CERTIFICATE OF NEED/ CONVERSION APPLICATION

SUPPLEMENTAL INFORMATION

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

March 28, 2016

WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
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Rebecca A. Matthews
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March 28, 2016

VIA EMAIL AND 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:

Eastern Connecticut Health Network, Inc. ("***ECHN***") and Prospect Medical Holdings, Inc. ("***PMH***" and, together with ECHN, the "***Applicants***") hereby submit the following supplemental materials in connection with the above-referenced docket:

1. Letters of support for the proposed transaction from various members of the public and from community leaders.

2. Copy of the PowerPoint presentation that ECHN plans to use as part of its direct testimony at the hearings on March 29, 2016 and March 30, 2016. The PowerPoint Presentation of PMH will be filed separately.

3. Additional information on certain charitable funds held by ECHN and its affiliates.

4. Additional CMS Forms 2567 relating to certain hospitals operated by PMH.

One (1) hard copy and one (1) electronic copy of this submission have been provided to each Office.

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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February 22, 2016

Ladies and Gentlemen,

I appear before you tonight to share my thoughts and insights on the proposed merger of ECHN with Prospect Medical Holdings. I am a retired physician, a urologist, who has practiced in the Vernon/Manchester community for 37 years, from 1975 through 2012, while on the active medical staffs of Rockville General Hospital, Manchester Memorial Hospital and ultimately at ECHN. During that time I had the privilege to serve terms as Chief of Urology at each hospital, President of the combined medical staffs and a hospital board member. In my retirement I proudly continue as an ECHN Corporator. I take this position quite seriously since, as a resident of South Windsor, my wife and I continue to receive a substantial portion of our continuing medical care at ECHN facilities just as we had when I was in practice. It is important to us that medical services at ECHN remain readily accessible, comprehensive and of the highest quality.

I am well acquainted with the challenges facing health care today, both nationally and at this local level. 20 years ago, before the advent of ECHN, when we first became acutely aware of the profound financial limitations impacting both Manchester and Rockville Hospitals, I served on a select hospital committee to explore our options. We realized we couldn't go it alone without initiating significant cost savings and more efficient measures in order to preserve the level of care our communities expected from us. To this end, with very capable leadership and much due diligence, we formed ECHN.

This action sufficed for many years, but as we all know, the financial burdens brought about by increasingly more expensive technology, progressive limitations on private and government reimbursement, and the burgeoning demand for health care services has again created a nation-wide crisis. In order to meet this reality, we can all agree that if there was a bottomless pool of money to pay for this demand we might continue to practice as we have been with individual, lavishly staffed hospitals providing all manner of specialty services with the latest instrumentation and technology. We know this is no longer possible. Our hospitals need access to capital to stay current, staffing needs to be optimal but realistic, and the pattern of practice needs to encourage the best outcomes for our population, not the most outcomes.

To achieve both access to capital and the implementation of a well-managed, cost efficient delivery system requires a new model that builds on our existing strengths. ECHN is recognized as a lower cost hospital network with excellent professional staff. When integrated into a well-managed, risk based system which incentivizes and equips our quality providers to produce the best outcomes for wellness and disease prevention along with effective chronic disease management, then both lower costs and optimal care are well served. The alternative of affiliating with a regional network that, by its very nature and interest, must funnel patients

into large, expensive downtown hospitals makes little sense. Such changes neither serve the current economic imperative or our local need for ready access to quality care.

For us, in this ECHN service area, our goal should be to maintain a broad range of quality medical services that emphasize coordinated care in a cost efficient environment. Anything less short changes us on access to care, misdirects an emphasis on preventative and wellness services, and diminishes the full range of quality care we expect within our community. Neither the State nor regional competitors can create the proper mix of changes that preserve all these goals. Prospect has access to needed financial resources as well as the proven data driven, management model to deliver the correct health care product for these ever changing times.

Thank you for your attention.

Respectfully submitted,

Robert D. Rodner

11 Rosemary Lane

South Windsor, CT. 06074

r.rodner@cox.net

(860) 644-9601

ECHN℠
Eastern Connecticut Health Network

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

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino:

As the Chair and Senior Medical Director of the Department of Emergency Medicine and the Service Line Director for Emergency Services at ECHN, I would like to express my excitement about the future acquisition of ECHN by Prospect Medical Holdings (PMH). For the past several years we have been facing one financial challenge after the next in the form of hospital taxes, sequestration, Medicare reimbursement cuts, pension reform, or unfunded quality reporting mandates. The only way we have been able to meet these challenges has been to "do more with less".

My view on Healthcare is that we are facing the same struggles now that the smaller department stores and hardware stores faced a decade or more ago with the emergence of Walmart and Home Depot. Their ability to purchase goods in such large quantities made it impossible to compete with their prices, and many of the mom and pop stores eventually went out of business. This is the path that I believe ECHN would be on if we didn't proceed with this acquisition.

I, as a healthcare provider, and ECHN as a healthcare system, have an obligation to the patients we serve. Our obligation is to be there for them in their time of need and to provide the expertise, staff, and equipment necessary to diagnose and treat them at any hour of the day or night. The acquisition of ECHN by a larger system is the only option that would allow us to continue our mission of "improving your well-being by providing high-quality, compassionate healthcare." Without the ability to join a larger system, our costs will be higher than our competitors, our ability to recruit skilled physicians and

nurses will become more difficult, and we would eventually find ourselves out of business.

I have been asked many times, "Why partner with PMH, rather than with one of the other large systems closer to Manchester and Rockville?" My desire for PMH is based on my belief that they would be the best option for both the patients we serve and for the staff we employ. In order to succeed, PMH has to help grow our system to allow us to directly compete with our local competitors. I feel that if we had chosen to partner with a nearby competitor, we would become victim to consolidations of services and locations. This would directly impact access to healthcare for our patients in our communities.

In my 15 years at ECHN, I have watched our competitors advertise their cutting edge therapies during the prime time news and open healthcare centers in our own neighborhood. I've read about their latest minimally invasive cardiac procedures and have heard on the radio about their world-class stroke therapies. It would be really nice to have the access to capital funding that would allow us to advertise the cutting-edge programs we have here at ECHN. However, the ability to grow and advertise these types of services is becoming virtually impossible under the financial constraints we are facing. With the implementation of the Affordable Care Act, the increase in Medicaid volume, and the State's tax on hospitals, remaining independent is futile and no longer an option. A partnership with PMH will afford us access to the clinical expertise our patients need, as well as access to the desperately needed capital funding so that we can resume investing in our technology, staff, and infrastructure. This partnership will position ECHN competitively for the foreseeable future of healthcare.

Sincerely,

R. Carroll MD

Robert Carroll, MD, FACEP, MBA
Chair and Senior Medical Director
Department of Emergency Medicine, ECHN

Laurence P. Rubinow
239 Cedar Ridge Drive
Glastonbury, CT 06033

February 29, 2016

Office of the Attorney General
55 Elm Street, PO Box 120
Hartford, CT 06141-0120
Attention: Deputy Attorney General Perry Zinn-Rowthorn

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, CT 06134
Attention: Deputy Commissioner Brancifort

Dear Messrs. Zinn-Rowthorn and Brancifort:

It is my understanding that the Office of the Attorney General and the Office of Health Care Access will hold public hearings March 15th and 16th on the Certificate of Need ("CON") application of Eastern Connecticut Health Care, Inc.("ECHN") relating to its intended partnership with Prospect Medical Holdings, Inc. ("Prospect"). I regret that I will be unable to attend the hearings. In my absence, however, I submit this letter to strongly support and recommend approval of the CON and the proposed partnership between ECHN and Prospect.

I have lived in the Manchester and Glastonbury communities my entire life. I was on the Board of Manchester Memorial Hospital ("MMH") and on its ad hoc committee that recommended the merger between MMH and Rockville General Hospital, a merger that made both institutions stronger.

Since that time, in response to the health-care needs of East of the River communities, ECHN has set high standards for quality of care, innovation, and accessibility. While it has always been a challenge to maintain top health care, ECHN has succeeded. To sustain the delivery of high-quality health care, ECHN must operate with reasonable financial returns in order to reinvest in its facilities, keep up with technological advances, and continue to attract highly qualified clinicians and staff. Unfortunately, due to severe economic constraints attributable to numerous factors, the existing business model is no longer sustainable.

Several years ago, ECHN recognized this economic reality and embarked on a process to find the best health-care provider partner. That partner must be dedicated to maintaining the highest standards of health care and also be able to meet the financial needs that those high standards require. In Prospect, ECHN has found such a partner. This conclusion has been reached by ECHN after substantial due diligence and after overwhelming support from ECHN's board, its incorporators, administration, medical staff, and employees.

I know that ECHN's partnership with Prospect will enable the communities that ECHN serves to continue to have accessibility to the highest quality of health care.

Accordingly, I respectfully request that the CON be approved.

Thank you for your consideration of my recommendation.

Very truly yours,

Laurence P. Rubinow

March 3, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

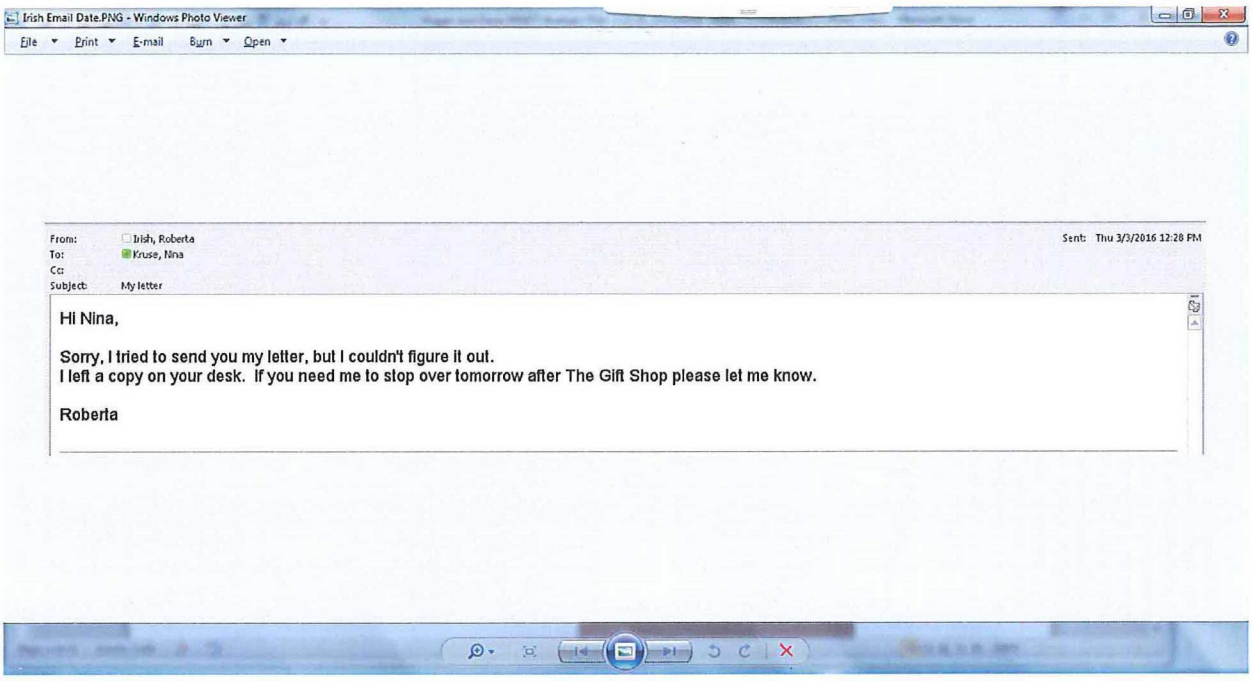
Dear Attorney General Jepsen and Commissioner Pino,

As the President of The Manchester Memorial Hospital Auxiliary, I appreciate the value of a community hospital. Our organization has been active for the last 93 years providing volunteers and fundraising. With our Gift Shop and Thrift Shop, we have raised millions of dollars to support the needs of our hospital, and now we realize things must change to continue to make our hospital as strong as it can be.

I think for ECHN to stay healthy, it must partner with a larger entity so that it can remain a community hospital. Quality care at Manchester Hospital is important to our residents and I don't ever want to see it go away.

We look forward to continuing volunteer opportunities, whatever they may be, in the future. Somewhere there will be a place for our Auxiliary where we can continue to make a difference.

Roberta Irish
President, Manchester Memorial Hospital Auxiliary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From: Irish, Roberta
To: Kruse, Nina
Cc:
Subject: My letter
Sent: Thu 3/3/2016 12:28 PM
Hi Nina,
Sorry, I tried to send you my letter, but I couldn't figure it out.
I left a copy on your desk. If you need me to stop over tomorrow after The Gift Shop please let me know.
Roberta

February 26, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino,

As a Corporator of ECHN, I have always been extremely impressed with the vision, intellect and communication skills of Peter Karl and Dennis O'Neill. I am comfortable with their decisions regarding the ECHN acquisition by Prospect Medical Holdings and it's my hope that the company becomes more viable and successful as a result.

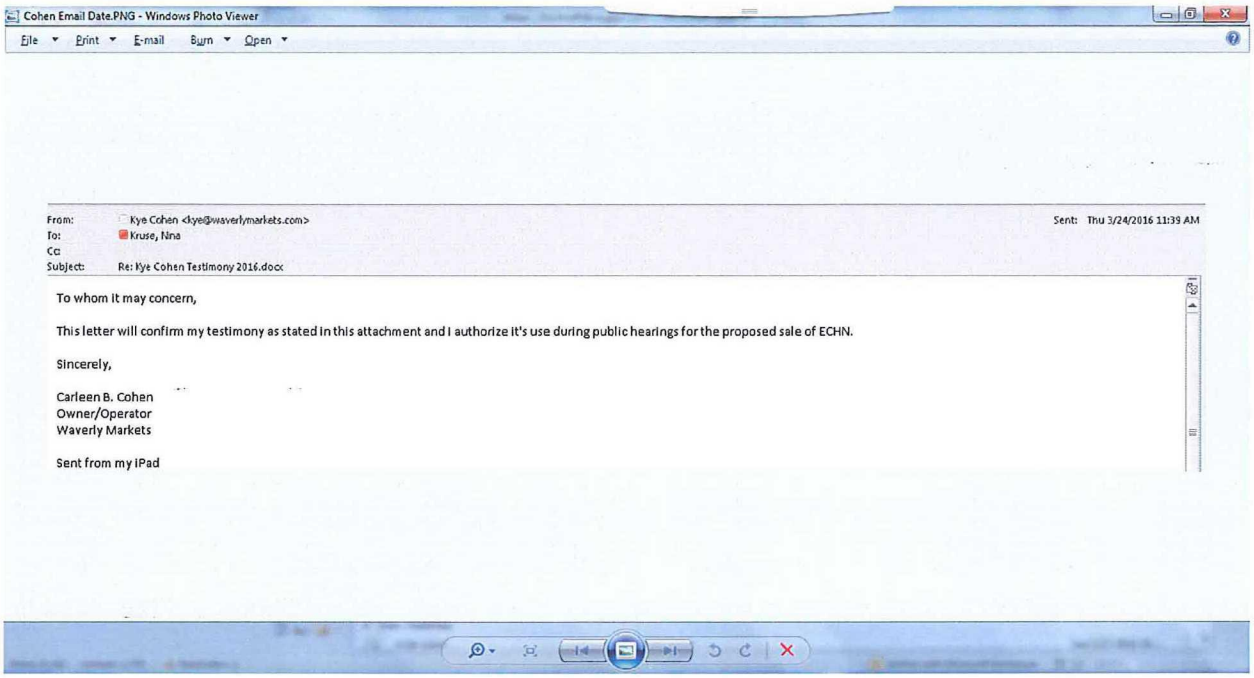
As a business owner, I am keenly aware of the need for "economies of scale". My organization's ability to partner with a larger entity allows us to stay in business, pass immense savings onto our customers and be philanthropic to the greater Manchester community.

The common thread that exists between ECHN and my business is that we both face a highly competitive marketplace.

I truly understand the need for ECHN to adapt to a rapidly changing healthcare environment and fully support the merger so that we may go forward and keep quality healthcare in greater Manchester.

Respectfully submitted,

Kye Cohen
Owner, ShopRite of Manchester and East Hartford


Cohen Email Date.PNG - Windows Photo Viewer
File Print E-mail Burn Open
From: Kye Cohen <kye@waverlymarkets.com>
To: Kruse, Nina
Cc:
Subject: Re: Kye Cohen Testimony 2016.docx
Sent: Thu 3/24/2016 11:39 AM
To whom it may concern,
This letter will confirm my testimony as stated in this attachment and I authorize it's use during public hearings for the proposed sale of ECHN.
Sincerely,
Carleen B. Cohen
Owner/Operator
Waverly Markets
Sent from my iPad

March 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino,

I am writing to strongly recommend the proposed acquisition of Eastern Connecticut Health Network by Prospect Medical Holdings. I and my family have lived in the ECHN service area for decades and have received both routine and critical care at its facilities. I am a Trustee of ECHN, having served for more than a decade first as a Corporator and then as a Trustee. I chair the Audit and Corporate Compliance Committee and also serve as Vice Chair of the Finance Committee and as a member of the Transaction Committee which worked with management to develop this proposed transaction, which has the unanimous support of our Board.

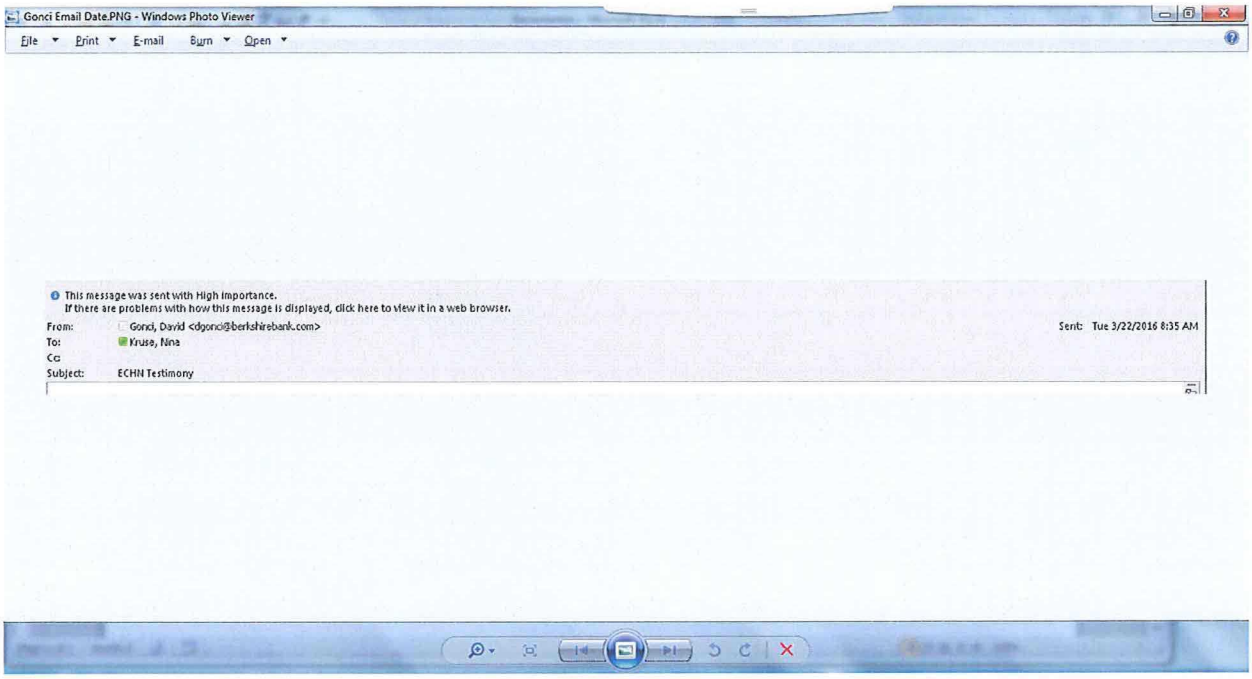
ECHN has demonstrated the compelling need to combine our operations with a larger system due to the sweeping changes in the healthcare environment. The majority of Connecticut community hospitals have arrived at a similar conclusion. The need for a combination has been made more urgent by the State's hospital tax, as well as the reduction and withholding of State payments to Connecticut hospitals.

ECHN has spent several years assessing and developing partnership options. The proposed Prospect transaction follows an early proposed transaction with Tenet Healthcare, which was withdrawn by Tenet following the imposition of burdensome approval conditions. We are convinced that the combination with Prospect provides the best opportunity available to sustain healthcare services in our communities, while meeting important quality and affordability objectives. ECHN cannot sustain its current service delivery in its current form of organization, and the pressures are mounting to complete this process as proposed, and without burdensome conditions that would make the combination unworkable.

Thank you for your prompt consideration of our proposal to implement the needed changes in order to support our communities.

David Gonci

Glastonbury, Connecticut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This message was sent with High importance.
If there are problems with how this message is displayed, click here to view it in a web browser.
From:
Gonci, David <dgonci@berkshirebank.com>
Sent: Tue 3/22/2016 8:35 AM
To:
Kruse, Nina
Cc:
Subject:
ECHN Testimony

ERIC L. KLOTER
24 Raisch Drive
Tolland, CT 06084

Tuesday, March 22, 2016
The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino,

The honor and privilege has been mine to serve on the ECHN Board of Trustees and numerous other ECHN committees including chairing both the Eldercare (Woodlake of Tolland) and VNHSC (Visiting Nurse and Health Services of CT) Boards of Trustees.

One of those "other" ECHN responsibilities has been to serve on the Transaction Committee which has reviewed all aspects of the ECHN – Prospect Medical Holdings, Inc (PMH) acquisition. The complexity and depth of this endeavor has been challenging, forced by the changing landscape of the medical field. For any industry, it is difficult to reduce cost as revenue sources shrink while preserving the highest level of quality and patient satisfaction possible is not a sustainable model. ECHN cannot survive without the benefit of scale and a new focus on program development.

This acquisition process has revealed to me without any doubt that the future of small community hospitals is short – especially in Connecticut. We have chosen Prospect Medical Holdings to acquire ECHN – based on:

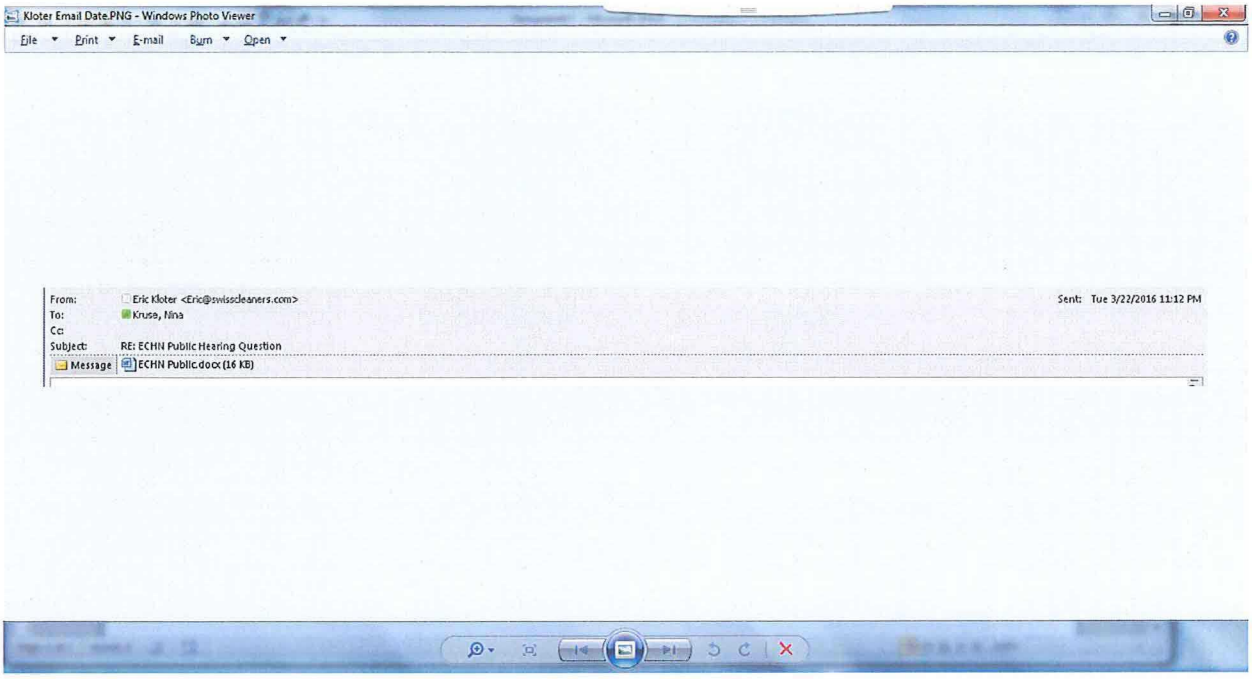
- our visits to PMH facilities and subsequent measures of due diligence in reviewing their practices
- PMH's achievements of high quality which are validated by their measurements and metrics
- the unique PMH vision to empower primary care physicians and oversee patient's as they navigate through a journey to sustain or regain health which leads to better patient outcomes
- implementation and extensive use of electronic medical records to help reduce duplication and cost
- a deep study of how PMH supports local culture and leadership
- and then . . . the resulting level of trust and confidence in PMH leadership and their program for managing population health.

The administrative team that leads PMH is actively committed to a vision that will change the way future healthcare is delivered. ECHN, its staff, and the physicians that serve our local communities have studied the

PMH business plan – Coordinated Regional Care (CRC) – and are eager to engage this new culture that will enhance ECHN's healthcare delivery in our local communities.

Having had the privilege of working closely with the PMH transaction team, I am convinced and confident of ECHN's ability to deliver the finest healthcare under PMH's guidance and with the benefits of PMH's scale and best practices. PMH's leadership has delivered on their commitments and promises. The PMH hospitals successes in California, Texas and Rhode Island further confirms to me that the ECHN Board of Trustees has made the right decision to be acquired by Prospect Medical Holdings and we look forward to integrating our mission, vision and values for healthcare in our region that will benefit our neighbors, family and friends across eastern Connecticut.

Sincerely,
Eric L. Kloter
Member, Transaction Committee and ECHN Board of Trustees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From:
Eric Kloter <Eric@swisscleaners.com>
Sent: Tue 3/22/2016 11:12 PM
To:
Kruse, Nina
Cc:
Subject:
RE: ECHN Public Hearing Question
Message
ECHN Public.docx (16 KB)

Letter of support for the partnership between Eastern Connecticut Health Network and Prospect Medical Holdings Inc.

To: Office of Healthcare Access and the State Attorney General

From: M. Saud Anwar MD, MPH, FCCP
Partner Northeastern Pulmonary Associates, LLC,
Chairman of Department of Medicine, Eastern Connecticut Healthcare Network.

RE: Certificate of Need, Application for Hospital Conversion to "For Profit" Status.

Dear Commissioner of the Office of Healthcare Access and State of Connecticut
Attorney General Mr. Jepsen,

My name is Saud Anwar, I am a Pulmonary and Critical Care physician affiliated with Eastern Connecticut Health Network for over 17 years. I support the proposed partnership of Eastern Connecticut Health Network and Prospect Medical Holdings. I am an independent physician who has the opportunity to interact not only with the patients in the community, but also the staff essentially in most parts of our hospital and I also have an opportunity to cooperate with the community physicians providing primary care to our community. As a medical director of the Clinically Integrated Network of Eastern Connecticut and also with the Eastern Connecticut Physician Hospital Organization and medical advisor to the care management department of the hospital, I have had the opportunity to closely observe the sustainability challenges our healthcare system has who are struggling to continue to provide best quality to all the patients with ongoing challenges with increasing social challenges and insurance reimbursement and bureaucracy.

I have also had the opportunity to learn first hand from the representatives of the Prospect Medical Holdings and their existing hospitals and their track record of providing quality care to patients with all capabilities of payments. It is quite clear to the physicians that integrated network and coordination of care in a healthcare system with strong primary care delivery along with collaborative specialty care with appropriate transitions according to the patients' needs is the best and the most effective way of maintaining and managing population health. Prospect Medical Holdings has many years of experience and success in managing risks with their delivery models. The size of our healthcare system and the opportunity to collaborate with an experienced partner who believes in collaboration between the independent physician in the community and the hospital will truly strengthen healthcare within our network.

Our hospital continues to employ members in the community and serves as a backbone of the economic engine within our towns. In my other role as a Mayor of the Town of South Windsor, I know that over 250 people in my community are employed by ECHN. Stronger, efficient and sustainable healthcare system allows industry to identify and

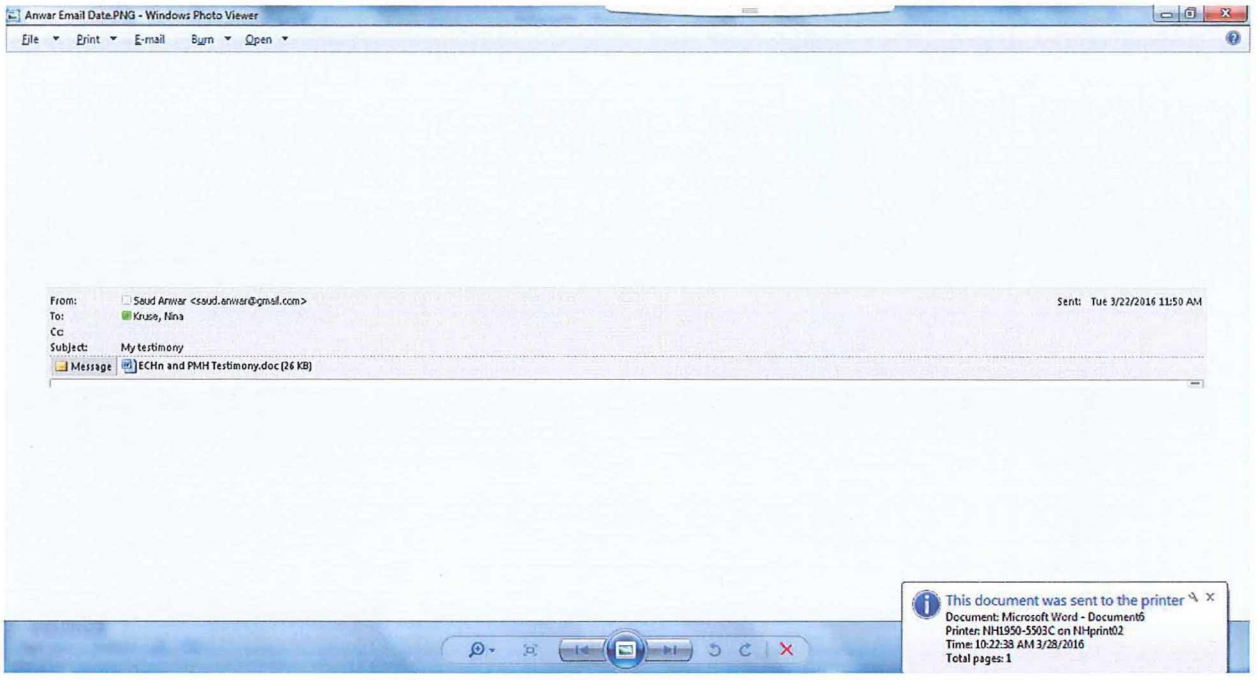
choose communities to invest in. With the growth of population health management, we truly can have an impact at all levels according to the needs of the people.

I strongly feel that the track record and the current system needs to move to "for-profit" model and this partnership will not compromise the quality of care, but actually enhance the quality of care and would be able to provide care to the patients irrespective of their insurance status and abilities to pay.

I thank you for your consideration. Should you have any questions, please do not hesitate to contact me.

Sincerely,

M. Saud Anwar, M.D.
Chairman of Department of Medicine,
Eastern Connecticut Health Network
860-875-2444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Total pages: 1

March 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino,

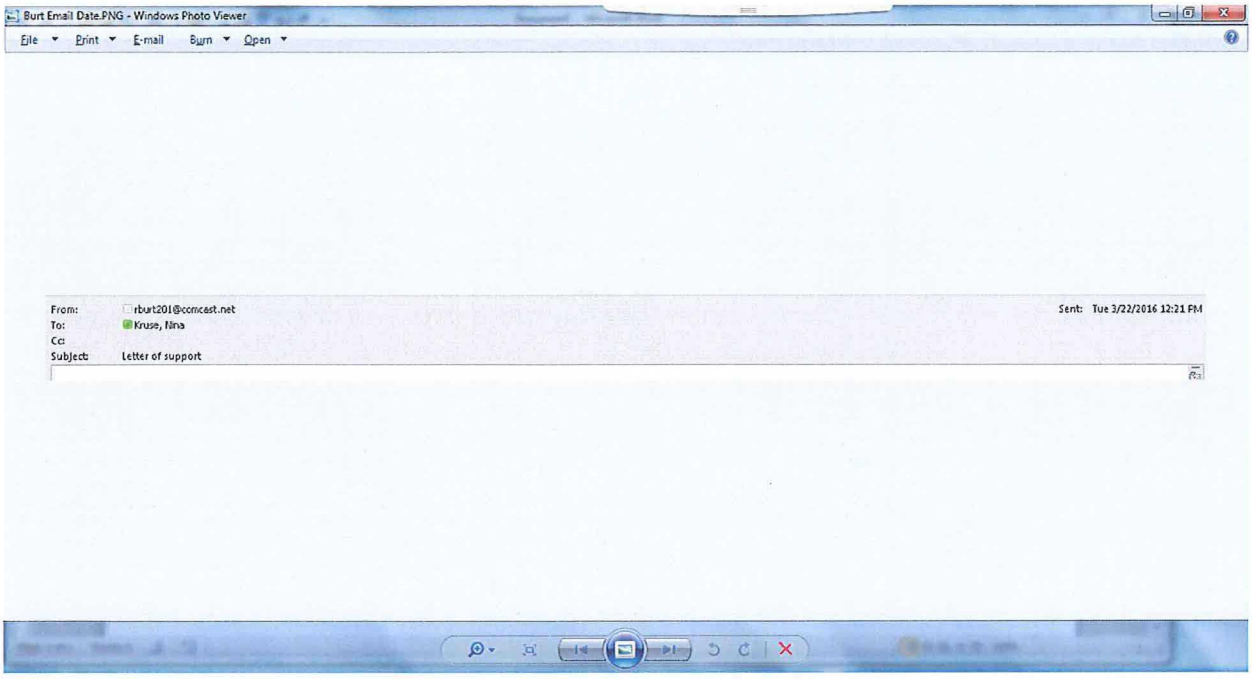
I would like to submit the following statement of my support for the proposed sales transaction of ECHN to Prospect Medical Holdings, for entry into the public record.

As a Connecticut physician practicing in Hartford and Tolland Counties for 30 years, I have been witness to, and very much involved in the evolution of all aspects of delivery of health care in central and eastern Connecticut, very much including those specifically relating to the ECHN organization. ECHN is a critical institution to the continued delivery of health care to the communities it serves. Challenges have never been as daunting as they are now, but the trustees and management of the organization have never been so fully dedicated to the preservation of ECHN's service to their community as they have been over the last several years. In this time, the necessity of all hospitals becoming parts of larger systems has been well recognized by all as the only organizational approach to both surviving, and even thriving, in the new paradigms of health care delivery. I strongly believe that ECHN, with the right corporate partner, has all the elements necessary to move forward successfully and durably. Tremendous expenditures of time, personal, and institutional commitment have been devoted by ECHN and its many supporters to identify the best organization within which to grow, and to negotiate the best possible terms under which to join such an organization. That extended and extraordinarily diligent process has brought ECHN to its current position of proposed acquisition by Prospect Medical Holdings. Prospect has already demonstrated its ability to assist hospitals in Southern New England to traverse the increasingly difficult regulatory and fiscally constrained environments within which health care is delivered in this region, and is extraordinarily well prepared to extend that record of success in furthering the availability and quality of health care services within the ECHN service area. Prospect has not simply been reactive in its responses to the new and continually changing realties of health care delivery, but has been proactive: anticipating, preparing for, and developing successful models of implementation of systems to respond to the need for population health management, cost containment, quality improvement, and successful operation within new models for reimbursement for services.

For all the above reasons, I very strongly support the proposed ECHN/Prospect Medical Holdings transaction and respectfully ask that the ECHN public community and involved Connecticut regulatory bodies support and approve the process.

Respectfully submitted,

Ronald E. Burt, M.D.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From: rburt201@comcast.net
Sent: Tue 3/22/2016 12:21 PM
To: Kruse, Nina
Cc:
Subject: Letter of support

ECHN
Eastern Connecticut Health Network, Inc.
Department of Medical Affairs
860-647-6866

February 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino:
I am writing this letter to express my total support for Prospect Medical Holdings acquisition of Eastern Connecticut Health Network. I have lived in this community and have been with ECHN for 32 years as a practicing emergency physician, Chair of Emergency & Ambulatory Care, Medical Director of EMS, and currently as Chief Medical Officer. These roles have enabled me to attain a deep understanding of our community's needs and how our health system can best continue to provide excellent care and improve the health of the residents of the towns we serve.

Clinical advances, maturation of health information technology, increasing economic pressures, and policy and legislative initiatives including the Affordable Care Act have driven unprecedented change in the healthcare system during the past 5 years. What worked before, no longer works today, and certainly won't work in the future.

ECHN has completed a carefully planned due diligence process to determine what best meets our future needs and those of the communities we serve. I was part of the team that visited Prospect Medical Holdings' health systems in Los Angeles, CA and Providence, RI. While health systems address their local needs, we found several things in common: (1) substantial capital investment, (2) significant growth of clinical services, (3) effective population health/community care management programs, and (4) highly satisfied community physicians. It is rare to see *any one* of these, and almost unheard of to see all in one place. Prospect Medical Holdings has applied its extensive experience in health system leadership & management, care coordination, independent physician association alignment, and value-based purchasing contracting to advance high quality patient care, while thoughtfully managing cost.

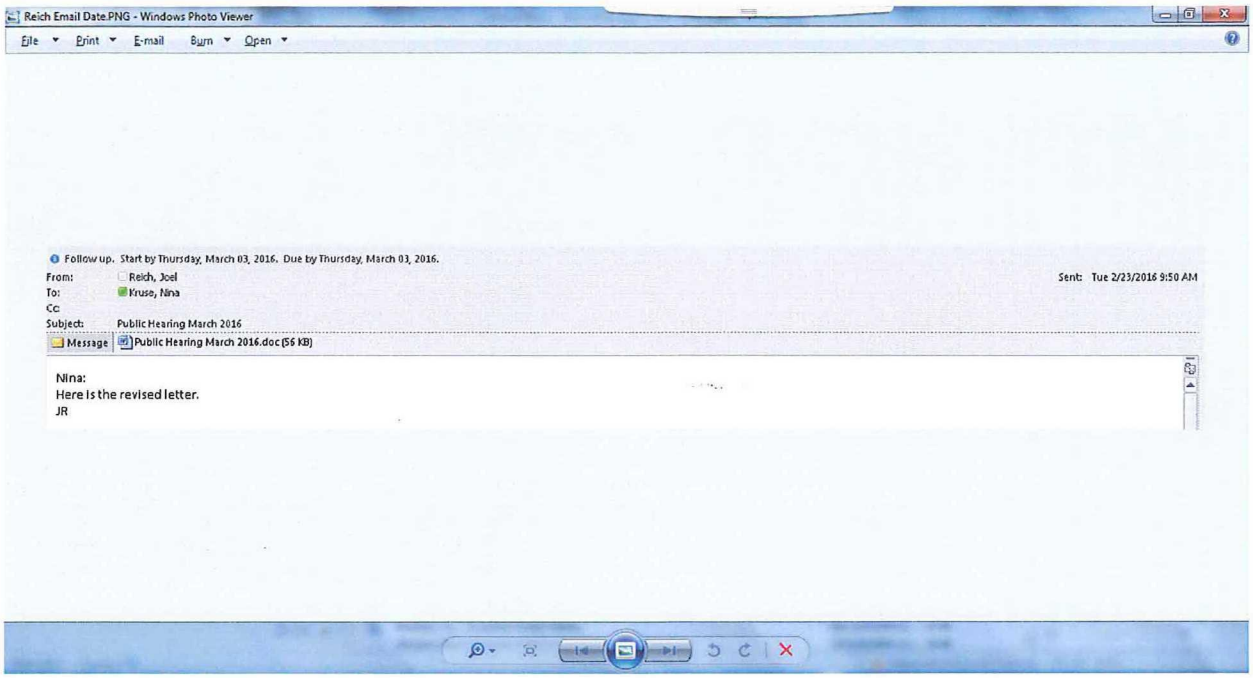
Prospect Medical Holdings is by far the best option for ECHN for the following reasons:

- It is the best "cultural fit". It has extensive experience with community hospitals serving communities very much like our own. Its leadership is focused on innovation and growth and its strategy execution is agile.
- It will bring much-needed capital investment to ECHN to ensure financial stability and future growth.
- Prospect Medical Holdings is much more than a "hospital company". It is healthcare services company. While it very successfully operates its 13 current hospitals, it has fully integrated 9,000 independent physicians, community health care centers, and other community care givers into its system model which is fully compatible with the Affordable Care Act.
- Through its care management programs, health coaching structure, and sophisticated health information and analytics capabilities, it helps patients and families navigate the complexities of the healthcare system, while reducing expenditures for non-value-added services. In short, Prospect Medical Holdings has already mastered what most other health systems are *talking about* doing in the future.

I believe that Prospect Medical Holdings is the best partner for ECHN and hope that you will be able to support this choice through the regulatory process. Thank you for your consideration of this request.

Sincerely,

Joel J. Reich, MD, FACEP
Chief Medical Officer/Senior Vice President for Medical Affairs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File
Print
E-mail
Burn
Open
Follow up. Start by Thursday, March 03, 2016. Due by Thursday, March 03, 2016.
From: Reich, Joel
To: Kruse, Nina
Cc:
Subject: Public Hearing March 2016
Sent: Tue 2/23/2016 9:50 AM
Message
Public Hearing March 2016.doc (56 KB)
Nina:
Here is the revised letter.
JR

Letter of Recommendation in favor of the Proposed Acquisition of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc., Provided for Public Hearing on March 30, 2016

To: The Office of Health Care Access and the State Attorney General

My name is Barbara L. Phillips, M.D., and I speak today as a family physician and as a member of the Board of Trustees of Eastern Connecticut Health Network, Inc. ("ECHN"), in support of the acquisition of ECHN by Prospect Medical Holdings, Inc. ("Prospect").

I have a great interest in preserving access to quality health care for the citizens of Connecticut. I have practiced independent family medicine in Manchester since 2004. I completed my internship and residency training at Middlesex Hospital here in Connecticut and have served on the Board of Directors for the Connecticut Academy of Family Physicians, all of which has informed my understanding of the healthcare needs of our state. My work in the Eastern Connecticut Physician Hospital Organization and our clinically integrated network have deepened and broadened my connections with communities in the ECHN service area. In helping to represent Connecticut family physicians and the physician hospital organization at the national level, I have tried to bring the voices of Connecticut residents into the dialog regarding health care reform, and to place the healthcare issues of our state in the national context. And now as Trustee for ECHN, through due diligence I have developed confidence in and a strong commitment to the choice of Prospect as the appropriate partner with ECHN to ensure the health of all residents of the ECHN service area.

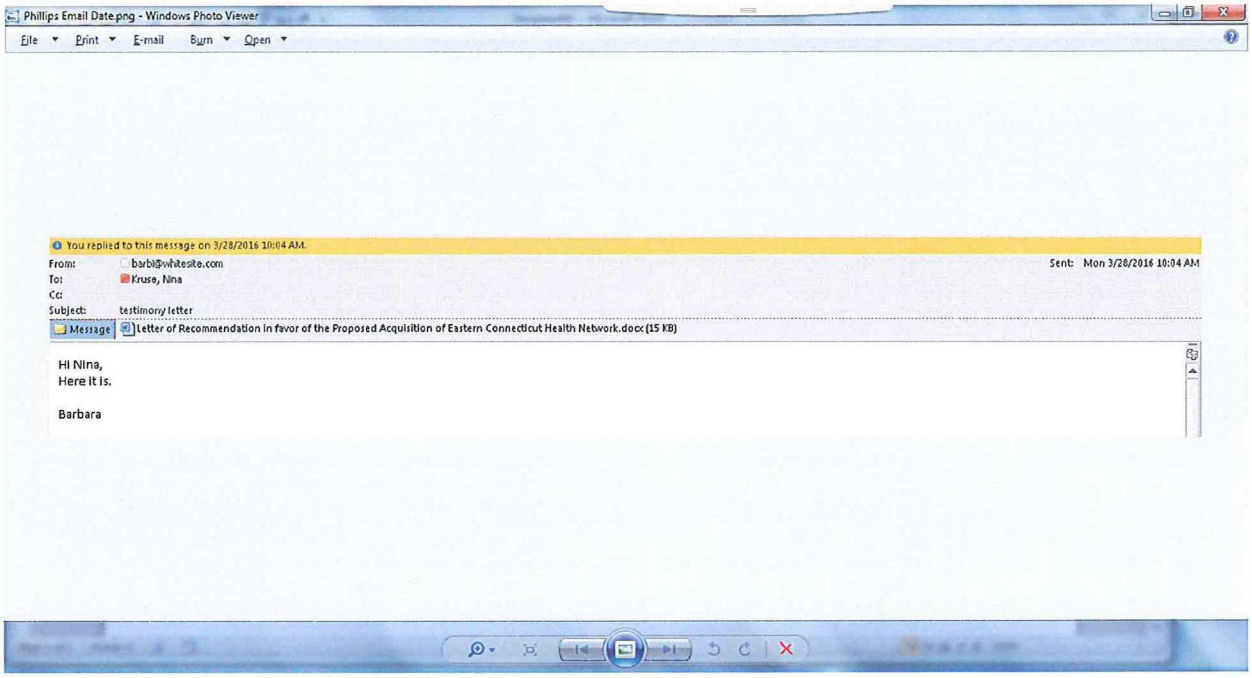
A number of years ago, the ECHN management team, Board of Trustees and medical staff leaders anticipated the significant challenges posed by the accelerating pace of change in healthcare in Connecticut. ECHN, like a number of community hospitals in the state, determined that aligning with a capital partner offered the best means of preserving and improving access and quality of local health care, and of "bending the cost curve" of medicine.

ECHN, with the Board of Trustees, conducted a thorough search to identify the best partner to support its mission to provide high-quality compassionate health care. Simultaneously, a collaborative organization was developed to better unite the efforts of healthcare providers, health system and community, and transition stakeholders toward inevitable risk-contracting. This organization is the ECHN Clinically Integrated Network of Eastern Connecticut, called "CINECT". The formation and growth of CINECT has allowed us to work cooperatively with our health insurance partners to more effectively manage the health of our population. With proper oversight and alignment of all involved in primary, specialty, acute and post-acute care, the clinical integration model has tremendous potential to achieve the Institute for Healthcare Improvement's Triple Aim -- to improve patient experience of care, improve the health of populations, and reduce the cost of health care.

As the health system's search for a partner progressed, it became and remains abundantly clear that Prospect is the most appropriate acquisition partner for ECHN. Prospect is best poised to build upon the bedrock of ECHN's deep community ties and historical stewardship of regional health care, and to bring their expertise to developing the path of clinical integration and

bettering the delivery of regional health care. In contrast to the fears of some regarding the entry into the state of a for-profit health system, Prospect has consistently demonstrated its commitment to the viability of its locally managed health systems and the promotion of robust primary care-driven physician networks. With its proven Coordinated Regional Care model and solid financial health, Prospect will help ensure that we preserve diversity, choice and access to health care in Connecticut, and I urge the State Attorney General and Office of Health Care Access to approve the acquisition.

Thank you and please feel free to contact me for further information.


Phillips Email Date.png - Windows Photo Viewer
File Print E-mail Burn Open
You replied to this message on 3/28/2016 10:04 AM.
From: barbl@whitesite.com
To: Kruse, Nina
Cc:
Subject: testimony letter
Sent: Mon 3/28/2016 10:04 AM
Message
Letter of Recommendation in favor of the Proposed Acquisition of Eastern Connecticut Health Network.docx (15 KB)
HI Nina,
Here it is.
Barbara

March 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, Hartford, CT 06134

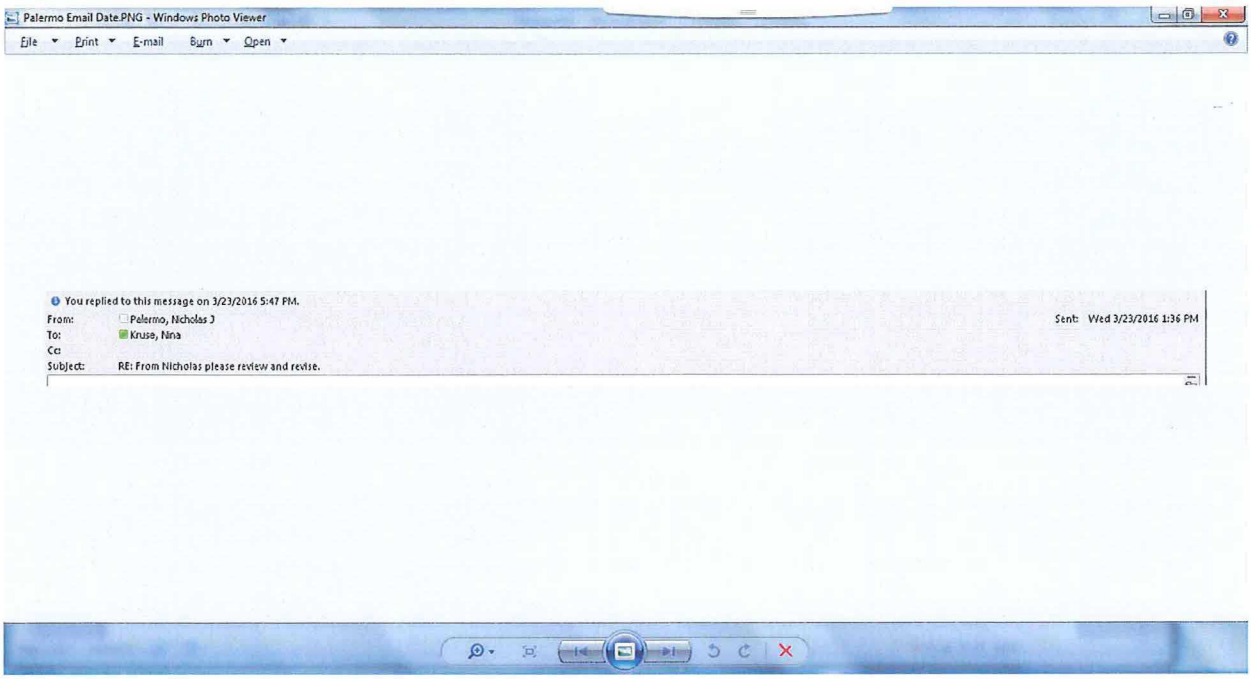
Dear Attorney General Jepsen and Commissioner Pino,

Over six years ago Manchester Memorial Hospital had a vision of expanding primary care for the communities we serve east of the Connecticut River. We developed a Department of Academic Affairs, and together with our academic partner, the University of New England and the College of Osteopathic Medicine, we developed a medical student program for those students to receive their clinical training at ECHN. This was received so well by the local and hospital community that a decision was made to expand our clinical teaching services by starting a Family Medicine Residency Program. The vision for this project was to continue the continuum of medical education training by developing graduate medical education programs. The benefit to developing our own residency programs is that we train our own physicians who will hopefully love our community as much as we do and stay in the area after they graduate.

The Eastern Connecticut Family Medicine Program graduated its first class of physicians in June of 2015. Chad McDonald, D.O., our Chief Resident at the time, is now practicing in South Windsor, CT. Another graduate, Tricia Hall, D.O., is also practicing in our community as a Neuromuscular Medicine Fellow. Keeping this trend alive, this year another one of our graduating physicians and chief resident, Katelyn Zachau, D.O. will also be establishing her practice in Ellington. The mission to bring primary care providers to our area is working and in the spring of 2017 two more graduates will be opening their offices in the Manchester and South Windsor area as well.

Prospect Medical Holdings, LLC has expressed one hundred percent commitment to both the undergraduate and graduate medical programs at Manchester Memorial Hospital. There are natural synergies between their vision to expand clinical services and our vision to provide those physicians for those projects. In addition, Prospect Medical Holdings, LLC shares our opinion that there is a tremendous value in academic medicine as we look to train our future medical providers today. We are confident that Prospect Medical Holdings, LLC's investment in our ECHN Family will be to strengthen our family medicine residency program as it continues to grow and to provide our primary care physicians with ample opportunities to practice in this wonderful community.

Nicholas J. Palermo, D.O., M.S.
Program Director
Eastern Connecticut Family Medicine Residency Program
Associate Regional Assistant Dean, UNECOM
Associate Professor of Family Medicine
p-860.533.4679


Palermo Email Date.PNG - Windows Photo Viewer
File
Print
E-mail
Burn
Open
You replied to this message on 3/23/2016 5:47 PM.
From: Palermo, Nicholas J
Sent: Wed 3/23/2016 1:36 PM
To: Kruse, Nina
Cc:
Subject: RE: From Nicholas please review and revise.

ECHN℠
Eastern Connecticut Health Network

The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

Presented to:
The Office of the Attorney General
The Office of Health Care Access
March 29 & 30, 2016

PROSPECT MEDICAL
Quality Service ~ Quality Care

Presenters:
Dr. Dennis O'Neill, Chairman, ECHN Board of Trustees
Joy Dorin, Vice Chairman, ECHN Board of Trustees
Peter J. Karl, President & CEO, ECHN

ECHN℠
Eastern Connecticut Health Network

Overview: ECHN's Journey, Its Mission

Dennis G. O'Neill, M.D.
Chairman, ECHN Board of Trustees

Preparing for the Future at ECHN

Our Mission : Our Community

- Caring for & serving the community, continuing our mission & vision
  - Improving the well-being of those we serve with quality, compassionate health care
  - Preserving ECHN: its name, local institutions, services and programs
  - Developing the next generation of physicians to serve our communities
  - Striving to continuously improve quality, safety, & outcomes with recognition by Joint Commission for the services offered
- While preserving over 3,000 jobs



ECHN℠
Eastern Connecticut Health Network

Preparing for the Future at ECHN

Serving the public need

- More than our two hospitals, a network of 13 wholly owned companies, 12 joint ventures companies, dozens of facilities serving our communities healthcare needs
- For 2015:
  - 114,000 people treated at its hospitals
  - 60,000 patients under the care of community-based physicians employed by ECHN
  - 4,690 patients cared for by Visiting Nurse and Health Services of CT
  - 805 people received homemaker and companion services
  - Comprehensive behavioral health services
  - 61,000 emergency visits

ECHN℠
Eastern Connecticut Health Network

ECHN℠
Eastern Connecticut Health Network

Understanding Its Past, Preserving Its Future

Peter J. Karl
President & CEO

Impact of Healthcare Reform
(PPACA)

- More than insuring 32M more people
- Declining government payments to hospitals
- Focus on value, lowest cost with best results
- New payment systems put providers at risk
- Community focused delivery models
- Major investments required for programs, technology and facilities

ECHN℠
Eastern Connecticut Health Network

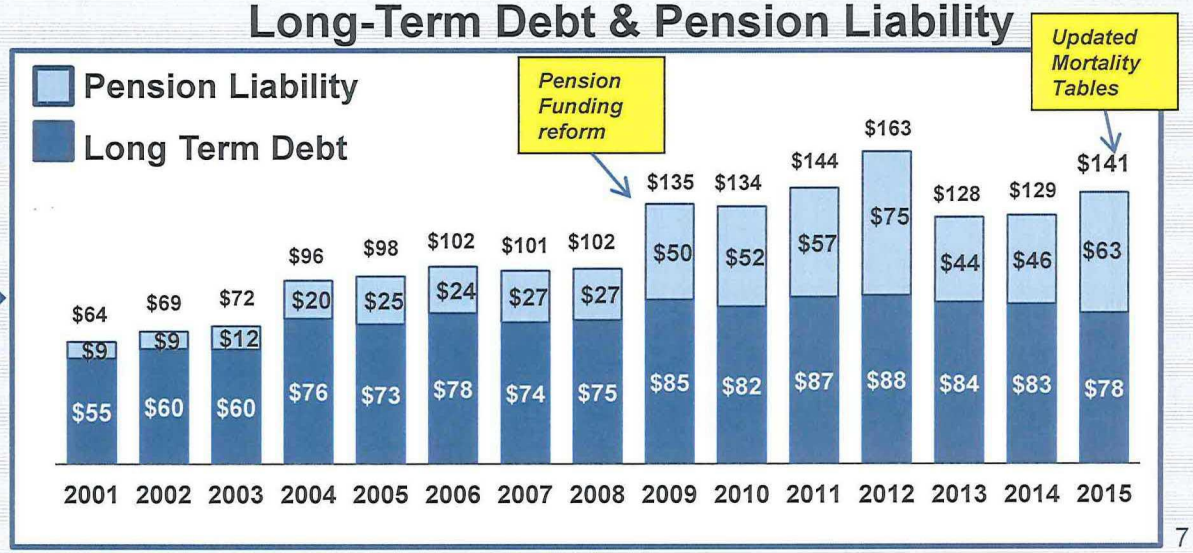
ECHN
Eastern Connecticut Health Network

Financial Challenges

Low margins and growth in debt forced ECHN to defer capital investments; our historical financial performance has left the organization with a large debt structure that cannot be mitigated through margin alone.

1. Operations contributed only $9M total over the last 15 years: Operational deficits in 2001-2004 of $23.1 million required 6 years to be overcome

2. Long term debt and pension liabilities have grown 123% ($78M) in the last 15 years– annual debt service and pension contributions now take up the lion's share of annual cash flows



ECHN
Eastern Connecticut Health Network

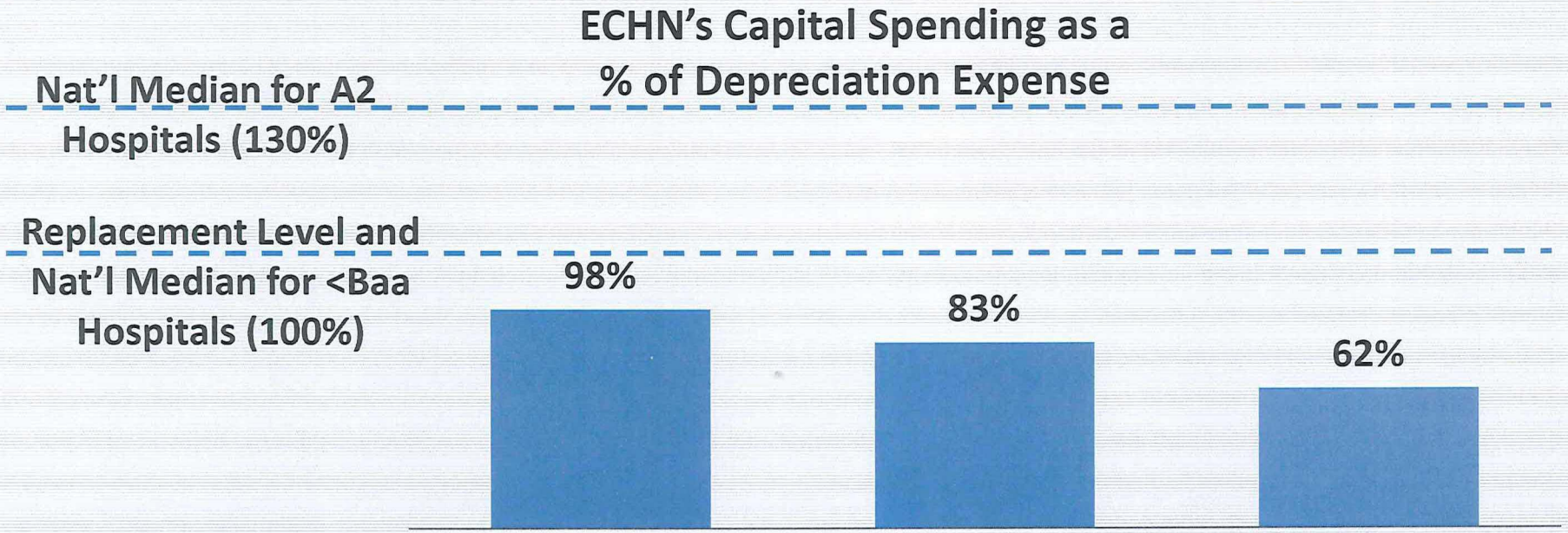
Continuing Financial Challenges
Taxes and Reduced Government Payments

	FY 2014	FY 2015	FY 2016
CT Hospital Tax	(3,914,000)	(7,960,000)	(9,942,000)
CMS Sequestration	(1,104,000)	(2,208,000)	(2,208,000)
Medicaid Inpatient Modernization Program		(1,200,000)	(1,600,000)
Low Cost Hospital Pool Eliminated			(300,000)
Medicare Wage Index		(4,825,000)	(6,525,000)
	($5,018,000)	($16,193,000)	($20,575,000)

ECHN
Eastern Connecticut Health Network

ECHN's Financial Challenges

Historically, and in the future, ECHN's ability to invest in capital is below replacement for depreciation – inherently leading to a decrease in its asset base. The age of plant for our hospitals in 2015 was 21 years.



	2013	2014	2015
Plant/Equipment Purchases	$12.1	$10.1	$7.4
Depreciation	$12.3	$12.2	$11.9

Negative Forces into the Future

-Continued payment erosion from federal government

-Declining levels of payment from state government

-Payment reforms with more financial risk

-Continued pension obligations

-Rising costs

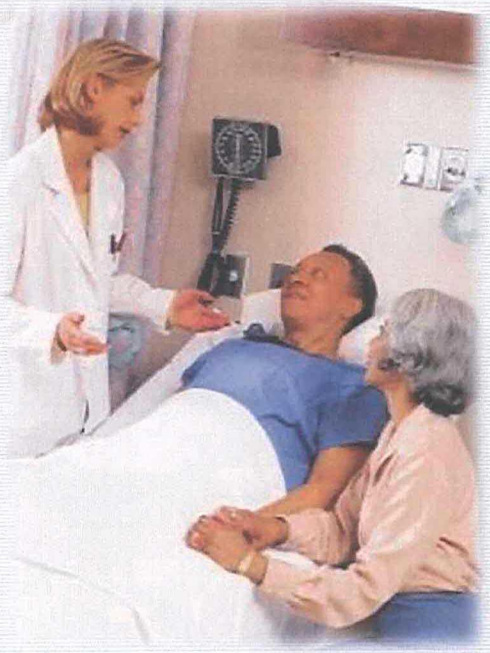
= Unsustainable results with an inability to REINVEST in ECHN

ECHN
Eastern Connecticut Health Network

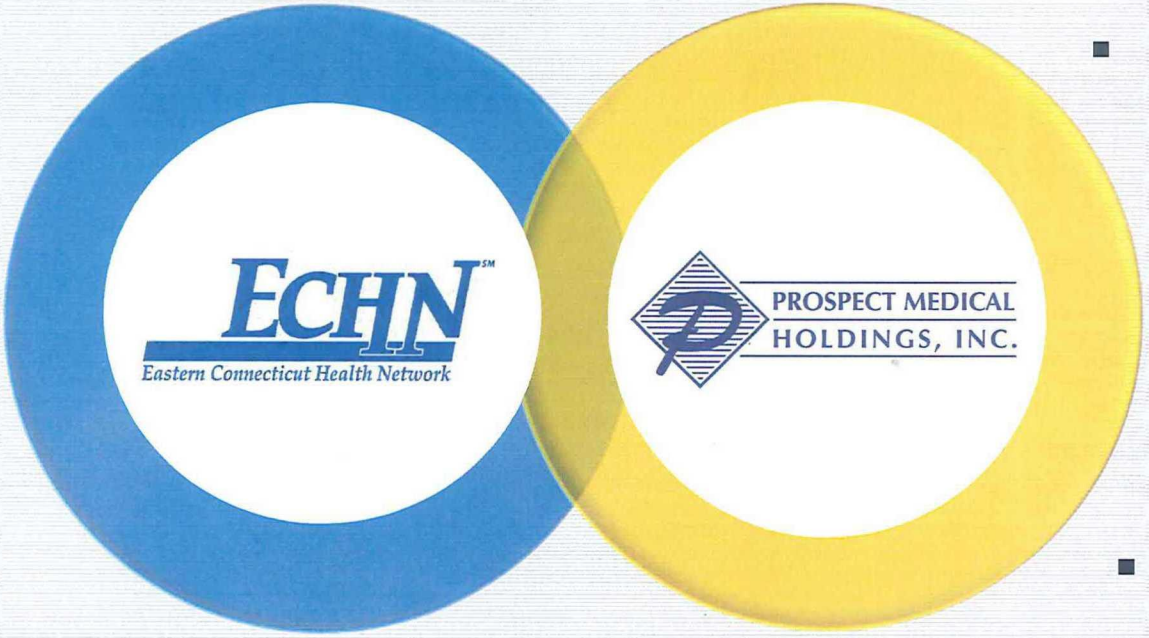
The Proposed Transaction

Prospect Medical Holdings to Buy ECHN

- **$105M** to satisfy all of ECHN's debt and liabilities
- **$75m of capital** to invest in ECHN
- Maintain Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland and Visiting Nurse & Health Services of Connecticut
- Continuation of the ECHN brand and mission
- Community advisory board
- Continued commitment to charity care, indigent care and community benefits
- Employment for all ECHN employees
- Establishment of a community foundation to oversee certain charitable funds



The combination of ECHN with Prospect Medical Holdings will secure the future of care and local access for residents



- Aligned mission, vision & values
- Strong medical staff partner
- Experienced health plan partner with extensive risk management experience
- Long history of population health management
- Resources to invest in programs, staff, facilities and technology

Together with our Medical Staff, building a sustainable, thriving network of value-based care for our communities.

ECHN℠
Eastern Connecticut Health Network

Future Quality Assurance at ECHN

Joy Dorin
Vice Chair, ECHN Board of Trustees
Chair, ECHN Transaction Committee

Due Diligence for the Transaction

- ✓ Serve the public's needs
- ✓ Positive impact on financial strength of our health care system
- ✓ Improve quality, accessibility and cost-effectiveness of health care delivery in the region, etc.
- ECHN's quality and safety efforts and achievements
  - High Reliability Organization
  - MMH and RGH, Joint Commission recognition Top Performers
- Due diligence efforts and results

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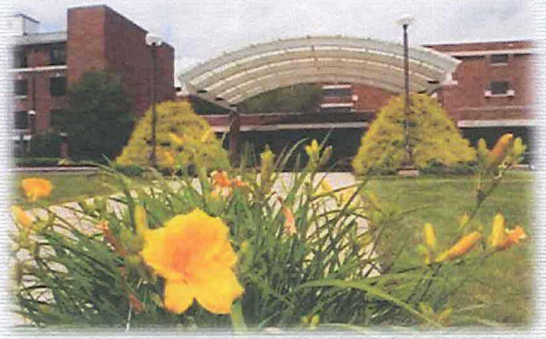
Eastern Connecticut Health Network

PROSPECT MEDICAL
Quality Service ~ Quality Care

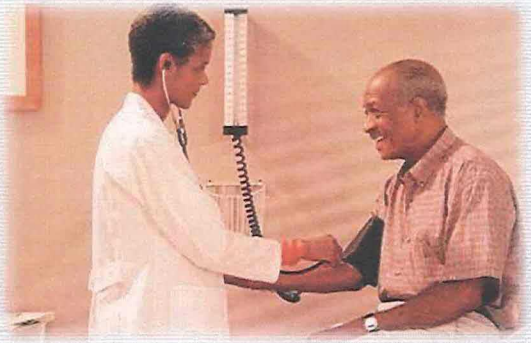
ECHN
Eastern Connecticut Health Network





Conclusion





STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

Attorney General Docket No.: 15-486-01
OHCA Docket No.: 15-32016-486
Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc. **March 28, 2016**

Supplemental Information for Question 11 and Exhibits Q11-1 and 11-2 of the Certificate of Need Related to ECHN's Charitable Funds

Eastern Connecticut Health Network, Inc. is submitting additional information related to Question 11 and Exhibits Q11-1 and 11-2 of the Certificate of Need concerning the charitable funds held by Manchester Memorial Hospital, Rockville General Hospital, ECHN Foundation, and Woodlake at Tolland. References are to Exhibit and Page numbers of the Certificate of Need.

Fund Number 11-1.1 in Exhibit Q11-2 (page 983) - Dwight W. Blish. A portion of the first page of the copy of Mr. Blish's Will dated September 6, 1923, was not included in the filing. Complete conformed copies of the Will and Codicil are provided as Attachment A.

Fund Number 11.1-30 in Exhibit Q11-1 (page 941) - Interests in the Estate of Raymond F. Damato. As stated in the original submission, Manchester Memorial Hospital is a beneficiary of an unrestricted gift from of the Estate of Raymond F. Damato. The Hospital's vested interest in the Estate has been partially distributed but will likely not be fully distributed to it prior to closing of the contemplated transaction. ECHN has considered the timing and use of the remaining distribution(s). ECHN has been working with the executors of the Estate to develop a plan for use of the gift and now contemplates using the funds to benefit the Manchester community through supporting the continued availability of physicians to serve the community and larger area and furthering medical education. Regardless of whether the remaining gift distributions are received prior to or after the closing, after the payment of all ECHN's debts, ECHN is planning to distribute the gift (or assign the right to receive it) to the University of New England College of Medicine ("UNECOM"), a 501(c)(3) organization that already provides

medical education in Manchester, to support the continued provision of medical education in Manchester, including but not limited to support for the construction and/or purchase of medical education facility space and/or equipment to be located in Manchester, medical education services to be provided within the boundaries of Manchester, and/or financial assistance to medical students and residents receiving their clinical education in Manchester. ECHN also plans to impose gift restrictions to insure that the gift may not be used out of Connecticut. ECHN plans to consult with the Office of the Attorney General in the future about the proposal for use of the gift.

Fund Number 11.1-34 in Exhibit Q11-1 (Page 943) - Stephen Goodale and Emeret Scott Risley. In addition to an endowment created under the Will, the testatrix Mary Risley Adams left her father's diploma and a 1720 clock to Rockville General Hospital. The Hospital has the clock, which is in the library of the mansion of the Hospital, and is looking for the diploma. Because these were outright gifts to the Hospital and not subject to a restriction, ECHN believes they are assets required under the APA to be transferred to PMH. If for some reason PMH does not want one or both of them, then ECHN will consider donating them to the library or the historical society.

Fund 11.1-55 in Exhibit Q11-1 (Page 951) – E. Stevens Henry. As noted in the Certificate of Need, the Hospital has received differing advice about the nature of this fund, which was received by the Hospital in 2003 upon termination of a trust. The Hospital is now evaluating how it believes the fund should be classified and in addition is investigating what the original gift value is.

Fund 11-1.66 in Exhibit Q11-1 (Page 959) – Swindells Fund. This fund contains distributions from a trust held by an outside trustee. Rockville General Hospital is not a named beneficiary of the trust, and the Hospital received its most recent distribution from the trust on October 4, 1996.

Fund 11-1.96 in Exhibit Q11-1 (Page 971) – ECHN Foundation: $10,000 One Life Charitable Gift Annuity. The Foundation has decided to ask the annuitant to accept payment of the present value of the right to receive the annuity payments in satisfaction of this agreement.

Fund 11-1.103 in Exhibit Q11-1 (Page 975) – Trust u/w Gertrude H. Rogers. The language in this trust reflects that the primary interest of the donor was to serve the health and welfare of the Manchester community. ECHN is considering ways in which this intent may continue to be furthered consistent with the structure of the trust overall.

Updated Market Values. ECHN is preparing updated values for the funds and will file them at or immediately after the public hearings.

765/2611/3442765.4

ATTACHMENT A

Complete Conformed Copy of the Will of Dwight W. Blish

MMH Hospital Dwight W Blish Fund #1402

MMH Dwight W Blish Fund #1401

BE IT KNOWN TO ALL PERSONS, THAT I, Dwight W. Blish of the Town of Manchester in the County of Hartford in the State of Connecticut being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

First: I direct that all my just debts and funeral expenses be paid by my executor hereinafter named.

Second: I give to the town of Manchester the sum of One Hundred Dollars, in trust however, to invest the sums and to use the income therefrom for the perpetual care of my burial plot in the East Cemetery in said Manchester.

Third: I give to my wife Alice M. C. Blish and to my son Hayward C. Blish all my wearing apparel, watches, jewelry, household furnishings, furniture, tools and my automobile.

Fourth: All the rest and residue of my property both real and personal and wheresoever situated I give, devise and bequeath to The Manchester Trust Company of said Manchester, in trust however, to take, hold, invest and reinvest the same and to use the income therefrom for the support and maintenance of my said wife and son or the survivor of them. In case the income from said trust fund is not sufficient for the comfortable support and maintenance of my said wife and son then I authorize said trustee to use any or all of the principal for said purpose. I direct said trustee to pay the funeral expenses of my said son from said trust fund and in the event that there should not be funds available for the funeral expenses of my said wife I direct said trustee to also pay her funeral expenses. It being my desire that my said wife and son shall always have a home of their own during their lifetime I hereby direct said trustee upon the written request of my said wife to sell the house occupied by her and my son and to purchase another home for her upon like request. Unless so requested by my said wife the house occupied by her and my son shall not be sold. I authorize and empower said trustee to sell all other real estate owned by me at the time of my death if it shall deem best. At the death of my said

wife and son I give whatever property may then remain in the hands of said trustee 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.

I APPOINT The Manchester Trust Company of the Town of Manchester, County of Hartford and State of Connecticut executor of this my Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester on the 6 day of September A. D., One Thousand, Nine Hundred and Twenty-three.

DWIGHT W. BLISH (L.S.)

Signed, sealed, published and declared by the said Dwight W. Blish as and for his Last Will and Testament, in presence of us who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 6 day of September A. D., 1923.

THOMAS K. CLARKE
RAYMOND R. BOWERS } Witnesses
WILLIAM S. HYDE

State of Connecticut }
County of Hartford } ss. Manchester, September 6, A. D., 1923

We the within named Thomas K. Clarke and Raymond R. Bowers being duly sworn, make affidavit and say: that we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his last Will and Testament in our presence on the 6 day of September A. D., 1923; and at the time of execution of said will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we

make this affidavit at the request of said testator.

THOMAS E. CLARKE

RAYMOND R. BOWERS

State of Connecticut)
) ss. Manchester September 6, A.D., 1935.
County of Hartford)

Then personally appeared before me a Notary Public duly qualified to administer oaths,

THOMAS E. CLARKE

and RAYMOND R. BOWERS

and subscribed and made oath to the truth of the foregoing affidavit.

WILLIAM G. ERWIN

Notary Public

KNOW ALL MEN BY THESE PRESENTS that I, Dwight W. Blish, of the Town of Manchester, County of Hartford, and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a codicil to my Last Will and Testament, dated September 6, 1933.

I.

I appoint The Manchester Trust Company, a Connecticut corporation located in said Manchester, Executor of this my Last Will and Testament

In all other respects I hereby ratify and confirm said Will.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester, on the 3rd day of July, A. D., One Thousand Nine Hundred and Thirty-three.

DWIGHT W. BLISH (L.S.)

Signed, sealed, published and declared by the said Dwight W. Blish as and for a codicil to his Last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 3rd day of July, A. D., 1933.

ELIN G. NIELSEN
LOUIS H. MARTH
ROBERT E. HATHAWAY
} Witnesses

State of Connecticut: ss. Manchester, July 3rd, A. D., 1933.
County of Hartford :

We the within named Elin G. Nielsen, Louis H. Marth, and Robert E. Hathaway being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil of the within named testator, and subscribed the same in his presence and at his request and in the presence of each other; that the said testator at published and declared the said instrument as and for a Codicil to h last Will and Testament in our presence on the 3rd day of July A. D. 1933; and at the time of execution of said Codicil, said testator wa

more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

ELIN G. NIELSEN

LOUIS H. MARTE

ROBERT E. HATHAWAY

State of Connecticut }
County of Hartford } ss. Manchester, July 3rd, A. D., 1933.

Then personally appeared before me a Commissioner of Superior Court, duly qualified to administer oaths.

ELIN G. NIELSEN

LOUIS H. MARTE

and ROBERT E. HATHAWAY

and subscribed and made oath to the truth of the foregoing affidavit.

HAROLD G. ALVORD
Notary Public.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

CENTERS FOR MEDICARE & MEDICAID SERVICES

Refer to: WDSC-RA

IMPORTANT NOTICE – PLEASE READ CAREFULLY

March 23, 2016

Deborah Webber, CEO
Los Angeles Community Hospital
4081 East Olympic Blvd
Los Angeles, CA 90023

CMS Certification Number (CCN): 050663

Dear Ms. Webber:

This is to inform you that based on a careful review of the findings of a revisit survey completed on February 17, 2016 by the California Department of Public Health (CDPH), the Centers for Medicare and Medicaid Services (CMS) has concluded that Los Angeles Community Hospital is still not in compliance with the applicable Conditions of Participation for a provider of hospital services in the Medicare program, established by Title XVIII of the Social Security Act.

Previously, in a letter dated January 14, 2016, you were informed that based on the findings of a November 10, 2015 complaint survey, the hospital's Medicare provider agreement could be terminated by April 13, 2016 if the facility did not come into compliance with the Medicare Conditions of Participation. Since that time, you submitted an allegation of correction, based upon which CDPH conducted the February 17, 2016 resurvey noted above. This resurvey demonstrated that the hospital remains out of compliance with the following Condition of Participation:

42 C.F.R. § 482.123 – Nursing Services
42 C.F.R. § 482.42 – Infection Control

The findings of the February 17, 2016 survey are set forth in the attached Statement of Deficiencies (Form CMS-2567). As you are aware, to participate in the Medicare program, a hospital must be in compliance with each of the applicable regulatory Conditions of Participation for hospitals at 42 C.F.R. Part 482.

Because Los Angeles Community Hospital is not in compliance with all Conditions of Participation at 42 C.F.R. Part 482, as determined by the survey completed on February 17,

2016, we must proceed with the process that could result in termination of the hospital's Medicare provider agreement. 42 C.F.R. §§ 489.53(a)(1) & (3). However, with this notice we are extending the date of termination of the hospital's Medicare provider agreement to **June 21, 2016** to provide you more time to achieve and maintain compliance. Accordingly, unless we are able to verify compliance termination is scheduled to take effect by June 21, 2016.

Importantly, termination of Los Angeles Community Hospital's provider agreement may still be avoided if by April 4, 2016 the hospital submits to the CDPH, Bakersfield District Office, credible documentation evidencing correction of all of the cited deficiencies and that the hospital is otherwise in compliance with all Conditions of Participation applicable to hospitals in the Medicare program as set forth at 42 C.F.R. Part 482. At a minimum, such submittal must include documentation detailing the actions taken that resulted in the alleged correction of each deficiency; the title or position of the person responsible for the correction; and a description of the monitoring process established to prevent recurrence of the deficiency. **Please note that mere plans of future correction or evidence of progress toward correction will not be sufficient.**

If we receive such a submittal by the close of business on April 4, 2016, **and** if we find that the submission constitutes a credible allegation of compliance, we will notify you of this finding and authorize a resurvey of Los Angeles Community Hospital.

In the event we do not receive a timely, credible allegation of compliance, or if a resurvey authorized on the basis of such an allegation shows that the hospital remains out of compliance, we will notify you that the termination action is to proceed, notify the public of the forthcoming termination, and advise you of appeal rights, in accordance with regulations at 42 C.F.R. § 489.53(d).

In the event termination does occur, there will be no payment for inpatient services rendered to Medicare beneficiaries admitted on or after the effective date. Payment for those beneficiaries in the hospital prior to the effective date will be limited to thirty (30) days. See 42 C.F.R. § 489.55.

Appeal Rights

If you do not agree with the determination to impose these actions, you may request a hearing before an administrative law judge (ALJ) of the Departmental Appeals Board in accordance with 42 C.F.R. §§ 498.40 through 498.78. A request for hearing must be filed electronically no later than sixty (60) calendar days after the date you receive this notice. 42 C.F.R. § 498.40. You should file your request for an appeal (accompanied by a copy of this letter) to the Departmental Appeals Board Electronic Filing System website (DAB E-file) at https://dab.efile.hhs.gov. Please note: All documents must be submitted in Portable Document Format ("pdf"). You are required to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing. Written request for appeals must also be filed no later than

sixty (60) calendar days from the date you receive this notice, and must be submitted to the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Ave, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A copy of the hearing request should be sent to:

Rufus Arther, Manager
Non Long Term Care Branch
Division of Survey and Certification
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Your request must identify the specific issues as well as the findings of fact and conclusions of law with which you disagree and explain your basis for contending that the findings and conclusions are incorrect. You will have an opportunity to present evidence and further argument at an in-person hearing, where you may be represented by counsel. **Completion of the administrative review process established by 42 C.F.R. Part 498 is a prerequisite to obtaining judicial review.**

Should you have any questions concerning this matter, please contact Rosanna Angeldones at 415.744.3735 or at Rosanna.Angeldones@cms.hhs.gov.

Sincerely,

Rufus Arther, Manager
Non-Long-Term-Care Branch
Division of Survey and Certification

Attachments - Form CMS-2567

cc: CDPH, Medicaid

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

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{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}		
{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}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 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}		

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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}		

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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}		

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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}		

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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}		

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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		

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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		

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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		

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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		

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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		

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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		

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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		

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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		

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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		

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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		
{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}		

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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}		

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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}		

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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}		

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

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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		

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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		
{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}	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}		

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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}		

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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}		

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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}		
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		

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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		

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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		
{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 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}		
{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}		

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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}		

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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}		

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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}		
{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}	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}		

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

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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}		

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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}		

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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}		

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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}		

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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}		

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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}		

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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}		

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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}		

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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}		

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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}		

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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}		

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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}		

COUNTY OF LOS ANGELES
Public Health

CYNTHIA A. HARDING, M.P.H.
Interim Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

ANGELO J. BELLOMO, REHS, QEP
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TERRI S. WILLIAMS, REHS
Acting Director of Environmental Health

5050 Commerce Drive
Baldwin Park, California 91706
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www.publichealth.lacounty.gov

March 17, 2016

Dear Administrator:

FACILITY: Southern California Hospital At Hollywood
COMPLAINT NUMBER: CA00401717

Enclosed is CMS 2567 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 fifteen (15) calendar days, 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 fifteen (15) calendar days, 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 Eric Stone, Program Manager (626) 312-1134.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Belinda Rancho for
Eric Stone, Program Manager
Acute and Ancillary Unit
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

Enclosure (CMS 2567)

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000064	A. BUILDING: _____ B. WING _____	C 03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLY	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(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) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the Department of Public Health during a complaint investigation. Intake Number: CA00401717 - substantiated Inspection was limited to the complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: 14041	E 000		
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to implement its Complaints and Grievances policy and procedure for Patient 1. Finding: On March 8, 2016, the evaluator completed the investigation into an alleged abuse of Patient 1 by Staff 1. During an interview at 1 p.m., the House Supervisor (Admin 1) stated that she recalled the incident in question. Admin 1 stated that she talked to Staff 1 and Staff 1 confirmed that she did remove a snack/candy from Patient 1 without his consent. Admin 1 stated that Staff 1 felt that	E 264		

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
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E 264	Continued From page 1 it was part of her job to remove the candy from the patient because of the patient's high glucose level reading, hyperglycemia. Admin 1 stated that another staff (II) was responsible for conducting the abuse investigation but Staff II no longer works at the facility. The evaluator requested all the documentation regarding the abuse / neglect investigation for review. At the time of the survey and investigation the facility had no documentation available and could not show that any investigation was conducted or if the patient was ever notified. Based on a review of the alleged allegation, the patient alleged that on 6/8/2014 at 2:30 p.m., Staff 1 checked his sugar level and saw that the level was very high. Staff 1 asked the patient what did he have in his hand? Staff 1 started to frisk and search the patient and it got physical. According to the complaint, the nurse started to get vocal and called the patient psychotic. The patient reported the incident and he alleged nothing happen. The patient complained that he was scared and felt unsafe with Staff 1. A review of the facility's Complaints and Grievances policy and procedure indicated: Complaints are to be documented by the person taking the complaint; if the issue is unresolved, he/she assist the patient/family to resolve the issue. The facility had no record of any compliance to the policy and procedure regarding a complaint received by the staff or if the patient was notified regarding the investigation.	E 264		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 264	Continued From page 2 Based on a review of the Staff 1's personnel file, she voluntarily resigned on 7/15/2015.	E 264		