Numerator:** # of staff articulating fire plan components correctly **Denominator:** # of staff queried	>90%	Plant Operations	R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
20	Preventative Maintenance on Life Safety System	**Numerator:** # of PM on Fire System **Denominator:** 4 total Fire System PM Conducted	<95%	Plant Operations	R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
21	Life Safety Assessment Conducted for all construction/ renovation projects	**Numerator:** # of ILSM assessments conducted **Denominator:** # of construction/renovation projects initiated	100%	Plant Operations	XX, R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
Patient Complaints / Grievances							
22	Timely Patient Grievance Response Rate	**Numerator:** # of patient grievances responded to w/7 days **Denominator:** # of grievances reviewed	TBD	Patient Advocate	R, P, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Clinical Excellence / Operational Quality							
CMS Core Measures							
23	Compliance with Core Measures See core measure descriptions	Indicator sets for AMI, Pneumonia, CHF with related core measure criteria will be reviewed on a quarterly basis (see attached) ❖	TJC Reported mean	Quality Director	XX, V, C, E	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	HCAHPS						
24a	Patient Satisfaction, overall level of care, Inpatient	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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24b	Patient Satisfaction, overall level of care, ED	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
24c	Patient Satisfaction, overall level of care, OP	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	HBIPS						
25a	HBIPS-1	Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25b	HBIPS-2	Hours of physical restraint use	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25c	HBIPS-3	Hours of seclusion use	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25d	HBIPS-4	Patients discharged on multiple anti-psychotropic medications	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25e	HBIPS-5	Patients discharged on multiple anti-psychotropic medications with appropriate justification	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25f	HBIPS-6	Post-discharge continuing care plan created	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25g	HBIPS-7	Post discharge continuing care plan transmitted to next level of care provider on discharge	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Contract Services						
26	Evaluation of Contracted Services	**Numerator:** Number of Contracted Services Evaluated **Denominator:** Total number of Contracted Services	Corp mean	COO	XX	PICC, Board (Annually)	Performance Improvement Coordinating Council will oversee the effectiveness of corrective actions
27	Effectiveness of Contracted Services	**Numerator:** # of services with positive evaluation **Denominator:** # of contract services	95%	COO	XX	PICC, Board (Annually)	Performance Improvement Coordinating Council will oversee the effectiveness of corrective actions
	Surgery/GI Lab						
28	Sedation Outcome (Use of Reversals)	**Numerator:** Number of sedation cases with reversal agents used **Denominator:** Total sedation procedures performed	0%	GI Laboratory and Sedation Team Director	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions Will refer physician identified trends to Peer Review Committee for review , determination and action as necessary

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29	Unplanned Returns to the OR	**Numerator:** Number of unplanned patient returns to OR for surgical procedure during same admission as initial procedure **Denominator: Number:** Number of surgical **cases** performed❖	TBD	Surgery Director	R, P, C, S	QSC,, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review , determination and action as necessary*
30	PI Project Status Temp and Humidity in the OR suites	**Numerator:** # of times temp and Humidity out of range **Denominator:** # of times temp and humid measured	100%	Surgery Director	R, P, V,C, E,	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
31	Sterilization of Surgical Instruments PI Project	**Numerator #** of instrument trays with no evidence of discoloration post sterilization/**Denominator#** of instrument trays inspected	100%	Surgery Director	R, P, V,C, E,	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
32	ALOS in PACU	Average Length of Time in Minutes	TBD	Surgery Director	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
			Health Outcomes / Complications –1				
33	Inpatient Mortality Rate	**Numerator:** Number of inpatient deaths **Denominator:** Number of patient days per month X 1000	TBD	Quality Director	R, V, P, C, S	QSC, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review , determination and action as necessary***
34	Postoperative Mortality Rate (new)	**Numerator:** Number of mortalities post surgical procedure **Denominator:** Total number of surgical **cases** performed	TBD	Quality Director	R, V, P, C, S	QSC, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review , determination and action as necessary
			Health Outcomes / Emergency Department				
35	Emergency Department LWBS rate	**Numerator**: Number of patients leaving ED WBS **Denominator:** Number of ED patient visits X 1000	<2%	ED Manager	R, V, P, C, S	QSC, BOARD Quality Steering Committee [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
36	Door to Physician Time	Average Monthly Time in Minutes	TBD	ED Manager	R, V, P, C, E	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
37	Door to Disposition Time	Average Monthly Time in Minutes	TBD	ED Manager	R, V, P, C, E	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
38	# of Pts in ED >4 hrs & ≤ 6 hrs	**Numerator:** # of registered pts in ED >4 hrs. but ≤ 6 hrs **Denominator:** # of ED visits X 1000❖	90%	ED Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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39	ED Adult Patient Average Length of Stay	Average Length of Time in Hours	TBD	ED Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Health Outcomes / Complications – Behavioral Health/IOP							
40	Assaultive behavior pt. vs. pt	**Numerator**: # of pt vs pt assaults **Denominator**: 1000 pt days:	<30%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
41	Assaultive behavior pt. vs st.	**Numerator**: # of pt vs st assaults **Denominator**: 1000 pt days::	<15%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
42	Assaultive Behavior st. vs. pt	**Numerator**: # of st vs pt assaults **Denominator**: 1000 pt days:	0%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
43	Patient rights: appropriate discharge	**Numerator**: # of appropriate discharges/ **Denominator**: # of discharged patients	2%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
44	Patient Rights: appropriateness of holds	**Numerator**: # appropriate holds **Denominator**: # of pt holds	<5%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
45	Patient Rights: Timely removal of holds	**Numerator**: # of timely removal of holds /**Denominator**: # of holds removed	TBD	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
46	Patient Rights: Use of seclusion/restraints	**Numerator**: # of pt in restraint/seclusion/ **Denominator**: 1000 pt days:	90%	BHU Nursing Manager	R, V, C, S	Quality Steering Committee	Quality Steering Committee will oversee the effectiveness of corrective actions
47	Patient Rights: Privacy	**Numerator**: # of pt denied privacy **Denominator**: 1000 pt days:	volume	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Medical Staff (new)							
Other medical staff indicators determined by individual departments and services and reported to individual department QAPI meetings with routine reporting format							
Resuscitation							
48	Cardiopulmonary Arrests	**Numerator:** Number of cardiopulmonary arrests **Denominator:** 1000 patient days	Trend	ED Director	R, P, C, E, S,	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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49	Rapid Response Team (REACT Team) Effectiveness	**Numerator:** Number of Rapid Response Team responses w/in 4 minutes **Denominator:** RRT calls per month (per reporting period)	100%	ED Director	R, V, P, C, E	Code Blue Team, QSC, MEC, Board (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of Rapid Response Team responses with transfer to higher level of care **Denominator:** RRT calls	Trend	ED Director	R, V, P, C, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
50	Resuscitation Outcome – Code Blue Efficiency	**Numerator**: Number of codes where all efficiency criteria is met **Denominator:** Total number full code arrests	100%	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of codes with patients surviving code **Denominator:** Number of full code arrests	Trend	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of codes with patients surviving to discharge **Denominator:** Number of full code arrests	Trend	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Patient Satisfaction HCAHPS							
51	Patient Satisfaction, overall level of care, Inpatient	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
52	Patient Satisfaction, overall level of care, ED	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
53	Patient Satisfaction, overall level of care, OP	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Pain Management							
54	Pain Assessment	**Numerator**: Pain Assessment per policy **Denominator:** Number of observations		Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
55	Pain Re-Assessment	**Numerator**: Pain Re-assessment post intervention **Denominator:** Number of observations		Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Hospital Acquired Pressure Ulcers							
56	Prevention of Hospital Acquired Pressure Ulcers	HAPU prevalence -overall	0.xx per CalNoc	Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions

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		HAPU prevalence - Rehab	0.xx per CalNoc	Nursing Admin	H, P, V, C, S	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions
Restraint Usage							
57	Restraint Prevalence	Restraint Prevalence – overall	x.xx per CalNoc	Nursing Admin	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions
58	Restraint Usage – Appropriateness of order (Physician) per policy	**Numerator:** Number of orders for restraint meeting restraint criteria per policy **Denominator:** Total number of orders for restraint	100%	Nursing Admin	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
59	Restraint Monitoring (Nursing) per policy	**Numerator:** Number of restraint records meeting monitoring criteria **Denominator:** Total number of restraint records reviewed *each episode of restraint reviewed – reported as variance per record ❖	100%	Nursing Admin	R, P, C, S	QSC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Medication Use							
60	Unit based Pharmacy Medication Error Rate	**Numerator**: total number of medication errors occurring in patient care areas **Denominator**: Total medications dispensed (or per 1000 medications dispensed) ❖	TBD	Pharmacy Director	R, V, P, C, E, S	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
61	Internal Pharmacy Medication Error Rate	**Numerator**: total number of internal pharmacy medication errors identified **Denominator:** Total number of drugs prepared for dispensing (or per 1000 drugs dispensed) ❖	TBD	Pharmacy Director	R, V, P, C, E, S	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions taken by Pharmacy
62	Adverse Drug Reaction Rate	**Numerator:** Number of adverse drug reactions **Denominator:** Number of medications administered ❖	TBD	Pharmacy Director	R, P, C	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
63	MERP program	See MERP Indicators per Facility		Pharmacy Director			

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Medical Records							
64	Medical Records Meeting Review Criteria (timeliness, legibility, authentication of data)	**Numerator**: Number of records meeting criteria at the 100% level **Denominator:** Random 30 record audit	90%	HIM Director	P, C, E	HISC, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
65	Medical Record Delinquency Rate	**Average monthly discharges over the past 4 quarters** Not greater than 50% of the AMD rate and no single quarterly measurement greater than 50% of the AMD rate	* not < 50%	HIM Director	XX, P, C, E	HISC, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
66	H&P Content per Medical Staff requirements	**Numerator:** Number of H&Ps performed **Denominator:** # H&Ps meeting MEC requirements❖	TBD	HIM Director	P, C, E	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Laboratory							
67	Crossmatch to Transfusion Ratio	**Numerator**: Number of units ordered for crossmatch **Denominator**: number of cross matched units transfused	2:1	Clinical Laboratory	R, V,C	QSC, MEC, BOARD [Quarterly]	Negative trends will be analyzed with drill down to identify ordering issues – analysis will include all areas where cross match is ordered
68	Transfusion reaction rate	**Numerator**: Number of identified hemolytic transfusion reactions **Denominator**: Number of units transfused	0%	Clinical Laboratory	R, P, C	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee action plan for investigation
69	Average time of reporting of critical results	Mean time from resulting availability to notification of the responsible practitioner (physician or other practitioner who may initiate appropriate intervention) ❖	TBD	Clinical Laboratory	XX, R, P, V	QSC, BOARD All "tier 1" critical non-laboratory testing results Quality Steering Committee [Quarterly].	Quality Steering Committee will oversee the effectiveness of corrective actions
70	Discrepant Pathology Reports		0%	Clinical Laboratory	R, P, C	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee action plan for investigation
Utilization/Case Management							
71	Appropriateness of Patient Discharge	**Numerator:** Number of inpatient readmissions within 30 days of discharge for AMI, HF, CAP **Denominator:** Total number of discharges per month AMI, HF, CAP	TBD	Case Manager	V, C, E, S	QSC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
72	Appropriateness of care and treatment – Medicare specific	**Numerator:** Number of Medicare denials **Denominator:** Total number of Medicare patient discharges per month	TBD	Case Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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73	Appropriateness of care and treatment – Medicaid specific	**Numerator:** Number of Medicaid denials **Denominator:** Total number of Medicaid patient discharges per month	TBD	Case Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Employee Health							
74	Employee Influenza Vaccination Compliance	**Numerator: # of staff who rcvd influenza vaccination Denominator: total number of staff**		Director of Infection Control	XX, R		
Dialysis Services							
75	Contract Service Dialysis	**See Standardized Indicators for Contract Services Dialysis**		Nursing Admin			
76	Contract Service Dialysis	**Numerator:** Daily Patient Schedule Provided **Denominator**: Total number of Observations		Nursing Admin			
Food and Nutrition Services: Refer to Department Audits							
77	Contract Service Food and Nutrition	**See Standardized Indicators for Contract Services Food and Nutrition**		Director of Dietary			
78	Delivered Diet Tray Accuracy (new)	**Numerator**: Number of accurate meal trays delivered to unit **Denominator**: number of meal trays delivered	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
79	Food Safety – Sanitary, Storage and Preparation (Sanitation)	**Numerator**: Number of Compartment Sinks with Correct Temperature for Sanitation **Denominator**: number of Compartment Sinks Tested for Correct Temperature	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
80	Food Safety – Sanitary, Storage and Preparation (Safe Storage – Temperature)	**Numerator**: Number of Refrigerator and Freezer Logs with Temperatures within Range **Denominator**: number of Refrigerator/Freezer Logs Reviewed	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
81	Food Safety – Sanity, Storage and Preparation (Safe Preparation – Hot Food Cooling Process)	**Numerator**: Number of Hot Food Cooling Items Within Temperature Range **Denominator**: Number of Hot Food Items Cooled and with Temperature Checks	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
Imaging Services							
82	Dosimeter Badge Readings	Radiology Reports to QC with fall outs, posted for staff and F/U with employee	NA	Director of Imaging	XX	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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83	Result Discrepancies/Re-reads	# of result discrepancies/ Total# of radiology reads/month	<5%	Director of Imaging	R, P	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
84	Radioactivity Monitoring	**Numerator:** The number of environmental swabs without radioactive traces. **Denominator:** The number of environmental swabs taken.	100%	Director of Imaging	XX, R, V,P, C,E	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
	Rehabilitation Services (Physical Therapy and Habilitation Services)						
85	Functional Independence Measure Scoring (FIMS)	**Numerator:** # of pts with FIMS scoring improving to < national benchmark and range **Denominator:** Number of FIMS scores measured	*target specific to dx process – national average 29	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
86	Rehabilitation Patients Discharged to Community	**Numerator:** # of rehabilitation patients discharged to the community **Denominator:** # of patient discharges	72	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
87	Therapy Assessments	**Numerator:** # of physical therapy evaluations performed within time frame per policy criteria **Denominator:** # of physical therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: # of speech therapy evaluations performed within time frame per policy criteria **Denominator:** # of speech therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: # of occupational therapy evaluations performed within time frame per policy criteria **Denominator:** # of occupational therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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Respiratory Therapy Services							
88	Arterial Blood Gas Management	**Numerator:** # ABGs resulted within 10 minutes of STAT draw **Denominator**: # of ABG STAT specimens requested included in study	100%	Respiratory Therapy Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
89	Timeliness of Treatment	**Numerator:** # of Missed/Delayed Treatments **Denominator**: # of treatments to be administered	0%	Respiratory Therapy Services	R, P, C, E. S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Outpatient Services/Spine Clinic							
90	Medication Reconciliation	**Numerator=# of medication recon forms completed with allergies identified/Denominator # of recon forms obtained/month**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
91	Medication Reconciliation	**Numerator= # of Med recon forms sent to internist/Denominator = # of patients referred to internist**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
92	Wait Times	**Numerator # of patients seen by physician within 20 minutes of arrival Denominator # of patients seen in center /month**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Outpatient Services/Cardiology Clinic							
93							
94	Post Procedure Pathology Reports	**Numerator: # of post-procedure pathology reports available for patient visit/Denominator: # of post-procedure patient visits**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Final Read Cardiology Test Results	**Numerator: # final-read cardiology test results available for patient visit/Denominator: # of cardiology results available for patient visit/month**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Wait Times	**Numerator: # of patients seen by physician within 20 minutes of arrival Denominator # of patients seen in center /month Denominator:**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Environmental Services							
95	Contract Service EVS	**See Standardized Indicators for Contract EVS Services**					

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Monthly statistical calculations unless otherwise stated

96	Cleanliness and Sanitation	**Composite Score** **Numerator:** # Areas Inspected Properly Cleaned and Disinfected **Denominator:** # of Areas included in Inspection	95%	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: SPD Terminally Cleaned per policy **Denominator:** # of observations	95%	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Composite Score **Numerator:** # Areas Inspected for Positive Glow Verification (effective disinfection) **Denominator:** # of Areas included in Inspection	TBD	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Performance Initiatives/Projects							
97	Rate of compliance with structured patient hand-off process	**Numerator:** Number of observations of patient hand-offs during which the hospital's structured process was followed. **Denominator:** number of patient hand-offs observed ❖	TBD	Quality Director	R, P, V	QSC, MEC, BOARD 10 hand-offs per month Quality Steering Committee [Quarterly]	Sampling should focus on various types of hand-offs.

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

3. Curriculum Vitae of PMH Corporate Quality Personnel.

Please see Exhibits 3(a), 3(b) and 3(c)

EXHIBIT 3(a)

DEBBIE BERRY, RN, MSN, LHRM, CPHQ, CPPS, CWCN, CCN

[redacted]

PROFESSIONAL EXPERIENCE

4/2015 – Present

Vice President of Quality and Patient Safety
Gulf Coast Division (GCD) of HCA, Houston, TX

- Work directly under the GCD Chief Medical Officer to provide oversight for clinical operations and excellence; quality assurance; performance improvement; patient safety, risk prevention and management; infection prevention and control; and medical staff operations for a 13 hospital division.
- Collaborate with the DCMO to build structure and processes to drive improvement in quality, patient safety and clinical excellence outcomes for the GCD by creating and co-chairing a Quality and Patient Safety Steering Council with subcommittees on Medication Safety, Infectious Disease Preparedness, CVAT, Hospital Acquired Conditions/Infection Prevention, and Clinical Excellence.
- Collaborated with the DCMO to build the quality and patient safety strategic plan for 2016 – 2018 that will maximize Value Based Purchasing and other pay-for-performance opportunities; as well as, lead to improved clinical and quality outcomes.
- Provide oversight for Quality and Clinical Operations data mining and analysis for division and facility opportunities.
- Developed and implemented performance improvement strategies and tactics leading to a 25% reduction in catheter associated urinary tract infections, 30% decrease in time to pain management for long bone fractures and a 32% improvement in Outpatient Stroke measures.
- Designed and implemented a Leapfrog "Getting to A" initiative that led to a division average score of "C" to a division average score of "B" and includes a division-wide IRR and validation process.
- Collaborate with the CMO and Performance Improvement team to drive an 11% improvement in sepsis mortality through improving sepsis bundle

compliance by 60%, an 11% improvement in blood utilization, and sustained improvements in 4 of 5 Cardiovascular PCI indicators.

4/2013 - 4/2015 **Assistant Vice President of Quality and Clinical Operations**
West Florida Division (WFD) of HCA, TAMPA, FL

- Work directly under the WFD VP of Quality and Clinical Operations to provide oversight for clinical operations and excellence; quality assurance; performance improvement; patient safety, risk prevention and management; infection prevention and control; and medical staff operations for a 16 hospital division.
- Provide oversight for many of the day to day operations of the Quality and Clinical Operations Department
- Provide oversight to all regulatory and accreditation activities in the 16 hospitals in the WFD of HCA.
- Created a Sentinel Event Webinar preparation program that has led to 100% acceptance of plans of correction and successful completion of measures of success for the past four years.
- Completed due diligence from a quality, patient safety, infection prevention, nursing operations and medical staff perspective for 4 hospitals under consideration for acquisition.
- Provided on-site facilitation for 5 newly acquired facilities to successfully transition to corporate standards and achieve 100% Joint Commission and CMS accreditations within 120 days of acquisition.
- Responsible for successful credentialing and privileging of 100% of the Medical Staff in new WFD facilities.
- Created a multilevel tracking system that enables a 30 day transition of Medical Staff from a closing facility to the closest HCA facility.
- Co-designed and implemented performance improvement "Key Elements" strategies leading to a 60% reduction in hospital acquired conditions in 4 years.
- Participated in the design of the WFD centralized claims management process.
- Co-designed and implemented a Core Measures Playbook II with gap analysis and tool kit leading to 13 of 16 WFD hospitals awarded Top Performers on Key Quality Indicators© by the Joint Commission for 2013.
- Assumed the Severe Sepsis project management in March 2012 leading to a decrease mortality rate from 42% to 32% and ALOS from 12 days to 9.5 days.
- Co-designed a Dependent Healthcare Provider Scope of Service and evaluation program which has been adopted by HCA Corporate.
- Created and provide oversight for the Quality and Patient Safety Leadership Orientation Program.

- Provide oversight for Quality and Clinical Operations data analysis and data presentation.

2/2011 – 4/2013 **Director of Regulatory and Accreditation Programs**
West Florida Division of HCA, Tampa, FL

- Worked directly under the WFD VP of Quality and Clinical Operations; serves as the Division expert on regulation, accreditation, clinical practice and risk prevention and management.
- Provided oversight to all regulatory and accreditation activities in the 16 hospitals in the WFD of HCA.
- Designed a QRS follow-up program for continuous survey readiness which has led to a decrease in TJC RFIs in the WFD.
- Co-designed a TJC Sentinel Event webinar process which has led to 100% acceptance of WFD hospital action plans and attainment of 100% Measures of Success within the required 4 months.
- Co-designed and implemented performance improvement "Key Elements" strategies leading to a 60% reduction in hospital acquired conditions and never events.
- Co-designed and implemented a Core Measures Playbook leading to 12 of 15 WFD hospitals awarded Top Performers on Key Quality Indicators© by the Joint Commission for 2012.
- Assumed the Severe Sepsis project management in March 2012 leading to a decrease mortality rate from 42% to 35% and ALOS from 12 days to 11 days in one year.

8/2009 – 2/2011 **Vice President of Quality, Risk Management and Infection Control**
Northside Hospital, HCA St. Petersburg, FL

- Provided oversight of all Quality, Performance Improvement, Risk Management, and Infection Control activities for Northside Hospital.
- During tenure significantly improved all Core Measures to the 90th percentile and increased HCAHPS composite score by 4%.
- Redesigned Medical Staff peer review, ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) program leading to improved oversight of physician and LIP practice.
- Achieved 90% measure of success compliance in 6 months on all QRS identified opportunities from May 2010 QRS survey.
- Facilitated all Root Cause Analysis and Failure Mode Effects Analysis activities and ensured 100% compliance with designed plans of correction.

- Responsible for presentation and facilitation of analysis of quality and performance improvement data in the Quality and Patient Safety Committee, Medical Executive Committee and Board of Trustees.

10/2007 – 6/2009 **Assistant Vice President of Clinical Practice**
Washington Adventist Hospital, Takoma Park, MD

- Provided clinical operation oversight for ED, Critical Care, Medical-Surgical, Telemetry, Women's Services, Surgical Services, and Pharmacy Services.
- Assumed the Interim Chief Nurse Executive role during the 6 month search process.
- Provided leadership for Case Management, Hospitalist Program, and Intensivist Program – decreased hospital LOS by 4% despite a 10% increase in Case Mix Index
- Facilitated the design, implementation and monitoring of a new Neurovascular Surgical Service Line and Stroke Program.
- Designed and implemented the Professional Practice Education Program (PPEP) and other professional practice programs led to a 20% increase in recruitment and retention of nurses
- Redesigned and provided oversight to the Montgomery County Latino Health Care Initiative Nurse-in-Training Program – wrote and was awarded a $259,000 NSPI grant to support the management of the program for four years.
- Improved customer satisfaction scores by 15 % in key clinical areas
- Assisted in a Pharmacy redesign program leading to a 55% decrease in medication errors reaching the bedside.
- Facilitated the design and implemented a Rapid Medical Evaluation process in the ED which decreased patients leaving without treatment by 30% in the first three months.

5/2005 – 10/2007 **Internal Consultant/Corporate Manager, Resource Management and Performance Improvement Department**
MedStar Health, Lutherville, MD (Seven hospital Healthcare System)

- MedStar Visiting Nurses Association (VNA) Error Reduction Project
- Decreased service batch errors by 50% in 6 months
- Decreased Medicare Revenue held by fatal billing errors from $2,687,806 to $1,248,860 in 6 months.

- Served as a clinical consultant to Corporate Supply Chain. Designed a 3- year corporate bed fleet replacement program leading to $400,000 in contract savings.
- Facilitator for System-wide Performance Improvement Task Forces that all led to decrease in mortality, morbidity, LOS and 30-day readmission rates including initiatives in Surviving Sepsis Campaign, pressure ulcer prevention, glycemic control, heart failure, and culture of safety.
- Redesign Projects leading to improved efficiency, improved revenue capture, decrease in length of stay and decreased wait times and improved customer satisfaction
    - Franklin Square Hospital Center– Preadmission Testing
    - Georgetown University Hospital – Case Management Department, Wound Center and Ankle and Foot Center
    - Good Samaritan Hospital – Heart Care Unit and Patient Flow initiative.

10/1999 – 5/2005 **Clinical Nurse and Case Management Specialist, Medicine Service Line**
Franklin Square Hospital, MedStar Health, Baltimore, MD

- Served as a clinical consultant to Corporate Supply Chain. Designed a 3- year corporate bed fleet replacement program leading to $400,000 in contract savings.
- Partnered with physicians to design and implement protocols, guidelines and outcomes measurement for multiple disease entities.
- Provided supervision for all educators and clinical specialists in the Medicine Service Line.
- Planned, implemented and sustained multiple evidence-based, performance improvement programs across the Medicine Service Line.
- Designed and implemented care coordination rounds on all units resulting in a 10% decrease in length of stay.
- Implemented the DRG Assurance Program maximizing coding for complexity of care leading to a 20% increase in CMI in one year.
- Achievements:
    - Delmarva Medicare Excellence Award for three areas of responsibility: CHF, MI, and Pneumonia
    - Solucient 100 recognition for Heart Failure, MI and Pneumonia
    - Achieved recognition in US News & World Report Top 100 Hospitals for cardiology and endocrinology.

4/1998 – **Clinical Liaison Nurse, Corporate Materials Management**

10/1999 *MedStar Health, Baltimore, MD*

- Served as clinical expert and liaison for all corporate contracts
- Served as medical and OR product consensus builder leading to over $1.5 million in systems savings in 18 months.
- Coordinated all new product implementations across the system.

3/1985 – 4/1998 **Nurse Director/Nurse Educator/Staff Nurse/Home Care Case Manager**
Church Hospital, MedStar Health, Baltimore, MD

- Provided Critical Care, Home Care and Medical-Surgical clinical practice, management and education
- Served as member and chairperson on multiple quality, patient safety and performance improvement committees.

9/1988 – 5/2009 **Adjunct Faculty Villa Julie College and Community College of Baltimore County**
Baltimore, MD

10/1981 – 3/1985 **Cardiac Rehabilitation Nurse/ICU Staff Nurse**
Greater Baltimore Medical Center, Baltimore, MD

6/1980 – 10/1981 **Telemetry Nurse**
Wheeling Hospital, Wheeling, WV

EDUCATION

2015 –	Doctoral Student in Nursing Practice	*Capella University, Minneapolis, MN*
2003 – 2005	Masters of Science in Nursing	*University of Phoenix, Phoenix, AZ*
1985 – 1987	Masters of Science in Instructional Technology	*Towson University, Towson, MD*
1976 – 1980	Bachelors of Science in Nursing	*Wheeling Jesuit College, Wheeling, WV*

LICENSES AND CERTIFICATIONS

- Licensed Registered Nurse (RN) Florida and Texas
- Licensed Healthcare Risk Manager (LHRM) Florida
- Certified Professional in Health Care Quality (CPHQ)
- Certified Professional in Patient Safety (CPPS)

- Certified Wound Care (CWCN)
- Certified Continence Nurse (CCN)

PUBLICATIONS

Author/Co-Author

- Hospital Readmission Prevention in Lippincott's Nursing Advisor (2015 in publication). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Core Measures in Lippincott's Nursing Advisor (2015, 2016). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Unethical Practices: Recognizing and Reporting in Lippincott's Nursing Advisor (2014). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott's CE Module - Mandatory Education, Hospital: National Patient Safety Goals (2013). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott's Nursing Advisor Core Measure Content Set for AMI and Heart Failure (2013). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Bahner, J, Berry, D, & Hooker, J. Nursing Leadership for Safety (Section XIV, Chapter 5) in Patient Safety in Emergency Medicine (2008), Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.

Contributor/Reviewer

- Sentinel Events in Lippincott's Nursing Advisor (2015). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott Nursing Procedures & Skills (2010, 2011, 2012, 2013, & 2014 versions). Wolters Kluwer/ Lippincott, Williams & Wilkens.
- Lippincott Patient Safety Program: Communication Among Caregivers and Restraints (2013). Wolters Kluwer/ Lippincott, Williams & Wilkens.
- Preceptor Preparation Program: Web based interactive e-learning course (2012). Wolters Kluwer/ Lippincott, Williams & Wilkens.

AWARDS, HONORS and Professional Activities

- Member of the National Advisory Board for Strayer University RN to BSN program
- Subject matter expert for quality, patient safety and risk management for Rasmussen University
- Subject matter expert for Core Measures for Lippincott, Williams and Wilkins publishing company.
- Alpha Sigma Nu (National Jesuit Honor Society)

- Sigma Theta Tau (International Nursing Honor Society)
- 2003 Nurse of the Year in a Clinical Support Role, Franklin Square Hospital
- 2004 Excellence in Care Coordination Leadership Award, Franklin Square Hospital

PRESENTATIONS

- **2012 FAHQ Annual Conference**: *Sustained Zero HAPU: Northside Hospital's Journey*
- **2007 SAWC Conference Poster Presentation:** *The design and early implementation of pressure ulcer prevention strategies in a large health care system*
- **2007 MedStar Surviving Sepsis Initiative** featured in Maryland Patient Safety Center and MHEI Director of Process Improvement Projects
- **2005 Care Science National Conference:** *Using Risk Adjusted Data to Evaluate Performance and Drive Change*
- **2005 Delmarva Courage to Improve Conference***: Establishing Core Measure Compliance*

Exhibit 3(b)

Thedosia L. Munford, MBA, MS, BSN, RN, NEA-BC

SUMMARY OF QUALIFICATION: Thirty years of diversified acute health care experience and accomplishments in positions of progressive managerial and executive responsibilities. Extensive involvement in organization redesign, renovation and restructuring; cost reduction; fiscal management; human resource management and development; project management; organizational transition; organization preparation for ANCC magnet designation and direction of clinical departments. Accomplishments include:

- Development and implementation of patient focus delivery systems
- Clinical lead for inpatient and outpatient units, ED renovations and construction
- Participated in building of new bed tower
- Facilitated throughput teams to expedite patient flow and decrease LOS by 16%
- Increased Emergency Department (NPS) patient satisfaction in an inner city hospital by 41%
- Decreased RN vacancy rate by 22%
- Exceeded goal for pressure ulcer rate by 44%
- Eliminated use of restraints in medical/surgical units and exceeded goal for decrease use in critical care by 69%
- Other quality matrix accomplishments included meeting and exceeding goals for hand washing, pneumococcal vaccine and influenza vaccine
- Achievement of TJC accreditation and licensure
- Implementation of management development program
- Labor management/union negotiations
- Patient care unit construction redesign for patient-centered care, and patient flow
- Preparation and management of annual budget in excess of $44 million
- Decreased use on incremental overtime by 60%
- Decreased use of external agency nurses by 50%
- Achieved productivity standards for staffing
- Organization development and change management
- Work redesign
- Reduced OR room turnover time down to <30 minutes

PROFESSIONAL EXPERIENCE AND ACHIEVEMENTS

HealthLinx Transitional Leadership **2014-2015**

A division of HealthLinx Executive Search, Inc. a healthcare-exclusive consulting and search firm specializing in i) leadership assessment, project management and consulting; ii) the identification and recruitment of permanent management and executive healthcare candidates; and iii) the placement, assistance, and management of transitional leaders.

- **Transitional Leader** -December 2014-April 2015
  Interim Director Professional Practice and Nursing Development (December 2014-April 2015)
  Mount Carmel East Hospital, Columbus Ohio
- As a transitional leader, deliverables included i) validate the recently developed on-boarding plan and provide opportunity for improvement with particular focus on new graduate nurses, medical/surgical, critical care and Emergency Department nurses; ii) assess Clinical Education Department, resource allocation, clinical education staff competency and staff competency assessment model for the Hospital; and iii) assess Shared Governance Model with particular

focus on practice council, support structure and current functioning. Selected accomplishments included,

Ascension Health System **2006-2013**

A national healthcare provider in more than 1400 locations in 23 states and District of Columbia rooted in the loving ministry of Jesus as healer and is committed to serving all persons with special attention to those who are poor and vulnerable.

- **Senior Vice President Patient Care Services/CNO (2010-2013)**
  Providence Hospital, Washington DC
  A 408 bed teaching hospital with ADC of 200 inpatients and 40 behavioral health inpatients, offering medical graduate teaching and serving as a rotational site for domestic and international nursing students. Located in northeast District of Columbia with an average of 45,000 ED visits annually. Other specialties include Diabetes, Certified Stroke Center, Bariatric Services and Wellness Programs, Cardiology, Orthopedics, Sleep Wellness and Geriatric Medicine. As SVP/CNO, reported to president/CEO. Responsibilities included management of total operating budget of >$47 million, staff of >600 FTEs, re-design of throughput processes for main hospital portals (IP and OP surgery, and ED), implemented mid-level leadership development and performance standards for accountability. Selected accomplishments included:
    - decreased RN vacancy rate from >9% to 7%
    - decreased LOS from >5 to 4.2 days
    - eliminated use of agency RNs by 50%
    - decreased ED patient throughput by 30%
    - increased ED patient satisfaction from 32% to 54%

- **Vice President, Inpatient Services (2006-2010)**
  Saint Agnes Hospital, Baltimore, Maryland
  A 296 bed full service teaching hospital with residency program and student nurse rotation serving the greater Baltimore area, located in southwest Baltimore serving diverse communities, with ED visits >82,000. Clinical areas of specialties include Cancer Care, Metabolic, Cardiovascular, Women's & Children's Health, Orthopedic & Spine, Plastic & Reconstructive Surgeries, Stroke, Chest Pain Emergency Program. As VP, reported to senior vice president/CNE. Responsibilities included management of inpatient medical/surgical and critical care units, Nursing Operations (House Supervisors, staff float pool, Nursing Office), Care Management, Nursing Education and Development, management of operating budget of >$25 million, and staff of >200 FTEs, and nursing shared decision making and professional development programs. Selected accomplishments included;
    - decreased LOS from 4.49FYTD July 2008 to 3.95 FYTD May 2010
    - developed and implemented RN Professional Clinical Ladder Program
    - facilitated implementation of nursing leadership academy
    - facilitated strategies in preparation of ANCC magnet designation
    - facilitated nursing clinical research with the first NRB approved nursing research study

Senior Director of Nursing **2003-2006**

Mercy Medical Center, Baltimore, Maryland

A 299 bed teaching ANCC Magnet Designated Hospital located in downtown Baltimore with ED visits >62,000 annually. Clinical specialties include Cancer Care, Diabetic & Endocrine, Gastroenterology & GI Surgeries, Geriatrics, Gynecology, Nephrology, Orthopedic and Pulmonology. As senior director, reported senior vice president/CNE. Responsibilities included management of inpatient medical/surgical units, inpatient substance abuse unit, and OP Chemotherapy, management of operating budget of >$10 million and staff of >250 FTEs. Selected accomplishments included:

- developed nursing management and leadership structure of responsibility and accountability
- managed and lead managers through radical change of re-structuring of responsibilities and accountability
- lead coordination, development and implementation of RN clinical ladder for professional practice
- served as interim VP Patient Care Services
- began nursing and organizational preparation for magnet designation

Director, Patient Care Service **1996-2003**
MedStar Harbor Hospital, Baltimore, Maryland
A 179 bed community focused hospital located in south Baltimore on Patapsco River with an average of 40,000 ED visits annually. Clinical specialties include Internal Medicine, Orthopedic, Oncology, Sports Medicine, Back & Spine, and Women's Service. Mission is to provide a quality, caring experience for patients, communities and those who serve with a patient centered care philosophy. As director, reported to vice president/CNO. Responsibilities included management of inpatient medical/surgical units, critical care and Women's Health. Selected accomplishments included:

- facilitated transition from traditional patient care delivery to patient centered care model
- clinically designed, planned and implemented several patient centered care units with external construction team
- chaired Human Resource Design work team for MedStar transition for recruitment, selection, orientation and retention
- co-chaired work re-design team for Hospital-wide patient flow from admission to discharge

ADDITIONAL EXPERIENCES:

- **Vice President, Patient Care Service** **1993-1995**
  Greater Southeast Community Hospital, Washington DC
  A 400 bed acute care community hospital located in southeast Washington DC serving Prince George's County Maryland communities and southeast Washington DC. As vice president reported to president/CEO. Responsible for all nursing services with select accomplishments that included
  -implementation of position control system
  -expansion of home health services which increased visits by 20%
  -reduced management positions by 40%

- **Assistant Executive Director** **1991-1993**
  Howard University Hospital, Washington DC
  A comprehensive and academic teaching hospital located on campus of Howard University in District of Columbia. Level I Trauma Center with average of 60,000 ED visits annually, performing kidney and liver transplants. As assistant executive director, reported to COO and responsible for all nursing services and nurse management team member for labor contract negotiations.

EDUCATION AND DEVELOPMENT

- Class of 2010 *The Leadership Program of the Greater Baltimore Corporate*
- MBA, University of Baltimore, Baltimore Maryland
- MS Human Development, Howard University, Washington DC
- BSN, Howard University, Washington DC
- Diploma in Nursing, Freedmen's Hospital School of Nursing, Washington DC

LICENSURE AND CERTIFICATION

- RN, District of Columbia #R29886
- RN, Maryland #R128737

- RN, Ohio #RN412755
- NEA-BC #2009013543

Exhibit 3(c)

CANDICE PETERS, R.N., B.S., MS

EXPERIENCE

KINDRED HEALTH CARE – HOSPITAL DIVISION – WEST REGION – WESTMINSTER, CA.
SENIOR DIRECTOR CLINICAL OPERATIONS (FEB 2009 – CURRENT)
Kindred is an acute long-term hospital caring for catastrophically ill and medically complex patients. Direct Oversight of 7-13 hospitals providing long term acute care (LTAC) in California. Ensured The Joint Commission accreditation for all assigned hospitals; assisted operations support, Quality and Regulator Review (Joint Commission and CMS survey preparation). In 2014 ensured 7 hospitals that were reviewed were re-accredited Joint Commission. Ensured 2 hospitals (2013 and 2015) -achieved first time JC Accreditation. Assisted two hospitals successfully though CMS condition out to achieve full conditions. Serves as an active Governing Board member to multiple Kindred hospitals. Able to review and prepare facilities for both Laboratory and Hospital Joint Commission accreditation.

CONVERGENCE HEALTH CONSULTING, INC.
SENIOR CONSULTANT (JULY 2007- FEB 2009)
ANAHEIM MEMORIAL MEDICAL CENTER – INTERIM CONSULTING POSITION AS RISK MANAGER – Interim Risk Manager to develop complaint and grievance process to meet CMS requirements; continued to fill position as the Risk Manager. AMMC was in the process of a sale. In Oct. advanced to Chief Nursing Officer.

KINDRED HEALTH CARE
REGIONAL DIRECTOR CLINICAL OPERATIONS (2004-2007)
Promoted from COO role (see next)
Had direct oversight over 6 hospitals in the West Region. Assisted all 24 facilities in the West Region as needed for operations support, plan implementation, developing plans of correction. Ensured Joint Commission re-accreditation of 3 facilities that experienced a denial of accreditation. Assisted 2 other facilities in Conditional Accreditation to achieve full Joint Commission accreditation. Assisted one hospital in Joint Commission re-accreditation.

KINDRED HOSPITAL ONTARIO
CHIEF OPERATIONS OFFICER (1996 –SEPTEMBER, 2004)
Had responsibility for all clinical areas including Nursing, Pulmonary, Rehabilitation, Dietary, Radiology, Laboratory, Housekeeping, Social Services, Surgery, Infection Control, Employee Health and Pharmacy.
Chair multiple committees including Quality Council, Policy and Procedure, Employee Activities, Bioethics, Environment of Care, ICU and Medical Records committees. Member of Medical Executive Committee and Governing Board. Served as interim CEO for 8 months until CEO was recruited.

ST. BERNARDINE MEDICAL CENTER, SAN BERNARDINO, CALIFORNIA
Director Patient Care Services (1989-1996)
Started as a manager in 1989 for a 17 bed Intensive Care Unit and 12 bed Coronary Care Unit. In 1992 became Director of Nurses, reporting to the Chief Nurse Executive. Areas included ICU/CCU, Telemetry, Intermediate Care, Medical-Surgical Units, Peri-Operative Surgery, Out Patient Surgery Center, Central Supply, Diabetes Health Services, Hemodialysis and Nursing Services. (1994). Included responsibility for 250 FTE's and 10 managers. Chaired Nursing Policy and Procedure Committee. Active on multiple committees, including Quality Council, Medical Staff Committees, such as ICU and Surgery Committees.

QUEEN OF THE VALLEY HOSPITAL, WEST COVINA, CALIFORNIA
Unit Coordinator, 1981-1989
Manager for the Intermediate Care Unit, an18 bed unit with telemetry monitoring. Responsibilities included interviewing, hiring, firing and counseling. Coordinated patient care and other activities. Worked as staff nurse in the same area for the first three years. Also covered House Supervisor Position.

SANTA TERESITA HOSPITAL, DUARTE CALIFORNIA
Paramedic Liaison Nurse, 1976-1981
Worked as staff nurse in the Emergency Department for the first three years. Promoted to Paramedic Liaison Nurse. Created and developed this position based on L.A. County Health Services Guidelines. Coordinated paramedic and mobile intensive nurse (MICN) training.

LIFE FLIGHT OF SOUTHERN CALIFORNIA
Flight Nurse, Fixed Wing, 1978-1983

HURON ROAD HOSPITAL, E. CLEVELAND OHIO
Circulating and Scrub Nurse, 1974-1976

EDUCATION

CAL STATE UNIVERSITY, SAN BERNARDINO *Masters of Science in Health Services Administration, 1997*

SOUTHERN ILLINOIS UNIVERSITY, CARBONDALE INDIANA
Bachelor of Science in Health Care Management, 1989

HURON ROAD HOSPITAL SCHOOL OF NURSING, EAST CLEVELAND, OHIO
Diploma, Registered Nurse, 1974

4. **Corrective Action Plan for Los Angeles Community Hospital (Responding to Deficiencies Cited as a result of Resurvey Conducted February 16-17, 2016)**

Please see attached for requested Corrective Action Plan. Also attached is an additional Corrective Action Plan filed in response to a CMS Form 2567 received on April 12, 2016 by Los Angeles Community Hospital. The deficiencies cited therein related to a third-party dialysis provider who has since been terminated.

Alta Los Angeles Hospitals, Inc.

Alta Hospitals
SYSTEM, LLC

Los Angeles Community Hospital
4081 East Olympic Blvd.
Los Angeles, CA 90023
(323) 267-0477
(323) 261-0809 Fax

Los Angeles Community Hospital at Bellflower
9542 Artesia Blvd.
Bellflower, CA 90706
(562) 273-1800
(562) 273-1818 Fax

Los Angeles Community Hospital at Norwalk
13222 Bloomfield Avenue
Norwalk, CA 90650
(562) 863-4763
(562) 207-9721 Fax

VIA FEDERAL EXPRESS

April 6, 2016

Rufus Arther
Branch Manager, Non-Long Term Care
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Survey & Certification Operations
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Re: Los Angeles Community Hospital (CCN: 050663)
Complaint Validation Resurvey 02/17/16
Credible Allegation of Compliance

Dear Mr. Arther:

Pursuant to the CMS letter, dated March 23, 2016, enclosed please find Los Angeles Community Hospital's (the "Hospital") timely submission of its credible allegation of compliance for the above-referenced survey.[1] The Hospital takes great pride in delivering quality health care services to the community and on its compliance with the Medicare Conditions of Participation. A copy of this letter and the credible allegation of compliance have been delivered to the Bakersfield District Office of the California Department of Public Health.

Thank you for your attention to this matter. Please contact me at 323-881-2600 if you have any questions or concerns.

Sincerely,

Deborah Webber

Deborah Webber
Chief Executive Officer

Enclosure
cc: California Department of Public Health, Bakersfield District Office (*via federal express*)

[1] Ms. Angeldones graciously granted an extension to respond by April 7, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(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 The following reflects the findings of the California Department of Public Health during a First Revisit Complaint Validation survey. Complaint Number: 462024 Representing the Department: 18790, HFEN 21905, HFEN 32233, HFEN 33399, Infection Control Consultant 22711, Medical Consultant Census was 132 Sample Size was 31 patients	{A 000}	A000 Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law. The following constitutes Los Angeles Community Hospital's credible allegation of compliance.	
{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. 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 observation, interview, and record review, the hospital failed to obtain adequate informed consents for three of 31 sampled patients (28, 44 and 45). This has the potential for the patients or the patients' responsible	{A 131}	A 131 482.13(b)(2) Patient Rights: Informed Consent	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Weinstein — TITLE: Chief Executive Officer — (X6) DATE: 04/06/2016

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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	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 131}	Continued From page 1 parties to be unaware of potential risks versus benefits of a proposed treatment prior to consent to the treatment. Findings: 1. During an interview and review of the clinical record of Patient 28 on 2/17/16, at 9:30 AM, the admission record documented she was re-admitted to the sub acute care unit on 1/27/16. It was noted she signed her hemodialysis (a treatment in which a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this adequately) consent on 1/27/16. It was illegible, but the nurse who witnessed it (Registered Nurse [RN] 7) stated she had obtained Patient 28's signature indicating informed consent. There was another consent for Prozac (antidepressant medication), dated 1/27/16. The signature for the antidepressant consent was different from the markings on the hemodialysis consent. RN 7 stated, "The physician signed that one." During an observation and interview on 2/17/16, at 10 AM, Patient 28 was lying in bed, breathing with a ventilator (breathing machine) connected to a tracheotomy (a surgically created hole through the front of a person's neck to the windpipe [trachea] which provides an air passage to help a person breathe and is often needed with long term ventilator use) and formula connected to Patient 28's feeding tube (a tube that is placed either through the nose and passed through the windpipe down to the stomach or directly to the stomach to provide liquid nutrition). Patient 28 did not wake up when spoken to. During another observation of Patient 28 with RN 7 and Licensed Vocational Nurse (LVN) 1 at 11:15 AM, RN 7	{A 131}	Findings 1-3: Immediate Actions Taken: 1. The Assistant Chief Nursing Officer (ACNO) discussed the survey findings with RN 7, with special emphasis on evaluating whether the patient is able to understand/sign the informed consent and steps to take if the patient cannot, including escalation to the ethics committee, as appropriate. Subsequent Actions Taken: 1. The Chief Executive Officer (CEO) and Nursing Leadership discussed the survey findings. The "Consent/Informed Consent" policy was reviewed and revised to align with current practice. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the	2/17/16 4/7/16

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{A 131}	Continued From page 2 physically touched the patient and encouraged her to answer questions. Patient 28's speech was difficult to understand and what could be understood did not seem to make a sentence. RN 7 was unable to identify what Patient 28 said with the approximately 6-8 words spoken. During a review of the clinical record of Patient 28, a son was listed by name and a telephone number documented. The Minimum Data Set (MDS, an assessment tool) identified Patient 28's cognitive (ability to think, remember, and understand the environment) status on 9/3/15, as "Severely impaired--never/rarely made decisions." The MDS assessment dated 12/4/15, identified her cognitive status as severely impaired. RN 7 was asked if there was a re-assessment upon admission on 1/27/16. RN 7 stated, "No. Because she hadn't changed." RN 7 was asked if Patient 28's son could give consent. She replied, "The son doesn't return phone calls. Sometimes he's in jail. That's why he doesn't give his consent." RN 7 was asked how she could assess this patient in regards to obtaining an informed consent. RN 7 stated, "I talk to her and she seems to understand. Sometimes we can read her lips." The hospital policy and procedure titled "Consent/Informed Consent" dated 1/2014, indicated: "...Policy:...1. Capacity to Consent. A person may give a valid consent only if he or she has 'capacity' which means he or she is able to understand the nature and consequence of a decision and to make and communicate the decision... If an adult lacks the capacity to make medical decisions, a surrogate decision-maker must be identified... iv. The hospital will establish a multi-disciplinary committee as a subcommittee	{A 131}	information the patient/representative needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. A person may give a valid consent only if he/she has capacity, which means he/she is able to understand the nature and consequence of a decision and to make and communicate the decision. If an adult lacks the capacity to make medical decision, a surrogate decision-maker will be identified. Except in emergency situations, issues with obtaining an informed consent from the patient/representative will be addressed by the Ethics Committee. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the procedure. The witness to the patient/representative signing the informed consent form should legibly print his/her name and sign, date/time the document. The Medical Executive Committee (MEC) and Governing Board approved the policy on 3/30/16 policy and completion of the informed consent form. 2. Additionally the hospital's consent form (the document on which the patient's consent is annotated) was reviewed and revised to streamline the narrative, simplify the format and reduce the overall form from six (6) pages to two (2) pages. The hospital elected to maintain a separate consent for blood transfusions and the use of psychotropic medications. The consent form was approved by the MEC and Governing	4/7/16

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{A 131}	Continued From page 3 of the Ethics Committee and delegate to it responsibility for acting as a surrogate decision-maker for patients who have no surrogate decision-maker... 4. 'Informed Consent' is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the physician is permitted to perform the procedure..." 2. During a review of the clinical record for Patient 44 and interview with LVN 3, on 2/17/16, at 9:04 AM, the clinical record indicated the patient was admitted on 2/15/16, with an abscess to the left lower extremity. The History and Physical dated 2/15/16, indicated the patient arrived to the Emergency Room (ER) with severe pain and redness to the posterior thigh. The "Assessment and Plan" section indicated the patient had an abscess of the left posterior thigh and a status post incision and drainage (I & D is a minor surgical procedure using a sharp instrument to release the pus and pressure built up under the skin caused by an abscess) was performed to the site. The nursing note dated 2/17/16, at 9:29 AM, read, "Received pt (Patient 44)...Admitting Dx (Diagnosis): cellulitis & abscess on left upper leg...ER nurse stated that pt had I & D at ER..." There was no informed consent noted in the clinical record indicating the physician had described the potential risks and benefits of the treatment prior to performing the I	{A 131}	Board on 3/30/16. Nursing and medical staff were educated on the form, with use of the form implemented by 4/7/16. 3. The Chief of Staff sent a memorandum on 2/26/16 to medical staff practitioners reminding them of the need for a complete informed consent. 4. The Chief of Staff discussed the survey finding related to informed consents at the MEC and Governing Board meetings on 3/30/16. It was emphasized that informed consents are to be complete. A repeat memo was sent to medical staff practitioners emphasizing the need to date and time their signature on the existing consent form. The revised consent form does not require physician signature, the new form requires patient/representative signature and witness signature, as the physician is not required by regulation to sign a consent form. The physician is required to provide the information so the patient can make an informed decision, which the consent form annotates, and which the patient then attests to. 5. Nursing staff is educated on informed consents upon hire and annually. 6. Compliance with informed consents is monitored through the QAPI program. Compliance and Monitoring: The Chief Nursing Officer or qualified designee performs daily reviews of informed consents (Monday through Friday) to achieve the goal of 100% compliance with obtaining complete and well documented informed consents. Data is analyzed and reported	2/26/16 3/30/16

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{A 131}	Continued From page 4 & D to the patient's abscess site. LVN 3 confirmed there was no informed consent obtained prior to the procedure, although there should have been one obtained. 3. During an observation on 2/17/16, at 9:44 AM, in the Intensive Care Unit, Patient 45 was observed with a tracheostomy attached to a ventilator. During a review of the clinical record and interview with LVN 3, on 2/17/16, at 10 AM, an informed consent document was noted for the tracheostomy placement signed on 2/11/16. The document was incomplete which was confirmed by LVN 3. No additional information was provided. The hospital policy and procedure titled "Consent/Informed Consent" dated 1/2014, indicated under the POLICY subheading, "...4. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the physician is permitted to perform the procedure..." Also under the subheading titled, Documenting Informed Consent it reads in part, "The doctor will complete the information in the Consent...form or provide the information... The patient's physician must document in the patient record that he or she has conveyed the information required for an informed decision..."	{A 131}	monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	

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{A 385}	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure: 1. One sampled patient who was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours to receive a nursing re-evaluation or check during his wait. (Refer to A 395, item 1) 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. (Refer to A 395, item 2) 3. The physician's orders were followed for two sampled patients. (Refer to A 395, item 3) 4. Nursing was aware of the hospital's policy for the crash cart and ensure one crash cart contained all the contents listed. (Refer to A 395, item 4) 5. Pertinent, individualized nursing care plans were developed for 12 sampled patients. (Refer to A 396) 6. One registered nurse was oriented to the emergency department (ED) when she was transferred there from another department. (Refer to A 397)	{A 385}	A 385 482.23 Nursing Services Executive and Nursing Leadership discussed the nursing survey findings and reviewed applicable policies and procedures to ensure adequacy for promoting and maintaining compliance with reassessing patients in the ED/urgent care, functioning nursing call lights, executing and documenting physician orders, crash carts, individualized nursing care plans, orientation of registry staff, and adequate supervision of contracted nursing personnel. Policies were revised to align with current practices and nursing staff was educated. Hospital Leadership hired a new Director of ICU/ED Services and Director of the Medical/Surgical Units. Monitoring of nursing services is part of the QAPI program and is used for performance improvement measures. Data on compliance is reported through the Quality Council and to the MEC and Governing Board. Finding 1 The identified patient was relocated into the Urgent Care at the time of survey and evaluated by nursing staff. There was no adverse outcome identified. The "Triage Treatment Protocols and Admission in the Emergency Department" policy was reviewed and revised to clarify that a reassessment of the patient is to occur in the Urgent Care/ Emergency Department (ED) based on the acuity of the patient's condition. Urgent Care and ED nursing staff were inserviced on the policy changes. ED and Urgent Care Nurses are educated on performing and	4/7/16 2/26/16 3/28/16 - 4/4/16

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

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{A 385}	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure: 1. One sampled patient who was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours to receive a nursing re-evaluation or check during his wait. (Refer to A 395, item 1) 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. (Refer to A 395, item 2) 3. The physician's orders were followed for two sampled patients. (Refer to A 395, Item 3) 4. Nursing was aware of the hospital's policy for the crash cart and ensure one crash cart contained all the contents listed. (Refer to A 395, item 4) 5. Pertinent, individualized nursing care plans were developed for 12 sampled patients. (Refer to A 396) 6. One registered nurse was oriented to the emergency department (ED) when she was transferred there from another department. (Refer to A 397)	{A 385}	the medication tag. If the numbers do not match, the nurse is to notify the pharmacist. Nursing staff was reeducated on crash carts and the content list. The CNO or qualified designee performs a daily review of the crash carts to ensure the tamper resistant lock is intact to achieve the goal of 100% compliance with intact crash carts. Finding 5 The CEO and Nursing Leadership discussed the survey findings regarding nursing care plans. In an attempt to refocus the nursing staff on critical thinking, paper nursing care plans were instituted to bring the nurse "back to basics." This method was pilot tested over a two-week period with nursing staff migrating from electronic care planning to paper care planning. After a two-week period, data collection and analysis revealed the paper process did not improve critical thinking and resultant improved documentation, as anticipated. After input from line nursing staff and analysis by Leadership, the request to revert back to an electronic care planning process was approved. Nursing staff was educated that care planning will revert back to the electronic format and renewed efforts will be applied to identifying the assessed needs of the patient and annotating these in the electronic care planning module. A process of concurrent record compliance monitoring, whereby a "care facilitator" (licensed	4/7/16

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{A 385}	Continued From page 6 7. Adequate supervision was provided to one contracted nursing personnel. (Refer to A 398) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure adequate nursing care to meet the needs of the patients.	{A 385}		
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 observation, interview, and record review, the registered nurses failed to ensure there was adequate supervision when: 1. One of 31 sampled patients (27) was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours with no nursing re-evaluation or check during his wait. This had the potential to result in medical conditions to go untreated. 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. This had the potential for the patients to be unable to call for required assistance. 3. The physician's orders were not followed for two of 31 sampled patients (38 and 45). This had the potential to result in untreated medical conditions which could result in an overall decline in the patients.	A 395	A 395 482.23(b)(3) RN Supervision of Nursing Care	

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A 395	Continued From page 7 4. Nursing was unaware of the hospital's policy for the crash cart and one crash cart did not contain all the contents listed. This had the potential to result in the emergency personnel to be unaware of the contents and to ensure the crash cart contained all the emergency contents. Findings: 1. During an observation and interview on 2/16/16, at 9 AM, Patient 27 was noted to be lying on an EMT (emergency medical technician) gurney in the hallway directly outside Urgent Care. An ambulance attendant (EMT 1) was sitting next to him. EMT 1 stated he brought Patient 27 to the hospital about 5 AM, and they have been waiting for a bed in the Urgent Care. EMT 1 stated no nurse has re-evaluated Patient 27 or taken the vital signs (blood pressure, pulse, temperature) since their arrival. During an observation and record review on 2/16/2016, at 9:40 AM, the Chief Nursing Officer (CNO) assisted EMT 1 to bring Patient 27 into the Urgent Care. Patient 27's medical record was reviewed and it documented that vital signs had been taken at 5:45 AM and not repeated until 9:30 AM. The registered nurse in charge of the Urgent Care (RN 6) stated patients who were waiting for a bed in the Urgent Care should have their vital signs taken every two hours. The hospital policy and procedure titled "Triage Treatment Protocols and Admission in the Emergency Department", dated 3/2014, indicated: "...2.12 It is the responsibility of the RN to continually reassess the status of those patients who are awaiting disposition to the treatment area ...."	A 395	Finding 1 Immediate Actions Taken: 1. Patient 27 was moved into the Urgent Care at the time of survey and evaluated (including vital signs) by the nursing staff. There was no adverse outcome identified.	2/16/16
			2. The CNO and ACNO discussed the survey findings with the Urgent Care staff at the time of survey, with special emphasis on the registered nurse's responsibility to reassess the status of patients awaiting disposition to the treatment area at least every two hours.	2/16/16
			Subsequent Actions Taken: 1. Hospital Leadership reviewed and revised the "Triage Treatment Protocols and Admission in the Emergency Department" policy to clarify that a reassessment of the patient is to occur in the Urgent Care/ED based on the acuity of the patient's condition. The Policy and Procedure Committee approved the policy on 3/28/16. The MEC and Governing Board approved the policy on 3/30/16. Urgent Care and ED nursing staff were inserviced on the policy.	3/28/16 - 4/4/16
			2. Hospital Leadership hired a new Director of ED and ICU Services, which includes oversight of the Urgent Care.	4/4/16

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A 395	Continued From page 8 2a. During an observation and interview with the RN 25 (the charge nurse for the medical surgical unit) and the Certified Nursing Assistant (CNA) 1 on 2/16/16, at 11:46 AM, Room 111 was noted with eight patients. Patient 39 (Room 111) was observed lying in bed G with CNA 1 next to his bed. The patient appeared confused and the call light button was not observed within reach of Patient 39. CNA 1 indicated she removed the call light from the patient because "he is always on it" but he did have it earlier. CNA 1 and RN 25 proceeded to search for the call light. When the call light button was found, the cord was cut at the level of the wall; therefore, could not be accessible for Patient 39 to use. Patient 39 was approximately 2 feet from the call light. RN 25 stated CNA 1 is the assigned staff to care for Patient 39. She was asked how the nurse call system works. She stated the nurse call system includes a button at the wall with a cord that has the call light attached to it. The cord with the call light attached is what is provided to the patient. When the patient presses the red call light, it should be audible and visible above the patient room door and at the nurse's station. During a review of the clinical record for Patient 39 and interview with RN 22, on 2/16/16, at 2 PM, the admitting diagnoses included: Altered Mental Status (AMS), Hypertension (high blood pressure), Diabetes Mellitus (a disease which results in the body's inability to produce enough insulin which results in elevated sugar levels), Abnormal Gait, Dementia and Convulsions. The care plan problem list included a care plan for patient's risk for harming himself, a care plan for pain and a care plan of fall. The fall care plan included an intervention which indicated, "...call	A 395	Finding 2 a-f Immediate Actions Taken: 1. Hospital Leadership took immediate action to address the call light findings at the time of survey. All call lights were checked at the L.A. and Norwalk campuses for functionality. The patients at the Norwalk campus with call lights that needed repair were provided with a sitter. The patients at the L.A. campus with call lights that needed repair were relocated to a room with a functioning call light. 2. Hospital Leadership notified the House Supervisors that patients were only allowed to be in a room with a call light that needed repair if the patient was provided with a sitter. Otherwise, the bed was to be closed and not for patient use. 3. Nursing Leadership assessed all patients at the time of survey to ensure that functioning call lights were within reach of the patient. Nursing staff was reeducated at the time of survey that call lights are to be within the patient's reach. Subsequent Actions Taken: 1. Hospital Leadership discussed the survey findings. The "Reporting Malfunction" policy was reviewed and did not require any revisions. It was also identified that there was an existing policy related to the nurse call system. The policy, entitled "Utility Disruption: Nurse Call System" policy, was reviewed and revised to align with current practice in the event of a disruption in the nurse call light system. Upon identification of a malfunctioning call light, the staff is to	2/16/16 2/16/16 2/16/16 3/1/16 - 4/7/16

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A 395	Continued From page 9 bell within reach..." 2b. During an observation of Room 111 Bed B with RN 25, on 2/16/16, at 11:50 AM, the call light was not noted accessible to Patient 42 who was lying in bed. RN 25 proceeded to search for the call light, which was found on the floor. During a review of the clinical record for Patient 42 with RN 22 and the Assistant Chief Nursing Officer (ACNO), on 2/16/16, at 2:50 PM, the patient was admitted on 2/11/16 with admitting diagnoses of Gastrointestinal (relating to the stomach or intestines) Bleed, Gastric Cancer and Anemia (a condition where you do not have enough healthy red blood cells to carry adequate oxygen to the body's tissue which can can cause weakness, fatigue and dizziness). Additional diagnoses included Failure to Thrive (FTT used to define faultering weight to indicate insufficient weight gain), nausea and vomiting, Schizophrenia (mental disorder), Diabetes, Gastritis (inflammation of the lining of the stomach), and Gastroesophageal Reflux Disease (a chronic digestive disorder which results in the stomach acid to flow back up through the food pipe [esophagus]). The care plan list was reviewed and there was a care plan which addressed his fall risk with an intervention to assist the patient from falling included "...call bell within reach..." A care plan was also developed due to the patient being harmful to himself due to the patient being impulsive and wandering tendencies and an intervention to assist the patient from harming himself is to "ensure safe environment". 2c. During an observation of Room 111 Bed C with RN 25, on 2/16/16, at 11:50 AM, Patient 43 was observed lying in bed. The call light was non	A 395	immediately notify the Director of Engineering or designee and the House Supervisor. The Engineering Department will take the necessary steps to correct any failures of the call light system or notify the proper service or persons when the repair is beyond their capabilities. The Engineering Department will notify the applicable Department Manager or designee as to when the call light will be repaired. Nursing shall notify the patient(s) when there is an issue with the call system. Patients affected by the call light outage will be assigned a sitter per room or be relocated to a bed with an operational call light. The MEC and Governing Board approved the policy on 3/30/16. Nursing staff was inserviced on the policy, with special emphasis on how to report a non-functioning call light, assigning a sitter if a call light is not functioning, and placing call lights within a patient's reach. Engineering staff was also educated on the revised policy. 2. Hospital Leadership posted a "Be Sure to Know" Poster at each nursing station that details the process for reporting of equipment malfunction. If the repair is an emergency, such as the nurse call system, the staff is to institute emergency procedures to ensure patient care is not compromised, including paging Engineer to report the malfunction and contacting the Nursing Supervisor for assistance in relocating the patient or assigning a sitter. This poster is to serve a dual purpose; to increase awareness of the nurse to the patient's lack of communication when call	4/7/16

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A 395	Continued From page 10 functioning with no audible sound above the room door or at the nurse's station. During a review of the clinical record for Patient 43 with RN 22 and the ACNO, on 2/16/16, at 3:20 PM, the patient was admitted on 2/14/16 with diagnoses of Mysitis (inflammation and degeneration of the muscle tissue), difficulty walking, and diabetes. A care plan problem was noted for fall risk with an intervention which included "call bell within reach". 2d. During an observation of Room 105 Bed A with RN 25, on 2/16/16, at 12 PM, Patient 41 was observed sitting at the edge of the bed with a lunch tray on the bedside table. When the call light was pressed to determine if it was functioning as intended, the call light was not audible or visible above the room door or at the nurse's station. Patient 41 stated, she thought the call light was broken when she called last night and no one came. During an interview with Patient 41, on 2/16/16, at 1:38 PM, she stated she used the call light last night to get assistance to the bathroom. Patient 41 was asked how long she waited, but she was unsure. When no one came to her room, she walked to the door to ask for assistance. She said she used the call light again today to ask for a brief, but RN 22 entered the room as she was using her call light. During a review of the clinical record for Patient 41 with RN 22 and the ACNO, on 2/16/16, at 2:40 PM, the patient was admitted on 2/14/16 for complaints of abdominal pain. The care plan problem list was reviewed and it included a fall care plan. The interventions included "...call bell	A 395	lights are not available and to instruct the nurse on instituting the process for call light repair. 3. The hospital purchased 40 additional call lights to be available as needed for replacements. The Director of Engineering is responsible for ensuring that an adequate number of call lights are available in the event that replacements are necessary. 4. Hospital Leadership met with an outside vendor regarding replacing the existing call light system. An OSHPD project number was obtained (No. S160776-19 for the Norwalk Campus and No. S160777-19 for the L.A. Community campus). 5. Compliance with call lights functioning and within patient reach is monitored through the QAPI program. Compliance and Monitoring: The Director of Engineering or qualified designee makes rounds daily on all patient care units to ensure the call lights are functioning. Corrective action is taken as necessary, including relocating the patient/or obtaining a sitter for the patient room until the call light is repaired. In addition, the CNO or qualified designee makes daily observation rounds in each patient environment to ensure that call lights are within the patient's reach. Corrective action is taken, including just-in-time training with the nurse and relocating the call light within the patient's reach. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance	3/28/16 3/31/16

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A 395	Continued From page 11 within reach..." 2e. During an observation of Patient 40 with RN 25, on 2/16/16, at 11:55 AM, in Room 110 Bed C, the patient was observed lying in bed. A call light to contact the nurse was not noted within reach of the patient. The patient was asked if she had a call light that could be used to call the nurse. As she felt around her bed, she was unable to locate a call light. She stated she was unable to see due to being "Legally Blind and (having) Macular Degeneration (an eye disease that progressively causes severe vision loss)". RN 25 proceeded to feel around the bed for the call light, which was then given to the patient. After being given the call light, Patient 40 proceeded to demonstrate she could use the call light. During a review of the clinical record of Patient 40 and interview with RN 25, on 2/16/16, at 2:15 PM, Patient 40 was admitted on 2/15/16. The care plan list was reviewed. A care plan was developed for the patient's fall risk due to her age, and unfamiliar environment. An intervention for the fall risk care plan included "call bell within reach..." 2f. During an observation of the Medical Surgical unit with RN 25, on 2/16/16, at 11:46 AM to 11:55 AM, in addition to the above call light issues, the following was noted: Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 111 Bed D, the call light was non functioning with no audible sound above the room	A 395	is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Chief Nursing Officer Director of Engineering	

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A 395	Continued From page 12 door or at the nurse's station. Room 110 Bed B, the call light was on the bedside table and not accessible to the patient. During an interview with RN 25, on 2/16/16, at 11:50 AM, she was asked how long have the call lights not been functioning as intended. She stated, they have not been working "on and off" but did not indicate a specific time frame. She was asked the process when repair of equipment, such as the call lights, is required. She stated, a "work order is generated" which goes directly to the maintenance/engineering department. She was not certain whether a work order request was generated and sent to the maintenance/engineering department for the nonfunctioning call lights. During an interview with Engineer Staff 1, on 2/16/16, at 11:52 AM, he stated the maintenance department was aware of the nonfunctioning call lights in Room 111, but the call lights have been on back order for approximately six days. He stated they have no extra call lights available for patient use. During an interview with the ACNO, on 2/16/16, at 1:33 PM, she stated, "I didn't know (referring to being aware the call lights have not been working)." She indicated the problem should have been brought to her attention and was not. She was asked to provide the policy and procedure for the nurse call system and the nurses' responsibility. During a subsequent interview with the ACNO, on 2/16/16, at 3:26 PM, after reviewing the hospital's policies and procedures, she stated they had no policy and procedure for the nurse call system/call light	A 395		

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A 395	Continued From page 13 system and the nurses' responsibility. During an interview with Director of Plant Operations, on 2/16/16, at 1:40 PM, he stated ES 1 informed him of the nonfunctioning call lights. He was informed the call lights have not been functioning for 1 to 1 1/2 weeks. Because he did not know the type of call lights to order from the vendor, no call light replacements had been ordered. He acknowledged there was no work order request for the nonfunctioning call lights for Room 111 or 105. The hospital policy and procedure titled, "Reporting malfunction" effective date 6/15/09, indicated in part, "Equipment Malfunctions - Patient Care Equipment...When a malfunction is evident, the following steps should be taken...Double check procedure techniques to ascertain whether there is a true malfunction... If the malfunction continues to occur, call the Engineering department and inform them of the problem..." 3a. During a review of the clinical record for Patient 38, with RN 25, on 2/16/16, at 10:36 AM, the patient was admitted with diagnoses of cellulitis to the left foot and right big toe wound. In addition he was diagnosed with Diabetes with a physician's order to monitor blood sugars AC&HS (before each meal and at hour of sleep) and administer insulin as needed depending on the blood sugar results. A review of the blood sugar results in the clinical record showed the blood sugars were not monitored as ordered. RN 25 confirmed the blood sugars were not monitored as ordered. No further information was provided. 3b. During a review of the clinical record for	A 395	Finding 3 a – c Immediate Actions Taken: 1. Nursing Leadership reviewed Patient 38's findings and it was determined that nursing staff performed the blood sugar checks but had not documented it. There was no adverse outcome identified. The nurse was educated on documenting blood sugar results as soon as they are received. 2. The ACNO discussed the survey finding with patient 45's nurse, with emphasis on complying with physician orders and documenting care.	2/16/16 2/17/16

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A 395	Continued From page 14 Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. In addition to the order for the liquid nutrition to be taken via the NGT, there was an order for 200 cc's of water every six hours for a total of 800 cc's/24 hr of water daily. From 2/10/16 to 2/16/16, there was insufficient documented evidence the additional 800 cc's of water were provided as ordered. LVN 3 validated the findings. 3c. During a review of the clinical record for Patient 45 and interview with LVN 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order was noted to notify the physician if the blood sugar result was less than 60 milligrams per deciliter (mg/dl). On 2/15/16, at 6 PM, the blood sugar was 58 and there was no documented evidence the physician was notified. No further evidence was provided. 4a. During an observation in the emergency room, on 2/16/16, at 9 AM, with RN 26 (Nursing Supervisor), ACNO, and RN 16, the adult crash cart was noted with a red lock on it. A list of the contents was requested. RN 16 and RN 26 stated there is no list of contents, each drawer has a sticker with the list of contents on the sticker. The font size of the content sticker was difficult to read. On the top of the crash cart a sticker read "top of cart to side" included the ambu-bag. After searching for the ambu bag it was noted on another crash cart. The third	A 395	Subsequent Actions Taken: 1. Nursing Leadership discussed the survey findings and determined that nursing staff would benefit from "back to basics" education on following physician orders and documenting such action in the medical record. An end-of-shift chart review was instituted whereby each nurse is required to review all orders received during his/her shift and ensure these are noted and completed (carried out) accordingly. Nursing staff was reeducated via formal inservices, daily huddles (Monday through Friday) and 1:1 instruction. 2. Nursing Leadership developed a "Nursing Tip List," which is a reminder list for nurses to review and complete physician orders and document evidence of such in the medical record. 3. Compliance with following physician orders and documenting care/services rendered in the medical record is monitored through the QAPI program.	2/19/16 – 4/7/16 3/28/16

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A 395	Continued From page 14 Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. In addition to the order for the liquid nutrition to be taken via the NGT, there was an order for 200 cc's of water every six hours for a total of 800 cc's/24 hr of water daily. From 2/10/16 to 2/16/16, there was insufficient documented evidence the additional 800 cc's of water were provided as ordered. LVN 3 validated the findings. 3c. During a review of the clinical record for Patient 45 and interview with LVN 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order was noted to notify the physician if the blood sugar result was less than 60 milligrams per deciliter (mg/dl). On 2/15/16, at 6 PM, the blood sugar was 58 and there was no documented evidence the physician was notified. No further evidence was provided. 4a. During an observation in the emergency room, on 2/16/16, at 9 AM, with RN 26 (Nursing Supervisor), ACNO, and RN 16, the adult crash cart was noted with a red lock on it. A list of the contents was requested. RN 16 and RN 26 stated there is no list of contents, each drawer has a sticker with the list of contents on the sticker. The font size of the content sticker was difficult to read. On the top of the crash cart a sticker read "top of cart to side" included the ambu-bag. After searching for the ambu bag it was noted on another crash cart. The third	A 395	Compliance and Monitoring The Chief Nursing Officer or qualified designee shall review at least 20 records weekly to achieve the goal of 100% compliance with following physician orders and documenting execution of such orders in the medical record. Corrective action is taken, including nursing re-education. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer Finding 4 a –b Immediate Actions Taken: 1. The identified crash carts were checked for necessary supplies in accordance with the crash cart content list. Subsequent Actions Taken: 1. Nursing Leadership reviewed and revised the "Crash Cart" policy to align with current practice. The crash carts are sealed with a tamper resistant breakaway lock and	2/16/16 4/7/16

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A 395	Continued From page 15 drawer's sticker was partially torn off making it difficult to determine the exact contents of the third drawer. At 9:12 AM, the pediatric cart was observed. The pediatric crash cart had nine drawers with each drawer secured with blue plastic lock. It also had each drawer with a sticker indicating the contents inside the drawer. The bottom drawer of the cart indicated there was a "Medication Tray" and 2 IV (intravenous) start kits, 2 - extension sets, 2 - tuberculin syringes, 2 - 5 cc syringes, IV catheters including 2 - 24 gauge (g), 2 - 20 g, 2 - 22 g, 2 - 18 gauge. There were no IV start kits, no extension sets, no tuberculin syringes, no 5 cc syringes, no IV catheters of any size. This was validated by RN 26 and the ACNO. RN 26 stated, maybe it was mislabeled. When RN 26, was asked what happens to ensure the contents of the crash carts gets restocked and what happens to secure the contents of the crash carts until they are restocked. She stated the adult crash cart is secured after the central supply staff restocks it. The central supply staff places a green plastic lock which notifies staff it is ready for pharmacy to secure it and is ready and is fully stocked. She was unable to indicate what happens to the pediatric crash cart when the cart is opened to ensure it is secured until the contents are restocked. RN 26 stated, "once opened no way to secure .." 4b. During an observation and interview with ACNO and RN 28 (Charge Nurse to the Intensive Care Unit [ICU] and the telemetry unit), on 2/16/16, at 9:54 AM, an adult crash cart was noted in the telemetry hallway. The crash cart also had a sticker on each drawer identifying the content of each drawer. RN 28 was asked the process when the items in the crash cart are used. RN 28 stated, if the crash cart is opened	A 395	assigned a log number. As detailed in the policy, any time that a crash cart is opened, it will be replaced with a fully stocked cart by central supply staff/designee, and will be locked by pharmacy staff/nursing supervisor (off hours) after the medication tray is added. The cart will then be returned to the unit. The MEC and Governing Board approved the policy on 3/30/16. Nursing staff was re-educated on the policy. 2. Hospital Leadership reviewed and updated the contents of the pediatric and adult crash carts. A new "easy to read" content list is now located on the top of the crash carts. The crash cart defibrillator checklist is on each crash cart, which addresses, among other things, that the nurse checks that all drawers are locked with a numbered lock and the lock number matches the number on the medication drawer tag. If the numbers do not match, the nurse is to notify the pharmacist. Nursing staff was reeducated on the updated content list and checklist. 3. All adult and pediatric crash carts were checked to make sure that they contain the necessary supplies/medications. 4. The Hospital purchased 9 pediatric crash carts which were stocked with supplies and medications. The Hospital also purchased 25 new adult crash carts on 3/2/16, which the vendor anticipates will be delivered by 4/13/16.	3/1/16 -3/31/16 2/16/16 3/2/16 - 4/13/16

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A 395	Continued From page 16 there is no means to secure the contents including the emergency medications inside it. RN 28 stated, she would call the pharmacy to refill it. The policy and procedure for the crash cart was requested from ACNO. The hospital policy and procedure titled, "CRASH CART", undated, indicated, "To ensure the availability of appropriate medications and supplies to effectively resuscitate a cardiac or respiratory arrest patient. Each crash cart shall contain a standardized binder, which includes a crash cart content list... A process shall be employed that ensures drug security, control and the availability of drugs identified by the Medical Staff for emergency use... To ensure that crash carts are standardized throughout the department and the facility... All crash carts shall be sealed with a tamper resistant red breakaway lock and assigned a log number... Crash carts will be open in a Code blue situation... Any time that a crash cart is opened, it will be replaced with a fully stocked cart by central supply staff/ designees, and will be Locked by Pharmacy staff after medication tray is added. Then the cart will be returned to the unit... Immediately after the code, The Nursing Supervisor shall notify Central Supply and a fully restock replacement crash cart will be delivered to the patient care area..."	A 395	Compliance and Monitoring The Chief Nursing Officer or qualified designee performs a daily review of the crash carts to ensure the tamper resistant lock is intact to achieve the goal of 100% compliance with intact crash carts. Corrective action is taken, including nursing re-education. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	
(A 396)	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview and record	(A 396)	A 396 482.23(b)(4) Nursing Care Plan	

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{A 396}	Continued From page 17 review, the hospital failed to have pertinent, individualized nursing care plans for 12 of 31 sampled patients (29, 30, 38, 40, 42, 45, 47, 48, 49, 51, 52, 55). This had the potential that patients would not receive necessary care or have unmet care needs. Findings: 1. During an interview and review of the clinical record for Patient 29 on 2/17/16, at 8:45 AM, the consents and admission paperwork were in Spanish. The charge nurse, Registered Nurse (RN) 8, stated he only spoke Spanish. Several care plans (anxiety, safety, hemodialysis) care plans were reviewed. There was no notation that Patient 29 only spoke Spanish on any care plan. RN 8 and Licensed Vocational Nurse (LVN) 1 confirmed this. 2. During an interview and review of the clinical record for Patient 30 on 2/17/16, at 10 AM, he was admitted on 2/12/16. One of his diagnoses was influenza and isolation was ordered on 2/13/16. Patient 30's care plans were reviewed (safety, respiratory, anxiety). None of his care plans addressed Patient 30 was on isolation. The hospital policy and procedure titled "Care Plan, Patient Interdisciplinary Plan of Care", dated 11/2012, indicated: "Policy Purpose To provide each patient with an individual interdisciplinary plan of care that is collaborative and goal directed... A care plan outlines the care to be provided to an individual/family patient. It is a set of actions the care provider will implement to resolve/support nursing diagnoses identified by nursing assessment...that will include patient's admitting problems....needs, or other condition..."	{A 396}	Findings 1-11 Immediate Actions Taken: 1. Nursing staff updated the nursing care plans for the identified patients. 2. Nursing staff labeled and dated Patient 47 and 48's gastrostomy tube tubing. 3. The CNO and ACNO educated the applicable nurses at the time of survey regarding documenting individualized nursing care plans based on the patient's condition. Subsequent Actions Taken: 1. The CEO and Nursing Leadership discussed the survey findings regarding nursing care plans. In an attempt to refocus the nursing staff on critical thinking, paper nursing care plans were instituted to bring the nurse "back to basics." This method was pilot tested over a two-week period with nursing staff migrating from electronic care planning to paper care planning. After a two-week period, data collection and analysis revealed the paper process did not improve critical thinking and resultant improved documentation, as anticipated. After input from line nursing staff and analysis by Leadership, the request to revert back to an electronic care planning process was approved. Nursing staff was educated that care planning will revert back to the electronic format and renewed efforts will be applied to identifying the assessed needs of the patient and annotating these in the electronic care planning module. A process of concurrent record compliance monitoring,	2/16/16 2/16/16 2/16/16 4/7/16

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{A 396}	Continued From page 18 3. During a review of the clinical record for Patient 38, with RN 25, on 2/16/16, at 10:36 AM, the patient was admitted with diagnoses of cellulitis (bacterial skin infection) to the left foot and right big toe wound. There was no individualized care plan for the treatment to the left foot or an individualized care plan for the treatment of the right big toe. During an observation of Patient 38 and interview with RN 26 (the treatment nurse), on 2/16/16, at 11:30 AM, Patient 38's right and left foot wounds were noted. The left fourth toe was uncovered and blackened. The inner portion of the right big toe was reddened. A review of the care plans was conducted and there was one care plan problem that was not specific to either the left foot or right foot. RN 26 stated, there should be two care plans to outline the care of each of the identified areas since they require different treatment interventions. No additional information was provided. 4. During an observation of Patient 40 with RN 25, on 2/16/16, at 11:55 AM, in Room 110 Bed C, the patient was observed lying in bed. A call light to contact the nurse was not noted within reach of the patient. The patient was asked if she had a call light that could be used to call the nurse. As she felt around her bed, she was unable to locate a call light. She stated she was unable to see due to being "Legally Blind and (having) Macular Degeneration (an eye disease that progressively causes severe vision loss)". RN 25 proceeded to feel around the bed for the call light, which was then given to the patient. After being given the call light, Patient 40 proceeded to demonstrate she could use the call light.	{A 396}	whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/provider in real time, and provides "just in time" education and training to correct clinical or documentation process issues, was implemented. This method allows for role modeling of strong clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff learns from ongoing facilitation to identify, correct and improve practice weaknesses. A Care Facilitation worksheet was developed for use by the care facilitators which includes, among other things, accuracy and completeness of the care plan, and that the care plan reflects the assessed needs of the patient. This process was implemented on 4-7-16. Prior to this time, assigned staff were designated to review the care plan on the nursing units identifying deficiencies and working with staff to enhance understanding and improve the care planning process. 2. The "Care Plan, Patient Interdisciplinary Plan of Care" policy was reviewed and revised to align to current practice. The nursing staff develops and keeps current, a nursing care plan for each patient that addresses the patient's individual acute hospitalization needs based on assessment outcomes. The plan of care is collaborative and goal directed and outlines the care that is to be provided to the patient/family. The MEC and Governing Board approved the policy on 3/30/16. Nursing staff was inserviced on the policy and received	4/7/16

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{A 396}	Continued From page 19 During a review of the clinical record of Patient 40 and interview with RN 25, on 2/16/16, at 2:15 PM, Patient 40 was admitted on 2/15/16. The care plans were reviewed, and there was no care plan to ensure staff were aware of the patient's vision impairment and to ensure staff would implement the care needs of the patient with vision impairment. RN 22 verified the findings. 5. During a review of the clinical record for Patient 42 and interview with RN 22, on 2/16/16, at 2:50 PM, the admitting diagnosis included diabetes mellitus. The physician's orders indicated he was being treated with regular insulin based on the results of the routine fingersticks. The care plans were reviewed and there was no care plan for the diabetes mellitus to ensure staff were aware of appropriate interventions to treat the problem. 6. During a review of the clinical record for Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. The care plan problems for the patient were reviewed. The nutrition care plan included interventions for a patient who was receiving a diet orally and not a diet provided via a nasogastric tube. Documented interventions after the NGT was placed for nutrition included: "demonstrates appropriate selection of meals...eating in response to internal cues other than hunger...encourage water intake..." LVN 3	{A 396}	refreshed education on the precepts of care planning. 3. Hospital Leadership hired additional nursing management staff, including a Director of ED/ICU Services and Director of Medical Surgical Services. 4. Nursing staff is educated on nursing care plans upon hire. 5. Compliance with nursing care plans is monitored through the QAPI program. Compliance and Monitoring: Effective 4/7/16, data is collected by the care facilitators, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve 100% compliance. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	3/14/16

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{A 396}	Continued From page 20	{A 396}		

acknowledged these were not appropriate interventions for a patient receiving NGT feeding. No additional information was provided.

The hospital policy and procedure titled, "CARE PLAN, PATIENT INTERDISCIPLINARY PLAN OF CARE POLICY AND PROCEDURE" effective date 12/2015, indicated the purpose of the care plan is "To establish guidelines for the initiation of Interdisciplinary plan of care for each patient admission...A care plan outlines the care to be provided to an individual/family/patient. It is a set of actions the care provider will implement to resolve/support nursing diagnoses...The plan of care will be based on the assessed needs of the patient and will include goals, problems/needs, proposed intervention(s), expected outcomes..."

7. During an observation with RN 22, on 2/16/16, at 9:32 AM, in the patient's room, Patients 47 and Patient 48 were in bed with the head of the bed elevated at 45 degree angle. Patient 47 had a GT (Gastrostomy tube- a tube that has been surgically inserted in the stomach for the introduction of nutrient solution) formula of Fibersource HN (a nutritionally complete tube feeding formula with fiber) at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare (a therapeutic nutrition for people with COPD [chronic obstructive pulmonary disease], cystic fibrosis or respiratory failure patient) at 50 ml/hr. Patient 47 and Patient 48's GT tubing were not labeled and dated.

During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and 48 were unable to communicate because of their medical

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{A 396}	Continued From page 21 condition. RN 22 also stated she was unable to determine Patient 47 and 48's tubing for the formula were new or old. During a review of the clinical record for Patient 47, the Physician's Order dated 1/1/16, indicated Patient 47 to receive a Fibersource HN at 50 ml/hr by Gastrostomy tube. During further review of the clinical record, the nutrition care plan did not indicate Patient 47 was receiving formula through GT. During a review of the clinical record for Patient 48, the Physician's Order dated 2/1/16, indicated Patient 48 to receive Pulmocare at 50 ml/hr for 20 hours through GT. During further review of the clinical record, the nutrition care plan did not indicate Patient 48 was receiving formula through GT. During an interview with RN 22, on 2/16/16, at 10:05 AM, she reviewed the clinical record for Patients 47 and 48 and verified there was no care plan found for the use of GT formula feeding for both patients. 8. During an observation with RN 22, on 2/16/16, at 9:40 AM, in the patients room, Patient 49 was in bed with the head part slightly elevated at 30 degree angle. He has an oxygen inhalation via nasal cannula. Patient 49 waved his hand when he was asked how he was doing. During an interview with RN 22, on 2/16/16, at 9:42 AM, she stated Patient 49 was on Hemodialysis (a procedure in which impurities or wastes are removed from the blood) three times a week. RN 22 also stated Patient 49 was alert and oriented and he was able to make his needs	{A 396}		

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{A 396}	Continued From page 22 known. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." During further review of the clinical record for Patient 49, there was no documentation a care plan for Hemodialysis related to hypoxia was initiated. During an interview with LVN 3, on 2/16/16, at 10:07 AM, she reviewed the clinical record for Patient 49 and verified there was no care plan found for a Hemodialysis order on 2/16/16 due to patient's hypoxia. 9. During a review of the clinical record for Patient 51, the Physician's Order/Blood Product dated 2/10/16, indicated Patient 51 to receive PRBC (packed red blood cells- red blood cells separated from liquid plasma) 2 units. During further review of the clinical record, there was no documentation a care plan for blood transfusion (BT- the administration of whole blood or a component, such as packed red cells, to replace blood lost) of PRBC was developed. During an interview with LVN 3, on 2/16/16, at 10:15 AM, she reviewed the clinical record for Patient 51 and verified there was no care plan found for blood transfusion. 10. During a review of the clinical record for Patient 52, the Physician's Order dated 2/5/16, indicated Patient 52 to receive Lasix (medication to treat Pulmonary edema, edema with CHF, hepatic disease, nephrotic syndrome, ascites,	{A 396}		

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{A 396}	Continued From page 23 hypertension) 40 mg IV [intra-venous] daily. During further review of the clinical record, there was no documentation a care plan for the use of IV Lasix was initiated. During an interview with LVN 3, on 2/16/16, at 10:25 AM, she reviewed the clinical record for Patient 52 and she was unable to find a care plan for the IV Lasix. 11. During a review of the clinical record for Patient 55, the Physician's Order dated 2/14/16, indicated Patient 55 to receive an oxygen therapy of "Albuterol-ipatropium [a bronchodilator-anticholinergic medication to treat asthma, brochospasm, bronchitis and other reversible airway obstructions] inhalation 2.5 mg-0.5 mg - give 3 milliliters (ml) nebulizer [a method of administering a drug by producing a fine spray into the respiratory passages of the patient] every 6 hrs PRN [as necessary]." During further review of the clinical record, there was no documentation a care plan for the use of an oxygen therapy was initiated. During an interview with LVN 3, on 2/16/16, at 2:45 PM, she reviewed the clinical record for Patient 55 and verified there was no care plan found for the oxygen therapy.	{A 396}		
A 397	482.23(b)(5) PATIENT CARE ASSIGNMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by:	A 397	A 397 482.23(B)(5) Patient Care Assignments Immediate Actions Taken: 1. Hospital Leadership confirmed with RN 16 that she was oriented in October 2015. Documentation is now in RN 16's file as of 2/17/16.	2/17/16

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A 397	Continued From page 24 Based on interview and record review, the hospital failed to provide documented evidence one Registered Nurse (RN 16) was oriented to the emergency department (ED) when she was transferred there from another department. This had the potential to result in RN 16 being unprepared to perform her duties in the ED effectively affecting patient care. Findings: During an interview with RN 16, on 2/16/16, at 8:53 AM, she stated she has been an RN at the hospital for approximately two years. During a review of RN 16's personnel file and interview with Human Resource Coordinator, on 2/17/16, at 11:12 AM, it was noted RN 16 transferred to the ED on 11/1/15. There was no documentation RN 16 was oriented to the ED. No further evidence was provided.	A 397	Subsequent Actions Taken: 1. Hospital Leadership discussed the survey finding with the HR Coordinator. Employee files were checked to ensure that nursing staff has documented evidence of orientation to their work unit. 2. Hospital Leadership developed a "Unit Specific Orientation" policy. The purpose of this policy is to document the requirements for nursing orientation and required education for nursing staff transferring to another department. All transferring employees will receive Unit Based Orientation and Competencies related to their new Department. Department specific orientation is provided for all transferring staff. This program is designed to exhibit and/or review the nurse's competency in, but not limited to the following: location of crash cart and other emergent equipment;	4/7/16 3/30/16
{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure adequate supervision was provided to one contracted nursing personnel (Registered Nurse [RN] 23). This had the potential to result in lack of quality of	{A 398}		

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{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure adequate supervision was provided to one contracted nursing personnel (Registered Nurse [RN] 23). This had the potential to result in lack of quality of	{A 398}		

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{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure adequate supervision was provided to one contracted nursing personnel (Registered Nurse [RN] 23). This had the potential to result in lack of quality of	{A 398}	A398 482.23(b)(6) Supervision of Contract Staff Immediate Actions Taken: 1. The identified nurse was immediately educated on infection control practices, including personal protective equipment (PPE) and handwashing. The CEO notified the dialysis contractor and stated the nurse was not to return to the hospital. The CEO also notified the dialysis contractor that failure of the dialysis nurses to follow the hospital's infection control practices would not be tolerated. The dialysis contractor advised the dialysis nurses of strict adherence to infection control practices.	2/17/16

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{A 398}	Continued From page 25 care provided to patients. Findings: During an observation on 2/16/16, at 2 PM, in Patient 49's room, RN 23 was seated on a chair wearing a PPE (Personal Protective Equipment). The yellow gown was worn mid way exposing her chest and back showing her [nurse] uniform. She was also observed wearing a mask but it was underneath her chin. Patient 49 was in bed with the head part slightly elevated at 30 degree angle. Patient 49 was connected to a Dialysis machine. On top of the Dialysis machine was a binder, a tablet computer and a box of blue colored gloves. During further observation on 2/16/16, at 3:50 PM, in Patient 49's room, RN 23 had disconnected the tubing from Patient 49. She was still wearing the yellow gown mid way exposing her chest and back. She was also wearing gloves and a mask. After she had disconnected the tubing from Patient 49, at 3:55 PM, she took a bottle of distilled white vinegar and placed an amount halfway in the canister. She returned the canister back to the machine. She was observed going across the hallway to get some wipes from the purple top container (germicidal ultra bleach wipes) wearing the same gloves. After placing the wipes on top of the Hemodialysis machine, she removed her gloves and disposed of them and proceeded to the station without washing her hands. RN 23 was observed working for two hours but there was no evidence the hospital employees had told her to wear the PPE appropriately. During an interview with RN 23, on 2/16/16, at 4	{A 398}	Subsequent Actions Taken: 1. Nursing Leadership reviewed and revised the "Contract Employees" policy, to address that the ACNO or qualified licensed designee is responsible for oversight/supervision of the contracted nursing staff assigned to their unit (e.g., dialysis nurses). The MEC and Governing Board approved the policy on 4/1/16. Nursing were inserviced on the policy. Compliance and Monitoring The HR designee reviews five samples per month of contracted staff to ensure all components of the individual's personnel files are present, including competency evaluations. Additionally, Unit Directors and/or the ACNO make random weekly observation rounds when contracted staff are on the work schedule to ensure compliance with supervision of contracted staff. Corrective action is taken as necessary. Data on compliance is tracked, trended, analyzed and reported monthly to Quality Council and MEC. Data on compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Person Responsible: Chief Nursing Officer	4/7/16

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{A 398}	Continued From page 26 PM, she stated it was her first time to do a Hemodialysis treatment in the hospital. She stated she was using the dialysis binder to check for the parameters and the tablet computer was used for her to check the orders. She also stated she placed the box of gloves on top of the Hemodialysis machine as it was more convenient for her. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." The Physician's Order dated 2/12/16, indicated Patient 49 to receive Hemodialysis treatment every Monday, Wednesday and Friday (current Hemodialysis order). During an interview with the Vice President-Hospital Operations(VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of RN 23's care during a Hemodialysis treatment. VP 2 and RN 24 both stated RN 23 had violated the infection control practices.	{A 398}		
{A 454}	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by:	{A 454}	A454 482.24(c)(2) Content of Record: Orders Dated & Signed Findings 1-4 Immediate Actions Taken: 1. Hospital Leadership met with the Information Technology (IT) Department to discuss the status of implementing a hard stop in the electronic medical record that will require the physician to complete authentication of telephone/verbal orders before being allowed to write new orders.	2/24/16

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{A 454}	Continued From page 27 Based on interview and record review, the hospital failed to follow its policy and procedure of having telephone or verbal orders signed by the physician within 48 hours, for four of 31 sampled patients (28, 31, 32, 52). This has the potential that medical records are not maintained within current clinical record standards. Findings: 1. During a review of the clinical record and interview with Licensed Vocational Nurse (LVN) 1 on 2/17/16, at 9:20 AM, Patient 28 was admitted 1/27/16. Four telephone orders from 1/27/16 had not been signed as of 2/17/16, three weeks. This was verified by LVN 1. 2. During a review of the clinical record and interview with LVN 1 on 2/17/15, at 9:30 AM, Patient 31 was admitted 2/9/16 with the diagnosis of "Diabetic Foot Ulcer". Patient 31's physician's medication orders were reviewed: 1. Eight verbal/telephone orders from 2/9/16 had not been signed by the ordering physician (six days date). 2. One verbal/telephone order from 2/10/16 had not been signed (five days late). 3. Three verbal/telephone orders from 2/13/16 had not been signed (two days late). LVN 1 verified the information. 3. During a review of the clinical record and interview with LVN 1 on 2/17/16, at 9:30 AM, Patient 32 was admitted 12/3/15, with a diagnosis of "leukocytosis" (high white count, usually indicated infection). Robitussin DM (cough suppressant) was ordered verbally or by telephone on 1/8/16. It was not signed by the physician until 1/28/16, three weeks later. Pancrelipase (medication to help the body digest	{A 454}	Subsequent Actions Taken: 1. Hospital Leadership reviewed the "Telephone, Verbal and Written Order for Medication" Policy, which delineates the process for physicians to authenticate their telephone and verbal medication orders within 48 hours. The policy did not require any revisions. 2. Effective 2/24/16, the "Allscripts" EMR system requires physicians to authenticate their unsigned orders prior to proceeding with any other system function. A memo was sent to the practitioners with implementation of the hard stop in the Allscripts EMR system. 3. The issue of compliance with authentication of verbal and telephone orders was discussed at the 3/30/16 MEC meeting. A refresher memo was sent on 3/31/16 to medical staff members regarding authenticating telephone and verbal orders timely. 4. The Medical Staff Office worked with physicians to obtain remote access to the EMR system to allow for timely completion of telephone/verbal order authentication. 5. Compliance with authenticating telephone and verbal orders is monitored through the QAPI program.	2/24/16 2/24/16 3/31/16 4/7/16

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{A 454}	Continued From page 28 food) was ordered 1/21/16, either verbally or by telephone. As of 2/17/16, it had not been signed. Insulin was ordered 1/21/16 either verbally or by telephone. It was signed by the physician on 1/28/16, five days late. The hospital policy and procedure titled "Telephone, Verbal and written order for Medication", dated 2/20/15, indicated: "....The prescribing practitioner must sign the written record of the verbal/telephone medication order within 48 hours of giving order." 4. During a review of the clinical record for Patient 52, the Physician's Order dated 2/5/16, indicated Patient 52 to receive Lasix 40 mg IV daily. During further review of the clinical record, there was no documented evidence the verbal order for Patient 52 was authenticated by the physician since the date it was ordered. During an interview with LVN 3, on 2/16/16, at 10:25 AM, she reviewed the clinical record for Patient 52 and she verified the verbal order was not authenticated since it was ordered on 2/5/16.	{A 454}	Compliance and Monitoring The Director of Health Information or qualified designee performs random reviews of at least 20 medical records weekly to achieve the goal of 90% compliance with authenticating telephone and verbal orders. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible Director of Health Information Management Chief of Staff Chief Nursing Officer	
A 467	482.24(c)(4)(vi) CONTENT OF RECORD: ORDERS,NOTES,REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.	A 467	A 467 482.24(c)(4)(vi) Content of Record: Orders, Notes, Reports.	

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	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

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A 467	Continued From page 29 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure the licensed nurses documentation contained information necessary to monitor one of 31 sampled patient's condition (49) receiving a Hemodialysis (a procedure in which impurities or wastes are removed from the blood) treatment. This failure had the potential to result in unmet care needs. Findings: During an observation with Registered Nurse (RN) 22, on 2/16/16, at 9:40 AM, in the patient's room, Patient 49 was in bed with the head part slightly elevated at 30 degree angle. He had an oxygen inhalation via nasal cannula. Patient 49 waved his hand when he was asked how he was doing. During an interview with RN 22, on 2/16/16, at 9:42 AM, she stated Patient 49 was on Hemodialysis three times a week. RN 22 also stated Patient 49 was alert and oriented and he was able to make his needs known. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." During further review of the clinical record for Patient 49, there was no documentation by the licensed nursing staff for the Hemodialysis treatment ordered on 2/16/16. The Hemodialysis treatment was an additional order by the physician from Patient 49's current order of three times a week (Monday-Wednesday-Friday). It was ordered due	A 467	Immediate Actions Taken: 1. The ACNO discussed the survey findings with the applicable nurse, with special emphasis on reassessing the patient's status and documenting his/her condition in the medical record (e.g., a one time stat order for hemodialysis). Subsequent Actions Taken: 1. Nursing Leadership reviewed the "Assessment/Reassessment of Patient" policy. As delineated in the policy, the nurse shall reassess the inpatient at least every shift (or more frequent depending on the patient status) to document changes in the patient's condition and/or diagnosis and to determine the patient's response to interventions. Nursing reassessments will be documented in the appropriate section of the EMR. Nursing staff was reeducated on the policy. 2. Nurses are educated on assessments and reassessments upon hire. 3. A process of concurrent record compliance monitoring, whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/provider in real time, and provides "just in time" education and training to correct clinical or documentation process issues, was implemented. This method allows for role modeling of strong clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff learns from ongoing	2/17/16 3/1/16 - 3/15/16 4/7/16

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A 467	Continued From page 30 to Patient 49's hypoxia. During an interview with RN 24, on 2/17/16, at 9:15 AM, RN 24 reviewed the licensed nurses documentation and verified there was no information found for the Hemodialysis STAT order. He also stated the licensed staff did not document the reason for the order and Patient 49's response to the treatment. During an interview with Vice President- Hospital Operations (VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of the lack of documentation by the licensed nursing staff for the one time STAT order of Patient 49's Hemodialysis treatment. VP 2 and RN 24 both gave no further information. The hospital policy and procedure titled "Assessment/Reassessment of Patient" dated 4/16/15, read in part, "...A-3. The goal of the assessment/reassessment process is to provide the patient the best care and treatment possible... 7. All reported changes in patient condition will be documented, as well as the patient response in the medical record..."	A 467	facilitation to identify, correct and improve practice weaknesses. A Care Facilitation worksheet was developed for use by the care facilitators which includes, among other things, patient assessments and reassessments. This process was implemented on 4-7-16. Prior to this time, assigned staff were designated to review patient assessments and reassessments on the nursing units identifying deficiencies and working with staff to enhance understanding and improve the assessment process. 4. Compliance with assessing and reassessing patients and documenting the evaluation in the medical record is monitored through the QAPI program. Compliance and Monitoring Effective 4/7/16, care facilitation data will be forwarded daily (M-F) to Clinical Leadership and the CEO for immediate intercession if necessary. In addition, the CNO or qualified designee reviews at least 10 random medical records weekly to achieve the goal of 95% compliance with reassessments of the	
{A 701}	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to maintain a safe environment in the Urgent Care area when one oxygen tank was	{A 701}		

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A 467	Continued From page 30 to Patient 49's hypoxia. During an interview with RN 24, on 2/17/16, at 9:15 AM, RN 24 reviewed the licensed nurses documentation and verified there was no information found for the Hemodialysis STAT order. He also stated the licensed staff did not document the reason for the order and Patient 49's response to the treatment. During an interview with Vice President- Hospital Operations (VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of the lack of documentation by the licensed nursing staff for the one time STAT order of Patient 49's Hemodialysis treatment. VP 2 and RN 24 both gave no further information. The hospital policy and procedure titled "Assessment/Reassessment of Patient" dated 4/16/15, read in part, "...A-3. The goal of the assessment/reassessment process is to provide the patient the best care and treatment possible... 7. All reported changes in patient condition will be documented, as well as the patient response in the medical record..."	A 467	patient's condition and documenting the reassessment in the medical record. Corrective action is taken as necessary, including reeducation of staff. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	
{A 701}	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to maintain a safe environment in the Urgent Care area when one oxygen tank was	{A 701}	A 701 482.241(a) Maintenance of Physical Plant Immediate Actions Taken: 1. The portable oxygen tank was secured. 2/16/16 2. The Director of Respiratory Therapy inserviced staff at the time of the survey on securing oxygen tanks. 2/16/16 3. Respiratory staff reviewed all oxygen tanks at the time of survey to ensure that they were properly secured. 2/17/16 Subsequent Actions: 1. Additional education was provided to nursing and respiratory therapy staff on the importance of securing oxygen tanks. 3/1/16	

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{A 701}	Continued From page 31 unsecured. This had the potential for the area to be unsafe for patients, visitors and staff. Findings: During an initial observation in the Urgent Care on 2/16/16, at 8:45 AM, a portable oxygen tank was noted to be unsecured, leaning against a wall. The Chief Nursing Officer (CNO) agreed it was an unsafe situation and requested staff call Respiratory Care stat to secure the tank. At 9 AM, the CNO put the oxygen tank into a holder under an Urgent Care gurney.	{A 701}	2. Compliance with securing oxygen tanks is monitored through ongoing Environment of Care (EOC) rounding. Compliance and Monitoring: The Director of Respiratory Therapy or qualified designee performs random daily rounds of patient care areas to achieve the goal of 100% compliance with securing oxygen tanks. Corrective action is taken as necessary, including reeducation of staff. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until	
{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: 2. During an observation of the Medical Surgical (MS) unit with Registered Nurse (RN) 25, on 2/16/16, at 11:46 AM to 11:55 AM, the following was noted: Room 111 Bed C, the call light was nonfunctioning with no audible sound above the room door or at the nurse's station. Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 11 Bed G, the call light was found with the cord cut at the level of the wall. Room 111 Bed D, the call light was non	{A 724}	sustained compliance is achieved and	

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{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: 2. During an observation of the Medical Surgical (MS) unit with Registered Nurse (RN) 25, on 2/16/16, at 11:46 AM to 11:55 AM, the following was noted: Room 111 Bed C, the call light was nonfunctioning with no audible sound above the room door or at the nurse's station. Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 11 Bed G, the call light was found with the cord cut at the level of the wall. Room 111 Bed D, the call light was non	{A 724}	A724 482.41(c)(2) Facilities, Supplies, Equipment Maintenance Finding 2 Immediate Actions Taken: 1. Hospital Leadership took immediate action to address the call light findings at the time of survey. Call lights were checked at the L.A. and Norwalk campuses for functionality. The patients at the Norwalk campus with call lights that needed repair were provided with a sitter. The patients at the L.A. campus with call lights that needed repair were relocated to a room with a functioning call light. 2. Hospital Leadership notified the House Supervisors that patients were only allowed to be in a room with a call light that needed repair if the patient was provided with a sitter. Otherwise, the bed was to be closed and not for patient use.	2/16/16 2/16/16

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{A 724}	Continued From page 32 functioning with no audible sound above the room door or at the nurse's station. Room 105 Bed A, the call light was non functioning and was not audible or visible above the room door or at the nurse's station. During an interview with RN 25, on 2/16/16, at 11:50 AM, she was asked how long have the call lights not been functioning as intended? She stated, they have not been working "on and off" but did not indicate a specific time frame. She was asked the process when repair of equipment, such as the call lights, is required. She stated, a "work order is generated" which goes directly to the maintenance department. She was not certain whether a work order request was generated and sent to the maintenance department for the nonfunctioning call lights. During an interview with Engineer Staff (ES) 1, on 2/16/16, at 11:52 AM, he stated the maintenance department was aware of the nonfunctioning call lights in Room 111 but the call lights have been on back order for approximately six days. He indicated he was the staff who cut the the cord to 111 Bed G otherwise it would keep signaling. He stated they have no extra call lights available for patient use. During an interview with Director of Plant Operations (DPO), on 2/16/16, at 1:40 PM, he stated ES 1 informed him of the nonfunctioning call lights. He was informed by ES 1 the call lights have not been functioning for 1 to 1 1/2 weeks. Because he did not know the type of call lights to order from the vendor, no call light replacements had been ordered. He was asked if the maintenance department has a system to	{A 724}	Subsequent Actions Taken: 1. Hospital Leadership discussed the survey findings. The "Reporting Malfunction" policy was reviewed and did not require any revisions. The "Utility Disruption: Nurse Call System" policy was also reviewed and revised to align with current practice in the event of a disruption in the nurse call light system. Upon identification of a malfunctioning call light, the staff is to immediately notify the Director of Engineering or designee and the House Supervisor. The Engineering Department will take the necessary steps to correct any failures of the call light system or notify the proper service or persons when the repair is beyond their capabilities. The Engineering Department will notify the applicable Department Manager or designee as to when the call light will be repaired. Nursing shall notify the patient(s) when there is an issue with the call system. Patients affected by the call light outage will be assigned a sitter per room or be relocated to a bed with an operational call light. The MEC and Governing Board approved the policy on 3/30/16. Nursing and engineering staff were inserviced on the policy. 2. The Hospital purchased forty (40) additional call lights to be available as replacements as needed. The Director of Engineering is responsible for ensuring that an adequate number of call lights are available in the event that replacements are necessary. 3. Hospital Leadership met with an outside vendor regarding replacing the existing call light system. An OSHPD project number was	3/1/16 - 4/7/16 3/13/16 4/7/16

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(A 724)	Continued From page 33 monitor the patients' call lights routinely to ensure they are in working order. He acknowledged the maintenance department does not check the call lights to ensure they are in working order. He acknowledged there was no work order request for the nonfunctioning call lights for Room 111 or 105. The hospital policy and procedure titled, "Reporting malfunction" effective date 6/15/09, indicated in part, "Equipment Malfunctions - Patient Care Equipment...When a malfunction is evident, the following steps should be taken...Double check procedure techniques to ascertain whether there is a true malfunction... If the malfunction continues to occur, call the Engineering department and inform them of the problem..." Based on observation, interview, and record review, the hospital failed to ensure a safe environment when: 1. Hazardous chemicals were not stored according to policy and procedures. This had the potential to result in staff lacking awareness for safety. 2. Several call lights were not functioning as intended. This had the potential for patients to be unable to call for assistance which impacts the patient's safety. Findings: 1. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:35 AM, at the back of the hospital's driveway, a Water Supply Room (Locked area) had 264 gallon bottles of drinking	(A 724)	obtained (No. S160887-19 for Norwalk campus and S160777-19 for Los Angeles Community campus). 4. Compliance with call lights functioning is monitored through the QAPI program. Compliance and Monitoring: The Director of Engineering or qualified designee makes rounds daily on all patient care units to ensure the call lights are functioning. Corrective action is taken as necessary, including relocating the patient/ or obtaining a sitter for the patient room until the call light is repaired. Data is analyzed and reported monthly to the EOC Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Engineering Finding 1 Immediate Actions Taken: 1. The identified chemicals were immediately removed from next to the emergency water supply and placed in	2/16/16

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{A 724}	Continued From page 34 water. There was a total of 1370 gallons of water inside the supply room. Besides the gallons of water, there were six containers (5 gallons each) of Enerex Chemical (a chemical compound used for treating steam boiler water in food and industrial plants) close to the door. One Enerex Chemical container was open and without a cover. The containers were marked as "Corrosive (is one that will destroy and damage other substances with which it comes into contact: it causes chemical burns on contact)." During an interview with LE 2, on 2/16/16, at 8:37 AM, he stated the chemicals were used for the boiler. He also stated the containers should have not been inside the water supply room or close to the water bottles. He was aware the chemicals were marked as corrosive. The hospital policy and procedure titled "Management of Hazardous Chemicals" dated 1/2015, read in part, "...7.5.5 Materials which are toxic as stored or which can decompose into toxic components from contact with heat, moisture, acids, or acid fumes should be stored in a cool, well ventilated place out of the direct rays of the sun...7.5.6 Corrosive materials are stored in a cool, well-ventilated area (i.e., above their freeze point) and in containers that will contain spills or leaks. NOTE: The containers are inspected at regular intervals to ensure they are labeled and kept closed. 7.5.7 Corrosives are isolated from other materials..."	{A 724}	area adjacent to the engineering department. 2. The Hospital purchased and installed a corrosive and flammable safety cabinet at the Norwalk campus and the identified chemicals were placed in the cabinet. Subsequent Actions Taken: 1. Hospital Leadership and the Director of Engineering reviewed the types of chemicals stored and the storage containers. In order to assure that all hazardous chemicals are stored in accordance with applicable regulation(s), the Hospital ordered corrosive, as well as flammable safety cabinets, which were installed on the L.A. Campus by 4/7/16. 2. The Director of Engineering reviewed the "Management of Hazardous Chemicals" policy, which did not require any revision. Hazardous materials and their wastes will be handled in a safe and compliant manner. Corrosive materials are isolated away from other materials and stored in a cool, well-ventilated area in containers that will contain spills or leaks. Engineering staff was reinserviced on the policy. 3. Monitoring storage of hazardous chemicals is part of weekly EOC rounds. In addition, hazardous chemical storage areas are inspected at least annually to evaluate the effectiveness of the storage, as well as	2/17/16 4/7/16 2/17/16 - 4/7/16
{A 747}	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an	{A 747}		

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{A 747}	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an	{A 747}	A747 482.42 Infection Control The Hospital assures that it has a comprehensive infection control program that provides for the prevention, control and investigation of infections and communicable diseases. The Hospital hired a	4/7/16

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{A 747}	Continued From page 35 active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the hospital failed to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases and conduct an active program for the prevention, control and investigation of infections and communicable diseases. These failures place the patient population, visitors and staff at risk for hospital acquired infections when: 1. Terminal cleaning (thorough cleaning done at the end of the work day to eliminate as many disease causing bacteria or viruses) was not performed daily in the areas connected to the operating rooms. The endoscopy processing room (specialized room used to clean medical equipment used for procedures) had no door to prevent the spreading of pathogens (disease causing bacteria or virus) into the restricted area of the operating room. (Refer to A 749, item 1) 2. Clean and sterile supplies were stored in the decontamination room. (Refer to A 749, item 2) 3. Operating room number two (one of two) did not meet state environmental standards. (Refer to A 749, item 3) 4. Surgical instruments were not properly sterilized. (Refer to A 749, item 4) 5. Glucometers (small, portable, hand held instrument that measure blood glucose immediately) were not disinfected between	{A 747}	new Director of Infection Control on 3/14/16, who reviewed the survey findings with Hospital Leadership and worked collaboratively to address the identified issues as discussed below. The Infection Control Annual Plan was reviewed and did not require any revision. The Director of Infection Control makes weekly rounds of patient care areas and also participates in monthly EOC rounds. An Infection Control Committee meeting was held on 4/6/16 to discuss the survey findings and compliance efforts. Data on compliance with infection control practices is monitored through the QAPI program. Finding 1 The identified room received a terminal cleaning. Hospital Leadership and the Director of Infection Control discussed the survey findings with the Director of Environmental Services (EVS) and Interim Director of the Operating Room (OR), with emphasis on compliance with terminal cleaning of the perioperative areas. A policy entitled "The Environmental Sanitation Perioperative Setting" policy was developed to address the terminal cleaning process and the "Perioperative Services EVS Terminal Cleaning Log" was reviewed and revised to be more comprehensive. As detailed in the policy, all procedure rooms, the scrub areas, the sterile instrument room and the sterile processing department are terminally cleaned on a daily basis when the scheduled procedures are completed for the day and each 24-hour period during the regular work	3/14/16 4/6/16 2/17/16 - 4/7/16

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{A 747}	Continued From page 36 patient use. (Refer to A 749, item 5) 6. Healthcare workers did not have adequate vaccination screening. (Refer to A 749, item 6) 7. Within the Urgent Care, employees' personal belongings were placed in clean areas. One employee was observed eating in the nursing station. (Refer to A 749, item 7) 8. On Unit III, family and staff were not following appropriate isolation measures. (Refer to A 749, item 8) 9. Improperly handled soiled linen. (Refer to A 749, item 9) 10. Improperly stored medical waste. (Refer to A 749, item 10) 11. New Gastrostomy (GT, a tube inserted directly into the stomach to provide nutrition) tubing was not labeled with time, date and initials of person hanging the feeding. (Refer to A 749, item 11) 12. In the telemetry unit, Personal Protective Equipment (PPE) was not utilized appropriately by staff. (Refer to A 749, item 12) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure a sanitary environment environment placing all patients, staff and visitors at risk of being exposed to infections and communicable diseases.	{A 747}	Finding 7 The employee belongings and the identified supplies were removed from the clean /dirty utility room in the Urgent Care area. This room is now designated as a dirty utility room only. An alternate area for employee belongings was created in the nursing station. Nursing staff was inserviced on use of this dirty utility room and storage of their belongings. The identified nurse was notified that the facility does not allow food consumption in the nursing station. The break room or cafeteria is where food consumption occurs. The Director of Infection Control, Nursing Leadership and consultants provided real time education to nursing staff in all patient care areas on storage of personal belongs and not eating in the nursing station. Finding 8 The Senior Vice President (VP) of Quality inserviced the identified nurse on proper use of PPE. The family belongings were removed from the room and the family was inserviced on the use of PPE before entering the patient's room. Formal education to nursing staff on use of PPE was implemented. Staff are trained on use of PPE upon hire and during annual skills day. RN 16's file was reviewed and it was identified that her antibody titer indicated that she had immunity and did not require the vaccination. Hospital Leadership reviewed	2/17/16 - 3/17/16 2/17/16 - 4/1/16
{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM	{A 749}		

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{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM	{A 749}		

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{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM	{A 749}	A 749 482.42(a)(1) Infection Control Program	

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{A 749}	Continued From page 37 The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: 7. During a concurrent observation and interview with the Chief Nursing Officer (CNO) and the Quality Analyst in the Urgent Care Center on 2/16/16, at 3:10 PM, in the Clean/Dirty utility room, two staff's personal back packs and one jacket are on the counter next to the sink, in the clean area. Binders, Christmas decorations, personal containers are stacked up within approximately 4" of the ceiling. The CNO verified "The top of the stack of boxes, etc, are too close to the ceiling. This room is really like a supply room rather than a Utility Room." During an observation in the Urgent Care Center on 2/17/16, at 8:25 AM with IC 2 and Licensed Vocational Nurse (LVN) 1, LVN 2 was noted to be eating within the nurse' station area. The smell of her food permeated the area. One patient was in the treatment area and the pediatrics' door was shut. IC 2 stated, "She's not supposed to be eating there." 8. During an observation on Unit III on 2/16/16, at 9:30 AM with IC 2 and LVN 1, Patient 30 was in isolation with a diagnosis of influenza. A family member put on the Personal Protection Equipment (PPE) which included a gown, mask and gloves before entering the room. This family member then placed her purse strap over her shoulder and entered Patient 30's room with the purse fully exposed. IC 2 asked the charge nurse	{A 749}	Finding 7 Actions Taken: 1. The employee belongings and the identified supplies were removed from the clean /dirty utility room in the Urgent Care area. This room is now designated as a dirty utility room only. An alternate area for employee belongings was created in the nursing station. Nursing staff was inserviced on use of this dirty utility room and storage of their belongings. 2. The identified nurse was notified that the facility does not allow food consumption in the nursing station. The break room or cafeteria is where food consumption occurs. 3. The Director of ICU/ED reeducated nursing staff on infection control practices, including the Hospital's policy on no food consumption in nursing stations. 4. The Director of Infection Control, Nursing Leadership and consultants provided real time education to nursing staff in all patient care areas on storage of personal belongs and not eating in the nursing station. Compliance and Monitoring: The Director of Infection Control or qualified designee makes at least weekly random rounds in nursing care areas to achieve the goal of 100% compliance with proper storage in dirty utility rooms and not eating in nursing stations. Corrective action is taken as necessary, including just-in-time training. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained	2/19/16 and 3/17/16 2/17/16 2/19/16-3/17/16 2/17/16

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{A 749}	Continued From page 38 (RN 10) who had instructed this family member how to protect herself using PPE. RN 10 then put on a gown, mask and gloves and entered Patient 30's room. RN 10 did not tie the isolation gown in the back and the front neckline of the gown dropped down to her right elbow, exposing the top of her uniform, while she spoke to Patient 30 and his family member. During a review of RN 16's personnel file with Human Resource Coordinator, on 2/17/16, at 11:15 AM, the Hepatitis B vaccine acceptance/refusal form dated 12/9/13, was noted. On the form, RN 16 documented that she would accept the Hepatitis B vaccine. There was no documented evidence the Hepatitis B vaccine was offered and/or given to RN 16. No further evidence was provided. 9. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:50 AM, at the back of the hospital's driveway, a soiled linen cart full of soiled linens (enclosed in plastic bags) was found unsecured close to the main oxygen supply tank storage area. The linen cart was unattended. During an interview with LE 2, on 2/16/16, at 8:52 AM, he stated the housekeeping staff forgot to store the cart inside the dirty linen locked storage room. He also stated the housekeeping staff collects the carts from the hospital and they would push them inside the dirty linen storage room. 10. During an observation with LE 2 and RN 22, on 2/16/16, at 9:10 AM, at the back patio, the "Biohazardous and Medical Wastes" locked storage area contained nine medical wastes containers. It was observed eight of the nine	{A 749}	compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control Finding 8 Actions Taken: 1. The Sr. VP of Quality inserviced the identified nurse on proper use of PPE. The family belongings were removed from the room and the family was inserviced on the use of PPE before entering the patient's room. 2. The prior Director of Infection Control inserviced nursing staff on other patient care units on PPE for staff and family at the time of survey. 3. Formal education to nursing staff on use of PPE was implemented. 4. Staff are trained on use of PPE upon hire and during annual skills day. 5. RN 16's file was reviewed and it was identified that her antibody titer indicated that she had immunity and did not require the vaccination. 6. Hospital Leadership reviewed and revised the hepatitis vaccination consent/declination form to clarify that the vaccine is only	2/17/16 2/17/16 3/1/16 - 3/15/16 2/17/16 4/1/16

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{A 749}	Continued From page 38 (RN 10) who had instructed this family member how to protect herself using PPE. RN 10 then put on a gown, mask and gloves and entered Patient 30's room. RN 10 did not tie the isolation gown in the back and the front neckline of the gown dropped down to her right elbow, exposing the top of her uniform, while she spoke to Patient 30 and his family member. During a review of RN 16's personnel file with Human Resource Coordinator, on 2/17/16, at 11:15 AM, the Hepatitis B vaccine acceptance/refusal form dated 12/9/13, was noted. On the form, RN 16 documented that she would accept the Hepatitis B vaccine. There was no documented evidence the Hepatitis B vaccine was offered and/or given to RN 16. No further evidence was provided. 9. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:50 AM, at the back of the hospital's driveway, a soiled linen cart full of soiled linens (enclosed in plastic bags) was found unsecured close to the main oxygen supply tank storage area. The linen cart was unattended. During an interview with LE 2, on 2/16/16, at 8:52 AM, he stated the housekeeping staff forgot to store the cart inside the dirty linen locked storage room. He also stated the housekeeping staff collects the carts from the hospital and they would push them inside the dirty linen storage room. 10. During an observation with LE 2 and RN 22, on 2/16/16, at 9:10 AM, at the back patio, the "Biohazardous and Medical Wastes" locked storage area contained nine medical wastes containers. It was observed eight of the nine	{A 749}	administered if indicated by negative titers. 7. The Director of HR created a spreadsheet of vaccinations that includes hepatitis consent and declination. The spreadsheet is updated at least weekly. Compliance and Monitoring: The Director of Infection Control or qualified designee performs at least weekly rounds to monitor compliance with PPE. The goal of compliance is 100%. In addition, the Director of Infection Control reviews the spreadsheet compiled by the Director of HR weekly to monitor compliance with employee immunizations. Corrective action is taken as necessary, including just-in-time training for PPE. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Director of Infection Control Director of HR	2/24/16

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{A 749}	Continued From page 38 (RN 10) who had instructed this family member how to protect herself using PPE. RN 10 then put on a gown, mask and gloves and entered Patient 30's room. RN 10 did not tie the isolation gown in the back and the front neckline of the gown dropped down to her right elbow, exposing the top of her uniform, while she spoke to Patient 30 and his family member. During a review of RN 16's personnel file with Human Resource Coordinator, on 2/17/16, at 11:15 AM, the Hepatitis B vaccine acceptance/refusal form dated 12/9/13, was noted. On the form, RN 16 documented that she would accept the Hepatitis B vaccine. There was no documented evidence the Hepatitis B vaccine was offered and/or given to RN 16. No further evidence was provided. 9. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:50 AM, at the back of the hospital's driveway, a soiled linen cart full of soiled linens (enclosed in plastic bags) was found unsecured close to the main oxygen supply tank storage area. The linen cart was unattended. During an interview with LE 2, on 2/16/16, at 8:52 AM, he stated the housekeeping staff forgot to store the cart inside the dirty linen locked storage room. He also stated the housekeeping staff collects the carts from the hospital and they would push them inside the dirty linen storage room. 10. During an observation with LE 2 and RN 22, on 2/16/16, at 9:10 AM, at the back patio, the "Biohazardous and Medical Wastes" locked storage area contained nine medical wastes containers. It was observed eight of the nine	{A 749}	Finding 9 Actions Taken: 1. The soiled linen cart was secured and relocated to the dirty linen storage room. 2. The Hospital purchased new linen cart covers for dirty linen. 3. The Director of EVS inserviced staff on storage of dirty linen. Compliance and Monitoring The Director of Infection Control or qualified designee performs random rounds at least weekly to achieve the goal of 100% compliance with storing of soiled linen carts. Corrective action is taken as necessary, including reeducation of staff. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control Finding 10 Actions Taken: 1. The identified medical waste containers were secured.	2/16/16 3/2/16 - 4/7/16 2/16/16

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{A 749}	Continued From page 39 containers were not properly sealed and without the secured tape on both sides. The containers were also found to have several used intravenous medication tubing sticking out of the containers. During an interview with RN 22, on 2/16/16, at 9:12 AM, she stated the staff should have placed the secured tape label on both sides and before the housekeeping staff would bring them to the storage area. The hospital policy and procedure titled "MEDICAL WASTE MANAGEMENT PLAN CHECKLIST" dated 8/2007, read in part, "...Indicate in the medical waste management plan that the accumulation area utilized by the facility to store containers of medical waste for accumulation must be secured so as to prevent or deny access by unauthorized persons and posted with warning signs, on or adjacent to, the exterior of the entry doors, on entry doors, gates, or lids..." 11. During a concurrent observation and interview with RN 22, on 2/16/16, at 9:32 AM, in the patients' room, Patients 47 and Patient 48 were in bed with the head part elevated at 45 degree angle. Patient 47 had a GT formula of Fibersource HN at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare at 50 ml/hr. Patient 47 and 48's GT tubing were not labeled and dated. During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and Patient 48 were unable to communicate because of their medical condition. RN 22 also stated she was unable to determine Patient 47 and Patient 48's tubing for the formula were new or old.	{A 749}	2. Hospital Leadership reviewed the "Medical Waste Management Plan Checklist", which did not require any revision. Nursing and EVS staff were reinserviced on the process for securing the medical waste containers. 3. The Hospital purchased new medical waste containers for pharmaceutical waste to ensure proper disposal of medical/ pharmaceutical waste. Compliance and Monitoring: The Director of Infection Control or qualified designee performs random rounds at least weekly to achieve the goal of 100% compliance with storing and securing medical waste containers. Corrective action is taken as necessary, including reeducation of staff. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control	4/7/16 4/7/16

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{A 749}	Continued From page 39 containers were not properly sealed and without the secured tape on both sides. The containers were also found to have several used intravenous medication tubing sticking out of the containers. During an interview with RN 22, on 2/16/16, at 9:12 AM, she stated the staff should have placed the secured tape label on both sides and before the housekeeping staff would bring them to the storage area. The hospital policy and procedure titled "MEDICAL WASTE MANAGEMENT PLAN CHECKLIST" dated 8/2007, read in part, "...Indicate in the medical waste management plan that the accumulation area utilized by the facility to store containers of medical waste for accumulation must be secured so as to prevent or deny access by unauthorized persons and posted with warning signs, on or adjacent to, the exterior of the entry doors, on entry doors, gates, or lids..." 11. During a concurrent observation and interview with RN 22, on 2/16/16, at 9:32 AM, in the patients' room, Patients 47 and Patient 48 were in bed with the head part elevated at 45 degree angle. Patient 47 had a GT formula of Fibersource HN at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare at 50 ml/hr. Patient 47 and 48's GT tubing were not labeled and dated. During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and Patient 48 were unable to communicate because of their medical condition. RN 22 also stated she was unable to determine Patient 47 and Patient 48's tubing for the formula were new or old.	{A 749}	Finding 11 Actions Taken: 1. The identified GT tubing was changed and labeled and dated. 2. The "IV/Enteral Tubing Change" policy was reviewed and did not require any revision. The policy was dated as of the last date of review. Tubing is to be labeled with the date, time and initials of the person performing the tubing change. Nursing staff were reinserviced on the policy. 3. Compliance with labeling IV/enteral tubing is monitored through the QAPI program. 4. Nursing is educated on IV/enteral tubing change, dating and labeling upon hire. 5. Observation rounds were implemented to measure compliance with proper tubing labeling. A daily "flash" tool is completed by Nursing Supervisors, which include, among other issues, verification of tubing labeling. Compliance and Monitoring: In addition to other compliance monitoring, the organization instituted an observation based unit inspection process and completion of the "flash" tool. Observation rounding is performed by a designated individual from a criteria driven list and is included in Medication Pass audits. Focused rounding is performed by leadership and includes myriad compliance issue checks, one of which is tubing labeling. Should issues be identified, corrective action is taken as necessary, including just-in time training of staff. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other	2/16/16 4/7/16 2/27/16

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{A 749}	Continued From page 40 The hospital policy and procedure titled "IV/Enteral Tubing Change" undated, read in part, "...Tubing Changes: Enteral/Tube Feeding - every 24 hours...DOCUMENTATION: 1. All IV (Intravenous)/Enteral tubing changes are to be documented on the nursing flowsheet. 2. New tubing should be labeled with date, time and initials of person doing the tubing change..." 12. During an observation on 2/16/16, at 2 PM, in Patient 49's room, RN 23 was seated on a chair wearing a PPE. The yellow gown was worn mid way exposing her chest and back showing her nurse uniform. She was also observed wearing a mask but it was underneath her chin. Patient 49 was in bed with the head part slightly elevated at 30 degree angle. Patient 49 was connected to a dialysis machine. On top of the dialysis machine was a binder, a tablet computer and a box of blue colored gloves. During further observation on 2/16/16, at 3:50 PM, in Patient 49's room, RN 23 had disconnected the tubing from Patient 49. She was still wearing the yellow gown mid way exposing her chest and back. She was also wearing gloves and a mask. After she had disconnected the tubing from Patient 49, at 3:55 PM, she took a bottle of distilled white vinegar and placed an amount halfway in the canister. She returned the canister back to the machine. She was observed going across the hallway to get some wipes from the purple top container (germicidal ultra bleach wipes) wearing the same gloves. After placing the wipes on top of the Hemodialysis machine, she removed her gloves and disposed of them and proceeded to the station without washing her hands. RN 23 was	{A 749}	month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control Finding 12 Immediate Actions Taken: 1. The identified nurse was immediately educated on infection control practices, including PPE and handwashing. The CEO notified the dialysis contractor and stated the nurse was not to return to the hospital. The CEO also notified the dialysis contractor that failure of the dialysis nurses to follow the hospital's infection control practices would not be tolerated. The dialysis contractor advised the dialysis nurses of strict adherence to infection control practices. Compliance and Monitoring The Director of Infection Control performs random observations of dialysis cases to ensure dialysis nurses wearing appropriate PPE and performing infection control practices performing hemodialysis procedures to achieve the goal of 100%	2/17/16

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{A 749}	Continued From page 41 observed working for two hours but there was no evidence the hospital employees had told her to wear the PPE appropriately. During an interview with RN 23, on 2/16/16, at 4 PM, she stated it was her first time to do a Hemodialysis (process involving a large portable machine that is attached to a patient so that their blood toxins and other fluids can be removed when the patient's kidneys no longer do it) treatment in the hospital. She stated she was using the dialysis binder to check for the parameters and the tablet computer was used for her to check the orders. She also stated she placed the box of gloves on top of the Hemodialysis machine as it was more convenient for her. During an interview with the Vice President-Hospital Operations(VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of RN 23's care during a Hemodialysis treatment. VP 2 and RN 24 both stated RN 23 had violated the infection control practices. Based on observation, interview, and document review, the hospital failed to maintain a clean hospital with cleaning procedures maintained to minimize and treat infections or communicability of diseases when: 1. Terminal cleaning (thorough cleaning done at the end of the work day to eliminate as many disease causing bacteria or viruses) was not performed daily in the areas connected to the operating rooms. The endoscopy processing room (where examination equipment is cleaned) had no door to prevent the contamination of pathogens (disease causing bacteria or virus) into	{A 749}	compliance with infection control practices including use of PPE, hand washing, and maintaining a clean environment. Corrective action is taken as necessary, including reeducation. Data on compliance is tracked, trended, analyzed and reported monthly to Quality Council and MEC. Data on compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control	

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{A 749}	Continued From page 42 the restricted area of the operating room. 2. Clean and sterile supplies were stored in the decontamination room. 3. Operating room number two (one of two) did not meet state environmental standards. 4. Surgical instruments were not properly sterilized. 5. Glucometers (small, portable, hand held instrument that measure blood glucose immediately) were not disinfected between patient use. 6. Healthcare workers did not have adequate vaccination screening. 7. Within the Urgent Care, employees' personal belongings were placed in clean areas. One employee was observed eating in the nursing station. 8. On Unit III, family and staff were not following appropriate isolation measures. 9. Improperly handled soiled linen. 10. Improperly stored medical waste. 11. New Gastrostomy (GT a tube inserted directly into the stomach to provide nutrition) tubing was not labeled with time, date and initials of staff who hung the feeding. 12. In the telemetry unit, Personal Protective Equipment (PPE) was not utilized appropriately by staff.	{A 749}		

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{A 749}	Continued From page 43 These failures have the potential to transmit infections to patients, staff and visitors. Findings: 1. On 2/16/16 at 8:40 AM in the surgical department of the hospital with Operating Room Technician (ORT) 1, Registered Nurse (RN) 29 (charge nurse) and RN 30 (circulating nurse), it was observed that the specialized room used to clean medical equipment used for procedures was adjacent to Operating Room (OR) 2, separated by a door, but open to the sterile part of the OR. During closer inspection, it was noted that the floor of the cleaning room was sticky to the foot and visibly soiled. RN 29 provided a check list for the terminal cleaning of the department, which is completed by environmental services at the end of each day. The last noted signature was dated 1/23/16 at 2 PM. No hospital policy on terminal cleaning of the perioperative areas was presented upon request prior to the end of the survey. On 2/16/16, during an interview with the Infection Control (IC) at 9:30 AM, he stated that the hospital has adopted the Association of periOperating Registered Nurses Guidelines (AORN) Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. According to AORN Guidelines for Perioperative Practice, Guideline for Environmental for Environmental Cleaning, Section V., Terminal cleaning and disinfection of perioperative areas, including sterile processing areas, should be	{A 749}	Finding 1 1. The identified room received a terminal cleaning. 2. Hospital Leadership and the Director of Infection Control discussed the survey findings with the Director of EVS and Interim Director of the OR, with emphasis on compliance with terminal cleaning of the perioperative areas. A policy entitled "The Environmental Sanitation Perioperative Setting" policy was developed to address the terminal cleaning process and the "Perioperative Services EVS Terminal Cleaning Log" was reviewed and revised to be more comprehensive. As detailed in the policy, all procedure rooms, the scrub areas, the sterile instrument room and the sterile processing department are terminally cleaned on a daily basis when the scheduled procedures are completed for the day and each 24-hour period during the regular work week. Unused rooms are cleaned once during each 24-hour period during the regular work week. Should any room remain unused over the week-end period, a brief cleaning (i.e., the cleaning used in a room turn-over after a procedure) will be performed prior to staff setting up the room for a case. The terminal cleaning log captures the date and time of the terminal cleaning, the location, the initials of the staff member and allows for comments to be documented. The truncated "Monday morning" cleaning is not required to be documented as this is a regular process for unused rooms every Monday. The MEC and Governing Board approved the policy and checklist on	2/17/16 4/7/16

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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{A 749}	Continued From page 44 performed daily when the areas are being used. AORN Guidelines for Perioperative Practice, Guideline for a Safe Environment of Care, Part 2, Section IIb states that the HVAC (heating, ventilation, air conditioning), surgical attire, and traffic pattern requirements of the surgical suite are designed to be more stringent as one moves from unrestricted to restricted areas. The progression of restrictions is intended to provide the cleanest environment in the restricted area. The designated areas should be separated by ... doors separating the restricted area from the semi-restricted area; and doors, signage, or a line of demarcation to identify the separation between the unrestricted and semi-restricted areas. The doors provide a physical barrier to assist in maintaining control of the HVAC. 2. On 2/16/16 at 9:23 AM, in the decontamination room, clean equipment (sequential compression devices [equipment used to mobilize the knee] wrapped in plastic) were observed to be piled two high on the horizontal surface adjacent to the decontamination area sink. During an interview with the IC at 9:30 AM, he stated the hospital has adopted the Association of periOperating Room Nurses Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. On 2/17/16 at 1:35 PM during a tour of the second decontamination room, it was noted that both decontamination and sterilization were performed in the same room without an additional sink for handwashing. The hospital policy entitled "Separation of Clean	{A 749}	Finding 2 1. The identified supplies were removed. The room is now a dedicated sterile processing room. 2. The Hospital installed a handwashing sink and four (4) foot barrier between the decontamination area and the autoclave. 3. Hospital Leadership reviewed the "Separation of Clean and Contaminated Items" policy, which did not require any revision. OR staff was reeducated on storage of sterile supplies versus clean. This has been reinforced through daily huddles and staff meetings.	3/31/16 4/7/16 2/17/16 – 4/7/16

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{A 749}	Continued From page 45 and Contaminated Items", dated 2/2/16, indicated: "no clean items will be stored in the decontamination area of central services or the contaminated utility room /area ...at no time will the clean/sterile items go through the decontamination areas of the dirty/contaminated items go through the clean sterile areas." According to AORN, Guidelines for Perioperative Practice, Guideline for Cleaning and Care of Surgical Instruments states that Instruments should be cleaned and decontaminated in an area separate from locations where clean items are handled. Physical separation of decontamination areas from areas where clean items are handled minimizes the risk of cross-contamination. Droplets and aerosols created during cleaning of soiled instruments can cause cross-contamination of any nearby clean items or surfaces. The sterile processing area should have separate clean and decontamination spaces, which may be rooms or areas; decontamination and clean spaces that are separated by one of three methods: a wall with a door or pass-through, a partial wall or partition that is at least 4 ft high and at least the width of the counter, or a distance of 4 ft between the instrument washing sink and the area where the instruments are prepared for sterilization; separate sinks for washing instruments and for hand hygiene. 3. During an interview with the Administrator 1 on 2/17/16 at 11:30 AM the annual air balance and certification report dated, 9/1/15, was reviewed. Under the section Crucial Area Validation Testing, OR 2 was noted to have "failed". According to the report this meant that the air exchanges per hour and space pressurization requirements	{A 749}	Compliance and Monitoring: The Director of Infection Control performs random at least weekly observations of the decontamination areas to achieve the goal of 100% compliance with AORN guidelines and hospital policy. In addition, the Interim Director of the OR or qualified designee performs daily rounds (Monday through Friday) of the OR, decontamination areas and sterile processing to assure proper storage of sterile supplies. Corrective action is taken as necessary, including reeducation. Data on compliance is tracked, trended, analyzed and reported monthly to the Patient Safety Committee, Quality Council and MEC. Data on compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Persons Responsible: Director of Infection Control Interim Director of OR Finding 3 Actions Taken: 1. The Hospital engaged a vendor to perform air balance testing for the identified areas and annual air balance certification was obtained. 2. Hospital Leadership discussed the survey findings with the Director of Engineering, with emphasis on implementing corrective action when deficiencies are identified through testing.	2/19/16 2/17/16

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(A 749)	Continued From page 46 found in the California Mechanical Code were not met. The additional rooms that failed testing were ICU 2, Isolation 104 and SPD Clean/Dirty. Administrator 1 he stated that recommended maintenance, detailed in the report, and re-testing had not been performed since the receipt of the report in 9/2015. During an observation and interview on 2/16/16 at 9:15 AM in OR 2, five peel packs (paper packages that contain sterilized small surgical instruments) were opened. In four out of the five packs opened, the instruments inside were in the closed and locked position. ORT 1 commented that the instruments were not processed correctly and the instrument technician who packaged them (ORT 2) should have known better. 4. During an interview with the IC on 2/16/16 at 9:30 AM, he stated the hospital has adopted the AORN Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. According to AORN, Guidelines for Perioperative Practice, Guideline for Selection and Use of Packaging Systems for Sterilization, V.h. Items to be sterilized should be placed in the package or tray in an open or unlocked position. The open or unlocked position facilitates sterilant contact of all surfaces of the item. 5. On 2/16/16 at 11:44 AM during an observation of RN 29 performing a glucose test for Patient 53 and Patient 49, it was noted that the glucometer was not cleaned and disinfected between patients and according to the manufacturer's instructions. During an interview and observation of the area	(A 749)	Compliance and Monitoring: The Director of Infection Control reviews the annual air balance testing reports to ensure that corrective action is taken if deficiencies are identified. Corrective action is taken as necessary. Data on compliance is tracked, trended, analyzed and reported annually to the EOC Committee, Infection Control Committee, Quality Council and MEC. Persons Responsible: Director of Infection Control Director of Engineering Finding 4 1. Sterile processing staff inspected all trays and peel packs to ensure that hinged instruments are placed in the package or tray in an open or unlocked position. 2. The sterile process technician working at the time of survey is no longer employed at the hospital. An OR tech certified in sterile processing is now working in the department. 3. The Director of infection Control and interim OR Director conducted extensive education with sterile processing staff regarding sterilization and maintaining sterile surgical instruments and other requirements of sound decontamination practices pursuant to AAMI ST79.	2/17/16 2/18/16 2/17/16

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{A 749}	Continued From page 47 outside of the emergency room with RN 16, on 2/16/16, at 8:53 AM, there were two containers on the wall. One container with a purple lid, had the manufacturer's label that read "MICRO-KILL ONE...GERMICIDAL ALCOHOL WIPES" and read, in part, "To disinfect hard, non-porous surfaces, use one or more wipes, as necessary to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed..." A second container, with a light blue lid, the label read, "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" and the product label read, in part, for hospital disinfection, "...Remove pre-saturated 7 in x 8 in wipe...Apply pre-saturated towelette and wipe desired surface to disinfect...CONTACT TIME [amount of time the item should remain visibly wet to kill the listed pathogens]: Allow surface to remain wet for 30 seconds to kill HBV and HCV, for 3 minutes to kill Clostridium difficile sores and 5 minutes to kill HIV..." RN 16 stated she uses the "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" to disinfect the glucometers (ACCU CHEK Inform II is a medical device that is used to determine the appropriate concentration of glucose [sugar] in the blood) and she stated the contact time is a 30 second contact time. She then indicated the kill/contact time was 3 minutes for these wipes. Although she uses "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" she was instructed to use "MICRO-KILL ONE...GERMICIDAL ALCOHOL WIPES". During an observation and interview with RN 28 (Charge Nurse for the Intensive Care Unit [ICU] and the telemetry unit), on 2/16/16, at 9:47 AM, she stated there are two glucometers in the ICU and she disinfects them using the "MICRO-KILL	{A 749}	2. The Hospital purchased additional glucometers for the patient care areas. 3. The "Accu-Check Inform Glucose Meter" policy was reviewed and revised to clarify the cleaning process. In addition, a cleaning and disinfectant guide, entitled "Cleaning of Glucometers" was attached to the exterior surface of the glucometers. Glucometers are cleaned with Clorox Healthcare Bleach Germicidal Wipes in accordance with manufacturer's instructions. The cleaning occurs after every glucometer use on each patient, at least every 24 hours (when quality control testing is done), and whenever there is a suspected or true contamination and follows the manufacturer's recommendations. Nurses were educated, with emphasis on proper use of cleaning products, wet contact time, and cleaning in between each use of the glucometer on a patient. 4. Nursing staff and CNAs are educated on use and cleaning of glucometers upon hire. In addition, education is part of the annual skills fair. 5. Compliance with cleaning/disinfecting glucometers is monitored through the QAPI program. <u>Compliance and Monitoring</u>: The Director of infection Control or qualified designee performs random at least weekly rounds in patient care areas to observe cleaning/disinfecting of glucometers to achieve the goal of 100% compliance. Corrective action is taken as necessary, including just-in-time training. Data on	2/19/16 2/19/16 – 3/17/16

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{A 749}	Continued From page 48 ONE...GERMICIDAL ALCOHOL WIPES" and she stated, she is the staff who is responsible for disinfecting the devices. She disinfects the glucometers once on her shift (morning) and then the night shift staff will disinfect the devices once on their shift. She was asked how many times are the glucometers being used currently and she stated approximately six times on the morning shift. She then proceeded to demonstrate how she wipes the devices and allows them to remain visibly wet for two minutes. She was again asked, how many times are the devices disinfected, and again she stated once on her shift. No further information was provided. The hospital policy and procedure titled, "ACCU-CHEK Inform Glucose Meter" effective date 2/19/14, indicated in part for the Cleaning/Disinfecting of the meters use "Super Sani-Cloth Wipes or 10% bleach...Frequency 1. In between every patients...3. Whenever there is suspected or true contamination...How to Clean Meters, Bases and Supply Cases 1. Meter...remove a wipe from the PDI Super Sani-Cloth or Clorox wipe tub and close the lid...Allow to air dry before use: 2 min for Sani-Cloth" The "ACCU-CHEK Inform II" Operator's manual Version 3.0, Revision dated 3/2013, with changes that included "Update cleaning and disinfecting chapter" was reviewed. Page 124 through page 131 indicated in part, "Cleaning and disinfecting the exterior surface of the meter is, at minimum, recommended daily for dedicated patient devices. Meters used with multiple patients may require more frequent cleaning and disinfecting...The meter should be cleaned and disinfected between each patient use...Acceptable active ingredients	{A 749}	compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control	

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{A 749}	Continued From page 49 and products for cleaning and disinfecting are...Clorox Germicidal Wipes...Super Sani-Cloth Germicidal Disposable Wipes...Always use Clorox Germicidal Wipes...or Super Sani-Cloth Germicidal Disposable Wipes...to clean and disinfect the meter. Do not use any other cleaning or disinfecting solution. Using solutions other than Clorox Germinal Wipes...or Super Sani-Cloth Germicidal Disposable Wipes...could result in damage to the system components..." 6. On 2/16/16 at 1:15 PM, during a review of employee health records, three out of three files did not have complete vaccination records (RN 29, ORT 2, Environmental Services Manager [EVS] 1). RN 29 did not have evidence of tDap (Tetanus (a serious illness caused by bacteria that can enter the body through a deep cut) Diphtheria (a serious bacterial infection), and Pertussis (commonly known as Whooping Cough, an infectious bacterial disease that causes uncontrollable coughing) or varicella (Chickenpox) immunity. ORT 2 did not have evidence of mumps immunity and EVS 1 did not have evidence of tDap and Varicella. The hospital policy entitled Immunizations for Healthcare Workers dated 2/2012 was reviewed on 2/16/16 at 2:30 PM. It states that as part of the preemployment evaluation, employees will be required to complete a questionnaire regarding prior vaccinations for, or exposure to communicable vaccine-preventable diseases. In situations where immunity is questionable or undetermined from the questionnaire the employee will be tested to determine his/her immune status.	{A 749}	Finding 6 1. Hospital Leadership, including the Director of Human Resources and Director of Infection Control, discussed the survey findings and the process for monitoring immunizations for hospital employees. The "Physical Examinations - Post Employment Offer" policy was reviewed and revised to align with current practice. The MEC and Governing Body approved the policy on 3/30/16. The Director of Infection Control researched the issue of Tdap vaccination for health care workers and discussed mandatory versus recommended guidelines with a representative from the Immunization Branch of the California Department of Public Health. It was confirmed that use of the Tdap vaccination is recommended but not mandatory. Nonetheless, Hospital Leadership elected to offer the Tdap vaccination to employees. The Tdap vaccine was ordered and a flyer distributed for employees (posted at time clocks and in department units) that the vaccine is being offered and when/where they can receive the vaccination. In addition, the Director of HR developed a Tdap consent/declination form for employees to complete, which will be maintained in the employee's personnel file. In addition, the Director of HR developed a spreadsheet that lists all employees and the status of their vaccinations for Tdap, hepatitis, and MMR and varicella. Employee files were reviewed to update the spreadsheet and employees. If information was not present regarding the status of the immunity for hepatitis, MMR	4/7/16

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State of California-Health and Human Services Agency

California Department of Public Health

CDPH

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

April 12, 2016

Los Angeles Community Hospital
4081 E Olympic Blvd
Los Angeles, CA 90023

Dear Administrator:

FACILITY: Los Angeles Community Hosp
COMPLAINT NUMBER: CA00449063

Enclosed is STATE FORM Statement of Deficiencies and Plan of Correction Form, which resulted from a recent visit to your facility. Please prepare a plan of correction, sign and date the document, return the original to this department within ten (10) calendar days from receipt of this STATE FORM Statement of Deficiencies, and retain a copy for your file.

The Plan of Correction for each deficiency must contain the following:

a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.
b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.
c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.
d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.
e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

If your Plan of Correction is unacceptable to the Department you will be notified in writing. You are ultimately accountable for compliance, and responsibility is not

alleviated where notification of the acceptability of the plan of correction is not timely. Your plan of correction will serve as the facility's allegation of compliance. If an acceptable plan of correction is not received within ten (10) calendar days from receipt of the STATE FORM Statement of Deficiencies, the Department will recommend to the regional office and/or the State Medicaid Agency that remedies be imposed as soon as the notice requirements are met.

If you have any questions, please contact Tamara Cleveland , Health Facilities Evaluator Supervisor, at 855-804-4205.

Sincerely,

Mic6ealTioyi

For Colleen Reeves, R.N., HFEM II, Chief
State Facilities Section
Licensing and Certification

CR/mf
Enclosure *(STATE FORM)*

California Department of Public Health

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00449063 Representing the California Department of Public Health: 2091, HFEN (Health Facilities Evaluator Nurse) The investigation was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were written for complaint CA00449063	E 000	AOOO Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law. The following constitutes Los Angeles Community Hospital's credible allegation of compliance.	
E 276	T22 DIV5 CH1 ART3-70214(a)(2)(A) Nursing Staff Development (a) There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217(m). The program shall include, but shall not be limited to, orientation and the process of competency validation as described in subsection 70213(c). (2) All patient care personnel, including temporary staff as described in subsection 70217(m), shall be subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions: (A) Assignments shall include only those duties and responsibilities for which competency has	E 276	E 276 Nursing Staff Development Immediate Actions Taken: The CEO and Nursing Leadership discussed the survey findings and had a discussion with the owner of the dialysis company regarding expectations on orientation and competencies for the dialysis staff. Nursing Leadership reviewed the "Contract Employees" Policy, to clarify the process for supervising and evaluating contracted nursing staff, including orientation requirements, evaluation of competencies and performance, and personnel file requirements. The policy did not require revision. A file is maintained in the nursing office for contracted nursing staff, including dialysis nurses.	8/17/2015 8/17/2015

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 08/17/2015

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E 276	Continued From page 1 been validated. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two of four Registered Nurses (Staff A and Staff B) from a contracted dialysis agency had demonstrated competency to provide hemodialysis treatments (a treatment that will remove harmful waste from the body when the kidneys cannot) for one of one patients (Patient 1). This failure had the potential to result in unsafe care for the patient. Findings: Patient 1 was admitted to the facility on 6/13/15 with diagnoses that included renal failure (a condition in which the kidneys lose the ability to remove waste from the body). Review of Patient 1's clinical record indicated that four RN's from the contracted dialysis agency had provided hemodialysis for Patient 1. During a review of the dialysis agency binder that contained licensure, qualification, and competency evaluations for dialysis staff providing care to patients in the facility indicated that two of the four RN's (Staff A and Staff B) did not have up to date annual competency skills for hemodialysis procedures. During a review of Patient I's clinical record, the dialysis treatment record dated 6/21/15, indicated Staff A provided hemodialysis treatment that began at 8:00 PM and ended at 11:00 PM. During a review of the dialysis agency binder,	E 276	The file includes primary source license verification and required competencies. The contracted nursing staff members also receive an orientation packet, with a copy maintained in his/her file. Nursing office staff was reinserviced on the policy. The CEO discussed the survey issues concerning the provision of dialysis services with the dialysis company, with special emphasis on completion of orientation and competencies for nurses working at the hospital. Subsequent Actions Taken: Dialysis nurses must check in first at the nursing office prior to going on to the patient care units, where upon their file will be reviewed for completeness. Dialysis nurses with incomplete files will not be allowed to practice. Over the ensuing months, the CNO had numerous conversations with the dialysis company regarding failure to comply consistently with contract obligations on completion of orientation and competencies for dialysis nurses working at the hospital. Staff who did not have a complete file, were not allowed to work until all required documents were submitted. Ultimately, the CEO terminated the dialysis contract and engaged a new dialysis company, effective 2/8/16. A new dialysis competency tool was provided to the new company and orientation and competencies for the new dialysis staff are maintained in the nursing office.	8/24 – 9/4/2015 8/17/2015 August 18, 2015 Aug – Dec 2015. 2/8/2016

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E 276	Continued From page 2 Staff A's Annual Competency Skills Checklist indicated there were no annual competencies for hemodialysis procedures demonstrated for 2014 and 2015. During an interview with the CNO (Chief Nursing Officer) on 7/9/15 at 11:00 AM, she reviewed Staff A's Annual Competency Skills Checklist and verified Staff A's last documented annual skills competency for hemodialysis procedures was 10/15/13. She stated that verification of skills and competencies for contracted staff that provide care within the facility was the responsibility of the contracted agency. She further stated, "We don't keep track of qualifications or expirations" of contracted staff credentials or licenses, and expect that information contained in the folder from the dialysis agency to be current. During a review of Patient I's clinical record, the dialysis treatment record dated 6/22/15, indicated Staff B provided hemodialysis treatment that began at 6:30 PM and ended at 10:00 PM. During an interview with QAC 1 (Quality Assurance Coordinator) on 7/9/15 at 10:15 AM, she reviewed Patient I's dialysis treatment record dated 6/22/15 and stated she did not know the identity of the staff who provided the hemodialysis treatment. During this interview, she reviewed the dialysis agency binder and was unable to locate licensure, competency validation, or qualifications for Staff B. On 7/9/15 at 10:45 AM, QAC 1 provided a copy of Staff B's California Board of Registered Nursing license, California Driver License, CPR (Cardiopulmonary Resuscitation) card, and ACLS (Advanced Cardiovascular Life Support) card. She stated she had just received these	E 276	Monitoring: The CNO or designee will perform a monthly audit of 100% of the contracted nursing staff files (for three months and then re-evaluate) to achieve 100% compliance with orientation and documented competencies. Data is analyzed and reported monthly to Quality Council and MEC, and at least every other month to Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until Quality Council determines sustained compliance has occurred, at which time the Quality Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability. (e.g.: Random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	4/7/2016

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E 276	Continued From page 3 documents via email from the contracted dialysis agency. There was no documentation provided to verify Staff B had demonstrated annual skills competency to provide hemodialysis procedures. During an interview with the Corporate Vice President of quality management for the facility, on 8/4/15 at 11:00 AM, she stated, "It was the facility's responsibility to verify licensure, skills, and competencies of all providers in the facility, just like for registry staff." The facility policy and procedure titled "Contracted Services, Performance Monitoring" dated July 2012, currently in "Draft" status under review, indicated dialysis services were included as a service affected by the policy. The policy indicated it was the facility's requirement to maintain required records for proof of staff licensure, training, continuing education, performance measurements and competency validation. The facility policy and procedure titled "Competency & Skills Validation" dated 10/1/2013, indicated the staff providing care would have competencies and skills validated prior to care provided to hospital patients.	E 276		
E2216	T22 DIV5 CH1 ART7-70749(a)(6)(A) Patient Health Record Content (a) Each inpatient medical record shall consist of at least the following items: (6) Nurses' notes which shall include but not be limited to the following: (A) Concise and accurate record of nursing care	E2216	E2216 Health Record Content Immediate Actions Taken: Upon receipt of the Statement of Deficiencies, the CEO and Nursing Leadership discussed the survey findings and process for nursing care planning with the nursing staff, and the owner of the dialysis company regarding expectations on medical record content, specifically the importance of a concise and accurate record of nursing care.	8/17/2015

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E2216	Continued From page 4 administered. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Patient I's medical record consisted of nurses' notes that included complete documentation of nursing care administered during CPR (cardiopulmonary resuscitation) that took place during a hemodialysis treatment. This failure had the potential to result in prevention of other members of the healthcare team from having access to accurate, vital medical information important to making care decisions. Findings: Patient 1 was admitted to the facility on 6/13/15 with diagnoses that included renal failure (a condition in which the kidneys lose the ability to remove waste from the body). During a review of the clinical record for Patient 1, the CPR record dated 6/26/15 at 12:12 PM, indicated Patient 1 had a witnessed full cardiac and respiratory arrest with an extreme low heart rate. Patient 1 was resuscitated with restoration of pulse, respirations, and consciousness at 12:22 PM and CPR was terminated. During a review of the clinical record for Patient 1, the Assessment and Cares flowsheet dated 6/26/15 at 12:12 PM, staff documented "HR (heart rate) is down to 59 then 48/min (per minute) and dialysis was stopped and called code blue."	E2216	Hospital Nursing Leadership discussed the nursing survey findings and reviewed the "Code Blue" policy to ensure compliance with applicable standards pertaining to emergency rescue were maintained. The policy did not require revision. Nursing and Dialysis staff were re-educated on the importance of complete and accurate documentation, and that failure to do so had the potential to result in the prevention of other members of the healthcare team from having access to accurate, vital medical information, important to making care decisions. Subsequent Actions Taken: The Hospital assures that it has an organized nursing service that Is furnished or supervised by registered nurses. The Hospital hired a new Chief Nursing Officer on 9/9/2015. Her initial focus was centered on reorganizing the nursing structure to support consistent processes, including emergency rescue. An Associate Chief Nursing Officer (ACNO) was hired on 12/16/15. The ACNO developed a presentation and educated nursing staff on nursing documentation, with special emphasis on the ongoing review and updating of nursing documentation as necessary to address the patient's ongoing needs (e.g., emergency rescue). Nursing leadership meetings are ongoing at least bimonthly to discuss compliance with current and accurate documentation in the medical record.	8/19/2015 8/24 – 9/4/2015 9/9/2015 12/16/2015 1/31/2016 3/1/2016

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E2216	Continued From page 5 During a review of the clinical record for Patient 1, the dialysis treatment record dated 6/26/15, dialysis staff documented hemodialysis had begun at 8:30 AM and was completed at 12:00 PM. The dialysis treatment record did not include documentation of CPR. During an interview with the Corporate Vice President of quality management for the facility, on 8/4/15 at 11:00 AM, she reviewed the dialysis treatment record dated 6/26/15 and was unable to find documentation of the CPR event by the dialysis staff. The dialysis agency policy and procedure titled "Code Blue Response" dated June 2003, indicated it was the procedure of dialysis staff to document the event, treatment, and patient response when CPR occurred during hemodialysis.	E2216	A Director of ICU and ED Services was hired on 3/1/2016. Her initial focus is centered on assessing and re-educating staff on competencies within their assigned clinical area/department, including emergency rescue procedures. Compliance with nursing documentation is monitored through the QAPI Program. Monitoring: Effective 4/7/2016 data is collected by care facilitators, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on staff education and development. The goal is to achieve 100% compliance. Data is analyzed and reported monthly to Quality Council and MEC, and at least every other month to Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until Quality Council determines sustained compliance has occurred, at which time the Quality Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability. (e.g.: Random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	3/1/2016 4/7/2016

5. Reports of ECHN's Quality Evaluation Team to the Board of ECHN

Please see attached report of the ECHN Quality Evaluation Team to the Board of ECHN, together with the resolutions adopted by the Board following such report.

REVIEW OF CHARTERCARE/PROSPECT MEDICAL HOLDINGS

Situation:

The ECHN Quality Department visited CharterCARE Hospitals, Roger Williams Medical Center (RWMC) and Our Lady of Fatima Hospital (OLF), in Providence RI on Friday March 4, 2016 to evaluate their quality improvement systems. RWMC is licensed for 250 beds with an average daily census of 100, OLF is licensed for 359 beds with an average daily census of 107.

Background:

CharterCARE Health Partners has joined in a joint venture with Prospect Medical Holdings (PMH) to develop an innovative regional coordinated health care network, anchored by Roger Williams Medical Center and Our Lady of Fatima Hospital. The two hospitals are not fully integrated; PMH is assisting in this transition. PMH acquired CharterCARE in June of 2014. Each hospital has a President who reports to the CEO of CharterCARE. The Quality Department reports directly to the President of each hospital. Risk management reports directly to both Presidents as well as to general counsel in California. Education and Infection Control report directly to the CNO of each hospital. Corporate Compliance officer reports to the CEO of corporate compliance in California.

Assessment:

- PMH has brought in safe transitions of care which has significantly reduced their readmission rates. Pharmacists and LPN brought on board for follow up calls.
- The integration of the hospitals will assist in eliminating the duplication of services as the two hospitals have a similar market place.
- PMH has invested in the renovation of the two hospitals with the patient in mind. Improving handicap access, improved lighting, single rooms, open concept nursing units (best practice), future renovation of cafeteria and nutritional services. A new diagnostic wing is in the process of being added at RWMC as well as new and larger (double the size) state of the art Emergency Departments which will include Behavioral Health (BH) areas at both hospitals.
- Hospitals have integrated similar departments including Quality, Risk, and Environmental Services and are continuing to evaluate for further integration.
- CharterCARE has a robust Quality Department. PMH has supported new positions to ensure that quality standards and metrics are met and maintained. PMH recognized RWMC's focus on Quality and Safety and supported the process that was already in place. PMH has increased staffing in the patient satisfaction area.
- A Quality Improvement diagram of reporting structure was provided.
- In speaking with the CNO's of each hospital PMH has allowed autonomy in managing departments that are meeting their performance measures. Those

departments that are not meeting expectations are assisted by PMH Corporate oversight.

- PMH has assisted in the pursuit of certifications including stroke, diabetes, and total joint replacement.
- PMH has good outreach for primary care doctors, started an Independent Practice Association (IPA).
- PMH is in the process of developing various VP positions for oversight of the PMH systems.
- PMH has been supportive in the development of safety programs at both hospitals including High Reliability Organization (HRO) training.
- PMH has allowed CharterCARE hospitals autonomy to continue to define and pursue their process improvement initiatives that work well, while also bringing forward and assisting CharterCARE in instituting additional best practices.
- CharterCARE was provided tools to assist with staffing and productivity.
- PMH looks at processes through evidence based standards and then analyzes cost and outcomes to choose the best pathway.
- PMH supports a multidisciplinary, timely review of serious events by medical peer review and nursing peer review processes.
- PMH provides strong legal support which has experience with healthcare unions.
- Recycling and reprocessing has improved with support from PMH.
- CharterCARE uses Meditech at both hospitals.
- Infection Control (IC) is robust, has not yet been integrated between both hospitals. Strong support of IC at both hospitals.
- PMH provides metrics displayed in an organized dashboard with clinical and financial outcomes.

Recommendation:

It is apparent by observation and interview that PMH has provided many new and positive opportunities to CharterCARE and has been supportive of Quality, Safety and Infection Control. Recommend continued contact with CharterCARE hospitals for assimilation of best practices seen in recent visit.

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

CERTIFICATE OF AUTHORITY

I, Michele B. Conlon, MD, Secretary, Board of Trustees of Eastern Connecticut Health Network, Inc., a corporation organized under the laws of the State of Connecticut, do hereby certify that the following is a full and true copy of a resolution adopted at a meeting of the Board of Trustees of Eastern Connecticut Health Network, Inc., duly held on the **23rd day of March, 2016:**

WHEREAS, the Board of Trustees (the "Board') of Eastern Connecticut Health Network, Inc. (the "Corporation"), following an extensive study of the health care market and future prospects and alternatives facing the Corporation, has determined that an affiliation with, or sale of substantially all of the Corporation's assets to, another healthcare organization is in the best interest of the Corporation and its affiliates; and

WHEREAS, after extensive evaluation of competing bids, the Board determined that a sale of substantially all of the Corporation's assets to subsidiaries of Prospect Medical Holdings, Inc. (collectively, "PMH") (the "Transaction") will best enable the continued availability of high-quality health care for residents of the Corporation's service area; and

WHEREAS, with the approval of the Board, the Corporation entered into that certain Letter of Intent with PMH dated June 25, 2015 (the "Letter of Intent") and negotiated a draft asset purchase agreement with PMH (the "APA"); and

WHEREAS, on October 13, 2015 the Corporation and PMH (i) executed an amendment extending the Letter of Intent and (ii) jointly submitted a Certificate of Need application to the Connecticut Attorney General and the Connecticut Department of Public Health Office of Health Care Access seeking approval for the Transaction; and

WHEREAS, in February 2016 the Corporation was made aware by PMH of certain quality issues that had occurred at certain health care facilities located in California owned by PMH that took place during the Fall of 2015 and Winter of 2016 and included "Immediate Jeopardy" findings by the California Department of Public Health as well as 90-day termination letters issued by the Centers for Medicare and Medicaid Services (collectively, the "Quality Issues"); and

WHEREAS, the management of the Corporation and the Transaction Committee of the Board of Trustees (the "Transaction Committee") have reviewed extensively the nature and extent of the Quality Issues with both internal and external advisors; and

WHEREAS, certain members of the management of the Corporation traveled to California to obtain first hand information concerning the Quality Issues and to meet with PMH executives to discuss the Transaction in February 2016; and

WHEREAS, certain of the Corporation's quality experts visited two PMH-owned health care facilities located in Rhode Island (the "Rhode Island Facilities") to learn about PMH's quality programs and summarized the findings of the visit for the Transaction Committee; and

WHEREAS, to ensure that PMH maintains the Corporation's current quality standards following the closing of the Transaction, the Corporation has drafted a side letter to the APA that binds PMH to (i) continue the Corporation's existing quality programs for two years following the closing of the Transaction; (ii) seek the approval of the local board established by the APA before making changes to such quality programs during the two years following the closing of the Transaction; and (iii) ensure that the Corporation receives the benefit of the quality improvement programs that have been implemented at the Rhode Island Facilities (the "Side Letter"); and

WHEREAS, the Transaction Committee, following its extensive review of the Quality Issues, has recommended that the Board (i) seek PMH approval of the Side Letter, and (ii) reaffirm the Transaction as being in the best interest of the Corporation; and

WHEREAS, the Board has determined that (i) in view of the likelihood of continuing changes in the health care market and ongoing financial pressures, and (ii) in light of its review of the Quality Issues and PMH's responses thereto, the Transaction remains in the best interest of the Corporation.

NOW, THEREFORE, be it resolved as follows:

Approve Side Letter

RESOLVED: That the Board directs management to seek PMH's approval of the Side Letter in such form and with such changes as the President and CEO of the Corporation may determine to be necessary or appropriate.

Reaffirm Transaction

RESOLVED: That the Board reaffirms the Transaction as being in the best interest of the Corporation.

AND I DO FURTHER CERTIFY that the above resolution has not been in any way altered, amended or repealed, and is now in full force and effect.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the corporate seal of said corporation this 23rd day of March, 2016.

Eastern Connecticut Health Network, Inc.

(SEAL)

By: _____
Michele B. Conlon, MD
Its Secretary

6. Delegation of Authority of Quality/Compliance to Local Boards in Rhode Island

Please see attached.

6. Delegation of Authority of Quality/Compliance to Local Boards in Rhode Island.

The Local Boards in Rhode Island are advisory boards without delegated authority over quality or compliance. The ultimate authority rests with the Prospect CCHP Board of Directors (the "Board"). The local advisory boards in RI have the following responsibilities: (a) making recommendations regarding medical staff credentialing, quality assurance and accreditation; (b) reviewing, and making recommendations with respect to, strategic and capital plans; (c) providing guidance and support on local market and community concerns, considerations, strategies, issues and politics; and (d) performing such other duties and providing review an recommendations with respect to other matters, as requested by the Board.

The Board works with hospital executives to provide a critical link between the hospital and the community, facilitating access to quality healthcare. Currently the following roles and responsibilities have been identified for the local advisory boards in RI:

- Monitor and oversee the quality of care being provided by the hospital
- Identify and present for discussion and solution, problems affecting patient care
- Serve as a liaison between the governing board and the community
- Make recommendations and provide key information and materials to the CCHP BOD to support the CCHP BOD's decision making on strategies, community issues, financial improvement, and capital plans
- Consult and advise in matters affecting the hospital's policies and programs as they relate to the citizens of the community
- Obtain information and give feedback to the CCHP BOD regarding the hospital's needs, service areas and programs and how they are perceived by the community
- Ensure that the community is kept informed of the hospital's goals and objectives
- Promote and foster hospital connections and visibility in the community
- Represent the hospital in the community
- Educate the public about the strengths and services provided by the hospital

7. Classification of E. Stevens Henry Fund and Updated Values of Charitable Funds as of March 31, 2016

Please see attached.

Classification of E. Stevens Henry Fund

ECHN has evaluated the classification of the E. Stevens Henry Fund (Fund 11.1-55) and determined that the Fund is properly classified as endowment as was originally reported in Exhibit Q11-1 (Page 951).

As to the Fund's original gift value, ECHN has checked probate court records and determined that the original principal value of the gift to RGH was $1,720,205 and not $1,742,007 as originally reported. The Affidavit of Closing (Revised) of the Trustee, a copy of which is provided, reports a principal distribution to RGH of $1,720, 205; the Affidavit also reports a distribution of income accumulated after the death of the life beneficiary, which is not part of the principal.

This corrected gift number is included in the following Excel chart showing the March 31, 2016, updated values of the charitable funds.

65/2611/3456406.1

VOL 2530 PG 722

TO THE COURT OF PROBATE FOR THE DISTRICT OF ELLINGTON

AFFIDAVIT OF CLOSING - Revised
FLEET NATIONAL BANK, TRUSTEE
E. STEVENS HENRY ESTATE TRUST
April 3, 2003 through November 6, 2003.

A. PRINCIPAL CHARGES

Property on hand, per Supplemental Final account dated April 2, 2003	$702,169.68
Total of reserves held for final expenses, per Supplemental Final account	7,025.00
Gain on sale or maturity of securities - Schedule A-1	1,015,563.09
	$1,724,757.77

B. PRINCIPAL CREDITS

Administration expenses - Schedule B-1	$4,552.40
Distributions to Rockville General Hospital Endowment Fund	1,720,205.37
	$1,724,757.77

C. INFORMATIONAL SCHEDULES - PRINCIPAL

Purchases - Schedule C-1
Transactions with no gain or loss - Schedule C-2

D. INCOME CHARGES

Income on hand, per Supplemental Final account dated April 2, 2003	$11,877.79
Total of reserves held for final expenses, per Supplemental Final account	7,025.00
Income received - Schedule D-1	12,478.95
Additional income received - Schedule D-2	101.27
	$31,483.01

E. INCOME CREDITS

Administration expenses - Schedule E-1	$4,552.43
Distributions to Rockville General Hospital Endowment Fund	26,930.58
	$31,483.01

F. INFORMATIONAL SCHEDULES - INCOME

NONE

G. CASH ACCOUNTS AND RECONCILIATIONS

Principal cash account - Schedule G-1

FLEET NATIONAL BANK, TRUSTEE, by:

Ann McGunnigle
its: Vice President

On the 21 day of April, 2004 Ann McGunnigle appeared before me and made oath that the foregoing is a true and complete account of all the receipts and disbursements in the capacity of the above mentioned ...that no person entitled to notice of a hearing on this account who has not signed and filed in Court a written appearance and waiver of notice of such hearing is in the military service of the United States or allied nation.

By: Shirley J. Beaulieu

MARILYN J. BEAULIEU
NOTARY PUBLIC
MY COMMISSION EXPIRES AUG. 31, 2006

E. Stevens Henry Estate Trust
#304557040

SCHEDULE A-1

Gain on sale or maturity of securities

Date	Units	Description	Received	Inventory	Gain/(Loss)
07/24/03	500	Ameren Corp	$21,159.00	$22,092.00	($933.00)
07/24/03	1,600	Automatic Data Processing Inc	57,517.30	15,598.00	41,919.30
07/24/03	528	BP P L C Sponsored Adr	21,398.83	11,370.29	10,028.54
07/24/03	1,200	Bristol Myers Squibb Co	31,642.51	19,890.71	11,751.80
07/24/03	2,133	Citigroup Inc	97,452.20	1,371.11	96,081.09
07/24/03	1,600	Coca Cola Co	71,916.63	3,193.14	68,723.49
07/24/03	1,800	Dupont E I De Nemours & Co	75,794.44	13,225.00	62,569.44
07/24/03	3,200	Exxon Mobil Corp	114,394.63	732.92	113,661.71
07/24/03	600	First Data Corp	23,968.87	25,092.00	(1,123.13)
07/24/03	3,600	General Electric Co	99,787.32	3,619.12	96,168.20
07/07/03	500	General Mtrs Corp	17,714.16	10,989.42	6,724.74
07/24/03	25,000	Hawaii St 5.125%, 02/01/06	25,397.50	24,768.50	629.00
07/24/03	600	Home Depot Inc	19,889.06	19,842.00	47.06
07/24/03	1,850	J P Morgan Chase & Co	64,839.46	8,379.38	56,460.08
07/24/03	1,600	Lilly Eli & Co	107,402.96	5,144.50	102,258.46
07/07/03	1,200	McDonalds Corp	26,277.76	10,798.50	15,479.26
07/24/03	1,600	Merck & Co Inc	95,195.54	1,874.42	93,321.12
07/24/03	1,000	Microsoft Corp	26,818.74	26,040.00	778.74
07/24/03	1,200	Pepsico Inc	56,673.34	20,834.96	35,838.38
07/24/03	1,200	Procter & Gamble Co	107,394.97	6,585.53	100,809.44
07/07/03	500	SBC Communications Inc	12,928.39	22,378.75	(9,450.36)
07/24/03	800	3M Co	106,275.02	7,744.76	98,530.26
07/24/03	600	Verizon Communications	21,568.98	23,598.00	(2,029.02)
07/24/03	400	Viacom Inc Cl B	17,599.17	17,300.00	299.17
07/24/03	900	Wisconsin Energy Corp	25,153.82	8,134.50	17,019.32
			$1,346,160.60	$330,597.51	$1,015,563.09

SCHEDULE B-1

Administration Expenses

Fleet National Bank, services as Trustee	$3,361.90
Ellington Probate Court, final probate fee	377.00
Day Berry & Howard LLP, final legal fee	813.50
	$4,552.40

SCHEDULE C-1

Purchases

Date	Units	Description	
07/07/03	500	Ameren Corp	$22,092.00
07/07/03	600	First Data Corp	25,092.00
07/07/03	600	Home Depot Inc	19,842.00
07/07/03	1,000	Microsoft Corp	26,040.00
07/07/03	600	Verizon Communications	23,598.00
07/07/03	400	Viacom Inc Cl B	17,300.00
			$133,964.00

SCHEDULE C-2

Transactions with no gain or loss

Galaxy Institutional Money Market Fund	
Balance on hand per last account	$505,536.17
Net purchases and sales	(505,536.17)
Balance on hand, dated November 6, 2003	$0.00

E. Stevens Henry Estate Trust
#304557040

SCHEDULE D-1

Income Received

Automatic Data Processing Inc	$192.00
BP P L C Sponsored Adr	198.00
Bristol Myers Squibb Co	672.00
Citigroup Inc	426.60
Coca Cola Co	352.00
Dupont E I De Nemours & Co	630.00
Exxon Mobil Corp	800.00
Galaxy Institutional Money Market Fund	2,269.39
General Electric Co	1,368.00
General Mtrs Corp	250.00
Hawaii St 5.125%, 02/01/06	615.71
J P Morgan Chase & Co	1,258.00
Lilly Eli & Co	536.00
Merck & Co Inc	576.00
Pepsico Inc	192.00
Procter & Gamble Co	1,038.00
SBC Communications Inc	166.25
3M Co	528.00
Verizon Communications	231.00
Wisconsin Energy Corp	180.00
	$12,478.95

SCHEDULE D-2

Additional Income Received

Galaxy Institutional Money Market Fund - bank management fee credits	$101.27

SCHEDULE E-1

Administration Expenses

Fleet National Bank, services as Trustee	$3,361.93
Ellington Probate Court, final probate fee	377.00
Day Berry & Howard LLP, final legal fee	813.50
	$4,552.43

SCHEDULE G-1

Principal Cash Account

Receipts

Cash on hand, per Supplemental Final account dated April 2, 2003	$505,536.17
Total of reserves held for final expenses, per Supplemental Final account	7,025.00
Proceeds from sale or maturity of securities, per Schedule A-1	1,346,160.60
	$1,858,721.77

Disbursements

Administration expenses, per Schedule B-1	$4,552.40
Purchases, per Schedule C-1	133,964.00
Distributions to Rockville General Hospital Endowment Fund	1,720,205.37
	$1,858,721.77

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EXHIBIT Q 11-1
ECHN ENDOWMENT AND OTHER CHARITABLE FUNDS - FUNDS 11-1.1 - 11-1.84

Explanatory Notes:

1. ECHN has provided a copy of each available gift instrument. In some cases, although it conducted a thorough review of its records as well as the records of local probate courts, it was unable to locate the original gift instrument. In those cases, it has provided other available documentation of the gifts, including copies of minutes of Board meetings and/or copies of old audited financials.
2. References to the 1990 Report of the Attorney General are to the June, 1990 Report of the Office of the Attorney General on Hospital Bed Fund Trusts.
3. Proposed requests for cy pres relief will apply to the balances of the funds remaining at the time and not appropriated or used by ECNH for proper purposes.

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
MANCHESTER MEMORIAL HOSPITAL								
	Endowment: Unrestricted Income Funds							
11-1.1	Dwight W. Blish Fund	$19,920	$189,989	Devise under Article Fourth of the Last Will and Testament of Dwight W. Blish dated September 6, 1923, with Codicil dated July 3, 1933	Upon the deaths of Mr. Blish's wife and son, the testamentary trust he had established for their benefit terminated, and the property then remaining was given outright "to The Manchester Memorial Hospital to be held by the trustees of said hospital as a trust fund to be known as the Dwight W. Blish fund, the income therefrom to be used for such purposes in connection with said hospital as the trustees shall decide." Income unrestricted	The Last Will and Testament of Dwight W. Blish dated September 6, 1923, and Codicil dated July 3, 1933		Request cy pres relief and transfer to the new Foundation
11-1.2	John & Eliza Carpenter	$2,555	$110,546	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.3	Helen G. Chapman	$5,000	$81,614	Bequest under Article FOURTH of the Last Will and Testament of Helen G. Chapman dated July 1, 1938	Bequest of $5,000 "to the Manchester Memorial Hospital, of Manchester, Connecticut, to be held by it in perpetuity, with power of investment, sale and reinvestment, and to apply the income only for the support of the Hospital maintained by it in the town of Manchester." Income unrestricted	The Last Will and Testament of Helen G. Chapman dated July 1, 1938		Request cy pres relief and transfer to the new Foundation
11-1.4	William H. Coates (Costes)	$500	$5,550	Bequest under the Last Will and Testament of William H. Coates (date unknown)	This bequest is documented in the minutes of the August 12, 1925 meeting of the Board of Trustees of the Hospital, which state that "A report was given by the Manchester Trust Company, Executor of the will of William H. Coates, of a gift of $500.00, the interest only to be used for hospital purposes." This bequest is also referenced in a document titled "Exhibit A - Report of the Finance Committee" apparently excerpted from Board minutes. That Exhibit also classifies this fund as an endowment fund and states [the income is to be used] "...as the trustees of said hospital may deem best..." Income unrestricted	Minutes of the August 12, 1925 meeting of the Board of Trustees; and "Exhibit A - Report of the Finance Committee" from other Board minutes.	Note: This fund has sometimes (incorrectly) been identifed as a gift from William H. Costes rather than William H. Coates.	Request cy pres relief and transfer to the new Foundation
11-1.5	Grace K. Dart	$4,007	$123,290	Devise under ARTICLE VI. of the Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931.	Devise of half the residuary estate. Article VI. provides as follows: All the rest, residue and remainder of my property, both real and personal, wherever it may be situated and of whatsoever it may consist I direct be divided into two (2) equal parts. The first of said equal parts, I give, devise and bequeath to The Manchester Memorial Hospital, a Connecticut Corporation, located in said Manchester, to take, hold, manage, invest and reinvest and to use the income therefrom for the general running expenses of said Hospital. Income unrestricted	The Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931		Request cy pres relief and transfer to the new Foundation
11-1-6	The Grace L. House Fund	$2,500	$30,080	Bequest under Article VI. of the Last Will and Testament of Charles E. House dated May 4, 1933	Bequest to the Hospital of $2500 "to be held by said Hospital as a permanent fund, and to be know[n] as "The Grace L. House Fund". The income therefrom is to be used for the running expenses of said Hospital." Income unrestricted	The Last Will and Testament of Charles E. House dated May 4, 1933		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.7	The John Porter & Caroline E. Porter Fund	$7,464	$172,767	Devise under Paragraph EIGHTH (c) of the Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937. Devise under Article SIXTH (f) of the Last Will and Testament of Caroline E. Porter, dated July 3, 1956.	Devise of a share in the residue of a testamentary trust established by the Will of John Porter as follows: "Twenty per cent. (20%) [of this trust], ..., I give in equal shares to the following fourteen charitable institutions, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz.: ...13. The Manchester Memorial Hospital, of Manchester,..." Subsequent devise by Caroline E. Porter of a portion of another testamentary trust established under the Will of John Porter through her exercise of a power of appointment over one-half of the trust as follows:: "SIXTH: ... Accordingly,..., I nominate and appoint [the following] to receive out of said one-half of said residuary estate of my late husband, John Porter, the following gifts, to wit: ... (f) The balance ... shall be distributed by said trustees in equal shares to the following fourteen charitable institutions, ..., in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz: ...13. The Manchester Memorial Hospital, of Manchester, Connecticut;..." Income unrestricted	The Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937; the Last Will and Testament of Caroline E. Porter, dated July 3, 1956; and May 23, 1958, letter from Hartford National Bank and Trust Company to Robert Hathaway of the Manchester Trust Company.		Request cy pres relief and transfer to the new Foundation
11-1.8	William & Mary Rice Fund	$122,361	$987,626	Devise under Article FOURTH of the Last Will and Testament of Richard W. Rice dated April 11, 1924	Upon the deaths of the last named life beneficiary, the testamentary trust Mr. Rice had established terminated, "... and the principal thereof, and all accumulations thereto, I give, devise and bequeath to the Manchester Memorial Hospital, of Manchester, Connecticut, in trust, to be known as the William and Mary Rice Fund, the income therefrom to be used for the purposes of uses of said Hospital." Income unrestricted	The Last Will and Testament of Richard W. Rice dated April 11, 1924		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.9	Robert N. and Florella Stanley Trust Fund	$3,000	$33,921	Bequest under ARTICLE V. of the Last Will and Testament of Flora May Stanley dated December 2, 1940	Bequest of $3000 to The Manchester Memorial Hospital, a Connecticut corporation, "... to be known as the Robert N. and Florella Stanley Trust Fund, to be added to the Endowment Fund of said hospital, and the income to be used for such purposes as the Trustees may deem best." Income unrestricted	The Last Will and Testament of Flora May Stanley dated December 2, 1940		Request cy pres relief and transfer to the new Foundation
11-1.10	George W. Strant and Rose B. Strant Memorial Fund	$128,043	$692,118	Two bequests and a share in the residuary estate as follows: (1) Bequest under Article THIRD 1. of the Last Will and Testament of Rose B. Strant dated December 22, 1954; (2) Bequest under Article THIRD 6. of said Will; and (3) Devise of a share in the residuary estate under Article FOURTH a. of said Will	Rose Strant left three testamentary gifts to Manchester Memorial Hospital, all of which were to the Hospital's endowment,"the income only from which is to be used for the general purposes of said hospital." The Bequest (in Article THIRD 1(b) and (c)) was the remainder interest in a $2000 trust or, if the life beneficary predeceased her, $2000: "b. Upon the death of [my cousin] "... said trust shall thereupon terminate and ...the principal of said trust, together with any unpaid income, [shall] be paid to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and the income only from which is to be used for the general purposes of said hospital. c. If my said cousin... shall predecease me, then in that event, I give and bequeath said Two Thousand (($2,000.00) Dollars to the Manchester Memorial Hospital, to be used as set forth above. Article THIRD 6. bequeathed "the sum of Five Thousand ($5,000.00) Dollars to the Manchester Memorial Hospital, to be added to its endowment fund and to be known as the George W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Article FOURTH A. left two of three three equal parts "to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and to be known as the Geroge W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Income unrestricted	The Last Will and Testament of Rose B. Strant dated December 22, 1954		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.11	Minnie R. Strickland	$2,511	$108,629	Devise under ARTICLE IX of the Last Will and Testament of Minnie R. Strickland dated June 29, 1942	Devise of one-third of the residuary estate pursuant to Article IX, which provides as follows: "I direct that all the rest and residue of my property of whatever kind and wherever situated shall be divided into three (3) equal parts: I give one of said equal parts to the Manchester Memorial Hospital; of Manchester, Conn., to be added to the Endowment Fund of said Hospital;..." Income unrestricted	The Last Will and Testament of Minnie R. Strickland dated June 29, 1942		Request cy pres relief and transfer to the new Foundation
11-1.12	Arthur B. and Carrie E. Ellis Trust Fund	$5,000	$55,579	Bequest under ARTICLE IV. of the Last Will and Testament of Carrie E. Ellis dated February 9, 1940, with Codicil dated October 8, 1942	Bequest to The Manchester Memorial Hospital of "the sum of Five Thousand ($5,000.00) Dollars, to be added to the Endowment Fund of said hospital and to be known as "The Arthur B. and Carrie E. Ellis Trust Fund", the income therefrom to be used for such hospital purposes as its Trustees may desire." Income unrestricted	The Last Will and Testament of Carrie E. Ellis dated February 9, 1940; Codicil dated October 8, 1942		Request cy pres relief and transfer to the new Foundation
11-1.13	Ralph and Lula Pinney Fund	$31,031	$312,382	Devise under Article 7th of the Last Will and Testament of Lula M. Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries,two testamentary trusts Mrs. Pinney had established terminated, and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income unrestricted as to this part of the gift; see also Fund 11-1.27.	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 11-1.27.	Request cy pres relief and transfer to the new Foundation
11-1.14	Emil L. G. Hohenthal	$750	$7,735	Unknown	This fund is documented in the June 16, 1953 minutes of a meeting of the Board of Trustees of the Hospital. The minutes do not quote or refer to gift language, but state that the "original amount" of the gift was $750, and the context suggests that this is an endowment. This fund has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	The minutes of the June 16, 1953 meeting of the Board of Trustees of the Hospital; the financial records of the Hospital.	Note: The Hospital located the Last Will and Testament of Mr. Hohenthal's wife Hazel, but it did not include this gift.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.15	George Wells Cheney and Harriet Richmond Cheney Memorial Fund	$75,000	$573,735	Devise under Article SEVENTH C. of the Last Will and Testament of Louis R. Cheney dated February 22, 1944	Devise of a share in the residuary estate as follows: "Seventh: I direct my Executors to divide all the rest, residue and remainder of my property both real and personal, and wheresoever situated including any property over which I may have power of disposal or appointment, into one Hundred Fifty-five (155) equal parts, and I give, bequeath and devise said parts as follows: ... C. Ten (10) of said parts to the Manchester Memorial Hospital as a memorial to my father and mother, George Wells Cheney and Harriet Richmond Cheney, to be held as a separate fund and the income only used for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Louis R. Cheney dated February 22, 1944		Request cy pres relief and transfer to the new Foundation
11-1.16	Helen Campbell Cheney Fund	$543,562	$4,657,104	Devise under Article Sixth (b) of the Last Will and Testament of Helen Campbell Cheney dated June 29, 1960	Devise of a share in the residuary estate as follows: "Sixth. All the rest, residue and remainder of my estate, both real and personal and wherever situated, I direct my Executor to divide into three (3) equal parts and to transfer and pay over said three (3) equal parts and I so give, devise and bequeath the same as follows: ... (b) One (1) of said equal parts to Manchester Memorial Hospital, a hospital corporation organized and existing under the laws of the State of Connecticut and located in said Manchester, to be held as a permanent fund in memory of my husband, Philip Cheney, with power of investment and reinvestment, the income only to be used and applied for the benefit of said Hospital in such manner as the Trustees of said Hospital may in their discretion determine." Income unrestricted	The Last Will and Testament of Helen Campbell Cheney dated June 29, 1960		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1011.17	Albert (Herbert) Dewey	$1,498	$64,828	Unknown	There is no original or specific documentation of the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Albert Dewey at the Manchester probate court, but the Will does not include this gift; the Will indicates that Mr. Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Albert or Herbert Dewey; the Hospital believes it is the Albert Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee reference an $8,000 bequest from Albert T. Dewey that will be memorialized with a plaque in the Vestibule on the Second Floor East Building (244) as the "Gift of Albert T. and Jane N. Dewey". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.18	Jane (June) Dewey	$936	$40,517	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Jane Dewey at the Manchester probate court, but it does not include this gift; the Will indicates that Jane Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Jane or June; the Hospital believes it is the Jane Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee note a $5,000 bequest from Jane N. Dewey that will be memorialized with a plaque in the Nurses' Lounge in the Surgical Suite "In memory of Hilma N. Dillon and Emily D. Coburn". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation
11-1.19	The Loren Gardner Fund	$25,000	$71,637	Bequest under Article FIFTH of the Last Will and Testament of Ella C. Livermore dated October 12, 1929	Bequest of "twenty five thousand dollars ($25,000) to the Manchester Memorial Hospital, a corporation specially chartered by the State of Connecticut, located at South Manchester in said State, in memory of my father, Loren Gardner, to be held by said Hospital as a fund to be known as The Loren Gardner Fund, the income therefrom to be used for the proper uses of the Hospital. I request, but do not make it a condition, that the income, or so much as may be necessary, be applied to the maintenance of a free bed in said Hospital for poor patients." Income unrestricted with a request that it be used for free care	The Last Will and Testament of Ella C. Livermore dated October 12, 1929	Note: The Hospital has historically classified and reported this fund as restricted for free care, and it reported this as a free bed fund to the Office of the Attorney General for inclusion in the 1990 Report of the Attorney General. The donor did not, however, impose that as a binding condition. This income from this endowment fund is thus unrestricted, and the fund has been reclassified.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.20	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,182	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 6/28/06 of portion of devise of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated Novermber 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 11-1.20 and 11-1.21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 11-1.81.	Request cy pres relief and transfer to the new Foundation
11-1.21	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,182	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 7/26/06 of portion of devise of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated Novermber 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 11-1.20 and 11-1.21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 11-1.81.	Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment: Unrestricted Income Funds		$1,130,638	$8,558,011					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Free Bed Funds (Endowment Restricted for Free Care)							
11-1.22	Drake Fund	$90,500	$174,202	Devise under Article EIGHTH (c)(2) of the Last Will and Testament of Edith Drake Quimby dated September 7, 1949 with Codicil dated October 4, 1950	Upon the deaths of the life beneficiaries and the payment of specific bequests, Article EIGHTH (c) directs that the Trustees divide the balance of the funds: "into ten(10) equal parts and I give, devise and bequeath said parts as follows:... " (2) Two (2) of said parts to the Manchester Public Hospital, of Manchester, Connecticut, in memory of my father and mother, Levi Drake and Julia Pease Drake, the income therefrom to be used to support a bed in said hospital. It is my wish that said fund shall be known as the "Drake Bed Fund" and I request that the nomination to this bed be vested in the governing body of the Congregational Church in North Manchester, Connecticut, of which my parents were members for many years." Income restricted for free care	The Last Will and Testament of Edith Drake Quimby dated September 7, 1949; and Codicil dated October 4, 1950	Note: MMH has an active contact at the Congregational Church, which is the nominator for this fund.	Request cy pres relief and transfer to the new Foundation
11-1.23	The Mattie Hills Preston Free Bed Endowment	$8,000	$8,006	Bequest under Article FIFTH (a) of the Last Will and Testament of Janes M. Preston dated April 3, 1924	Bequest of "Eight Thousand ($8,000) Dollars, the same to be held by said Hospital in trust and the income thereof applied for the maintenance of a free bed, such endowment to be known as "The Mattie Hills Preston Free Bed Endowment." Income restricted for free care	The Last Will and Testament of Janes M. Preston dated April 3, 1924	Note: As stated in the Will and in the 1990 Report of the Attorney General, Article FIFTH (d) of the Will creates a second $8,000 bed fund in the name of Janes Preston if there is sufficient money. The Hospital's records do not reflect that this second bed fund was established or what happened to the second bequest.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.24	F. O. Boynton	$923	$924	Devise under Last Will and Testament of F.O. Boynton (date and location unknown)	Devise of the residuary estate as follows: "I give and bequeath to the Manchester Memorial Hospital of Manchester, Connecticut,...all the rest, residue and remainder of my estate, to be held as a separate and permanent fund and the income therefrom to be used for the general purposes of the hospital with special reference to the furnishing of hospital facilities to persons then not able to pay for the service so rendered." Income restricted for free care	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995 with supporting reconciliation of funds as of 9/30/1995; excerpt from the 1990 Report of the Attorney General; and undated Exhibit A to Report to Finance Committee		Request cy pres relief and transfer to the new Foundation
11-1.25	Erna W. Loomis	$196,394	$196,547	(1) Bequest under ARTICLE V, paragraph L. of the Last Will and Testament of Erna W. Loomis dated July 20, 1992; and (2) Devise of a share in the residuary estate under ARTICLE V, paragraph R.4. of said Will	Erna W. Loomis left two testamentary gifts to Manchester Memorial Hospital, both of which were endowment restricted for the same purpose: Bequest under ARTICLE V, paragraph L.of "TWENTY-FIVE THOUSAND ($25,000) DOLLARS to MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, to be held in trust, the income only to be included in any program providing for the payment of anyone's expenses who cannot otherwise afford the same." Devise under ARTICLE V, paragraph R.: "All of my property thereafter remaining is to be divided into the following four (4) equal parts: ... 4. The fourth of said parts is to be added to my bequest to MANCHESTER MEMORIAL HOSPITAL, under Article V, Paragraph L of this Will and held and administered in accordance with its terms." Income restricted for free care	The Last Will and Testament of Erna W. Loomis dated July 20, 1992		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.26	Elsie Cheney Disher (Sophie H. Cheney)	$151,579	$151,697	Gift of an interest in the remainder of a trust created by Elsie C. Disher upon termination of the trust (date of trust unknown.)	The Trust provided as follows: "The remainder in equal shares to the Manchester Memorial Hospital of Manchester, Connecticut, and to _____. The gift to the Manchester Memorial Hospital is to be held as a permanent fund, in memory of my mother, the income thereof to be used so far as is necessary for the support of a private room in said Hospital, to be known as the "Sophie H. Cheney Room", said room in the discretion of the Hospital authorities to be used for the benefit of worthy cases of special need. Any balance of the income not necessary for the foregoing purpose shall be used by the Hospital authorities for the general purposes of the Hospital. I request that said authorities use a portion of the income for the erection of a suitable table in said room to be inscribed with an appropriate reference to my said mother and to her general benefactions to the community." Income restricted for free care	Excerpt from Trust Agreement of Elsie C. Disher.	Note: The Hospital has only a copy of an excerpt from the Trust agreement, which was an inter vivos trust. The Hospital has a copy of Mrs. Disher's Last Will and Testament dated May 11, 1923; that included a contingent unrestricted gift to the Hospital but did not include this trust provision. Mrs. Disher died in 1923.	Request cy pres relief only for funds, if any, not used by the Hospital
11-1.27	Sanford Keeney	$10,344	$10,352	Devise under Article 7th of the Last Will and Testament of Lula M. Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries, two testamentary trusts Mrs. Pinney had established terminated, and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income restricted for free care as to this part of the gift; see also Fund 11-1.13	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that during her lifetime Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 11-1.27. The balance of her testamentary gift is reported at Fund 11-1.13.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$457,740	$541,728					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Endowment Restricted to Purposes Other Than Free Care								
11-1.28	Thomas D. Trotter Memorial Fund	$500	$500	Bequest under ITEM VII of the Last Will and Testament of Thomas D. Trotter dated January 20, 1951	Bequest to Manchester Memorial Hospital of "the sum of Five Hundred (500) Dollars to be known as the Thomas D. Trotter Memorial Fund, and I direct that only the income from this fund is to be used, in the absolute and uncontrolled discretion of the supervisor of said hospital, in some way for the benefit of the children patients." Income restricted to benefit pediatric patients	The Last Will and Testament of Thomas D. Trotter dated January 20, 1951		Request cy pres relief and transfer to the new Foundation
11-1.29	William and Rebecca J. Wright Fund	$6,124	$6,128	Devise under ARTICLE IV of the Last Will and Testament of Rebecca J. Wright dated May 26, 1948	Devise of a share in the residuary estate as follows: "ARTICLE IV: ....In the event my said brother should die before me, I direct my Executor, without the requirement of setting up the Trust, to distribute the funds designated for the Trust directly to the remainder men thereof as hereinafter set forth. I direct my Trustee to divide all funds in its hands into three (3) equal shares and I direct my Trustee to pay over one (1) of said shares to The Manchester Memorial Hospital of Manchester, Connecticut, and that said share shall be kept intact as an endowment fund and that the income therefrom shall be used in the fight again Cancer, and that said share or fund shall be known as the William and Rebecca J. Wright Fund." Income restricted for cancer	The Last Will and Testament of Rebecca J. Wright dated May 26, 1948		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purposes Other Than Free Care		$6,624	$6,629					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Miscellaneous Funds								
11-1.30	Interests in the Estate of Raymond F. Damato	Unknown at this time	Unknown at this time	(1) Devise under Article SEVENTH D. of the Last Will and Testament of Raymond F. Damato dated July 7, 2009, with Codicils dated April 10, 2010, and February 11, 2011; and (2) bequests of trust termination shares under Article SIXTH of the Will.	Devise of 20% of the residuary estate "to Manchester Memorial Hospital, of Manchester, Connecticut.....Except as set forth in the individual bequests above, the bequests subject to this Paragraph shall be unrestrcied in purpose and left to the discretion of the governing board of each of the respective charitable organizations. Article SIXTH provides that, upon the termination of each of the eleven trusts created under that Article, "...the Trustee shal distribute the then remaining Trust of said deceased beneficiary,... absolutely and free of trust, to those beneficiaries and in the respective percentages set forth in Article Seventh of this my last Will and Testament. Unrestricted	The Last Will and Testament of Raymond F. Damato dated July 7, 2009,Codicil dated April 10, 2010; and Codicil dated February 11, 2011;	Note: Mr. Damato died April 25, 2014, and his Will and Codicils were admitted to probate May 6, 2014. It is premature to estimate the values of the Hospital's interests, but the estate is known to be substantial.	Use by the Hospital in the discretion of its Board
11-1.31	Life Insurance Policy (Name of Insured withheld)	NA	$58,147	Life Insurance Policy with face value of $50,000 issued by National Life Insurance Company	Policy owned by the Hospital with a current cash value of $58,147. Unrestricted	Face sheet of the Policy, with the name of the insured redacted		Request cy pres relief and transfer to the new Foundation if the insured is then living
Subtotal: Miscellaneous		$0	$58,147					
Grand Total: Manchester Memorial Hospital		$1,595,003	$9,164,514					

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Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ROCKVILLE GENERAL HOSPITAL							
Endowment: Unrestricted Income Funds								
11-1.32	Alice Farmer Bissell Fund	$25,000	$3,717,384	Bequest under Article Fourth of the Last Will and Testament of Arthur T. Bissell dated September 1, 1932	Bequest to the Rockville City Hospital of "the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Arthur T. Bissell dated September 1, 1932		Request cy pres relief and transfer to the new Foundation
11-1.33	Frances Taylor Maxwell Memorial Fund	$50,000	$83,261	Devise under Article FOURTEENTH (b) of the Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956, with Codicil dated April 9, 1959	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "FOURTENTH: All the rest, residue and remainder of my estate of every name and nature, real and personal,..., I direct my executors hereinafter named to divide into six (6) equal shares: ...(b) I give, devise and bequeath one (1) of said shares to said Hartford National Bank and Trust Company, absolutely and in fee simple, but in trust, nevertheless,... to pay over, apply or expend for the benefit of my granddaughter VIRGINIA BELDING ...the net income thereof ...Upon the death of said VIRGINIA BELDING, I direct my said Trustee to divide the principal of said trust fund into two equal portions. One (1) such portion shall be paid over to ROCKVILLE CITY HOSPITAL, an eleemosynary corporation of Connecticut located in Rockville, the principal to be kept safely invested and known as the FRANCIS TAYLOR MAXWELL MEMORIAL FUND, and the net income only used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956; and Codicil dated April 9, 1959		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.34	Stephen Goodale and Emeret Scott Risley Fund	$89,689	$918,485	(1) Bequest under Paragraph NINTH of the Last Will and Testament of May Risley Adams dated February 26, 1944; and (2) Devise under Paragraph TWENTY-FIRST of said Will	May R. Adams left two testamentary gifts to Rockville City Hospital, both of which were endowment restricted for the same purpose as follows: Bequest under Paragraph NINTH to "THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital; together with the diploma of my late father, Stephen Goodale Risley, M.D. and my John Hamilton clock, made in Glasgow, Scotland, before 1720." Devise of the residue of the estate under Paragraph TWENTY-FIRST: "All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC., in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is estabished in paragraph Ninth of this my last will and testament. Income unrestricted	The Last Will and Testament of May Risley Adams dated February 26, 1944		Request cy pres relief and transfer to the new Foundation
11-1.35	United German Society Fund	$10,724	$25,686	Gift from United German Society	Excerpt from "Source and Terms of Fund Held": "Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 6)		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.36	William H. Prescott	$50,000	$660,877	Bequest under Article 13. of the Last Will and Testament of William H. Prescott dated January 17, 1908 Bequests under Paragraphs 5, 9, and 15 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Bequest as follows: "13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of fifty thousand dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick . . ." Bequests under the Will of Celia E. Prescott of the remainders of three $5,000 trusts upon the deaths of the respective life beneficiaries, the remainder of each given "... to the trustees of the Rockville City Hospital, in trust, for the benefit of said hospital, that the same may be added to the endowment fund provided for in the will of my late husband, William H. Prescott, for the purpose of establishing and maintaining said proposed hospital." Income unrestricted	The Last Will and Testament of William H. Prescott dated January 17, 1908; and The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation
11-1.37	William Maxwell Fund	$171,719	$437,248	Devise under Article FOURTEENTH of the Last Will and Testament of William Maxwell dated December 3, 1938, with Codicils dated December 3, 1938 and January 3, 1939; inter vivos gifts, and life insurance proceeds	Devise of share of residue of estate as follows: "FOURTEENTH: To ROCKVILLE CITY HOSPITAL in Rockville, Connecticut, I give, devise, and bequeath four of said equal [one hundred] parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of William Maxwell dated December 3, 1938; Codicil dated December 3, 1938; Codicl dated January 3, 1939; document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 3); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.38	Cora Lloyd Smith Fund	$7,658	$19,128	Devise under Article SIXTH (b) of the Last Will and Testament of Cora Lloyd Smith dated May 10, 1940	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "... Upon the death of my said husband CLARENCE SMITH, I direct that said trust shall cease and terminate, and I give, devise and bequeath said trust fund remaining at said time, as follows, to wit: ... (b) The remaining one-half thereof unto The ROCKVILLE CITY HOSPITAL, INC. of said town of Vernon, to be known as the Cora Lloyd Smith Fund. I direct the trustees of said Hospital to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Cora Lloyd Smith dated May 10, 1940		Request cy pres relief and transfer to the new Foundation
11-1.39	Bruno E. and Maud J. Doss	$8,000	$15,180	Bequest under Article THIRD d. of the Last Will and Testament of Bruno E. Doss dated May 4, 1956, as amended by Codicil dated June 17, 1957, with additional Codicils dated October 14, 1958 and January 22, 1959	Bequest under the Codicil of "... Eight Thousand (8,000) Dollars in cash to ROCKVILLE CITY HOSPITAL, INC., in trust for the following purpose: To set up a fund to be known as BRUNO E. DOSS and MAUD J. DOSS fund; to invest and reinvest the same in its discretion and to pay over only the income therefrom, at least annually, to the ROCKVILL CITY HOSPITAL GENERAL OPERATING EXPENSE ACCOUNT." Income unrestricted (for use for operations)	The Last Will and Testament of Bruno E Doss dated May 4, 1956; Codicil dated June 17, 1957, Second Codicil dated October 14, 1958; and Third Codicil dated January 22, 1959		Request cy pres relief and transfer to the new Foundation
11-1.40	Eva Noble Wood Fund	$1,000	$13,399	Bequest under Article FIFTH of the Last Will and Testament of Eva Noble Wood dated June 18, 1964	Bequest to "...the ROCKVILLE CITY HOSPITAL, INC., of said Town of Vernon, the sum of One Thousand (1,000) Dollars to be held by said Hospital and the income from said sum to be used for its general uses and purposes and said sum is to be known as the Eva Noble Wood Fund." Income unrestricted	The Last Will and Testament of Eva Noble Wood dated June 18, 1964		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.41	Maud Henry	$50,000	$167,491	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest "...to the Hospital to be established in Rockville under the provisions of the will of the late William H. Prescott to be known as the "Rockville City Hospital" This bequest is to constitute a special endowment fund of Fifty thousand dollars $50,000. to be set apart and known as the Maud Henry fund in memory of my deceased daughter Maud....The income of [this fund] is to be used for the maintenance of said Hospital..." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation
11-1.42	Lenore Henry	$50,000	$148,115	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest of "...Fifty thousand dollars $50,000. to said [Rockville City] Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" fund in memory of my deceased daughter Lenore. Income of [this fund] is to be used for the maintenance of said Hospital...." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.43	George Palmer Charter Fund	$10,000	$14,398	Bequest under Article SECOND of the Last Will and Testament of George Palmer Charter (date unknown)	Bequest "...to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital." In addition, the Hospital's records indicate it was entitled to a share of the residue as follows: "SEVENTEENTH. All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Pages 3-4)	Note: This fund holds the bequest of $10,000. Whether the Hospital received any distribution under Article SEVENTEENTH is unknown.	Request cy pres relief and transfer to the new Foundation
11-1.44	Anna & Albert Bilson Fund	$10,372	$14,933	Devise under Article NINTH of the Last Will and Testament of Anna M. Bilson dated October 3, 1952	Devise of a share in the residue of the estate as follows: "NINTH: All the rest, residue and remainder of my estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. .... The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc., of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Anna M. Bilson dated October 3, 1952		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.45	Alvah N. Belding Fund	$3,000	$5,759	Bequest under Paragraph 4. of the Last Will and Testament of Alvah N. Belding dated October 4, 1916	Bequest "...to the trustees of the Rockville City Hospital of Rockville, Connecticut, the sum of Three Thousand (3,000.) Dollars to be used and expended by them for the purposes indicated in the will of the late William H. Prescott regarding the establishment of a City Hospital, as they may deem most advisable." Income unrestricted	The Last Will and Testament of Alvah N. Belding dated October 4, 1916	Note: The Will of William H. Prescott created an endowment with income to be used to establish the Hospital. See Fund 11-1.36	Request cy pres relief and transfer to the new Foundation
11-1.46	Frederick W. Bradley	$2,000	$2,880	Bequest under Article FOURTEENTH of the Last Will and Testament of Frederick W. Bradley dated June 22, 1948	Bequest to "...THE ROCKVILLE CITY HOSPITAL, INC. of said Town of Vernon, the sum of Two Thousand Dollars, in memory of the donor and I direct that said sum be added to the endowment fund of said Hospital, the income thereof to be used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Frederick W. Bradley dated June 22, 1948		Request cy pres relief and transfer to the new Foundation
11-1.47	Ruth T. Britton Fund	$5,000	$7,199	Bequest under Article SIXTEENTH of the Last Will and Testament of Ruth Talcott Britton dated March 12, 1924, with Codicil dated January 26, 1929	Bequest "...to the Rockville Hospital, of Rockville, in the Town of Vernon, Connecticut, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees." Income unrestricted	The Last Will and Testament of Ruth Talcott Britton dated March 12, 1924; and Codicil dated January 26, 1929		Request cy pres relief and transfer to the new Foundation
11-1.48	William B. and Lizzie Lathrop Sprague Fund	$5,000	$7,199	Bequest under the Will of Lizzie L. Sprague dated February 5, 1921	Bequest of the residue of a testatmentary trust following the death of the life beneficiary as follows: "...at her decease said principal sum of five thousand dollars shall go to The Rockville City Hospital of Rockville, Conn, the same to be known as The Wm. B. and Lizzie Lathrop Sprague Fund." This fund is treated as endowment with income unrestricted.	The Last Will and Testament of Lizzie L. Sprague dated February 5, 1921; and minutes of February 18, 1924 meeting of the Board of Trustees of the Hospital.	Note: The Hospital has treated this as an endowment fund but the language is not clearly so restricted.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.49	George S. Doane	$5,000	$7,199	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 1); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of a George W. Doane in Springfield, but it did not include a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation
11-1.50	Edgar Keney (Keeney)	$500	$720	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 2); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of Edgar Keeney and that of Clara, his wife, but neither included a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.51	Rockville Chapter American Red Cross Fund	$4,000	$5,759	Gift from Rockville Chapter	The minutes of the 1920 meeting of the Board at which the gift was reported do not document any restriction on use. The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital". Income unrestricted	Minutes of the January 29, 1920 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957;	Note: The Hospital has treated this as an endowment fund but the 1920 minutes do not document that restriction.	Request cy pres relief and transfer to the new Foundation
11-1.52	Fred Talcott Fund	$5,000	$7,199	Bequest under Article SIXTEENTH of the Last Will and Testament of Fred Talcott dated January 16, 1917	Bequest as follows: "SIXTEENTH. Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital." Income unrestricted	The Last Will and Testament of Fred Talcott dated January 16, 1917	Note: See Fund 11-1.36 for the William Prescott Fund and its terms.	Request cy pres relief and transfer to the new Foundation
11-1.53	J. Alice Maxwell Fund	$6,095	$8,775	Devise under Article NINTH of the Last Will and Testament of J. Alice Maxwell dated March 28, 1941; with Codicil dated April 17, 1942	Devise to the Hospital as follows: "NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital." Income unrestricted	The Last Will and Testament of J. Alice Maxwell dated March 28, 1941; and Codicil dated April 17, 1942		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.54	William A. and Caroline E. Metcalf Fund	$7,231	$10,411	Devise under Article NINTH of the Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941	Devise of all the rest, residue and remainder of the estate "...to the Trustees of the Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, ...in trust, nevertheless, to hold, invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said Trust shall be known as the William A. and Caroline E. Metcalf Fund." Income unrestricted	The Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941		Request cy pres relief and transfer to the new Foundation
11-1.55	E. Stevens Henry	$1,720,205	$2,690,344	Article Fourteenth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Devise of the residue of a testamentary trust following the death of the last surviving life beneficiary as follows "Fourteenth: I give and bequeath One hundred thousand dollars - $100000- to constitute a Trust Fund to be set apart and in custody of the "Security Trust Company" of Hartford or in some other Connecticut Trust Company to be determined by Executors. The net income of said trust fund shall if my wife survives me be paid to my said wife Lucina E. Henry ... If my said wife does not survive me then upon my death, and if she does survive me then upon her death, this trust fund shall thereupon accumulate, if my grand daughter Lucina Ackerly, is then living until she attains the age of twenty five years and then and thereafter the original fund and its accumulations up to the time she attains the age of twenty five years shall be deemed to be the principal of said trust fund, the net income of said principal after said Lucina Ackerly attains the age of twenty five years, as aforesaid shall be paid to my said grandaughter Lucina Ackerly ... Upon the death of said Lucina Ackerly the entire principal fund then remaining I give, devise and bequeath to the Rockville City Hospital hereinbefore referred to, and the same shall thereupon become part of the endowment fund of that institution, absolutely and forever, it being my intention and will that said Rockville City Hospital shall have and possess all the rest residue and remainder of the said trust fund and the principal aforesaid to it absolutely and forever. Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: The Hospital received differing advice about the nature of this fund from outside counsels; one advised the Hospital that this fund is totally unrestricted, and another advised that it is endowment with income only to be spent. The fund has been classified as endowment.	Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Subtotal: Endowment: Unrestricted Income Funds		$2,297,193	$8,989,027					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Free Bed Funds (Endowment Restricted for Free Care)								
1[illegible].56	Trumbull Chapter DAR	$157,268	$219,720	Gift of a free bed fund from the Sabra Trumbull Chapter of the Daughters of the American Revolution	Gift from the Sabra Trumbull Chapter of the D.A.R. Althugh the early history of the fund is cloudy, it appears that the fund was started at a bank in 1919, and by 1921 it had reached $5,000. In December 1954, the Advisory Board of the Chapter adopted resolutions governing the use of the bed fund summarized as follows: Income from the fund was to be used for free care with preference given to Chapter members, and, if on January 1 of a year, any income from the prior year remained on hand, it could be used for "deserving and needy people," with any unused income added to principal. The Advisory Board of the Chapter had to right to designate use of the fund. The Chapter subsequently dissolved, and by letter to the Hospital's Board of Trustees dated May 29,1962, Mrs. Donald Fisk of the Chapter advised the Hospital of the dissolution of the Chapter. The letter stated that the bank would continue to maintain the fund "with the discretion in you, as trustees, to choose beneficiaries. The former members of the Sabra Trumbull Chapter will appreciate any preference which you may choose to give to them or to other D.A.R. members as beneficiaries of this fund." Income restricted to free care, with a request to consider use for former members of the Chapter or other members of the D.A.R.	Resolution of the Board of Advisors of the Sabra Trumbull Chapter of the Daughters of the American Revolution dated December 4, 1954; letter dated May 29, 1962 from Mrs. Donald C. Fisk to the Board of Trustees, Rockville City Hospital		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1201.57	Celia E. Prescott Fund holding (two bed funds): 1. Francis and Eliza Porter Keeney Bed Fund (originally $10,000); and 2. Francis Keeney Prescott Bed Fund (originally $5,000)	$15,000	$15,009	Bequests under Paragraph 34 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Two bequests to establish free bed funds as follows: 34. I give to the trustees of the said Rockville City Hospital for the benefit of the same, the sum of Ten Thusand (10,000.) Dollars, for the establishment of a free bed in honor of my late father and mother, Francis and Eliza Porter Keeney, and I request that in the use of the same preference be given, if occasion arises, to any of the descendants of the Keeney family....I also give to the trustees of the said hospital, for the benefit of the same, the sum of Five Thousand (5,000.) Dollars, for the establishment of a free bed in loving memory of my late son, Francis Keeney Prescott. Income restricted to free care, with preference for descendants of the Keeney family members for the Francis and Eliza Porter Keeney Bed Fund	The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.58	Charles Phelps Free Bed Fund	$10,000	$10,006	Inter Vivos Gift from Elsie S. Phelps	Inter vivos gift from Elsie S. Phelps to establish a free bed fund in honor of her husband to be known as the Charles Phelps Free Bed Fund. Per the records of the Hospital, the terms are as follows: "Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary. Terms of Gift. 1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide. 2. For the general use and benefit of the residents of the City of Rockville. The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund. will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers or sale, investment and reinvestment." Income restricted to free care, first for members of Elsie Phelps's household staff and their families and then for residents of Rockville	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 3)		Request cy pres relief and transfer to the new Foundation
11-1.59	Winchell-Foster	$15,000	$15,009	Bequest under ARTICLE THIRD (j) of the Last Will and Testament of Minnie Foster Riley	Bequest of "The sum of Fifteen Thousand ($15000) Dollars to the Rockville City Hospital of Rockville, Connecticut, as a permanent fund to be known as the "Winchell-Foster Free Bed Fund" in memory of my grandparents, Cyrus and Hester Winchell, and my parents, Wilbur and Mary Edna Foster, and which sum shall be held and invested and reinvested as the governing body of said Hospital shall, in its sole discretion deem best, and the income from which shall be used for the maintenance of a free bed in said Hospital." Income restricted for free care	Letter of unclear date (July 31, 19??) from The First National Bank of Denver to the Hospital with the extract from the Will		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.60	Betsey C. Tucker	$2,000	$2,001	Bequest under Article SECOND of the Last Will and Testament of Betsey C. Tucker dated June 21, 1949	Bequest "to the Rockville City Hospital, of Rockville, Connecticut, Two Thousand (2000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital." Income restricted for free care	The Last Will and Testament of Betsey C. Tucker dated June 21, 1949		Request cy pres relief and transfer to the new Foundation
11-1.61	Anna Shelton Whitlock	$20,120	$20,133	Devise under Article 2. of the Last Will and Testament of Florence R. Whitlock dated August 28, 1929	Upon the death of the life beneficiary of the residuary trust, the remainder of the residue was ro be divided into ten (10) equal parts, to be "disposed of as follows:... The remaining Four-tenths (4/10th) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock." Income restricted for free care	The Last Will and Testament of Florence R. Whitlock dated August 28, 1929		Request cy pres relief and transfer to the new Foundation
11-1.62	Elsie Sykes Phelps Free Bed Fund	$5,975	$5,979	Bequest under Article IV (c) of the Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955	Bequest "To the ROCKVILLE CITY HOSPITAL, of said Rockville, founded by the late William H. Prescott of said Rockville, fifty (50) shares of the capital stock of The Travelers Insurance Company, and I direct that the Trustees of said Hospital add the same to the permanent endowment of a free bed for said Rockville City Hospital, such gift to be called the "Elsie Sykes Phelps Free Bed Fund". Income restricted for free care	The Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955		Request cy pres relief and transfer to the new Foundation
11-1.63	John and Martha Kress Fund	$500	$500	Bequest under Article Fourth of the Last Will and Testament of Martha M. Kress dated April 3, 1918	Bequest of "...the sum of Five Hundred Dollars to the Rockville City Hospital to be used for the purpose of equipping, furnishing and maintaining a room in [the] Hospital to be known and called the "John and Martha Kress room." Income restricted for free care	The Last Will and Testament of Martha M. Kress dated April 3, 1918	Note: The Hospital has historically classified this as a free bed fund, but the language of the bequest is not clear on this point.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$225,863	$288,358					
Endowment Restricted to Purpose Other Than Free Care								

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1161.64	Julia and Percy Baker Family Memorial Fund	$145,770	$145,861	Devise under ARTICLE III (a) of the Last Will and Testament of Percy W. Baker dated June 22, 1990, with Codicils dated April 26, 1995 and May 16, 1997	Devise of a share in the residuary estate as follows: "Residue. All the rest, residue and remainder of my property, real and personal, of whatever nature and wherever situated, I give, devise and bequest as follows: (a) twenty (20) per cent to be held in trust to establish a fund known as the Julia and Percy Baker Family Memorial Fund. Said fund is to be used for the upkeep and physical maintenance of the Rockville General Hospital, Rockville, Connecticut. The physical maintenance of the Hospital by said fund is defined to include items such as painting, roof repairs, furnace repairs or replacement carpet repairs or replacement, or any other repairs or replacement of existing fixtures so as to keep the Hospital in good physical condition. The intent is that the principal of the fund so established and known as the Julia and Percy Baker Family Memorial Fund not be invaded. Only interest or other income generated by the Fund shall be used for purposes of physical maintenance, and the corpus of said fund is not to be invaded by the Trustee." Income for the upkeep and physical maintenance of the Hospital	The Last Will and Testament of Percy W. Baker dated June 22, 1990; First Codicil dated April 26, 1995, and Second Codicil dated May 16, 1997		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1201.65	Faith S. Schortmann Fund	$132,820	$132,907	(1) Bequest under ARTICLE VI of the Last Will and Testament of Faith S. Schortmann dated November 21, 1990; and (2) Devise of a share in the residuary estate under ARTICLE VIII A of said Will.	Bequest to ROCKVILLE GENERAL HOSPITAL of "the proceeds of all my investments with the IDS Financial Services, Inc., and its related companies, to be held as a separate fund known as the FAITH S. SCHORTMANN FUND. Said Fund shall be restricted, and the Board of Trustees or other governing body of said ROCKVILLE GENERAL HOSPITAL, INC., shall invest and reinvest such Fund in any manner it deems appropriate, but shall use or expend only the income therefrom (without invasion of the principal of said Fund) for such purposes directly related to the operation and/or improvement of the maternity and nursery facilities of said ROCKVILLE GENERAL HOSPITAL, INC., in whatever manner it deems appropriate." Devise of "FORTY-FIVE PERCENT (45%) of my said residuary estate to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be added to and become a part of the FAITH S. SCHORTMANN FUND, to be used and expended in accordance with the terms of Article VI of this, my Last Will and Testament." Income for the operation or improvement of the maternity and nursery facilities of the Hospital.	The Last Will and Testament of Faith S. Schortmann dated November 21, 1990		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purpose Other Than Free Care		$278,589	$278,769					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Unrestricted Funds								
11-1.66	Swindells Fund	$74,473	$107,224	Gifts from the F.W. Swindells Charitable Foundation, which was established under Article Sixth of the Last Will and Testament of Frederick W. Swindells dated October 15, 1930	The income from the Foundation (Trust) established under the Will is to be paid "... to charitable corporations or societies incorporated for the relief of sick and suffering poor children and/or for the sick, suffering and indigent, aged men and women, and/or for the support of public and charitable hospitals....The ultimate beneficiaries of this charity shall be poor and suffering individuals." Available documentation supports that this fund is fully expendable.	The Last Will and Testament of Frederick W. Swindells dated October 15, 1930; Letters dated October 24, 1933, from The Hartford National Bank and Trust Company and The Travelers Bank and Trust Company, Trustees, transmitting two $500 checks (unrestricted); Minutes of January 27, 1936 meeting of the Board of Trustees documenting receipt of $500; Minutes of January 21, 1941 meeting of the Board of Trustees documenting receipt of $500; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 5)	Note: In an effort to obtain additional information, the Hospital spoke with Kate Kirkheart of the Swindells Charitable Foundation at the Bank of America; although the Bank has some old correspondence related to donations, it declined to release copies of the correspondence or a statement of gifts.	Request cy pres relief only for funds, if any, not used by the Hospital
11-1.67	Harriet K. Maxwell Fund	$5,000	$15,326	Bequest under Article Third of the Will of Harriet K. Maxwell	Bequest "... unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)". Unrestricted	Minutes of the January 20, 1953 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 2)	Note: A Harriet K. Maxwell died in 1996 in Arizona, but her Will does not include this gift, which is believed either to have come from the Will of a different member of the family or have been incorrectly designated in the old Board records as a bequest. A May 11, 1998 letter from William W. Graulty concerning gifts from the Harriet K. Maxwell Foundation also does not include any information about this fund.	

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.68	Robert Maxwell Fund	$100,000	$143,977	Bequest under Article First of the Last Will and Testament of Robert Maxwell dated November 21, 1919	Bequest to "...my Executors hereinafter named, or the survivors or survivor of them, the sum of One hundred thousand dollars ($100,000.), to be devoted by them to the establishment and maintenance of a suitable building or buildings, grounds and equipment in the CIty of Rockville, State of Connecticut, where the residents of the City of Rockville and vicinity may, without charge and without regard to race or religion, obtain healthful exercise, recreation, amusement and instruction, or, in the discretion of my Executors, the said principal sum or the income thereof, or both, to be devoted by them in such other manner as they deem suitable for the benefit of the said residents of Rockville and vicinity." Unrestricted	The Last Will and Testament of Robert Maxwell dated November 21, 1919		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.69	F. Maxwell Memorial	$283,919	$1,172,044	Bequest under Article FIRST of the Codicil dated Novermber 19, 1941; and Devise under Article THIRTEENTH of the Last Will and Testament of Francis T. Maxwell dated May 15, 1940	Bequest to Rockville City Hospital of "the sum of One hundred thousand dollars ($100,000)." Devise of a share of trust assets upon termination of various testamentary trusts if no issue of the Testator is living at the time of termination as follows: "THIRTEENTH: All the rest, residue and remainder of my property, real and person, of every kind, nature and description and wheresoever situated, ... I give, devise, bequeath and appoint to my TRUSTEES....(e) In the event that, upon the termination of any of said trusts, there should be no issue of mine then living, then, and in such event, I direct that the capital of such trust shall be divided into two equal parts, one of which parts I give, devise and bequeath to ROCKVILLE CITY HOSPITAL and the other to HARTFORD HOSPITAL." Unrestricted	The Last Will and Testament of Francis T. Maxwell dated May 15, 1940; and Codicil dated November 13, 1940		Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.70	Memorial Funds	$328,454	$1,284,374	Unknown	This fund holds on a consolidated basis many gifts contributed to the Hospital over the years from many sources. It has been reported as unrestricted endowment for many years. The creation of this fund is referenced in the January 20,1953 Minutes of the Board of Trustees of the Hospital. This fund is believed to be totally unrestricted as to income and principal.	Minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital; and January 24, 1968 letter from Attorney Donald B. Caldwell to Robert C. Hector of CHEFA		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.71	Mary E. Snyder	$1,621	$2,122	Devise under Paragraph SIXTH(hh) of the Last Will and Testament of Mary E. Snyder dated My 20, 1955	Devise of a share in the residuary estate as follows: "SIXTH: All the rest, residue and remainder of all my property, both real and person, of whatsoever the same may consist or wheresoever it may be situated, I direct be divided into thirty-five equal shares and distributed as follows, to wit:... (hh) one equal share to the ROCKVILLE CITY HOSPITAL, INC. of said Rockville, in memory of my late sister Flora C. Snyder and in my memory, for its general uses and purposes." Unrestricted	The Last Will and Testament of Mary E. Snyder dated May 20, 1955		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.72	Charles F. Batz	$4,000	$5,957	Inter Vivos Gift from Emma Batz for her brother, Charles F. Batz	Inter vivos gift of $4,000 Unrestricted	Correspondence between the Hospital and Emma Batz in 1993 and 1994; and the Last Will and Testament of Charles F. Batz dated November 2, 1992.	Note: ARTICLE FIVE of Charles Batz's Last Will and Testament dated November 2, 1992, left the residue of his estate outright to his sister, Emma, and, if she did not survive him, one-fourth of the residue to the Hospital outright. Emma did survive, so the Hospital was not entitled to a portion of the Estate, but Emma Batz made a $4,000 gift to the Hospital in his memory. The correspondence documenting the gift incorrectly says or suggests that this gift was a bequest from the Estate.	Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.73	Francis J. Gregory	$122,965	$34,241	Devise under Article FOURTH of the Last Will and Testament of Francis J. Gregory dated March 16, 1979	Devise of a share of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my estate, wherever it may be found, shall be distributed equally among the following [six organizations] ...Rockville General Hospital, Rockville, Connecticut,..." Unrestricted	The Last Will and Testament of Francis J. Gregory dated March 16, 1979		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.74	John A. Duell	$5,000	$7,447	Bequest under Article THIRD of the Last Will and Testament of John A. Duell dated September 14, 1988	Bequest to "ROCKVILLE GENERAL HOSPITAL of Rockville, Connecticut, the sum of FIVE THOUSAND ($5,000) DOLLARS, for its general use and purpose." Unrestricted	The Last Will and Testament of John A. Duell dated September 14, 1988		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.75	Edna O. Rider	$10,000	$14,893	Bequest under Article THIRD A. of the Last Will and Testament of Edna O. Rider dated April 1, 1982	Bequest as follows: "THIRD: I give, devise and bequeath all the rest, residue and remainder of the property which I may own at the time of my death, real, personal and mixed, of whatsoever nature and wheresoever situated, as follows: A. The sum of Ten Thousand ($10,000.00) Dollars to the ROCKVILLE GENERAL HOSPITAL of Rockville, Connectiuct to be used and expended for the benefit of such hospital in any manner it deems appropriate." Unrestricted	The Last Will and Testament of Edna O. Rider dated April 1, 1982		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.76	Barbara J. Sadrozinski	$20,739	$30,441	Devise under Article THIRD B. of the Last Willl and Testament of Barbara J. Sadrozinski dated January 22, 1993.	Devise of a share of the residuary estate as follows: "THIRD I give, devise and bequeath all the rest, residue and remainder of my proprty, both real and personal, of which I shall die seized and possessed, wherever situated, as follows:...B. Twenty (20%) percent thereof to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be its absolutely and forever." Unrestricted	The Last Willl and Testament of Barbara J. Sadrozinski dated January 22, 1993.		Request cy pres relief only for funds, if any, not used by the Hospital
Subtotal: Unrestricted Funds		$956,171	$2,818,047					

3336704.1

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Additonal Information								
11-1.77	$9,603.46 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$9,603.46 Two-Life Survivor Charitable Gift Annuity; remainder to Hospital on the death of the second to die Unrestricted	Two-Life Survivor Charitable Gift Annuity Agreement dated December 20, 1993 (with names redacted)	One of the two joint annuitants has now lived beyond his/her life expectancy determined as of the time of the gift. This annuity therefore now is a contractual liability of the Hospital rather than a charitable asset.	RGH will explore options with the annuitant to terminate this arrangement at fair value.
11-1.78	$10,000 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$10,000 Two-Life Survivor Charitable Gift Annuity; remainder to Hospital on the death of the second to die Unrestricted	Two-Life Survivor Charitable Gift Annuity Agreement dated November 3, 1994 (with names redacted)	One of the two joint annuitants has now lived beyond his/her life expectancy determined as of the time of the gift. This annuity therefore now is a contractual liability of the Hospital rather than a charitable asset.	RGH will explore options with the annuitant to erminate this arrangement at fair value.
Subtotal: Additional Information		$0	$0					
Grand Total: Rockville General Hospital		$3,757,816	$12,374,200					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.							
	Endowment for Benefit of MMH: Unrestricted Income							
11-1.79	Hazel Burgess	$113,624	$113,624	Devise under Article THIRD of the Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Devise of half the residue of a testamentary trust following the death of the last surviving life beneficiary as follows: "THIRD: All the rest, residue and remainder of my estate, both real and personal, of whatsoever the same may consist and wheresoever the same may be located, I give, devise and bequeath to CONNECTICUT BANK AND TRUST COMPANY, IN TRUST NEVERTHELESS, for the following uses and purposes:... (d) Upon the death of all of the beneficiaries hereunder, I direct that this Trust shall thereupon terminate, and the principal, together with any accumulation of income, be paid equally to the Board of Trustees of South Methodist Chruch and the Trustees of Manchester Memorial Hospital, both of Manchester, Connecticut, to be safely invested by each, and the income only therefrom to be used for the general uses and purposes of said Church and Hospital." Income unrestricted	The Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
11-1.80	Raymond A. St. Laurent and Helen St. Laurent	$10,000	$10,000	Bequest under Article NINTH 2. of the Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Bequest of "...the sum of TEN THOUSAND ($10,000.00) DOLLARS each unto each of the following named institutions or foundations, the income only from each of said bequest to be used for the general uses and purposes of said institution or foundation, the fund for each to be in memory of RAYMOND A. ST. LAURENT and HELEN E. ST. LAURENT. ... 2. MANCHESTER MEMORIAL HOSPITAL, presently of 71 Haynes St., Manchester, Connecticut; ..." Income unrestricted	The Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1201.81	Donald G. Piper and Hazel B. Piper	$1,161,399	$1,161,399	Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30, 1990	Devise of residue of estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death), I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated November 30, 1990	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment for Benefit of MMH: Unrestricted Income		$1,285,023	$1,285,023					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Endowment for Benefit of RGH Restricted Income							
1171.82	Harriet K. Maxwell Fund	$250,000	$250,000	Grant from the Harriet K. Maxwell Foundation dated May 11, 1998	Grant to the Hospital of $250,000 as follows: "On behalf of the Directors of the Harriet K. Maxwell Foundation, I am pleased to report that the Foundation has made a grant to Rockville Hospital in the aggregate amount of $400,000. This grant consists of two parts, namely, a grant of $250,000 to establish the Harriet K. Maxwell Fund, an endowment fund to provide for the normal maintenance and repair of the Maxwell Home and its grounds and a separate grant of $150,000 to pay for the major structural repairs to the Home which are considered essential for its preservation and continued use as an integral part of the Hospital. With regard to the $250,000 Fund, this grant is conditioned on the continued use of the Maxwell Home as a part of the Hospital; and that if the Home is not so used for a period of 24 consecutive months or if the Home is damaged or destroyed and not restored to its prior level of usefulness within a reasonable time thereafter, then the balance of the Fund shall be transferred to the George Maxwell Library of Rockville, Connecticut, to be held as an endowment fund for its general uses and purposes." Income restricted for the Maxwell House	Letter dated May 11, 1998, from Attorney William W. Graulty to Annette B. Leahy of the Hospital awarding the grant; letter of June 1, 1998, from Mr. Graulty to Ms. Leahy; letter of June 1 from Mr. Graulty to Ms. Leahy forwarding a corrected copy of the May 11, 1998 letter; and press release dated June 11, 1998	Note: This contains a gift over to the George Maxwell Library of Rockville if the Hospital no longer uses the Maxwell Home as part of the Hospital.	Gift over to the George Maxwell Library of Rockville

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1991.83	Majorie Risley Scholarship Fund	$32,289	$32,289	Established by gifts to the Hospital	Endowment fund restricted as follows: "The Majorie Risley Scholarship Fund is established with the following primary objective: To assist nurses with their continuing education programs. The money to be used would be for educational programs that will help the nurse maintain a high level or expertise. A second use for the money would be to bring educators to this hospital to bring educational programs to a group of nurses. The principal of the fund is to be invested with high interest in mind. The income only is to be used for the above purposes. The Director of Nurses will determine who is to receive the assistance. If she needs advice relative to who should receive assistance she will consult the committee members. The members are: George E. Risley; Bunny Whelton, Geraldine Strong and Margaret Connors, R.N." Income restricted for nursing education	Statement titled "Marjorie Risley Scholarship Fund" and dated February 1, 1982		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment for Benefit of RGH: Restricted Income		$282,289	$282,289					
Grand Total: ECHN Community Healthcare Foundation, Inc.		$1,567,312	$1,567,312					
GRAND TOTAL FOR ECHN		$6,920,131	$23,106,027					
Additional Information								

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1001.84	Katherine Sykes Bissell	–	—	Bequest under Article SEVENTH (a) of the Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969 with two codicils	Seventh: (a) I give and bequeath the sum of Fifty Thousand Dollars ($50,000) to The Rockville General Hospital, Incorporated, of Rockville, Connecticut, in memory of my parents, Mr. and Mrs. Thomas W. Sykes, the income therefrom to be used for the general purposes of said Hospital.	Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969; Codicil dated April 13, 1970: and Codicil dated April 28, 1972	Note: During its search of probate court records for original documentation, the Hospital found this Last Will and Testament, which includes a $50,000 bequest. This bequest is not separately booked or recorded on the Hospital's records, and the Hospital has not located any other records about this bequest.	

EXHIBIT Q11-1
ECHN: SPECIAL PURPOSE FUNDS - FUNDS 11-1.85 - 11-1.96

Notes:

1. The funds are held by ECHN Community HealthCare Foundation ("ECHN Foundation) for the benefit of Manchester Memorial Hospital ("MMH"), Rockville General Hospital ("RGH"), and Woodlake at Tolland ("Woodlake").
2. The names of the donors to various funds have been redacted.
3.The current fund balance of a given fund will generally be less than the total gifts to the fund because funds are being used on an onging basis for the specific purpose.

Fund Number	Fund Name	Fund Balance 3/31/16	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.85	MMH: DeQuattro Cancer Center - Avis Lloyd Tree of Life	$0	Donors make a contribution for a leaf, dove or boulder to be added to the Tree of Life sculpture. Contributions are used for Survivorship Navigation and other services at the Cancer Center and are disbursed quarterly.	Fund profile with list of donations; copies of 2009 and 2012 brochures	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.86	ECHN Foundation: Team Towanda Foundation	$0	For uninsured women over the age of 40 for mammography, breast ultrasounds, surgical consultations, and related services. The fund also provides pharmacy gift cards to purchase medical and personal care items for use after surgery or to purchase medication (Outpatient).	Fund profile with list of donations; copies of representative letters and communications with Team Towanda Foundation re gifts and uses	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.87	ECHN Foundation: Employee Care Fund	$3,797	To provide confidential emergency assistance to employees in need; employee requests are made through a chaplain to the Fund. The Fund no longer solicits (the most recent appeal was in 2009); the existence of the Fund is well-known to employees, who make unsolicited contributions to it.	Fund profile with summary information	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.88	ECHN Foundation: Breast and Cervical Cancer Program	$59	For outreach, education, enrollment, screening and diagnostic follow-up for underinsured women for cancer and heart disease, whether inpatient or outpatient.	Fund profile with list of donations; copy of representative fundraiser flyer from major donor (fire department) and documentation of gifts from another major donor (hospital volunteers)	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Fund Balance 3/31/16	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.89	MMH: Adult Ambulatory Administrative Education & Development	$0	To offset costs in excess of ECHN tuition reimbursement for the pursuit and completion of a Master's Degree related to the roles of Adult Ambulatory Behavioral Health Coordinator, Adult Ambulatory Behavioral Health Associate Director, or Adult Ambulatory Behavioral Health Director at Manchester Memorial Hospital. Costs may include tuition, books, supplies, travel, or any other miscellaneous expenses, including computer hardware and software.	Fund profile and list of recent gifts	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.90	MMH: Drs' Campbell and Oh Trophies	$3,678	The fund maintains the trays for the Daniel Paul Purcell MD Memorial Golf Classic tournament (now called the ECHN Mason & Purcell Golf Classic), an annual fundraising event; it pays for, among other things, the engraving of the names of the low gross winners.	Fund profile	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.91	Woodlake: Woodlake at Tolland Wishes Program	$1,573	These funds are used to grant "wishes" for long term care residents at Woodlake (long term care facility). Wishes have included a trip to NY, limo rides, luncheon trips, and special outings. Some gifts were made for listing names (honor/memorial) in the Woodlake at Tolland 10th Anniversary Program Book.	Fund profile with list of donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.92	ECHN Foundation: Van Fund	$0	Donations from members of the Business Alliance for Community Health to purchase a new van for ECHN.	Fund profile with list of donations; email re van	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.93	RGH: Risley Fund	$35	Supports educational opportunities for nursing staff.	Fund profile; this is the income from the Marjorie Risley Scholarship endowment held by the ECHN Foundation.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.94	Doris Fields	$582	Funds are used to support the RGH Hospice unit as a memorial to Doris Fields.	Fund profile with list of memorial donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Fund Balance 3/31/16	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.95	Woodlake Resident Council Fund	$254	This account is funded by the residents of Woodlake at Tolland. The goal is to provide the residents a mechanism for self-	Fund profile with list of donations	Continued use by Woodlake residents
GRAND TOTAL		$9,979			
Additional Information					
11-1.96	ECHN Foundation $10,000 One Life Charitable Gift Annuity (Name of Annuitant withheld)	Current value of the residuum is $4,196.	If there is a value on termination, to be used for intensive care unit expansion fund	Charitable Gift Annuity Agreement	Gift of remainder interest in annuity. Present value of remainder will be held until the termination of the agreement; depending on the actual life of the donor, this arrangement could eventually become a liability rather then an asset. ECHN Foundation will explore options with the donor to terminate this arrangement at

EXHIBIT Q11-1
ECHN: TRUSTS HELD BY OUTSIDE TRUSTEES - FUNDS 11-1.97 - 11-1.106

Note: The outside Trustee(s) will have primary responsibility for actions and decisions on the distribution of trust income/assets after ECHN ceases operations and will be responsible for requesting any necessary judicial cy pres relief. ECHN will support, to the extent possible and to the extent consistent with the terms of a given trust, the payment of trust income to the new Foundation to be used to promote the health of the ECHN communities.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O MANCHESTER MEMORIAL HOSPITAL						
11-1.97	Barton Family Trust (Trust u/w Mary K. Barton)	$ 1,187,076.83	Bank of America	"FOURTH: If my sister, ANNA H. BARTON, does not survive me, then all the rest, residue and remainder of my estate, real, personal and mixed, together with any lapsed legacies, I give, devise and bequeath unto the SHAWMUT BANK, with offices in Hartford, Connecticut, or its successors, as Trustee of a certain trust to be known as the BARTON FAMILY TRUST. I ORDER AND DIRECT my Trustee ... to pay all of the net income thereof in convenient installments at least quarter/annually to or for the benefit of, the Manchester Memorial Hospital. If the Manchester Memorial Hospital or its lawful successor is no longer in existence, or if it is not then a charitable organization within the meaning of the Internal Revenue Code, the net income shall be distributed to one or more organizations selected by the trustee, each of which is a charitable organization as defined in Sections 170(c) and 2055(a) of the Internal Revenue Code of 1986, as amended from time to time, in such proportions among such organizations as the trustee shall decide."	Last Will and Testament of Mary K. Barton dated February 1, 1993	Note: This trust directs the trustee to shift the income to one or more charitable organizations if MMH or its lawful successor is no longer in existence.
11-1.98	The Addison L. Clark Fund (Trust u/w Luella C. Hale)	$144,830.89	Bank of America	"ARTICLE XI. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Twenty Thousand Dollars ($20,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income derived therefrom to the TRUSTEES OF THE MANCHESTER MEMORIAL HOSPITAL, to be used for such general hospital charges and expenses as said Trustees shall deem best, said fund to be known as "THE ADDISON L. CLARK FUND." "	Last Will and Testament of of Luella C. Hale dated February 7, 1938	Note: This Will does not provide for another disposition if MMH no longer exists.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.99	The Willie T. Morton Fund (Trust u/w Willie T. Morton)	$215,138.29	Bank of America	"ELEVENTH: If the conditions set out in the two preceding clauses shall not be met with, and said sum of One Hundred Thousand (100,000) Dollars shall not be paid to said young Men's Christian Association or used for said The Morton Library Association, then I direct that said sum of One Hundred Thousand (100,000) Dollars, with accumulated interest, shall be disposed of by my said Trustee, as follows: . . . [Sections A-C direct that $20,000 be distributed to two trusts established for other charities and$10,000 given to the residue of the estate] D. The remainder of said sum of One Hundred Thousand (100,000) Dollars, I direct shall be held by my said Trustee, and one-third of said income shall be paid to the Young Men's Christian Association of Hartford, Connecticut; one-third to the Newington Home for Crippled Children of Newington, Connecticut; and one-third to the Memorial Hospital of Manchester, Connecticut. TWELFTH: [The residary estate] I give, devise and bequeath to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, as Trustee, IN TRUST, for the uses and purposes and with the powers and subject to the provisions and limitations hereinafter set out: ...C. If at my death, neither my wife nor any descendants survive me; or if at the death or remarriage of my said wife, no descendants of mine should be living, or if there should be funds in my Trustee's hands under the provisions of sub-section B above and there should be no descendants of mine living at any time, then I direct that the funds in my Trustee's hands shall be used as follows. One-third of the income therefrom shall be paid to the Young Men's Christian Association of Manchester, or to The Morton Library Association of Manchester, whichever institution may take the funds under the provision of Clauses Ninth and Tenth of this Will, One-third of said income shall be paid to the Memorial Hospital of Manchester, Connecticut; and one-third of said income shall be paid to the Newington Home for Crippled Children. If neither the Young Men's Christian Association of Manchester nor The Morton Memorial Library receive the funds under the provisions of Sections Ninth and Tenth of this Will, then I direct that one-half of said income be paid to said Memorial Hospital of Manchester, and one-half said income be paid to the Newington Home for Crippled Children. I direct that the income so held and used for charitable purposes under the provisions of this Clause Twelfth shall be known as "The Willie T. Morton Fund." THIRTEENTH provides for an alternative dispoisiton of the income interest if any organization receiving income should cease to exist,	Last Will and Testament of Willie T. Morton dated February 27, 1924	Note: The trust provides for a gift over of the income interest if MMH ceases to exist.
11-1.100	Trust u/w Grace Robertson	$134,862.54	Bank of America	**Last Will and Testament signed August 20th, 1940**. ARTICLE VII: I give to The Manchester Trust Company, a Corporation under the laws of the State of Connecticut, and located in said town of Manchester, the sum of Forty Thousand ($40,000.00) Dollars, in trust, however, to take hold, manage, invest and reinvest, and to pay the net income therefrom to the Trustees of the Manchester Memorial Hospital, a Connecticut corporation, located in said Town of Manchester, to be used for general hospital purposes. **Codicil signed August 20th, 1940**. ARTICLE I: In case my estate does not amount to enough to pay all of the special bequests or gifts made in said will, it is my will that such special bequests and/or gifts be eliminated in the following order: . . . (g) Gift for the benefit of the Manchester Memorial Hospital, set forth in Article VII; to the end that all special bequests be paid in full with the exception of the seven gifts named in this Article and that those be paid in full, if the amount of my estate admits such payment, but if such payment cannot be made, then and in that event, so far as possible, bequests and/or gifts be paid as set forth; First to the Hospital; second to the Playgrounds; Third to the Manchester Y.M.C.A.; Fourth for Education; Fifth for Parks; Sixth to the Connecticut Humane Society; and Seventh to Thorsby Institute.	Last Will and Testament of Grace Robertson dated August 20, 1940; Codicil dated August 20, 1940; Codicil dated September 10, 1942: Codicil signed August 29, 1945; and Codicildated November 10, 1953	Note: This Will does not provide for another disposition if MMH no longer exists.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.101	Albert L. Crowell & Maytie Case Crowell Fund (Trust u/w Maytie Case Crowell)	$163,975.83	Bank of America	SIXTH: [This Article makes provision for the perpetuation of a memorial to the Testatrix's mother, Marietta Stanley Case, in the form of an Austin organ given by her family to South Methodist Church, in Manchester, Connecticut,. After reserves for a certain purpose have been accumulated], income from the trust estate herein provided for organ purposes may be distributed from time to time to Manchester Memorial Hospital for its general purposes, but provision for distribution to said Hospital shall not prevent the trustee from again accumulating and using income for organ purposes. SEVENTH: I give and bequeath the sum of fifteen thousand (15,000) dollars IN TRUST to said The Connecticut Bank and Trust Company, and in its successors in this trust upon the following trusts: Said trustee shall have power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and it may also invest in a common trust fund managed by it; and after the payment of administration expenses it shall pay over the net income therefrom quarterly, or oftener in its discretion, in perpetuity, to The Manchester Memorial Hospital for its general purposes, this gift to be known as the Albert L. Crowell and Maytie Case Crowell Fund. Articles NINTH, ELEVENTH, THIRTEENTH and FOURTEEN provide for contingent addiitonal gifts to the Article SEVENTH trust.	Last Will and Testament of Maytie Case Crowell dated May 17, 1957	Note: This Will does not provide for another disposition if MMH no longer exists.
11-1.102	Trust u/w Andrew Ferguson	$3,532,993.99	Bank of America	ELEVENTH: All the rest, residue and remainder of my estate of every name and nature, both real and personal, including any lapsed or void legacies and devises, I give, devise and bequeath to THE CONNECTICUT BANK AND TRUST COMPANY, absolutely and in fee simple, BUT IN TRUST, NEVERTHELESS, to be held as a permanent fund in memory of ANDREW and ANN FERGUSON, for the benefit of MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, and the net income therefrom, after the payment of all necessary expenses, including reasonable compensation to my said trustee, to be paid not less often than quarterly to said Manchester Memorial Hospital, for its general uses and purposes.	Last Will and Testament of Andrew Ferguson dated April 4, 1961	Note: This Will does not provide for another disposition if MMH no longer exists.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.103	Trust u/w Gertrude H. Rogers	$3,486,457.84	Original Trustees: Phoenix State Bank and Trust Company, and Robert S. Morris, of West Hartford, Connecticut	Article FIFTH creates a trust with $100 each month paid to a life beneficiary. The balance of the net income and, after the death of the life beneficaiary, the entire net income "shall be held, used and applied for the benefit of the Manchester Memorial Hospital, a charitable corporation located in said Manchester, for which this fund shall be held as a charitable use in perpetuity, subject to the following limitations: I direct that the net income from this fund shall be used and applied for the support and development of that department of said Hospital which shall be devoted to the medical or pathological service of that Hospital, and more specifically to its research and laboratory work, that is, any investigation towards the alleviation of illness, including payment of salaries of an adequate staff, and the installation and maintenance of proper equipment, to enable that hospital to furnish complete laboratory service of this kind to the staff of that Hospital and to the physicians of the Town of Manchester for their patients of that town, whether they are then patients of that Hospital or not. Accordingly, I direct that the net income each year shall only be disbursed to the said Hospital upon a budget for this department submitted by the Hospital to the trustees under this will and approved in writing by two competent physicians..." [The Will thereafter contains very long and detailed provisions about the physicians, the budget, and the use of funds.] My purpose in creating these limitations and conditions is to keep this fund a living force in building up the quality of medical service in that Hospital and in that community, through the establishment of highly competent technical service in research and laboratory work. If at any time the trustees of my estate shall be satisfied, after conferring with the disinterested physicians whose duty it shall then be to approve the budget as above provided, that The Manchester Memorial Hospital is not devoting said funds to the purposes for which the gift is made, or is not maintaining as adequate and competent a research and laboratory staff and department as the available income will permit, said trustees shall notify the Manchester Memorial Hospital to that effect and if the failure is not corrected within a reasonable time said trustees may terminate the right of The Manchester Memorial Hospital to receive further funds under this will and thereafter said trustees may apply the income of said fund for similar purposes at the Hartford Hospital in Hartford, Connecticut. [The section continues with the requirement that there shall be two trustees, and describes how trustees shall be appointed]. Article FIRST of the Second Codicil amends Article FIFTH but does not modify the requirement that if MMH does not use the funds as specified the trustees may terminate the right of MMH to receive further funds.	Last Will and Testament of Gertrude H. Rogers dated July 13, 1937; Codicil dated October 11, 1939; Codicil dated October 21, 1940.	Note. There is no specific gift over if MMH no longer exists as a charitable organization. The Will states that if MMH fails to use the gift as intended, the trustee may apply the income for similar purposes at Hartford Hospital.
	Subtotal: Manchester Memorial Hospital	$ 8,865,336.21				

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O ROCKVILLE GENERAL HOSPITAL						
11-1.104	Emma Dillon Rockville City Hospital Fund (Trust u/w Laurence M. Dillon)	$420,914.72	Bank of America	"9. I hereby give, devise and bequeath all the rest, residue and remainder of my estate, both real and personal, of whatsoever kind or character, including lapsed legacies and devises, and wheresoever situated, to THE CONNECTICUT BANK AND TRUST COMPANY, Hartford, Connecticut, as Trustee. Said Trustee shall hold, manage and control all of the aforesaid property as a trust estate, with all the rights and powers, and subject to the limitations, hereinafter enumerated, for the following uses and purposes: . . . [Part A creates a life estate for Mr. Dillon's cousin, and Part B provides that upon the death of the cousin, or if she does not survive him], the Trustee shall divide the corpus of the trust estate into two (2) equal parts, IN TRUST, NEVERTHELESS , for the following uses and purposes: 1) One of said parts, so divided, shall be set apart for the benefit of the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, in perpetuity, and the Trustee shall pay to it, or its successors or assigns, all of the net annual income derived from its said particular fund, in annual or other convenient installments. It is my wish that said fund be named the EMMA DILLON ROCKVILLE CITY HOSPITAL FUND in memorial of my beloved mother. Said net income shall be used for such general purposes as its governing board shall deem proper, and at is discretion. 2) The remaining second part, so divided, shall be set apart for the benefit of ST. BERNARD'S SOCIETY, INC. of Rockville, Connecticut . . . . In the event any or all the net income of this trust directed to be distributed to said ST. BERNARD'S SOCIETY, INC. is not distributable to said Society for a period of fifty (50) years from the date of my death for any reason, including a disclaimer by said income beneficiary, the net income of this second part shall be distributed to the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, until fifty (50) years from the date of my death, when the remaining net corpus and accretions of said remaining second part shall be paid over absolutely to said ST. BERNARD'S SOCIETY, INC., its successors or assigns.	Last Will and Testament of Laurence M. Dillon dated February 5, 1964	Note: The Will includes the language "its successors or assigns" after naming Rockville City Hospital
11-1.105	The Marguerite E. Moxon and Dorothy Moxon Yost Memorial Trust	$261,108.50	Bank of America	4. Use of Trust Fund. The Trustee shall distribute not less than annually all of the net income from the Trust as follows. One-half of said income to the Trustees of the Rockville General Hospital, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of such Rockville General Hospital solely for such capital improvements as the Board of Trustees or other governing body may see fit. The remaining one-half of said income to the Union Congregational Church, now located on Union Street, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of the Union Congregational Church in any manner it deems fit.	Trust Agreement dated April 2nd, 1982 between Marguerite E. Moxon and Dorothy Moxon Yost and the Connecticut Bank and Trust Company	Note: The Trust Agreement does not provide for another disposition if MMH no longer exists.
11-1.106	Trust u/w William E. Barton	$1,356,611.63	Bank of America	THIRD: All the rest, residue and remainder of my estate, real, personal and mixed, and wherever the same may be situated, I give, devise and bequeath in manner and form as follows, to wit: . . . [Section a) describes a gift in trust to ST. CATHERINE CEMETERY]. b) I give, devise and bequeath all the rest, residue and remainder of my estate unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee. I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom all the net income thereof unto my two sisters, ANNA H. BARTON and MARY K. BARTON, both of the Town of South Windsor, for so long as they shall live. Upon their death, I order and direct that all of the net income thereof be paid over and distributed unto the ROCKVILLE GENERAL HOSPITAL, of Rockville, Connecticut, to be used by it as it deems fit.	Last Will and Testament of William E. Barton dated December 9, 1988	Note: The Will does not provide for another disposition if MMH no longer exists.
Subtotal: Rockville General Hospital		$2,038,634.85				
	GRAND TOTAL	$ 10,903,971.06				

3336706.1

8. Revised/Updated Table 8 – Net Proceeds Analysis

Please see attached updated Table 8, together with a document explaining various of the changed values.

APA
PROJECTED NET PROCEEDS

		Actual 9/30/2015	Actual 3/31/2016
ACQUISITION PRICE (EV)	A	105,000,000	105,000,000
ASSUMED ASSETS & LIABILITIES:			
Pension & Retiree Medical		(62,598,000)	(67,598,000)
Captive & Workers Comp.		(1,705,000)	(1,705,000)
Net Working Capital True-up		(9,107,000)	(8,275,000)
RGH Eating Disorder Loan		0	0
Seller's Reimbursable Costs		(424,000)	(424,000)
Capital Leases		(6,764,000)	(5,922,000)
Asbestos Abatement		(1,000,000)	(1,000,000)
TOTAL ACQ LIABILITIES	B	(81,598,000)	(84,924,000)
THRESHOLD on LIABILITIES	C	(77,000,000)	(77,000,000)
GUARANTEED NET PROCEEDS	D A-C	28,000,000	28,000,000
CASH & INVESTMENTS (ECHN) *	E	58,454,000	54,968,000
TOTAL CASH for DEBT PAYOFF	F D+E	86,454,000	82,968,000
LONG TERM DEBT (Net AWUIL)	G	(78,420,000)	(75,896,000)
SURPLUS after DEBT DEFEASANCE	H F-G	8,034,000	7,072,000
Post-Closing Pool "Wind Down" Funds	I	1,000,000	1,000,000
Excess Liabilities Assumed	J B-C	(4,598,000)	(7,924,000)
Funds Remaining after PMH Reimbursed	K H-I+J	2,436,000	(1,852,000)
Deduction to Capital Commitment **	L	0	1,852,000
Available for Indemnity Reserve	M K+L	2,436,000	0
Legacy ECHN ***			2,139,000

* PMH is assuming a $5,000,000 loan for the RGH Eating Disorder Unit without a price deduction. To the extent that cash is available beyond the $1,000,000 for post-closing costs and $4,500,000 for the indemnity reserve, ECHN can mitigate a deduction to the capital commitment up to $5,000,000.

** If line K is less than zero, then there was not sufficient ECHN cash left to make PMH whole on additional liabilities assumed, thus a dollar for dollar reduction to the $75 million capital commitment applies.

*** Estimated value of future settlements on funds due from Medicare and Medicaid less fund due to Medicare and Medicaid for prior years still pending final review.

NWC & CASH NET	49,347,000	46,693,000

NET PROCEEDS

UPDATED as of March 31, 2016

Changes from Previous Table

- Original filing for 9/30/15 was estimated based on incomplete information specifically around the pension, captive and workers compensation liabilities for year end. The revised table 9/30/15 figures are per the audited financial statements and also include other adjustments we did not have estimated impact assessed, i.e. extended reporting period premium cost, debt payoff costs, etc.
- Pension unfunded gap is projected to grow by $5,000,000 due to the performance or decline of interest rates since 9/30/15.
- NWC (net working capital) fluctuates month to month, but at two points of the year it diminishes due to the slowdown of accounts payable, March 31 and September 30. This has an offsetting impact to cash as it increases. These two dates are measurement points for our bond covenants and we hedge the potential slowdown of payments from third party payers, governmental or otherwise.
- Capital lease obligations are now reported separately and not including a deduction to the purchase price for asbestos abatement (FIN47 accounting) as it now is reported on a separate line item. Capital lease obligations and long-term debt were "cleaned up" from previous 9/30/15 due to re-classes from one category to the other for specific financings. The figure for March 31 reflects payments outpacing any new financing.
- Per the Asset Purchase Agreement, ECHN will credit against the purchase price $424,000 of its transaction-related expenses for which is has been previously reimbursed by PMH. This figure is a price deduct but it also increased cash since 9/30/15 so it's a "wash".
- As noted above, asbestos abatement capped at $1,000,000 is a price deduction at closing. Previously reported at book value at 9/30/15 in original filing at $412,000. It will be assessed by an independent expert post-closing.
- The next line notes the "cap" or threshold on the assumed liabilities at $77,000,000. If the sum of the assumed liabilities is over this, then the difference is computed and set aside for settling up further along in the transaction – see line J. The difference between the purchase price line A and the threshold liabilities line C is the guaranteed lowest net purchase price paid to ECHN.
- Cash has been reduced by several factors. First is a re-class of an endowment fund that has been recently reviewed legally as permanently restricted. The permanently restricted amount of the endowment is $1,720,000. Other deductions to cash reflect purchasing extended reporting period insurance policies as well as the legal fees, etc. to pay off the long-term debt. State nonpayment of supplemental payments since June 30, 2015 has also impacted the cash on hand.
- Long-term debt continues to be paid down without any new debt added – see separate reconciliation attached.
- After the pay down of the debt, the remaining funds are to be allocated as follows:

- The first $1,000,000 is set aside for post-closing wind down expenses. If there were insufficient funds to do this, the funding would be made by PMH and deducted from the capital commitment.
- Whatever remains satisfies line J, the excess liabilities assumed. If line H, the surplus after debt is paid off is insufficient to fund the post-closing costs of $1,000,000 and reimburse PMH fully for the excess liabilities assumed, the shortfall will be deducted from the capital commitment of $75,000,000. In this case, PMH would fund this and reduce further the capital commitment by the $1,000,000.
- If line H is sufficient to fund the $1,000,000 and reimburse PMH fully, whatever funds remain up to $4,500,000 will go into an indemnity reserve fund.

Clarifications will be made to the Asset Purchase Agreement related to the above.

- Legacy ECHN would assume the value of any collections post-closing on the net of due from and due to third party payers, specifically Medicare and Medicaid. The current book value is $2,139,000 at March 31. The timing of payments coming in or going out is unknown at this time. Any collection of these funds would become available to reimburse PMH for the funds referenced in the previous bullet and sub-bullets to help restore partially or fully the capital commitment.
- Although it appears unlikely based on figures presented today, if ECHN were to have sufficient cash available at the end of the transaction to fully fund the $1,000,000 wind down expenses, and fund the indemnity reserve to $4,500,000 and not require the $5,000,000 of cash currently securing the RGH Eating Disorder Loan (and convey this to PMH at closing), ECHN would not have a $5,000,000 deduction to the capital commitment due to the loan PMH is assuming without a price deduction.

ECHN, INC.

	SEP 2015	MAR 2016
Assets		
Current assets		
Cash and cash equivalents	$16,286,829	$19,785,945
Current portion of assets whose use is limited	$1,097,600	$2,273,720
Accounts receivable, net	$41,607,499	$41,109,230
Inventory	$5,553,809	$5,546,594
Estimated settlements due from third-party payors	$3,377,723	$2,358,442
Prepaid expenses and other current assets	$6,653,091	$5,964,909
Total current assets	$74,576,551	$77,038,840
Assets whose use is limited, net of current portion		
Donor Restricted investments	$5,590,241	$5,113,603
Board designated investments	$36,824,677	$33,642,774
Investments held in trust for estimated self-insurance liabilities	$5,278,426	$5,614,840
Investments held under bond indentures	$5,172,061	$5,120,641
Beneficial interest in trust assets	$10,809,693	$10,903,971
Total assets whose use is limited, net of current portion	$63,675,098	$60,395,829
Investments	$7,118,433	$5,310,923
Investments in joint ventures	$18,190,809	$18,455,808
Property and equipment, net	$88,275,419	$85,793,506
Other assets		
Due from affiliated entities		
Pledges receivable		
Other accounts receivable, net		
Notes receivable, net		
Estimated settlements due from third-party payors		
Other, net	$4,541,099	$4,923,873
Goodwill	$4,026,827	$3,918,407
Total other assets	$8,567,926	$8,842,280
Total assets	**$260,404,236**	**$255,837,186**

ECHN, INC.

Liabilities and net assets

	SEP 2015	MAR 2016
Current liabilities		
Accounts payable and accrued expenses	$33,429,551	$35,065,970
Current portion of accrued pension and other postretirement benefits	$190,189	$190,189
Estimated settlements due to third-party payors	$2,929,392	$2,657,091
Current portion of long-term debt and capital lease obligations	$7,018,708	$6,458,787
Line of credit	$3,800,000	$2,900,000
Other current liabilities	$4,134,712	$3,720,409
Security deposits and agency funds		
Total current liabilities	$51,502,552	$50,992,446
Other liabilities		
Due to affiliated entities		
Long-term debt and capital lease obligations, net of current portion	$80,122,247	$79,783,737
Estimated self-insurance liabilities	$7,196,797	$7,859,966
Accrued pension and postretirement benefits, net of current portion	$62,407,379	$63,865,959
Annuities payable		
Estimated settlements due to third-party payors		
Conditional asset retirement obligation/Other liabilities	$467,711	$473,975
Total other liabilities	$150,194,134	$151,983,637
Total liabilities	$201,696,686	$202,976,083
Net assets		
Unrestricted	$42,167,566	$36,653,204
Temporarily restricted	$1,486,536	$1,060,174
Permanently restricted	$15,053,448	$15,147,725
Total net assets	$58,707,550	$52,861,103
Total liabilities, equity and net assets	**$260,404,236**	**$255,837,186**
	$0	$0

ECHN, INC.

DEBT RECONCILIATION

BALANCE SHEET

	SEP 2015	MAR 2016
Gross Debt (yellow highlighted accts liabilities)		
Current portion of long-term debt and capital lease obligations	$7,018,708	$6,458,787
Line of credit	$3,800,000	$2,900,000
Long-term debt and capital lease obligations, net of current portion	$80,122,247	$79,783,737
	$90,940,955	$89,142,524
Interim Payments & Debt Service Funds (yellow highlights assets)		
Current portion of assets whose use is limited	$1,097,600	$2,273,720
Investments held under bond indentures	$5,172,061	$5,120,641
Less: Interest payments	($511,173)	($567,589)
	$5,758,488	$6,826,772
Net Debt (Capital Leases + Long-term Debt + Line of Credit)	$85,182,467	$82,315,752
Less: RGH Eating Disorder Loan*	$0	$498,337
Adjusted Net Debt per Balance Sheet	$85,182,467	$81,817,415

APA NET PROCEEDS

Capital Leases (assumed by PMH)	$6,764,000	$5,922,000
Long Term Debt (Net AWUIL)	$78,420,000	$75,896,000
Net Debt per APA Net Proceeds	$85,184,000	$81,818,000
Difference (due to rounding per APA schedule)	($1,533)	($585)

ECHN
Principal and Interest Payments
Fiscal Years 2015-2019

	2015	2016	2017	2018	2019	5 Year Average
Interest payments - debt *	3,194,961	3,116,216	3,296,246	3,120,535	2,989,155	3,143,422
Interest payments - capital leases	297,078	273,918	176,346	107,678	57,696	182,543
	3,492,039	3,390,134	3,472,592	3,228,212	3,046,852	3,325,966
Principal payments - debt *	5,602,278	5,813,346	6,269,252	6,063,944	5,284,227	5,806,610
Principal payments - capital leases	3,227,560	3,256,988	2,093,153	1,109,296	986,203	2,134,640
	8,829,838	9,070,334	8,362,405	7,173,240	6,270,430	7,941,249
Total Annual Debt Service	12,321,877	12,460,468	11,834,998	10,401,453	9,317,281	11,267,215
Total Annual Debt Service -- Gone after Closing	8,797,239	8,929,562	9,565,498	9,184,479	8,273,382	8,950,032

* Includes line of credit

9. Example of Health Needs Assessment Conducted by PMH or Letter describing community involvement in health needs assessments.

Prospect Medical Holdings has not completed a Community Health Needs Assessment in the Rhode Island market. However, attached as Exhibit 9(a) is a 2013 Statewide Community Health Needs Assessment prepared by Hospital Association of Rhode Island ("HARI") which is not specific to the Prospect CharterCARE facilities. The 2013 report was prepared by HARI prior to the Prospect - CharterCARE Health Partners transaction. Because the report was prepared prior to the Prospect transaction, Prospect did not produce or assist in producing the 2013 HARI CHNA. CharterCARE was involved with the Needs Assessment report created by HARI before its transaction with Prospect.

In the fall of 2015, HARI commenced the process of updating the 2013 Community Health Needs Assessment. Prospect CharterCARE is represented on the HARI committee tasked with leading the effort to update the Community Health Needs Assessment and related implementation plans. A report for 2015 has not been issued.

Attached as Exhibit 9(b) are excerpts from the 2013 HARI Community Needs Assessment utilized in application for OB services in Rhode Island.

In Rhode Island, CharterCARE continued its tax exempt status as a joint venture partner with Prospect in operating the CharterCARE hospitals. As such, one of the Rhode Island Department of Health's conditions to the CharterCARE transaction required that PMH collaborate with the Department of Health on one (1) community health needs assessment. In general, CHNAs are a requirement of federal tax exempt charitable hospitals developed to support their continued exemption. Pertinent CHNA information is required to be provided on the Form 990 Schedule H, which is only required to be filed by tax exempt hospitals. Hospitals that do not seek or continue tax exempt status whether independently or part of a joint venture are not required by law to adopt or continue a CHNA, including any previous CHNA developed. In Connecticut, for example, Connecticut General Statutes Section 19a-127k discusses community benefit programs which hospitals may have and suggests that the programs be based on an assessment of the community, but does not require that all hospitals conduct formal community assessments. Similarly, Connecticut General Statutes Section 19a-649 requires only that tax exempt hospitals submit a CHNA required under federal law to OHCA.

PMH is not seeking to continue the tax exempt status of any of the entities in the ECHN transaction nor does the ECHN transaction involve a tax exempt joint venture partner. Although PMH is not tax exempt and therefore not required to engage in a CHNA, PMH is committed to meaningfully investing in and providing needed care to the communities it serves. PMH works with its Local Boards to assess and determine the community health needs of the population served and how to best implement these needs.

EXHIBIT 9(a)

HARI

Community Health Needs Assessment

Final Report

2013

HOLLERAN

Executive Summary

Background

The Hospital Association of Rhode Island, in collaboration with its member hospitals, led a statewide comprehensive Community Health Needs Assessment (CHNA) to assess the health indicators and health needs of residents in the state of Rhode Island. The CHNA was conducted from September 2012 to May 2013. The assessment was conducted in a timeline to comply with requirements set forth in the Affordable Care Act, as well as to foster collaboration among Rhode Island hospitals in their commitment to community health and population health management. The findings from the assessment will be utilized by HARI and its members to guide community health improvement efforts and to engage partners to address the identified health needs.

Research Components

HARI and its hospital members undertook an in-depth, comprehensive approach to identifying the needs in the communities it serves. A variety of quantitative and qualitative research components were implemented as part of the CHNA. These components included the following:

- Analysis of Rhode Island Department of Health BRFSS Data
- Secondary Data
- Key Informant Surveys
- Focus Groups
- Prioritization of Community Health Needs

The following areas were common health issues identified throughout the various research components.

Identified Community Health Issues

- Mental Health and Substance Abuse
- Diabetes
- Overweight/obesity
- Access to Care
- Heart Disease
- Cancer (specifically breast, lung)
- Asthma (adult and child)

ECHN Proposed Asset Purchase by PMH
Late Files
Submitted April 20, 2016
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Methodology

Rhode Island State BRFSS Data Analysis

The state of Rhode Island annually participates in the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) survey. The BRFSS study is conducted nationally each year and is led at the state level through the respective state health departments. HARI's intent was not to duplicate existing survey processes, but rather to partner with the Rhode Island Department of Health to utilize the existing state BRFSS data sets. With support from the Department of Health, raw BRFSS data sets were released to Holleran, a third party research and consulting firm, for in-depth analysis. Each hospital's service area was defined and the associated data points were extracted for each hospital. The survey assessed indicators such as general health status, prevention activities (screenings, exercise, etc.), and risky behaviors (alcohol use, etc.). The results were also examined by a variety of demographic indicators such as age, race, ethnicity, and gender.

Secondary Data Profile

HARI and its CHNA partners, contracted with Healthy Communities Institute to gather and present existing secondary data. The secondary data included statistics such as mortality rates, cancer statistics, communicable disease data, and social determinants of health (poverty, crime, education, etc.), among others. This information was used to supplement the primary data and to flesh out research gaps not addressed in the BRFSS results. Where available, the local-level data was compared to state and national benchmarks. This data was also built in a web portal for full access to the public.

Key Informant Surveys

Key informant surveys were conducted with 49 professionals and key contacts from throughout Rhode Island. Working with leadership from each of the hospitals, prospective individuals were identified and invited to participate in the study. The survey included a range of individuals, including elected officials, healthcare providers, health and human services experts, long-term care providers, representatives from the business community, and educators. A detailed list of participants can be found in Appendix A. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived key health issues prominent in the community, health care access and challenges, and solutions.

Focus Groups

Two focus groups were facilitated by Holleran in March 2013. The focus groups were intended to gather feedback regarding mental health issues and resources within Rhode Island. The participants included mental health experts, providers, and referral sources. A moderator guide, developed in consultation with the CHNA partners, was used to prompt discussion and guide the facilitation. In total, 21 people participated in the two focus groups. Participants were recruited by the CHNA partners. Each session lasted approximately two hours and was facilitated by Holleran. It is important to note that the focus group results reflect the perceptions of a small sample of community members and may not necessarily represent all mental health professionals in the hospital service areas.

Prioritization of Community Health Needs

HARI and its CHNA partners jointly conducted a prioritization to identify key statewide community health needs. The prioritization session included representatives from HARI, the hospital partners, and public health experts.

Limitations of Study

It should be noted that limitations of the research may have prevented the participation of some community members. The time lag of secondary data, the hospital service area sample, language and cultural barriers, the project timeline, and other factors may present some research limitations. To mitigate limitations of the research, HARI and its CHNA partners sought to include representatives of diverse and underserved populations, public and community health experts, and other community representatives to present the most comprehensive assessment of community health needs given the research constraints.

Research Partner

HARI and its CHNA partners contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has more than 20 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data
- Conducted, analyzed, and interpreted data from Household Telephone Survey
- Conducted, analyzed, and interpreted data from Key Informant Interviews
- Conducted Focus Groups with healthcare consumers
- Facilitated a Prioritization and Implementation Planning Session
- Prepared the Final Report and Implementation Strategy

Community engagement and feedback were an integral part of the CHNA process. HARI and its CHNA partners sought community input through interviews with key community stakeholders, focus groups with healthcare providers, and inclusion of partner hospital representatives as well as public health officials in the prioritization and implementation planning process.

Following the completion of the CHNA research, HARI and its CHNA partners will develop a plan to address prioritized community needs.

KEY CHNA FINDINGS

ANALYSIS OF BRFSS DATA

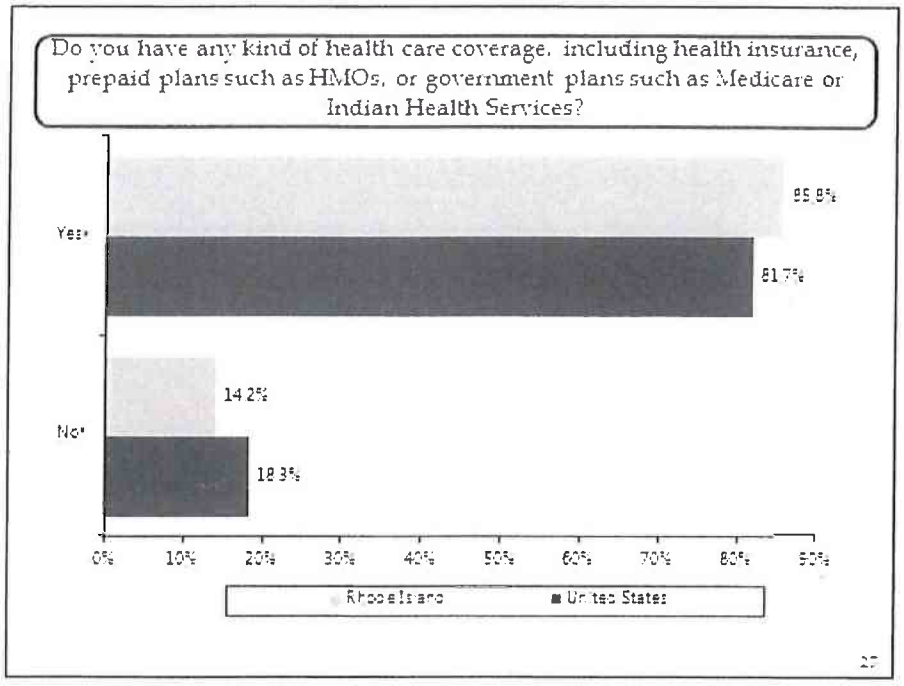
Behavioral Risk Factor Surveillance System data was analyzed between the dates of November 1, 2012 and January 10, 2013. BRFSS data was released to Holleran by the Rhode Island Department of Health on behalf of the Hospital Association of Rhode Island and its members.

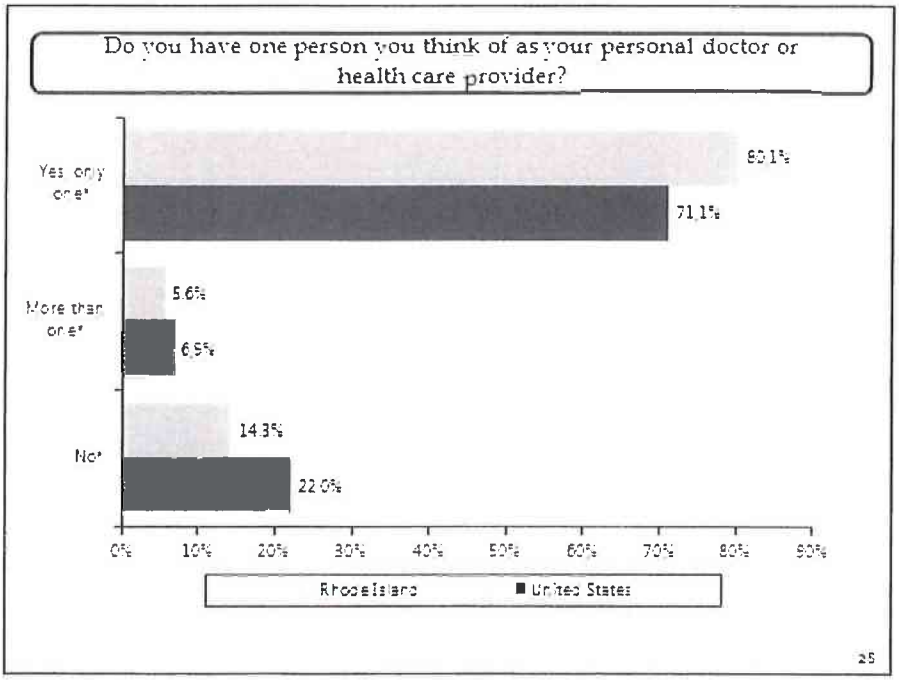
The final sample (6,533) yields an overall error rate of +/-1.2% at a 95% confidence level. This means that if one were to survey all residents within Rhode Island, the final results of that analysis would be within +/-1.2% of what is displayed in the current data set. All comparisons represent 2011 BRFSS data.

Household Survey Findings

A number of the items on the survey assessed **general health status**. When asked to rate their general health, 83% of residents in Rhode Island responded "good," "very good" or "excellent." This is above the 81.8% nationally. However, area residents were more likely to report one or more days of poor physical or mental health in the previous month when compared to residents across the nation. Approximately 40% of adults surveyed in the hospital's service area reported at least one day in the past month when their physical health was not good and 37.9% reported at least one day where their mental health was not good. Just over 45% percent indicated that these poor mental or physical health days keep them from doing their usual activities. This is higher than the nation (42.3%).

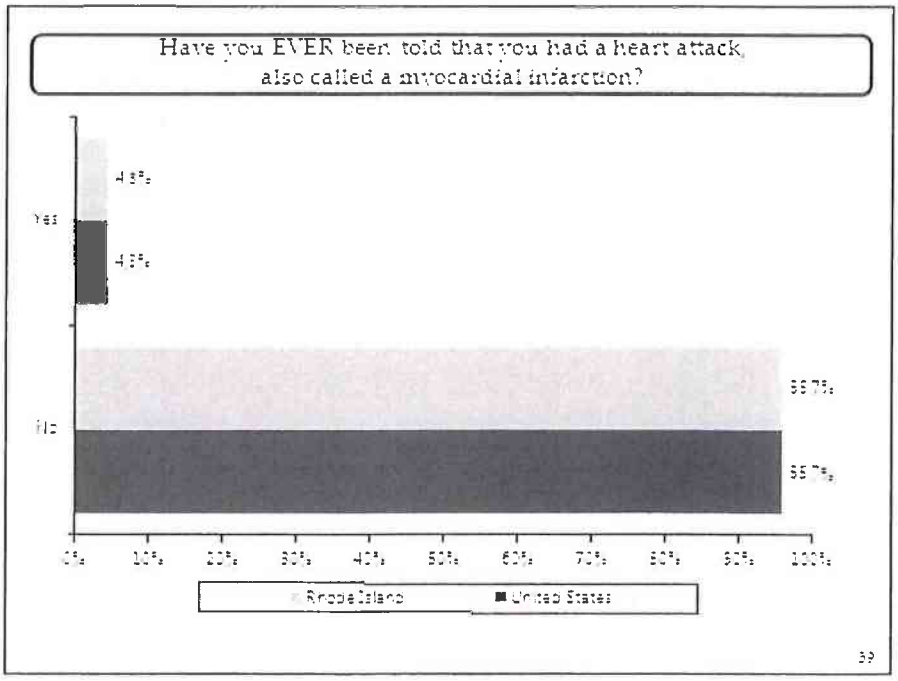
The survey also asked questions regarding **access to care** issues such as health care coverage, having a regular source of care, and cost. As detailed in the graph below, 85.8% of area adults reported having some kind of health care coverage, which is higher than the 81.7% across the U.S. Females in the area are significantly more likely than males to have health insurance coverage (88.7% vs. 82.8%). Roughly 80% of those surveyed reported having one person they think of as their personal doctor or healthcare provider. This is above the nation (71.1%). Cost was less of a barrier to seeking health care in the previous year for local adults. In Rhode Island, 15.8% of those surveyed indicated that there was a time in the past year when they needed to see a doctor, but could not because of cost. This compares to 17% throughout the country. Approximately 75% of respondents visited a doctor for a routine checkup in the previous year. This compares to 66.9% across the U.S.


Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services?
Yes*
No*
85.8%
81.7%
14.2%
18.3%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Rhode Island
United States


Do you have one person you think of as your personal doctor or health care provider?
Yes, only one*
More than one*
No*
80.1%
71.1%
5.6%
6.9%
14.3%
22.0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Rhode Island
United States

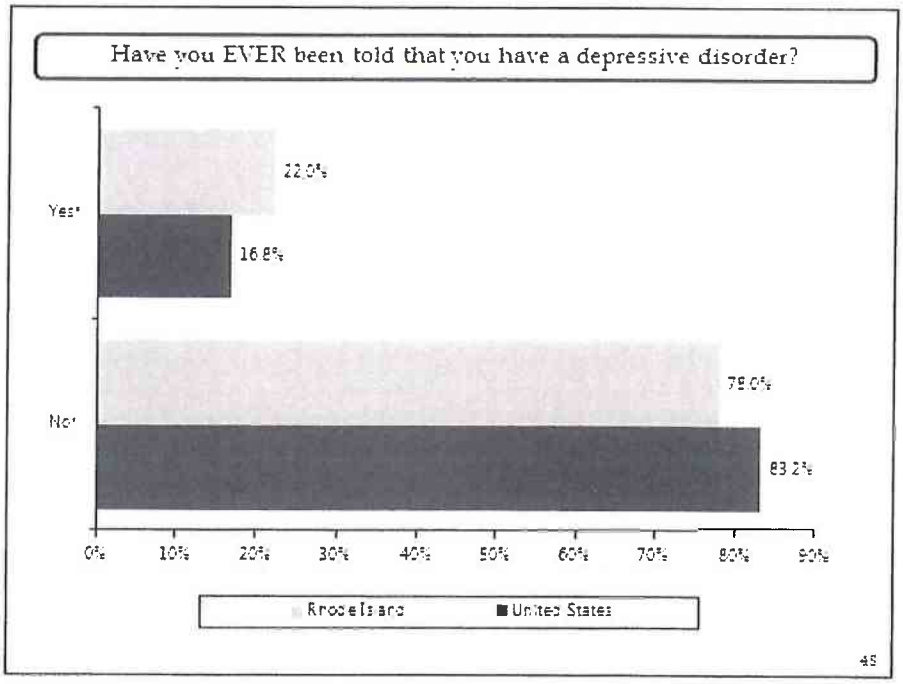
Awareness of individual "numbers" for **blood pressure and cholesterol** has been a national focus in recent years. Locally, 32.9% reported that they have been told by a doctor or health professional that they have high blood pressure. This is similar to the U.S. figure (31.6%). Nearly eight out of 10 residents who have high blood pressure reported that they are currently taking medicine for their high blood pressure. This is similar to the nation (77.3%). Among those with high blood pressure, 78.4% are changing their eating habits, 79.4% are cutting down on salt, 41.8% are drinking less alcohol, and 65.8% are exercising more to help lower or control their condition. These figures are similar to or better than nationally. In addition, a greater percentage of residents with high blood pressure reported being advised by their doctor to change their lifestyle habits to help lower or control their blood pressure than individuals nationally. With respect to blood cholesterol levels, 85.1% of area adults reported having their blood cholesterol checked which is above the national figure (79.4%). The percentage of residents reporting elevated cholesterol levels (38.5%) is in line with the nation (38.5%).

Cardiovascular health was also assessed by asking individuals if they have ever had a heart attack, stroke, or coronary heart disease. Residents living in Rhode Island look fairly similar to or better than those throughout the rest of the country with respect to these conditions. The graph below details the percentage of adults reporting a cardiovascular disease diagnosis.

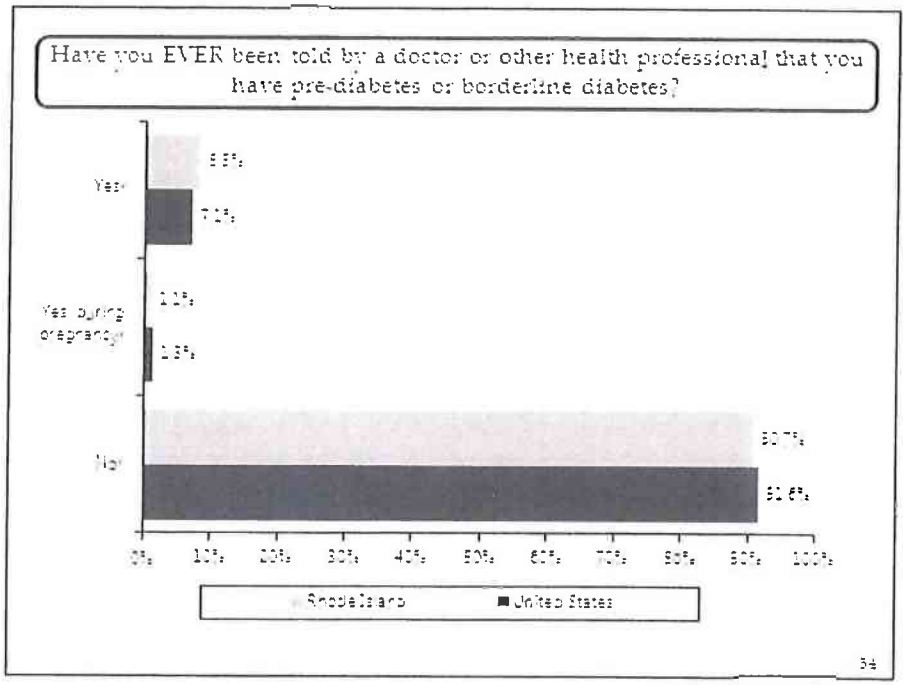


An **asthma** diagnosis was reported by approximately 16% of adults in the state and among this group, 74.1% reported that they still have asthma. The proportion that still has asthma is higher than the national proportion. The percentage of children who have been diagnosed with asthma (18.2%) is above the nation (13.4%). Survey respondents were also asked if they have COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis. The percentage among residents (6.2%) was similar to the U.S. (6.3%).

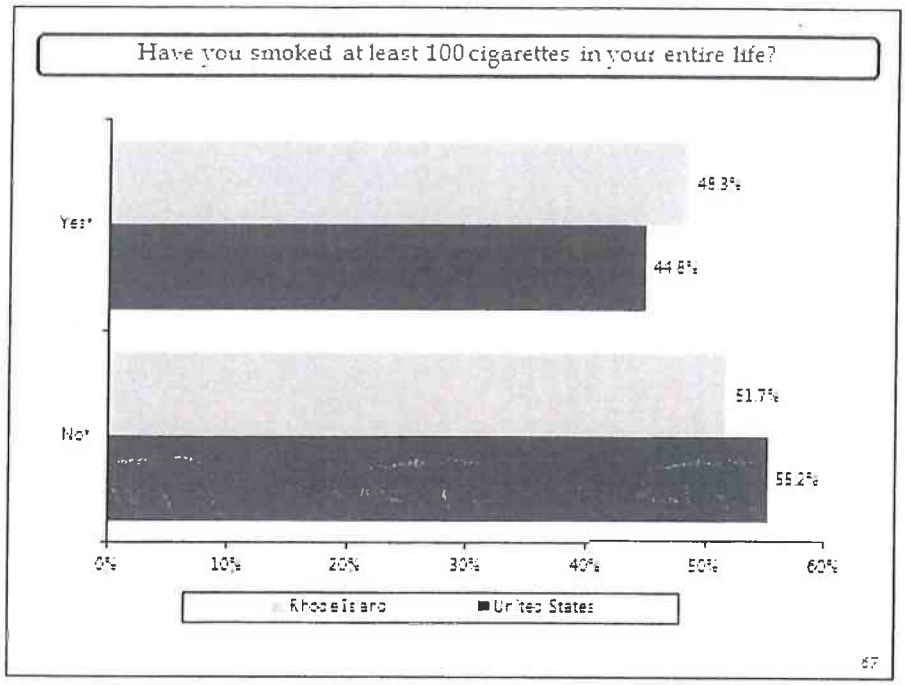
As a follow-up to the initial question regarding poor mental health days, the survey inquired about the incidence of **depressive disorders**. Twenty-two percent of those surveyed reported being told that they had/have a depressive disorder. This is higher than the nation (16.8%). Similar to national trends, females reported a higher incidence of depression than males (25.9% vs. 17.7%). When asked how many days in the previous two weeks they had little interest or pleasure in doing things, 36.5% of adults in Rhode Island mentioned at least one day. This is higher than national percentages. The following graph details a sampling of these findings.

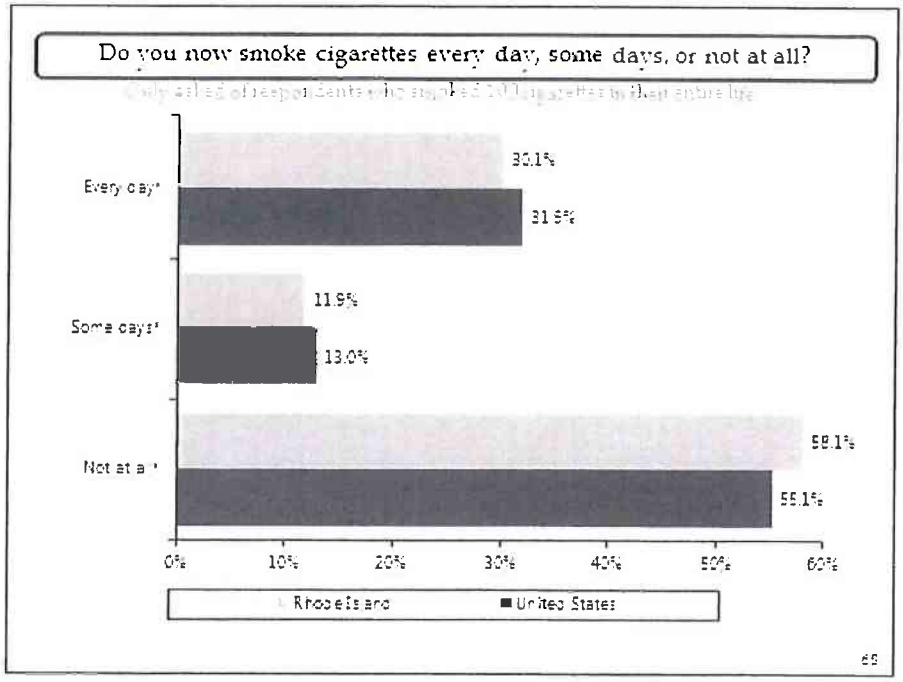


Diabetic conditions such as pre-diabetes, gestational diabetes, and adult diabetes were included in the survey as well. The percentage of residents with diabetes is lower than what is seen throughout Rhode Island and the rest of the country. Approximately 8% of area adults reported having diabetes compared to 9.8% across the nation. An additional 8.3% of residents reported having pre-diabetes or borderline diabetes. Among those with diabetes, 45.1% have taken a class to manage their diabetes compared to 52.2% throughout the U.S. When asked about having a test for high blood sugar or diabetes in the past three years, 59.5% of local adults indicated that they have had such a test. This is above the figure nationally (54.4%).

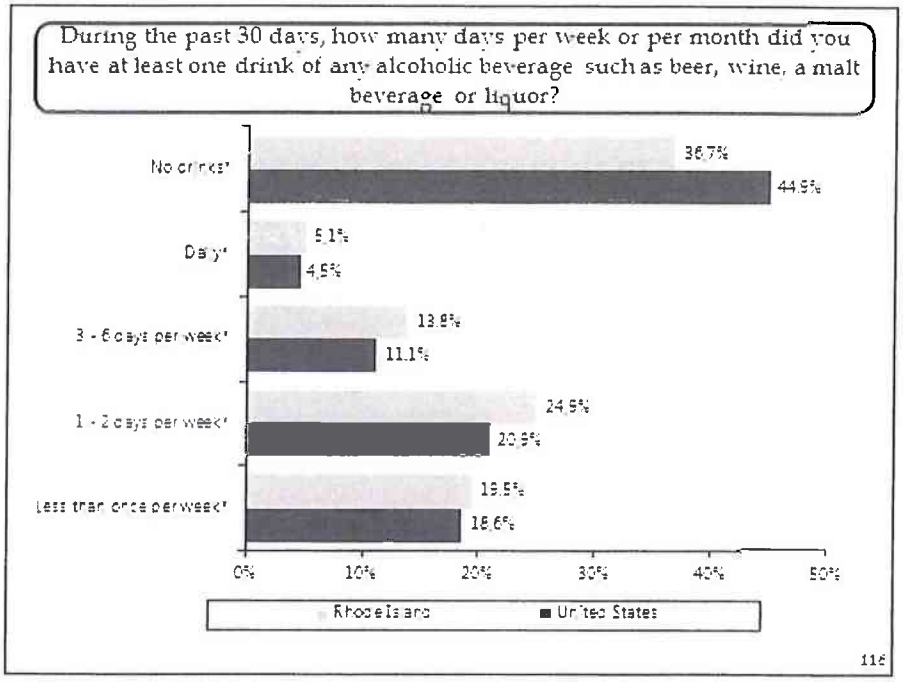


Risky behaviors related to **tobacco and alcohol use** were measured as part of the survey. Roughly 48% of area adults reported smoking at least 100 cigarettes in their lifetime, which is above the U.S. figure (44.8%). However, fewer residents reported that they still smoke. Among those residents who are still smoking, 63.2% have attempted to quit smoking in the past year. This is higher than throughout the U.S. and suggests that there are fewer current smokers in the area, and those who do smoke, are more likely to quit.


Have you smoked at least 100 cigarettes in your entire life?
Yes*
No*
49.3%
44.8%
51.7%
55.2%
0%
10%
20%
30%
40%
50%
60%
Rhode Island
United States
67

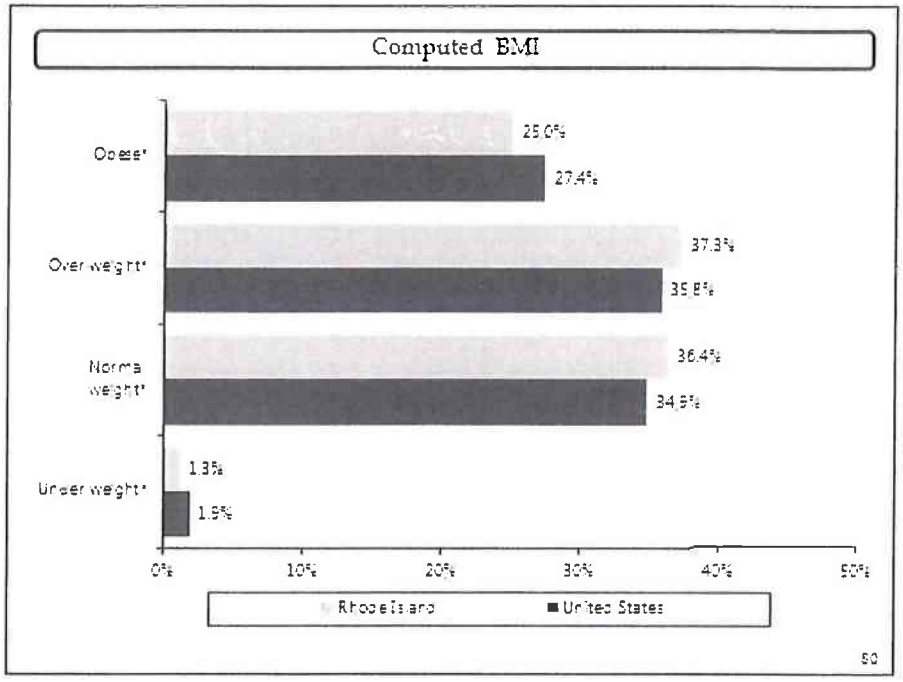

Do you now smoke cigarettes every day, some days, or not at all?
Every day*
Some days*
Not at all*
30.1%
31.9%
11.9%
13.0%
58.1%
55.1%
0%
10%
20%
30%
40%
50%
60%
Rhode Island
United States
68

Around 63% of local adults report at least one day in the previous month when they consumed alcohol. This is above the nation (55.1%). Of those who consumed alcohol, the majority (69.1%) reported having 1-2 drinks per occasion. Roughly 32% reported having four or more drinks (females)/five or more drinks (males) on one or more occasions in the past month. This compares to 33.4% nationally.



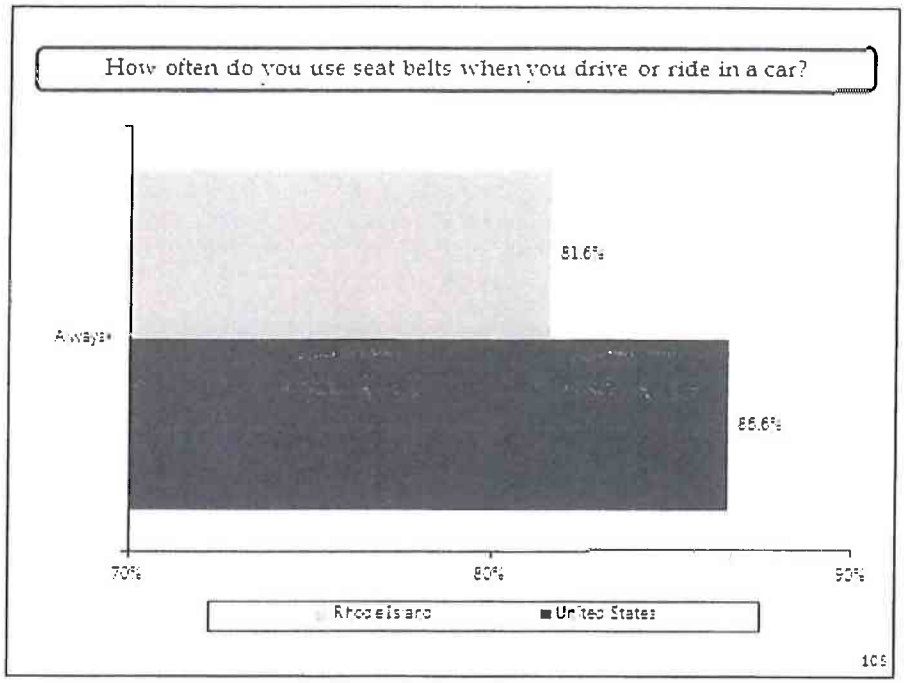
Nutrition and exercise habits were assessed by asking about fruit and vegetable consumption as well as the frequency and duration of physical activity. Approximately 30% of residents reported drinking 100% pure fruit juices once or more per day and 52.5% reported consuming fruit once or more per day. Nearly 26% of adults consumed dark green vegetables, while 9.0% ate orange-colored vegetables daily and 39% ate other vegetables daily. The consumption of fruits and vegetables looks similar to national figures.

Roughly 74% of survey respondents indicated that they participated in physical activities such as running, walking or calisthenics in the previous month. This is similar to the U.S. (74.3%). Walking was the most common form of exercise and was reported by 52.2% of those who exercised. Approximately 58% of residents reported exercising 1 to 5 times a week and 13.4% of residents reported exercising 6 to 10 times per week. The majority, 55.9%, engaged in exercise for less than one hour. **BMI (Body Mass Index)** was calculated from self-reported measures of height and weight. As displayed below, 62.3% of surveyed residents were either obese or overweight, which is similar to the U.S. (63.2%).

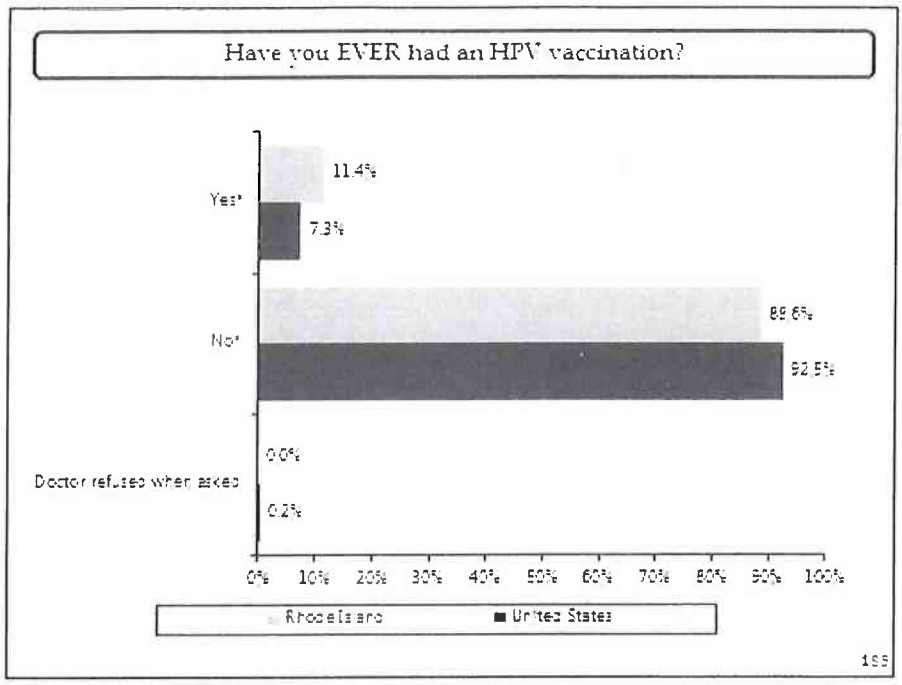


More than half of the surveyed residents (50.4%) indicated that they have limitations because of **arthritis or joint symptoms** and 32.2% reported that these symptoms affect the amount and type of work that they can do. Both of these figures are lower than what is seen among residents throughout the U.S.

Seatbelt use was identified as an area of concern on the survey. As shown below, fewer residents always wear their seatbelt when riding in or driving a car.



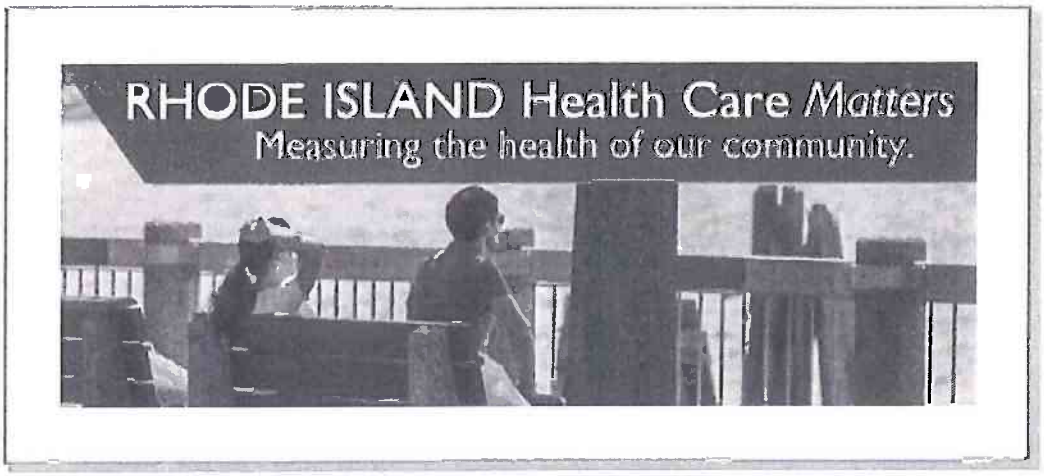
Immunization rates were assessed by asking residents about various vaccinations that they or their children may have received. Nearly forty-one percent (40.6%) of adults in Rhode Island had the seasonal flu vaccine in the previous year. This is above the nation (36.7%). When asked about children who live in the household, 73.2% indicated that their child had a seasonal flu vaccination. This compares to 48.2% nationally. Roughly 34% of those surveyed reported that they have had a pneumonia shot at some point in their lifetime. This compares to 30.6% across the U.S. When asked if they received a tetanus shot in the past 10 years, 72.6% indicated that they had. HPV (Adult Human Papillomavirus) vaccinations are slightly more prevalent among residents than what is seen throughout the nation. Roughly 12% have had the HPV vaccination and 72.2% have had all three shots.



In summary, the household survey results reveal a number of areas of opportunity and needs in the community, such as mental health status (depressive disorder and symptoms), alcohol use, and asthma. The household survey results should be examined along with the secondary data, key informant interviews, and focus groups to examine areas of overlap.

SECONDARY DATA PROFILE

Secondary data, such as mortality rates, cancer incidence rates, and social determinants of health (poverty, education, and housing to name a few) were gathered and reported by Healthy Communities Institute (HCI). The Hospital Association of Rhode Island established a relationship with HCI to measure and depict health status and risky behaviors throughout Rhode Island communities. The following information summarizes select health statistics and findings for Rhode Island, compared to U.S. A full, detailed listing of all the indicators collected for all Rhode Island counties, ZIP codes, and census tracts can be found at www.rihealthcarematters.org. All figures and statistics presented below were obtained from the Rhode Island Health Care Matters website.



Access to Health Services

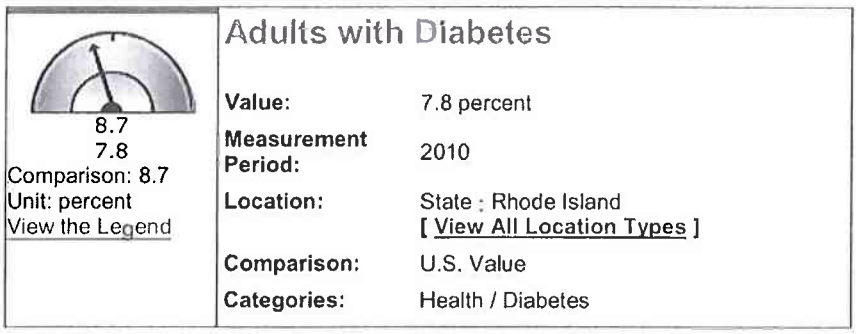
When compared against other U.S. Counties, both adults and children living in Rhode Island are more likely to have health insurance coverage. The primary care provider rate, which is the rate per 100,000 population, is also better locally than what is seen nationwide. Primary care providers include physicians practicing in general practice medicine, family medicine, internal medicine, and pediatrics. For Rhode Island, it is estimated that there are 90 providers per 100,000 population.

Cancer

Cancer statistics were evaluated through an examination of incidence rates and age-adjusted death rates. Specifically, rates for breast, colorectal, lung, cervical, prostate, and oral cavity/pharynx cancers were gathered. The age-adjusted death rates for breast, colorectal, lung, and prostate cancer are all well below the associated rates throughout the country. The area of greatest concern is breast cancer incidence rate. Based on 2005-2009 data, the incidence rate for breast cancer in Rhode Island is 133.2 cases per 100,000 females. This ranks Rhode Island in the bottom quartile of incidence rates nationally. It is important to note that the likelihood of females aged 50 and over having had a mammogram in the past two years in Rhode Island rates favorably against national figures. Nearly 85% of females in this age group have had a mammogram in the past two years. Other cancer incidence rates that were slightly elevated included colorectal cancer and lung or bronchus cancer incidence.

Diabetes

Diabetes statistics related to incidence, mortality, and screenings were reported. According to 2010 figures, 7.8% of Rhode Island adults have diabetes. Nationally, the figure is 8.7%. The picture below details this comparison.



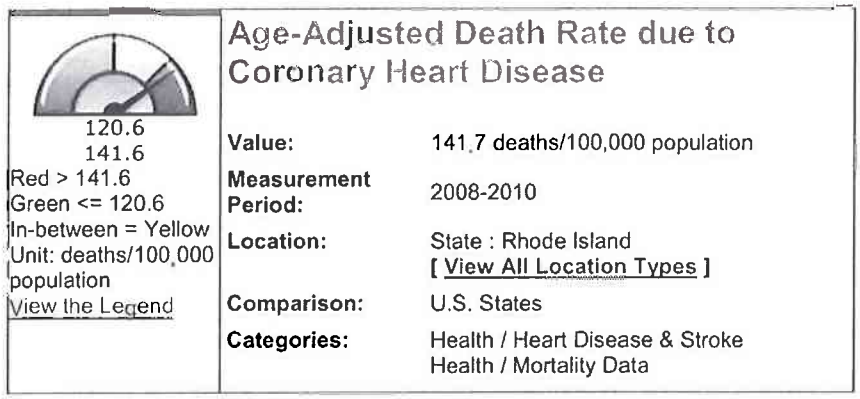
The age-adjusted death rate due to diabetes within Rhode Island is 15.9 deaths per 100,000 population. This is in the top quartile nationally. Among Medicare patients who have diabetes, 84.4% report having had their blood sugar tested in the past year. This is comparable to, or slightly above, what is seen nationally among other Medicare recipients with a diabetes diagnosis.

Exercise, Nutrition, and Weight

It is well documented that individuals who are overweight or obese have a higher incidence of chronic disease and other illnesses. The percentage of Rhode Island residents who are obese is estimated at 25.4% and the percentage of residents who are overweight or obese is 62.5%. It is estimated that there are 1,050,292 adults living in Rhode Island, which translates to roughly 656,433 adults who are overweight or obese. One in four, 26.2%, Rhode Island adults are sedentary, compared to 26.2% nationally.

Heart Disease and Stroke

The age-adjusted death rate for stroke in Rhode Island (32.3 deaths per 100,000 population) is favorable to what is seen nationwide. However, the age-adjusted death rate due to coronary heart disease is elevated. As depicted below, the statewide rate is 141.7 deaths per 100,000 population, which puts it in the bottom quartile nationally.



Immunizations

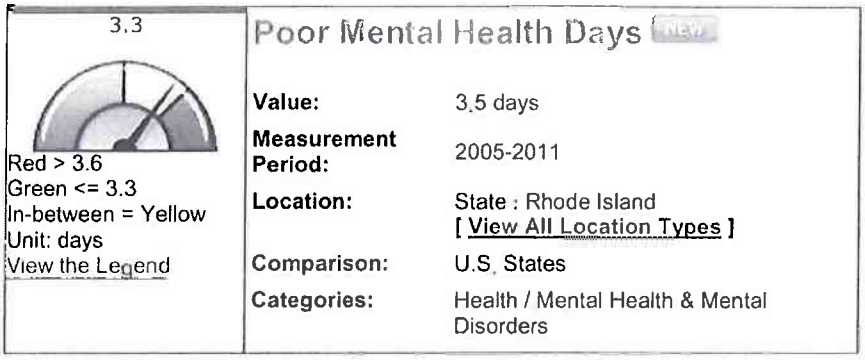
The age-adjusted death rate due to influenza and pneumonia (16.0 per 100,000) is below the national rate. The percentage of adults 65 and over who had an influenza vaccination in the previous year (56.6%) is similar to the nationwide percentage of 61.3%. Pneumonia vaccination rates among county residents 65 and over are also similar to nationwide rates. In Rhode Island, 73.1% of seniors have had a pneumonia vaccination at some point in their lifetime. The national figure is 70.0%.

Maternal, Fetal, and Infant Health

The Healthy People 2020 national health goal is to reduce the proportion of infants born with low birth weight to 7.8%. Low birth weight infants have a birth weight of 2,500 grams (5 pounds, 8 ounces) or less. Rhode Island has not met the Healthy People goal, with a figure of 8.0%. Pre-term births are also an indicator for maternal and child health. Approximately 12% of all births in Rhode Island are pre-term. This is slightly below the national value of 12.5%.

Mental Health & Mental Disorders

According to 2008-2010 statistics, the suicide death rate in Rhode Island is 11.0 deaths per 100,000 population. This is in the bottom quartile nationally for suicide deaths. However, self-reported measures of poor mental health are elevated. On average, Rhode Island adults report 3.5 days a month of poor mental health. This is higher than the 50th percentile figure of 3.3 days.



Additional Mortality Data

In general, Rhode Island has favorable mortality rates compared to the nation. Premature death is less likely and conditions in which the age-adjusted death rates are lower than what is seen nationally include Alzheimer's disease, unintentional injuries, and motor vehicle collisions. The one area that is slightly elevated compared to the nation is death due to falls. Mortality rate due to falls is 9.8 per 100,000 population. The 50th percentile nationally is 8.1 deaths.

Asthma

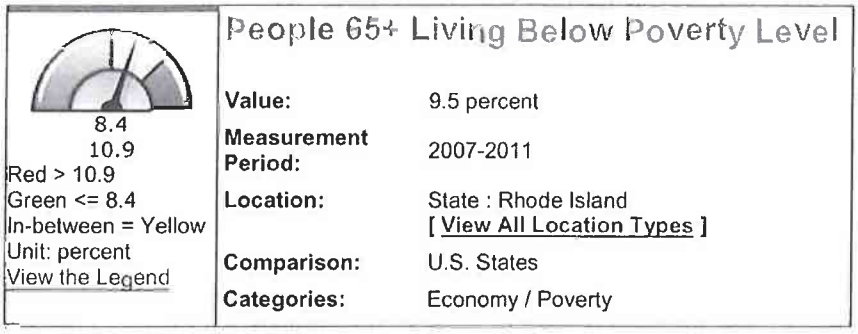
It is estimated that 10.9% of Rhode Island adults have asthma. Nationally, the figure is 9.1%. These statistics reflect adults who have been diagnosed as having asthma by a doctor of health professional.

Tobacco and Alcohol

The percentage of adults who binge drink in Rhode Island is 19.7%. The percentage of adults who smoke in Rhode Island is 20.0%. Both of these statistics are similar to the United States (18.3% and 21.2% respectively).

Economic Indicators

A variety of economic indicators were gathered including education levels, homeownership, income, and poverty. The findings suggest that there may be significant disparities in Rhode Island between demographic populations. Overall per capita income and median household income for the state compare favorably to national comparisons. A number of the poverty indictors also compare favorably. The number of adults 65 and older who live below the poverty level is the one exception. Nearly 10% of adults 65 and older live below the poverty line. This is in comparison to 8.4% as the 50th percentile nationally.



Additional statistics that are in the upper 50th percentile in terms of comparisons to national benchmarks include the unemployment rate, households with cash public assistance income, the home foreclosure rate. The percentage of people 25+ with a high school degree or higher is also less than what is seen nationally.

The Environment

The built environment can play a significant role in a community's health. For Rhode Island, areas of concern are the density of liquor stores, and houses built prior to 1950 compared to the U.S.

Social Environment

The percentage of single-family households in Rhode Island is higher than what is typically seen throughout the country. The percentage of children living in single-parent family households (with a male or female householder and no spouse present) is 34.8%. This ranks in the bottom quartile nationally. It is also estimated that 31.1% of seniors who are 65 years and older in Rhode Island live alone, which is higher than the national average.

Transportation

A variety of transportation measures were gathered. For the most part, Rhode Island compares favorably to national statistics with regard to workers commuting by public transportation and average travel time to work. However, unfavorable comparisons are the percentage of households without a vehicle, and workers who drive alone to work. Approximately nine percent (9.4%) of state households do not have a vehicle. It is important to note, however, that this may be a function of geography (e.g. urban living) and the presence of public transportation options, and may or may not represent a negative statistics.

In closing, the secondary data that was compiled should be examined collectively with the BRFSS analysis and the other research components. As with primary data, these statistics represent point-in-time information and patterns and comparisons can vary over time.

KEY INFORMANT INTERVIEWS

Key informants were interviewed to gather a combination of quantitative ratings and qualitative feedback through open-ended questions. A general summary of the findings is below.

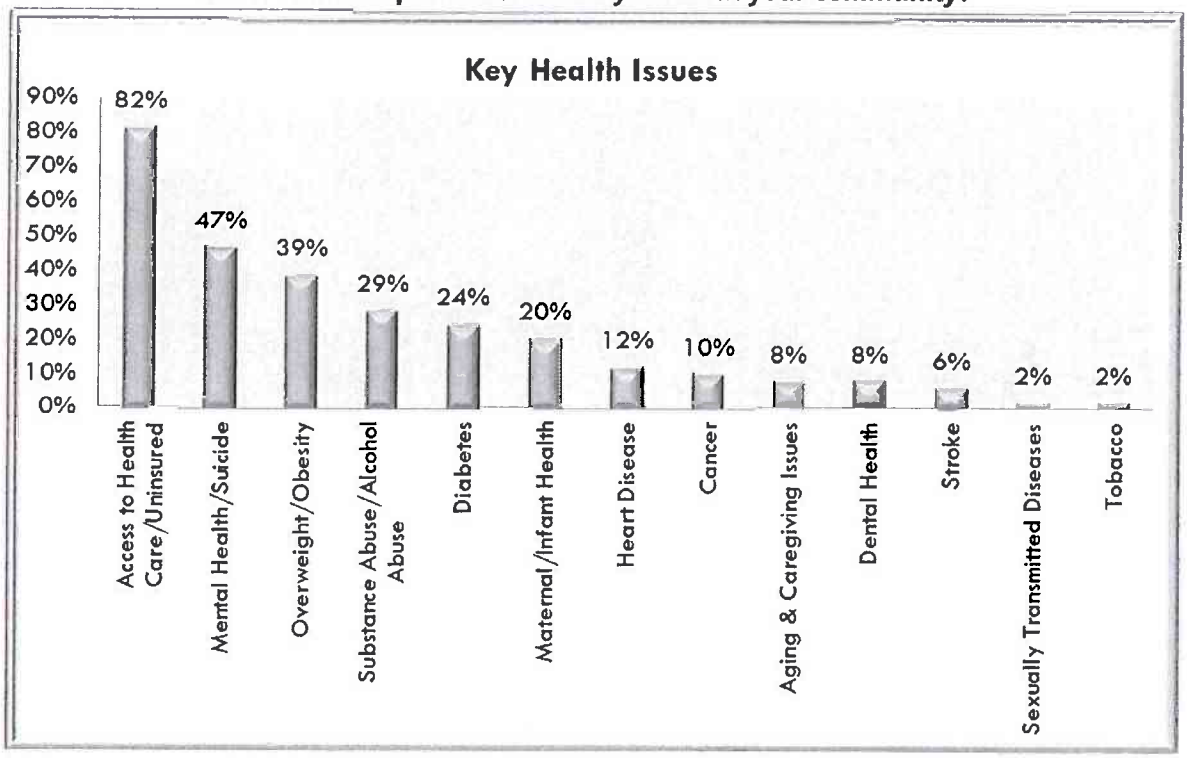
Key Health Issues

The initial section of the survey focused on the key health issues facing the community. Individuals were asked to select the top three health issues that they perceived as being the most significant. The three issues that were most frequently selected were:

- Access to Health Care/Uninsured/Underinsured
- Mental Health/Suicide
- Overweight/Obesity

The bar graph below shows the key informant rankings of all of the key health issues. The bar depicts the total percentage of respondents who ranked the issue among the top three concerns. Additional health concerns that were mentioned included childhood asthma, teenage pregnancy, and health disparities among those living in poverty.

"What are the top 3 health issues you see in your community?"



Access to health care was the most frequently selected health issue with 82% of informants ranking it among the top three key health issues. Forty-one percent of informants ranked it as the most significant issue facing the community. Concerns were voiced about hospitals serving as the safety-net provider for individuals who are uninsured and the number of uninsured patients that providers of free or reduced health care are seeing. While these clinics and options are in place, they do not provide high-level specialty care that is often needed.

The second most frequently selected health issue was **mental health/suicide** with 47% of informants selecting it among the top three key health issues. Sixteen percent of respondents ranked mental health as the most significant issue facing the community. Respondents indicated that the resources available for the treatment of mental health issues are insufficient. The greatest concerns were for the lack of psychiatrists, children's specialists, and professionals trained in co-occurring disorders (mental health and addiction). Key informants reported that emergency rooms are often addressing these mental health issues among residents.

The third most frequently selected health issue was **overweight/obesity** with 39% of informants ranking it among the top three key health issues. Ten percent of informants ranked overweight/obesity as the most significant issue facing the community. Respondents feel that reducing obesity can lead to improvements in many of the other chronic health issues identified as areas of concern. Those interviewed acknowledged that Rhode Island is not alone in its struggle with obesity.

Health Care Access

The survey respondents were asked to elaborate further on access to care issues in the area. They were asked questions regarding access to primary care, specialty care, and bilingual healthcare, and potential transportation barriers. As detailed in the table below, area professionals were least likely to agree that there are a sufficient number of bilingual providers. In addition to limited bilingual providers, the availability of mental/behavioral health providers, providers accepting Medicaid, dentists, specialists, and transportation were also rated as areas of concern. The highest rated statement was with regard to having access to a primary care provider when needed. While this was rated the highest among those interviewed, it only averaged a 3.02 rating on a 5-point scale.

Factor	Mean Response (1=strongly disagree; 5=strong agree)
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	3.02
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	2.57
Residents in the area are able to access a dentist when needed.	2.49
There is a sufficient number of providers accepting Medicaid and medical assistance in the area.	2.37
There is a sufficient number of bilingual providers in the area.	1.88
There is a sufficient number of mental/behavioral health providers in the area.	2.20
Transportation for medical appointments is available to residents in the area when needed.	2.41

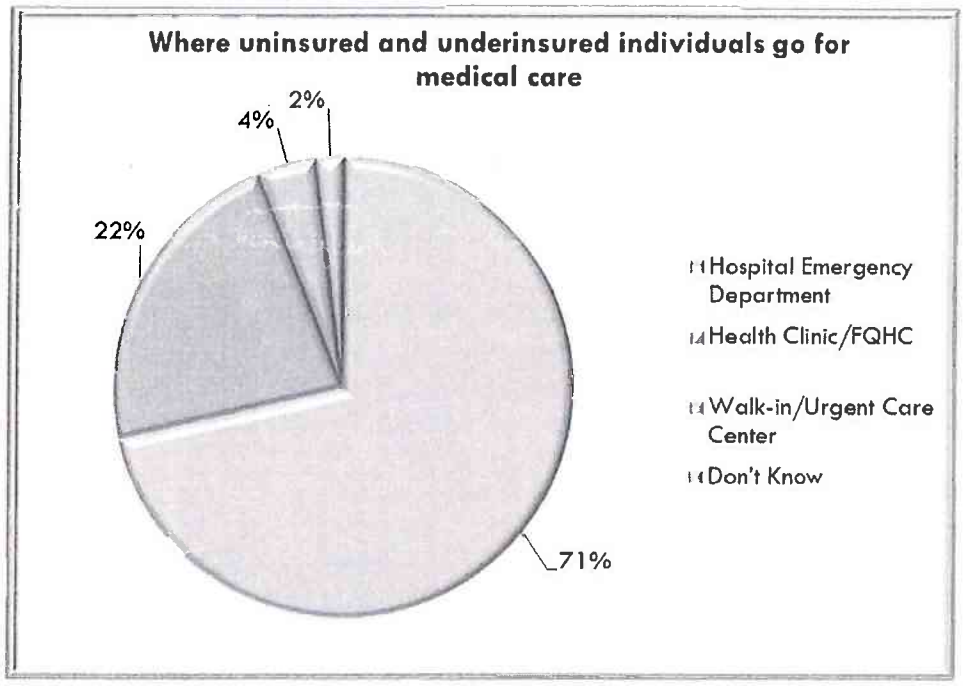
After rating availability of health care services, informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Lack of Health Insurance Coverage
- Lack of Transportation
- Inability to Pay Out of Pocket Expenses

Respondents also identified concerns related to having too few providers, limited appointment times (particularly for the uninsured), language and cultural barriers, and difficulties navigating the health care system. While the greatest concerns were for the uninsured, many commented on increasing barriers for those with health insurance. One barrier that was mentioned was the escalating out-of-pocket expenses for co-pays and prescriptions medications. Another barrier that was mentioned was transportation. Transportation services were identified as "practically non-existent" in some areas. Those areas with bus or other public transportation options also have limitations that present additional barriers such as restricted eligibility requirements or expensive fares.

Informants were then asked whether they thought there were specific populations that were not being adequately served by local health services. The majority of respondents (88%) indicated that there are underserved populations in the community. The immigrant/refugee population was identified as the most underserved followed by the low-income/poor. These groups were followed by the uninsured/underinsured, the Hispanic/Latino population, and individuals with mental health issues as the groups most underserved.

When asked where they think most uninsured and underinsured individuals go when they are in need of medical care, 71% stated the hospital emergency department. The bar chart below details the responses. Health clinics and FQHCs (Federally Qualified Health Centers) were mentioned by 22% of those interviewed.



Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many informants indicated that mental health services were needed. Informants also felt there was a need for more health education, information, and outreach. In addition, respondents suggested that additional free and low cost medical and dental services would help improve access. Additional frequent mentions included transportation options, assistance with basic needs (housing, food), and more primary care providers.

Challenges and Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community. When asked what challenges people in the community face in trying to maintain healthy lifestyles, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort

- Time/Convenience
- Education/Knowledge

Several participants indicated that cost is a barrier. They explained that healthy foods like fresh fruits and vegetables can be expensive, and unhealthy foods are often cheaper. Participants also mentioned that gym memberships and fitness programs can be expensive. In addition, informants expressed concerns about lack of awareness and education. Suggestions were made to integrate more planning activities into community health improvement initiatives. An example that was mentioned was ensuring that communities are walkable and safe. A number of programs and organizations were praised for their efforts, but it was generally agreed that more are needed.

Concluding Thoughts

The key informants expressed appreciation for the opportunity to share their thoughts and experiences and indicated interest and support for efforts to improve community health. Based on the feedback from the key informants, access to health care is a significant issue in the community. A number of barriers contribute to access including health insurance coverage, transportation, and inability to pay out of pocket expenses. The need for mental and behavioral health services was also repeatedly mentioned by informants. In addition, informants expressed concern about the growing problem of obesity and indicated that there are number of challenges that contribute to obesity including cost, accessibility, convenience, education, and motivation. Many respondents indicated the need for increased awareness, education, prevention, and outreach and encouraged more collaboration and coordination among health and human service providers.

The feedback from the key informant surveys will be utilized in conjunction with secondary data, BRFSS analysis, and focus group discussions to understand community health needs and prioritize public health endeavors.

FOCUS GROUPS

On March 26, 2013, Holleran conducted two focus groups with 21 mental and behavioral health care professionals. Both groups were held at Butler Hospital in Providence, Rhode Island. Focus group participants were recruited by HARI and its member hospitals. A full report of the focus groups was provided. A list of participants is included as Appendix B.

The aim of the focus groups was to identify mental and behavioral health needs throughout Rhode Island. Focus group participants discussed Rhode Island's challenges and successes in providing care to residents with mental health needs. Special populations, access to care, community perception, emerging trends, and recommendations were discussed.

Adolescents, the elderly, homeless individuals, and those who do not speak English were seen as some of the most underserved populations when it came to mental health needs. Of particular concern is increased substance abuse, especially among adolescents, and the co-occurring diagnosis of mental illness and substance abuse. The participants also expressed concerns about the complexity of patients' conditions and the relationship between mental and physical health.

Challenges with accessing care included lack of insurance and ability to afford care, as well as provider reimbursement rates and acceptance of insurance. Coordination of services within the system needs to be improved to create a transparent system where providers can easily provide referrals to the appropriate level of care in an efficient and expedient manner.

Stigma, as well as the recognition of signs and symptoms of mental health conditions, continues to be a barrier to treatment. Recommendations were made to continue to explore the integration of primary care and mental health, as well as regular mental health screening of patients with chronic conditions.

Continued collaborations between schools and community-based services were seen as successful and in need of additional support. Advocacy to ensure continued funding successful programs is needed.

A shift from payer-led treatment plans to provider-led treatment plans would enable the appropriate level of care and likely cut costs in the end. Providers feel as though "their hands are tied" when it comes to providing the best treatment for patients.

Participants, encouraged by the dialogue with a cross-section of providers, referral sources, and community agencies, suggested a statewide mental health summit to further explore issues and opportunities.

Identified Areas of Need

Each individual research component provides a unique perspective on the health status of the service area for Rhode Island. While each component provides a different perspective, a number of overlapping health issues are evident. The following list outlines the key themes that stood out across the four research components.

- **Access to Care:** Concerns for healthcare access were seen as greatest for the uninsured and under-insured and those attempting to access specialty care. Specialty care includes medical specialists, dentists, and child and senior providers. The growing immigrant population was also noted as an increasing challenge on the local health care system. Specifically, it was stated that there are too few bilingual providers locally and that cultural competencies are not fully integrated into the health system. The household survey did reveal that residents in the hospital's service area are more likely to have health insurance coverage and one person they think of as their personal doctor or health care provider.

- **Alcohol Use:** The secondary data revealed that there is a high density of liquor stores in Rhode Island. Adults who participated in the household survey were also more likely to report alcohol use in the past month when compared to national statistics. Professionals who participated in the focus groups and key informant interviews voiced concerns about co-occurring disorders with mental health issues and addiction.

- **Asthma:** The household survey revealed a higher proportion of adults who have had a diagnosis of asthma and also a higher proportion that still have asthma when compared against national figures. Elevated asthma statistics were also uncovered for children living in the service area. The secondary data confirmed elevated asthma rates.

- **Breast Cancer Incidence:** The incidence data for cancers shows that Rhode Island has elevated rates for breast cancer. However, death rates are lower in the state, indicating that those with a diagnosis of breast cancer are more likely to have a positive prognosis.

- **Mental Health Status:** The key informants that were interviewed identified mental health issues as one of the primary health concerns for the area. Specifically, concerns were voiced about the limited number of treatment options, particularly for those who are uninsured or underinsured. As a result, individuals with mental health issues often utilize the hospital emergency room. The household survey also reported a higher number of individuals with a depressive disorder and more days when poor physical or mental health interfered with functioning. On a positive note, the suicide rate in the area is not elevated above national figures.

- **Overweight & Obesity:** The BMI statistics for adults in the area show that the majority are either overweight or obese (62.3%). Adults in the area are just as likely to exercise compared to their peers nationally. Key informants also noted their concern with the issue of overweight/obesity and its relationship to chronic diseases such as diabetes.

Prioritization of Community Health Needs

On April 30, 2013, approximately 20 individuals representing the Hospital Association of Rhode Island (HARI), its member hospitals, and the Rhode Island Department of Health gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). A list of attendees can be found in Appendix C. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for statewide community health improvement initiatives and the development of the hospitals' Implementation Strategies.

The meeting began with an abbreviated research overview presented by Holleran Consulting. The presentation covered the purpose of the study, research methodologies, and the key findings. Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. Holleran then facilitated an open group discussion for attendees to share what they perceived to be the needs and areas of opportunity in the region.

A broad list of needs was identified through the research and discussion. Holleran facilitated group discussion to identify overlapping strategies, cross-cutting issues, and the ability for regional health and human services providers to effectively address the various needs. After dialogue and consolidation, the following "Master List of Needs" was developed by the attendees to be evaluated as potential priority areas for community health improvement activities.

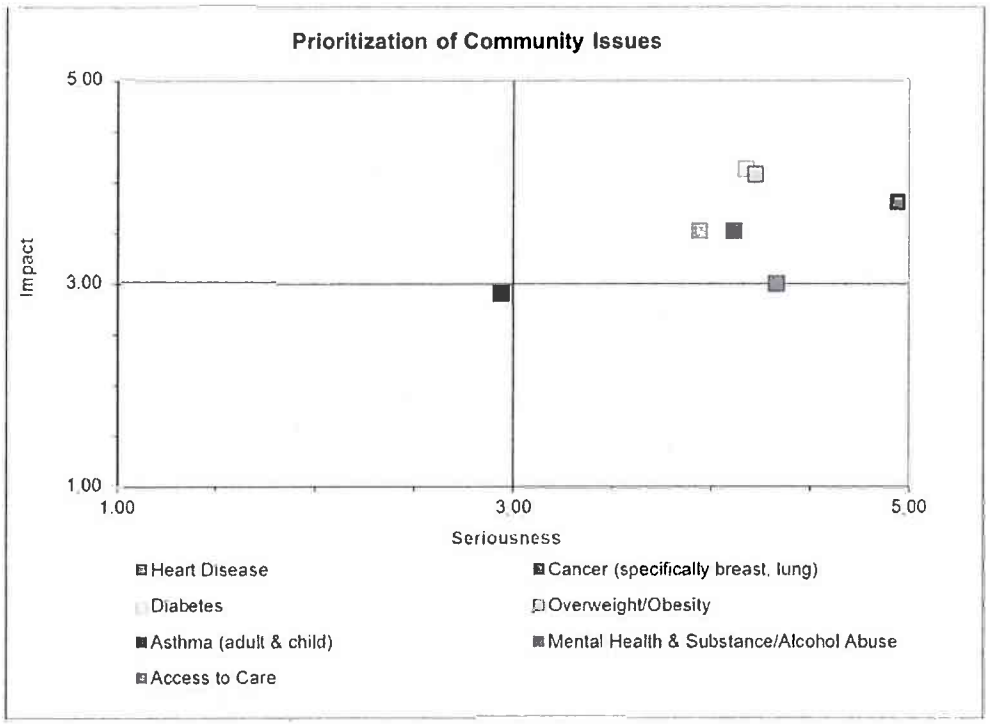
Master list of community priorities (in alphabetical order):

- Access to Care
- Asthma
- Cancer
- Diabetes
- Heart Disease
- Mental Health and Substance Abuse
- Overweight and Obesity

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included seriousness of the issue and the ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise from highest rated need to lowest based on the average score of the two criterions.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health and Substance Abuse	4.94	3.78	4.36
Diabetes	4.17	4.11	4.14
Overweight/obesity	4.22	4.06	4.14
Access to Care	4.11	3.50	3.81
Heart Disease	3.94	3.50	3.72
Cancer (specifically breast, lung)	4.33	3.00	3.67
Asthma (adult and child)	2.94	2.89	2.92

The priority area that was perceived as the most serious was Mental Health (4.94 average rating), followed by Cancer (4.33 average rating), and Overweight and Obesity (4.41 average rating). The ability to impact Diabetes was rated the highest at 4.11, followed by Overweight and Obesity with an impact rating of 4.06, and Mental Health, with a score of 3.78. The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Appendix A: Key Informants

Name	Title	Organization
Ana Novais	Executive Director	Community, Family Health & Equity/HEALTH
Ann Barrone	Chief WIC	Rhode Island Dept. of Health
Ann Nolan	President	Cross Roads
Benedict Lessing Jr.	Executive Director	Family Resources Community Action
Beth Lamarre	Director	Community Health Care Workers Association
Carol Holmqust	President & CEO	Dorcas Place
Catherine Taylor	Director of Elderly Affairs	DHS
Christopher Koller	Health Insurance Commissioner	RI Dept. of Health
Chuck Jones	President and CEO	Thundermist
Cindy Gardiner	Social Services Manager	Wood River Health Services
Clark Rumfelt	Chaplain & Community Volunteer	The Westerly Hospital
Dale Klatzker	President & CEO	Providence Center
Dennis Keefe	President & CEO	Care New England
Dennis Langley	President	Urban League of RI
Rich Leclerc	President	Gateway
Donna Nabb	Family Literacy Coordinator	Westerly Public Schools
Elena Nicolella	RI Medicaid Director	EOHHS/DHS
Elizabeth Burke Bryant	Executive Director	RI Kids Count
Elizabeth Lange	Pediatrics, MD	Coastal Medical of RI
Graciela Fontana	ESL Teacher Assistant & Translator	Westerly Public Schools
Jane Hayward	CEO	RI Health Center Association
Jerry Cutler	VP of Clinical Services	South Shore Mental Health Center
Jim Nyberg	Director	RIAFSA
Jim Berson	President & CEO	YMCA of Greater Providence

Name	Title	Organization
Kate Brewster	Executive Director	Economic Progress Institute
Kelly Lee	Executive Director	Adult Day Services of Westerly
Kristen Edward	HIT Director	TriTown Community Action
Laurie White	President	Greater Providence Chamber of Commerce
Liz Pasqualini	Executive Director	The JonnyCake Center
Louis Giancola	President & CEO	South County Hospital
Mario Bueno	Executive Director	Progreso Latino
Matthew Cox	Executive Director	RI Parent Information Network
Merrill Thomas	CEO	Providence Community Health Center
Michael Van Leesten	CEO	OIC of Rhode Island
Michele Iacoi, RN	School Nurse (Middle School)	Westerly Public Schools
Neil Corkery	Executive Director	DATA
Patricia Nolan	Executive Director	RI Public Health Institute
Patricia Recupero	President	Butler Hospital
Paul Despres	CEO	Eleanor Slater Hospital
Paul Theroux	Pastor	Saint Francis Parish
Raymond Lavoie	Executive Director	Blackstone Valley Community Health Care
Russ Partridge	Executive Director	The Warm Center
Scott Avedisian	Mayor	City of Warwick, RI
Sean Walsh, LICSW	Director, Family Care Community Partnerships	South County Community Action
Steve Florio	Executive Director	RI Commission on Deaf & Hard of Hearing
Susan Orban, LICSW	Coordinator	VNS Home Health Services
Terrie Wetle	Associate Dean of Medicine for Public Health & Public Policy	Brown University
Tony Maione	President & CEO	United Way of Rhode Island
Virginia Burke	President & CEO	RI Health Care Association

Appendix B: Focus Group Participants

Name	Title	Agency
Tom Allen	LICSW, Director, Outpatient Addiction Medicine & Behavioral Health Social Work	Roger Williams Medical Center
Fay Baker	LICSW, Director, Project Implementation and Acute Care Services	The Providence Center
Susan Bruce	LICSW	
Gary Bubly	MD, Director, Department of Emergency Medicine	The Miriam Hospital
Joseph Dziobek	President & CEO	Fellowship Health Resources
Charlene Elie	RN, Chief Nursing Officer	Landmark Medical Center
Peter Erickson	PhD	
Dr. Roberta Feather	Marriage and Family Counseling	Private practice
Diane Ferreira	RN, Director of Social Services	Butler Hospital
Robert Hamel	RN, Director of Psychiatric Partial Hospital Psychiatric Services	Butler Hospital
Margaret Howard	PhD, Director of Post-Partum Depression Day Hospital	Women & Infants Hospital
Sue Jameson		VNS Home Health Services
Dale K. Klatzker	President & CEO	The Providence Center
Rich Marwell		Eleanor Slater Hospital
Sally Mitchell	PsyD	
Caroline Obrecht	LICSW	
Deborah O'Brien	Vice President & COO	The Providence Center
Francis Paranzino	Vice President & COO	Newport County Community Mental Health Center
David Robinson	Office of Primary Care and Rural Health	Rhode Island Department of Health
Lisa Shea	MD, Deputy Medical Director	Butler Hospital
Curt Wilkins	Director of Social Services	Landmark Medical Center

Appendix C: Prioritization Session Participants

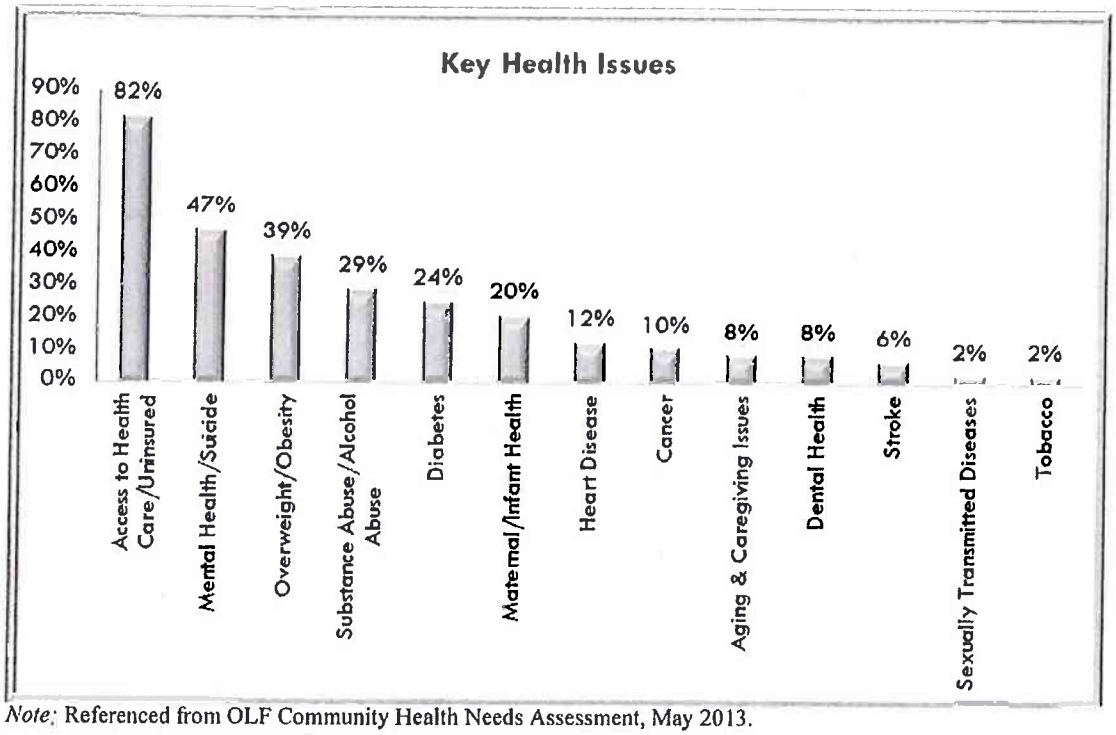
Name	Title	Organization
Mike Souza	Senior Vice President	HARI
Liz Almanzor	Project Coordinator	HARI
Stephanie Anderson	Senior Planning Analyst	Care New England
Gina Rocha	VP, Clinical Affairs	HARI
Ed Quinlan	President	HARI
May Kernan	Senior VP, Marketing Communications	Care New England
Gary Epstein-Lubow	Assistant Unit Chief, inpatient geriatric psychiatry unit	Butler Hospital
Lisa Shea	Associate Medical Director, Quality & Regulation	Butler Hospital
Patti Melaragno	Director, Marketing & Public Affairs	Butler Hospital
Jeff Borkan	Physician-in-Chief of Family Medicine	Memorial Hospital of Rhode Island
Kellie Sullivan	Planning Implementation Manager	Care New England
Gail Costa	Senior VP Planning	Care New England
Cindy Wyman	VP, Planning & Market Development	South County Hospital
Rene Fischer	Senior VP Patient Care Services, CNO	Kent Hospital/Care New England
James Alves	Associate VP	Butler Hospital
Ana Novais	Executive Director, Division of Community, Family Health & Equity	Rhode Island Department of Health
Magaly Angeloni	Performance Improvement and Accreditation Manager	Rhode Island Department of Health
Otis Brown	VP, External Affairs	CharterCARE Health Partners
Darlene Kershaw	Clinical Nurse Manager	Roger Williams Medical Center
Linda Zaman	Director of Perioperative Services	Roger Williams Medical Center
Patricia Nadle	CNO	St Joseph Health Services of RI/CharterCARE
Margaret Duff	Clinical Operations Manager for Behavioral Health	St Joseph Health Services of RI/CharterCARE
Paula DiLeonardo	Interim Director, Nursing Operations	St Joseph Health Services of RI
Michele Danish	Director, Performance Improvement	St Joseph Health Services of RI

Exhibit 9(b)

D. Please identify the health needs of the population in (C) relative to this proposal.

OLF participated in a comprehensive Community Health Needs Assessment (CHNA) from September 2012 to May 2013. The assessment was conducted to identify the health needs of the service population as well as to comply with requirements in the Affordable Care Act. This assessment was an effort to ensure that hospital community health improvement initiatives and community benefit activities are aligned and prioritized with community need. Information was collected through surveys, interviews and consumer focus groups, as well as utilizing available health data statistics.

From the interviews on individual health issues, the following bar graph lists the key health issues perceived as being the most significant. Access to health care/uninsured/underinsured and mental health/suicide were two of the top issues.

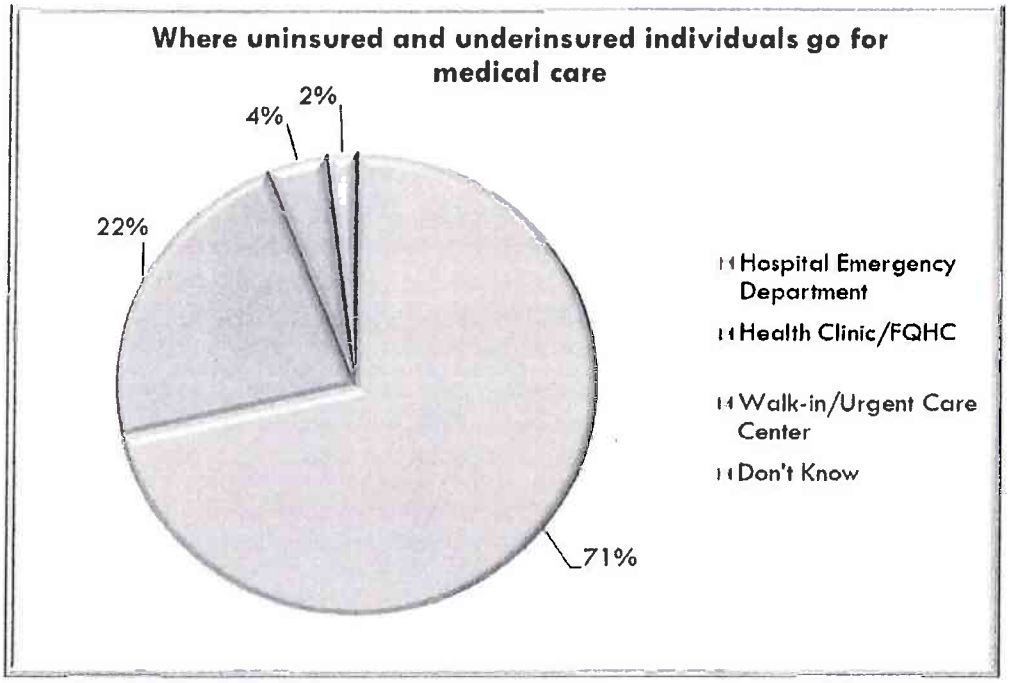


Note; Referenced from OLF Community Health Needs Assessment, May 2013.

Access to health care was the most frequently selected health issue with 82% of participants ranking it among the top three key health issues. Forty-one percent (41%) of participants ranked it as the most significant issue facing the community. Concerns were delineated about hospitals serving as the safety-net provider for individuals who are uninsured and the number of uninsured patients that providers of free or reduced cost health care centers are seeing.

Participants were asked whether they thought there were specific populations that were not being adequately served by local health services. The majority (88%) indicated that there are underserved populations in the community. The immigrant/refugee population was identified as the most underserved population followed by the low-income/poor. These groups were followed by the uninsured/underinsured, the Hispanic/Latino population, and individuals with mental health issues as the groups most underserved. The growing immigration population was also noted as an increasing challenge to the local health care system.

When asked where they think most uninsured and underinsured individuals go when they are in need of medical care, 71% stated the hospital emergency department. The bar chart below details the responses. Health clinics and FQHCs (Federally Qualified Health Centers) were mentioned by 22% of those interviewed.



Note: Referenced from OLF Community Health Needs Assessment, May 2013

While population health management care delivery systems are being established, the hospital emergency department remains one of the most important portals to access care. Women seeking emergent or urgent obstetrical care often seek out care from their local community hospital and/or the hospital that is located closest to their home, often without regard to whether or not the hospital may specialize in, or provide such services. OLF is proposing to open an inpatient OB unit to ensure that such services are immediately available in order for patients to receive the best care and services possible. The proposed OB unit will ensure best practices through access to care for OLF's community and OB patient populations.

10. Description of PMH's Corporate Quality Program (to include organizational chart showing staffing).

Attached hereto as Exhibit 10, is a draft PMH Corporate Performance Improvement, Quality and Patient Safety Program Proposal. Please note that PMH's Corporate Chief Quality Officer was hired on April 4, 2014 and has recently drafted the attached draft proposal. As such, the attached draft PMH Corporate Performance Improvement, Quality and Patient Safety Program is under corporate review and is subject to change.

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PMH Corporate Performance Improvement, Quality and Patient Safety Program Proposal (Draft)

Introduction

Philosophy: To ensure that our patients receive the right care, at the right time, in the right setting, with efficiency and compassion.

Mission: Above all, we are committed to quality in all aspects of healthcare delivery, including:

- Striving for the best possible patient outcomes
- Maintaining the highest standards of patient safety
- Acting with integrity at all times
- Promoting open communication
- Collaborating to better serve the healthcare needs of our communities

Purpose: The PMH Quality and Patient Safety Program will focus on continuous enhancement of quality and safety for all we serve. Every employee plays a crucial role in ensuring patient, visitor and employee safety. We will work to reconnect quality and patient safety to clinical care thereby promoting high quality, safe, effective and efficient care. Additionally, the program will strive to build a just culture of safety by implementing strategies to reduce medical errors. Reducing risk and ensuring safety requires increased attention to systems that prevent and mitigate errors. The corporate quality and patient safety team will work with hospital to provide appropriate solutions to ensure best practices, resulting in quality patient care and service.

Goal: Build corporate and regional structures and processes necessary to become a high reliability organization promoting patient-focused, high quality, safe, compassionate, efficient, and effective care.

Model: We will achieve our mission and purpose through building and sustaining a robust quality and patient safety program at all levels of the organization. The key elements of this program will include: innovation, service, education, transparency, patient and physician partnerships. We will be using the Donabedian Quality of Care Model as our framework for building the program. Our initial focus will be on creating the corporate structure to enhance our ability to build processes and achieve outcomes.

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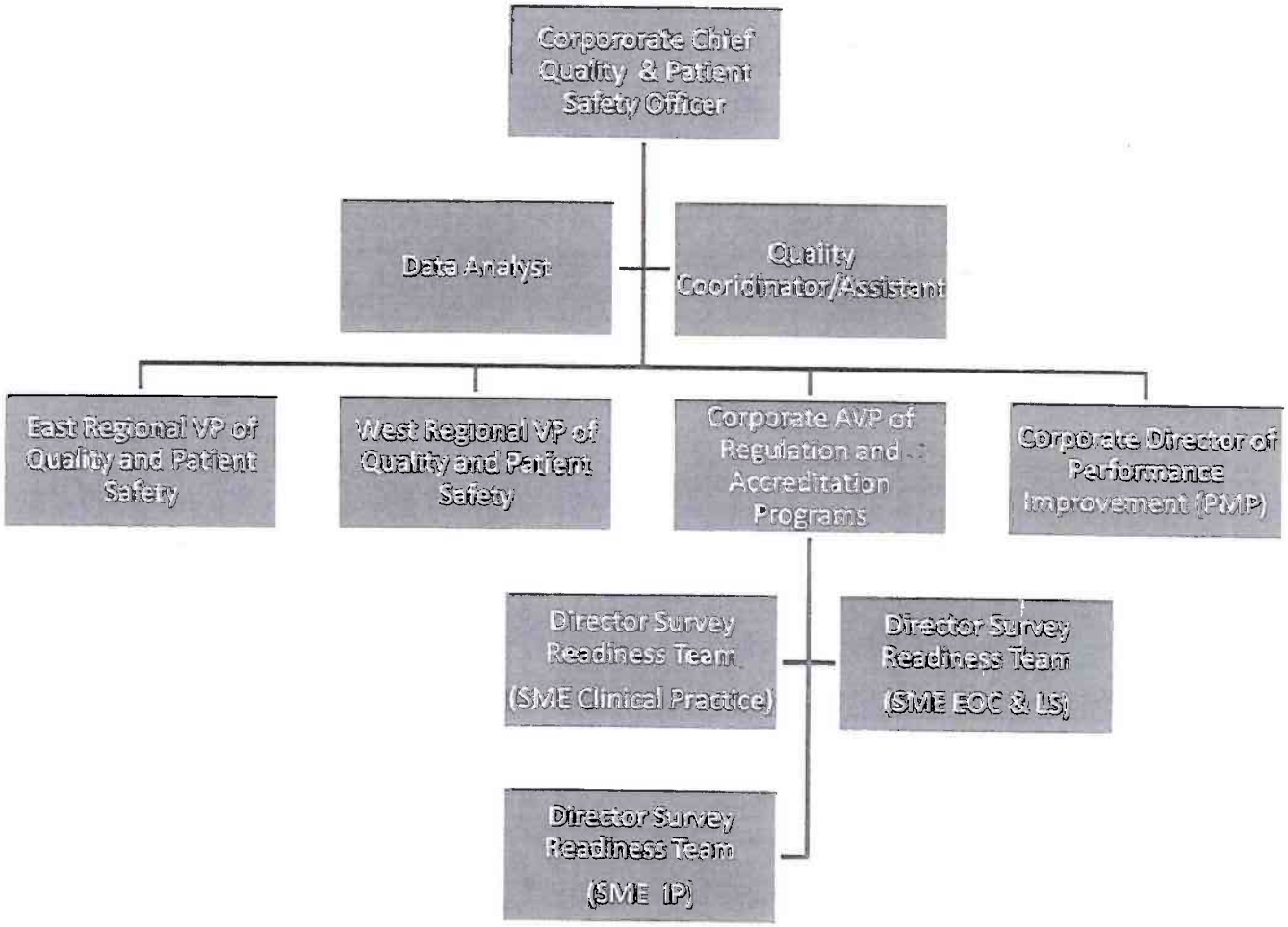
Structure

Corporate and Regional Quality Department Structure



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Roles and Responsibilities

Chief Quality Officer - Provides Oversight to the Corporate Quality and Patient Safety Agenda. Activities may include but are not limited to:

- Collaborates with hospital executives, and engages with hospital leaders and clinicians in identifying and implementing unique and varied initiatives aimed at improving patient care quality and safety
- Leads continuous improvement programs throughout the organization and helps develop a culture of continuous improvement and excellence
- Collaborates with hospital executives and engages with leaders and clinicians throughout the organization to build quality, efficiency, effectiveness and a sense of shared accountability
- Collaborates with hospital executives and engages with leaders to ensure continuous survey readiness.
- Takes a clinical leadership role in evaluating care delivery and develops the infrastructure for improvement
- Strengthens the data and information capabilities of the organization and champions a data-driven environment

Regional VP of Quality and Patient Safety – Reports to the CQO.

- Provides regional support and expertise to hospital leadership
- Leads continuous improvement programs in the assigned region and helps develop a culture of continuous improvement and excellence in those regions
- Reviews all regional hospital serious events and assists the hospital leadership in mitigation as appropriate.
- Collaborates with regional hospital executives and engages with leaders and clinicians throughout the organization to build quality, efficiency, effectiveness and a sense of shared accountability
- Collaborates with hospital executives and engages with leaders to ensure continuous survey readiness and sustainment of performance improvement activities
- Strengthens the data and information capabilities at the regional level and champions a data-driven environment

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Corporate AVP Regulation and Accreditation – Reports to the CQO

- Provides oversight to all aspects of the Survey Readiness program
- Serves as subject matter expert and hospital resource for regulation and accreditation programs
- Creates, implements, and maintains survey readiness tools that meet federal, state, and local statutes and regulations.
- Ensures survey readiness tools meet the applicable accreditation standards i.e. TJC, DNV, etc.
- Deploys and provides oversight to the survey readiness team during hospital site visits.
- Reviews all survey action plans and provides constructive input prior to submission to the appropriate regulatory or accreditation agency.

Director Survey Readiness Team – Reports to AVP of Regulatory and Accreditation Programs

- Serves as a subject matter expert and support person to all hospitals.
- Completes full survey readiness assessments at hospitals and provides recommendations for improvement
- Tracks hospital performance improvement activities based on site visit findings

Director of Performance Improvement – Reports to CQO

- Leads and facilitates system and hospital wide strategic quality and safety improvement projects.
- Develops and coaches performance improvement implementation strategies in support of the strategic goals.
- Collaborates with hospital executives, and engages with hospital leaders and clinicians in designing and implementing quality, patient safety and clinical excellence performance improvement activities.
- Leverages complex decision support/data systems to establish operation and quality related metrics to measure progress and sustainability of improvement efforts/initiatives.
- Ensures seamless hand-off of completed improvement initiatives to hospital operations leadership
- Engages with hospital leadership in Implementing special initiatives to support the high reliability performance improvement initiatives of PMH as required.

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Data Analyst - Reports to CQO

- Interprets data, analyzes results using statistical techniques and provides ongoing quality, patient safety, and clinical effectiveness reports
- Develops and implements data collection systems and other strategies that optimize statistical efficiency and data quality
- Works closely with management to prioritize business and information needs
- Locates and defines new process improvement opportunities
- Prepares tables, charts and graphs to summarize the results of these analyses

Quality Coordinator/Assistant – Reports to CQO

- Serves as Administrative Assistant to the Corporate Quality and Patient Safety program
- Assists with gathering quality and patient safety data for analysis

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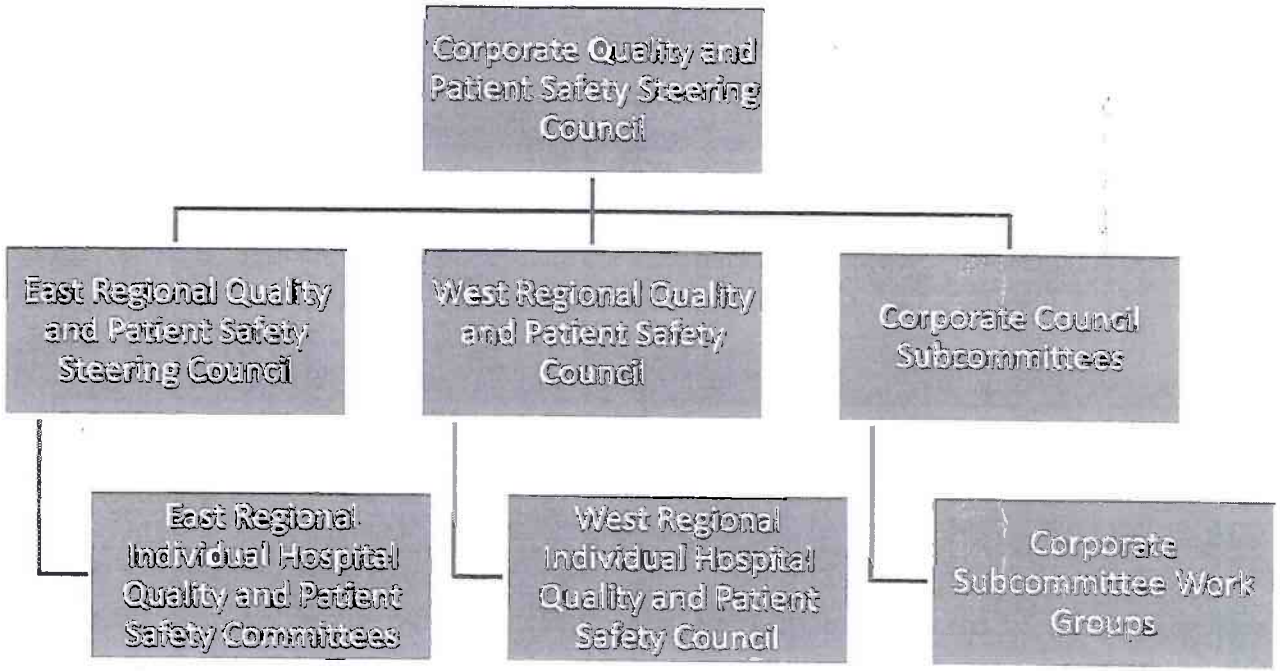
Quality and Patient Safety Communication and Reporting Structure



Note: Hospital Quality and Patient Safety Committees will report up through the appropriate regional steering council which will then report up through the corporate Quality and Patient Safety Steering Council.

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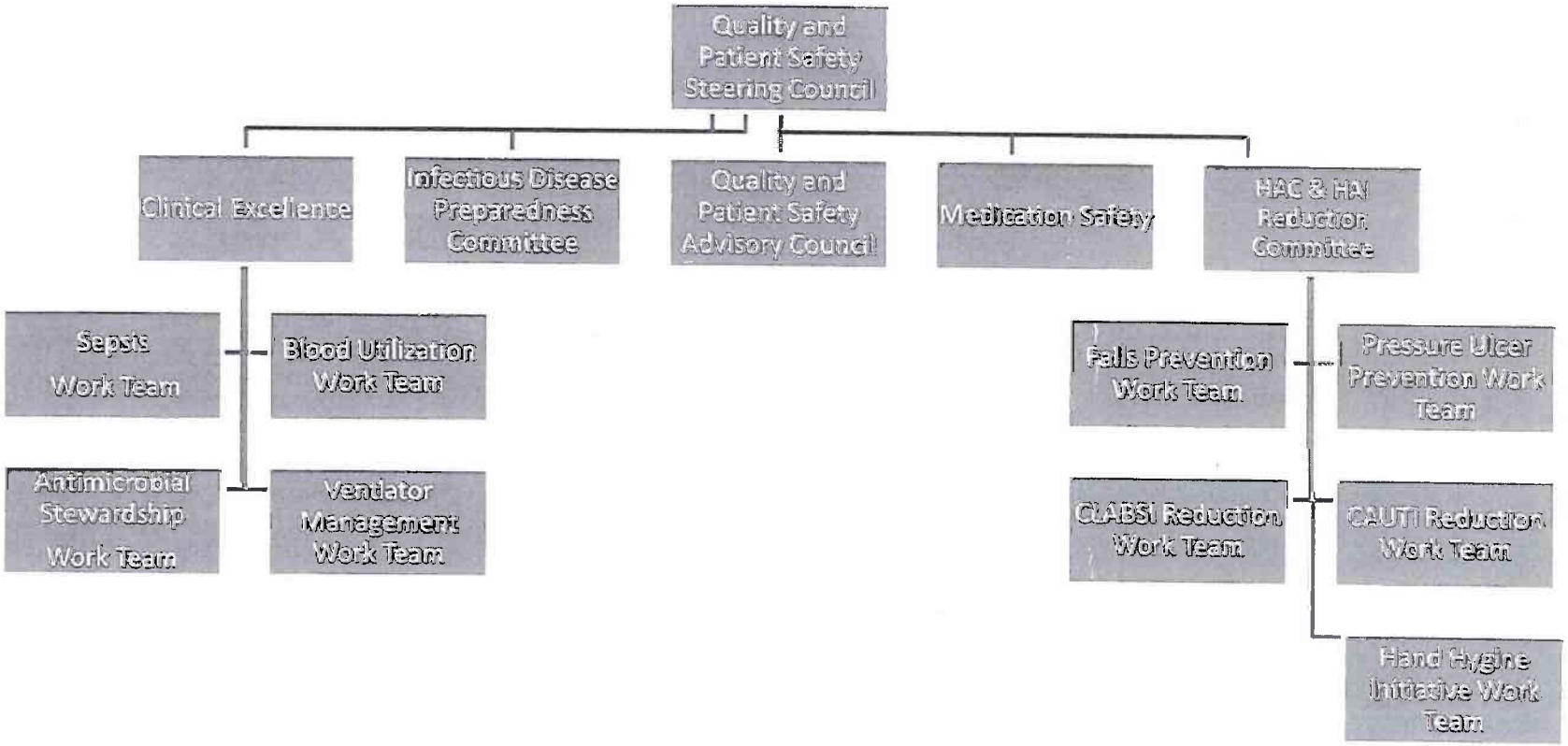
Corporate Quality and Patient Safety Steering Council Subcommittee and Work Group Sample Structure



Note: The above diagram outlines potential subcommittees and work groups. The actual infrastructure will be dependent upon the identified needs at the hospital, regional and corporate levels.

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Corporate Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the regional councils
- Assists with the development of the corporate quality and patient safety strategy
- Prioritizes Quality and Patient Safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from chartered committees and work teams
- Engages in identifying ongoing quality and patient safety performance improvement opportunities.
- Ensures follow-up on regional initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety.
- Assist with barrier removal to achieve quality and patient safety strategies.

Regional Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the hospital councils
- Assists with the development of the corporate and regional quality and patient safety strategy
- Prioritizes regional quality and patient safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from regional chartered committees and work teams
- Engages in identifying ongoing quality and patient safety performance improvement opportunities for the region.
- Ensures follow-up on hospital initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety at the regional level.
- Assist with barrier removal to achieve quality and patient safety strategies.

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Corporate Steering Council Chair: PMH Chief Quality Officer

Suggested Members: Appropriate Corporate Senior Leadership, Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, Medical Staff Director, IT&S Director, Supply Chain, others

Regional Steering Council Chair: TBA

Suggested Members: Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, IT&S Director, Supply Chain,

Ad Hoc Members: Radiology, Lab, Medical Staff, others as appropriate to subject matter

Committees: Responsible for building the infrastructure and provide input for key quality and patient safety activities. Potential Committees may include Medication Safety, Clinical Safety Improvement, Infectious Disease Preparedness, Regulation and Accreditation, Clinical Excellence, others as needed.

Rapid Action Work Groups: Completes rapid work for quick process and outcome improvement as needed. Examples include Core Measure improvement, HAC prevention, HAI prevention, Clinical Excellence etc. The team is responsible for creating and initiating performance improvement programs to include project plan, key elements, tool kits etc. Teams have a limited life depending upon the work product and outcomes.

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Process

High Reliability Organization: A high reliability organization is an organization able to continually manages their environment thoughtfully and assume a constant state of vigilance resulting in the fewest possible number of errors, despite operating in a high stress, high-risk environment. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations. These changes will be achieved through:

- Leadership's commitment to achieving zero patient harm
- A fully functional just culture of safety throughout the organization
- Widespread deployment of highly effective process improvement tools

PMH is in the process of adopting high reliability behaviors and strategies to ensure a reduction in overall medical errors for our patients. High reliability organizations are built on a foundation of a just culture of safety. A key component of building this foundation is a robust incident reporting and analysis system to better understand trends, opportunities and strengths. We encourage that every unsafe condition, near miss/great save or harm event be reported and analyzed to identify opportunity for improvement to prevent future harm. We commit to maintaining transparency through sharing best practices and lessons learned across all of our hospitals. We further commit to build and share evidence-based, best practice, and performance improvement processes and tools kits to assist with supporting our quality and patient safety high reliability organization initiatives.

Strategies:

- **Accreditation and Regulation Readiness** – Implement an accreditation and regulation survey readiness team to ensure all hospitals are continually in compliance with the highest level of quality care and patient safety standards as defined by CMS, TJC, DNV, NCQA, and applicable State and local statutes and regulations. Provide subject matter expertise and tools to support the facilities in ongoing survey readiness.
- **Patient Experience** – Create and implement a patient experience program to ensure that each patient is treated with respect, compassion, consideration and is an integral partner in his or her plan of care.

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- **Quality Measurement and Process Evaluation** – Build a standardized corporate quality and patient safety dashboard with national benchmarks. Institute monthly Quality and Patient Safety calls to review metrics, analysis and action plans to ensure ongoing improvement.
- **Patient Safety Improvement** – Create and implement a plan to move all hospitals towards a just culture of safety and accountability. Ensure quality and safe delivery of healthcare by defining and promoting consistent processes for identifying situations that may put patients or others at risk and acting to prevent or control those risks i.e. thorough and credible analysis of incidents of harm, near misses/great catches; FMEAs; ongoing learning through transparency, and implementation of patient safety tools.
- **Quality Improvement** - Maximize pay-for-performance for quality performance and outcomes metrics including VBP, readmission reduction program, HAC/HAI reduction program, Medicare spending per beneficiary (MSPB), Meaningful Use etc.
- **Technology Integration** – Maximize available patient safety technologies including CPOE, health information technology, clinical decision support, bar coding and other technologies to enhance the quality and patient safety strategy.
- **Clinical Excellence** – Improve mortality, complications, and length of stay through implementation of clinical excellence initiatives such as sepsis, stroke and STEMI management; effective blood utilization; ventilator management; and antibiotic stewardship.
- **High Reliability Organization** – Implement proven high reliability techniques and nationally recognized best practices to prevent harm and promote quality of care such as Red Rules (limited), SBAR (Situation, Background, Assessment and Recommendation), and STAR (Stop, Think, Act and Review) etc.

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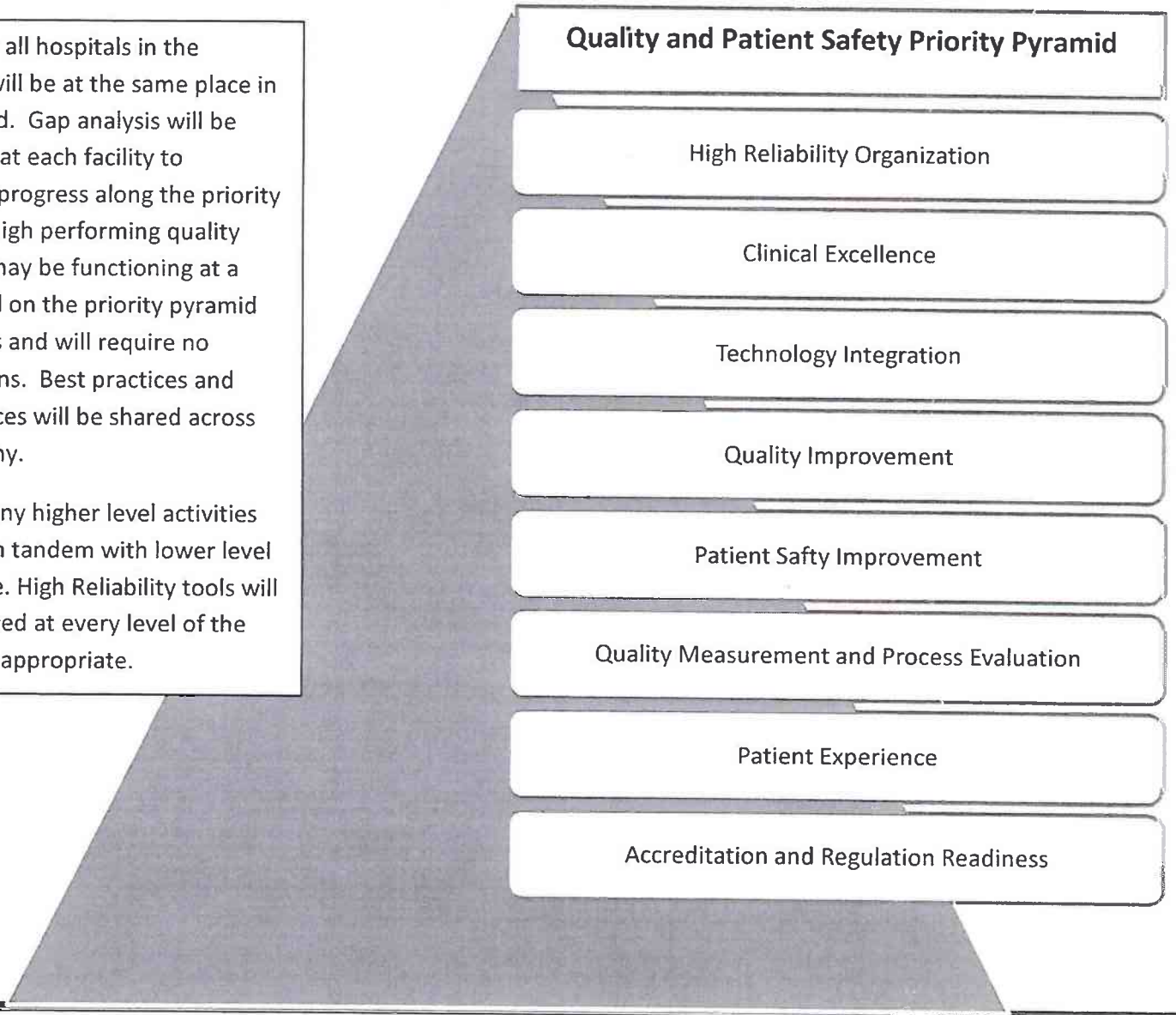
Note I: Not all hospitals in the Company will be at the same place in the pyramid. Gap analysis will be completed at each facility to determine progress along the priority pyramid. High performing quality programs may be functioning at a higher level on the priority pyramid than others and will require no interventions. Best practices and performances will be shared across the company.

Note II: Many higher level activities will occur in tandem with lower level activities i.e. High Reliability tools will be introduced at every level of the pyramid as appropriate.



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Outcomes

Corporate Quality and Patient Safety Dashboard

Quality, clinical and patient safety performance and outcomes will be measured via the newly created corporate Quality and Patient Safety Dashboard. Dashboards will be share across the company for the purpose of benchmarking and learning from other.

Hospital Quality and Patient Safety Call

Outliers will be addressed during the regularly scheduled hospital quality and patient safety calls. Best practices will be identified and shared with other hospitals in the company during these calls. The hospital will implement performance improvement activities to address the root cause and followed-up will occur during the next call. Once well established, the hospital call will occur at the regional level with a summary report forwarded to the corporate CQO.

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11. Description of Process for Development of Strategic Plan

Please see attached.

Prospect ECHN Strategic Planning Process

Overview

The purpose of this document is to describe the development of a Strategic Business Plan to guide the future growth and development of Prospect ECHN, Inc. and its affiliates (ECHN), as well as a related Strategic Capital Plan. In order to offer high value healthcare and participate in the emerging value-based payment models, an essential focus of healthcare reform, providers across the ECHN continuum must establish new relationships, infrastructure and capabilities to provide cost efficient care. The development and management of an advanced, comprehensive care continuum delivery network to manage the health of a defined population of patients requires strategies and significant investments necessary for health systems to develop new competencies, process skills and knowledge.

Goal, Objectives and Timing

The overall goal for the Strategic Business Plan is to develop and implement growth initiatives for the benefit of the surrounding communities served by ECHN, so long as that care can be delivered in a high quality and financially responsible manner. Assuming State approvals are obtained to proceed with the proposed acquisition of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc. (PMH) and affiliates, a strategic planning process led by the local management team and the Local Boards and supported by the resources and expertise of PMH will be organized and implemented soon after closing the transaction. It is expected that the Strategic Business will be produced over a 5-6 month period and that the Strategic Capital Plan will follow from the goals and initiatives identified in the Strategic Business Plan.

Structure

A Steering Committee will be formed with membership from the Local Boards, ECHN Medical Staff and representation from PMH to create a Strategic Business Plan including the clinical strategies to best serve the populations in the ECHN service area. The involvement of the Local Boards will provide input and feedback for health issues of concern to the community. The involvement of the medical community will allow for the local healthcare leaders and decision makers to assist in identifying the needs, or gaps, in care and consider the best approaches available to address those needs to the benefit of their patients. PMH will contribute the process skills and knowledge that promote clinical integration and the coordination of care through the alignment of the interests of the physician community, hospitals, post-acute providers and other providers needed to ensure that patients receive appropriate care, at the appropriate time, in the appropriate setting and with the best outcomes.

Strategic Capital Plan

The strategic business planning effort will allow for the development of a Strategic Capital Plan to support the initiatives designed to address the community and health system needs and priorities identified and included in the Strategic Business Plan. The Strategic Capital Plan will include investments at the ECHN hospitals, affiliates and joint ventures. Those investments will be in the form of new and replacement technology, equipment and facilities in support of health programs and services.

12. List of Critical, Immediate (over next 2-3 years) Capital Needs at ECHN

Please see attached.

LATE FILE # 12 - Priority Facility Capital Needs

	YEAR AND PRIORITY		
	1	2	3
Manchester Memorial Hospital			
Masonry Repairs to Buildings and Parking Garage	$ 175,000		
West Elevator Hydraulic Cylinder Replacement	$ 75,000		
Separate Signal Alarm Panel for Medical Gases	$ 65,000		
Upgrade HVAC Control Systems	$ 50,000		
Fire Alarm System Upgrade	$ 35,000		
Access Control System *	$ 275,000		
Infant Security System Replacement	$ 150,000		
Roof Replacements	$ 350,000	$ 350,000	$ 350,000
Emergency Generator, Distribution System		$ 800,000	
Automatic Transfer Switch Upgrade		$ 450,000	
Generator Monitoring Software and Alarms		$ 40,000	
Nurse Call Systems		$ 350,000	
Upgrade HVAC Control Systems		$ 100,000	
Replace Air Handlers	$ 50,000	$ 25,000	$ 25,000
Exhaust Stack		$ 45,000	
Roof Ductwork Insulation		$ 30,000	
Gas Manifolds		$ 20,000	
Oxygen Tank Concrete Pad		$ 15,000	
North Building Elevators			$ 575,000
East Building Elevators			$ 450,000
Ambulatory Building Elevators			$ 270,000
Site Paving and Sidewalks			$ 125,000
CCTV Upgrade			$ 85,000
Fire Extinguisher Management System			$ 20,000
Conference Room Wall Dividers			$ 65,000
Door Replacements, Ambulatory Building			$ 55,000
Maternity Expansion	$1,845,000		
BHU patient room improvements	$ 385,000		
Rockville General Hospital			
Basement Main Entrance flooring	$ 52,000		
Sprinkler System	$ 106,000		
Automatic Electrical Switch Gear	$ 314,000		
Walk-In-Coolers	$ 70,000		
Roof Replacements	$ 80,000	$ 30,000	
Boiler Upgrade	$ 30,000		
Oxygen Tank Concrete Pad	$ 15,000		
Roof Ductwork Insulation	$ 26,000		
Cooling Tower		$ 75,000	
Cooling Tower Sand Filter	$ 9,000		
Chiller Refrigerant		$ 15,000	
IT Data Room Air Conditioning	$ 25,000		

LATE FILE # 12 - Priority Facility Capital Needs

	YEAR AND PRIORITY			
	1	2	3	
Parking Lot, Sidewalk, Exterior Stair Repairs		$ 425,000		
Nurse Call Systems		$ 120,000		
Signage - Wayfinding		$ 80,000		
Air Curtains		$ 60,000		
HVAC Units		$ 40,000	$ 40,000	
Upgrade HVAC Control Systems		$ 60,000		
Helicopter Landing Pad Lighting		$ 11,000		
Elevator Modernization			$ 1,160,000	
Window Replacements			$ 110,000	
MRI Chiller			$ 60,000	
WoodLake at Tolland				
Roof top air handler units (3)	$ 390,000			
HVAC Controls	$ 20,000			
Boiler Room Vent	$ 7,000			
Fire Horns and Strobes Replacements	$ 5,000			
Roam Alert Wander Detection System	$ 17,700			
Nurse Call System		$ 72,000		
Flooring		$ 65,000		
Patient Room Upgrades			$ 475,000	
Hoyer lifts			$ 12,500	
	$4,621,700	**$3,278,000**	**$3,877,500**	
TOTAL				**$11,777,200**

* Includes MMH, RGH and WAT

13. **Description of Local Board (to include composition, process for appointment and authority)**

Please see attached description of the Local Board, together with draft bylaws for such board.

Description of PMH/ECHN Post-Closing Local Board

Relevant APA Provisions

The proposed Asset Purchase Agreement (APA) between Eastern Connecticut Health Network, Inc. (ECHN) and Prospect Medical Holdings, Inc. (PMH) outlines the role of the Local Board. Section 1.01(71) defines the "Local Board" as follows:

> **Local Board** means the advisory board of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The Initial members of the Local Board shall include at least five members of ECHN's Board of Trustees immediately prior to Closing and five other individuals identified by ECHN prior to Closing.

Sections 5.18, 5.21, 5.26 and 5.27 of the APA outline the Local Board's functions. Pursuant to these provisions, the Local Board shall, among other things:

- consult with PMH in the development of the post-closing Strategic Capital Plan (Section 5.18);
- serve as a resource for PMH with respect to PMH's investment of the Capital Commitment (Section 5.27);
- serve as a resource for PMH with respect to maintenance and implementation of the Strategic Business Plan and in connection with any proposed changes to the Strategic Business Plan (Sections 5.26 and 5.27);
- be responsible for medical staff credentialing at the Hospitals (Section 5.27);
- maintain and oversee the quality assurance program at the Hospitals (Section 5.27);
- collaborate with PMH and management on clinical quality matters of the Hospital Businesses to share best practices, establish clinical quality goals and measure progress (Section 5.21); and
- oversee and manage the accreditation process for the Hospitals (Section 5.27).

The Local Board's role in overseeing quality is further established in the Quality Commitment Letter executed by PMH and ECHN on March 28, 2016. The Quality Commitment Letter clarifies that the Local Board will have oversight over quality assurance programs at the Hospitals and that changes in any programs will require review and approval of the Local Board.

Local Board Structure

Based on ECHN's past experience with the effective and efficient operation of concurrently serving Hospital boards, the post-closing entity PMH/ECHN will structure the two Local Boards to have identical membership, and to meet concurrently. The initial Local Board of PMH/ECHN will be composed of five (5) physicians, the Hospital CEO, and five (5) additional members of the community. At least five (5) of the initial appointees to the Local Board will be individuals who are serving on the ECHN Board of Trustees at the time of the closing of the transaction. The Governance Committee of the ECHN Board of Trustees will nominate, and the ECHN Board of Trustees will elect, the remaining members of the initial Local Board from the community prior to Closing. Thereafter, local PMH/ECHN management, working with PMH regional management, will appoint the Local Board Members.

In appointing the initial Members of the Local Board, ECHN will give strong consideration to the following factors, and post-closing ECHN/PMH will apply the same criteria:

- Assuring diverse Board Member composition as to age, gender, race, and town of residence with the goal of reflecting the composition of the communities served by PMH/ECHN
- Inclusion of individuals involved in the development of ECHN's strategic plan prior to closing, in order to maintain forward momentum for the strategic plan
- Tapping expertise and backgrounds that align with Local Board roles and responsibilities
- For community member slots, consideration will be given to those who have demonstrated a commitment to ECHN's mission by serving as ECHN corporators prior to the closing of the transaction

Terms of Office/Frequency of Meetings/Termination

The Initial Local Board Members will be appointed prior to closing to serve staggered three year terms per the Local Board Bylaws. See additional details in the attached Bylaws.

LOCAL BOARD OF ADVISORS BYLAWS

MANCHESTER MEMORIAL HOSPITAL

ADOPTED _____, 2016

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LOCAL BOARD BYLAWS

ARTICLE I - DEFINITIONS

The following terms, when capitalized, shall have the meanings set forth in these Bylaws; when not capitalized they shall have the meanings generally accorded to them by a dictionary:

1. **"Allied Health Professional Staff"** or **"AHP Staff"** means the allied health professional staff of the Hospital, all of whom have been appointed pursuant to the Medical Staff Bylaws.

2. **"Board of Directors"** means the board of directors of the Hospital.

3. **"Bylaws"** means these Local Board Bylaws.

4. **"Chief Executive Officer"** or **"CEO"** means the administrator of the Hospital who is responsible for the day-to-day management of the Hospital.

5. **"Clinical Privileges"** or **"Privileges"** means the permission granted to a Practitioner by the Health System Parent, on recommendation of the Medical Executive Committee and the Local Board, to render specific diagnostic, therapeutic, medical, dental, podiatric, surgical, or other professional services.

6. **"Health System"** means the system of health care providers under the common control of the Health System Parent, and including the Hospital and Rockville General Hospital.

7. **"Health System Parent**" means Prospect ECHN, Inc., the sole shareholder of the Hospital.

8. **"Health System Parent Board**" means the board of directors of the Health System Parent, designated by the Board of Directors to serve as the governing body of the Hospital with respect to Medical Staff matters.

9. **"Hospital"** means Manchester Memorial Hospital.

10. **"Local Board"** means the Manchester Memorial Hospital Local Board of Advisors.

11. **"Medical Executive Committee"** means the medical executive committee of the Medical Staff.

12. **"Medical Staff"** or **"Staff"** means the medical staff of the Hospital, all of whom have been appointed pursuant to the Medical Staff Bylaws.

13. **"Medical Staff Bylaws"** means the bylaws adopted by the Health System Parent Board governing appointment to, organization of, duties of, and operation of the Medical and AHP Staffs.

14. **"Practitioner"** means a licensed health care professional other than nurses, nursing assistants, technicians, and similar support personnel who are employees of the Hospital, and includes individuals eligible for appointment to either the Medical or AHP Staff.

15. **"Purchase Agreement"** means that certain Asset Purchase Agreement dated as of _____, 2016 by and among Eastern Connecticut Health Network, Inc., Prospect Medical Holdings, Inc. and various of its affiliates, including the Health System Parent.

ARTICLE II - GENERAL PROVISIONS

2.1 PURPOSES

The Hospital is an acute-care hospital providing health care services to the community. These Bylaws have been adopted to facilitate collaboration between the Board of Directors and the Local Board, which includes representatives of the Medical Staff and the community.

2.2 ADVISORY ROLE OF LOCAL BOARD

The Board of Directors retains all general authority and control over the business, policies, operations, and assets of the Hospital.

The Board of Directors has delegated to the Health System Parent the authority to act as the governing body of the Hospital with respect to Medical Staff matters, including adoption of and amendments to the Medical Staff Bylaws and the credentialing and re-credentialing of Medical Staff members.

The Board of Directors has also granted to the Local Board certain responsibilities as further described in these Bylaws. The Local Board shall serve generally in an advisory role and shall not have authority over or responsibility for the business of the Hospital.

The Board of Directors expressly reserves the right to amend, modify or rescind at any time, on reasonable advance notice, any rights or responsibilities given to the Local Board and is not obligated to approve or comply with any recommendations made by the Local Board. Notwithstanding anything herein to the contrary, nothing herein shall permit the Board of Directors to limit any rights of the Local Board in contravention of the terms of the Purchase Agreement.

ARTICLE III – MEMBERS OF LOCAL BOARD

3.1 QUALIFICATIONS OF LOCAL BOARD

The Board of Directors, in consultation with the CEO, shall establish the criteria for selection of members of the Local Board, which shall include, but not be limited to:

(a) Willingness to give as much time as is reasonably requested;

(b) Availability to participate actively in Local Board and committee activities, especially those activities where the member has a special interest and expertise;

(c) Experience in organizational and community activities;

(d) Proficiency in the art of managing people and property; and

(e) Integrity, objectivity, and loyalty.

3.2 COMPOSITION

The Local Board shall consist of at least eleven (11) but no more than fifteen (15) voting members. To the extent practicable, the Local Board should include both appointees to the Medical Staff and a broad representation of lay persons from the community served by the Hospital. The CEO shall serve as a voting member of the Local Board.

3.3 SELECTION

Members of the Local Board, whether they will commence new terms or fill vacancies for the balance of a term, shall be appointed by the Board of Directors. The Board of Directors shall give strong consideration to the nominations made by a nominating committee composed of the existing chairperson of the Local Board, the existing vice chairperson of the Local Board, and the CEO, which committee shall be chaired by the CEO (the "**Governing & Nominating Committee**"). The Governance & Nominating Committee will make Board diversity (in terms of age, gender, race and town of residence) a priority for recruitment of new members to the Local Board.

The Governance & Nominating Committee shall work with the CEO to recruit new Board nominees in order to present each candidate at the Annual Board Meeting in December for election. New Board members' terms will be effective January 1st of each year (introduced at the normally scheduled January Board meeting), unless otherwise determined by the Board of Directors.

Notwithstanding anything to the contrary herein, the initial Local Board shall be composed of the CEO, five (5) physicians and five (5) additional members of the community, all of whom are selected by the Board of Trustees of Eastern Connecticut Health Network, Inc. at the time of the closing of the transactions described in the Purchase Agreement. In the selection of the initial

members of the Local Board, the Board of Trustees of Eastern Connecticut Health Network, Inc. will endeavor to include individuals who have served on such Board prior to closing and who have been involved in strategic planning and/or have otherwise demonstrated a commitment to the mission of Eastern Connecticut Health Network, Inc.

3.4 TERM

The initial members of the Local Board will serve for one (1), two (2) or three (3) year terms. As terms expire, members will be elected or reelected to serve terms of three (3) years; provided, however, that no member of the Local Board will be permitted serve for more than three (3) consecutive three (3) year terms (or any portion thereof of more than one and one-half years). Members rotating off of the Local Board may return after a one year hiatus in membership, and may participate, during this hiatus period, in Hospital committees that do not require a committee member to be a member of the Local Board.

Notwithstanding the foregoing, to promote the objective of having the terms of approximately one-third of the elected members of the Local Board expire each year, a member may be appointed to serve a one (1), two (2) or three (3) year term, as determined by the Board of Directors. A member of the Local Board appointed to fill a vacancy shall serve the remainder of his or her predecessor's term.

3.5 REMOVAL

A member of the Local Board may be removed at any time by the Board of Directors, with or without cause. A member of the Local Board, other than the CEO, who has failed to attend two-thirds of the regular meetings of the Local Board during the calendar year or two-thirds of the meetings of Local Board committees of which he or she is a member may also be removed by a two-thirds affirmative vote of the remaining members of the Local Board. A member of the Local Board may resign at any time by tendering his or her resignation in writing to the Local Board. Resignation or removal as a member of the Local Board shall also constitute resignation or removal as an officer of the Local Board and as a member of any committee of the Local Board.

3.6 CONFLICT OF INTEREST

Members of the Local Board shall comply with all conflict of interest policies and procedures of the Hospital.

3.7 COMPENSATION

Members of the Local Board shall receive no compensation for any services rendered in their capacities as members of the Local Board or as officers or members of committees of the Local Board.

3.8 DUTIES

The duties of the Local Board are:

(a) Make recommendations for appointment to the Medical Staff of only those Practitioners meeting the qualifications prescribed in the Medical Staff Bylaws and other written or unwritten Hospital standards;

(b) Recommend standards for the quality of services to be made available at the Hospital and recommend Hospital policies implementing such standards;

(c) Recommend standards for programs to (i) improve patient safety and (ii) identify and reduce medical errors at the Hospital, and recommend Hospital policies implementing such standards;

(d) Serve as a resource to the CEO and the Board of Directors regarding the Hospital's short-range and long-range plans and goals, including providing input on the development of any strategic capital plan (which shall include plans for investment of the Capital Commitment referenced in the Purchase Agreement) and any strategic business plan or any modification to any of the foregoing;

(e) Review the Hospital's quality assurance programs, plans for improving the organization's quality performance and the quality of patient care rendered at the Hospital on an ongoing basis and, as appropriate, and identify to the CEO, the Board of Directors and the Health System Parent Board opportunities to improve the foregoing;

(f) Cooperate with the CEO on matters relating to obtaining and maintaining accreditation by the applicable accrediting bodies;

(g) Subject to approval of the Board of Directors, adopt such Local Board rules as may be necessary to further the purposes of these Bylaws, which rules shall become a part of these Bylaws; and

(h) Periodically review and propose amendments to these Bylaws.

The Board of Directors may make revisions to the scope of duties and responsibilities of the Local Board from time to time; provided, however, that nothing herein shall permit the Board of Directors to limit any rights of the Local Board in contravention of the terms of the Purchase Agreement.

3.9 INDEMNIFICATION

The Hospital shall indemnify any Indemnified Party (as hereinafter defined) against actual and necessary expenses, costs, and liabilities (including settlements approved by the Hospital) incurred by him in connection with the defense of any pending or threatened action, suit, or proceeding to which he or she is made a party by reason of acting or having acted in an official capacity on behalf

of the Hospital and shall, consistent with any policies of the Hospital, advance funds to pay for any such reasonable expenses or costs expected to be incurred pending the final disposition of any such action, suit or proceeding (including, without limitation, attorneys' fees). As used in these Bylaws, the term "Indemnified Party" shall mean a present or former member of the Local Board acting in good faith on behalf of the Hospital through the Local Board, a committee or other service. This indemnification shall not be exclusive of any other rights of indemnity to which the Indemnified Party may be entitled. Notwithstanding any other provision of these Bylaws to the contrary, no person shall be entitled to indemnity if the acts giving rise to the liability constituted misconduct, breach of fiduciary duty, self-dealing, and/or bad faith. Any indemnification under this Section (unless ordered by a court) shall be made by the Hospital only as authorized in the specific case upon a determination that indemnification is proper in the circumstances because he or she has met the applicable standard of conduct set forth above. Such determination shall be made by the Board of Directors. To the extent, however, that any Indemnified Party has been successful on the merits or otherwise in defense of any action, suit or proceeding described above, or in defense of any claim, issue or matter therein, he or she shall be indemnified against expenses (including attorney's fees) actually and reasonably incurred by him in connection therewith, without the necessity of authorization in the specific case. Notwithstanding the foregoing, nothing in this Section 3.9 shall obligate the Hospital to indemnify an Indemnified Party in excess of the fullest extent permitted by the Connecticut law.

ARTICLE IV - OFFICERS

4.1 IDENTITY; SELECTION; TERM

The officers of the Local Board shall be the chairperson, the vice chairperson, the secretary, and such other officers as the Local Board shall deem advisable. The remaining officers shall be elected annually by the Local Board from its members at its annual meeting. Except for the chairperson and the vice chairperson who shall each serve for a term of two (2) years, all other officers shall hold office for a term of one year and until a successor is appointed.

4.2 REMOVAL

The Local Board may remove an officer at any time with or without cause upon the affirmative vote of a majority of the members of the Local Board excluding the officer. An officer may resign from office at any time by tendering his or her resignation in writing to the chairperson or vice chairperson of the Local Board.

4.3 DUTIES

(a) Chairperson - The chairperson of the Local Board shall preside at all meetings of the Local Board. He or she shall appoint all committees and their chairpersons and shall be a member of all committees. He or she hall have such other duties and responsibilities as may be delegated by these Bylaws and by the Board of Directors from time to time.

(b) Vice Chairperson - In the absence of the chairperson of the Local Board or in the event of that individual's inability or refusal to act, the vice chairperson shall perform the duties of the chairperson and in so doing shall have all the powers of the chairperson. The vice chairperson shall perform such other duties as may be assigned by the chairperson from time to time.

(c) Secretary - The secretary shall keep or cause to be kept the minutes of the meetings of the Local Board, send out all notices of meetings, and perform such other duties as may be assigned by the chairperson of the Local Board from time to time. The secretary shall forward copies of all minutes to the appropriate corporate officer.

ARTICLE V - COMMITTEES

5.1 ESTABLISHMENT

The chairperson of the Local Board may appoint standing or special committees as he or she deems necessary and consistent with these Bylaws, and determine their membership, which may include members who are not members of the Local Board. The chairperson shall include members of the Local board who are also Medical Staff appointees on any committee that deliberates upon issues affecting the discharge of Medical Staff responsibilities.

5.2 TERM

Each member of a committee shall serve on such committee until the next annual meeting of the Local Board or until otherwise specified by the chairperson of the Local Board.

5.3 MEETINGS

The provisions of Article VI of these Bylaws (governing meetings of the Local Board) shall apply to all meetings of committees of the Local Board, unless the context clearly indicates otherwise, and references to "Local Board" shall be deemed to include "committees of the Local Board".

ARTICLE VI - MEETINGS

6.1 ANNUAL MEETINGS

The annual meeting of the Local Board shall be held on such day in each year as may be determined by the Local Board. The purpose of the annual meeting shall be to elect officers and to transact such other business as may properly come before the meeting and shall not be limited to the matters set forth in the notice of the meeting.

6.2 REGULAR MEETINGS

Regular meetings of the Local Board shall be held at least quarterly. Business to be transacted at any regular meeting of the Local Board shall not be limited to the matters set forth in the notice of the meeting.

6.3 SPECIAL MEETINGS

Special meetings of the Local Board may be called at any time by the chairperson of the Local Board, the CEO, or any three (3) or more members of the Local Board. The business to be transacted at any special meeting of the Local Board shall be limited to those items of business set forth in the notice of the meeting.

6.4 NOTICE AND PLACE

The Secretary of the Local Board shall give each member of the Local Board notice of each meeting of the Local Board personally, by telephone, by mail to his or her residence or place of business as listed in the CEO's office, or by electronic mail to an address provided by the member for purposes of receiving such notice. This notice shall be received not less than two (2) days prior to the meeting. It shall set forth the time and place of the meeting and notice of the matters of business to be transacted. The meeting shall be held at the Hospital unless the CEO approves another location. Notice of any meeting of the Local Board may be waived by the execution by all members of a written waiver of such notice at any time, which writing shall be filed with or entered upon the records of the meeting. Attendance at any meeting without protesting the lack of notice prior to or at the commencement of the meeting shall be deemed to be a waiver by such member of notice of the meeting. A majority of the members of the Local Board present, whether or not a quorum exists, may adjourn any meeting of the Local Board to another time and place. Notice of any such adjourned meeting shall be given to the members of the Local Board who are not present at the time of adjournment and, unless the time and place of the adjourned meeting are announced at the time of adjournment, to all members of the Local Board.

6.5 ATTENDANCE

Members of the Local Board shall attend as many meetings of the Local Board as possible. The chairperson shall review annually the attendance records of all members and shall counsel each member whose unexcused absences exceed one-third of the regular meetings of the Local Board.

6.6 QUORUM

A majority of the members of the Local Board then in office shall constitute a quorum for the transaction of business. A member of the Local Board shall be deemed to be present at a meeting if such member participates in the meeting using a conference telephone, speaker telephone, or similar communications device by means of which all persons participating in the meeting can hear each other at the same time.

6.7 VOTING

The act of a majority of the members of the Local Board present and voting at a meeting at which a quorum is present shall be the act of the Local Board.

6.8 ACTION WITHOUT A MEETING

Any action that may be taken at a meeting of the Local Board may be taken without a meeting if consent in writing setting forth such action is signed by all of the members of the Local Board and is filed in the minutes of the proceedings of the Local Board.

6.9 MINUTES

A written record of all proceedings of the Local Board, attendance, and actions shall be maintained by the CEO.

ARTICLE VII - AMENDMENTS TO BYLAWS

At least once every two (2) years the Local Board shall review these Bylaws to determine whether they require amending. These Bylaws may be amended only by either of the following methods:

(a) By an affirmative vote of two-thirds of the members of the Local Board, provided a full presentation of such proposed amendments shall have been published in the notice calling the meeting, and provided the amendments are approved in writing by the Board of Directors;

Or

(b) In the event that the Local Board fails to exercise its responsibility and authority, and after notice from the Board of Directors to such effect, including a reasonable period of time for response, by the Board of Directors.

ARTICLE VIII - ADOPTION AND EXECUTION

These Bylaws shall not be effective until they have been approved by the Board of Directors and by the Local Board. The signatures set forth below signify that these Bylaws are the duly adopted Local Board Bylaws of the Hospital.

LOCAL BOARD BYLAWS

APPROVED BY THE BOARD OF DIRECTORS ON _____, 2016.

_____
Secretary of the Hospital
(Acting at the direction of the Board of Directors)

APPROVED BY THE LOCAL BOARD OF ADVISORS ON _____, 2016.

_____
Secretary of the Local Board
(Acting at the direction of the Local Board)

14. Description of Proposed Allocation of Responsibility for Quality Matters (corporate v. local)

Please see attached.

Prospect Medical Holdings, Inc. and Prospect ECHN, Inc.

Quality Program Management -- Corporate and Local Roles

The following outlines a proposed allocation of roles between the Prospect Medical Holdings Inc.'s local and corporate organizations in the development and management of the quality program in PMH's ECHN facilities. The proposal covers three areas of activity: (i) the development and management of ECHN's annual quality goals and metrics; (ii) the process for addressing ECHN regulatory and accreditation surveys and implementing corrective actions; and (iii) the process by which the corporate and local roles may be modified.

I. Process for Developing Annual Quality Goals and Metrics

A. **Initiation of Annual Goal Development Process**. The local Quality management of Prospect ECHN, Inc. ("ECHN Local Quality Management") will have the role of initiating Prospect ECHN's Annual Quality Plans and Goals. No later than October 1 of each year, ECHN Local Quality Management will complete the following steps:

1. Review each of the following plans (together, the "Quality Improvement Program Plans") and make appropriate additions, updates and deletions:

    a. **The Annual Quality Assurance Performance Improvement Plan**

    b. **The Annual Patient Safety Plan.**

    c. **The Annual Patient Experience Plan.**

    d. **The Annual Infection Control Plan.**

    e. **The Annual Risk Management Plan.**

    Potential revisions may include but are not limited to any of the following:

- New or revised Goals, Objectives and/or measurement standards
- New or revised planned activities
- Clarifications of authority and accountability
- Changes to communication plans
- Identification of or changes to committee or action team objectives, goals and/or composition
- Revisions to emphasize future initiatives and areas of focus (e.g., patient experience)
- Revisions to reflect regulatory agency reporting requirements
- Revisions to leadership and/or reporting structure
- Revisions to include new information
- Addition of new criteria (e.g., Serious Safety Events)
- Inclusion of new forms of intervention and initiatives to improve patient safety

- Language clarifications
- Other updates as appropriate

2. Create a grid to track current fiscal year and review year-end Quality Improvement Goals and accomplishments and develop upcoming fiscal year Quality Improvement Goals

    a. Review current year goals– Identify and document how goals were met – place information on grid specific to how goals were met

    b. Develop new goals for incoming year related to each objective subject material related to Quality Assurance Performance Improvement Plan Objectives. Ensure that there are goals for each Objective category. Document in SMART goal format. Include all areas identified as highest need for improvement. Place all goals on grid.

B. **Submission for Local Governance Review and Approval.** Beginning no later than October 1 of each year, ECHN Local Quality Management will begin the process to obtain local governance review and approval of the annual Quality Improvement Program Plans and the upcoming fiscal year Quality Improvement Goals (together the "Annual Quality Plans and Goals"), as follows:

1. Quality Improvement Council
2. Medical Executive Council
3. Local Board

C. **Submission for PMH Corporate Chief Quality Officer Review.** On or about the later of (i) November 15 of each year or (ii) the date on which approval has been received from each level of Local Governance Review, ECHN Local Quality Management will submit the Annual Quality Plans and Goals to the PMH Corporate Chief Quality Officer for approval. The PMH Corporate Chief Quality Officer will be authorized to make those changes to the Annual Quality Plans and Goals that are required to comply with law or regulation. The PMH Corporate Chief Quality Officer may additionally recommend changes to the Annual Quality Plans and Goals in order to align them with regulatory and accreditation requirements, quality improvement best practices or with PMH corporate initiatives, which recommendations ECHN management will submit to the ECHN Quality Improvement Council, the ECHN Medical Executive Council and the Local Board for consideration and acceptance in their discretion. A conference call will occur between the PMH Chief Quality Officer, Regional VP of Quality and ECHN Local Quality Management to review rational for rejection of any recommendations and build consensus concerning next steps. The PMH Corporate Chief Quality Officer will notify ECHN Local Quality Management of the required or recommended changes and the reasons for them in writing within thirty (30) days of receipt. If the PMH Corporate Chief Quality Officer does not provide a notification within

the thirty (30) days the Annual Quality Plans and Goals submitted by local ECHN management will be deemed accepted and complete.

D. **Informal Collaboration.** It is anticipated that there will be continuing informal collaboration throughout the year between local ECHN management, the Regional VP of Quality, and the PMH Corporate Chief Quality Officer regarding quality improvement goals, initiatives and best practices, and that the PMH Corporate Chief Quality Officer and Regional VP of Quality, will serve as a continuing resource for the robust exchange of information in order to enhance quality, safety and patient satisfaction in ECHN facilities. In furtherance of such collaboration, the local ECHN Quality management may (but is not required to) share draft Annual Quality Plans and Goals with the Regional VP of Quality and PMH Corporate Chief Quality Officer in order to obtain feedback and suggestions throughout the process outlined above.

E. **Other Matters.** In addition to the foregoing roles, the PMH Corporate Chief Quality Officer and/or Regional VP of Quality will develop policies and procedures in conjunction with local ECHN quality management as appropriate to support Annual Quality Plans and Goals, and will create a framework and mechanism to permit ECHN to share quality best practices with PMH's other health systems while maintaining the flexibility to allow each organization to respond to its specific needs and circumstances.

II. Process for Responding to Quality Surveys and Instituting Corrective Action (corporate and local roles)

A. **Procedure to Follow During Survey**: During any accreditation or regulatory survey, the ECHN Local Quality Management will maintain direct accountability for responding to surveyors and instituting corrective actions

B. **Post-Survey Procedure**:

1. The ECHN Local Quality Management or designee will immediately inform the Regional VP of Quality of the arrival of any accreditation or regulatory survey team via e-mail or phone call. The Regional VP of Quality will serve as the liaison for informing the PMH Corporate Chief Quality Officer.

2. As soon as feasible but no later than close of business after the surveyors' completion of their onsite review, the ECHN Local Quality Management will provide an oral report to the Regional VP of Quality of the information communicated during the surveyors' exit conference, including but not limited to any deficiencies identified. Except in the event of an Immediate Jeopardy finding, which will be reported immediately, a surveyors' onsite review that is completed after business hours may be reported the following morning. If the survey extends beyond one day, the ECHN Local Quality Management will provide a daily oral report to the Regional VP of Quality for the duration of the survey visit. The Regional VP of Quality will be the liaison to update the PMH Corporate Chief Quality Officer.

3. The following time frames will apply to the exchange of information between the ECHN Local Quality Management and the PMH corporate representatives regarding written reports:

    a. **Joint Commission Accreditation Surveys**: The ECHN Local Quality Management will send the written report received from the Joint Commission to the Regional VP of Quality within one business day of receipt, and will submit the proposed corrective action plan to respond to the survey findings to the Regional VP of Quality no later than fifteen (15) days before the due date. Where Conditions of Participation are cited in the written report received from the Joint Commission the ECHN Local Quality Management will outline the findings, the person responsible, the date the corrective actions were completed and the verification seven (7) days before the due date.

    b. **Connecticut Department of Public Health Surveys**: The ECHN Local Quality Management will send the written report received from DPH to the Regional VP of Quality within one business day of receipt, and will submit the proposed corrective action plan to respond to the survey findings to the Regional VP of Quality no later than four (4) days before the due date.

    In each instance, the Regional VP of Quality will forward to the PMH Corporate Chief Quality Officer within one (1) business day of receipt the surveyor's written report or the proposed corrective action plan.

    Upon the completion of the proposed corrective action plan, the ECHN Local Quality Management will confer with the Regional VP of Quality to confirm either that (i) the corrective action taken to date have addressed the identified deficiencies, or (Ii) the corrective actions require supplementation, in which case an additional plan of correction will be developed.

    If the ECHN Local Quality Management considers it infeasible to complete the corrective actions within the time frame expected by the regulatory agency by means of the available local resources, it will identify this issue to the Regional VP of Quality and will outline those additional resources that will be required in order to complete the corrective actions within such expected time frame. The Regional VP of Quality will serve as the liaison to the PMH Corporate Chief Quality Officer in order to review the request and secure the necessary resources to complete the corrective actions as deemed necessary.

    The Regional VP of Quality will review, edit and forward any changes to the proposed corrective action plan to the Chief Quality Officer for final review. Once approved and returned, the local ECHN Quality Management will submit the final form to the surveying agency prior to the due date. The final copy will be sent to the Regional VP of Quality within one (1) business day of submission to the surveying agency. The Regional VP of Quality will then forward to appropriate Corporate Leaders.

4. **Incorporation of Survey Results into Annual Quality Goals.** It shall be an ongoing objective of ECHN Local Quality Management to incorporate the quality and patient safety related results of accrediting and regulatory agencies into the annual Quality Improvement Program Plans. Any revisions to the Quality Improvement Program Plans will be submitted to the Prospect Chief Quality Officer within five (5) days of approval for comment and recommendations as outline in section I subsection C above.

III. Revisions to Procedures

The quality management roles and responsibilities outlined above are intended to be exercised within a collaborative and dynamic process which will be subject to modification in order to better serve the goals patient safety, patient satisfaction, clinical quality and efficiency in PMH's ECHN facilities. When either the local ECHN Quality Management or the PMH Corporate Chief Quality Officer consider a modification to be advisable for any of those reasons, the local and corporate representatives will share and discuss the proposed modification with each other, after which the local, regional and corporate representatives will work in a cooperative and timely fashion to implement the modification.

15. Copies of all CMS Statement of Deficiencies for PMH's Rhode Island Hospitals since the date of Acquisition

Please See Exhibit 15 as attached. Please note that the statement of deficiencies includes corrective action plans which have been implemented.

COPY

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HEALTH PARTNERS

March 8, 2016

Via hand delivery

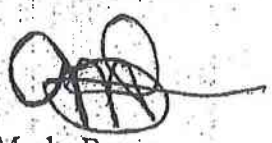
Ms. Seema Dixit, MS, MPH, Chief
Center for Health Facilities and Regulations
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

Re: Investigation completed on February 2, 2016

Dear Ms. Dixit:

Enclosed please Roger Williams Medical Center's corrective action plan pursuant to the above referenced matter.

Very truly yours,



Moshe Berman
General Counsel

cc: Kimberly O'Connell (via email)

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

PRINTED 02/15/2016
FORM APPROVED

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00133	A. BUILDING _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

(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 DEFIFICENCY	(X5) COMPLETION DATE
Z 0	INITIAL COMMENTS A State complaint investigation survey was conducted at this facility. State deficiencies were identified.	Z 0		
Z 850	PATIENT CARE SERVICES 31.1 Pharmaceutical Service Section 31.0 Pharmaceutical Service 31.1 Each hospital shall provide pharmaceutical services either directly within the institution or by contractual arrangement. In either instance, there shall be evidence of a current pharmacy license in compliance with section 5-19-28 of reference 13. Pharmaceutical services shall be provided in accordance with the regulations of reference 62 herein. This requirement is not met as evidenced by: Based upon record review and staff interview, it has been determined that the hospital has failed to ensure patient safety relative to sterile compounding areas in accordance with State Regulation and applicable standards of practice. Findings are as follows: 1) The State of Rhode Island Rules and Regulations Pertaining to Pharmacists, Pharmacies, and Manufacturers, Wholesalers and Distributors, [R5-19.1-PHAR], State of Rhode Island and Providence Plantations, Department of Health, March 1985 and revised April 2014, under 19.28A, States, in part: "...written plan and schedule for the environmental monitoring procedures for viable micro organisms shall be established and followed. The plan shall be adequate to evaluate the various controlled air environment areas	Z850	A written plan and schedule for the environmental monitoring procedures for viable microorganisms was established to ensure patient safety relative to sterile compounding areas in accordance with State Regulation and applicable standards of practice. The Pharmacy Department will at a minimum conduct a monthly evaluation of the sterile compounding area used for low-and-medium-risk preparations conducted by Accuratus Lab Services. Attachment #1 Staff members were trained on the policy changes. A New Regional Director of Pharmacy started February 8, 2016, and is reviewing all pharmacy practices. The results of the monthly environmental testing will be reported to the Regional Director, Pharmacy and Director, Infection Prevention & Control. Any negative results will be immediately reported to the President and CEO. Additionally, the results of the monthly testing and any corrective action will be reported quarterly to the Infection Control Committee. First report will be due to the Infection Control Committee meeting on April 21, 2016. Attachment #2	3/7/2016 Ongoing monthly 2/3/2016 & 2/4/2016 4/21/16 & quarterly

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT — (X6) DATE: 3/8/16
STATE FORM 6899 — NBX11 — IF CONTINUATION SHEET 1 OF 6

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z850	Continued From Page 1 (LAFW, barrier isolators, biological safety cabinets, buffer or clean room, and anteroom) of the designated sterile compounding area(s). For sterile compounding areas used for low-and medium-risk preparations, a minimum monthly evaluation shall be required ..." Review of the Department of Pharmacy services Corrective Action Plan dated 06/23/2015 revealed that fungus was found in the Ante and Clean Rom of the sterile compounding areas. There was one location in Clean Room (#6 on their diagram) and two locations in Ante Room (#'s 8 and 10 on their diagram). The document further reveals that environmental monitoring was conducted on 09/21/2015 which revealed a fungus was still found in the air sampling for location 10 in the Ante Room. A Testing Certificate dated 12/21/2015 identified bacteria on the floor in the Ante Room. The Director of Pharmacy was interviewed on 2/2/2016 at 2:15 PM and was unable to produce evidence that the monthly testing was conducted as required between June and September and December 2015.	Z850	CAP: The hospital will ensure that all parts of the hospital are maintained in good repair relative to the pharmacy.	
Z1700	ENVIRONMENTAL & MAINTENANCE SERVICES 50.2 Housekeeping & Maintenance Services 50.2 All parts of the hospital and its premises shall be kept clean, neat, free of litter and rubbish, and all furnishings maintained in good repair	Z1700	All floor cracks that were identified had a work order entered into the Meditech work order system in the Maintenance Department. All future environmental safety issues will be entered into the Meditech work order system. Pharmacy staff have been trained and given access to enter work orders into the Meditech work order system. Attachment #3	

PRESIDENT 3/8/16

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z1700	Continued From page 2 This Requirement is not met as evidenced by: Based upon surveyor observation, record review and staff interview, it has been determined that the hospital has failed to ensure that all parts of the hospital are maintained in good repair relative to the pharmacy. Findings are as follows: On 2/2/2016 at approximately 10:00 AM in the presence of a pharmacy technician (Staff B), the Clean room was observed with a 2 to 3 inch crack in the wall where it meets the wall. The Chemo room was observed with an 8 to 10 inch crack right above the baseboard where it meets the wall. Another crack was observed near the entrance door measuring approximately 2 to 3 feet in length. This crack was covered with blue tape that was torn/cracked and appeared worn. Subsequent interview with the Director of Pharmacy on 2/2/2016 at 10:15 AM failed to reveal evidence/documentation that these floor cracks were brought to the attention of maintenance services.	Z1700	Identified cracks were repaired on February 4, 2016 and February 19, 2016 respectively. See Attachment #3. The Administrative Assistant in the Maintenance & Engineering Department will be manually tracking all open safety work orders to ensure timely completion. Maintenance will report monthly to the Safety Committee The Pharmacy Department will report adverse environmental findings in the compounding areas to the Infection Prevention and Control Program. The New Regional Director of Pharmacy is overseeing an inspection of the pharmacy physical environment and reporting all findings to the Maintenance and engineering Department, President and CEO.	2/4/16 & 2/19/16
Z1725	ENVIRONMENTAL & MAINTENANCE SERVICES 51.1 Infection Control Section 51.0 Infection Control 51.1 The medical staff in cooperation with other disciplines shall establish a multidisciplinary group which shall report to the governing body and which shall be responsible for no less than the following: a) establishing and maintaining a hospital-wide infection surveillance program which shall include	Z1725	Quarterly reports will be submitted to the Infection Prevention & Control Program by the Regional Director, Pharmacy on environmental testing for the Pharmacy sterile compounding room including the ante room. An alternate pharmacy staff will be assigned to attend the Infection Prevention & Control Committee Meeting when the Regional Director, Pharmacy is unable to attend.	

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Z1725	Continued From page 3 an infection surveillance officer to conduct all infection surveillance activities; b) developing and implementing written policies and procedures for the surveillance, prevention, and control of infections in all patient care departments/services; c) establishing policies governing the admission and isolation of patients with known or suspected infectious diseases; d) developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate phases of hospital operation and services. e) developing and implementing a system for evaluating and recording the occurrences of all infections among personnel and patients; such records shall be made available to the licensing agency upon request; f) implementing a TB infection control program requiring risk assessment and development of a TB infection control plan; early identification, treatment and isolation of strongly suspected or confirmed infectious TB patients; effective engineering controls; an appropriate respiratory protection program; health care worker TB training, education, counseling and screening; and evaluation of the program's effectiveness, per guidelines in reference 33. g) developing and implementing an institution-specific strategic plan for the prevention and control of vancomycin resistance, with a special focus on vancomycin-resistant enterococci, per guidelines in reference 50. h) developing and implementing protocols for discharge planning of patients with infectious diseases which may present the risk of continuing transmission	Z1725	Monthly EOC rounds will be conducted by Regional DOP or designee and Director of Environment or designee. These results will be reported to the Infection Prevention & Control Committee including any action(s) taken. Attachment #2	4-21-16 & quarterly

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Z1725	Examples of such diseases include, but are not limited to, tuberculosis (TB), Continued From page 4 Methicillin resistant staphylococcus aureus (MRSA), clostridium difficile, etc. i) assuring that patient care support departments (i.e., central services, laundry, etc) are available to assist in the prevention and control of infectious diseases and are provided with adequate direction, training, staffing and facilities to perform all required infection surveillance, prevention and control functions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the pharmacy has failed to report adverse environmental findings in the compounding areas to the Infection and Prevention Control Program. Findings are as follows: Review of the hospitals manual titled "Infection Prevention and Control Committee Policy", states, in part, under section IV, Responsibility, ... "Review of results of surveillance activities". This policy also states, in part, under section V, Procedure, "Membership includes representatives from the following departments: ...Pharmacy, ..." Review of the Department of Pharmacy Services Corrective Action Plan dated 6/23/2015 revealed that fungus was found in the Ante and Clean Rooms of the Main Hospital Sterile Compounding) Areas. There was one location in the Clean Room (#6 on their diagram) and two locations in the Ante Room (#s 8 and 10 on their diagram).	Z1725		

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Z1725	Continued From page 5 The document further reveals that environmental monitoring was conducted on 9/21/2015 which revealed fungus was still found in the air sampling for location 10 in the Ante Room. A Testing Certificate dated 12/21/2015 identified bacteria on the floor in the Ante Room. Review of the Infection Prevention and Control Committee Meeting revealed the meetings were held on 10/15/2015, 11/19/2015, 12/17/2015, and 1/21/2016. There was no evidence that the committee has reviewed the results of the above findings. Additionally, there was no evidence that any representative from pharmacy attended the meetings on 12/17/2015 and 1/21/2016. The Director of Infection and Prevention Control was interviewed on 2/2/2016 at 1:25 PM and was unaware of the above findings as they had not been reported to Infection Control. During a subsequent interview on 2/2/2016 at 2:00 PM, the Director of Pharmacy stated the above findings had not been reported to the Infection Prevention and Control Committee.	Z1725		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K Clarke PRESIDENT 3/8/16

16. Updated Information on Pension Obligation and Impact on Cash Flow

Please see attached.

ECHN
Pension Funding & Expense
Historical & Projected

Historical

	Funding	Expense
FY 2006	$ -	$ 5,893,968
FY 2007	$ 2,511,000	$ 4,704,480
FY 2008	$ 3,100,000	$ 3,087,800
FY 2009	$ 500,000	$ 1,527,909
FY 2010	$ 2,896,690	$ 907,347
FY 2011	$ 6,570,000	$ 1,972,795
FY 2012	$ 10,910,000	$ 4,795,189
FY 2013	$ 3,000,000	$ 3,232,959
FY 2014	$ 4,800,000	$ 131,191
FY 2015	$ 970,000	$ 2,844,430
FY 2016	$ 1,840,000	$ 4,600,000
	$ 37,097,690	$ 33,698,068

Projected

	Funding	Expense
FY 2017	$ 3,790,000	$ 5,300,000
FY 2018	$ 5,060,000	$ 5,200,000
FY 2019	$ 7,060,000	$ 5,000,000
FY 2020	$ 14,250,000	$ 4,800,000
FY 2021	$ 13,340,000	$ 4,100,000
	$ 43,500,000	$ 24,400,000

Funding & Relief Legislation:

Pension Protection Act -- enacted in 2006, effective 1/1/2008
Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010
Moving Ahead for Progress in the 21st Century (MAP-21) passed in 2012
Highway and Transportation Funding Act of 2014
Bipartisan Budget Act of 2015

MAP-21 provided the most significant funding relief and HATFA continued this as you can see the funding requirements since FY 2012 have been held down; without this relief ECHN would have breached days cash on hand bond covenants by now. Without new relief legislation in the near future the funding requirements start to spike up beginning next fiscal year.

17. Reconciliation of Revised Financials

Please see attached.

OHCA Financial Statistics Report

Most schedules originally provided had roll-up issues and so anything previously provided needed to re-done. We will provide an overview of some of the high level changes for our end September 30, 2015 (as compared to year end September 30, 2014) and for mid-year March 31, 2016 (as compared to March 31, 2015).We have provided the DSCR (debt service coverage ratio) for only the year end and mid-year schedules as they are measurement points per our bond covenants. Furthermore, we have computed for the system only and not for each hospital as we do not report these individually as part of routine bond covenant reporting.

We have computed DCOH (days cash on hand) per the measurement criteria of our bond covenants.

September 2015 YTD vs. September 2014 YTD

- The margins for FY 2015 were negative and lower than the prior year due to the continued pressure of governmental reimbursement reductions at both the federal and state level. The Medicare wage index changes along with the continued reduction in the State supplemental payments were most significant, but we also saw State inpatient reimbursement reduced as it transitioned to a new payment model.
- DCOH closed out 6 days lower than the prior year per the same reasons noted in the first bullet.
- Long-term Debt to Equity and Long-term Debt to Capitalization increased primarily due to a) the increase in the unfunded pension due to the new mortality tables and impact on pension liabilities and b) operating performance.
- DSCR closed out just above the bond covenant minimum of 1.25 again due to the pressures of declining reimbursement.
- All other significant ratios or performance indicators in section D. are essentially impacted by the factors already cited in the prior bullets.
- The Unrestricted Assets decline of over $17,000,000 is mostly due to the pension and the new mortality tables which contributed $14,000,000 of this decline.

March 2016 YTD vs. March 2015 YTD

- The same issues that carried throughout the prior year's performance are prevalent in FY 2016 as we see additional erosion in federal and state reimbursement, again both the Medicare wage index reduction which took place in two phases, and the continued reductions to the State supplemental payments.
- Note the margin performance, DCOH, and DSCR. All trending in the wrong direction.
- It is worth noting that the performance from the prior year is somewhat mitigated by reserves that were still carried on the balance sheet at 9/30/14 that were viewed as conservative and thus were able to reduce these as offsets in the prior year.
- Some of the financial ratios where equity or unrestricted net assets are included will reflect a large delta for this March YTD vs the prior March YTD, as the equity hit for the pension happens at year end only.

OHCA Financial Statistics Report (July FY 2015 and July FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014
A. Operating Performance												
Operating Margin	4.12%	3.32%	2.51%	3.23%	-3.13%	0.81%	-2.72%	1.05%	3.71%	0.89%	-0.98%	0.34%
Non-Operating Margin	-1.21%	-1.76%	-0.89%	-0.88%	-1.20%	-1.71%	-0.69%	-0.45%	-0.92%	-1.36%	-0.67%	-0.59%
Total Margin	2.91%	1.56%	1.62%	2.35%	-4.32%	-0.90%	-3.41%	0.60%	2.80%	-0.47%	-1.65%	-0.25%
Bad Debt as % of Gross Revenue	0.58%	0.38%	0.61%	0.66%	0.99%	0.35%	0.72%	0.63%	-0.76%	0.48%	0.65%	0.75%
B. Liquidity												
Current Ratio	1.16	1.31	1.16	1.31	1.54	1.50	1.54	1.50	1.38	1.40	1.38	1.40
Days Cash on Hand	39	47	37	47	102	92	95	94	63	67	61	67
Days in Net Accounts Receivable	55	61	54	61	64	57	60	59	54	57	55	57
Average Payment Period	64	56	61	56	49	48	46	49	57	57	55	57
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.07	1.64	2.07	1.64	0.91	0.74	0.91	0.74	1.11	0.93	1.11	0.93
Long-term Debt to Capitalization	67	62	67	62	48	42	48	42	67	59	67	59
Unrestricted Cash to Debt	1.30	0.90	10.83	12.60	0.08	0.43	2.49	9.86	1.37	0.49	4.36	7.21
Times Interest Earned Ratio	6.75	5.72	5.82	6.03	2.44	4.94	2.99	6.96	7.70	4.40	3.49	4.46
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	16.17	21.64	16.17	21.64	35.23	41.31	35.23	41.31	28.11	32.92	28.11	32.92
D. Additional Statistics												
Income from Operations	$633,053	$520,994	$3,919,130	$5,079,849	($166,895)	$49,602	($1,534,668)	$637,755	$1,033,957	$251,617	($2,648,012)	$961,199
Revenue Over/(Under) Expense	$446,906	$244,365	$2,524,988	$3,695,991	($230,700)	($55,083)	($1,924,686)	$362,997	$778,733	($133,319)	($4,472,987)	($691,635)
EBITDA	$1,413,261	$1,163,486	$11,890,204	$13,184,731	$149,301	$305,483	$1,744,517	$4,002,648	$2,291,661	$1,335,849	$10,337,145	$14,344,707
Cash from Operations	$14,290,215	$15,719,667	$144,425,712	$146,612,175	$5,527,405	$6,707,356	$57,671,830	$58,437,110	$24,789,135	$27,474,495	$250,964,684	$255,091,516
Cash and Cash Equivalents	$1,272,319	$4,390,167	$1,272,319	$4,390,167	$774,122	$1,311,776	$774,122	$1,311,776	$10,096,797	$13,568,664	$10,096,797	$13,568,664
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$22,865,409	$21,212,266	$22,865,409	$21,212,266
Unrestricted Assets	$10,376,011	$19,815,466	$10,376,011	$19,815,466	$20,665,705	$26,324,679	$20,665,705	$26,324,679	$54,034,965	$71,217,658	$54,034,965	$71,217,658
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (August FY 2015 and August FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014
A. Operating Performance												
Operating Margin	4.05%	-3.59%	2.65%	2.64%	-2.38%	-0.70%	-2.69%	0.90%	-0.94%	-4.14%	-0.97%	-0.05%
Non-Operating Margin	-1.66%	-0.44%	-0.96%	-0.84%	-1.58%	-0.17%	-0.76%	-0.43%	-1.29%	-0.29%	-0.73%	-0.56%
Total Margin	2.39%	-4.03%	1.69%	1.80%	-3.96%	-0.87%	-3.46%	0.47%	-2.23%	-4.43%	-1.70%	-0.61%
Bad Debt as % of Gross Revenue	-1.22%	0.66%	0.44%	0.66%	-1.21%	0.84%	0.55%	0.65%	-0.96%	0.79%	0.51%	0.75%
B. Liquidity												
Current Ratio	1.19	1.19	1.19	1.19	1.48	1.69	1.48	1.69	1.36	1.39	1.36	1.39
Days Cash on Hand	42	46	39	45	107	93	95	89	67	67	62	65
Days in Net Accounts Receivable	56	64	54	60	64	63	57	60	57	60	54	57
Average Payment Period	67	61	61	60	52	44	47	42	60	58	56	56
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.14	1.74	2.14	1.74	0.92	0.77	0.92	0.77	1.14	0.97	1.14	0.97
Long-term Debt to Capitalization	68	64	68	64	48	44	48	44	67	61	67	61
Unrestricted Cash to Debt	1.20	0.06	11.86	12.11	0.06	0.77	2.55	10.84	0.30	(0.08)	4.60	7.04
Times Interest Earned Ratio	6.91	1.53	6.41	5.64	2.68	5.33	2.96	6.81	3.45	0.91	3.49	4.16
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	15.99	20.58	15.99	20.58	34.93	41.46	34.93	41.46	27.76	32.38	27.76	32.38
D. Additional Statistics												
Income from Operations	$597,835	($531,932)	$4,516,964	$4,547,917	($119,527)	($40,468)	($1,654,194)	$597,288	($240,325)	($1,110,535)	($2,888,337)	($149,336)
Revenue Over/(Under) Expense	$353,116	($597,128)	$2,878,103	$3,098,864	($198,666)	($50,522)	($2,123,350)	$312,476	($570,339)	($1,188,772)	($5,043,326)	($1,880,407)
EBITDA	$1,400,713	$316,488	$13,088,122	$13,501,219	$156,631	$307,715	$1,901,150	$4,310,364	$1,003,678	$275,706	$11,340,823	$14,620,413
Cash from Operations	$13,850,383	$14,385,361	$158,276,095	$160,997,536	$5,606,279	$5,677,456	$63,278,109	$64,114,566	$24,438,646	$24,966,839	$275,403,330	$280,058,355
Cash and Cash Equivalents	$2,171,516	$3,473,258	$2,171,516	$3,473,258	$626,557	$310,037	$626,557	$310,037	$10,397,030	$11,377,699	$10,397,030	$11,377,699
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,129,948	$21,924,557	$21,129,948	$21,924,557
Unrestricted Assets	$10,308,640	$18,971,156	$10,308,640	$18,971,156	$20,279,098	$26,051,748	$20,279,098	$26,051,748	$53,344,364	$70,108,676	$53,344,364	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (September FY 2015 and September FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014
A. Operating Performance												
Operating Margin	27.16%	-1.98%	4.79%	2.26%	-61.17%	26.83%	-5.63%	3.70%	15.95%	12.12%	-0.09%	0.67%
Non-Operating Margin	0.00%	-1.87%	-0.88%	-0.93%	-2.39%	-1.16%	-0.85%	-0.51%	-0.49%	-2.06%	-0.71%	-0.65%
Total Margin	27.16%	-3.85%	3.91%	1.33%	-63.56%	25.67%	-6.47%	3.20%	15.46%	10.06%	-0.80%	0.01%
Bad Debt as % of Gross Revenue	8.22%	4.49%	1.14%	0.97%	13.33%	7.75%	1.59%	1.23%	8.43%	5.32%	1.19%	1.10%
B. Liquidity												
Current Ratio	1.19	1.16	1.19	1.16	1.47	1.63	1.47	1.63	1.45	1.35	1.45	1.35
Days Cash on Hand	62	52	49	56	111	95	104	98	140	124	72	78
Days in Net Accounts Receivable	55	64	55	53	85	60	51	52	59	64	52	52
Average Payment Period	82	73	71	79	52	47	49	48	120	111	62	70
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.30	2.03	3.30	2.03	1.19	0.83	1.19	0.83	1.36	1.06	1.36	1.06
Long-term Debt to Capitalization	77	67	77	67	54	45	54	45	75	65	75	65
Unrestricted Cash to Debt	6.25	(0.06)	17.33	10.79	(5.87)	7.00	(3.35)	17.47	2.63	2.02	7.13	8.60
Times Interest Earned Ratio	45.65	2.24	7.82	5.38	(30.75)	42.56	0.28	9.76	19.37	14.16	4.38	4.82
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.27	1.53
Equity Financing Ratio	9.60	16.28	9.60	16.28	28.52	37.89	28.52	37.89	22.53	28.14	22.53	28.14
D. Additional Statistics												
Income from Operations	$4,438,312	($312,411)	$8,955,278	$4,235,504	($1,985,465)	$2,163,409	($3,639,661)	$2,760,693	$2,607,887	$2,322,057	($280,450)	$2,172,721
Revenue Over/(Under) Expense	$4,438,503	($606,680)	$7,316,608	$2,492,182	($2,063,001)	$2,069,656	($4,186,353)	$2,382,129	$2,527,466	$1,927,377	($2,515,860)	$46,970
EBITDA	$5,138,862	$440,393	$18,429,780	$13,941,610	($1,704,420)	$2,421,228	$196,729	$6,731,589	$3,745,382	$3,513,673	$15,086,205	$18,134,086
Cash from Operations	$14,563,917	$14,901,325	$172,840,012	$175,898,861	$5,514,418	$5,768,359	$68,792,527	$69,882,925	$24,854,112	$25,589,485	$300,257,442	$305,647,840
Cash and Cash Equivalents	$5,266,042	$9,361,439	$5,266,042	$9,361,439	$2,130,526	$1,772,696	$2,130,526	$1,772,696	$16,286,829	$18,947,190	$16,286,829	$18,947,190
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$15,479,150	$12,036,522	$15,479,150	$12,036,522
Unrestricted Assets	$2,829,380	$11,344,473	$2,829,380	$11,344,473	$14,969,087	$24,211,838	$14,969,087	$24,211,838	$42,167,565	$59,544,873	$42,167,565	$59,544,873
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (January FY 2016 and January FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015
A. Operating Performance												
Operating Margin	-4.59%	3.59%	1.40%	2.62%	0.81%	4.56%	-3.51%	1.49%	-4.33%	0.55%	-1.55%	0.18%
Non-Operating Margin	-0.45%	-0.41%	-0.56%	-0.57%	-0.45%	-0.11%	-0.59%	-0.29%	-0.36%	-0.27%	-0.46%	-0.40%
Total Margin	-5.04%	3.18%	0.84%	2.05%	0.36%	4.45%	-4.09%	1.19%	-4.70%	0.28%	-2.01%	-0.22%
Bad Debt as % of Gross Revenue	2.71%	1.04%	1.54%	0.83%	-0.08%	1.32%	0.74%	0.90%	1.90%	1.17%	1.29%	0.92%
B. Liquidity												
Current Ratio	1.30	1.13	1.30	1.13	1.79	1.83	1.79	1.83	1.60	1.47	1.60	1.47
Days Cash on Hand	33	37	34	36	91	95	91	93	60	66	60	66
Days in Net Accounts Receivable	68	54	65	54	57	57	60	60	62	52	60	54
Average Payment Period	56	62	57	61	39	43	39	42	54	55	54	55
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.52	2.07	3.52	2.07	1.29	0.83	1.29	0.83	1.41	1.08	1.41	1.08
Long-term Debt to Capitalization	78	67	78	67	56	45	56	45	76	52	76	52
Unrestricted Cash to Debt	(0.23)	1.37	3.67	4.73	0.94	1.77	0.47	4.50	(0.22)	0.83	1.35	3.00
Times Interest Earned Ratio	0.44	6.89	4.79	6.19	6.18	10.84	2.14	6.97	0.37	4.98	2.84	4.64
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	9.59	16.58	9.59	16.58	27.72	38.33	27.72	38.33	22.42	29.08	22.42	29.08
D. Additional Statistics												
Income from Operations	($680,072)	$574,121	$864,479	$1,669,209	$46,191	$277,536	($756,822)	$354,387	($1,130,134)	$155,525	($1,650,097)	$204,864
Revenue Over/(Under) Expense	($746,095)	$508,138	$517,032	$1,304,511	$20,484	$270,781	($883,647)	$284,914	($1,225,108)	$79,732	($2,138,708)	($241,790)
EBITDA	$84,071	$1,361,055	$3,981,552	$4,966,613	$359,645	$609,467	$494,318	$1,705,321	$103,004	$1,453,322	$3,375,431	$5,587,674
Cash from Operations	$12,827,534	$13,797,665	$57,103,426	$58,532,206	$5,023,259	$5,182,780	$20,929,423	$23,781,040	$22,373,026	$23,611,869	$97,908,556	$102,338,435
Cash and Cash Equivalents	$676,536	$187,209	$676,536	$187,209	$375,383	$357,032	$375,383	$357,032	$12,454,497	$8,315,256	$12,454,497	$8,315,256
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$25,233,356	$26,799,174	$25,233,356	$26,799,174
Unrestricted Assets	$1,852,814	$11,243,924	$1,852,814	$11,243,924	$13,508,694	$23,899,791	$13,508,694	$23,899,791	$40,397,950	$59,273,090	$40,397,950	$59,273,090
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (February FY 2016 and February FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015
A. Operating Performance												
Operating Margin	-1.08%	-4.46%	0.93%	1.34%	-16.89%	-2.71%	-5.85%	1.04%	-4.86%	-5.46%	-2.17%	-0.85%
Non-Operating Margin	-0.63%	-0.51%	-0.58%	-0.56%	-0.86%	-0.71%	-0.64%	-0.37%	-0.55%	-0.45%	-0.48%	-0.41%
Total Margin	-1.71%	-4.98%	0.35%	0.77%	-17.75%	-3.42%	-6.48%	0.67%	-5.41%	-5.91%	-2.65%	-1.26%
Bad Debt as % of Gross Revenue	1.50%	1.16%	1.53%	0.89%	1.68%	1.44%	0.92%	1.00%	1.47%	1.28%	1.32%	0.99%
B. Liquidity												
Current Ratio	1.28	1.23	1.28	1.23	1.61	1.66	1.61	1.66	1.56	1.46	1.56	1.46
Days Cash on Hand	37	40	38	41	91	87	92	91	62	62	62	65
Days in Net Accounts Receivable	59	58	60	58	58	56	54	57	56	53	55	53
Average Payment Period	58	62	60	64	41	43	42	45	54	54	54	57
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.63	2.16	3.63	2.16	1.37	0.84	1.37	0.84	1.47	1.10	1.47	1.10
Long-term Debt to Capitalization	78	68	78	68	58	46	58	46	76	66	76	66
Unrestricted Cash to Debt	0.44	(0.15)	4.06	4.48	(1.89)	0.27	(1.43)	4.99	(0.29)	(0.64)	1.07	2.31
Times Interest Earned Ratio	3.20	0.76	4.48	5.00	(8.13)	4.32	0.10	6.97	0.20	(1.82)	2.34	3.48
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	9.19	15.77	9.19	15.77	26.41	37.66	26.41	37.66	21.44	28.53	21.44	28.53
D. Additional Statistics												
Income from Operations	($156,488)	($629,128)	$707,993	$1,040,080	($773,124)	($148,581)	($1,529,946)	$305,803	($1,193,898)	($1,370,764)	($2,843,995)	($1,165,900)
Revenue Over/(Under) Expense	($248,519)	($701,662)	$268,515	$602,847	($812,613)	($187,431)	($1,696,260)	$197,481	($1,328,700)	($1,485,069)	($3,467,408)	($1,726,859)
EBITDA	$632,119	$172,056	$4,613,672	$5,138,669	($465,266)	$160,782	$29,051	$1,966,100	$56,153	($477,995)	$3,431,584	$5,109,679
Cash from Operations	$15,819,230	$12,814,988	$72,922,656	$71,347,194	$5,625,773	$5,412,922	$26,555,196	$29,193,962	$26,001,171	$22,558,897	$123,909,726	$124,897,331
Cash and Cash Equivalents	$2,795,549	$3,540,829	$2,795,549	$3,540,829	$541,657	$182,113	$541,657	$182,113	$14,115,498	$10,287,744	$14,115,498	$10,287,744
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$22,034,346	$25,718,738	$22,034,346	$25,718,738
Unrestricted Assets	$1,364,644	$10,193,774	$1,364,644	$10,193,774	$12,563,178	$23,532,658	$12,563,178	$23,532,658	$37,485,690	$57,832,005	$37,485,690	$57,832,005
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (March FY 2016 and March FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015
A. Operating Performance												
Operating Margin	-2.40%	13.52%	0.38%	3.59%	-7.77%	-9.03%	-6.16%	-0.52%	-3.88%	4.40%	-2.45%	0.07%
Non-Operating Margin	0.34%	-1.09%	-0.42%	-0.66%	1.10%	-0.92%	-0.36%	-0.45%	0.41%	-0.85%	-0.33%	-0.49%
Total Margin	-2.06%	12.43%	-0.05%	2.93%	-6.67%	-9.95%	-6.51%	-0.97%	-3.47%	3.55%	-2.78%	-0.42%
Bad Debt as % of Gross Revenue	2.17%	0.18%	1.64%	0.76%	0.94%	-0.29%	0.92%	0.79%	1.75%	0.07%	1.40%	0.82%
B. Liquidity												
Current Ratio	1.26	1.28	1.26	1.28	1.48	1.62	1.48	1.62	1.53	1.49	1.53	1.49
Days Cash on Hand	47	47	47	46	107	102	102	101	70	71	69	71
Days in Net Accounts Receivable	57	50	55	55	50	59	47	54	52	51	50	53
Average Payment Period	63	65	63	64	50	50	47	50	58	59	57	58
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.47	1.99	3.47	1.99	1.35	0.86	1.35	0.86	1.51	1.07	1.51	1.07
Long-term Debt to Capitalization	78	67	78	67	58	46	58	46	76	52	76	52
Unrestricted Cash to Debt	0.35	3.39	4.33	7.88	(0.28)	(0.82)	(1.67)	4.05	0.05	1.50	1.10	3.81
Times Interest Earned Ratio	2.21	17.07	4.14	6.84	(1.44)	(2.62)	(0.16)	5.30	0.86	9.34	2.11	4.39
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.06	1.40
Equity Financing Ratio	9.45	16.81	9.45	16.81	26.21	36.66	26.21	36.66	20.79	28.79	20.79	28.79
D. Additional Statistics												
Income from Operations	($364,135)	$2,391,901	$343,857	$3,431,980	($390,250)	($484,731)	($1,920,196)	($178,926)	($1,008,920)	$1,274,585	($3,852,915)	$108,685
Revenue Over/(Under) Expense	($312,094)	$2,199,226	($43,581)	$2,802,073	($334,997)	($534,143)	($2,031,258)	($336,660)	($901,686)	$1,027,537	($4,369,094)	($699,322)
EBITDA	$407,054	$3,150,529	$5,020,726	$8,289,197	($83,791)	($155,704)	($54,739)	$1,810,399	$231,351	$2,514,856	$3,662,935	$7,624,535
Cash from Operations	$15,965,442	$15,273,142	$88,888,098	$86,620,336	$5,737,195	$6,069,379	$32,292,391	$35,263,341	$26,739,615	$26,384,632	$150,649,342	$151,281,963
Cash and Cash Equivalents	$5,964,125	$5,921,692	$5,964,125	$5,921,692	$1,533,320	$1,922,740	$1,533,320	$1,922,740	$19,785,944	$14,322,420	$19,785,944	$14,322,420
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$15,533,852	$19,649,222	$15,533,852	$19,649,222
Unrestricted Assets	$2,070,127	$12,023,463	$2,070,127	$12,023,463	$12,770,207	$22,848,732	$12,770,207	$22,848,732	$36,462,098	$59,066,325	$36,462,098	$59,066,325
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (October FY 2016 and October FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015
A. Operating Performance												
Operating Margin	3.51%	1.11%	3.51%	1.11%	-12.22%	-0.64%	-12.22%	-0.64%	-1.97%	-0.35%	-1.97%	-0.35%
Non-Operating Margin	-0.90%	-0.93%	-0.90%	-0.93%	-0.47%	-0.67%	-0.47%	-0.67%	-0.64%	-0.69%	-0.64%	-0.69%
Total Margin	2.61%	0.17%	2.61%	0.17%	-12.70%	-1.31%	-12.70%	-1.31%	-2.61%	-1.05%	-2.61%	-1.05%
Bad Debt as % of Gross Revenue	0.63%	0.66%	0.63%	0.66%	0.60%	0.80%	0.60%	0.80%	0.70%	0.76%	0.70%	0.76%
B. Liquidity												
Current Ratio	1.18	1.11	1.18	1.11	1.86	1.82	1.86	1.82	1.48	1.43	1.48	1.43
Days Cash on Hand	41	41	41	41	96	88	96	88	64	67	64	67
Days in Net Accounts Receivable	58	49	58	49	54	53	54	53	55	50	56	50
Average Payment Period	60	61	60	61	32	37	32	37	54	54	54	54
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.26	2.05	3.26	2.05	1.24	0.85	1.24	0.85	1.38	1.09	1.38	1.09
Long-term Debt to Capitalization	77	67	77	67	55	46	55	46	75	66	75	66
Unrestricted Cash to Debt	1.31	0.84	1.31	0.84	(1.41)	0.63	(1.41)	0.63	0.24	0.59	0.24	0.59
Times Interest Earned Ratio	6.62	5.13	6.62	5.13	(5.42)	4.88	(5.42)	4.88	2.61	4.21	2.61	4.21
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	10.26	16.63	10.26	16.63	29.08	38.33	29.08	38.33	22.80	28.92	22.80	28.92
D. Additional Statistics												
Income from Operations	$554,185	$178,673	$554,185	$178,673	($624,549)	($40,097)	($624,549)	($40,097)	($522,871)	($101,391)	($522,871)	($101,391)
Revenue Over/(Under) Expense	$412,522	$28,057	$412,522	$28,057	($648,781)	($82,468)	($648,781)	($82,468)	($692,147)	($298,674)	($692,147)	($298,674)
EBITDA	$1,363,716	$1,033,764	$1,363,716	$1,033,764	($312,933)	$295,442	($312,933)	$295,442	$768,569	$1,271,801	$768,569	$1,271,801
Cash from Operations	$15,452,957	$16,077,536	$15,452,957	$16,077,536	$5,280,181	$6,848,006	$5,280,181	$6,848,006	$26,028,117	$28,483,054	$26,028,117	$28,483,054
Cash and Cash Equivalents	$1,684,265	$2,379,059	$1,684,265	$2,379,059	$348,170	$670,049	$348,170	$670,049	$10,087,005	$11,113,845	$10,087,005	$11,113,845
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,659,267	$23,289,473	$21,659,267	$23,289,473
Unrestricted Assets	$2,961,600	$11,060,535	$2,961,600	$11,060,535	$14,229,387	$23,492,992	$14,229,387	$23,492,992	$41,250,914	$57,524,881	$41,250,914	$57,524,881
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (November FY 2016 and November FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015
A. Operating Performance												
Operating Margin	3.25%	-4.33%	3.38%	-1.44%	-1.81%	0.20%	-6.96%	-0.24%	-0.54%	-3.64%	-1.26%	-1.90%
Non-Operating Margin	0.00%	-1.59%	-0.46%	-1.24%	-0.30%	-1.22%	-0.39%	-0.93%	-0.07%	-1.19%	-0.36%	-0.92%
Total Margin	3.26%	-5.93%	2.93%	-2.69%	-2.11%	-1.02%	-7.35%	-1.17%	-0.61%	-4.83%	-1.62%	-2.83%
Bad Debt as % of Gross Revenue	1.42%	0.63%	1.03%	0.65%	1.44%	0.31%	1.02%	0.57%	1.35%	0.65%	1.02%	0.71%
B. Liquidity												
Current Ratio	1.20	1.10	1.20	1.10	1.75	1.71	1.75	1.71	1.45	1.39	1.45	1.39
Days Cash on Hand	43	45	42	44	104	100	101	96	65	73	65	71
Days in Net Accounts Receivable	61	52	60	50	51	57	52	55	55	52	55	50
Average Payment Period	63	66	62	65	38	46	37	44	57	60	57	59
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.15	3.24	2.15	1.26	0.84	1.26	0.84	1.39	0.96	1.39	0.96
Long-term Debt to Capitalization	76	68	76	68	56	46	56	46	76	67	76	67
Unrestricted Cash to Debt	1.30	(0.22)	2.59	0.61	0.49	0.71	(0.88)	1.32	0.60	(0.06)	0.84	0.51
Times Interest Earned Ratio	5.86	1.22	6.23	3.17	3.71	5.51	(0.86)	5.21	3.63	1.70	3.12	2.94
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	10.23	15.77	10.23	15.77	28.38	37.99	28.38	37.99	22.40	32.38	22.40	32.38
D. Additional Statistics												
Income from Operations	$484,666	($617,807)	$1,038,851	($439,134)	($94,623)	$11,206	($719,172)	($28,891)	($141,076)	($924,261)	($663,947)	($1,025,652)
Revenue Over/(Under) Expense	$485,190	($845,187)	$897,712	($817,130)	($110,173)	($57,474)	($758,954)	($139,942)	($159,224)	($1,226,090)	($851,371)	($1,524,764)
EBITDA	$1,228,216	$249,367	$2,591,932	$1,283,131	$213,600	$357,458	($99,333)	$652,900	$1,081,351	$524,935	$1,849,920	$1,796,736
Cash from Operations	$13,356,567	$14,014,676	$28,809,524	$30,092,212	$5,149,913	$5,761,100	$10,430,094	$12,609,106	$23,154,591	$24,487,028	$49,182,708	$52,970,081
Cash and Cash Equivalents	$1,845,940	$3,481,745	$1,845,940	$3,481,745	$870,293	$1,473,722	$870,293	$1,473,722	$11,037,049	$13,330,484	$11,037,049	$13,330,484
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,653,544	$19,750,219	$21,653,544	$19,750,219
Unrestricted Assets	$3,079,176	$9,883,749	$3,079,176	$9,883,749	$13,959,228	$23,752,272	$13,959,228	$23,752,272	$40,845,738	$70,108,676	$40,845,738	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (December FY 2016 and December FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015
A. Operating Performance												
Operating Margin	3.14%	8.83%	3.30%	2.29%	-1.50%	3.52%	-5.05%	1.00%	0.52%	3.66%	-0.65%	0.06%
Non-Operating Margin	-0.87%	0.46%	-0.60%	-0.63%	-1.10%	0.83%	-0.64%	-0.35%	-0.74%	0.44%	-0.49%	-0.45%
Total Margin	2.27%	9.28%	2.70%	1.67%	-2.60%	4.35%	-5.68%	0.64%	-0.22%	4.10%	-1.14%	-0.39%
Bad Debt as % of Gross Revenue	1.30%	0.97%	1.12%	0.76%	1.04%	1.12%	1.03%	0.75%	1.16%	1.07%	1.07%	0.83%
B. Liquidity												
Current Ratio	1.30	1.15	1.30	1.15	1.76	1.73	1.76	1.73	1.60	1.44	1.60	1.44
Days Cash on Hand	38	47	39	47	94	108	95	101	63	72	64	72
Days in Net Accounts Receivable	56	45	57	48	49	53	51	51	52	47	53	49
Average Payment Period	56	65	58	65	37	48	37	45	51	58	52	58
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.05	3.24	2.05	1.28	0.84	1.28	0.84	1.40	1.06	1.40	1.06
Long-term Debt to Capitalization	76	67	76	67	56	46	56	46	76	65	76	65
Unrestricted Cash to Debt	1.22	2.69	3.86	3.30	0.40	1.67	(0.48)	2.99	0.73	1.64	1.59	2.16
Times Interest Earned Ratio	5.85	11.61	6.10	5.96	4.07	8.58	0.78	6.34	4.53	7.72	3.61	4.53
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	10.37	16.35	10.37	16.35	27.98	37.97	27.98	37.97	22.73	29.09	22.73	29.09
D. Additional Statistics												
Income from Operations	$505,704	$1,534,223	$1,544,555	$1,095,089	($83,842)	$205,743	($803,014)	$176,852	$143,984	$1,074,991	($519,963)	$49,339
Revenue Over/(Under) Expense	$365,418	$1,613,504	$1,263,130	$796,374	($145,178)	$254,076	($904,132)	$114,134	($62,229)	$1,203,242	($913,600)	($321,522)
EBITDA	$1,305,554	$2,322,428	$3,897,486	$3,605,559	$234,004	$542,956	$134,671	$1,195,856	$1,422,507	$2,337,616	$3,272,427	$4,134,352
Cash from Operations	$15,466,368	$14,643,053	$44,275,892	$44,735,265	$5,476,070	$5,989,154	$15,906,164	$18,598,260	$26,352,822	$25,757,209	$75,535,530	$78,727,290
Cash and Cash Equivalents	$2,504,593	$4,699,318	$2,504,593	$4,699,318	$474,590	$1,950,314	$474,590	$1,950,314	$14,328,446	$14,119,287	$14,328,446	$14,119,287
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,890,691	$18,384,525	$21,890,691	$18,384,525
Unrestricted Assets	$3,089,534	$11,027,298	$3,089,534	$11,027,298	$13,672,423	$23,806,253	$13,672,423	$23,806,253	$40,751,104	$59,337,036	$40,751,104	$59,337,036
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

18. Revised/Updated Exhibit R – PMH Free Cash Flow

Please see attached.

Prospect Medical Holdings
Free Cash Flow

	FYE 9/30/2015	TTM 12/31/15
Operating Income	$ 108,060,000	$ 87,966,000
Change in WC (Increase)	$ 34,374,000	$ 63,971,000
Taxes Paid	$ (35,778,000)	$ (38,367,000)
Net Change in PP&E	$ (10,863,000)	$ (11,459,000)
Free Cash Flow	$ 95,793,000	$ 102,111,000
Average Monthly Free cash Flow	**$ 7,982,750**	**$ 8,509,250**