COPY

TriStar Maury Regional Behavioral Healthcare

CN1610-036

DSG Development Support Group

October 14, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application Submittal
TriStar Maury Regional Behavioral Healthcare
Columbia, Maury County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. for a 60-bed Mental Health Hospital in Columbia, to be joint-ventured between affiliates of Maury Regional Hospital and HCA. The affidavit and filing fee are enclosed.

I am the contact person for this project. Jerry Taylor is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

TRISTAR MAURY REGIONAL BEHAVIORAL HEALTHCARE

CERTIFICATE OF NEED APPLICATION FOR A 60-BED BEHAVIORAL HEALTH HOSPITAL TO SERVE ADOLESCENTS AND ADULTS

Columbia, Maury County

Filed October 14, 2016

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

TriStar Maury Regional Behavioral Healthcare
Name

East side of North James Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike	Maury
Street or Route	*County*

Columbia	TN	38401
City	*State*	*Zip Code*

none
Website Address

2. Contact Person Available for Responses to Questions

John Wellborn	Consultant
Name	*Title*

Development Support Group	jwdsg@comcast.net
Company Name	*E-Mail Address*

4219 Hillsboro Road, Suite 210	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*

CON Consultant	615-665-2022	615-665-2042
Association With Owner	*Phone Number*	*Fax Number*

NOTE: **Section A is intended to give the applicant an opportunity to describe the project. Section B addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures. Please answer all questions on 8.5" X 11" white paper, clearly typed and spaced, single-sided, in order and sequentially numbered. In answering, please type the question and the response. All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed and signed notarized affidavit.**

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total, explaining each numbered point.

(1) Description (Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant.)

- The project is to establish a 60-bed mental health hospital in Columbia (Maury County), to introduce acute psychiatric and substance abuse care for adolescent and adult patients ages 13-69, who live in a 10-county rural area south and southwest of Nashville.

- The project is a joint venture to be developed by Maury Regional Hospital and HCA, who have been working together for two years on a plan to introduce these services in the area. The name of the hospital will be TriStar Maury Regional Behavioral Healthcare.

- It will have 42 adult beds and 18 adolescent beds, and will be licensed by the Department of Mental Health and Developmental Disabilities as a 60-bed mental health hospital.

- A detailed physical description of the project and a summary of its clinical programs are provided in Attachment Section A-3A(1).

(2) Ownership Structure

- The CON applicant, owner, and licensee for this hospital will be TriStar Maury Behavioral Healthcare, LLC. At the time of this application, that LLC's sole member is Maury County Behavioral Health, LLC, whose sole member is HTI Hospital Holdings, Inc., which is wholly owned by HCA Holdings, Inc. through wholly-owned subsidiaries. However, it is intended that a 49% membership interest in that LLC will be acquired in the near future by Maury Regional Behavioral Healthcare, LLC, whose sole member is Maury Regional Hospital, a 501 (C)(3) non-profit entity. At that time, a 51% membership interest in this applicant LLC will be retained by

the HCA entities. For further details please see the organizational charts of Maury Regional Hospital and of HCA Holdings, Inc. in Attachment Section A-4A.

- The applicant has also established a new management company to manage the facility; its name is Maury County Behavioral Health, LLC. It is wholly owned by HCA Holdings, Inc., through wholly-owned subsidiaries. It will have a management contract with the CON applicant to manage the facility.

- Other than wholly owned affiliates of Maury Regional Hospital and HCA Holdings, Inc., no individual or legal entity owns, or is intended to own, directly or indirectly, any interests in the applicant LLC or the new management company for the project.

- Moreover, if a definitive agreement cannot be concluded between the HCA affiliate and the Maury Regional affiliate, to jointly own and implement this project, and the joint venture is not finalized, the CON will be surrendered by the applicant.

- An organization chart of the applicant's current ownership is in Attachment Section A-4A. Also included is a chart of Maury Regional, showing this proposed project's relationship to the Maury Regional organization.

(3) Service area

- The location of the project is in Columbia, Tennessee, the largest population center southwest of greater Nashville, in rural southwest Middle Tennessee.

- From this location, the project will serve a primary service area consisting of ten contiguous counties surrounding Columbia. They are Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, and Wayne Counties.

- The largest cities in these counties are significantly closer to the project site in Columbia, than they are to alternative providers of similar services outside the service area, in Nashville, Franklin, and Murfreesboro.

(4) Existing similar service providers

- The service area contains no provider of acute inpatient behavioral care for both adolescents (ages 13-17) and adults (ages 18-69), which are the focus of this project.

- The area contains three small hospitals with inpatient geropsychiatric units for the elderly. These are Hillside Hospital in Pulaski/Giles County (14 beds); Lincoln Medical Center in Fayetteville/Lincoln County (10 beds); and Perry Community Hospital in Linden/Perry County (14 beds).

- The service area also includes a 16-bed mental health hospital located in a facility with multiple inpatient and outpatient services--THM (Tennessee Health Management, Inc). However, its most recent Joint Annual Report indicates that in 2014 it served almost entirely geropsychiatric patients.

(5) Project cost

- The estimated project cost is $24,033,431.

(6) Funding

- The project cost will be funded in cash by the two owners of the applicant in proportion to their ownership interests. Maury Regional Hospital will contribute 49%, or approximately $11,776,381. HCA will contribute 51%, or approximately $12,257,050.

(7) Financial feasibility, including when the proposal will realize a positive financial margin; and

- The proposed hospital is projected to operate with a positive financial margin from its second year of operation onward (CY2020 and beyond).

(8) Staffing

- The applicant projects having a total of 27 clinical staff and 3 non-clinical staff (in addition to a Medical Director) in the facility's first year of operation.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B of this application. Please summarize, in one page or less, each of the criteria.

(1) Need

a. The project is needed to provide reasonable accessibility to acute inpatient mental healthcare. This ten-county rural service area has a wide array of acute care services--yet has no significant acute inpatient care for adolescents (ages 13-17) and non-geriatric adults (ages 18-69) who need behavioral healthcare. This is a serious deficiency. Currently, such area patients must seek admission to mental health hospitals in Davidson, Williamson, and Rutherford Counties, which are very long drives from their homes--averaging 1 to 1.5 hours' drive times between service area population centers and those hospitals. This project in Columbia will reduce one-way average drive times to only 45 minutes, along local highways more familiar to local residents. And for residents of the service area counties that comprise 85% of the CY2020 target population, the average drive time will average only approximately 36 minutes.

b. Placing a mental health hospital within the service area also assures that appropriate post-discharge care will be reasonably accessible to these ages of patients for the first time.

c. Need for the project is supported by the State Health Plan. The State Health Plan's criteria for CON review of Psychiatric Inpatient Services, which are considered very conservative by many providers of psychiatric care today, contain a bed need methodology indicating that between 60.2 to 66.3 beds are needed for the service area, for the care of adolescents and adults 13-69 years of age. While the area contains four small hospitals with licensed "adult" beds in very small units, these are used almost exclusively for geropsychiatric services to patients 65 years and older.

d. Without this resource, service area hospitals' Emergency Departments (ED) will continue to receive hundreds of patients annually, who cannot be adequately cared for in general

hospitals and who must be retained in the ED at significant expense until transferred to facilities out of the area. Being simply held in an ED for a mental health disorder is not good care for the patient; and it consumes staff resources and room ED space that hard-pressed rural hospitals can ill afford.

(2) Economic Feasibility

a. The TriStar Maury Regional Behavioral Healthcare facility has funding assured by large healthcare organizations with ample cash resources.

b. The hospital is also projected to operate at financially feasible levels. In Year Two it is projecting positive cash flow and a positive operating margin.

(3) Appropriate Quality Standards

The hospital will be licensed by the Tennessee Department of Mental Health and Developmental Disabilities, and will be accredited by the Joint Commission. It will meet or exceed all relevant quality standards of those organizations, and of the parties themselves, who have robust quality improvement programs in all of their hospital facilities, and are recognized by national rating organizations as having high quality services. Please see detailed quality discussions in the response on Quality at the end of Section B of this application.

(4) Orderly Development of adequate and effective health care

a. The project has been carefully considered and planned. For approximately two years, Maury Regional Hospital and HCA have been in discussions about how best to bring this type of care into the service area. Consideration was given to converting existing hospital beds to inpatient behavioral healthcare units; but due to the size of area demand, and to the difficulties of accommodating large behavioral care units and programs in existing spaces and patient populations, the parties decided that it would be preferable to pursue a co-owned, free-standing facility that could provide ample space for inpatient and outpatient programs of care in a more efficient and specialized setting. At one point, consideration was given to acquiring and

converting a local, soon-to-be-vacated skilled nursing facility; but that was not considered optimal because of the extensive renovation and design compromises that would entail, and because of the site's proximity to a church daycare program.

b. There is a general regional need for additional psychiatric beds even in Davidson and Rutherford Counties, to which some area patients out-migrate for mental healthcare. Expansions of inpatient behavioral bed capacity have been proposed and will continue to be proposed in these urban counties, indicating a need for the Columbia service area to invest in facilities that will retain its own patients for high-quality care more convenient to their homes.

c. The service area has long had acute psychiatric care for the elderly, in hospital units in four local hospitals. This having been deemed appropriate, it is logical and orderly to extend the area's scope of local inpatient behavioral care to the larger populations of adolescents and non-geriatric adults who need it.

d. The most appropriate providers to introduce this type of care in the service area are the area's acknowledged acute care service leader, Maury Regional Hospital, and one of Middle Tennessee's most experienced behavioral healthcare providers, HCA. No other hospital in this area of almost a quarter-million persons has the clinical scope and areawide support to undertake a project of this magnitude. No other Tennessee provider has more experience than HCA in designing and operating mental health beds and services; HCA is the third largest provider of acute mental healthcare services in the United States and has a corporate division dedicated to the operation of behavioral health programs in HCA facilities in Middle Tennessee and across the United States.

C. Consent Calendar Justification

If consent calendar is requested, please provide the rationale for an expedited review. A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

N/A

SECTION A (CONTINUED): PROJECT DETAILS

4.A. Owner of the Facility, Agency, or Institution

TriStar Maury Behavioral Healthcare, LLC c/o TriStar Health	615-886-4900
Name	*Phone Number*

100 Winners Circle, First Floor	Williamson
Street or Route	*County*

Brentwood	TN	37027
City	*State*	*Zip Code*

B. Type of Ownership or Control (Check One)

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	X
D. Corporation (For-Profit)		I. Other (Specify):	
E. Corporation (Not-for-Profit)			

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the TN Secretary of State's website hpps://tnbear.tn.gov/Ecommerce/FilingSearch.aspx.

See Attachment Section A-4A.

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

The CON applicant, owner, and licensee for this hospital will be TriStar Maury Behavioral Healthcare, LLC. At the time of this application, that LLC's sole member is Maury County Behavioral Health, LLC, whose sole member is HTI Hospital Holdings, Inc., which is wholly owned by HCA Holdings, Inc. through wholly-owned subsidiaries. As evidenced by an executed Letter of Intent (see Attachments), it is intended that a 49% membership interest in that LLC will be acquired in the near future by Maury Regional Behavioral Healthcare, LLC, whose sole member is Maury Regional Hospital, a 501 (C)(3) non-profit entity. At that time, a 51%

membership interest in this applicant LLC will be retained by the HCA entity. For illustration and additional details about ownership, please see the organizational charts of Maury Regional Hospital and of HCA, Inc. in Attachment Section A-4A.

Once the joint ownership arrangement is finalized, and the hospital is under development, the applicant will engage a management company to manage the facility; it will be Maury County Behavioral Health, LLC, the current sole member of the applicant LLC. As described above, that LLC is wholly owned by HCA Hospital Holdings, Inc., through wholly-owned subsidiaries. It will have a formal management contract with the CON applicant to manage the facility. It also owns HCA's membership interest in the applicant entity.

Other than wholly owned affiliates of Maury Regional Hospital and HCA, Inc., no individual or legal entity owns, or is intended to own, directly or indirectly, any interests in the applicant LLC or the new management company for the project.

Moreover, if a definitive agreement cannot be concluded between the HCA affiliate and the Maury Regional affiliate, to jointly own and implement this project, and the joint venture is not finalized, project implementation will not begin; and the CON will be surrendered by the applicant.

5A. Name of Management/Operating Entity (If Applicable)

Maury County Behavioral Health, LLC c/o TriStar Health
Name

100 Winners Circle, First Floor	Williamson
Street or Route	*County*

Brentwood	TN	37027
City	*State*	*Zip Code*

tristarhealth.com
Website Address

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.

See Attachment Section A-5A.

6A. Legal Interest in the Site of the Institution (Check One)

A. Ownership		D. Option to Lease	
B. Option to Purchase	X	E. Other (Specify):	
C. Lease of ____ Years			

Check appropriate line above: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

See Attachment Section A-6A.

6B. Attach a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site, on an 8.5" X 11 sheet of white paper, single-sided. Do not submit blueprints. Simple line drawings should be submitted and need not be drawn to scale.

(1) Plot Plan must include:

a. Size of site (in acres);
b. Location of structure on the site;
c. Location of the proposed construction/renovation; and
d. Names of streets, roads, or highways that cross or border the site.

See Attachment Section A-6B-(1).

(2) Attach a floor plan drawing for the facility, which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8.5" X 11" sheet of paper or as many as necessary to illustrate the floor plan.

See Attachment Section A-6B-(2). The private and semi-private sizes of the patient rooms are indicated by the placement of one or two beds in each room in the drawing. All other clinical and support areas are clearly labeled.

(3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

The facility is located on North James Campbell Boulevard, a well-known major street in Columbia, on the northwest side of downtown Columbia.

Columbia is the largest hub of retail services, education and healthcare services in Middle Tennessee southwest of Nashville. Residents of the project service area have good access to the project site via multiple radial highway networks: Fayetteville by US 64, I-65, and US 412; Lewisburg by US 431 and US 42; Pulaski by US 31; Lawrenceburg by US 43; Linden and Hohenwald by US 412; Waynesboro by US 64 and US 43; Centerville by SR 50; and Lynchburg by SR 50 and US 431.

Table A-6B-(3) on the following page is a drive time table comparing average drive times between service area cities and this project, and between service area cities and the closest non-geriatric adult and adolescent inpatient mental healthcare providers that service area residents currently use outside the area.

This project will provide significantly increased accessibility to care for area residents. With only one negligible exception, every principal service area city is closer in drive time to this project in Columbia, than to any existing inpatient behavioral care provider. (The single exception is that the drive time from Lynchburg to Rolling Hills Hospital in Franklin is one minute shorter than the drive time to the Columbia project site.)

The round-trip drive times between all ten service area population centers and the proposed project average 90 minutes, compared to 131-188 minutes drive time to existing out-of-area providers. And the average of round-trip drive times from the six service area cities in counties comprising approximately 78% of the area population is only 64 minutes. Therefore, this project will significantly improve drive time accessibility for family members visiting inpatients who average staying more than a week in the hospital. Any region that is served by a sophisticated hospital like Maury Regional Hospital should have within its borders an inpatient resource for troubled adolescents and non-geriatric adults who need behavioral healthcare intervention in a controlled environment.

Table A-6B-(3): TriStar Maury Regional Behavioral Healthcare
Service Area Accessibility To The Project and To Closest Alternative Providers of
Both Adolescent and Adult Acute Behavioral Care (All Are Outside the Project's Primary Service Area)

Service Area County and Principal City		To Proposed Project in Maury County		To Rolling Hills Hospital in Williamson County		To Trustpoint Hospital in Rutherford County		To Centennnial Medical Center in Davidson County		To Vanderbilt Psychiatric Hospital in Davidson County		To Skyline Madison Medical Center in Davidson County	
County	***Principal City***	**Miles**	**Minutes Drive Time**	**Miles**	**Minutes Drive Time**	**Miles**	**Minutes Drive Time**	**Miles**	**Minutes Drive Time**	**Miles**	**Minutes Drive Time**	**Miles**	**Minutes Drive Time**
Giles	Pulaski	32.0	43	60.3	69	75.7	71	74.5	73	73.3	75	86.2	87
Hickman	Centerville	28.3	34	54.5	59	74.4	75	58.3	67	61.5	73	70.8	80
Lawrence	Lawrenceburg	35.3	39	63.8	70	83.9	87	82.7	89	81.5	91	94.4	106
Lewis	Hohenwald	32.4	37	60.9	68	81.0	84	79.8	87	78.6	88	91.5	102
Lincoln	Fayetteville	48.2	63	70.9	66	54.9	74	89.8	85	88.6	87	102	101
Marshall	Lewisburg	22.9	34	39.2	40	59.3	57	58.2	60	57.0	62	69.9	72
Maury	Columbia	2.7	5	27.7	31	47.8	48	46.6	50	45.1	51	58.4	62
Moore	Lynchburg	57.0	75	55.9	74	43.8	61	74.6	90	74.3	92	83.6	101
Perry	Linden	51.5	62	93.7	90	114.0	107	85.8	88	89.0	99	98.3	103
Wayne	Waynesboro	53.1	57	81.5	87	102.0	105	100.0	108	99.2	108	112.0	126
Average 1-Way Drive Times			***45***		***65***		***77***		***80***		***83***		***94***
Average RT Drive Times			***90***		***130***		***154***		***160***		***166***		***188***

Source: Google Maps, 10-11-16 at 1:30 PM
Note: Drive Times 1-way are rounded; RT drive times are 2X the 1-way rounded time.

ADDRESSES OF MENTAL HEALTH ACUTE CARE PROVIDERS
Project:North James Campbell Boulevard at Old Willliamsport Pike, Columbia 38401
Rolling Hills: 2014 Quail Hollow Circle, Franklin 37067
Trustpoint: 1009 North Thompson Lane, Murfreesboro 37219
Centennial: 2300 Patterson Street, Nashville 37203
Vanderbilt: 1211 Medical Center Drive, Nashville 37232
TriStar Madison: 500 Hospital Drive, Madison 37115

Designates longer drive time than to the proposed project.

7. Type of Institution (Check as appropriate—more than 1 may apply)

A. Hospital (Specify):		H. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		I. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		J. Rehabilitation Facility	
D. Home Health Agency		K. Residential Hospice	
E. Hospice		L. Non-Residential Substitution-Based Treatment Center for Opiate Addiction	
F. Mental Health Hospital	X	M. Other (Specify):	
G. Intellectual Disability Institutional Habilitation Facility ICFF/IID			

8. Purpose of Review (Check as appropriate—more than 1 may apply)

A. New Institution	X	F. Change in Bed Complement *Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*	
B. Modifying an ASTC with limitation still required per CON		G. Satellite Emergency Department	
C. Addition of MRI Unit		H. Change of Location	
D. Pediatric MRI		I. Other (Specify):	
E. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4): acute adult and adolescent behavioral health care	x		

9. Medicaid/TennCare, Medicare Participation

MCO Contracts (Check all that apply): *The applicant will seek contracts with all these.*
____Amerigroup ____United Healthcare Community Plan _____BlueCare _____TennCare Select
Medicare Provider Number: To be requested
Medicaid Provider Number: To be requested
Certification Type: Mental Health Hospital
If a new facility, will certification be sought for Medicare or for Medicaid/TennCare?
Medicare Yes_X_ No___ N/A__
Medicaid/TennCare Yes__X_No___N/A__

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.)

	Beds Currently Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempt	TOTAL Beds at Completion
1. Medical						
2. Surgical						
3. ICU/CCU						
4. Obstetrical						
5. NICU						
6. Pediatric						
7. Adult Psychiatric			42			42
8. Geriatric Psychiatric						
9. Child/Adolescent Psychiatric			18			18
10. Rehabilitation						
11. Adult Chemical Dependency						
12. Child/Adolescent Chemical Dependency						
13. Long-Term Care Hospital						
14. Swing Beds						
15. Nursing Home SNF (Medicare Only)						
16. Nursing Home NF (Medicaid Only)						
17. Nursing Home SNF/NF (dually certified MCare/Maid)						
18. Nursing Home-Licensed (Noncertified)						
19. ICF/IID						
20. Residential Hospice						
TOTAL	**N/A**	**N/A**	**60**	**N/A**	**N/A**	**60**

** Beds approved but not yet in service* *** Beds exempted under 10%/3 yrs provision*

B. Describe the reasons for change in bed allocations and describe the impact the bed changes will have on the applicant facility's existing services.

N/A

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete the chart below.

N/A

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

N/A

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart for TriStar Maury Regional Behavioral Healthcare

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Administrative						7,025	7,025
Building Support						3,000	3,000
Dietary						3,900	3,900
Inpatient Nursing Units						17,815	17,815
Outpatient Therapy						3,455	3,455
Pharmacy						360	360
Public Spaces						1,275	1,275
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
Unit/Dept GSF Subtotal		0				36,830	36,830
Other GSF Subtotal						15,170	15,170
Total GSF		0				52,000	52,000
Total Cost*						$14,300,000.00	$14,300,000.00
**Cost Per Square Foot							$275.00
Cost per Square Foot is Within Which Range? (For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)					___ Below 1st Quartile	___ Below 1st Quartile	___ Below 1st Quartile
					___ Between 1st and 2nd Quartile	___ Between 1st and 2nd Quartile	__X_ Between 1st and 2nd Quartile
					___ Between 2nd and 3rd Quartile	___ Between 2nd and 3rd Quartile	___ Between 2nd and 3rd Quartile
					___ Above 3rd Quartile	___ Above 3rd Quartile	___ Above 3rd Quartile

** The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.*

*** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.*

13. MRI, PET, and/or LINEAR ACCELERATOR

Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding an MRI scanner in counties with population less than 250,000, or is initiating pediatric MRI in counties with population greater than 250,000, and/or describe the acquisition of any Positron Emission Tomography (PET) unit or Linear Accelerator unit if initiating the service by responding to the following:

A. Complete the Chart below for acquired equipment. **N/A**

LINEAR ACCELERATOR	
Mev:	Total Cost*: $
Types: (indicate one)	By Purchase? __
__ SRS	By Lease? __
__ IMRT	
__ IGRT	Expected Useful Life (yrs): __
__ Other :	New? __
	Refurbished? __
	If not new, how old (Yrs)? __

MRI	
Tesla:	Total Cost*: $
Magnet: (indicate one)	By Purchase? __
__ Breast	By Lease? __
__ Extremity?	
__ Open?	Expected Useful Life (yrs): __
__ Short Bore?	New? __
__ Other -- _____	Refurbished? __
	If not new, how old (Yrs)? __

PET	
PET Only? __	Total Cost*: $
	By Purchase? __
PET/CT? __	By Lease? __
PET/MRI? __	Expected Useful Life (yrs): __
	New? __
	Refurbished? __
	If not new, how old (Yrs)? __

**As defined by Agency Rule 0720-9-.01(13)*

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

N/A

C. Compare the lease cost of the equipment to its fair market value. Note: Per Agency rule, the higher cost must be identified in the project cost chart.

N/A

D. Schedule of Operations: **N/A**

Location	Days of Operation (Sun-Sat)	Hours of Operation
Fixed Site (Applicant)		
Mobile Locations		
Applicant		
Name of other location		
Name of other location		

E. Identify the clinical applications to be provided, that apply to the project.

N/A

F. If the equipment has been approved by the FDA within the past five years, provide documentation of the same.

N/A

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

APPLICANT'S STATEMENT OF THE NEED FOR THE PROJECT

The project is needed to provide reasonable accessibility to acute inpatient mental healthcare. This ten-county rural service area has a wide array of acute care services--yet has no acute inpatient care for adolescents (ages 13-17) and non-geriatric adults (ages 18-69) who need behavioral healthcare.

This is a serious deficiency. In CY2015, an estimated 2,049 area residents left the area to seek admission to mental health hospitals in Davidson, Williamson, and Rutherford Counties, which are very long drives from their homes. The applicant projects that this number will increase 10% to 2,254 patients by CY2019. One-way drive times average 1 to 1.5 hours' drive times between service area population centers and those hospitals. This project in Columbia will reduce one-way average drive times to only 45 minutes, along local highways more familiar to local residents. And for residents of the service area counties that comprise 85% of the CY2020 target population, the average drive time will average only approximately 36 minutes. Because of these advantages, the applicant expects to have 1,352 adult and adolescent admissions to this local facility in CY2019. That equates to 60% of the projected area demand for patients of all ages.

Placing a mental health hospital within the service area also assures that appropriate post-discharge and outpatient care will be reasonably accessible to these patients for the first time.

Need for the project is supported by the Guidelines for Growth for Psychiatric Inpatient Services, as described in the next section of this application. Their criteria for CON review of Psychiatric Inpatient Services (which are considered too conservative by many providers of psychiatric care today), contain a bed need methodology indicating that between 60.2 to 66.3 more beds are needed in the service area, for the care of adolescents and adults 13-69 years of age. There are no such beds in this project's service area at the present time.

Without this proposed resource, service area hospitals' Emergency Departments (ED) will continue to receive hundreds of patients annually, who cannot be adequately cared for in general hospitals and who must be retained in the ED at significant expense until transferred to facilities out of the area. Being simply held in an ED for a mental health disorder is not good care for the patient; and it consumes staff resources and room ED space that hard-pressed rural hospitals can ill afford.

QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the THSDA or found on the agency's website at http://tjn.gov/hsda/article/hsda-criteria-and-standards.

GUIDELINES FOR GROWTH
CERTIFICATE OF NEED STANDARDS AND CRITERIA
FOR
PSYCHIATRIC INPATIENT SERVICES

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in the Joint Annual Reports).

2. For adult persons, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

3. For child inpatients under age 13, and if adolescent program the age group of 13-17 should be used.

4. These estimates for total need should be adjusted by the existent staffed beds operating in the area, as counted by the Department of Health in the Joint Annual Report.

Complies. Table B-Need-4A(2) in this application shows several population cohorts compiled from projections of the Tennessee Department of Health. This project will serve primarily adolescents and adults, ages 13-69. The applicant does not plan to offer a formal geropsychiatric unit or program because four "adult" programs limited almost entirely to geropsychiatric patients already exist in service area hospitals, and are underutilized. The applicant's adult program will admit some adults ages 65 through 69--but its focus will not be on the 65+ population.

The Guidelines above state a planning standard of 30 beds per 100,000 population, making no distinctions between use rates by age. The 30-bed standard is to be applied to children age 0-13, to adolescents age 13-17, and to adults age 18 and older--again, making no distinction between geriatric and non-geriatric adults. However, this project will not serve all

adults; it serves adolescents and adults up to age 69--leaving the geriatric population to be served by the four existing geropsychiatric programs in area hospitals. The Guidelines should be applied taking that into account.

To reasonably apply the bed need planning Guideline to this specific project, the applicant has projected bed need by three separate age cohorts in Table B-Need-A1 below. The population projections are from the current Tennessee Department of Health population projections. Population estimates and projections by county, service area, and the target cohort of 13-69 years are shown in Table B-Need-4A(2) in a later section of this application.

Table B-Need-A1: Service Area Behavioral Acute Care Bed Need CY2020 Applying Guidelines for Growth Planning Standard

Age Cohort Used	*Ages 13-69*	*Ages 13-64*	*Ages 65 +*
Service Area Population 2020	221,097	200,672	63,191
Bed Need @ 30 beds / 100,000	66.3	60.2	19.0
Behavioral Beds Available *	0*	0*	54*
Net Bed Need (Surplus)	66.3	60.2	(-35)

** All 54 existing beds are "adult" from a licensure standpoint. They are at Hillside Hospital (14), Lincoln Medical Center (10); Perry Community Hospital (14); and THM (16). However, from a health planning standpoint they are available almost exclusively to geropsychiatric patients.*

From the applicant's perspective, the Guideline when properly applied indicates a need for 66.3 acute behavioral beds in the service area, because the area has no hospital beds at all that are used to serve any significant numbers of adolescents and non-geriatric adults. When applied to the more restrictive age cohort of 13-64 years of age, the Guideline still shows a need for 60.2 acute behavioral beds. The Guideline also indicates that there are more geriatric beds in the area than are needed for the elderly 65+ population; and this may be one factor in the 56.1% collective occupancy reported by the area's four acute geropsychiatric care programs.

In conclusion, reasonable application of the Guideline planning standard to the populations served by this project, taking into account the actual availability of existing beds for non-geriatric patients, indicates a need for the proposed 60-bed facility.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity of the Community Service Agency.

The ten-county service area is accessible to the project site within a reasonable drive time, as shown below. Approximately 85% of the project's target population live in Maury and five other counties, which have an average drive time to the project of approximately 36 minutes.

The area contains sufficient population to support the proposed mental health hospital. There are no facilities in the area that offer psychiatric inpatient care to adolescents, or to non-geriatric adults.

Table B-Need-B1: Mileage and Drive Times Between Major Communities in the Primary Service Area and the Project Site (N. James Campbell Boulevard @ Old Williamsport Pike)

Principal Community	County	% of Target Population CY2020	Distance in Miles	Drive Time in Minutes
Pulaski	Giles*	9.5%	32.0	43 min.
Centerville	Hickman*	9.1%	28.3	34 min.
Lawrenceburg	Lawrence*	13.9%	35.3	39 min.
Hohenwald	Lewis	4.2%	32.4	37 min.
Fayetteville	Lincoln*	11.3%	48.2	63 min.
Lewisburg	Marshall*	11.3%	22.9	34 min.
Columbia	Maury*	29.9%	2.7	5 min.
Lynchburg	Moore	2.3%	57.0	75 min.
Linden	Perry	2.6%	51.5	62 min.
Waynesboro	Wayne	6.0%	53.1	57 min.

Source: Google Maps, 10-11-16 at 1:30 pm.
** Six counties comprising 85% of target population. Average drive time of 36 minutes.*

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

Complies. The project is a joint effort by two leading acute care providers in Middle Tennessee. One brings to the project deep national and regional expertise in psychiatric care and inpatient facility management. The other is a hospital that is nationally recognized for its quality

of care, and is the recognized leader in acute care in the rural areas that this project will serve. Both operate facilities in Middle Tennessee that are highly accessible to the groups of patients listed above. The proposed facility will provide involuntary hospitalization in cooperation with the court systems of the service area.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

Complies. The State of Tennessee has reduced its financial support of inpatient psychiatric facilities in recent years. As public programs have closed, need for new providers of this care have intensified due to unavailability of city, county, and regional facilities adequate for these types of conditions.

In addition, page 5 of the State Guidelines for Growth take positions that are supported by this project. They support directing delivery of services to the most medically appropriate and cost-effective settings, which this acute care service will offer, and which no other provider in the service area offers. The Guidelines also recommend that preference be given to patient accessibility and availability, which this project will improve. Currently hundreds of patients are having to leave the area to travel to Nashville and other locations for adolescent and adult mental healthcare in an acute care setting.

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

All or parts of the ten service area counties have been designated as Medically Underserved Areas. Please see Attachment "Miscellaneous" for details.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

This project will not adversely impact the utilization of State-operated facilities, none of which exist within the service area. The Middle Tennessee Mental Health Institute in Davidson County has exceeded 85% occupancy for the past three years; and last year only 6.4% of its patient days originated from this service area.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

The applicant does intend to take involuntary admissions. It will provide short-term acute care (8.6 days ALOS) rather than long-term care.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

The applicant will contract with all area TennCare MCO's as well as Medicare. However, few Medicare-age will be accepted, due to the availability of established geropsychiatric programs distributed across the service area at three accessible hospitals.

It should be noted that the only hospital program in Columbia itself, with "adult" behavioral care beds, appears from its 2014 Joint Annual Report to not contract with any TennCare MCO's or any Medicaid program. Its reimbursement that year came almost entirely from Medicare, indicating its commitment to serving the geriatric, non-Medicaid patient population.

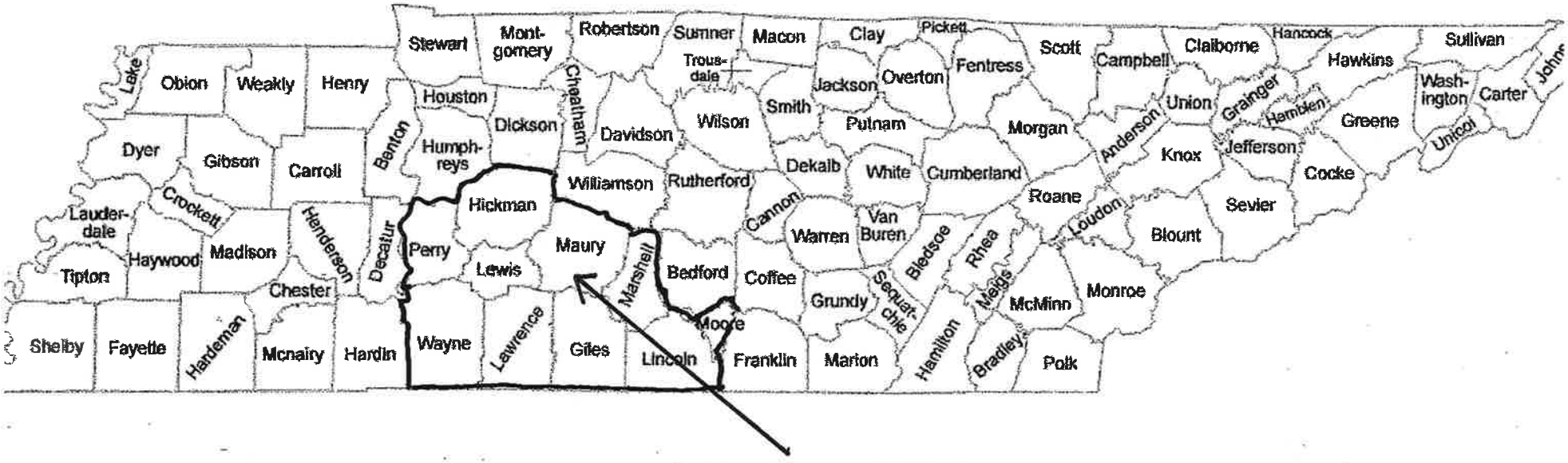
(APPLICATION SECTION B "NEED" QUESTIONS CONTINUED)

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to previously approved projects of the applicant.

Two acute care providers have joined together to bring these needed services to this rural service area. Maury Regional Hospital operates three hospitals in this rural area, and is the area's healthcare resource for a wide range of services. Maury Regional's facilities need a local resource to which their Emergency Departments can transfer patients in need of acute behavioral care beyond purely medical care. At the same time, many of these patients have co-morbidities that require medical care as well as care for psychiatric and substance abuse problems. A dedicated behavioral health hospital operated in close coordination with Maury Regional Hospital and its physicians is an ideal improvement in local health care services. The hospital has been evaluating such an extension of its scope of services for two years, culminating in this project. Maury Regional Hospital's partnership with HCA brings to the project extensive operational experience in serving this particular group of patients, and major assistance with capital funding. The two parties, after first evaluating the feasibility of building managed inpatient behavioral care units within the main hospital, concluded that a freestanding facility close to the hospital would be preferable--due to the size of area demand and also to the opportunity to design the most efficient spaces for inpatient and outpatient programs of care.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area, using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the bordering states, if applicable.

The service area map is provided after this page, and in Attachment Section B-Need-3. The project service area consists of ten counties: Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, and Wayne. Together they form a wedge-shaped service area south and southeast of Nashville and Franklin, extending from Maury County south to the Alabama state line. This area is based on (a) service area cities' accessibility to Columbia; (b) Maury Regional Hospital's historic leadership in providing continuous improvements in acute care in this rural region, (c) and the significant demand for this type of care--as evidenced by conservative State planning methodologies and by strong outmigration to behavioral health providers one to in the greater Nashville urban area.



PRIMARY SERVICE AREA
TRISTAR MAURY REGIONAL BEHAVIORAL HEALTHCARE

3. (Continued) Please complete the following tables, if applicable:

Primary Service Area Counties	CY2015 Cases Age 13-69 in TN Acute Psychiatric Units	% of Total Admissions
Giles	147	8.3%
Hickman	192	10.8%
Lawrence	224	12.6%
Lewis	43	2.4%
Lincoln	133	7.5%
Marshall	156	8.8%
Maury	774	43.6%
Moore	5	0.3%
Perry	39	2.2%
Wayne	62	3.5%
Totals	1,775	100.0%

Source: Decision Support Systems, HCA, from THA Database.

Primary Service Area Counties	Projected Admissions To The Project in CY2020 (Year Two) Alphabetic By County	% of Total Admissions
Giles	174	9.5%
Hickman	167	9.1%
Lawrence	254	13.9%
Lewis	76	4.2%
Lincoln	207	11.3%
Marshall	207	11.3%
Maury	547	29.9%
Moore	41	2.3%
Perry	48	2.6%
Wayne	109	6.0%
Totals	1,830	100.0%

Primary Service Area Counties	Projected Admissions To The Project in CY2020 (Year Two) Largest to Smallest	% of Total Admissions
Maury	547	29.9%
Lawrence	254	13.9%
Marshall	207	11.3%
Lincoln	207	11.3%
Giles	174	9.5%
Hickman	167	9.1%
Wayne	109	6.0%
Lewis	76	4.2%
Perry	48	2.6%
Moore	41	2.3%
Totals	1,830	100.0%

Source: Admissions projected in proportion to counties' percentages of the target population.

4A(1). Describe the demographics of the population to be served by the proposal.

As indicated by Table B-Need-4A(2) on the following page, the project's primary service area population of 300,636 will increase 3.2% to 310,326 persons between CY2016 and CY2020. This is a slightly slower growth rate than the 4.3% State average projected for that period. The project's target population (ages 13-69) will be adolescent and adults other than geriatric adults. It is estimated in 2016 at 217,732 persons; and it is projected to increase 1.5% by CY2020, to a total of 221,097 persons--at which time it will constitute 71.2% of the total service area population. The median age of residents of the 10-county primary service area is 40.9 years, older than the 38.0 median age Statewide. These counties' median household income is 13% below the State's--$38,634 compared to $44,621. The area has a higher poverty rate than the State average--18.1% compared to 17.8%--and a higher percentage of TennCare enrollees--23.2% compared to 22.8% Statewide.

4A(2). Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the U.S. Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data:

http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data:

http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder:

http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Please see table B-Need-4A(2) on the following page, whose data was compiled from the sources listed above.

Table B-Need-4A(2): TriStar Maury Regional Behavioral Healthcare
Demographic Characteristics of Primary Service Area--Ages 13-69
2016-2020

	Department of Health / Health Statistics							Bureau of the Census				TennCare	
Primary Service Area Counties	Current Total Population 2016	Projected Total Population 2020	Total Population % Change 2016 - 2020	Current Target* Population Age 13-69 2016	Projected Target* Population Age 13-69 2020	Projected Target* Population % Change 2016 - 2020	Projected Target* Population As % of Projected Total Population 2020	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Poverty Level as % of Total Population	Current TennCare Enrollees	TennCare Enrollees as % of Total County or Zip Code Population
Giles	29,743	29,817	0.2%	21,430	20,999	-2.0%	70.4%	42.1	$38,739	5,294	17.8%	6,778	22.8%
Hickman	26,351	27,363	3.8%	19,711	20,179	2.4%	73.7%	40.0	$38,032	4,954	18.8%	6,558	24.9%
Lawrence	43,164	43,849	1.6%	30,393	30,645	0.8%	69.9%	39.7	$37,371	8,374	19.4%	11,382	26.4%
Lewis	12,752	13,072	2.5%	9,144	9,183	0.4%	70.2%	41.2	$36,114	2,525	19.8%	3,139	24.6%
Lincoln	34,695	35,469	2.2%	24,725	24,958	0.9%	70.4%	41.8	$41,328	5,655	16.3%	8,030	23.1%
Marshall	33,105	34,648	4.7%	24,342	25,023	2.8%	72.2%	38.9	$41,822	5,131	15.5%	7,289	22.0%
Maury	88,337	92,944	5.2%	64,129	66,150	3.2%	71.2%	38.4	$46,565	14,222	16.1%	19,750	22.4%
Moore	6,795	7,056	3.8%	4,880	5,001	2.5%	70.9%	43.3	$43,393	836	12.3%	889	13.1%
Perry	8,266	8,466	2.4%	5,796	5,760	-0.6%	68.0%	43.1	$31,750	1,967	23.8%	2,208	26.7%
Wayne	17,428	17,642	1.2%	13,182	13,199	0.1%	74.8%	40.9	$31,225	3,712	21.3%	3,586	20.6%
Service Area Total	300,636	310,326	3.2%	217,732	221,097	1.5%	71.2%	40.9	$38,634	54,445	18.1%	69,609	23.2%
State of TN Total	6,812,005	7,108,031	4.3%	4,990,563	5,104,476	2.3%	71.8%	38.0	$44,621	1,212,537	17.8%	1,553,725	22.8%

Sources: TDOH Population Projections, 2015; U.S. Census QuickFacts; TennCare Bureau.
Service area data is either total, or average, as appropriate.

4B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

The applicant will serve all of the groups listed above, except the elderly over the age of 69, without discrimination on the basis of age, gender, race, ethnicity, or source of insurance. This service area is a significant group of counties, within which live almost a quarter-million adolescents and non-geriatric adults without reasonable access to acute inpatient mental healthcare programs. More than two thousand residents of this service area of all ages drive long distances to mental healthcare programs in Davidson and Williamson Counties, for lack of local resources for any but geriatric adults. (Additional patients may be using such programs in Alabama, although data quantifying that outmigration is not available from Alabama hospitals). This project seeks to provide needed resources for the majority of these persons, closer to their homes.

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must provide the following data: admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the appropriate measures, e.g., cases, procedures, visits, admissions, etc. This does not apply to projects that are solely relocating a service.

Table B-Need(5) on the following page shows the past three years' utilization of the four geropsychiatric programs operated by rural hospitals in the service area. They do not offer inpatient care for adolescents or for any significant number of non-geriatric adults. They are 10-to16-bed units in very small hospitals, with individual occupancies ranging between 5.6% and 74.2% over the past three reporting years (2012-2014). Their 2015 Joint Annual Reports are not yet available from TDOH. Their 2014 Joint Annual Reports indicated a group average occupancy of 56.1%. Of the four hospitals, only Lincoln Medical Center in Fayetteville has increased its geropsychiatric utilization since 2012.

Table B-Need-5: TriStar Maury Regional Behavioral Healthcare
Acute Behavioral Care Bed Utilization in Primary Service Area
2012-2014

2012 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Psychiatric Beds	Admissions	Bed Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Hillside Hospital	Giles	14	277	3,633	13.1	10	71.1%
	Lincoln Medical Center	Lincoln	10	161	2,369	14.7	6	64.9%
	Perry Community Hospital	Perry	14	243	2,709	11.1	7	53.0%
	THM-Tennessee Health Management	Maury	16	246	3,212	13.1	9	55.0%
	SERVICE AREA TOTALS		**54**	**927**	**11,923**	**12.9**	**33**	**60.5%**

2013 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Hillside Hospital	Giles	14	212	2,725	12.9	7	53.3%
	Lincoln Medical Center	Lincoln	10	130	2,171	16.7	6	59.5%
	Perry Community Hospital	Perry	14	236	2,618	11.1	7	51.2%
	THM-Tennessee Health Management	Maury	16	281	3,476	12.4	10	59.5%
	SERVICE AREA TOTALS		**38**	**859**	**10,990**	**12.8**	**30**	**79.2%**

2014 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Hillside Hospital	Giles	14	181	2,470	13.6	7	48.3%
	Lincoln Medical Center	Lincoln	10	184	2,709	14.7	7	74.2%
	Perry Community Hospital	Perry	14	194	2,278	11.7	6	44.6%
	THM-Tennessee Health Management	Maury	16	32	326	10.2	1	5.6%
	SERVICE AREA TOTALS		**38**	**591**	**7,783**	**13.2**	**21**	**56.1%**

Source: Joint Annual Reports of Hospitals

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Table B-Need-6: Utilization Projection TriStar Maury Regional Behavioral Healthcare									
THE SERVICE AREA									
					Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Calendar Year	2015	2016	2017	2018	2019	2020	2021	2022	2023
Current PSA Patients*	2,049								
Projected Ann. Change	--				--	+1.5%	+1.5%	+1.5%	+1.5%
Projected PSA Patients*	--				2,254**	2,288	2,322	2,357	2,392
THE PROJECT									
Market Share					60%	80%	82%	84%	86%
Admissions					***1,352***	***1,830***	1,904	1,980	2,057
Length of Stay (Days)					***8.6***	***8.6***	8.6	8.6	8.6
Patient Days					***11,630***	***15,739***	16,375	17,026	17,693
Capacity (21,900 days)					***21,900***	***21,900***	21,900	21,900	21,900
Occupancy					***53.1%***	***71.9%***	74.8%	77.7%	80.8%

**Mental Health Inpatients in Acute Care Facilities*
*** CY2019 projected at 10% increase over CY2015*

The two providers who are partnering in this project are HCA, one of Middle Tennessee's largest providers of inpatient acute mental healthcare, and Maury Regional Hospital, the largest hospital in Middle Tennessee west of Davidson County. They bring to the project the twin benefits of operational experience and deep familiarity with local needs.

In projecting utilization for this project, HCA identified patients of all ages who left the area in CY2015 to obtain acute behavioral care at inpatient programs throughout Middle Tennessee. The approximate number of these was 2,049 patients in CY2015. Some additional patients from the southern part of this service area may have out-migrated to mental healthcare providers in Alabama, but specific data on that is not available. Every year, the Emergency Departments of Maury Regional Hospital's three-hospital system in this area transfer hundreds of patients to Tennessee mental healthcare providers outside the service area, for lack of a local program that can meet their needs.

With increasing national awareness of the growing need to expand behavioral care resources, the applicant projects a minimum 10% increase in area patients seeking such care, between CY2015 and CY2019. Thereafter the projection is for a minimum *annual* increase of 1.5% through Year Five (CY2023) of this project. The 8.6 day average length of stay reflects the current experience of HCA's Nashville-based behavioral health programs.

For the proposed facility, the applicant projects that its adult and adolescent programs will attract a 60% share of the total behavioral market demand (all ages) in Year One, increasing incrementally to 86% market share in Year Five. Utilization is projected to increase steadily from 53.1% in the startup year (CY2019) to 80.8% in Year Five (CY2023). This is realistic, given the size of the market demand, and the fact that the projection is conservative in not including additional admissions that will likely come from counties outside the primary service area. The reputation of Maury Regional Hospital and HCA medical staffs and hospital programs in Middle Tennessee are expected to attract rapid utilization increases, once the facility opens in CY2018.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

A. All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee), (See application instructions for Filing Fee.)

B. The cost of any lease, The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

The Square Footage Chart has been completed and is provided as page 17 of this application. Its total construction cost matches line A.5 of the Project Cost Chart that follows this page.

E. For projects that include new construction, modification, and/or renovation documentation must be provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

1) A general description of the project;

2) An estimate of the cost to construct the project; and

3) A description of the status of the site's suitability for the proposed project;

4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

See Attachment Section B-Economic Feasibility-1E.

PROJECT COST CHART-- TRISTA MAURY REGIONAL BEHAVIORAL HEALTHCARE

A. Construction and equipment acquired by purchase:

1.	Architectural and Engineering Fees	8% of A5	$ 1,001,000
2.	Legal, Administrative, Consultant Fees (Excl CON Filing Fee)		75,000
3.	Acquisition of Site		850,000
4.	Preparation of Site		1,960,000
5.	Total Construction Cost		14,300,000
6.	Contingency Fund	10% of A5	1,430,000
7.	Fixed Equipment (Not included in Construction Contract)		638,000
8.	Moveable Equipment (List all equipment over $50,000 as separate attachment)		1,098,250
9.	Other (Specify) Information Technology Systems and Misc		2,000,000

B. Acquisition by gift, donation, or lease:

1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify)	
5.	Other (Specify)	

C. Financing Costs and Fees:

1.	Interim Financing	586,181
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	

D. Estimated Project Cost (A+B+C) 23,938,431

E. CON Filing Fee 95,000

F. Total Estimated Project Cost (D+E) **TOTAL $** 24,033,431

Actual Capital Cost	24,033,431
Section B FMV	0

2. **Identify the funding sources for this project.**

Check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

__ A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan,

and any restrictions or conditions;

__ B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ D. Grants – Notification of intent form for grant application or notice of grant award;

_x_ E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

__ F. Other – Identify and document funding from all other sources.

See Attachment Section B-Economic Feasibility-2 for documentation of financing. The project will be financed / funded by cash contributions from the two partnering entities, in proportion to their ownership in the applicant LLC. Maury Regional Medical Center will provide 49% of the project cost; HCA will provide 51% of the project cost.

3. **Complete Historical Data Charts on the following pages—<u>Do not modify the Charts provided or submit Chart substitutions</u>!**

Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. Only complete one chart if it suffices.Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Not applicable to a proposed new facility.

4. **Complete Projected Data Charts on the following pages – *Do not modify the Charts provided or submit Chart substitutions!***

   The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. Only complete one chart if it suffices.

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

   Please see the Projected Data Chart attached after this page.

X TOTAL FACILITY
O PROJECT ONLY

PROJECTED DATA CHART -- MAURY PSYCHIATRIC HOSPITAL

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

		Year 2019	Year 2020
A. Utilization Data	Discharges	1,352	1,830
(Specify unit or measure)	Bed Days	11,630	15,739
B. Revenue from Services to Patients			
1. Inpatient Services		$ 46,925,000	$ 60,831,000
2. Outpatient Services		2,870,000	5,264,000
3. Emergency Services			
4. Other Operating Revenue			
(Specify) See notes page			
	Gross Operating Revenue	$ 49,795,000	$ 66,095,000
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments		$ 36,301,000	$ 49,032,000
2. Provision for Charity Care		1,159,000	1,502,500
3. Provisions for Bad Debt		1,159,000	1,502,500
	Total Deductions	$ 38,619,000	$ 52,037,000
NET OPERATING REVENUE		$ 11,176,000	$ 14,058,000
D. Operating Expenses			
1. Salaries and Wages			
a. Clinical		$ 4,649,400	5,226,300
b. Non-Clinical		516,600	580,700
2. Physicians Salaries and Wages			
3. Supplies		871,000	843,000
4. Rent			
c. Paid to Affiliates			
d. Paid to Non-Affiliates			
5. Management Fees			
a. Paid to Affiliates		447,040	562,320
b. Paid to Non-Affiliates			
6. Other Operating Expenses	See notes page	3,474,000	3,761,000
	Total Operating Expenses	$ 9,958,040	$ 10,973,320
E. **Earnings Before Interest, Taxes, and Depreciation**		$ 1,217,960	$ 3,084,680
F. Non-Operating Expenses			
1. Taxes		$ 281,000	$ 1,058,000
2. Depreciation		950,000	950,000
3. Interest			
4. Other Non-Operating Expenses			
	Total Non-Operating Expenses	$ 1,231,000	$ 2,008,000
NET INCOME (LOSS)		$ (13,040)	$ 1,076,680

Chart Continues Onto Next Page

	Year 2019	Year 2020
NET INCOME (LOSS)	$ (13,040)	$ 1,076,680
G. Other Deductions		
1. Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$ 0	$ 0
NET BALANCE	$ (13,040)	$ 1,076,680
DEPRECIATION	$	
FREE CASH FLOW (Net Balance + Depreciation)	$ (13,040)	$ 1,076,680

X **TOTAL FACILITY**

X **PROJECT ONLY**

PROJECTED DATA CHART -- OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2019	Year 2020
1. Professional Services Contract	$	
2. Contract Services		
3. Repairs & Maintenance		
4. Utilities		
5. Insurance		
6. Other		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14		
15.		
Total Other Expenses	$ 0	$ 0

5.A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Project Previous Year	Project Current Year	Project Year One	Project Year Two	% Change (Current Yr to Yr2)
Average Gross Charge (Gross Operating Revenue/Utilization Data	N/A	N/A	$4,282/day $36,831/stay	$4,199/day $36,117/stay	N/A
Average Deduction from Revenue (Total Deductions/Utilization Data)	N/A	N/A	$3,321/day $28,564/stay	$3,306/day $28,436/stay	N/A
Average Net Charge (Net Operating Revenue/Utilization Data)	N/A	N/A	$961/day $8,266/stay	$893/day $7,682/stay	N/A

Note: Average Gross Charge includes inpatients and outpatients. Variances due to rounding of entries to nearest dollar in Projected Data Chart from which the data is taken.

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

The project is for a new hospital, licensed independently of existing hospitals. Therefore its charges and revenues will not impact existing patient charges at any existing hospital. The proposed charges are provided in the comparison of charges in the question immediately below.

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Net revenue is gross revenue minus contractual adjustments, bad debt, and charity, and other deductions. Net revenue per patient day is what consumers actually pay. In the table below, for consistent comparison, the applicant used total (inpatient and outpatient) gross revenue and inpatient day data from the Joint Annual Reports and the Projected Data Chart of this application. The Columbia project will be similar to the net total gross revenues per patient day experienced at two psychiatric hospitals in Williamson and Rutherford Counties. However, the two comparison hospitals' charge data is four years before this project's CY2019 estimate.

Charge Comparison						
Hospital	Year	Days	Gr Revenue	Net Revenue	GR/Day	Net Rev/Day
Rolling Hills	2014	24,666	$42,462,512	$19,803,284	$1,721	$803
Trustpoint	2014	21,095	$39,859,504	$19,146,104	$1,890	$908
This Project	2019 (Yr 1)	11,630	$49,795,000	$11,176,000	$4,282	$961

6.A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved.

As shown in the Projected Data Chart, the hospital is expected to reach a positive cash flow its first year of operation and thereafter. Financial viability as calculated by the HSDA chart indicates a positive operating margin in Year Two, which will continue as census increases. The financial strength of the two owning organizations--HCA Holdings, Inc. and Maury Regional Hospital-- are shown in their financial statements provided in Attachment Section B-Economic Feasibility-6A, which document that these organizations have sufficient financial resources to support the hospital in its startup months, until viability is achieved.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project.

Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. NOTE: Publicly held entities only need to reference their SEC filings.

See Attachment Section B-Economic Feasibility-6A.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

	2nd Yr Previous to Current Yr	1st Yr Previous to Current Yr	Current Yr	Projected Yr 1	Projected Yr 2
Net Operating Margin Ratio	N/A	N/A	N/A	0.11	0.22

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1		
Payor Source	**Projected Gross Operating Revenue**	**As a Percent of Total Revenue**
Medicare/Medicare Managed Care	$	
TennCare/Medicaid	$	
Commercial/Other Managed Care	$	
Self-Pay	$	
Charity Care	$	
Other	$	
Total	$49,795,000	100.0%

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTE) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Please see Table C-Economic Feasibility-8 on the following page. The Medical Director's qualifications are documented in the Attachment "Miscellaneous". He will be interim Medical Director for the project during project development and staff recruitment. A permanent Medical Director has not been named at this time.

Table B-Need-12: TriStar Maury Regional Behavioral Health Projected Staffing				
Position Classification	**Existing FTEs (N/A)**	**Projected FTEs (Yr 1)**	**Average Wage (Contractual Rate)**	**Areawide / Statewide Average Wage**
A. Direct Patient Care Positions				
Director of Nursing		1.00		
Director of Clinical Therapy		1.00		
Nurse Manager		1.00		
RN		12.00		
Mental Health Technician		12.00		
Total Direct Patient Care Positions		**27.00**		
B. Non-Patient Care Positions				
Administrator		1.00		
Human Resources Director		1.00		
Secretary		1.00		
Total Non-Patient Care Positions		**3.00**		
Total Employees (A + B)		**30.00**		
C. Contractual Staff				
Medical Director		1.00		
Total Contractual Staff		**1.00**		
Total Staff (A+B+C)		**31.00**		

Source: Applicant's management.

9. Describe all alternatives to this project that were considered and discuss the advantages and disadvantages of each alternative, including but not limited to:

A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

The most obvious rejected alternative was to not establish inpatient behavioral health services for the area's many adolescents and adults who are either going without needed behavioral healthcare, or are obtaining it with difficulty by out-migrating to programs at out-of-area hospitals much farther from their homes and support groups. This was rejected because the missions of Maury Regional Hospital and HCA are to provide appropriate, high quality, locally accessible acute care services to all residents of their service areas. This is a service line that has not yet been offered in the service area; and it is now timely to do so in partnership with the area's largest and best-known acute care provider.

The next alternative that was considered was development of inpatient units and outpatient programs within the existing campus and buildings of Maury Regional. This was rejected due to large space requirements, internal disruption factors during renovations, and the difficulties of integrating such a large group of behavioral health patients into the general patient population.

The third alternative explored was to acquire and convert a local nursing home facility; but this was rejected after in-depth exploration of conversion costs and limitations of the older building and its site.

The chosen alternative was to establish a partnership that would provide advantages in local experience and trust, expertise in treating behavioral patients of these ages, and strong capital funding resources. This is the basis of the partnership between these two well-known provider organizations, and their proposed establishment of this jointly developed and jointly operated free-standing behavioral health hospital.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as transfer agreements or contractual agreements for health services.

The applicant and the applicant's Medical Director will work closely with Maury Regional Hospital physicians to ensure that the medical needs of prospective and current mental health patients are being appropriately addressed in a timely fashion, so that optimal behavioral care can be delivered. The facility will have access to the clinical and operational expertise of HCA's corporate Behavioral Health Services Group, which manages numerous hospitals of this type across the country. The facility will have a transfer agreement with Maury Regional Hospital, a copy of which is provided in the Miscellaneous Attachment to the application.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

The project will greatly benefit service area consumers. It will provide needed, high quality inpatient behavioral healthcare that is not available in the area currently. It will eliminate the need for service area residents to drive long distances into Davidson, Williamson, and Rutherford Counties for this care. It will extend the continuum of behavioral health care services available locally, by serving more age groups and by offering both inpatient and outpatient mental healthcare to a large rural population that is underserved at the present time.

B. Negative Effects

Because there are no adolescent and non-geriatric adult programs in the service area (despite licenses that are legally available to any adults), the project will not have any adverse impact on any facility in the service area. It will not compete significantly with local hospital-

based geropsychiatric units, because it will serve only adolescents and adults ages 13-69. The only Mental Health Hospital license in the area is for the 16-bed unit at THM in Columbia. In 2014 it reported only 326 days of care, which is a 5.6% occupancy. More significant for this project is that it reported admitting only 3 adults ages 18-64, whose utilization constituted 0.4% (less than a half percent) of its overall utilization. It reported no adolescent admissions. So again, this proposed project for patients ages 13-69 would not reduce that small unit's last reported utilization.

The project may have some temporary negative impact on acute behavioral healthcare providers far outside the service area, by retaining more than a thousand area patients who are currently forced to drive long distances outside the area for this type of care. But the applicant foresees strong growth in demand for this type of inpatient services both nationally and in Middle Tennessee, particularly because of population growth in the Nashville urban area where these existing providers are located. Therefore the applicant anticipates that the negative effects of this project on utilization of those providers will be only temporary. In fact, HCA providers in Nashville will be the first to be negatively impacted--because HCA facilities there are currently the second largest provider of these services to the area's out-migrating residents. Nonetheless, HCA believes that improved local accessibility is a high priority for service area patients; and HCA is supportive of partnering with Maury Regional to enable treatment of these patients closer to their homes and families.

3.A Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

As established providers of acute inpatient care services, the applicant's owners (Maury Regional and HCA) are well aware of the staffing requirements of the Joint Commission and the State of Tennessee licensing agencies. The applicant does not anticipate being able to recruit all of the projected positions incrementally as the facility opens and builds its census.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations

concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

The applicant so verifies.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

This is a proposed new facility without any established training rotations with health professions programs.

4. Identify the type of licensure and certification requirements applicable and verify that the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: **Mental Health Hospital**
By Department of Mental Health and Developmental Disabilities

Certification Types: **Medicare (Mental Health Hospital)**
by the US Department of Health and Human Services

TennCare
By Tennessee Medicaid

Accreditation: **Acute Behavioral Healthcare Hospital**
by The Joint Commission

A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Not applicable to a proposed new facility.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected, by providing a letter from the appropriate agency.

Not applicable to a proposed new facility.

C. Document and explain inspections within the past three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23- ore 90-day termination proceedings from Medicare or Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.
(1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Not applicable to a proposed new facility.

5. Respond to all of the following and for such occurrences, identify, explain, and provide documentation:

Maury Regional Hospital Responses:

A. Has any of the following:
(1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);
(2) Any entity in which any person(s) or entity with more than 5% ownership (direct of indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or
(3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than5%...

B. Been subjected to any of the following:
(1) Final Order or Judgment in a State licensure action;

No.

(2) Criminal fines in cases involving a Federal or State health care offense;

No.

(3) Civil monetary penalties in cases involving a Federal or State health care offense;

No.

(4) Administrative monetary penalties in cases involving a Federal or State health care offense;

No.

(5) Agreement to pay civil or monetary penalties to the Federal government or any State in cases involving claims related to the provision of health care items and services; and/or

No. However, in 2012, Maury Regional Medical Center and Wayne Medical Center (wholly owned DBA's of Maury Regional Hospital) voluntarily disclosed an EMS billing issue and repaid overpayments to the Federal government due to the billing issue. In addition, in 2014, Maury Regional Medical Center settled a qui tam lawsuit with a former employee who claimed physician documentation was substandard in a specific department of the hospital. The government declined to intervene in this case.

(6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs;

No.

(7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware;

No.

(8) Is presently subject to a corporate integrity agreement.

No.

HCA Responses:

This will be submitted under separate cover, for insertion into Attachment Section B-Orderly Development-4 & 5.

6. Outstanding Projects:

a. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and
b. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Outstanding Projects					
			Annual Progress Report*		
CON Number	Project Name	Date Approved	Due Date	Date Filed	Expiration Date
MAURY REGIONAL HOSPITAL					
CN 1505-017	5th Floor CCU	8-26-2015	8-26-2016	7-11-2016	10-1-2018
Status: scheduled to be completed in early November 2016					
HCA AFFILIATED HOSPITALS					
CN					
Status:					
CN					
Status:					
CN					
Status:					

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

7. Equipment Registry -- For the applicant and all entities in common ownership with the applicant.

a. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography Scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)?

Yes, for Maury Regional Hospital dba Maury Regional Medical Center.

b. If yes, have you submitted their registration to HSDA? If you have, what was the date of the submission?

Yes.

c. If yes, have you submitted their utilization to HSDA? If you have, what was the date of the submission?

Yes.

Facility	Date of HSDA Registration	Date of Last Utilization Submittal
Maury Regional Hospital dba Maury Regional Medical Center--Mobile PET		

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency, concerning continued need and appropriate quality measures as determined by the Agency pertaining to the Certificate of Need, if approved.

The applicant so verifies. The applicant's partnering owners, HCA and Maury Regional Hospital (one of whose dba entities is Maury Regional Hospital), have strong commitments to maintaining and improving quality of care in the services they offer. This commitment extends well beyond compliance with Licensure and Joint Commission accreditation requirements in their facilities.

Maury Regional Hospital

1. Awards & Recognitions

Maury Regional

- Top Health System–Truven Health Analytics (2011, 2012 & 2015)
- Leapfrog "A" Hospital Safety Score (2012, 2014, 2015 & 2016—quarterly now)
- Top home care agency in nation by HomeCareElite (10 years)
- Excellence Award–Tennessee Center for Performance Excellence (2014)
- QUEST: High Performing Hospitals Top Performer (2010, 2011, 2012, 2013 & 2014)
- 100 Top Hospital–Truven Health Analytics (1993, 2008, 2010 & 2013)
- Top Performer on Key Quality Measures–Joint Commission (2013)
- 100 Great Community Hospitals–Becker's Hospital Review (2013)
- 100 Hospitals with Great Orthopedic Programs–Becker's Hospital Review (2013)
- EMS honored with Star of Life Award (2009, 2011 & 2013)
- Best Practice Recognition–Strategic Planning & Workforce–Baldrige Performance Excellence Program (2012)
- 50 Top Cardiovascular Hospital (2012)

2. Accreditation, Certifications & Designations

The facilities of Maury Regional Medical Center, Marshall Medical Center and Wayne Medical Center (all owned by Maury Regional Hospital) are all accredited by The Joint Commission, an independent, not-for-profit organization. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. Additional accreditations, certifications, and designations are as follows:

Maury Regional Hospital

- Advanced Inpatient Diabetes Certification, The Joint Commission
- Advanced Certification for Total Hip and Total Knee Replacement, The Joint Commission
- American Academy of Sleep Medicine
- American Association of Blood Banks
- American Association of Cardiovascular and Pulmonary Rehabilitation
- Breast Imaging Center of Excellence by the American College of Radiology
- Breast MRI Accreditation, American College of Radiology
- Chest Pain Center with PCI Accreditation, Society of Cardiovascular Patient Care
- College of American Pathologists
- Commission on Cancer of the American College of Surgeons
- CT Accreditation, American College of Radiology
- Heart Failure Certification, The Joint Commission
- National Accreditation Program for Breast Centers, American College of Surgeons
- Nuclear Medicine Accreditation, American College of Radiology
- Planetree Designated® Patient-Centered Hospital
- MRI Accreditation, American College of Radiology
- Radiation Oncology Practice Accreditation Program, American College of Radiology
- Sepsis Certification, The Joint Commission
- Ultrasound Accreditation, American College of Radiology

Marshall Medical Center

- College of American Pathologists
- CT Accreditation, American College of Radiology
- Mammography Accreditation, American College of Radiology
- MRI Accreditation, American College of Radiology
- Nuclear Medicine Accreditation, American College of Radiology

Wayne Medical Center

- Laboratory Accreditation, The Joint Commission
- CT Accreditation, American College of Radiology
- Mammography Accreditation, American College of Radiology
- MRI Accreditation, American College of Radiology

Lewis Health Center

- Ambulatory Care Accreditation, The Joint Commission
- Federally Qualified Health Center Designation, Health Resources and Services Administration
- MRI Accreditation, American College of Radiology
- Primary Care Medical Home-Ambulatory Care Certification, The Joint Commission

Spring Hill Surgery Center

- Ambulatory Healthcare Accreditation, The Joint Commission (Spring Hill Surgery Center)

3. 2017 CareChex Award Summary (Evaluation against 4,200 member hospitals)

#1 in the State

Medical Excellence:

- Overall Hospital Care
- Gallbladder Removal
- Gastrointestinal Care
- Heart Failure Treatment
- Joint Replacement
- Orthopedic Care
- Pneumonia Care
- Pulmonary Care

Patient Safety:

- Gastrointestinal Care
- General Surgery

Top 100 in the Nation

Medical Excellence:

- Overall Hospital Care
- Overall Medical Care
- Overall Surgical Care
- Gallbladder Removal
- Gastrointestinal Care
- General Surgery
- Heart Failure Treatment
- Joint Replacement
- Orthopedic Care
- Pneumonia Care
- Pulmonary Care

Patient Safety:

- Overall Hospital Care
- Overall Surgical Care
- Gallbladder Removal
- Gastrointestinal Care
- General Surgery
- Major Bowel Procedure
- Major Orthopedic Surgery

Top 10% in the Nation

Medical Excellence:

- Overall Hospital Care
- Overall Medical Care
- Overall Surgical Care
- Cardiac Care
- Gallbladder Removal

- Gastrointestinal Care
- Gastrointestinal Hemorrhage
- General Surgery
- Heart Failure Treatment
- Joint Replacement
- Major Bowel Procedures
- Neurological Care
- Orthopedic Care
- Pneumonia Care
- Pulmonary Care

Patient Safety:

- Overall Hospital Care
- Overall Surgical Care
- Gallbladder Removal
- Gastrointestinal Care
- General Surgery
- Joint Replacement
- Major Bowel Procedures
- Major Orthopedic Surgery
- Pneumonia Care
- Pulmonary Care

#1 in the Market

Medical Excellence:

- Overall Hospital Care
- Overall Medical Care
- Cardiac Care
- Gallbladder Removal
- Gastrointestinal Care
- General Surgery
- Heart Failure Treatment
- Joint Replacement
- Neurological Care
- Orthopedic Care
- Pneumonia Care
- Pulmonary Care

Patient Safety:

- Gastrointestinal Care
- General Surgery

Wayne Medical

- Top Performer Recognition from The Joint Commission (2015)

HCA Behavioral Health Services

This section of HCA is a national leader in behavioral health services, operating 62 behavioral health programs in 17 States--72% of whose patients are adolescents and adults, which are the focus of this CON application for Columbia. HCA is ranked as the nation's third largest provider of behavioral health services. Its hospitals are all accredited. HCA Behavioral Health Services is doing cutting-edge research and development in several major areas of behavioral healthcare, including the following:

- Development of new evidence-based care measures for behavioral health services;
- Development of telepsychiatry to improve the speed, cost, and quality of patient evaluations in hospital Emergency Departments and other settings;
- Improved Integration of behavioral health services with medical care processes in hospitals. An estimated 29% of adults with medical conditions also have mental health conditions; and an estimated 68% of adults with mental health conditions also have medical conditions. Assessment and management of patients in hospital Emergency Departments and in mental health hospitals must take both types of care into account. The integration and coordination of clinical and behavioral care that will be offered in this proposed Columbia project will provide experience that will be useful in many communities across the nation.

Attention to quality of care in its behavioral health programs has led to superior achievements in several aspects of this type of care. With respect to HBIPS Core Measures used internally, HCA facilities in CY2014 (most recent available data) have demonstrated:

- one-tenth of the national average for physical restraint of patients (.03/1000 compared to 0.32/1,000 nationally).
- less than one-tenth of the national average for imposition of patient seclusion (.04/1,000 vs. 0.51/1,000 nationally);
- Significantly higher rate (c. 85% vs. c. 55%) of appropriate use of multiple antipsychotic medications when needed.
- Much less frequent need for multiple antipsychotic medications at discharge;
- A higher rate of post-discharge continuing care planning

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

The project will improve the health of service area residents. It will provide locally accessible inpatient and outpatient behavioral health programs, for persons not now receiving such care because of unwillingness or inability to drive long distances to large Middle Tennessee cities whose providers do offer such care.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Improved accessibility for service area residents will be one of the most significant positive effects of this proposed facility.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

This project represents an optimal development concept, with two experienced and well-regarded acute care organizations partnering to provide the type of care that is needed, at a location where they can access it more efficiently from the consumer's perspective.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

The acute care organizations that are proposing this facility are recognized for their attention to quality of care. Please see the "Quality Measures" responses in this application, immediately preceding this Section C.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

One of the advantages of HCA's participation in this project is its current emphasis on recruitment of psychiatrists and other mental health professionals into the communities it serves. The high qualifications of this project's initial Medical Director, Dr. Rodney A. Poling, are documented in the Miscellaneous Attachments to the application.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

See Attachment C-5-Proof of Publication., for hard copy of the published notice. A newspaper copy will be submitted under separate cover.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction) Note that T.C.A. §68-11-1607(c)(3) states that "...Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member(s) of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Not applicable.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   The Chart has been completed.

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Not applicable. The applicant expects to complete the project within the three-year period of validity for a hospital project.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Initial HSDA Decision Date	0	2-22-17
1. Architectural & engineering contract signed	38	4-1-17
2. Construction documents approved by TDH	98	6-1-17
3. Construction contract signed	112	6-15-17
4. Building permit secured	127	6-30-17
5. Site preparation completed	187	8-30-17
6. Building construction commenced	188	9-1-17
7. Construction 40% complete	308	1-1-18
8. Construction 80% complete	428	5-1-18
9. Construction 100% complete	548	9-1-18
10. * Issuance of license	577	9-30-18
11. *Initiation of service	578	10-1-18
12. Final architectural certification of payment	683	1-15-19
13. Final Project Report Form (HF0055)	743	3-15-19

*** For projects that <u>DO NOT</u> involve construction or renovation: please complete items 11-12 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

INSERT AFFIDAVIT

INDEX OF ATTACHMENTS

Section A

A-3A(1)	Detailed Project Description
A-4A	Legal Status and Ownership Structure of the Project Entities
A-5	Draft Management Contract
A-6A	Site Control Documentation
A-6B(1)a-d	Plot Plan of Project Site
A-6B(2)	Facility Floor Plan

Section B

B-Need-3	1. Service Area Map 2. Site Location Map
B-Economic Feasibility-1E	Documentation of Construction Cost Estimate
B-Economic Feasibility-2	Documentation of Funding/Financing Availability
B-Economic Feasibility-6A	Applicant's Financial Statements
B-Orderly Development-4& 5	Descriptions of Penalties or Sanctions Incurred
C-5	Proof of Publication
Miscellaneous Attachments	1. Medical Director Qualifications 2. TennCare Enrollment 3. Census QuickFacts--Service Area 4. Medically Underserved Parts of the Project Service Area 5. Draft Transfer Agreement 6. Letters of Support

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A-3A(1)
Detailed Project Description

A-3A(1): Detailed Project Description

1. Location of the Project

The project site is a 5.25-acre level tract on the east side of North James Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike. It is northwest of downtown Columbia. A location map is provided in Attachment A-6B(1)a-d. The applicant has an option to purchase the site, a copy of which is in Attachment A-6A below.

2. Site and Facility Design

TriStar Maury Regional Behavioral Healthcare is currently planned as a 52,000 gross square foot, one-story building. It will face North James Campbell Boulevard, with ample surface parking in front of the building for staff and visitors. A circulatory drive will surround the building. On the front of the building will be a main entrance and entrance for outpatients. An ambulance entrance will be on the north side; a dock and service entrance will be on the south side. The back of the building will open to four fenced outdoor activity yards, bordered by a fire lane and a retaining wall at the edge of the site.

Within the main entrance will be a reception and waiting area, bordered by the admissions area on one side, and on the other side by two outpatient therapy rooms, one for adults and one for adolescents. Beyond these spaces, also at the front of the building, are spaces for administrative services, dietary preparation, a dining room, a pharmacy, and other support spaces.

The patient care areas will be divided into two wings, one for adults and one for adolescents. The facility's 60 licensed beds will be assigned and distributed as shown below.

Bed and Room Assignments and Distribution				
Sub-Unit Name	**Total Beds**	**Private Beds/Rooms**	**Semiprivate Beds**	**Semiprivate Rooms**
Adult 1	30	2	28	14
Adult 1A	12	0	12	6
Adolescent 2	8	0	8	4
Adolescent 2A	10	2	8	4
Totals	60	4	56	28

The adolescent and adult beds are separated into two wings. Each wing has the following clinical and support areas:

Clinical Program and Staff Spaces	
Type of Space	**Number of Spaces**
Nurses Station	1
Group Therapy	2
Noisy Activity	2
Quiet Activity	2
Exterior Activity Yard	3
Seclusion Room	1
Lab / Exam Room	1
Comfort Room	4
Consultation Room	2
Treatment Planning	1
Staff Office	2
Staff Lounge	1

3. Hours of Operation, Licensure, Certification and Accreditation

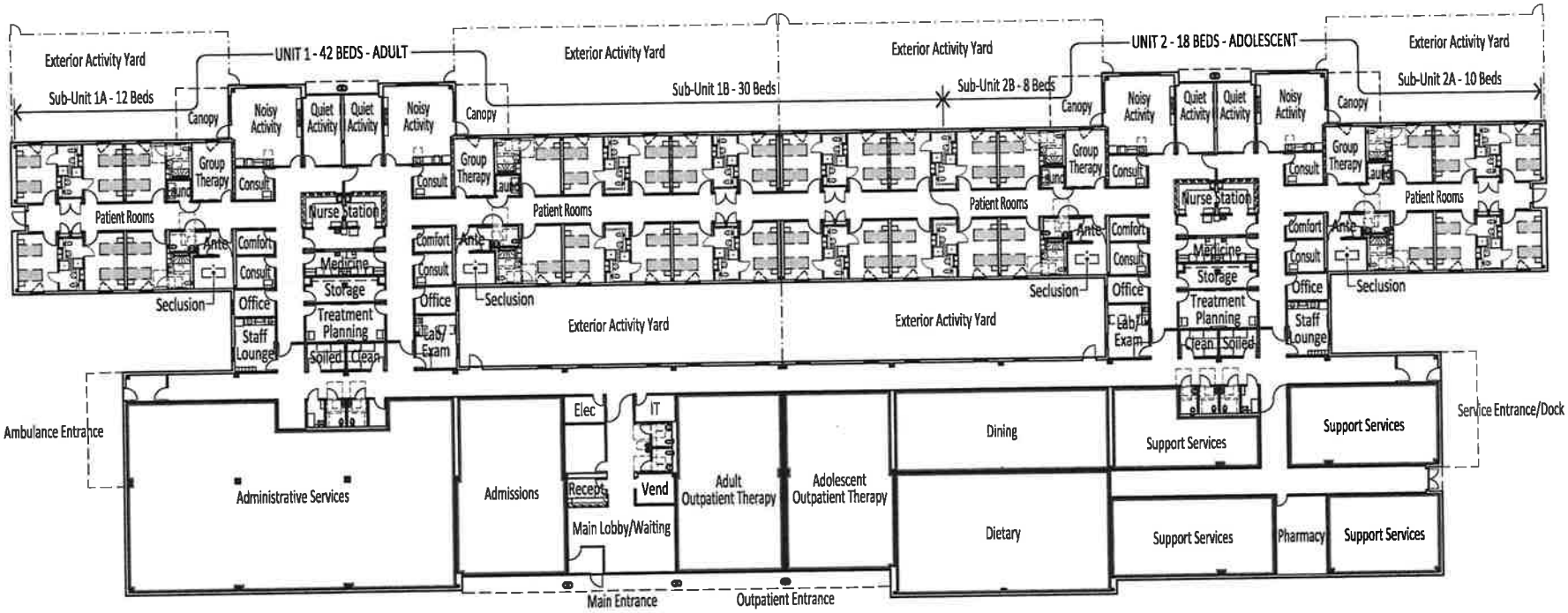
The facility will operate 24 hours daily throughout the year. It will seek licensure as a 60-bed hospital, from the Tennessee Department of Mental Health and Developmental Disabilties. It will seek contracts with all area MCO's and will seek certification by both Medicare and Medicaid.

4. Floor Plan of the Proposed Hospital

Please see the following page.

5. Representative Program Descriptions

These begin on the second following page.



GROSS BUILDING AREA = 52,000 SF

COMPOSITE FLOOR PLAN

NORTH

GRAPHIC SCALE

0' 25' 50' 100'

NEW BEHAVIORAL HEALTH HOSPITAL
TriStar Maury Regional Behavioral Health - Columbia, Tennessee
October 11, 2016

Sample / Partial Program Description: Dual Treatment Program (DTP)

Goal

- The Dual Treatment Program (DTP) is designed to provide a treatment program that meets the physical, psychological, education, and social needs of individuals who have a major mental illness and evidence or history of addiction or substance abuse.

Scope

- The program focuses on the provision of the following essential services:
  - Comprehensive assessment and treatment planning
  - Psychiatric and medical care
  - Crisis stabilization and intensive treatment
  - ADL care/maintenance
  - Patient/Family education
  - Community resources referral
  - Discharge planning

Department Description

- The DTP unit will provide inpatient treatment to patients 18 years of age or older who seek treatment for acute psychiatric symptoms which cannot be safely and adequately addressed on an outpatient basis, and who demonstrate evidence or history of addiction or substance abuse. Common disorders of patients treated in this program include, but are not limited to: major depressive disorder, schizoaffective disorder, schizophrenia, bipolar disorder, adjustment disorder, post-traumatic stress disorder, and a variety of co-morbid character pathologies. Patients receive a pre-admission evaluation by an assessment specialist, and upon admission are assessed by psychiatry and nursing. Additionally, a psychosocial assessment will be conducted by a social worker and/or adjunctive therapist. All psychosocial assessments are reviewed by the patient's assigned social worker. History and physical examinations are completed per departmental policy. Assessment by other services may be conducted as warranted by the patient's status. Recovery planning teams, composed of multidisciplinary staff members from core mental health disciplines of psychiatry, clinical nurse leaders, nursing, case management, social services, and adjunctive therapies formulate interdisciplinary plans of care and discharge plans. Recovery and discharge plans are customized to address the needs of the patient, with input from the patient and/or their family/significant other. Involvement of other disciplines in the recovery and discharge planning process (ex. pharmacy, psychology, dietary, substance abuse counselor) will be requested on identified patient need. Periodic reviews of the recovery plan are conducted to assess the patient's progress toward identified goals, and to evaluate the potential need for modification of the plan. Plans may include a variety of modalities offered by the program such as:
  - Group psychotherapy
  - Social skills groups

- Psycho-educational groups
- Exercise/fitness group
- Expressive therapy
- Relaxation therapy
- Music therapy
- Patient/family education
- ECT
- Psychopharmacology

The scope of services available includes:

- All adult patients admitted to the facility will participate in the Treatment Mall program that can functionally participate.

- Treatment modalities are identified and implemented by each patient's recovery planning team.

- Specialty tracks include groups focusing on: Thought disorder, mood disorder, chemical addiction, trauma, grief, depression, and anxiety.

  Interventions provided by a multidisciplinary staffing design for the Treatment Mall Program utilizes staff members from social work, adjunctive therapies, nursing, clinical pharmacy, chemical dependency counselors, psychologist, chaplain, and care coordinators.

- Patients continue with medication and supervision from nursing staff as they participate in the Treatment Mall Program.

Program Provided

- The Treatment Mall Program operates seven days a week from 9:30 a.m. – 2:30 p.m. Groups are scheduled at 4 specific time periods with multiple tracks at each scheduled group time. Group offerings are adjusted due to census. Groups are lead and co-facilitated by a variety of disciplines that must have the education and level of licensure or certification required by their job description and professional requirements.

- Program services are provided by registered nurses, mental health counselors, and mental health assistants, unit assistants, utilization managers (RN or MSW), LMSW's, or LCSW's, or Licensed LPC and adjunctive therapists.

- Visitation Hours are daily from 6:15 – 7:15 PM.

Mechanisms Used to Identify Needs

- Needs of the patient population served by the program are identified on an ongoing basis by the experiences and observations of staff, results of outcome measures, patient/family feedback and physician input.

- Staff educational needs are determined at least annually, as part of a department needs assessment. Special educational programs are initiated in response to staff requests, acquisition of new technologies, changes in requirements of accrediting and regulatory agencies, results of patient/ family satisfaction surveys and management observation. Individualized educational opportunities are also provided at the request of staff members and/or the immediate supervisor.

Performance Improvement Program

- DTP participates in unit-specific, departmental, and hospital-wide performance improvement activities. The Quality Improvement Program is designed to provide a planned, systemic approach to process design, performance measurement, assessment, and improvement. The Quality improvement activities of the program are under the direction of the Nurse Manager. Results of the program's Quality improvement activities are reported to the Department of Psychiatry on a semiannual basis. Hospital-wide indicators are reported to the Department of Quality Management quarterly for assimilation into overall Behavioral Health summary report findings Hospital-wide indicators include pain management, medication safety, falls, hand hygiene, and utilization of restraint and seclusion.

- Department Specific Monitors

  - Falls monitoring
  - Home medication reconciliation monitoring
  - Hand hygiene monitoring
  - Critical lab documentation monitoring
  - Utensil Safety

Patient Safety Initiatives

- Violence protocol
- Falls monitoring
- Home medication reconciliation monitoring
- Hand hygiene monitoring
- Critical lab documentation monitoring

Admission Criteria

- The patient will be 18 years or older.

- The patient seeks admission on a voluntary basis or has a surrogate decision maker who has the legal authority to consent for the patient to receive treatment, or the patient meets commitment criteria set forth in TCA33-6-404.

- The patient must carry a primary psychiatric Axis I DSM-IV-TR diagnosis.
- The patient must present with acute exacerbation of treatable symptoms which are responsive to short-term intervention.
- Alternatives to inpatient care are inappropriate or unavailable, and the patient's safety cannot be managed in an outpatient setting.
- The patient requires continuous nursing care and/or observation.
- Medication initiation or adjustment under observation is required to enable the patient to be managed in a less restrictive environment.
- Patients who present with issues related to medical and/or surgical care needs will be reviewed with the Nurse Manager, the Manager's designee or the nursing supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission.
- Patients who present with issues related to mental retardation care needs must be reviewed with the Nurse Manager, the Manager's designee or the nursing supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission.

Exclusion Criteria

- The patient has an acute primary medical or surgical problem requiring active treatment in a medical facility.
- The patient has medical needs which require specialized clinical competencies not core to hospital staff and which cannot be readily and continuously accessed in the Medical Center.
- The patient is at the point of delirium tremens (DTs) or has a blood alcohol level (BAL) greater than .40.
- The patient has active tuberculosis and requires rule-out evaluation for tuberculosis.
- The patient manifests behaviors precluding their ability to be safely managed in the care environment (ex. excessive violence, history of hospitalizations in forensics units, history of elopement attempts requiring security levels exceeding those of this facility, history of assaultive behavior toward hospital staff will be viewed on a case by case evaluation, etc.).
- Issues related to medical and/or surgical care needs must be reviewed with the Nurse Manager, the Manager's designee, or the Administrative Supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission.
- The patient has chronic behavioral symptoms for which assessment/treatment in an acute

setting is not likely to produce significant clinical improvement.

- The patient with mental retardation needs requiring specialized clinical competencies not core to hospital staff. Issues related to mental retardation care needs must be reviewed with the Nurse Manager, the Manager's designee or the Nursing supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission. Patients for admission will be assessed for adaptive behavior. To assess adaptive behavior, professionals compare the functional abilities of an individual to those of other individuals of similar age. Certain skills are important to adaptive behavior such as daily living, communication, social skills and IQ. Mental retardation with IQ scores less than 50 and classed as moderate, severe, and profound mental retardation are excluded., These classes are based on Standard Scores of intelligence tests, reflect the categories of the American Association of Mental Retardation, the Diagnostic and Statistical Manual of Mental Disorders-IV-TR, and the International Classification of Diseases (ICD-9-CM)

Transfer Criteria

- The patient is expected to be able to participate in, and benefit from, the program activities.
- Assessment subsequent to the initial admission assessment indicates that the patient's needs may be more adequately addressed by another program such as the Dual Diagnosis Program, or Adult Treatment program.

Discharge Criteria

- The Recovery team will make every effort to ensure discharge from treatment is a joint decision between the patient, the psychiatrist, and the other members of the Recovery team, taking into consideration current assessment of the patient's status, progress, response to treatment, attainment of treatment goals, strengths, weaknesses, prognosis, support systems, and the safety of the patient and others. The following typically signifies attainment of maximum benefit of inpatient treatment:
  - Improvement of symptoms and/or behavioral problems with associated improvement in social, familial, and/or educational functioning.
  - Reduced risk of exacerbation of symptoms which precipitated admission.
  - Goals established for treatment have been substantially met.
  - Structural clinical support and observation are no longer required.
  - Establishment of a support system in the community and arrangement of necessary follow-up plans.

- Patients may request discharge at any time. Patients requesting discharge before maximum benefit from treatment has been reached, will be allowed to terminate treatment unless they meet the criteria set forth in hospital policies and procedures. A physician's order for discharge is required. The following policies detail steps to be taken when a patient requests termination of treatment:

  - "Patient Request for Discharge" (Department-specific policy)
  - "Patient Request for Discharge Resulting in Commitment Proceedings" (Department-specific policy)
  - "Discharge Against Medical Advice" (Hospital policy)

- Patient's whose medical needs override their psychiatric needs may be discharged to a medical/surgical unit before maximum benefit from their psychiatric treatment has been reached. Patients discharged to a unit at a medical hospital will be referred for liaison services from the mental health hospital's community assistance program.

Department Governance

- The Nurse Manager assumes twenty-four hour accountability for the coordination and operation of the program including the supervision of all nursing personnel. Major responsibilities include personnel management (hiring, termination, counseling, evaluation, consultation, and staff development), quality management, problem solving, and communication with patients, visitors, physicians, staff, and other members of the health care team. In conjunction with the Staffing Coordinator and/or supervisor, the Nurse Manager ensures adequate staffing coverage based on patient needs. He/she works with other hospital departments to ensure sufficient resources for patient care are available on a continuous basis. The nurse manager also develops and revises policies and procedures as appropriate, and participates in departmental and hospital-wide committees and teams as requested.

- The Nurse Manager reports to the Director of Nursing, who is accountable to the Administrator and the Chief Nursing Officer of the hospital. A board certified psychiatrist who is a member of the medical staff provides clinical direction.

- An Assistant Nurse Manager or Charge Nurse is scheduled on each shift. They are responsible for staff assignments, problem solving, communication, and clinical management for the assigned shift. They report to the Nurse Manager or to the Nursing Supervisor.

- A Clinical Nurse Leader is assumes twenty four hours/seven days a week accountability. They are responsible for the coordination and direct patient care of nursing care. They report to the Lead Clinical Nurse Leader or to the Director of Nursing.

- After hours and on weekends, the Nursing Supervisor acts in lieu of the Nurse Manager and functions as the administrative representative of the hospital in consultation with the Administrator-On-Call.

Staffing

- Competency

  All staff members who function under federal, state, and/or local requirements for licensure, registration, or certification are required to produce annual documentation of having met such requirements. All staff members have current CPR certification, and are trained annually in non-violent crisis intervention. All staff members will receive department and unit-specific orientations at the time of their employment which includes demonstration and documentation of core competencies. Reassessments of safety, infection control, hazardous materials, seclusion/restraint, patient rights, age appropriate care, and department-specific core competencies are conducted annually. Clinical in-service education is provided for all staff, and is a requirement of their employment per hospital policy and procedure.

- Plan

  Treatment is delivered employing a multidisciplinary team model. Within this framework, nursing care is delivered using a modified team approach.

  Staffing of nursing personnel is based upon census, acuity, care needs of the patients, and program/unit activities with a minimal of 3 staff per physical unit at all times.

Sample / Partial Program Description: Dual Treatment Program (DTP)

Goal

- The Adult Treatment Program (ATP) is designed to provide inpatient psychiatric treatment to voluntary and involuntary adult patients ages 18 or older employing a multidisciplinary team approach. The program provides services to patients who are at risk for harm to self or others.

Scope

- The program focuses on the provision of the following essential services:
  - Comprehensive assessment and treatment planning
  - Psychiatric and medical care
  - Crisis stabilization and intensive treatment
  - ADL care/maintenance
  - Patient/Family education
  - Community resources referral
  - Discharge planning

Department Description

- The ATP is a three unit program specializing in the care and treatment of adult patients acutely mentally ill as well as those individuals in an acute phase of a chronic mental illness. Common disorders of patients treated in this program include, but are not limited to, schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, and personality disorders. Patients receive a pre-admission evaluation by an assessment specialist, and upon admission are assessed by psychiatry and nursing. Additionally, a psychosocial assessment will be conducted by a social worker and/or adjunctive therapist. All psychosocial assessments are reviewed by the patient's assigned social worker. History and physical examinations are completed per departmental policy. Assessment by other services may be conducted as warranted by the patient's status. Recovery planning teams, composed of multidisciplinary staff members from core mental health disciplines of psychiatry, clinical nurse leaders, nursing, case management, social services, and adjunctive therapies formulate interdisciplinary plans of care and discharge plans. Recovery and discharge plans are customized to address the needs of the patient, with input from the patient and/or their family/significant other. Involvement of other disciplines in the recovery and discharge planning process (ex. pharmacy, psychology, dietary, substance abuse counselor) will be requested on identified patient need. Periodic reviews of the recovery plan are conducted to assess the patient's progress toward identified goals, and to evaluate the potential need for modification of the plan. Plans may include a variety of modalities offered by the program such as:
  - Group psychotherapy
  - Social skills groups
  - Psycho-educational groups

- Exercise/fitness group
- Expressive therapy
- Relaxation therapy
- Music therapy
- Patient/family education
- ECT
- Psychopharmacology

The scope of services available includes:

- All adult patients admitted to the hospital will participate in the Treatment Mall program that can functionally participate.

- Treatment modalities are identified and implemented by each patient's recovery planning team.

- Specialty tracks include groups focusing on: Thought disorder, mood disorder, chemical addiction, trauma, grief, depression, and anxiety.

  Interventions provided by a multidisciplinary staffing design for the Treatment Mall Program utilizes staff members from social work, adjunctive therapies, nursing, clinical pharmacy, chemical dependency counselors, psychologist, chaplain, and care coordinators.

- Patients continue with medication and supervision from nursing staff as they participate in the Treatment Mall Program.

Program Provided

- The Treatment Mall Program operates seven days a week from 9:30 a.m. – 2:30 p.m. Groups are scheduled at 4 specific time periods with multiple tracks at each scheduled group time. Group offerings are adjusted due to census. Groups are lead and co-facilitated by a variety of disciplines that must have the education and level of licensure or certification required by their job description and professional requirements.

- Program services are provided by registered nurses, mental health counselors, and mental health assistants, unit assistants, utilization managers (RN or MSW), LMSW's, or LCSW's, or Licensed LPC and adjunctive therapists.

- Visitation Hours are daily from 6:15 – 7:15 PM.

Mechanisms Used to Identify Needs

- Needs of the patient population served by the program are identified on an ongoing basis by the experiences and observations of staff, results of outcome measures, patient/family feedback and physician input.

- Staff educational needs are determined at least annually, as part of a department needs assessment. Special educational programs are initiated in response to staff requests, acquisition of new technologies, changes in requirements of accrediting and regulatory agencies, results of patient/ family satisfaction surveys and management observation. Individualized educational opportunities are also provided at the request of staff members and/or the immediate supervisor.

Performance Improvement Program

- ATP participates in unit-specific, departmental, and hospital-wide performance improvement activities. The Quality Improvement Program is designed to provide a planned, systemic approach to process design, performance measurement, assessment, and improvement. The Quality improvement activities of the program are under the direction of the Nurse Manager. Results of the program's Quality improvement activities are reported to the Department of Psychiatry on a semiannual basis. Hospital-wide indicators are reported to the Department of Quality Management quarterly for assimilation into overall Behavioral Health summary report findings Hospital-wide indicators include pain management, medication safety, falls, hand hygiene, and utilization of restraint and seclusion.

- Department Specific Monitors

  - Seclusion monitoring
  - Falls monitoring
  - Home medication reconciliation monitoring
  - Hand hygiene monitoring
  - Critical lab documentation monitoring
  - Utensil Safety

Patient Safety Initiatives

- Seclusion monitoring
- Violence protocol
- Falls monitoring
- Home medication reconciliation monitoring
- Hand hygiene monitoring
- Critical lab documentation monitoring

Admission Criteria

- The patient will be 18 years or older.

- The patient seeks admission on a voluntary basis or has a surrogate decision maker who has the legal authority to consent for the patient to receive treatment, or the patient meets commitment criteria set forth in TCA33-6-404.

- The patient must carry a primary psychiatric Axis I DSM-IV-TR diagnosis.

- The patient must present with acute exacerbation of treatable symptoms which are responsive to short-term intervention.

- Alternatives to inpatient care are inappropriate or unavailable, and the patient's safety cannot be managed in an outpatient setting.

- The patient requires continuous nursing care and/or observation.

- Medication initiation or adjustment under observation is required to enable the patient to be managed in a less restrictive environment.

- Patients who present with issues related to medical and/or surgical care needs will be reviewed with the Nurse Manager, the Manager's designee or the nursing supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission.

- Patients who present with issues related to mental retardation care needs must be reviewed with the Nurse Manager, the Manager's designee or the nursing supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission.

Exclusion Criteria

- The patient has an acute primary medical or surgical problem requiring active treatment in a medical facility.

- The patient has medical needs which require specialized clinical competencies not core to hospital staff and which cannot be readily and continuously accessed in the Medical Center.

- The patient is at the point of delirium tremens (DTs) or has a blood alcohol level (BAL) greater than .40.

- The patient has active tuberculosis and requires rule-out evaluation for tuberculosis.

- The patient manifests behaviors precluding their ability to be safely managed in the care environment (ex. excessive violence, history of hospitalizations in forensics units, history of elopement attempts requiring security levels exceeding those of this facility, history of assaultive behavior toward staff will be viewed on a case by case evaluation, etc.).

- Issues related to medical and/or surgical care needs must be reviewed with the Nurse Manager, the Manager's designee, or the Administrative Supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission.

- The patient has chronic behavioral symptoms for which assessment/treatment in an acute setting is not likely to produce significant clinical improvement.

- The patient with mental retardation needs requiring specialized clinical competencies not core to hospital staff. Issues related to mental retardation care needs must be reviewed with the Nurse Manager, the Manager's designee or the Nursing supervisor and, if indicated, the Clinical Director and/or assigned internist prior to acceptance for admission. Patients for admission will be assessed for adaptive behavior. To assess adaptive behavior, professionals compare the functional abilities of an individual to those of other individuals of similar age. Certain skills are important to adaptive behavior such as daily living, communication, social skills and IQ. Mental retardation with IQ scores less than 50 and classed as moderate, severe, and profound mental retardation are excluded., These classes are based on Standard Scores of intelligence tests, reflect the categories of the American Association of Mental Retardation, the Diagnostic and Statistical Manual of Mental Disorders-IV-TR, and the International Classification of Diseases (ICD-9-CM)

Transfer Criteria

- The patient is expected to be able to participate in, and benefit from, the program activities.

- Assessment subsequent to the initial admission assessment indicates that the patient's needs may be more adequately addressed by another program such as Dual Diagnosis Program, or Dual Treatment program.

Discharge Criteria

- The Recovery team will make every effort to ensure discharge from treatment is a joint decision between the patient, the psychiatrist, and the other members of the Recovery team, taking into consideration current assessment of the patient's status, progress, response to treatment, attainment of treatment goals, strengths, weaknesses, prognosis, support systems, and the safety of the patient and others. The following typically signifies attainment of maximum benefit of inpatient treatment:

  - Improvement of symptoms and/or behavioral problems with associated improvement in social, familial, and/or educational functioning.

  - Reduced risk of exacerbation of symptoms which precipitated admission.

  - Goals established for treatment have been substantially met.

  - Structural clinical support and observation are no longer required.

  - Establishment of a support system in the community and arrangement of necessary follow-up plans.

- Patients may request discharge at any time. Patients requesting discharge before maximum benefit from treatment has been reached, will be allowed to terminate treatment unless they meet the criteria set forth in hospital policy and procedure. A physician's order for discharge is required. The following policies detail steps to be taken when a patient requests termination of treatment:

  - "Patient Request for Discharge" (Department-specific policy)
  - "Patient Request for Discharge Resulting in Commitment Proceedings" (Department-specific policy)
  - "Discharge Against Medical Advice" (Hospital policy)

- Patient's whose medical needs override their psychiatric needs may be discharged to a medical/surgical unit before maximum benefit from their psychiatric treatment has been reached. Patients discharged to a unit at a medical hospital will be referred for liaison services from the hospital's community assistance program.

Department Governance

- The Nurse Manager assumes twenty-four hour accountability for the coordination and operation of the program including the supervision of all nursing personnel. Major responsibilities include personnel management (hiring, termination, counseling, evaluation, consultation, and staff development), quality management, problem solving, and communication with patients, visitors, physicians, staff, and other members of the health care team. In conjunction with the Staffing Coordinator and/or supervisor, the Nurse Manager ensures adequate staffing coverage based on patient needs. He/she works with other hospital departments to ensure sufficient resources for patient care are available on a continuous basis. The coordinator also develops and revises policies and procedures as appropriate, and participates in departmental and hospital-wide committees and teams as requested.

- The Nurse Manager reports to the Director of Nursing, who is accountable to the Administrator and the Chief Nursing Officer of the hospital. A board certified psychiatrist who is a member of the medical staff provides clinical direction.

- An Assistant Nurse Manager or Charge Nurse is scheduled on each shift. They are responsible for staff assignments, problem solving, communication, and clinical management for the assigned shift. They report to the Nurse Manager or to the Nursing Supervisor.

- A Clinical Nurse Leader is assumes twenty four hours/seven days a week accountability. They are responsible for the coordination and direct patient care of nursing care. They report to the Lead Clinical Nurse Leader or to the Director of Nursing.

- After hours and on weekends, the Nursing Supervisor acts in lieu of the Program Coordinator and functions as the administrative representative of the hospital in consultation with the Administrator-On-Call.

Staffing

- Competency

  All staff members who function under federal, state, and/or local requirements for licensure, registration, or certification are required to produce annual documentation of having met such requirements. All staff members have current CPR certification, and are trained annually in non-violent crisis intervention. All staff members will receive department and unit-specific orientations at the time of their employment which includes demonstration and documentation of core competencies. Reassessments of safety, infection control, hazardous materials, seclusion/restraint, patient rights, age appropriate care, and department-specific core competencies are conducted annually. Clinical in-service education is provided for all staff, and is a requirement of their employment per hospital policy and procedure.

- Plan

  Treatment is delivered employing a multidisciplinary team model. Within this framework, nursing care is delivered using a modified team approach.

  Staffing of nursing personnel is based upon census, acuity, care needs of the patients, and program/unit activities with a minimal of 3 staff per physical unit at all times.

A-4A
Legal Status and Ownership Structure of Applicant

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Columbia News Herald, which is a newspaper of general circulation in Maury County, Tennessee, on or before October 10, 2016, for one day.

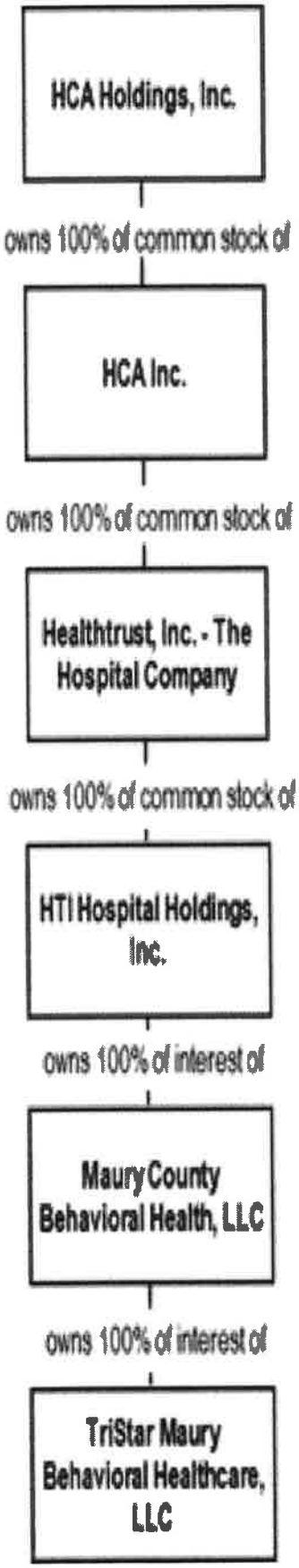
This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Maury Regional Behavioral Healthcare, (a proposed mental health hospital), to be owned by TriStar Maury Behavioral Healthcare, LLC (a limited liability company), and to be managed by Maury County Behavioral Health, LLC (a limited liability company), intends to file an application for Certificate of Need to establish a mental health hospital for adolescent and adult patients, located on the east side of North James Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike, in Columbia, Tennessee 38401. The estimated project cost is $24,400,000.

The project will seek licensure by the Tennessee Department of Mental Health and Substance Abuse Services as a 60-bed mental health hospital. The project does not initiate or discontinue any other health service and it will not affect any other facility's licensed bed complements.

The anticipated date of filing the application is on or before October 14, 2016. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.
The anticipated date of filing the application is on or before October 14, 2016. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

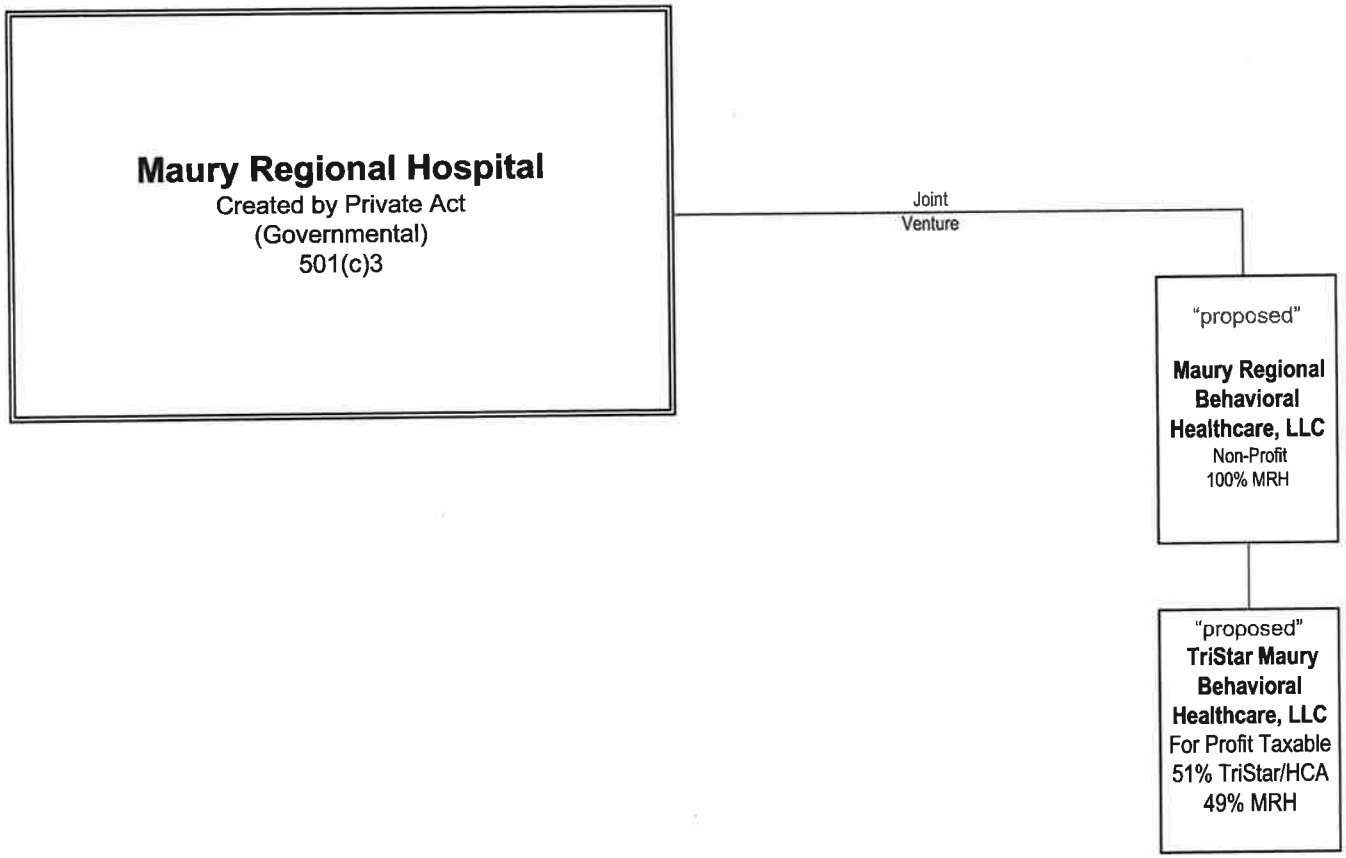
John L. Wellborn 10-7-16 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)


HCA Holdings, Inc.
owns 100% of common stock of
HCA Inc.
owns 100% of common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of common stock of
HTI Hospital Holdings, Inc.
owns 100% of interest of
Maury County Behavioral Health, LLC
owns 100% of interest of
TriStar Maury Behavioral Healthcare, LLC

TriStar Maury Behavioral Health, LLC

Legal Structure



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

TriStar Maury Behavioral Healthcare, LLC
PO BOX 750
NASHVILLE, TN 37202-0750

September 22, 2016

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000867618**	Formation Locale:	DELAWARE
Filing Type:	Limited Liability Company - Foreign	Date Formed:	09/21/2016
Filing Date:	09/22/2016 10:01 AM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2017
Duration Term:	Perpetual	Image # :	B0278-6970
Managed By:	Manager Managed		

Document Receipt

Receipt # : 002899284	Filing Fee:	$300.00
Payment-Account - #23391 CFS-1, NASHVILLE, TN		$300.00

Registered Agent Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Principal Address:
1 PARK PLZ
NASHVILLE, TN 37203-6527

Congratulations on the successful filing of your **Application for Certificate of Authority** for **TriStar Maury Behavioral Healthcare, LLC** in the State of Tennessee which is effective on the date shown above. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Charmayne Blair

APPLICATION FOR CERTIFICATE OF AUTHORITY
LIMITED LIABILITY COMPANY (sa-4233)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

To The Secretary of the State of Tennessee:
Pursuant to the provisions of T.C.A. §48-249-904 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby applies for a certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

1. The name of the Limited Liability Company is: TriStar Maury Behavioral Healthcare, LLC

   If different, the name under which the certificate of authority is to be obtained is: _____

NOTE: The Secretary of State of the State of Tennessee may not issue a certificate of authority to a foreign Limited Liability Company if its name does not comply with the requirements of T.C.A. §48-249-106 of the Tennessee Revised Limited Liability Company Act. If obtaining a certificate of authority under an assumed Limited Liability Company name, an application must be filed pursuant to T.C.A. §48-249-106(d).

2. The state or country under whose law it is formed is: Delaware

   and the date of its formation is: 09 / 21 / 2016 (Month / Day / Year) and the date it commenced doing business in Tennessee is: ___ / ___ / ___ (Month / Day / Year)

   NOTE: Additional filing fees and proof of tax clearance confirming good standing may apply if the Limited Liability Company commenced doing business in Tennessee prior to the approval of this application. See T.C.A. §48-249-913(d) and T.C.A. §48-249-905(c)

3. This company has the additional designation of:

4. The name and complete address of its registered agent and office located in the state of Tennessee is:

   Name: C T Corporation System
   Address: 800 S. Gay Street, Suite 2021,
   City: Knoxville State: TN Zip Code: 37929 County: Knox

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)

   Effective Date: ___ / ___ / ___ (Month / Day / Year) Time: _____

7. The LLC will be: ☐ Member Managed ☒ Manager Managed ☐ Director Managed ☐ Board Managed ☐ Other

8. Number of Members at the date of filing: 1

9. Period of Duration: ☒ Perpetual ☐ Other ___ / ___ / ___ (Month / Day / Year)

10. The complete address of its principal executive office is:

    Address: One Park Plaza
    City: Nashville State: TN Zip Code: 37203

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "TRISTAR MAURY BEHAVIORAL HEALTHCARE, LLC", FILED IN THIS OFFICE ON THE TWENTY-FIRST DAY OF SEPTEMBER, A.D. 2016, AT 11:20 O`CLOCK A.M.

Jeffrey W. Bullock, Secretary of State

6159233 8100
SR# 20165875325

Authentication: 203029821
Date: 09-21-16

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 11:20 AM 09/21/2016
FILED 11:20 AM 09/21/2016
SR 20165875325 - File Number 6159233

CERTIFICATE OF FORMATION

OF

TRISTAR MAURY BEHAVIORAL HEALTHCARE, LLC

1. The name of the limited liability company is TriStar Maury Behavioral Healthcare, LLC

2. The address of its registered office in the State of Delaware is: Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation of TriStar Maury Behavioral Healthcare, LLC this 21st day of September, 2016.

/s/ Kevin A. Ball
Kevin A. Ball
Authorized Person

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Maury County Behavioral Health, LLC
PO BOX 750
NASHVILLE, TN 37202-0750

September 22, 2016

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000867614**	Formation Locale:	DELAWARE
Filing Type:	Limited Liability Company - Foreign	Date Formed:	09/21/2016
Filing Date:	09/22/2016 10:01 AM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2017
Duration Term:	Perpetual	Image # :	B0278-6967
Managed By:	Manager Managed		

Document Receipt

Receipt # : 002899262	Filing Fee:	$300.00
Payment-Check/MO - CFS-1, NASHVILLE, TN		$600.00
Deposit-Account - CFS-1, NASHVILLE, TN		$300.00

Registered Agent Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Principal Address:
1 PARK PLZ
NASHVILLE, TN 37203-6527

Congratulations on the successful filing of your **Application for Certificate of Authority** for **Maury County Behavioral Health, LLC** in the State of Tennessee which is effective on the date shown above. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Charmayne Blair

APPLICATION FOR CERTIFICATE OF AUTHORITY
LIMITED LIABILITY COMPANY (ss-4233)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

To The Secretary of the State of Tennessee:
Pursuant to the provisions of T.C.A. §48-249-904 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby applies for a certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

1. The name of the Limited Liability Company is: Maury County Behavioral Health, LLC

   If different, the name under which the certificate of authority is to be obtained is: _____

NOTE: The Secretary of State of the State of Tennessee may not issue a certificate of authority to a foreign Limited Liability Company if its name does not comply with the requirements of T.C.A. §48-249-106 of the Tennessee Revised Limited Liability Company Act. If obtaining a certificate of authority under an assumed Limited Liability Company name, an application must be filed pursuant to T.C.A. §48-249-106(d).

2. The state or country under whose law it is formed is: Delaware

   and the date of its formation is: 09 / 21 / 2016 (Month / Day / Year) and the date it commenced doing business in Tennessee is: ___ / ___ / ___ (Month / Day / Year)

   NOTE: Additional filing fees and proof of tax clearance confirming good standing may apply if the Limited Liability Company commenced doing business in Tennessee prior to the approval of this application. See T.C.A. §48-249-913(d) and T.C.A. §48-249-905(c)

3. This company has the additional designation of:

4. The name and complete address of its registered agent and office located in the state of Tennessee is:

   Name: C T Corporation System
   Address: 800 S. Gay Street, Suite 2021,
   City: Knoxville State: TN Zip Code: 37929 County: Knox

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)

   Effective Date: ___ / ___ / ___ (Month / Day / Year) Time: _____

7. The LLC will be: ☐ Member Managed ☒ Manager Managed ☐ Director Managed ☐ Board Managed ☐ Other

8. ~~Number of Members at the date of filing:~~ 1

9. Period of Duration: ☒ Perpetual ☐ Other ___ / ___ / ___ (Month / Day / Year)

10. The complete address of its principal executive office is:

    Address: One Park Plaza
    City: Nashville State: TN Zip Code: 37203

APPLICATION FOR CERTIFICATE OF AUTHORITY
LIMITED LIABILITY COMPANY (ss-4233)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

The name of the Limited Liability Company is: Maury County Behavioral Health, LLC

11. The complete mailing address of the entity (if different from the principal office) is:

Address: PO Box 750

City: Nashville State: TN Zip Code: 37202

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

☐ I certify that this entity meets the requirement of T.C.A. §48-249-1123(b)(3)

Licensed Profession: _____

14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.)

☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(i)

If the provisions of T.C.A. §48-249-309(i) (relating to foreign series LLCs) apply, then the information required by that section should be attached as part of this document.

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: ____/____/____ (Month Day Year)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES FOR THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. Other Provisions: _____

9-21-2016
Signature Date

Signature

Manager
Signer's Capacity (if other than individual capacity)

John M. Franck II
Name (printed or typed)

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "MAURY COUNTY BEHAVIORAL HEALTH, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-FIRST DAY OF SEPTEMBER, A.D. 2016.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL FRANCHISE TAXES HAVE BEEN ASSESSED TO DATE.

Jeffrey W. Bullock, Secretary of State

6159234 8300

SR# 20165883032

Authentication: 203032752

Date: 09-21-16

You may verify this certificate online at corp.delaware.gov/authver.shtml

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "MAURY COUNTY BEHAVIORAL HEALTH, LLC", FILED IN THIS OFFICE ON THE TWENTY-FIRST DAY OF SEPTEMBER, A.D. 2016, AT 11:21 O`CLOCK A.M.

Jeffrey W. Bullock, Secretary of State

6159234 8100
SR# 20165875326

Authentication: 203029873
Date: 09-21-16

You may verify this certificate online at corp.delaware.gov/authver.shtml

CERTIFICATE OF FORMATION

OF

MAURY COUNTY BEHAVIORAL HEALTH, LLC

1. The name of the limited liability company is Maury County Behavioral Health, LLC

2. The address of its registered office in the State of Delaware is: Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation of Maury County Behavioral Health, LLC this 21st day of September, 2016.

/s/ Kevin A. Ball
Kevin A. Ball
Authorized Person

DE083 - 2/20/07 CT System Online

State of Delaware
Secretary of State
Division of Corporations
Delivered 11:21 AM 09/21/2016
FILED 11:21 AM 09/21/2016
SR 20165875326 - File Number 6159234

A.5
Management Contract

A.6A

Site Control Documentation

REAL ESTATE PURCHASE AND SALE AGREEMENT

THIS REAL ESTATE PURCHASE AND SALE AGREEMENT (this "Agreement"), dated as of the "Agreement Date" (as defined in Section 14(o)), by and between WHITE, KILGORE, AND WHITE, G.P., a Tennessee general partnership, ESLICK E. DANIEL, and ROGER WITHEROW, herein collectively referred to as "Seller," and TRISTAR MAURY BEHAVIORAL HEALTHCARE, LLC, a Delaware limited liability company, or its successors or assigns, herein referred to as "Buyer."

WHEREAS, Seller is the owner of certain real property, consisting of approximately 5.26 acres of land, located at North James Campbell Boulevard and Old Williamsport Pike, Columbia, Maury County, Tennessee, and comprising a part of Tax Map 89, Parcel 41.00; and

WHEREAS, Seller desires to sell and Buyer desires to purchase said property on the terms and conditions set forth herein;

IN CONSIDERATION OF THE MUTUAL UNDERTAKINGS of the parties hereto it is agreed as follows:

1. Property Included in Sale. Subject to the terms and conditions set forth in this Agreement, Seller agrees to sell and convey to Buyer, and Buyer agrees to purchase from Seller, the following:

   (a) That certain real property generally described above and more particularly described in Exhibit A attached hereto (the "Land"); and

   (b) Seller's interest in all rights, privileges and easements appurtenant to the Land, including, without limitation, all minerals, oil, gas and other hydrocarbon substances as well as all development rights, air rights, water, water rights (and water stock, if any) relating to the Land and any easements, rights-of-way or other appurtenances used in connection with the beneficial use and enjoyment of the Land;

All of the items referred to in subparagraphs (a) and (b) above are hereinafter collectively referred to as the "Property."

Buyer will not assume any liabilities, indebtedness, commitments or obligations of any nature whatsoever (whether fixed of contingent) of Seller in respect of the Property or otherwise, except as otherwise expressly set forth in this Agreement.

2. Purchase Price. The total purchase price for the Property will be Eight Hundred Fifty Thousand and 00/100 Dollars ($850,000.00) (the "Purchase Price") payable as follows:

(a) The sum of $25,000.00 will be paid as an earnest money deposit (the "Earnest Money") to First American Title Insurance Company, National Commercial Services, 6363 Poplar Avenue, Suite 434, Memphis, TN 38119, Attn: Ms. Carol Slone, within five (5) business days after the Agreement Date. Subject to the terms of this Agreement, the Earnest Money will be applied to the payment of the Purchase Price at Closing.

(b) The balance of the Purchase Price will be paid in full at the Closing by wire transfer of immediately available funds to the Escrow Agent's escrow account for disbursement in accordance with the closing statement described in Section 8(c) of this Agreement.

3. Review of Property.

(a) At all times prior to the Closing, Buyer and its representatives, contractors, agents and employees will have the right to enter upon the Property for the purposes of inspecting the Property and for the purposes of conducting engineering and environmental studies and investigations, soil and subsoil tests, surveys, feasibility studies and planning and other testing and exploration work necessary, appropriate or desirable for inspecting or examining the Property or for developing or formulating plans for Buyer's intended use of the Property; provided, however, Buyer (i) will restore the surface of the ground as nearly as possible to its original condition if this Agreement is terminated pursuant to the terms of this Agreement, (ii) will indemnify and hold Seller harmless from and against any loss, claim or liability arising or resulting from any physical damage to the Property occurring during any such inspections. Seller will cooperate with Buyer and its representatives in connection with the conduct of any of the foregoing inspections, investigations, examinations, studies, surveys and tests.

(i) (i) Buyer will have a period commencing on the Agreement Date and expiring at 11:59 p.m., Central Time, on the date that is one hundred twenty (120) days after the Agreement Date (the "Inspection Period") during which to determine whether the condition and suitability of the Property are satisfactory to Buyer. If the Property is not satisfactory to Buyer, Buyer may elect not to purchase the Property by delivering written notice of termination to Seller and the Escrow Agent by the last day of the Inspection Period. Upon receipt of any such timely notice, the Escrow Agent will return the Earnest Money to Buyer and this Agreement will terminate and no party hereunder will have any further rights or obligations under this Agreement other

than those rights and obligations that are expressly stated to survive the termination of this Agreement. If Buyer does not timely deliver such notice, then Buyer will be deemed to have waived its right to terminate this Agreement pursuant to this Section 3(b) (though such will not constitute a waiver of any other rights of Buyer pursuant to this Agreement).

(ii) Notwithstanding the provisions of Section 3(b)(i) above, Buyer will have the right to extend the Inspection Period for up to two (2) additional periods of one hundred and twenty (120) days each by delivering written notice to Seller before the expiration of the original 120-day Inspection Period or before 11:59 p.m., Central Time, of the last day of the first extension of the Inspection Period, as applicable. If Buyer exercises the first extension option, the $25,000.00 deposit of Earnest Money will become non-refundable, absent Seller's default or as set forth in Section 6 of this Agreement. If Buyer exercises the second extension option, Buyer will deposit an additional $25,000.00 as additional Earnest Money, which will also be non-refundable absent Seller's default or as set forth in Section 6 of this Agreement.

(c) Within five (5) days after the Agreement Date, Seller will furnish Buyer with true and complete copies of all of the following (the "Documents"):

(i) All plans and specifications, engineering studies, soils reports, surveys, site plans, plats, environmental studies and reports and other engineering documents relating to the Property that are in Seller's possession;

(ii) All title insurance policies, commitments, reports or opinions for the Property that are in Seller's possession;

(iii) All surveys of the Property in Seller's possession;

(iv) Any evidence of utility locations, availability and capacity in Seller's possession relating to the Property;

(v) All petitions, motions and similar litigation documents in Seller's possession and any information of which Seller is aware relating to any actual, pending or reasonably anticipated or expected litigation relating to the Property; and

(vi) All bills for the 2014, 2015 and if available, 2016 real estate taxes assessed against the Property.

All documents, materials, and information furnished to or made available to Buyer pursuant to this Section 3(c) are being furnished or made available to Buyer for information purposes only and without any representation or warranty by Seller with respect thereto, express or implied, except as may otherwise be expressly set forth in Section 9 below and as limited by Section 9(b) below; provided, however, that Seller represents and warrants to Buyer that, to the best of Seller's knowledge and information, the documents, materials, and information furnished to or made available to Buyer pursuant to Section 3(c)(ii) and Section 3(c)(iii) are true, correct and complete in all respects.

(d) In addition to the Documents to be delivered to Buyer pursuant to Section 3(c) above, Seller will promptly deliver to Buyer such additional documents relating to the Property in Seller's possession as Buyer or Buyer's counsel may reasonably request during the Inspection Period.

4. Title to the Property. At the "Closing" (as hereinafter defined), Seller will convey to Buyer good, record, marketable, and indefeasible title to the Property as provided hereinafter.

5. Conditions to Closing. The following conditions are conditions precedent to Buyer's obligation to purchase the Property:

(a) All representations and warranties made by Seller in Section 9(a) hereof will be true and correct as if made on and as of the time of Closing.

(b) At the time of Closing, Seller will have performed all of the covenants and agreements to be performed by Seller under this Agreement.

(c) The Title Company will have committed itself to issue the Title Policy.

(d) Buyer will have satisfied itself in its sole and absolute discretion that the transactions contemplated in this Agreement, to be carried out with Seller will not result in a violation of any applicable laws and regulations, including without limitation, federal and state health care laws and regulations. Such health care laws and regulations include, without limitation, Medicare Anti-Kickback and Stark laws and regulations.

(e) Seller will have constructed and completed a new sewer line in a good and workmanlike manner in accordance with all applicable laws and codes to the boundary of the Land in a location reasonably acceptable to Buyer. In the event Seller is unable to have the extension of the

sewer line completed prior to the Closing due to circumstances beyond its control, Buyer agrees to proceed with the Closing provided that there is established at Closing an escrow with the Title Company in the amount of one hundred fifty percent (150%) of the contract price for the cost of the sewer work. Seller covenants that it will use its best efforts to complete the sewer work prior to the Closing, or as soon after the Closing as reasonably possible, as applicable. The foregoing covenant of Seller will survive the Closing if the sewer work is not completed by the Closing.

The costs for all other utility, drainage and stormwater construction on the Property shall be the responsibility of Buyer. Buyer agrees to allow Seller, at Seller's sole cost and expense, to extend the 8" CPWS water line and the 4" ATMOS gas line located on the front of the Property to the remainder of Parcel 89-41 owned by Seller. The locations of such lines and related facilities will be reasonably acceptable to Buyer. Seller will (i) conduct such work in such a manner as to minimize disruption of Buyer's use or the Property, including without limitation using its best efforts to complete such work as quickly as reasonably possible, (ii) restore the surface of the ground as nearly as possible to its original condition promptly after completion of such work and (iii) indemnify and hold Buyer harmless from and against any loss, claim or liability arising or resulting from any such work. Seller's obligations in the previous sentence will survive the Closing.

The conditions precedent set forth in this Section 5 are intended solely for the benefit of Buyer. If any of such condition(s) are not satisfied by the Closing, Buyer will have the right, at its sole election, either to waive the condition(s) in question, either in whole or in part, and proceed with the purchase or, in the alternative, terminate this Agreement by giving Seller written notice of such election. If this Agreement is terminated pursuant to this Section 5, the Earnest Money will be returned to Buyer, both parties are released from all liabilities and obligations under this Agreement and neither party will be entitled to any damages or any other relief on account of such termination.

6. Title Evidence.

(a) Buyer will obtain, at Buyer's expense, a commitment for an owner's policy of title insurance and all exception documents ("Title Commitment") issued by the Escrow Agent (the "Title Company"). If the Title Commitment shows that either Seller does not have good, record and marketable indefeasible, fee simple title to the Property, or that there are any defects, liens or encumbrances or any other matters

which are not acceptable to Buyer , Buyer shall notify Seller on or before the date which is ten (10) business days following Buyer's receipt of the Title Commitment. By not later than thirty (30) days after receipt of notice of such title objections (the "Cure Period"), Seller, at its election, will have (i) delivered notice to Buyer that Seller elects not to cure the alleged defect or other matter, or (ii) taken and completed all actions as are necessary to (A) render the title to the Property marketable and in accordance with the foregoing requirements and/or (B) remove any such defects, liens and encumbrances, except any "Monetary Liens" (as hereinafter defined) which Seller will pay at Closing and provide Buyer satisfactory evidence of payment and release. If Seller elects not to cure the alleged defect or other matter, or fails within the Cure Period to (a) eliminate any such defects, liens and encumbrances, and (b) obtain an endorsement deleting such matters as exceptions in the Title Commitment and the title policy, Buyer will have the option, prior to Closing, to accept the status of the title subject to such defects, liens or encumbrances and other matters and proceed with this Agreement, or give Seller written notice of termination, in which event this Agreement will terminate and Buyer will be released of all liabilities and obligations under this Agreement. If this Agreement is timely terminated in accordance with any provision of this Section 6, then the Escrow Agent will deliver the Earnest Money to Buyer and Buyer and Seller will be released of all liability hereunder; provided, however, the indemnity obligations of the parties under this Agreement will survive such termination.

(b) Notwithstanding the foregoing, if the basis of Buyer's objection to Seller's title are any mortgages, judgments, debts, security interests, liens, encumbrances, tax or assessment liens or obligations (other than those that are created or incurred as a consequence of the acts or omissions of Buyer) (which matters are collectively hereinafter referred to as "Monetary Liens"), the provisions of this Section 6 will not apply and Seller will obtain and deliver at the Closing all instruments as may be necessary to secure full discharge of all Monetary Liens and to release them of record, and will cause the Title Company to issue the policy referred to in the Title Commitment without exception for any such Monetary Liens. Seller will also pay all attorney's fees, costs and expenses incurred in connection with obtaining the discharge and release of such Monetary Liens, obtaining any prior title insurance policies,and the recording of instruments necessary for the release of such Monetary Liens. If Seller so desires, all or a part of the net proceeds payable to Seller at the Closing may be applied to payment of such Monetary Liens at the Closing.

7. Survey. Buyer shall, at Buyer's sole cost and expense during the Inspection Period, obtain a survey of the Property which will delineate and monument the exact boundary lines of the Property (the "Survey"). Buyer will order the Survey promptly after the Agreement Date. The Survey shall meet ALTA standards and specifications and will be certified to Seller, Buyer and the Title Company and will include such information, details and certifications as to permit the Title Company to issue the title insurance policy without a general survey exception. The Survey will set forth the exact square footage of the Property and a metes and bounds description of the Property and the Easement Area (as hereinafter defined) prepared by a registered surveyor licensed in the State of Tennessee, which surveyor will be selected by Buyer and reasonably acceptable to Seller. Said metes and bounds description for the Property will be used in Seller's deed to Buyer at Closing. If the Survey reveals matters which, in the opinion of Buyer, constitute objections to or affect the marketability of the Property, or Buyer's intended use of the Property, Buyer shall advise Seller of its objections within ten (10) days after the delivery of the Survey, and Seller shall then have a reasonable time in which to cure or remove said objection. If Seller shall fail to cure or remove any such objection, then, at the election of Buyer, as evidenced by written notice to Seller, the sale shall be closed subject to said matters, or in the alternative, Buyer may elect to terminate this Agreement in which event the Earnest Money shall be promptly returned to Buyer and neither party shall have any further claim or rights against the other; provided that Buyer shall advise Seller of its election to either so close this transaction (at the time and otherwise in the manner as herein provided), or to terminate this Agreement and obtain a return of the Earnest Money, within three (3) days following notice from Seller to Buyer as to any such objection that will not be cured or removed.

8. The Closing. The sale and purchase of the Property (the "Closing") will be held and delivery of all items to be made at the Closing under the terms of this Agreement will be made at the offices of Escrow Agent on the earliest practicable date mutually agreed upon by Buyer and Seller, but in no event later than the thirty (30) days after the expiration of the Inspection Period as it may be extended in accordance with Section 3(b)(ii) (the "Closing Date").

At the Closing, the following actions will be taken and will be deemed to occur simultaneously:

(a) Deliveries By Seller. Seller will deliver to Buyer:

(i) Seller's duly executed, witnessed and acknowledged transferable and recordable Limited Warranty Deed in form approved by Buyer's counsel, conveying to Buyer or its related assignee good record and marketable, indefeasible title to the Property in fee

simple, free and clear of all liens and encumbrances except the following (collectively, the "**Permitted Exceptions**"): (i) easements and other matters of record that are accepted by Buyer in accordance with Section 6 and Section 7; (ii) zoning and building laws, ordinances, resolutions, and regulations; and (iii) ad valorem real estate taxes and assessments for public improvements not then due and payable.

(ii) A written certificate complying under the Foreign Investment in Land Act and the regulations thereunder ("FIRPTA"), satisfactory to Buyer, certifying that Seller is neither a foreign person nor subject to withholding under FIRPTA, and containing Seller's tax identification or social security number and address.

(iii) A certificate signed by Seller certifying that the representations and warranties of Seller set forth in this Agreement are true and correct as of the Closing.

(iv) Such other certificates, instruments and documents as may reasonably be necessary to assure Buyer and its counsel that the provisions of and conditions specified in this Agreement to be performed or satisfied by Seller have been performed or satisfied and to permit the Title Company to issue the title insurance policy pursuant to the Title Commitment. Such certificates, instruments and documents may include without limitation, such certificates, instruments and documents as are required by Buyer or the Title Company to evidence the status and capacity of Seller and the authority of the person or persons who are executing the various documents on Seller's behalf in connection with the transactions contemplated in this Agreement.

(b) Deliveries by Buyer. Buyer will deliver to Seller or Escrow Agent:

(i) The Purchase Price (less all credits adjustments and prorations) due at the Closing in accordance with this Agreement;

(ii) Buyer shall have delivered to Seller a development plan and site plan for the Property which are reasonably acceptable to Seller.

(c) Deliveries by Buyer and Seller. Seller and Buyer each will deliver a closing statement to each other.

(d) Except as otherwise set forth hereinafter, if the transaction contemplated by this Agreement is consummated, the following items will be paid, prorated or adjusted as of 12:01 a.m. on the date this

transaction is closed and the deed is recorded ("Proration Date"), in the manner hereinafter set forth:

(i) All real estate taxes and all personal property taxes due and owing as of the Proration Date, and all assessments for public improvements or other matters or facilities which constitute a lien against the Property as of the Proration Date, whether payable in installments or not, and all penalties and interest thereon will be paid by Seller on or before the closing.

(ii) Real estate taxes not yet due and owing as of the Proration Date will be prorated as of the Proration Date upon the tax year of the applicable taxing authority so that the portion of the prorated taxes allocable to the period from the beginning of each tax year through the Proration Date will be credited to Buyer and the portion of the current taxes allocable to the portion of such tax year following the Proration Date to the end of such tax year will be the responsibility of Buyer. The adjustment will be predicated upon most recently available tax bills or actual rates and assessments, provided that such real estate taxes will be reprorated forthwith upon Buyer's receipt of the actual tax bill or bills for the tax year or tax years in question.

(iii) Seller will pay all costs and be responsible for all expenses, liabilities (actual or contingent), claims and obligations incurred, accrued or arising prior to the Proration Date in connection with the ownership, management, operation, repair, maintenance or leasing of the Property. Any costs or expenses of ownership, management, repair or maintenance of the Property which are prepaid as of the Proration Date will be credited to Seller, and Buyer will be responsible to pay such costs and expenses accruing subsequent to the Proration Date.

(iv) Buyer will bear and pay all costs of the title examination fees, title insurance premiums, and one-half of the fees for closing in escrow, if any, all costs of the Survey, and recording fees. Seller will pay one-half of the fees for closing in escrow, if any.

(v) All other items which are customarily prorated in transactions similar to the transaction contemplated hereby, and which were not heretofore dealt with, will be prorated as of the Proration Date.

(e) All prorations will be calculated on the basis of a 365-day year. Seller and Buyer hereby agree that if any of the aforesaid prorations cannot

be calculated accurately on the Proration Date, then the same will be calculated within 30 days after the Proration Date and either party owing the other party a sum of money based on such subsequent proration(s) will promptly pay said sum to the other party.

9. Representations, Warranties, and Agreements of Seller.

(a) Seller represents and warrants to Buyer, as of the Agreement Date and the Closing Date, and hereby covenants and agrees with Buyer, that:

(i) White, Kilgore and White, G.P. ("WKW"), is a general partnership duly organized and existing under the laws of the State of Tennessee and is in good standing under the laws of the State of Tennessee; this Agreement and all documents executed by WKW which are to be delivered to Buyer at the Closing will be duly authorized, executed, and delivered by WKW, will be legal, valid, and binding obligations of WKW, will be sufficient to convey title, and do not violate any provisions of any agreement to which WKW is a party or to which it is subject.

(ii) There are no leases affecting all or any part of the Property and there are no written promises, understandings, agreements or commitments between Seller, and there are no tenants or other occupants or users of the Property, other than Seller. There are no outstanding options or rights to purchase or options or rights to lease all or any part of the Property.

(iii) Seller has received no written notice of any pending, or threatened actions, suits or proceedings against or affecting the Property or any portion thereof, or relating to or arising out of the ownership, leasing, operation, management, use or maintenance of the Property.

(iv) Seller has received no written notice of any attachments, executions, assignments for the benefit of creditors, or voluntary or involuntary proceedings in bankruptcy or under any other debtor relief laws contemplated or pending or threatened against Seller or the Property.

(v) Seller has received no written notice of any condemnation proceedings or proceedings for change of grade of any street affecting the Property or improvement of any street or sidewalk abutting the Property which are currently threatened or pending.

(vi) To Seller's actual knowledge, the Property is not located within an area which has been designated by the Federal Emergency Management Agency, the Army Corps of Engineers or any other Governmental agency as being subject to special flood hazards, and has not been designated or classified as a wet land or similar conservation area by any Federal, State or local governmental authority.

(vii) To Seller's actual knowledge, there are no underground storage tanks or hazardous and/or toxic substances, waste, materials, pollutants or contaminates, or any other substances or materials which are included under or regulated by Environmental Laws ("Hazardous Substances") on, in or under the Property or any part thereof, and neither Seller nor, to the best of Seller's knowledge, any third party, has engaged in the generation, production, use, handling, manufacture, treatment, storage or disposal of any material amount of any Hazardous Substance on, in or under the Property or any part thereof.

(viii) Seller is the sole owner of the Property, subject to the Permitted Exceptions.

(ix) To Seller's actual knowledge, the Property complies with and does not violate any existingzoning, subdivision laws, ordinances, codes, orders, regulations or requirements affecting all or any portion of the Property, and Seller has received no written notice of any such violation from any governmental or public authority having jurisdiction.

(b) From and after the Agreement Date, through the time of the Closing, Seller will conduct the business involving the Property as follows:

(i) Seller will keep in full force and effect through the Closing public liability insurance with respect to damage or injury to persons or property occurring on the Property in at least the amounts as are maintained by Seller as of the Agreement Date;

(ii) Seller will not hereafter without Buyer's prior written approval contract for any service, or make or enter into any leases, commitments or obligations which will bind Buyer with respect to the Property.

(iii) Seller will cause the Property to be maintained in accordance with the standards of maintenance currently being applied with respect to the Property.

(c) Seller hereby represents and warrants to Buyer that Seller is not a "Referral Source" (as hereinafter defined), and that no ownership or beneficial interest in Seller is owned or held by any Referral Source. "Referral Source" shall mean (i) a physician, an immediate family member or member of a physician's immediate family, an entity owned in whole or in part by a physician or by an immediate family member or member of a physician's immediate family or by any other "Person" (as hereinafter defined) who (a) makes, who is in a position to make, or who could influence the making of referrals of patients to any health care facility; (b) has a provider number issued by Medicare, Medicaid or any other government health care program; or (c) provides services to patients who have conditions that might need to be referred for clinical or medical care, and participates in any way in directing, recommending, arranging for or steering patients to any health care provider or facility; and (ii) any Person or entity that is an "Affiliate" (as hereinafter defined) of any Person or other entity described in clause (i) above. "**Immediate family member or member of a physician's immediate family**" means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild. "**Affiliate**" shall mean, any Person that directly or indirectly controls or is controlled by or is under common control with a Referral Source. For purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used herein, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities, partnership interests or other equity interests. "**Person**" shall mean any one or more natural persons, corporations, partnerships, limited liability companies, firms, trusts, trustees, governments, governmental authorities or other entities.

(d) All of Seller's representations and warranties in this Section 9 will survive the Closing for a period of one (1) year from the date of Closing.

10. Representations and Warranties of Buyer. Buyer hereby represents and warrants to Seller as follows: Buyer is a limited liability company, duly organized and validly existing under the laws of the State of Tennessee; this Agreement and all documents executed by Buyer which are to be delivered to Seller at the Closing are or at the time of delivery will be duly authorized, executed, and delivered by Buyer and are or at the time of delivery will be legal, valid, and binding obligations of Buyer, and do not and at the Closing will not violate any provisions of any agreement to which Buyer is a party or to which it is subject.

11. Indemnification. Subject to the limitations contained in Sections 9(c), each party hereby agrees to indemnify the other party and hold it harmless from and against any and all claims, demands, liabilities, costs, expenses, penalties, damages and losses, including, without limitation, reasonable attorneys' fees, resulting from any misrepresentations or breach of warranty or breach of covenant made by such party in this Agreement or in any document, certificate, or exhibit given or delivered to the other pursuant to or in connection with this Agreement.

12. Loss by Condemnation. In the event that, prior to Closing, condemnation proceedings are commenced against the Property, Buyer will have the right, exercisable by giving notice of such decision to Seller within 15 days after receiving written notice of such condemnation proceedings, to terminate this Agreement, in which case neither party will have any further rights or obligations hereunder. If Buyer elects to accept the Property in its then condition, all condemnation awards payable to Seller by reason of such condemnation will be paid or assigned to Buyer.

13. Default and Termination.

(a) If Seller defaults in any material respect in the performance of any of the Seller's obligations in this Agreement for any reason other than the Buyer's default, the Buyer may terminate this Agreement and receive a refund of the Earnest Money. In the alternative, Buyer may sue the Seller for specific performance.

(b) If the Buyer defaults in any material respect in the performance of any of the Buyer's obligations in this Agreement for any reason other than the Seller's default, then as Seller's sole and exclusive remedy, Seller may terminate this Agreement upon five (5) days' prior written notice to Buyer and retain the Earnest Money as liquidated damages. Seller will not be entitled to sue Buyer for specific performance or damages.

14. Miscellaneous.

(a) Notices. Any notice or other writing required or permitted to be given to a party under this Agreement will be given in writing and will be (i) delivered by hand or (ii) delivered through the United States mail, postage prepaid, certified, return receipt requested, or (iii) delivered through or by UPS or Federal Express, or other nationally-recognized expedient mail or package service, addressed to the parties at the addresses set forth below. Any notice or demand that may be given hereunder will be deemed complete; (a) upon depositing any such notice or demand in the United States mail with proper postage affixed thereof, certified, return receipt requested; (b) upon depositing any

such notice or demand with UPS or Federal Express, or other nationally-recognized expedient mail or package delivery, or (c) upon hand delivery to the appropriate address as herein provided. Any party hereto may change said address by notice in writing to the other parties in the manner herein provided. The appropriate address for notice hereunder will be the following:

Seller: Roger Witherow
1517 Hatcher Lane
Columbia, TN 38401
rwitherow@hotmail.com

WITH COPY TO: John Hill
Maury County Realty
1217 Trotwood Ave
Columbia, TN 38401
johnrosshill@gmail.com
Facsimile: 931-388-2364

George E. Mudter, Jr.
Mudter & Patterson
3811 Bedford Avenue, Suite 205
Nashville, TN 37215
gem@mudter.com
Facsimile: 615-383-2605

Buyer: _____
_____
_____

(b) Brokers. Seller represents to Buyer that there is no broker or other person entitled to a commission or similar fee from Seller in connection with the transactions described in this Agreement, other than John Hill with Maury County Realty, to whom Seller will pay a commission at Closing equal to three percent (3%) of the Purchase Price. Buyer represents to Seller that there is no broker or other person entitled to a commission or similar fee from Buyer in connection with the transaction described in this Agreement, other than Cushman & Wakefield, to whom Seller will pay a commission at Closing equal to three percent (3%) of the Purchase Price. Seller and Buyer covenant and agree to defend, indemnify and save harmless the other from and against any claim for any broker's commission or similar fee or compensation for any service rendered in connection with the sale and purchase of the Property.

(c) Successors and Assigns. This Agreement will be binding upon, and inure to the benefit of, the parties hereto and their respective

successors, heirs, administrators and assigns. Buyer will have the right at any time to assign its rights under this Agreement to an affiliated entity but any other assignment will require Buyer to obtain Seller's prior written consent, which consent will not be unreasonably withheld, delayed or conditioned, and that such assignment will not release Buyer under this Agreement. Seller may assign its rights to receive the proceeds of sale, subject to the terms of this Agreement.

(d) Amendments and Terminations. Except as otherwise provided herein, this Agreement may be amended or modified by, and only by, a written instrument executed by Seller and Buyer.

(e) Continuation and Survival of Representations and Warranties. All representations and warranties by the respective parties contained herein or made in writing pursuant to this Agreement are intended to and will remain true and correct as of the time of Closing, will be deemed to be material, and will survive the execution and delivery of this Agreement.

(f) Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of Tennessee.

(g) Merger of Prior Agreements. This Agreement supersedes all prior agreements and understandings between the parties hereto relating to the subject matter hereof.

(h) Enforcement. In the event either party hereto fails to perform any of its obligations under this Agreement or in the event a dispute arises concerning the meaning or interpretation of any provision of this Agreement, the defaulting party or the party not prevailing in such dispute, as the case may be, will pay any and all costs and expenses incurred by the other party in enforcing or establishing its rights hereunder, including, without limitation, court costs and reasonable attorneys' fees.

(i) Captions. Captions and paragraph headings are for convenience of reference only, and will not be used in connection with the construction or interpretation of any provision of this Agreement.

(j) Entire Agreement. This Agreement contains the entire agreement of the parties relating to the property and there are no other agreements or understandings, written or oral concerning the same.

(k) Time. Time is of the essence in this Agreement.

(l) Confidentiality of Agreements. Buyer and Seller agree that the terms and conditions of this Agreement, and all other agreements and instruments executed and delivered by the respective parties in connection with this Agreement (excepting any documents which are intended to be recorded in the public records), including all preliminary drafts of such documents (collectively, the "Transaction Documents"), will remain confidential. Neither Seller nor its respective agents and representatives, will distribute the Transaction Documents, or any part thereof, to any third party unless required by law to do so, except that Seller may distribute the Transaction documents to its partners, attorneys, financial advisers, tax preparers, lenders and property managers (provided that such partners, attorneys, financial advisers, tax preparers, lenders and property managers first agree in writing to be bound by the provisions of this Section 14(l)).

(m) Execution. The presentation of this Agreement for review by Seller does not constitute an offer on the part of Buyer to enter into the transactions described herein and this Agreement will become effective and legally binding only when it has been signed by a duly authorized officer or representative of each of the parties and delivered to the other party.

(n) Business Day. In the event that the date for taking any action under this Agreement (including, but not limited to, the giving of a notice of termination or closing) falls on a Saturday, Sunday or legal holiday, then such time period will automatically be extended until 5:00 p.m. local time on the next regularly scheduled business day in Columbia, Tennessee.

(o) Agreement Date. "Agreement Date" will mean the date on which this Agreement is executed by the last party to sign this Agreement.

(p) Counterparts. This Agreement may be executed in one or more counterparts. A version of this Agreement delivered by facsimile or in .pdf format will be the same legal effort as an original.

[Signatures Appear On Following Page]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the dates listed below their respective signatures.

BUYER:

TRISTAR MAURY BEHAVIORAL HEALTHCARE, LLC

a Delaware limited liability company

BY: _____

NAME: Joseph A. Sowell

TITLE: Vice President

DATE OF EXECUTION: 10/12/16

[Signatures continue on following page]

SELLER

WHITE, KILGORE, AND WHITE , G.P.
a Tennessee general partnership

BY: _____

NAME: Carroll W. Kilgore, Managing Partner
ITS GENERAL PARTNER

DATE OF EXECUTION: 10-13-16

_____
ESLICK E. DANIEL

DATE OF EXECUTION: 10-13-16

_____
ROGER WITHEROW

DATE OF EXECUTION: 10.13.2016

ESCROW AGENT

The undersigned joins herein for the purpose of agreeing to serve as Escrow Agent, subject to the provisions of this Agreement.

FIRST AMERICAN TITLE INSURANCE COMPANY

By: _____

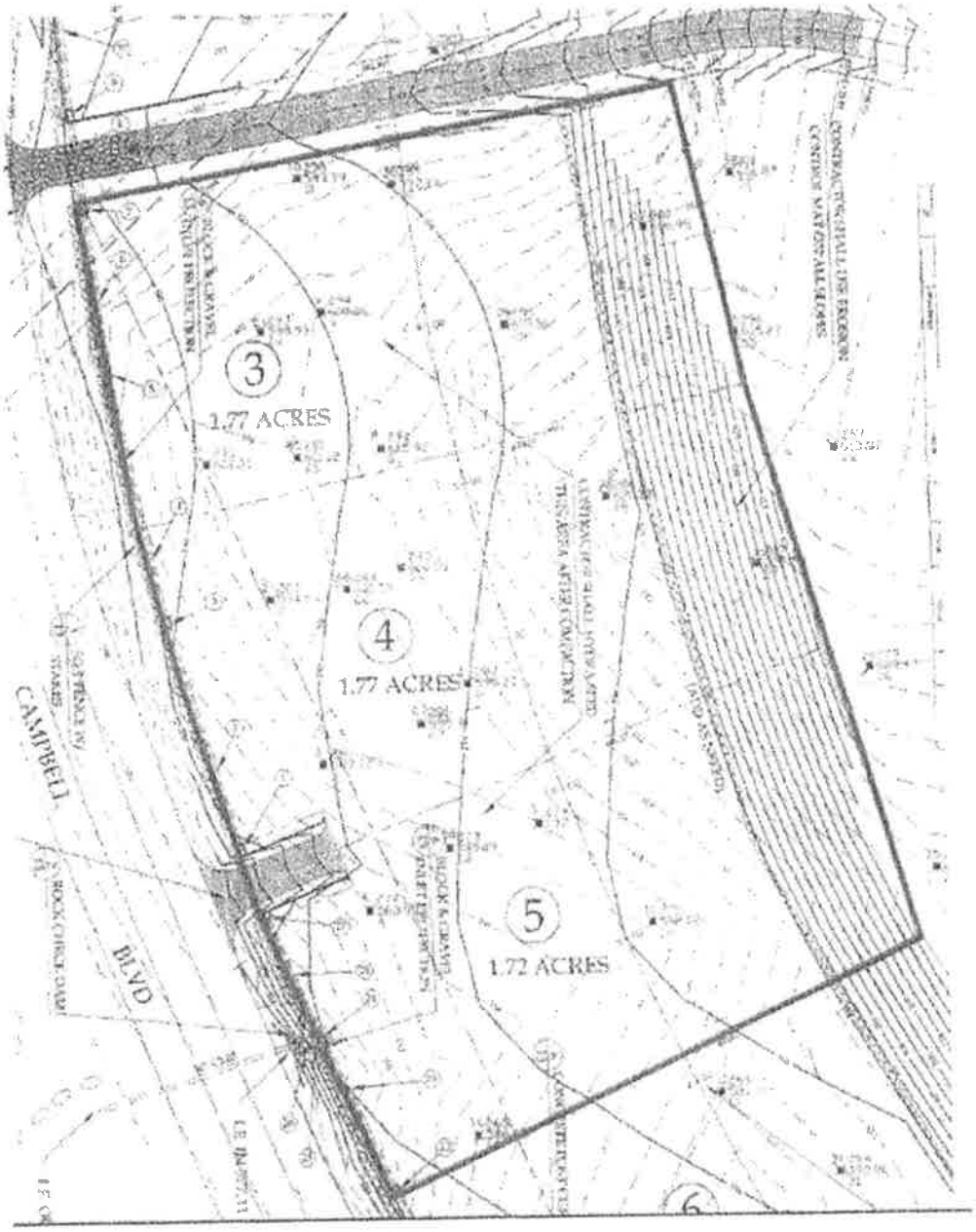
Name: _____

Title: _____

DATE OF EXECUTION: _____

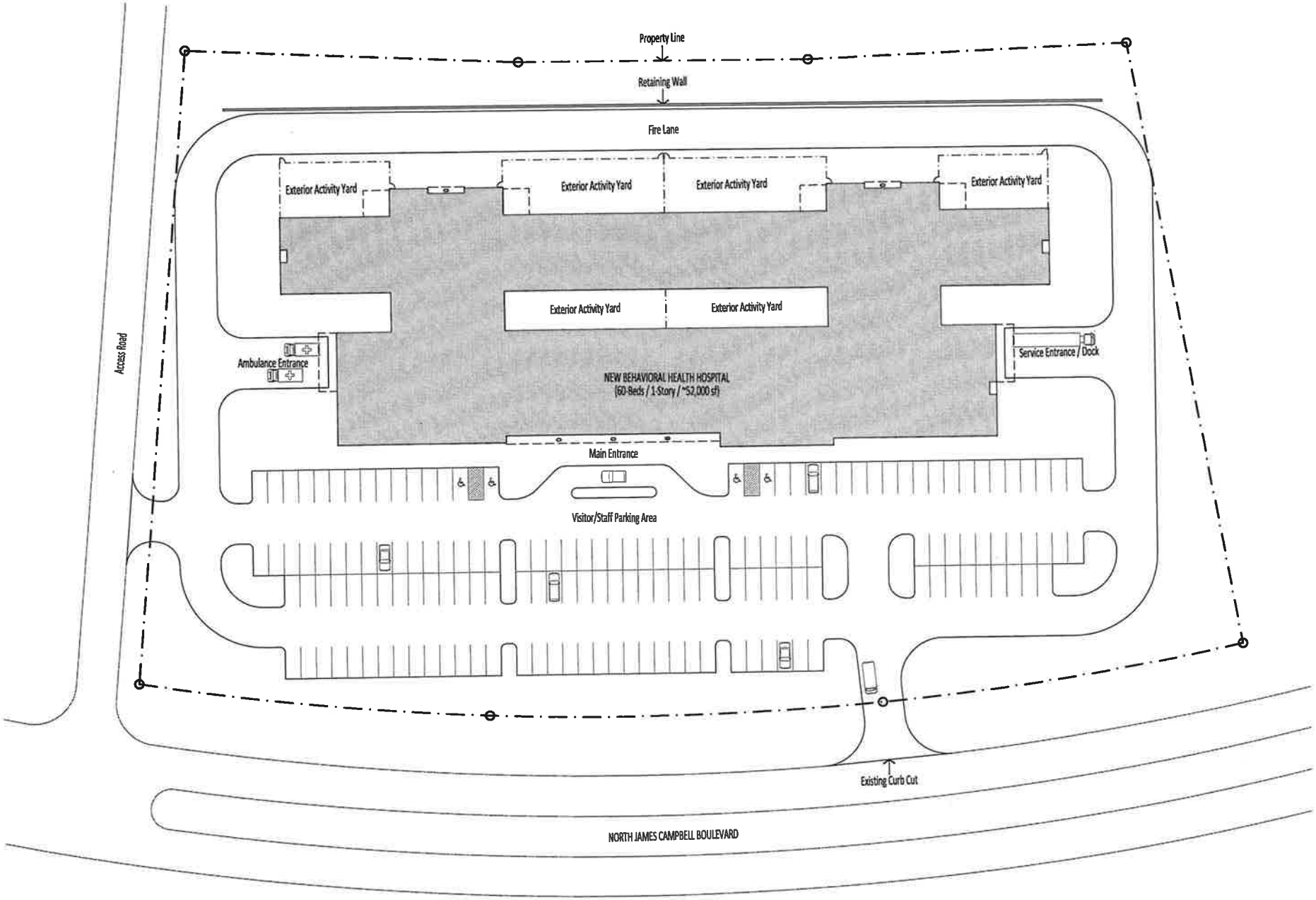
Exhibit A

The Land



A-6B(1)a-d

Plot Plan



GROSS SITE AREA = 5.25 ACRES

SITE PLAN

NORTH

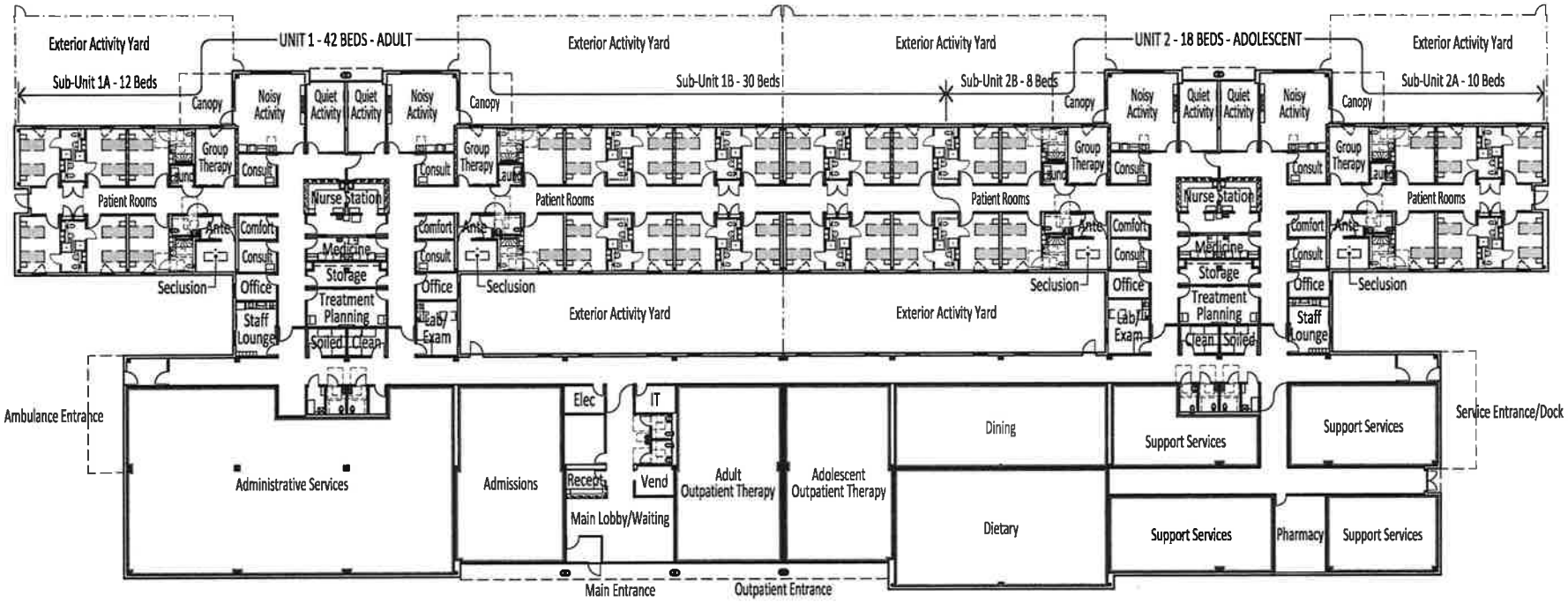
GRAPHIC SCALE

0' 40' 80' 160'

NEW BEHAVIORAL HEALTH HOSPITAL
TriStar Maury Regional Behavioral Health - Columbia, Tennessee
October 11, 2016

A-6B(2)

Floor Plans



GROSS BUILDING AREA = 52,000 SF

COMPOSITE FLOOR PLAN

NORTH

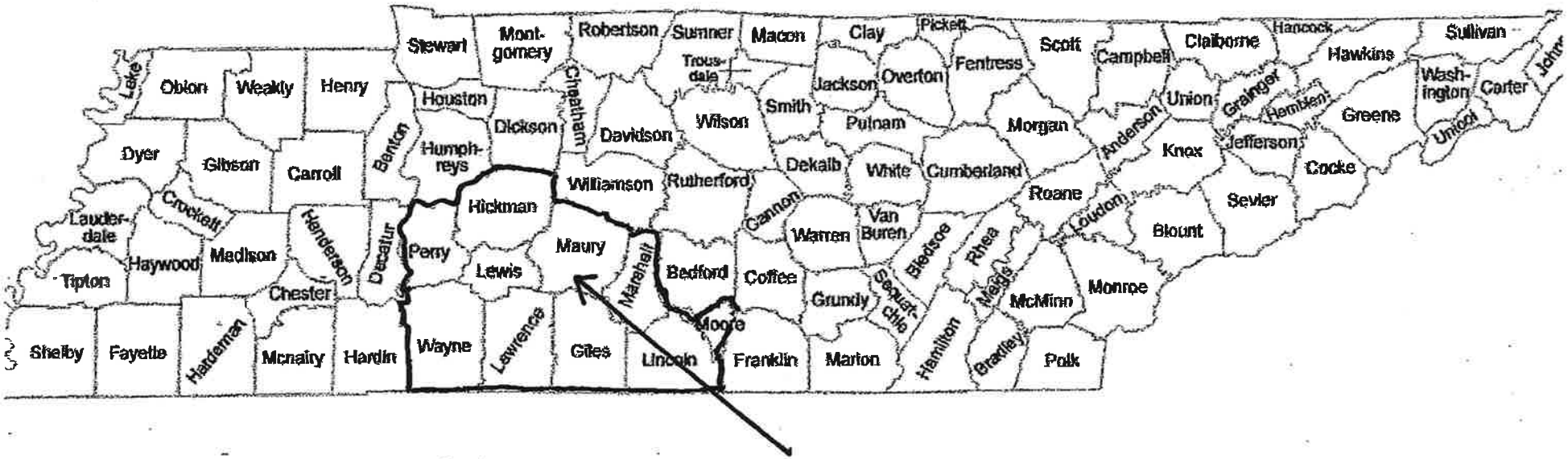
GRAPHIC SCALE

0' 25' 50' 100'

NEW BEHAVIORAL HEALTH HOSPITAL
TriStar Maury Regional Behavioral Health - Columbia, Tennessee
October 11, 2016

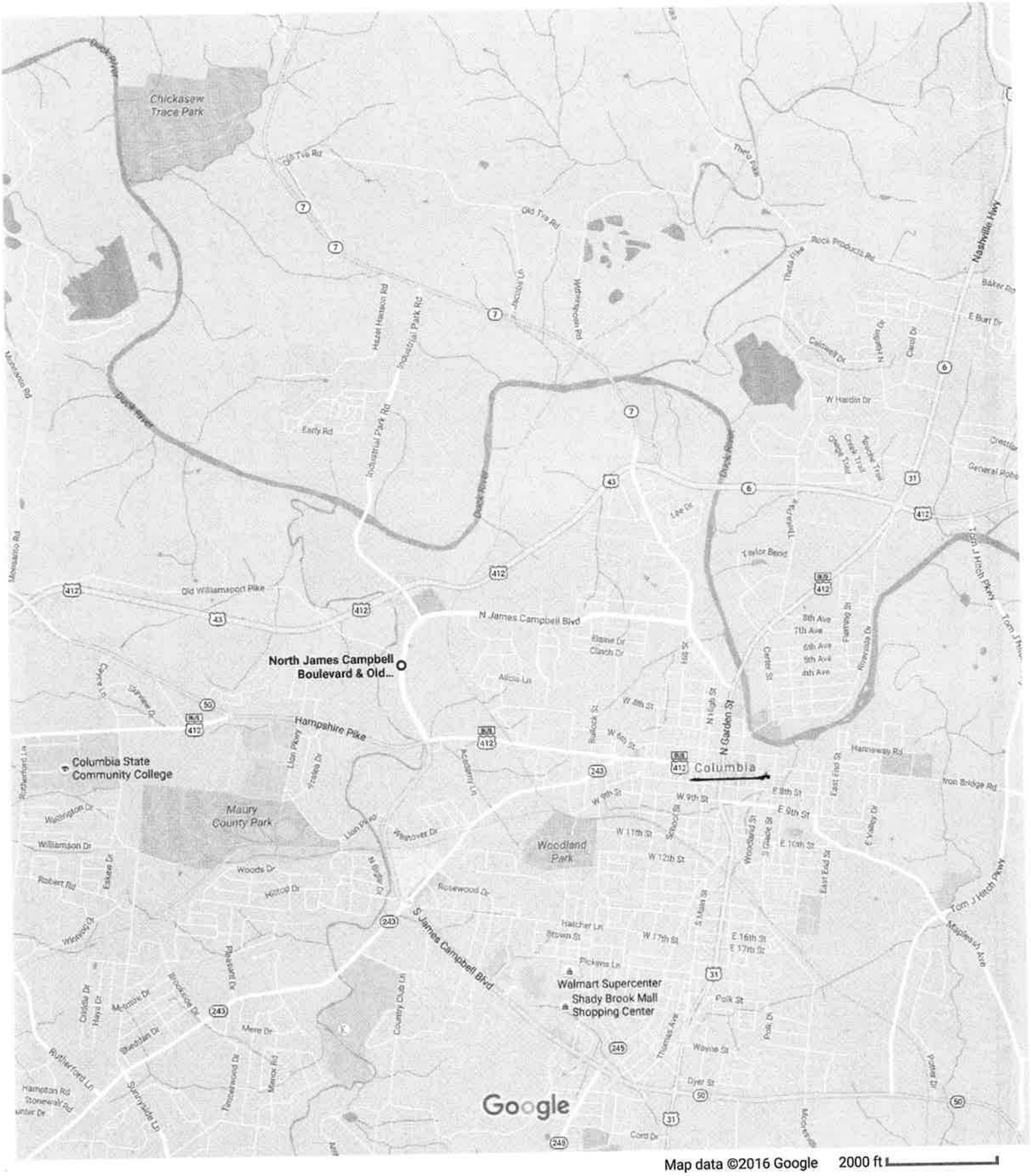
B-Need-3

Service Area Map



PRIMARY SERVICE AREA
TRISTAR MAURY REGIONAL BEHAVIORAL HEALTHCARE

Google Maps



Map data ©2016 Google 2000 ft

B-Economic Feasibility-1E

Documentation of Construction Cost Estimate

David Tropauer
Vice President
HCA Behavioral Health Services
One Park Plaza
Nashville, TN 37203

RE: Attestation of Construction Cost
New Behavioral Health Hospital
TriStar Maury Regional Behavioral Health
Columbia, Tennessee

11 October 2016

David,

Per recent conversations with you regarding a Certificate of Need Submission for a New Behavioral Health Hospital for TriStar Maury Behavioral Health in Columbia, Tennessee, I have prepared the following supporting documentation for your review.

I have reviewed the construction cost estimate provided by Tristar Maury Behavioral Health, LLC in the CON Submission for this Project. Based on my experience and knowledge of the current health care market, it is my opinion that the projected construction cost of $14,300,000 appears to be reasonable for a project of this type and size.

Additionally, the proposed site on North James Campbell Boulevard southeast of the intersection with Old Williamsport Pike in Columbia, Tennessee appears to be appropriate for construction of the proposed facility.

Finally, the physical environment will conform to applicable federal standard, manufacturer's specifications, and licensing agencies' requirements including the FGI Guidelines for Design and Construction of Health Care Facilities in current use by the licensing authorities.

If you have any questions or comments regarding this information, please do not hesitate to contact me at your convenience.

Thank you.

Bradford P. Stengel, AIA
Tennessee Registered Architect No. #000102 523

BRADFORD P. STENGEL
REGISTERED ARCHITECT
AGRICULTURE
COMMERCE
No. 000102 523
STATE OF TENNESSEE

B-Economic Feasibility--2

Documentation of Funding/Financing Availability

MAURY REGIONAL
MEDICAL CENTER

October 7, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Dear Mrs. Hill:

Maury Regional Medical Center is participating with HCA in developing a jointly owned Mental Health Hospital in Maury County. Maury Regional is a 49% member of the LLC that is filing the Certificate of Need application for that facility. The estimated cost of the project is approximately $24,308,500. Maury Regional is funding 49% of that, or approximately $12,000,000.

As Chief Financial Officer of Maury Regional Medical Center, I am writing to confirm that we have sufficient operating cash flow and cash reserves to provide all of the required funds in cash, and intend to do so after receipt of CON approval.

The application includes our financial statements documenting that sufficient cash reserves, operating income, and lines of credit exist to fund this project.

Sincerely,

Nick A. Swift
SVP/Chief Financial Officer

October 12, 2016

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application for TriStar Maury Regional Behavioral Healthcare
Columbia, Maury County

Dear Mrs. Hill:

TriStar Maury Behavioral Healthcare, LLC is applying for a Certificate of Need to develop a 60-bed mental health hospital in Columbia. Through a wholly-owned subsidiary, Maury County Behavioral Health, LLC, HCA currently is the sole owner of the LLC filing the application. However, the application contemplates that an affiliate of Maury Regional Hospital (a public nonprofit entity) will acquire 49% membership interest in the applicant LLC in the near future. HCA and Maury Regional have planned this as a joint venture over the past two years.

The estimated project cost is $24,033,041. As the prospective 51% owner of the applicant LLC, HCA's share of this cost will be $12,256,851.

As Chief Financial Officer of TriStar Health, the HCA Division Office for Middle Tennessee, I am writing to confirm that HCA, Inc. will provide through TriStar Health the $12,256,851 in funding required to implement HCA's future share of the project cost. HCA, Inc.'s financial statements are provided in the application.

Sincerely,

Eric Lawson, CFO
Tristar Health

B-Economic Feasibility-6A

Applicant's Financial Statements

MAURY REGIONAL HOSPITAL

Annual Financial Report

June 30, 2015

PYA

Certified Public Accountants

MAURY REGIONAL HOSPITAL

Combined Statements of Net Position

	June 30, 2015		June 30, 2014 (Restated)	
	Maury Regional Hospital	*Discretely Presented Component Units*	*Maury Regional Hospital*	*Discretely Presented Component Units*
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 37,900,703	$ 339,945	$ 37,077,128	$ 428,549
Certificates of deposit	322,164	-	320,251	-
Investments	1,532,267	-	1,129,753	-
Patient accounts receivable, net of estimated allowance for doubtful accounts of approximately $24,500,000 in 2015 and $21,800,000 in 2014	33,666,240	443,121	30,728,755	368,202
Inventories	4,781,254	10,378	4,413,292	36,865
Prepaid expenses	3,297,028	39,709	3,251,369	45,962
Due (to) from affiliates	555,192	(555,192)	585,192	(585,192)
Other receivables	1,794,952	1,001	1,131,981	2,089
TOTAL CURRENT ASSETS	83,849,800	278,962	78,637,721	296,475
ASSETS LIMITED AS TO USE	69,387,898	-	38,793,535	-
EQUITY INTEREST IN JOINT VENTURES	(99,446)	-	80,124	-
PROPERTY, PLANT AND EQUIPMENT, net	116,794,350	5,126,269	117,585,335	5,796,004
OTHER ASSETS	4,218,278	-	3,597,888	-
TOTAL ASSETS	274,150,880	5,405,231	238,694,603	6,092,479
DEFERRED OUTFLOWS OF RESOURCES				
Deferred pension adjustments	614,779	-	-	-
Deferred amounts from debt refunding	221,073	-	-	-
DEFERRED OUTFLOWS OF RESOURCES	835,852	-	-	-
COMBINED ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 274,986,732	$ 5,405,231	$ 238,694,603	$ 6,092,479

See notes to combined financial statements.

MAURY REGIONAL HOSPITAL

Combined Statements of Net Position - Continued

	June 30, 2015		June 30, 2014 (Restated)	
	Maury Regional Hospital	*Discretely Presented Component Units*	*Maury Regional Hospital*	*Discretely Presented Component Units*
LIABILITIES AND NET POSITION				
CURRENT LIABILITIES				
Current portion of long-term debt	$ 4,076,164	$ 1,010,067	$ 3,005,939	$ 740,130
Accounts payable and accrued expenses	10,038,115	469,539	9,708,959	290,049
Accrued salaries and wages	7,294,133	-	7,022,034	-
Accrued compensated absences	6,115,974	-	5,581,195	-
Accrued workers' compensation	2,049,013	-	4,145,265	-
Estimated amounts due to third party payers, net	5,998,390	-	4,734,690	-
Interest payable	82,427	-	44,677	-
TOTAL CURRENT LIABILITIES	35,654,216	1,479,606	34,242,759	1,030,179
OTHER LONG-TERM LIABILITIES	10,949,532	-	8,088,541	-
LONG-TERM DEBT				
Bonds payable	37,306,694	-	12,017,892	-
Other long-term debt	1,946,118	5,223,371	6,772,553	5,762,366
	39,252,812	5,223,371	18,790,445	5,762,366
Less current portion	(4,076,164)	(1,010,067)	(3,005,939)	(740,130)
TOTAL LONG-TERM DEBT	35,176,648	4,213,304	15,784,506	5,022,236
DEFERRED INFLOWS OF RESOURCES				
Deferred pension adjustments	864,558	-	1,188,985	-
TOTAL DEFERRED INFLOWS OF RESOURCES	864,558	-	1,188,985	-
NET POSITION				
Net investment in capital assets	96,702,069	(97,102)	98,880,738	33,638
Unrestricted	95,639,709	(190,577)	80,509,074	6,426
TOTAL NET POSITION	192,341,778	(287,679)	179,389,812	40,064
COMBINED LIABILITIES, DEFERRED INFLOWS AND NET POSITION	$ 274,986,732	$ 5,405,231	$ 238,694,603	$ 6,092,479

See notes to combined financial statements.

MAURY REGIONAL HOSPITAL

Combined Statements of Revenue, Expenses and Changes in Net Position

	Year Ended June 30, 2015	
	Maury Regional Hospital	*Discretely Presented Component Units*
OPERATING REVENUE		
Net patient service revenue	$ 296,154,015	$ 4,557,230
Other operating revenue	11,412,522	1,230
TOTAL OPERATING REVENUE	307,566,537	4,558,460
OPERATING EXPENSES		
Salaries, employee benefits and contract labor	179,084,670	1,174,998
Supplies	52,940,319	123,924
Purchased services	20,879,750	1,020,599
Professional fees	3,136,365	1,243,838
Repairs and maintenance	3,836,064	28,758
Utilities	4,220,118	16,216
Leases	4,561,970	674,121
Insurance	2,066,108	6,595
Other expenses	8,774,768	161,780
Depreciation and amortization	16,880,780	680,993
TOTAL OPERATING EXPENSES	296,380,912	5,131,822
INCOME (LOSS) FROM OPERATIONS	11,185,625	(573,362)
NONOPERATING REVENUE (EXPENSES)		
Contributions and grants	1,917,901	-
Investment income	810,051	1
Interest expense	(444,286)	(254,382)
Other	(37,755)	-
Equity in joint venture losses	(479,570)	-
TOTAL NONOPERATING REVENUE (EXPENSES)	1,766,341	(254,381)
EXCESS (DEFICIT) OF REVENUE OVER EXPENSES	12,951,966	(827,743)
Capital contributions/funding	-	500,000
CHANGE IN NET POSITION	12,951,966	(327,743)
NET POSITION, BEGINNING OF YEAR	179,389,812	40,064
NET POSITION, END OF YEAR	$ 192,341,778	$ (287,679)

See notes to combined financial statements.

MAURY REGIONAL HOSPITAL

Combined Statements of Cash Flows

	Year Ended June 30, 2015	Year Ended June 30, 2014 (Restated)
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from patients and insurance programs	**$ 296,419,251**	$ 283,422,880
Payments to vendors for supplies and other	**(100,499,927)**	(101,330,031)
Payments to and on behalf of employees	**(179,776,501)**	(167,108,455)
Other receipts	**9,856,998**	11,710,980
NET CASH PROVIDED BY OPERATING ACTIVITIES	**25,999,821**	26,695,374
CASH FLOWS FROM NONCAPITAL FINANCIAL ACTIVITIES:		
Contributions and grants	**1,917,901**	1,163,994
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Acquisition of property, plant and equipment	**(15,621,477)**	(8,362,006)
Proceeds from sale of equipment	**63,411**	151,220
Proceeds from issuance of long-term debt	**34,186,582**	-
Payments on long-term debt	**(13,714,312)**	(5,024,391)
Interest paid on long-term debt	**(569,316)**	(791,436)
Deferred amounts from bond refunding	**(221,073)**	-
NET CASH PROVIDED BY (USED IN) CAPITAL AND RELATED FINANCING ACTIVITIES	**4,123,815**	(14,026,613)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Interest income received on cash and investments	**810,051**	1,022,764
Proceeds from maturities of certificates of deposit	**642,415**	638,022
Purchase of certificates of deposit	**(644,328)**	(640,502)
Purchases of investments and AWUL	**(30,996,877)**	(5,099,921)
Investment in joint venture	**(300,000)**	(393,020)
Issuance of notes receivable	**(729,223)**	(813,761)
NET CASH USED IN INVESTING ACTIVITIES	**(31,217,962)**	(5,286,418)
INCREASE IN CASH AND CASH EQUIVALENTS	**823,575**	8,546,337
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	**37,077,128**	28,530,791
CASH AND CASH EQUIVALENTS, END OF YEAR	**$ 37,900,703**	$ 37,077,128

See notes to combined financial statements.

MAURY REGIONAL HOSPITAL

Combined Statements of Cash Flows - Continued

	Year Ended June 30, 2015	Year Ended June 30, 2014 (Restated)
RECONCILIATION OF INCOME FROM OPERATIONS TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Income from operations	$ 11,185,625	$ 6,363,647
Adjustments to reconcile income from operations to net cash provided by operating activities:		
Depreciation and amortization	16,880,780	16,969,349
Provision for bad debts	29,919,639	39,303,585
Amortization of deferred pension adjustments	(33,076)	(324,427)
Changes in:		
Patient accounts receivable	(32,857,124)	(37,203,018)
Inventories	(367,962)	525,253
Prepaid expenses	(45,659)	(419,480)
Due from affiliates	30,000	25,617
Other assets	(970,745)	(772,810)
Accounts payable and accrued expenses	329,156	2,273,036
Accrued salaries and wages	272,099	1,244,530
Accrued compensated absences	534,779	4,272
Accrued workers' compensation	(2,096,252)	265,608
Estimated amounts due to third party payers	1,263,700	(491,065)
Other long-term liabilities	1,954,861	(1,068,723)
TOTAL ADJUSTMENTS	14,814,196	20,331,727
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 25,999,821	$ 26,695,374
SUPPLEMENTAL INFORMATION:		
Equipment acquired through capital leases	$ 152,877	$ 4,747,956

See notes to combined financial statements.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2015

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission File Number 1-11239

HCA Holdings, Inc.

(Exact Name of Registrant as Specified in its Charter)

Delaware (State or Other Jurisdiction of Incorporation or Organization)	**27-3865930** (I.R.S. Employer Identification No.)
One Park Plaza **Nashville, Tennessee** (Address of Principal Executive Offices)	**37203** (Zip Code)

Registrant's telephone number, including area code: (615) 344-9551

Securities Registered Pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $0.01 Par Value	New York Stock Exchange

Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of January 31, 2016, there were 396,958,400 outstanding shares of the Registrant's common stock. As of June 30, 2015, the aggregate market value of the common stock held by nonaffiliates was approximately $29.839 billion. For purposes of the foregoing calculation only, Hercules Holding II, LLC and the Registrant's directors and executive officers have been deemed to be affiliates.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy materials for its 2016 Annual Meeting of Stockholders are incorporated by reference into Part III hereof.

HCA HOLDINGS, INC.
CONSOLIDATED INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013
(Dollars in millions, except per share amounts)

	2015	2014	2013
Revenues before the provision for doubtful accounts	$ 43,591	$ 40,087	$ 38,040
Provision for doubtful accounts	3,913	3,169	3,858
Revenues	39,678	36,918	34,182
Salaries and benefits	18,115	16,641	15,646
Supplies	6,638	6,262	5,970
Other operating expenses	7,103	6,755	6,237
Electronic health record incentive income	(47)	(125)	(216)
Equity in earnings of affiliates	(46)	(43)	(29)
Depreciation and amortization	1,904	1,820	1,753
Interest expense	1,665	1,743	1,848
Losses (gains) on sales of facilities	5	(29)	10
Losses on retirement of debt	135	335	17
Legal claim costs	249	78	—
	35,721	33,437	31,236
Income before income taxes	3,957	3,481	2,946
Provision for income taxes	1,261	1,108	950
Net income	2,696	2,373	1,996
Net income attributable to noncontrolling interests	567	498	440
Net income attributable to HCA Holdings, Inc.	$ 2,129	$ 1,875	$ 1,556
Per share data:			
Basic earnings per share	$ 5.14	$ 4.30	$ 3.50
Diluted earnings per share	$ 4.99	$ 4.16	$ 3.37
Shares used in earnings per share calculations (in millions):			
Basic	414.193	435.668	445.066
Diluted	426.721	450.352	461.913

The accompanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.
CONSOLIDATED COMPREHENSIVE INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013
(Dollars in millions)

	2015	2014	2013
Net income	$ 2,696	$ 2,373	$ 1,996
Other comprehensive income (loss) before taxes:			
Foreign currency translation	(63)	(74)	18
Unrealized gains (losses) on available-for-sale securities	1	9	(7)
Defined benefit plans	30	(158)	134
Pension costs included in salaries and benefits	32	21	38
	62	(137)	172
Change in fair value of derivative financial instruments	(36)	(36)	3
Interest costs included in interest expense	125	132	131
	89	96	134
Other comprehensive income (loss) before taxes	89	(106)	317
Income taxes (benefits) related to other comprehensive income items	31	(40)	117
Other comprehensive income (loss)	58	(66)	200
Comprehensive income	2,754	2,307	2,196
Comprehensive income attributable to noncontrolling interests	567	498	440
Comprehensive income attributable to HCA Holdings, Inc.	$ 2,187	$ 1,809	$ 1,756

The accompanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2015 AND 2014
(Dollars in millions)

	2015	2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 741	$ 566
Accounts receivable, less allowance for doubtful accounts of $5,326 and $5,011	5,889	5,694
Inventories	1,439	1,279
Deferred income taxes	—	366
Other	1,163	1,025
	9,232	8,930
Property and equipment, at cost:		
Land	1,524	1,524
Buildings	12,533	11,941
Equipment	19,335	18,496
Construction in progress	1,222	1,019
	34,614	32,980
Accumulated depreciation	(19,600)	(18,625)
	15,014	14,355
Investments of insurance subsidiaries	432	494
Investments in and advances to affiliates	178	165
Goodwill and other intangible assets	6,731	6,416
Other	1,157	620
	$ 32,744	$ 30,980
LIABILITIES AND STOCKHOLDERS' DEFICIT		
Current liabilities:		
Accounts payable	$ 2,170	$ 2,035
Accrued salaries	1,233	1,370
Other accrued expenses	1,880	1,737
Long-term debt due within one year	233	338
	5,516	5,480
Long-term debt, less net debt issuance costs of $167 and $219	30,255	29,088
Professional liability risks	1,115	1,078
Income taxes and other liabilities	1,904	1,832
Stockholders' deficit:		
Common stock $0.01 par; authorized 1,800,000,000 shares; outstanding 398,738,700 shares — 2015 and 420,477,900 shares — 2014	4	4
Accumulated other comprehensive loss	(265)	(323)
Retained deficit	(7,338)	(7,575)
Stockholders' deficit attributable to HCA Holdings, Inc.	(7,599)	(7,894)
Noncontrolling interests	1,553	1,396
	(6,046)	(6,498)
	$ 32,744	$ 30,980

The accompanying notes are an integral part of the consolidated financial statements.

Proof of Publication

PUBLICATION OF INTENT--HEALTH SERVICES & DEVELOPMENT AGENCY

The following shall be published in the "Legal Notices" section of the newspaper, in a space no smaller than two (2) columns by two (2) inches:

NOTIFICATION OF INTENT
TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Maury Regional Behavioral Healthcare, (a proposed mental health hospital), to be owned by TriStar Maury Behavioral Healthcare, LLC (a limited liability company), and to be managed by Maury County Behavioral Health, LLC (a limited liability company), intends to file an application for Certificate of Need to establish a mental health hospital for adolescent and adult patients, located on the east side of North James Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike, in Columbia, Tennessee 38401. The estimated project cost is $24,400,000.

The project will seek licensure by the Tennessee Department of Mental Health and Substance Abuse Services as a 60-bed mental health hospital. The project does not initiate or discontinue any other health service and it will not affect any other facility's licensed bed complements.

The anticipated date of filing the application is on or before October 14, 2016. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Miscellaneous Information

1. Medical Director Qualifications

CURRICULUM VITAE

RODNEY A. POLING, M.D.
Psychiatry
1402 Rosewood Drive
Columbia, TN 38401
(931) 381-5886

MEDICAL LICENSE

California	#G-53146
Kentucky	#25737
Tennessee	#020300

APPOINTMENTS

Clinical Assistant Professor,
Department of Psychiatry
Vanderbilt University School of Medicine
January 1997 to December 2010

EDUCATION

University of Kansas, School of Medicine
Kansas City, Kansas
M.D. May 15, 1983
August 1979 to May 1983

Tulane University of Louisiana
New Orleans, Louisiana
B.S. Chemical Engineering (cum laude)
May 11, 1979
August 1975 to May 1979

HONORS

Distinguished Fellow, American Psychiatric Association
Navy Commendation Medal
Navy Achievement Medal
Tau Beta Pi (Engineering Honor Society)

POST GRADUATE TRAINING

Psychiatry Residency
U.S. Naval Hospital
San Diego, California
August 1, 1985 to July 31, 1988

Internship – Diversified Psychiatry
U.S. Naval Hospital
San Diego, California
July 1, 1983 to June 30, 1984

PRACTICE

Medical Director
Behavioral Healthcare Center – Columbia
Columbia, Tennessee
January 2011 to Present

General Psychiatry
Private Practice
Maury Regional Hospital
Columbia, Tennessee
August 1990 to Present

Medical Director
Senior Life Expressions
Marshall County Medical Center
Lewisburg, Tennessee
July 2011 to December 2013

Consultant, Geriatric Psychiatry Program
Williamson County Counseling Center
Franklin, Tennessee
May 1991 to January 1993

Staff Psychiatrist
Consultant, Geriatric Psychiatry Program
Columbia Area Mental Health Center
Columbia, Tennessee
August 1990 to January 1993

Chief, Inpatient Psychiatry
U.S. Naval Hospital
Orlando, Florida
October 1988 to July 1990

Head, Psychiatry Department (Acting)
U.S. Naval Hospital
Orlando, Florida
August 1988 to October 1988

Squadron Medical Officer
Amphibious Squadron One
U.S.S. TARAWA LHA – 1 (Flagship)
July 1984 to July 1985

COLLATERAL DUTY

President
Tennessee Psychiatric Association
May 2016 to present

President Elect
Tennessee Psychiatric Association
May 2014 to May 2016

Secretary
Tennessee Psychiatric Association
May 2012 to May 2014

Chief of Staff
Maury Regional Hospital
Columbia, Tennessee
2003

Vice Chief of Staff
Maury Regional Hospital
Columbia, Tennessee
2002

President
Maury County Medical Society
Columbia, Tennessee
2000, 2012, 2013

Chairman, Department of Medicine
Maury Regional Hospital
Columbia, Tennessee
199

Chief-Department of Psychiatry
Maury Regional Hospital
Columbia, Tennessee
January 1998 to December 1999
January 1993 to December 1994

Chairman, Education and Library Committee
Maury Regional Hospital
Columbia, Tennessee
January 1998 to December 1999

Chairman, Credentials Committee
Maury Regional Hospital
Columbia, Tennessee
January 1996 to December 1996

Chairman, Bioethics Review and Protection
Of Human Subjects Committee
U.S. Naval Hospital
Orlando, Florida
December 1998 to June 1990

Psychiatric Consultant
Naval Support Force Antarctica
June 1987 to June 1988

BOARDS

American Board of Psychiatry and Neurology
June 1990 – Psychiatry
April 1994 – Geriatric Psychiatry
May 2004 – Re-Certified
April 2014—Re-Certified

National Board of Medical Examiners
July 1984

PROFESSIONAL ORGANIZATIONS

American Psychiatric Association
Tennessee Psychiatric Association
Tennessee Medical Association
Maury County Medical Society
American Association of Geriatric Psychiatry
Tennessee Association of Geriatric Physicians
Tennessee Association of Long Term Care Physicians

LECTURES

"Game Day Strategies
For the Treatment of Depression"
Medical Staff Conference
Maury Regional Hospital
November 2000

"Treatment of Insomnia"
Annual Meeting
Tennessee Osteopathic Association
Chattanooga, Tennessee
May 2000

"Delirium"
Medical Staff Conference
Maury Regional Hospital
March 1998

"Obsessive Compulsive Disorder"
Community Awareness Series
Maury Regional Hospital
Columbia, Tennessee
October 1995

"Depressive Disorders: Recognition & Treatment"
Clinical Conference Lecture Series
Maury Regional Hospital
Columbia, Tennessee
November 1992, 1994

"Adjustment Disorder in the Navy"
Resident Lecture Series
Psychiatry Department
U.S. Naval Hospital
San Diego, California
1987 to 1988

"Schizophrenia, the One Percent Dilemma"
Grand Rounds
U.S. Naval Hospital
1986

PAPERS

"An Approach to the Violent Patient"
Shale, J. H., Poling, R. A. 1986
Unpublished

"Sundowning: A Problem in the Elderly Patient"
Shale, J. H., Poling, R. A. 1986
Unpublished

TOPICS OF INTEREST

Mood and Anxiety Disorders
Geriatric Psychiatry
Delirium
Consultation Psychiatry

APPOINTED BOARDS

Maury Regional Medical Center, Board of Trustees 2016
TennCare Pharmacy Advisory Committee 2015
CAHABA Medicare Advisory Committee 2012

The American Board of Psychiatry and Neurology

Incorporated 1934

This is to certify that

Rodney A. Poling, M.D.

has satisfied the requirements of the Board

and is hereby certified as a Diplomate in the specialty of

Psychiatry

June, 1990

Layton McCurdy
President

Elwood L. Minnicoll
Vice-President

Stephen C Scheeher
Executive Vice-President

William E. Bell
Secretary

Maurice J. Martin

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY · INC 1934 · APA ANA NAV AMA

AMERICAN BOARD OF MEDICAL SPECIALTIES · OPIBUSQUE

Certificate No 32845

American Board of Psychiatry and Neurology, Inc.

A Member Board of the American Board of Medical Specialties (ABMS)

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Rochester, MN
J. Clay Goodman, M.D.
Houston, TX
Laurie Gutmann, M.D.
Iowa City, IA
Kerry H. Levin, M.D.
Pepper Pike, OH
Noor A. Pirzada, M.D.
Monclova, OH
Ann Tilton, M.D.
New Orleans, LA

Please Address All Communications to:
President and CEO
Larry R. Faulkner, M.D.
2150 E. Lake Cook Road, Suite 900
Buffalo Grove, IL 60089
Phone: 847.229.6500
Fax: 847.229.6600
www.abpn.com

May 30, 2014

Rodney A. Poling, M.D.
Rodney A Poling MD
1402 Rosewood Dr
Columbia, TN 38401-4878

Dear Dr. Poling:

The American Board of Psychiatry and Neurology, Inc. is pleased to inform you that you have passed your Geriatric Psychiatry Maintenance of Certification examination held April 21 - 25, 2014.

Your certificate will be printed with certificate number 1144 and will be sent to you in approximately three months. Certificates no longer carry an end date. To continue to be certified, diplomates must meet requirements for Maintenance of Certification. Please refer to the enclosed MOC Activities Calendar for more information.

The Board will submit your name and address for listing in a future edition of the *Official ABMS Directory of Board Certified Medical Specialists*. Lists of Diplomates are also sent to other selected publications and your name and publication address will be included in these lists. You may request a prepared Press Release statement to submit to your local publication. E-mail your 'Press Release' request to ComputerExams@abpn.com. Additionally, verification of your certification is available on-line through ABPN's *verifyCert® Status Verification System* at www.abpn.com/verifycert.

Please check your mailing and publication addresses on the enclosed form. If there is a discrepancy, update your information as necessary using the *ABPN Physician Folios* system at www.abpn.com/folios. Certificates will not be shipped to P.O. Boxes. See the enclosed Certificate Shipping form.

As a diplomate, the Board encourages you to include a statement on your stationery and printed material stating "a diplomate of the American Board of Psychiatry and Neurology, Inc., a member Board of the American Board of Medical Specialties."

Sincerely yours,

Larry R Faulkner

Larry R. Faulkner, M.D.
President and CEO
LRF/ab

The American Board of Psychiatry and Neurology

Incorporated 1934

This is to certify that

Rodney A. Poling, M.D.

has satisfied the requirements of the Board and is hereby certified as a Diplomate in the subspecialty of

Psychiatry with Added Qualifications in Geriatric Psychiatry

April 1994 - April 2004

James H. Shore
President

Ludwig Gutmann
Vice-President

Lenore C. Terr
Secretary

K. Altshuler M.D.
Treasurer

Stephen C. Scheiber
Executive Vice-President

William T. McKinney
Committee Chair

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AMERICAN BOARD OF MEDICAL SPECIALTIES · OPIBUSQUE

Certificate No 1144

2. TennCare Enrollment

TennCare Enrollment Report for August 2016

MCO	REGION	Total
AMERIGROUP COMMUNITY CARE		457,366
BLUECARE	East Tennessee	210,420
BLUECARE	Middle Tennessee	175,716
BLUECARE	West Tennessee	154,527
UnitedHealthcare Community Plan	East Tennessee	167,533
UnitedHealthcare Community Plan	Middle Tennessee	175,544
UnitedHealthcare Community Plan	West Tennessee	142,048
TENNCARE SELECT HIGH	All	50,146
TENNCARE SELECT LOW	All	20,132
PACE		266
Awaiting MCO assignment		28
Grand Total		1,553,726

	Female				Female	Male					
COUNTY	0 - 18	19 - 20	21 - 64	65 -->	Total	0 - 18	19 - 20	21 - 64	65 -->	Male Total	Grand Total
ANDERSON	4,276	356	4,644	644	9,920	4,589	281	2,216	283	7,369	17,289
BEDFORD	3,948	264	3,309	257	7,778	4,085	246	1,363	123	5,817	13,595
BENTON	1,071	92	1,224	148	2,535	1,111	80	637	79	1,907	4,442
BLEDSOE	832	73	888	123	1,916	905	78	511	58	1,552	3,468
BLOUNT	6,211	528	6,537	685	13,961	6,307	418	2,874	333	9,932	23,893
BRADLEY	6,112	503	6,340	704	13,659	6,412	394	2,718	291	9,815	23,474
CAMPBELL	2,986	291	3,918	703	7,898	3,189	218	2,155	387	5,949	13,847
CANNON	793	73	890	136	1,892	825	68	422	53	1,368	3,260
CARROLL	1,883	188	2,280	324	4,675	2,079	164	1,158	127	3,528	8,203
CARTER	3,232	286	3,753	700	7,971	3,408	227	1,928	277	5,840	13,811
CHEATHAM	2,053	178	2,128	165	4,524	2,193	164	943	93	3,393	7,917
CHESTER	1,055	92	1,109	160	2,416	1,080	72	482	71	1,705	4,121
CLAIBORNE	2,122	202	2,630	567	5,521	2,230	178	1,576	266	4,250	9,771
CLAY	539	44	576	117	1,276	565	44	371	62	1,042	2,318
COCKE	2,825	260	3,320	463	6,868	2,958	229	1,782	237	5,206	12,074
COFFEE	3,752	296	3,861	408	8,317	3,865	228	1,694	166	5,953	14,270
CROCKETT	1,138	81	1,047	203	2,469	1,094	63	503	83	1,743	4,212
CUMBERLAND	3,417	305	3,578	504	7,804	3,555	228	1,732	248	5,763	13,567
DAVIDSON	43,811	2,871	38,673	3,424	88,779	44,987	2,480	15,881	1,861	65,209	153,988
DECATUR	690	66	809	198	1,763	782	47	440	61	1,330	3,093
DEKALB	1,383	125	1,428	194	3,130	1,499	98	751	106	2,454	5,584
DICKSON	3,051	236	3,146	318	6,751	3,216	219	1,366	135	4,936	11,687
DYER	2,808	256	3,187	428	6,679	2,947	218	1,369	154	4,688	11,367
FAYETTE	1,849	156	1,898	296	4,199	1,974	124	781	149	3,028	7,227
FENTRESS	1,367	137	1,635	376	3,515	1,481	127	1,077	201	2,886	6,401
FRANKLIN	2,057	194	2,264	278	4,793	2,220	164	1,079	112	3,575	8,368
GIBSON	3,411	282	3,824	595	8,112	3,614	262	1,710	261	5,847	13,959
GILES	1,738	151	1,852	245	3,986	1,714	111	843	124	2,792	6,778
GRAINGER	1,515	140	1,640	306	3,601	1,540	126	960	155	2,781	6,382

	Female				Female	Male					
COUNTY	0 - 18	19 - 20	21 - 64	65 -->	Total	0 - 18	19 - 20	21 - 64	65 -->	Male Total	Grand Total
GREENE	3,774	344	4,544	728	9,390	4,036	266	2,225	377	6,904	16,294
GRUNDY	1,086	116	1,340	206	2,748	1,214	98	774	123	2,209	4,957
HAMBLEN	4,772	298	4,065	539	9,674	4,904	291	1,856	228	7,279	16,953
HAMILTON	18,681	1,335	19,303	2,396	41,715	19,541	1,157	7,896	1,085	29,679	71,394
HANCOCK	521	67	654	151	1,393	563	41	378	69	1,051	2,444
HARDEMAN	1,829	180	2,107	327	4,443	1,818	144	970	156	3,088	7,531
HARDIN	1,767	153	2,107	382	4,409	1,855	159	1,043	202	3,259	7,668
HAWKINS	3,469	296	3,967	602	8,334	3,624	268	2,027	297	6,216	14,550
HAYWOOD	1,477	128	1,741	250	3,596	1,631	124	620	100	2,475	6,071
HENDERSON	1,851	161	2,099	269	4,380	1,969	124	952	103	3,148	7,528
HENRY	2,063	174	2,333	301	4,871	2,226	180	1,127	92	3,625	8,496
HICKMAN	1,570	151	1,763	188	3,672	1,733	147	907	99	2,886	6,558
HOUSTON	495	40	586	122	1,243	541	28	281	72	922	2,165
HUMPHREYS	1,137	86	1,263	151	2,637	1,184	62	600	62	1,908	4,545
JACKSON	672	56	805	132	1,665	775	59	455	91	1,380	3,045
JEFFERSON	3,349	302	3,384	514	7,549	3,531	259	1,711	202	5,703	13,252
JOHNSON	1,075	99	1,240	266	2,680	1,131	77	772	142	2,122	4,802
KNOX	21,104	1,647	22,242	2,503	47,496	22,069	1,365	9,753	1,176	34,363	81,859
LAKE	472	47	670	162	1,351	553	42	308	85	988	2,339
LAUDERDALE	2,095	200	2,328	298	4,921	2,204	176	992	124	3,496	8,417
LAWRENCE	2,863	214	2,998	411	6,486	3,066	188	1,495	147	4,896	11,382
LEWIS	814	73	811	129	1,827	794	69	393	56	1,312	3,139
LINCOLN	2,123	173	2,056	278	4,630	2,201	129	967	103	3,400	8,030
LOUDON	2,654	200	2,502	267	5,623	2,763	148	1,142	122	4,175	9,798
MACON	1,910	167	1,817	234	4,128	2,033	131	897	114	3,175	7,303
MADISON	6,966	537	7,294	859	15,656	7,076	436	2,680	375	10,567	26,223
MARION	1,876	171	2,145	233	4,425	1,907	154	943	130	3,134	7,559
MARSHALL	1,985	133	1,931	174	4,223	2,084	119	790	73	3,066	7,289
MAURY	5,368	375	5,239	513	11,495	5,669	309	2,081	196	8,255	19,750
MCMINN	3,255	275	3,568	506	7,604	3,543	224	1,656	229	5,652	13,256
MCNAIRY	1,826	189	2,230	355	4,600	2,007	150	1,229	190	3,576	8,176
MEIGS	856	83	935	77	1,951	876	70	463	40	1,449	3,400
MONROE	2,988	288	3,241	496	7,013	3,272	221	1,660	260	5,413	12,426
MONTGOMERY	10,287	697	10,226	706	21,916	10,620	503	3,563	257	14,943	36,859
MOORE	226	19	200	50	495	256	22	101	15	394	889
MORGAN	1,248	123	1,302	200	2,873	1,298	120	678	101	2,197	5,070
OBION	2,163	178	2,397	304	5,042	2,274	133	1,009	132	3,548	8,590
OVERTON	1,258	149	1,393	282	3,082	1,344	108	765	136	2,353	5,435
PERRY	570	47	547	89	1,253	567	54	302	32	955	2,208
PICKETT	264	28	319	72	683	290	27	168	48	533	1,216
POLK	1,086	109	1,207	159	2,561	1,112	89	633	81	1,915	4,476
PUTNAM	4,525	367	4,759	748	10,399	4,783	302	2,494	326	7,905	18,304
RHEA	2,498	207	2,497	358	5,560	2,565	173	1,220	145	4,103	9,663
ROANE	2,821	231	3,420	506	6,978	3,154	244	1,775	239	5,412	12,390
ROBERTSON	4,097	306	3,577	382	8,362	4,316	255	1,445	153	6,169	14,531
RUTHERFORD	15,144	1,085	13,529	1,014	30,772	15,922	817	4,920	441	22,100	52,872
SCOTT	1,965	170	2,232	373	4,740	2,067	166	1,196	186	3,615	8,355
SEQUATCHIE	1,025	97	1,135	147	2,404	1,071	78	601	52	1,802	4,206
SEVIER	6,010	450	5,564	494	12,518	6,460	352	2,355	179	9,346	21,864

	Female				Female	Male					
COUNTY	0 - 18	19 - 20	21 - 64	65 -->	Total	0 - 18	19 - 20	21 - 64	65 -->	Male Total	Grand Total
SHELBY	78,757	6,035	74,192	6,878	165,862	80,642	5,431	24,935	3,091	114,099	**279,961**
SMITH	1,173	106	1,257	166	2,702	1,211	74	571	63	1,919	**4,621**
STEWART	782	66	874	110	1,832	815	61	434	59	1,369	**3,201**
SULLIVAN	8,495	694	9,987	1,314	20,490	8,942	612	4,996	595	15,145	**35,635**
SUMNER	8,455	686	8,156	798	18,095	8,923	572	3,204	303	13,002	**31,097**
TIPTON	3,797	318	3,805	385	8,305	4,043	276	1,538	136	5,993	**14,298**
TROUSDALE	558	56	586	75	1,275	548	25	275	38	886	**2,161**
UNICOI	954	90	1,144	253	2,441	1,074	85	547	129	1,835	**4,276**
UNION	1,442	120	1,418	155	3,135	1,381	109	757	88	2,335	**5,470**
VAN BUREN	334	26	360	59	779	383	23	199	49	654	**1,433**
WARREN	3,052	231	3,108	443	6,834	3,180	195	1,497	203	5,075	**11,909**
WASHINGTON	6,292	471	7,261	981	15,005	6,448	425	3,459	417	10,749	**25,754**
WAYNE	872	63	952	167	2,054	904	75	481	72	1,532	**3,586**
WEAKLEY	1,890	178	2,181	314	4,563	1,949	151	1,028	120	3,248	**7,811**
WHITE	1,817	180	1,985	284	4,266	1,954	130	1,091	119	3,294	**7,560**
WILLIAMSON	3,593	255	3,137	360	7,345	3,833	264	1,316	153	5,566	**12,911**
WILSON	5,494	447	5,296	479	11,716	5,737	341	2,076	193	8,347	**20,063**
Other	4,754	360	5,320	183	10,614	5,068	304	1,990	109	7,471	**18,085**
Grand Total	**408,366**	**32,128**	**413,018**	**47,975**	**901,487**	**425951**	**27367**	**176984**	**21936**	**652238**	**1,553,725**

Reports include some membership additions that are the result of retroactivity; however, additional retroactivity may still occur. The "Other" county category reflects recipients who are Tennessee residents for which their domicile is temporarily located outside of the state.

3. Census QuickFacts for Service Area

4. Medically Underserved Designations

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Giles County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Giles County	055	Giles County	03192	Medically Underserved Area	59.90	11/01/1978	05/21/2014

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Hickman County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Hickman County	081	HICKMAN SERVICE AREA	03201	Medically Underserved Area	46.60	11/01/1978	11/01/1978

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Lawrence County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Lawrence County	099	LAWRENCE SERVICE AREA	03207	Medically Underserved Area	60.90	11/01/1978	11/01/1978

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Lewis County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Lewis County	101	LEWIS SERVICE AREA	03208	Medically Underserved Area	61.90	05/18/1984	05/18/1984

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Lincoln County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Lincoln County	103	LINCOLN SERVICE AREA	03209	Medically Underserved Area	53.40	11/01/1978	11/01/1978

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Marshall County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Marshall County	117	MARSHALL SERVICE AREA	03216	Medically Underserved Area	58.60	11/01/1978	11/01/1978

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Maury County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Maury County	119	Bakerville/ Boldspringdiv. Service Area	03258	Medically Underserved Area	54.53	05/12/1994	05/12/1994

MCD (91640) District 9
MCD (91070) District 6
MCD (91450) District 8

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Moore County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Moore County	127	Moore County	03220	Medically Underserved Area	57.80	11/01/1978	05/21/2014

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Perry County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Perry County	135	Perry County	03224	Medically Underserved Area	62.00	11/01/1978	05/21/2014

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 10/12/2016

State: Tennessee
County: Wayne County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Wayne County	181	Wayne County	1472214764	Medically Underserved Area	55.20	11/01/1978	04/19/2016

1 Page Size: 20 01 items in 01 pages

5. Draft Transfer Agreement

TRANSFER AGREEMENT

Between

MAURY REGIONAL HOSPITAL
D/B/A MAURY REGIONAL MEDICAL CENTER
And
TRISTAR MAURY BEHAVIORAL HEALTHCARE, LLC
D/B/A TRISTAR MAURY REGIONAL BEHAVIORAL HEALTHCARE

THIS AGREEMENT is made and enter into this the ____ day of _____, 2016, by and between MAURY REGIONAL HOSPITAL D/B/A MAURY REGIONAL MEDICAL CENTER (hereinafter referred to as "HOSPITAL"), and TRISTAR MAURY BEHAVIORAL HEALTHCARE, LLC D/B/A TRISTAR MAURY REGIONAL BEHAVIORAL HEALTHCARE (hereinafter referred to as "FACILITY").

WHEREAS, HOSPITAL is licensed as an acute care hospital in the State of Tennessee and is also certified for participation under the Medicare and Medicaid Programs; and

WHEREAS, FACILITY is a Tennessee limited liability company which plans to operate and/or operates an inpatient behavior health services facility in Columbia, Maury County, Tennessee; and

WHEREAS, FACILITY and HOSPITAL wish to enter into an agreement to facilitate the continuity of care and timely transfer of patients and records from FACILITY to HOSPITAL in the event that a patient's physician determines a transfer is medically necessary.

NOW, THEREFORE, in consideration of the promises and mutual agreements contained herein, the parties, intending to be legally bound, agree as follows:

1. **Transfer of Patients**. Whenever a patient's attending physician determines that it is medically necessary to transfer a patient from FACILITY to HOSPITAL, HOSPITAL agrees to accept and admit the patient as promptly as possible, provided admission requirements are met and bed space to accommodate the patient is available. Such transfers shall be made in accordance with normal policies and procedures of HOSPITAL, as well as federal and state laws and regulations.

2. **Documentation**. FACILITY will complete and send with each patient at the time of transfer, or in the case of emergency as promptly as possible following the transfer, an abstract or pertinent medical and other information necessary or useful for the continuation of the patient's care and treatment. FACILITY shall also furnish completed transfer and referral forms mutually agreed upon by the parties as appropriate for the care and treatment of the patient.

3. **Transportation**. FACILITY shall be responsible for effectuating the transfer of the patient, including arranging for safe and appropriate transportation and care of the patient during the transfer in accordance with applicable federal and state laws and regulation.

4. **Patient Personal Effects**. FACILITY will be responsible for effectuating the transfer or other appropriate disposition of the patient's personal effects, including money and valuables, as well as information relating to these personal items. FACILITY shall keep records relating to the transfer/disposition of all such items.

5. **Payment for Services**. Each party shall be responsible for collection of its own accounts for services rendered and shall have no responsibility for collection for services performed by the other party.

6. **Independent Contractor Status**. None of the provisions of this Agreement are intended to create (nor shall be deemed or construed to create) any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective officers, directors, employees or agents, shall have authority to bind the other or shall be deemed or construed to be the agent, employee or representative of the other, except as may be specifically provided herein. Neither party, nor any employees or agents thereof, shall have any claim under this Agreement or otherwise against the other party for social security benefits, workman's compensation, disability benefits, unemployment insurance, vacation, sick pay or any other employee benefits of any kind.

7. **Insurance**. During the term of this Agreement, each party shall maintain, at its own expense, general liability and professional malpractice insurance. Such policies shall have limits not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate per year. On or prior to the effective date of this Agreement, the parties shall furnish to each other a certificate of insurance evidencing the maintenance in full force of said policies of insurance. Each party agrees to provide to the other at least thirty (30) days advance notice of the cancellation, material modification, or non-renewal of such policies.

8. **Non-Exclusivity Provision**. Nothing in this Agreement shall be construed as limiting the rights of either party to affiliate or contract with any other facility on either a limited or general basis while this Agreement is in place.

9. **Term**. This Agreement shall commence as of the date first set forth above and shall continue in full force and in effect for an initial term of one (1) year, and at the expiration of such initial term will thereafter automatically renew annually unless sixty (60) days prior written notice is given by either party. Either party may terminate this Agreement at any time, upon sixty (60) days prior written notice to the other party, whereupon this Agreement shall terminate in accordance with any such notice. Additionally, either party may terminate this Agreement immediately upon

written notice to the other party in the event the other party ceases to be duly licensed by the State of Tennessee.

10. **Indemnification**. FACILITY hereby agrees to indemnify and hold harmless HOSPITAL from and against any and all claims, costs, actions, causes of action, suits, judgments, damages, liabilities, losses or expenses, including, without limitation, attorneys' fees and the fees of expert witnesses and other consultants, which arise or are asserted against or imposed upon or incurred by HOSPITAL as a consequence of any adjudicated malfeasance, neglect or medical malpractice by FACILITY, its employees, agents or contractors; provided, however, in the event of a finding of an independent breach of duty or negligence or otherwise wrongful act or omission of HOSPITAL or its employees or agents, FACILITY's liability to HOSPITAL shall be reduced proportionally thereby.

    HOSPITAL hereby agrees to indemnify and hold harmless FACILITY from and against any and all claims, costs, actions, causes of action, suits, judgments, damages, liabilities, losses or expenses, including, without limitation, attorneys' fees and the fees of expert witnesses and other consultants, which arise or are asserted against or imposed upon or incurred by FACILITY as a consequence of any adjudicated malfeasance, neglect or medical malpractice by HOSPITAL, its employees, agents or contractors; provided, however, in the event of a finding of an independent breach of duty or negligence or otherwise wrongful act or omission of FACILITY or its employees or agents, HOSPITAL's liability to FACILITY shall be reduced proportionally thereby.

11. **Miscellaneous**.

    a.) **Controlling Law**. This Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee. Each party hereby consents to the jurisdiction of all state and federal courts sitting in Maury County, Tennessee; agrees that venue for any such action shall lie exclusively in such courts; and agrees that such courts shall be the exclusive forum for any legal actions brought in connection with this Agreement or the relationships among the parties hereto. If a provision hereto or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder hereof, or the application of such provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each provision hereof shall be valid and be enforced to the fullest extent permitted by law, provided that the parties shall exercise their best efforts to accommodate the terms and intent of this Agreement to the greatest extent possible consistent with the requirement of law.

    b.) **Notices**. Any notices required under this Agreement shall be in writing and shall be deemed to have been given if: i) sent by certified or registered mail, return receipt requested, with adequate postage; ii) sent by means of an express delivery service if it obtains a receipt to confirm delivery; or iii) by facsimile if

such facsimile transmission permits confirmation to the addresses or facsimile numbers set forth below:

To HOSPITAL:

Maury Regional Hospital
d/b/a Maury Regional Medical Center
Attn: Chief Executive Officer
1224 Trotwood Avenue
Columbia, TN 38401

Fax Number: (931) 540-4160

To FACILITY:

TriStar Maury Behavioral Healthcare, LLC
d/b/a TriStar Maury Regional Behavioral Healthcare
Attn: _____
_____
_____

Fax Number: _____

c.) **Regulatory Compliance**. The parties acknowledge their intent that this contract, and all services performed hereunder, shall be in compliance with all applicable federal and state regulatory standards, all Joint Commission and CMS standards, all HOSPITAL and FACILITY policies and procedures and any other agency regulatory standards or those promulgated or required by third-party payors, whether currently existing or created during the term of this Agreement.

d.) **Confidentiality**. Each of the parties represents and warrants to the other party in particular, with respect to all protected health information (as that term is defined under the Standards for Privacy of Individually Identifiable Health Information (December 28, 2000; 65 F. Reg. 82462, as amended from time to time), that it is a covered entity (and not a Business Associate of the other party) under the HIPAA Privacy Regulations and that it shall protect the privacy, integrity, security, confidentiality and availability of the protected health information disclosed to, used by, or exchanged by the parties by implementing appropriate privacy and security policies, procedures, and practices and physical and technological safeguards and security mechanisms, all as required by, and set forth more specifically in, the HIPAA Privacy Regulations and the HIPAA Security Regulations.

e.) **Governmental Compliance**. The parties hereto acknowledge that the healthcare industry is subject to numerous regulatory requirements which may change in substance and interpretation over time. To this end, the parties

reaffirm their absolute intention to continuously comply with all such requirements. In the event FACILITY or HOSPITAL believes that this Agreement poses a substantial risk of violating (1) a federal or state law; (2) a requirement stated in a regulation, rule, general counsel memorandum, or private letter ruling of the Internal Revenue Service which must be followed by a tax-exempt organization to maintain tax exemption or to avoid the payment of taxes; (3) a rule or regulation promulgated by Joint Commission or similar regulatory body; or (4) a regulation or interpretative policy of a Medicare authority (such as the Department of Health and Human Services or the Centers for Medicare and Medicaid Services), a Medicaid authority, or the Tennessee State Board of Medical Examiners or a similar authority having jurisdiction over matters relating to this Agreement, the parties shall commence and attempt to complete in good faith negotiations to confirm the Agreement to comply with the applicable law. Should the parties not reach an agreement within thirty (30) days of negotiations, this Agreement shall immediately terminate effective upon notice to the other party.

f.) **No Inducement**. The parties agree to comply in all respects with the Medicare and Medicaid/TennCare laws and regulations, including, without limitation, the anti-kickback and fraud and abuse provisions thereof, and the parties warrant and represent that no direct or indirect payment shall be made by either party to induce the referral of a patient for services. It is hereby specifically acknowledged and agreed that any benefits which are received under this Agreement in no way require, are no way contingent upon, and are no way intended to induce the admission or referral of any person as a patient to either FACILITY or HOSPITAL, nor any of their affiliates. In addition, there is no requirement that either party make referrals to, be in a position to make or induce referrals to, or otherwise generate business for FACILITY or HOSPITAL, nor any of their affiliates, as a condition for receiving such benefits.

g.) **No Third Party Rights**. Nothing in this Agreement, express or implied, shall give to any person, other than the parties hereto and their respective successors, any legal or equitable right, remedy, or claim under this Agreement.

h.) **Assignment**. This Agreement may not be assigned by either party, nor any rights claimed hereunder for any other person or persons whatsoever without prior written consent.

i.) **Binding of Successors and Approved Assigns**. The terms, covenants, conditions, provisions and agreements herein contained shall be binding upon and inure to the benefit of the parties hereto, and their successors and permitted assigns.

j.) **Entire Agreement**. This Agreement contains the entire understanding between FACILITY and HOSPITAL and supersedes all prior and contemporaneous agreements and understandings, express or implied, oral or written. This Agreement may be modified, altered or amended only by written agreement between FACILITY and HOSPITAL.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the respective dates written below.

FACILITY:

TRISTAR MAURY BEHAVIORAL HEALTHCARE, LLC D/B/A TRISTAR MAURY REGIONAL BEHAVIORAL HEALTHCARE

By: _____
_____,
_____

HOSPITAL:

MAURY REGIONAL HOSPITAL D/B/A MAURY REGIONAL MEDICAL CENTER

By: _____
Paul Betz, FACHE
Senior Vice-President/COO

Approved As To Legal Form:

_____
Linda L. (Rippey) Moore
MRH General Counsel

6. Support Letters

RODNEY A. POLING, M.D., PLLC
Psychiatry
1402 Rosewood Drive
Columbia, Tennessee 38401
(931) 381-5886
Fax (931) 381-9246

September 30, 2016

To whom it may concern,

I write in favor of the proposed 60 bed psychiatric inpatient facility, a joint venture between Maury Regional Medical Center and HCA, for Maury County. I have been in psychiatric practice in Maury County for 26 years. I serve on the Board of Trustees for Maury Regional Medical Center. Since our inpatient psychiatric unit closed in 1997, I have seen the growing need for inpatient care in our community. Patients from our service area are sometimes "boarded" in our Emergency Departments for hours, days or weeks at a time, awaiting proper referral to a comprehensive psychiatric inpatient facility. Though we have geriatric beds available, adolescents and other adults, and their families, are forced to travel as far away as Memphis, TN to receive proper care. This distance erodes the therapeutic alliance which is needed for healing and recovery.

I urge the Commission to approve this request for the patients and families of South Central Tennessee, to again provide true community care for their psychiatric needs. Treating a patient in their own community is a much healthier way to address the complex problems which they face. I am confident the proposed facility would begin to meet these urgent psychiatric needs of our patients and families.

Thank you for your thoughtful consideration.

Yours very truly,

Rodney A Poling MD DFAPA
President, Tennessee Psychiatric Association

Charlie Norman
County Mayor

Maury County Government

Room 101
Maury County Courthouse
Columbia, Tennessee 38401

Phone
(931) 375-1001
(931) 375-1002

October 3, 2016

Ms. Melanie Hill
Executive Director
Tennessee Health services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Ms. Hill,

I am writing in support of the certificate of need application submitted by TriStar HCA and Maury Regional for the establishment of a 60 bed behavioral health hospital in Columbia, TN.

This hospital will help meet the needs of patients that currently do not have access to such services. Patients frequently have to be boarded in emergency rooms while they are waiting for disposition and transfer to an appropriate facility. There are no adult or adolescent beds located in the targeted service area.

By having the facility located in Maury County, it will help reduce travel time as well as keep deputies in the area when they are required to transport the patients.

Please consider this application and feel free to contact me at 931-375-1001 if you have any further questions.

Sincerely,

Maury County Mayor Charlie Norman

MAURY REGIONAL
MEDICAL CENTER

October 3, 2016

Ms. Melanie Hill
Executive Director
Tennessee Health services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Ms. Hill,

I am writing in support of the certificate of need application submitted by TriStar HCA and Maury Regional for the establishment of a 60 bed behavioral health hospital in Columbia, TN.

This hospital will help meet the needs of patients that currently do not have access to such services. Patients frequently have to be boarded in emergency rooms while they are waiting for disposition and transfer to an appropriate facility. There are no adult or adolescent beds located in the targeted service area.

Please consider this application and feel free to contact me at (615) 612-9473 if you have any further questions.

Sincerely,

Chad R. Bowser, MD
Facility Medical Director, Emergency Department
Maury Regional Medical Center

CENTERSTONE

October 3, 2016

Ms. Melanie Hill
Executive Director
Tennessee Health services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Ms. Hill,

I am writing in support of the certificate of need application submitted by TriStar HCA and Maury Regional for the establishment of a 60 bed behavioral health hospital in Columbia, TN.

This hospital will help meet the needs of patients that currently do not have access to such services. Patients frequently have to be boarded in emergency rooms while they are waiting for disposition and transfer to an appropriate facility. There are no adult or adolescent beds located in the targeted service area.

Please consider this application and feel free to contact me at 931-490-1589 or sherry.randles@centerstone.org if you have any further questions.

Sincerely,

Sherry Randles

Sherry Randles, LPC-MHSP
Director Crisis Services
Centerstone of Tennessee

NHC
HEALTHCARE

October 3, 2016

Ms. Melanie Hill
Executive Director
Tennessee Health services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Ms. Hill,

I am writing this letter in support of the certificate of need application submitted by TriStar HCA and Maury Regional for the establishment of a 60 bed behavioral health hospital in Columbia, TN. This joint venture is a great opportunity and investment for community.

This hospital will help meet the needs of patients that currently do not have access to such services. Patients frequently have to be boarded in emergency rooms while they are waiting for disposition and transfer to an appropriate facility. There are no adult or adolescent beds located in the targeted service area. I have worked in health care administration here in Maury County for twenty five years and I believe this hospital is a much needed addition to our overall health care delivery system.

I strongly support this application and I hope the board will give it full consideration. Please feel free to contact me at 931-388-7182 if you have any further questions.

Sincerely,

NHC Hillview, Administrator

2710 Trotwood Ave. • Columbia, TN 38401 • (931)388-7182

SHERIFF OF MAURY COUNTY

1300 Lawson White Drive
Columbia, Tennessee 38401
Phone 931-388-5151 • Fax 931-380-1122
ORI No. TN 0600000

BUCKY ROWLAND
Sheriff

RAY JETER
Chief Deputy

October 5, 2016

Ms. Melanie Hill
Executive Director
Tennessee Health services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

Dear Ms. Hill,

I am writing in support of the certificate of need application submitted by TriStar HCA and Maury Regional for the establishment of a 60 bed behavioral health hospital in Columbia, TN.

This hospital would be a great benefit to Maury County residents and to the Maury County Sheriff's Department. We are currently transporting patients, sometimes hundreds of miles, to facilities throughout the State of Tennessee. It would be a benefit to us all to have a facility in our county to serve these patients.

Please consider this application and feel free to contact me at 931-375-8605 if you have any further questions.

Sincerely,

Ray Jeter
Chief Deputy

DSG Development Support Group

October 14, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application Submittal
TriStar Maury Regional Behavioral Healthcare
Columbia, Maury County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. for a 60-bed Mental Health Hospital in Columbia, to be joint-ventured between affiliates of Maury Regional Hospital and HCA. The affidavit and filing fee are enclosed.

I am the contact person for this project. Jerry Taylor is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

December 1, 2016

John Wellborn
Development Support Group
4219 Hillsboro Road, Suite 210
Nashville, TN 37215

RE: Certificate of Need Application -- TriStar Maury Regional Behavioral Healthcare - CN1610-036
The establishment of a 60 bed mental health hospital for adolescents and adult patients located on the east side of North Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike, Columbia (Maury County), Tennessee 38401. The estimated project cost is $24,033,431.

Dear Mr. Wellborn:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Marthagem Whitlock at the Tennessee Department of Mental Health and Substance Abuse Services for Certificate of Need review by the Division of Planning, Research, & Forensics. You may be contacted by Ms. Whitlock or someone from her office for additional clarification while the application is under review by the Department. Ms. Whitlock's contact information is Marthagem.Whitlock@tn.gov or 615-532-6717.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on December 1, 2016. The first 60 days of the cycle are assigned to the Department of Mental Health and Substance Abuse Services, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Mental Health and Substance Abuse Services or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on February 22, 2017.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Marthagem Whitlock, TDMHSAS, PRF

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Marthagem Whitlock, Assistant Commissioner
of Planning Research & Forensics
TN Department of Mental Health and Substance Abuse Services
Division of Planning, Research & Forensics
Andrew Jackson Building, 5th Floor
500 Deaderick Street
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: December1, 2016

RE: Certificate of Need Application
TriStar Maury Regional Behavioral Healthcare - CN1610-036

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on December 1, 2016 and end on February 1, 2017.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: John Wellborn

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Columbia News Herald, which is a newspaper of general circulation in Maury County, Tennessee, on or before October 10, 2016, for one day.

- -

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Maury Regional Behavioral Healthcare, (a proposed mental health hospital), to be owned by TriStar Maury Behavioral Healthcare, LLC (a limited liability company), and to be managed by Maury County Behavioral Health, LLC (a limited liability company), intends to file an application for Certificate of Need to establish a mental health hospital for adolescent and adult patients, located on the east side of North James Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike, in Columbia, Tennessee 38401. The estimated project cost is $24,400,000.

The project will seek licensure by the Tennessee Department of Mental Health and Substance Abuse Services as a 60-bed mental health hospital. The project does not initiate or discontinue any other health service and it will not affect any other facility's licensed bed complements.

The anticipated date of filing the application is on or before October 14, 2016. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.
The anticipated date of filing the application is on or before October 14, 2016. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John L. Wellborn 10-7-16 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

SIGNATURE/TITLE

Sworn to and subscribed before me this 7th day of October (Month), 2016 (Year) a Notary

Public in ~~and for~~ the County/State of DAVIDSON

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

NOTARY PUBLIC

My commission expires July 2, (Month/Day), 2018 (Year).

Supplemental #1
-COPY-

TriStar Maury Regional Behavioral Health

CN1610-036

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

DSG Development Support Group

October 28, 2016

Phillip M. Earhart, Health Services Development Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application CN1610-036
TriStar Maury Regional Behavioral Healthcare

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section A. , Executive Summary, (2) Ownership Structure**

a. Please explain the reason a joint venture between HCA Holdings, Inc. and Maury County Regional Hospital was not finalized prior to submitting the application for a CON.

The parties to the joint venture agreed to have HCA form the applicant LLC, which was required in order to file this application. Additional time and resources will be required to complete and to fund the 51% / 49% ownership division of the LLC over the next several months. The parties saw no advantage in delaying the application--either for themselves or for the HSDA. The HSDA and both parties are fully protected by the applicant's commitment to surrender the Certificate of Need if a joint venture is not finalized. The parties expect, and will agree to, HSDA addition of that condition to the Certificate of Need, should it be granted. See the response to your question 3 below.

b. If the agreement falls through with Maury, would HCA seek another partner?

No.

2. **Section A. , Executive Summary, Overview and (6) Funding**

a. It is noted the project cost will be funded by Maury Regional Hospital (49%, or $11,776,381) and HCA (51%, or $12,257,050). However, Maury Regional Hospital is not currently an owner of TriStar Maury Behavioral Healthcare, LLC. Please provide a replacement page 5 that correctly identifies entities that are currently part of TriStar Maury Behavioral Healthcare, LLC and will fund the project.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

Attached after this page is a revised page 5R. It clarifies the applicant's current ownership by HCA only. It states how funding will be provided once joint ownership is in place. It adds that HCA will not provide full funding or implement the project if the joint venture is not finalized.

Please note that revised page 5 also changes response (8) regarding staffing. The submitted application erroneously listed startup FTE data rather than full Year One data. It also adds Behavioral Healthcare at Columbia as a fourth hospital in response (4) on that page.

b. What is the distance from the proposed site of the project and Maury Regional Hospital?

The distance is 1.6 miles, a 4-minute drive.

c. Please clarify if children in state custody will be admitted to the adolescent unit.

No.

d. Please clarify if the proposed pediatric unit will serve those that are dually diagnosed with a psychiatric and chemical dependency diagnosis.

Yes, it will.

e. Please clarify if the applicant will also offer adolescent/adult partial hospitalization and intensive outpatient programs.

These two programs are similar except in their weekly lengths of stay. An IOP (intensive outpatient program) typically is three hours a day, for three days a week. This hospital will offer an IOP. However, a PHP (partial hospitalization program) will not be offered because those typically are five days a week for four to five hours per day and the project will not be staffed to provide such service, during its first two years.

(4) Existing similar service providers

• The service area contains no provider of acute inpatient behavioral care for both adolescents (ages 13-17) and adults (ages 18-69), which are the focus of this project.

• The area contains four small hospitals with inpatient geropsychiatric units. These are Hillside Hospital in Pulaski/Giles County (14 beds); Lincoln Medical Center in Fayetteville/Lincoln County (10 beds); Perry Community Hospital in Linden/Perry County (14 beds); and Behavioral Healthcare Center at Columbia (16 beds).

(5)-(6) Project cost and Funding

• The estimated project cost is $24,033,431. Currently, the applicant LLC is owned entirely by HCA Holdings,Inc. After the CON is granted, and before further project funding is committed, Maury Regional Hospital will acquire 49% interest in the applicant LLC. The full project cost will then be funded in cash by the two owners in proportion to their ownership interests. Maury Regional Hospital will contribute 49%, or approximately $11,776,381. HCA Holdings, Inc. will contribute 51%, or approximately $12,257,050. If these two parties do not finalize their joint venture, HCA will not fund the project and will surrender the CON.

(7) Financial feasibility, including when the proposal will realize a positive financial margin; and

• The proposed hospital is projected to operate with a positive financial margin from its second year of operation onward (CY2020 and beyond).

(8) Staffing

• The applicant projects having a total of 93.14 employed and contracted staff in the facility's first full calendar year of operation, CY2019.

(4) Existing similar service providers

• The service area contains no provider of acute inpatient behavioral care for both adolescents (ages 13-17) and adults (ages 18-69), which are the focus of this project.

• The area contains four small hospitals with inpatient geropsychiatric units. These are Hillside Hospital in Pulaski/Giles County (14 beds); Lincoln Medical Center in Fayetteville/Lincoln County (10 beds); Perry Community Hospital in Linden/Perry County (14 beds); and Behavioral Healthcare Center at Columbia (16 beds).

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• The estimated project cost is $24,033,431. Currently, the applicant LLC is owned entirely by HCA Holdings,Inc. After the CON is granted, and before further project funding is committed, Maury Regional Hospital will acquire 49% interest in the applicant LLC. The full project cost will then be funded in cash by the two owners in proportion to their ownership interests. Maury Regional Hospital will contribute 49%, or approximately $11,776,381. HCA Holdings, Inc. will contribute 51%, or approximately $12,257,050. If these two parties do not finalize their joint venture, HCA will not fund the project and will surrender the CON.

(7) Financial feasibility, including when the proposal will realize a positive financial margin; and

• The proposed hospital is projected to operate with a positive financial margin from its second year of operation onward (CY2020 and beyond).

(8) Staffing

• The applicant projects having a total of 93.7 employees in the facility's first full calendar year of operation, CY2019, increasing to 103.3 FTE's in Year Two.

f. Please clarify if the proposed hospital will admit patients with intellectual disabilities.

To be admitted, a patient must demonstrate sufficient cognitive abilities to participate in both individual and group therapy. The facility's psychiatrists and clinical teams will make that judgment using a Behavioral Health Assessment, not an arbitrary IQ standard.

g. Please clarify if the adolescent unit will serve both males and females.

Yes. As shown on the floor plan, the adolescent and adult areas are both divided into two distinct sub-units of patient rooms, for appropriate gender separation--which at times of high census can also be achieved by separating male and female patients into rooms on opposite sides of corridors that are continuously monitored.

h. In the 2014 JAR, Maury has ADC of 114, meaning on average they have 141 empty beds. Why won't a unit in hospital work?

A small unit would not provide enough bed capacity to meet adult and adolescent needs in this 10-county area. However, over a period of months, and with assistance from healthcare architects, Maury Regional and HCA studied the feasibility of developing a large in-hospital behavioral health program. They determined that such a "carve-out" would require too much renovation to provide all the required space for gender-and age-separated patient rooms and support areas. The renovation option would have intruded to an unacceptable degree into existing ancillary departments, interfering with the hospital's current services. To avoid such disruptions and compromises, both parties agreed to work toward a freestanding facility close to Maury Regional.

i. Please clarify the reason why the applicant is not planning to open a unit for children ages 0-12, particularly, when a child in need of treatment would be required to transfer to a distant facility away from their family for inpatient care. Is there not a need for beds 0-12 in the proposed 10 county service area?

There is a need for one; and a program for children ages 0-12 would not be ruled out in the future. But it is very difficult to implement one, because accreditation standards require the presence of a psychiatrist Board-certified in child psychiatry and there is a national shortage of such physicians, making recruitment to a rural service area very challenging. Services for adolescents and adults are also needed, and can be implemented immediately with the assistance of psychiatrists who are already in Columbia and on staff at Maury Regional Medical Center.

3. Section 4B. Facility Owner

If approved, please indicate if the applicant would agree to place the following condition on the CON: *"that a definitive agreement between the HCA affiliate and Maury Regional affiliate, to jointly own and implement the project would be required, if not, the CON would be surrendered."*

Yes. That reflects the intent of the parties, as stated in the application.

4.Section 5A. Management/Operating Entity

Please provide a copy of the management agreement referenced in Attachment Section A-5A.

The draft management agreement is attached at the end of this letter.

5. Section 6B. (2) Floor Plan

a. The floor plan is noted. However, please indicate where adolescent patients will participate in recreational and leisure activities, family visitation, and receive educational services.

Please refer to the floor plan. Short-stay adolescents do not require a gymnasium; this design provides three outdoor fenced recreational yards as well as "Noisy Activity" rooms for adolescents' use. Family visitations will be scheduled in the Quiet Activity rooms on the unit, with staff consult rooms also available in overflow situations. Short-stay adolescents do not require classrooms for an in-house educational program; longer-stay patients must by law receive educational services from the local school district.

b. Please indicate if the proposed adolescent unit will be secured.

Yes. The entire facility will be secured.

c. Please clarify if there will be a secured area for triage and assessment.

Yes. The plan shows a large "Admissions" space adjoining the main entrance lobby. This space will be subdivided into several related spaces, one of which will be a secured area for triage and assessment.

d. Please clarify if the proposed psychiatric units will have a restraint room in each.

Yes; this is a required space under industry standards. There are four--one for each sub-unit. They are labeled "Seclusion" on the floor plan.

6. Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-)

Please note revised Psychiatric Inpatient Services Standards and Criteria were recently approved. The criteria is located at the following web-site:
http://tennessee.gov/assets/entities/hsda/attachments/FINAL_Certificate_of_Need_Standards_and_Criteria_for_Psychiatric_Inpatient_Services.pdf

a. Please address the Psychiatric Inpatient Service Specific Criteria by listing each question and providing a response underneath.

Responses to the new Criteria are attached at the end of this response letter, due to their length.

b. Please complete the following table to determine psychiatric bed need (1).

	Population 2020		Gross Need Pop. X (30 beds/100,000)		Current Licensed Beds		Net Need	
	Adolescents 13-17	Adults 18-64	Adolescents 13-17	Adults 18-64	Adolescents 13-17	Adults 18-64	Adolescents 13-17	Adults 18-64
Proposed Service Area	21,064	179,608	6.3	53.9	0	0	6.3	53.9

c. Please explain why the applicant will serve patients up to the age of 69 while there are already 54 licensed geriatric beds in the proposed service area that serve patients 65 and over.

Over the years, the applicant expects to occasionally admit patients between the ages of 65 and 69, based on HCA's experience at other adult units that do not hold themselves out in the community as "geropsychiatric" programs. This would not be done unless admissions of such patients were not feasible at existing geropsychiatric units in the area. It was necessary to make this disclosure in the application; but no geropsychiatric admissions are even projected in the facility's early years.

d. The statement on page 27 that the State of Tennessee has reduced its financial support of inpatient facilities in recent years is noted. However, please clarify how financial support has been reduced by the State and how it applies to this proposed project.

This statement simply pointed out the State's reduction in its complement of State-owned inpatient facilities, two examples being the closure several years ago of the Lakeshore Mental Health Institute in Knox County, and the Clover Bottom facility in Nashville (the latter for care of persons of low IQ or with developmental disabilities; it was not a psychiatric hospital). In Middle Tennessee, State-owned Middle Tennessee Mental Health Institute, a behavioral health hospital in Nashville, replaced the old Central State Hospital, and in 2014 admitted 371 residents of this project's service area. However, its beds run full (85.6%) and the State has not proposed to expand its capacity to meet growing regional needs. With pressures on State funding, the hospital industry has found it necessary to begin to offer more inpatient behavioral health programs.

7. Section B, Need Item 3

a. Please complete the following table for ages 13-17 and 18-69 of Year Two of the proposed project.

CY 2020 Projected Utilization By County Residents

Service Area Counties	Ages 13-17	Ages 18-64
Giles	57	113
Hickman	51	111
Lawrence	102	163
Lewis	27	49
Lincoln	73	132
Marshall	74	135
Maury	190	359
Moore	14	27
Perry	16	31
Wayne	32	74
Total Admissions	636	1,194

Note: The distribution of cases is based on each county's population for that age cohort as a percent of the total service area population in that cohort, times the total projected service area cases.

The applicant has completed the table for ages 13-17 and 18-64, to comply with standard age brackets and because there may not be any admissions 65-69 years of age during Year Two.

b. The applicant has included Tennessee 2015 acute cases in the table on the top of page 31 using the THA Database. Please clarify if Rolling Hills and Middle Tennessee Mental Health Institute's utilization are included in the table.

Neither reports utilization to the THA database. But both file Joint Annual Reports. In its 2014 JAR, Rolling Hills admissions for psychiatric diagnoses were not reported by age cohort--only total admissions and their county of origin.

The applicant's originally submitted Page 31 table included all 638 of Rolling Hills' admissions from the project service area--even though that may have included some geriatric and substance abuse patients. To roughly offset that potential over-estimate, the applicant excluded all 371 of Middle Tennessee Mental Health Institute's service area admissions and all 32 BHC service area admissions.

This data should now be amended, by excluding patients admitted to Rolling Hills, MTMHI and BHC--while noting their significant additional utilization, many of which are probably patients 13-64 years of age. Please see the data in response to question 9a below. Please see the notes about the utilization of the three excluded hospitals, none of which reports to THA to the applicant's best knowledge. A revised page 31R is provided following this page.

8. Section B, Need Item 4.A

The population table of the proposed project is noted. The applicant's population table will need to be revised to reflect Current Year (CY) 2016 and Projected Year (PY) 2019 as prescribed in the most recent Psychiatric Inpatient Services-Service Specific Criteria. Please revise Table B-Need-4A (2) and provide a replacement page.

This response is waived by permission of HSDA staff.

9. Section C. Need, Item 5

a. Your response to this item is noted. However residents 0-17 and 18-69 of the proposed 10 county service area are currently receiving inpatient psychiatric care at hospitals in surrounding counties. Please provide patient day utilization by age group (including patients 0-17, 18-64, and 65+) by hospital of where patients from the proposed service area were receiving inpatient psychiatric for the most recent year available.

Hospital members of the THA Database are contractually prohibited from disclosing in public documents the utilization data of individual hospitals.

3. (Continued) Please complete the following tables, if applicable:

Primary Service Area Counties	Estimated CY2015 Cases Age 13-64 in TN Acute Psychiatric Units	% of Total Admissions That Were Reported to THA
Giles	102	9.7%
Hickman	152	14.4%
Lawrence	146	13.9%
Lewis	27	2.6%
Lincoln	105	10.0%
Marshall	99	9.4%
Maury	353	33.5%
Moore	5	0.5%
Perry	29	2.8%
Wayne	36	3.4%
Totals	1,054	100.0%

Source: THA Database.
Note: This includes only the 1,054 cases reported to the THA by age group; three other hospitals admitted an estimated 995 additional service area cases, whose origin by county can not be accurately determined from their JAR's.

Primary Service Area Counties	Projected Admissions To The Project in CY2020 (Year Two) Alphabetic By County	% of Total Admissions
Giles	174	9.5%
Hickman	167	9.1%
Lawrence	254	13.9%
Lewis	76	4.2%
Lincoln	207	11.3%
Marshall	99	11.3%
Maury	547	29.9%
Moore	41	2.3%
Perry	48	2.6%
Wayne	109	6.0%
Totals	1,830	100.0%

Source: Admissions projected in proportion to counties' percentages of the target population.

Attached on the following page is a new table showing THA data on unidentified providers that admitted service area patients in CY2015, by the three age cohorts 13-17, 18-64, and 65+. In addition to that data, please consider imperfect data from three other providers, as described below.

Rolling Hills does not report to the THA database. Its 2014 JAR reported 638 admissions from the project service area, but provided no age breakdowns specific to psychiatric or dual-diagnosis admissions only (They have a substance abuse unit).

Middle Tennessee Mental Health Institute does not report to THA. Its 2014 JAR reports 371 total admissions from the project service area, but does not break those admissions down by age group. However, MTMHI's JAR Schedule H, page 32, indicates that 98.6% of its admissions were adults ages 18-64. Their patient origin by county indicates that 371 patients were admitted from this project's service area. Applying 98.6% to that number would imply that 366 MTMHI admissions were probably adults ages 18-64.

The Behavioral Healthcare Center at Columbia does not report to THA. It holds a license for 16 geropsychiatric beds. Its 2014 JAR reported 3 psychiatric bed admissions ages 18-64 and 29 psychiatric admissions ages 65+. Their JAR's patient origin data, however, covers all admissions to all of their programs, not just their psychiatric program. The applicant believes that virtually all its psychiatric admissions were from the project service area.

So in the Table B-Need-6, on revised page 36R of the application, the 2,049 service area patients ages 13-64 in CY2015 was estimated as follows:

1. THA-reporting hospitals: 1054 admissions ages 13-64
2. Middle Tennessee Mental Health Institute: 366 admissions ages 13-64
3. Rolling Hills Hospital: estimated 626 admissions ages 13-64 which is 98% of its 638 admissions from this service area
4. Behavioral Healthcare Center at Columbia: 3 admissions ages 18-64

In the original submittal, the applicant erroneously described the 2,049 patients as "all ages". To correct the narrative, attached after this page are revised page 36R-37R.

SUPPLEMENTAL TABLE: SERVICE AREA RESIDENTS ADMITTED FOR BEHAVIORAL HEALTH INPATIENT CARE--AGES 13+
THA DATABASE CY2015

Provider	Giles			Hickman			Lawrence			Lewis			Lincoln		
	13-17	18-64	65+	13-17	18-64	65+	13-17	18-64	65+	13-17	18-64	65+	13-17	18-64	65+
Undisclosed	-	21	37	-	-	-	-	1	18	-	2	1	-	1	3
Undisclosed	-	-	1	-	-	-	-	-	-	-	-	-	-	15	29
Undisclosed	-	5	1	-	2	-	-	3	2	-	1	1	-	3	1
Undisclosed	-	-	-	-	-	2	-	-	1	-	2	1	-	-	-
Undisclosed	-	-	-	-	2	1	-	-	-	-	-	-	-	-	-
Undisclosed	-	-	2	-	5	2	-	1	2	-	1	1	-	-	-
Undisclosed	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
Undisclosed	-	15	3	-	48	9	-	32	5	-	5	3	-	13	4
Undisclosed	4	17	-	3	29	-	3	33	-	1	4	-	-	15	-
Undisclosed	-	15	-	-	19	3	-	20	2	-	1	1	-	32	3
Undisclosed	-	3	-	-	8	-	-	11	-	-	1	-	-	6	-
Undisclosed	3	13	-	7	19	4	7	20	2	1	5	-	2	11	3
Undisclosed Other Providers	3	3	1	-	9	4	3	12	5	3	-	-	2	5	12
TOTALS	10	92	45	10	142	25	13	133	37	5	22	8	4	101	55

Provider	Marshall			Maury			Moore			Perry			Wayne		
	13-17	18-64	65+	13-17	18-64	65+	13-17	18-64	65+	13-17	18-64	65+	13-17	18-64	65+
Undisclosed	-	2	4	-	-	1	-	-	-	-	-	-	-	-	3
Undisclosed	-	-	2	-	-	-	-	-	1	-	-	-	-	-	-
Undisclosed	-	3	2	-	16	9	-	-	-	-	1	-	-	2	-
Undisclosed	-	-	-	-	-	-	-	-	-	-	4	22	-	1	3
Undisclosed	-	-	-	-	2	-	-	-	-	-	-	-	-	1	-
Undisclosed	-	-	1	-	-	2	-	-	-	-	-	-	-	-	-
Undisclosed	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-
Undisclosed	-	15	6	-	66	20	-	-	-	-	2	-	-	14	2
Undisclosed	4	18	1	23	71	2	-	-	-	-	6	-	-	6	-
Undisclosed	-	27	4	-	48	3	-	2	-	-	1	-	-	5	4
Undisclosed	-	6	-	-	21	-	-	-	-	-	-	-	-	1	2
Undisclosed	3	13	4	26	58	6	1	1	1	5	6	-	-	5	-
Undisclosed Other Providers	1	5	5	7	15	9	-	1	3	-	4	2	-	1	1
TOTALS	8	91	29	56	297	52	1	4	5	5	24	24	-	36	15

Source: DSS, from THA Database

	13-17	18-64	65+	TOTAL, 13+
Total, All Providers	112	942	295	1,349
Total Excluded hospitals (estimate)				1,041

Source: Joint Annual Reports, 2014

Notes on three acute psychiatric providers who are not in the THA database, but admitted a total of 1,041 patients many of whom might have been from the project service area. Data is not available to quantify that.
1. Excludes Middle Tennessee Mental Health Institute's 371 admissions from service area, in 2014 JAR, which did not list short-stay admissions by ages or county of origin.
2. Excludes Rolling Hills Hospital's 638 admissions from service area, in 2014 JAR, which did not provide admissions by age group by county. Its admission and patient origin data may include some admissions of children and substance abuse patients without a psychiatric diagnosis.
3. Excludes Behavioral Health of Columbia because its 32 admissions on page 32 of the 2014 JAR are not broken down by county of origin. Their patient origin idata is for all of their mental health clients. just their psychiatric patients.
4. The undisclosed hospital names in the THJA database are (not in order of the data) Hillside Hospital,Vanderbilt, Lincoln County Medical Center, Perry Community Hospital, Maury Regional Medical Center, University Medical the three Saint Thomas hospitals in Murfreesboro and Nashville, TriStar Centennial Medical Center, TriStar Skyline Medical Center at Madison, and Trustpoint in Murfreesboro.

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Table B-Need-6: Utilization Projection--Patients Ages 13-64 TriStar Maury Regional Behavioral Healthcare									
THE SERVICE AREA									
					Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Calendar Year	2015	2016	2017	2018	2019	2020	2021	2022	2023
Current PSA Patients*	2,049								
Projected Ann. Change	--				--	+1.5%	+1.5%	+1.5%	+1.5%
Projected PSA Patients*	--				2,254**	2,288	2,322	2,357	2,392
THE PROJECT									
Market Share					60%	80%	82%	84%	86%
Admissions					*1,352*	*1,830*	1,904	1,980	2,057
Length of Stay (Days)					*8.6*	*8.6*	8.6	8.6	8.6
Patient Days					*11,630*	*15,739*	16,375	17,026	17,693
Capacity (21,900 days)					*21,900*	*21,900*	21,900	21,900	21,900
Occupancy					*53.1%*	*71.9%*	74.8%	77.7%	80.8%

**Estimate from combination of THA database and estimatedd 13-64 age patients at three other hospitals that do not report to the THA database.*
*** CY2019 projected at 10% increase over CY2015*

The two providers who are partnering in this project are HCA, one of Middle Tennessee's largest providers of inpatient acute mental healthcare, and Maury Regional Hospital, the largest hospital in Middle Tennessee west of Davidson County. They bring to the project the twin benefits of operational experience and deep familiarity with local needs.

In projecting utilization for this project, HCA identified service area patients ages 13-64 who in CY2015 were admitted to Tennessee hospitals that report data to the THA. The approximate number of these was 1,054 patients. Some additional patients from the southern part of this service area probably out-migrated to mental healthcare providers in nearby North Alabama, but specific Alabama data on this is not available. A large number of patients also were admitted to three Tennessee hospitals that do not participate in the THA database system: Middle Tennessee Mental Health Institute, Rolling Hills Hospital, and the Behavioral Healthcare Center at Columbia. Those agencies' most recent 2014 Joint Annual Reports indicated that they admitted more than 1,000 service area residents; but gaps in the format or reponses to their JAR's do not definitively indicate the number of age 13-64 patients that the two largest programs served from this project's 10-county service area.

The applicant made the assumption that for ages 13-64, a close estimate of admissions from this service area in 2015 would be 2,049 patients--the sum of the 1,054 THA-documented patients plus an estimated 995 additional patients served in the three non-THA hospitals and in Alabama,

Then with increasing national awareness of the growing need to expand inpatient behavioral care resources, the applicant projected a minimum 10% increase in area patients ages 13-64, between CY2015 and CY2019. Thereafter the applicant projected a minimum *annual* increase of 1.5% through Year Five (CY2023) of this project. The 8.6-day overall average length of stay reflects the current experience of HCA's Nashville-based behavioral health programs for adolescents and adults.

For the proposed facility, the applicant projected that its adult and adolescent programs will attract a 60% share of the market demand (ages 13-64) in Year One, increasing incrementally to 86% market share in Year Five. Utilization is projected to increase steadily from 53.1% in the startup year (CY2019) to 80.8% in Year Five (CY2023). This is realistic, given the size of the market demand, and the fact that the projection is conservative in not including additional admissions that from counties outside the primary service area. The reputation of Maury Regional Hospital and HCA medical staffs and hospital programs in Middle Tennessee are expected to attract rapid utilization increases, once the facility opens in CY2018.

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

b. The tables on page 35 are noted. However, the total psychiatric beds for 2013 and 2014 appear to not total correctly. Please correct and revise any other calculation in the table as a result of changing the total psychiatric bed count.

The corrected table, with 54 existing beds showing consistently in all three years, is attached following this page.

Table B-Need-5: TriStar Maury Regional Behavioral Healthcare
Acute Behavioral Care Bed Utilization in Primary Service Area
2012-2014 REVISED ON SUPPLEMENTAL CYCLE

2012 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Psychiatric Beds	Admissions	Bed Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Hillside Hospital	Giles	14	277	3,633	13.1	10	71.1%
	Lincoln Medical Center	Lincoln	10	161	2,369	14.7	6	64.9%
	Perry Community Hospital	Perry	14	243	2,709	11.1	7	53.0%
	THM-Tennessee Health Management	Maury	16	246	3,212	13.1	9	55.0%
	SERVICE AREA TOTALS		**54**	**927**	**11,923**	**12.9**	**33**	**60.5%**

2013 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Hillside Hospital	Giles	14	212	2,725	12.9	7	53.3%
	Lincoln Medical Center	Lincoln	10	130	2,171	16.7	6	59.5%
	Perry Community Hospital	Perry	14	236	2,618	11.1	7	51.2%
	THM-Tennessee Health Management	Maury	16	281	3,476	12.4	10	59.5%
	SERVICE AREA TOTALS		**54**	**859**	**10,990**	**12.8**	**30**	**55.8%**

2014 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Psychiatric Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Hillside Hospital	Giles	14	181	2,470	13.6	7	48.3%
	Lincoln Medical Center	Lincoln	10	184	2,709	14.7	7	74.2%
	Perry Community Hospital	Perry	14	194	2,278	11.7	6	44.6%
	THM-Tennessee Health Management	Maury	16	32	326	10.2	1	5.6%
	SERVICE AREA TOTALS		**54**	**591**	**7,783**	**13.2**	**21**	**39.5%**

Source: Joint Annual Reports of Hospitals

10. Section C, Need, Item 6
a. Please complete the following tables for Year One and Year Two:

The requested projections are provided below. You should know that the applicant did not originally project utilization by age cohort. The following data is a new projection based on HCA's experience, which ties to the facility utilization data that has already been submitted, on which the applicant relies. The ALOS, ADC, and occupancy numbers in the table below are rounded to one decimal place.

Projected Inpatient Utilization		
Variable	Yr 1-2019	Yr 2-2020
Ages 13-17 Psych. Licensed Beds	18	18
Ages 13-17 Psych. Admissions	471	636
Ages 13-17 Psych. Patient Days	3,333	4,770
Ages 13-17 Psych. ALOS	7.5 days	7.5 days
Ages 13-17 Psych. ADC	9.1	13.1
Ages 13-17 % Lic'd. Bed Occupancy	50.7%	72.6%
---	---	---
Ages 18-64 Psych. Licensed Beds	42	42
Ages 18-64 Psych. Admissions	881	1,194
Ages 18-64 Psych. Patient Days	8,097	10,973
Ages 18-64 Psych ALOS	9.2 days	9.2 days
Ages 18-64 Psych. ADC	22.2	30.1
Ages 18-64 % Lic'd. Bed Occupancy	52.8%	71.6%

b. It is noted the applicant estimates 2,049 patients in CY2015 went outside the proposed service area to obtain acute behavioral inpatient care. Please cite the source for the data. In addition, please breakout the 2,049 patient estimates by ages 13-17 and 18-69.

That was quoting an early market analysis of total service area use of behavioral health facilities--all ages, not just ages 13-69. The 2,049 figure included limited geropsychiatric admissions within the service area. It did not include 371 service area admissions to Middle Tennessee Mental Health Institute in Nashville (see the response to your question 9a above). It did not include the 32 geropsychiatric admissions to Behavioral Healthcare Center at Columbia, which does not report to THA. Please see our revisions of the data for your question 9a above. The new table covers admissions from all ten service area counties, to all hospitals reporting to the THA database.

However, as explained in 9a above, there are probably close to 1,000 admissions from the service area, going to hospitals that do not report to THA.

11. Section C. Economic Feasibility Item 1 Project Costs Chart

a. It is noted Architectural and Engineering Fees are 8% of the total construction cost. However, 8% of the total construction cost totals $1,144,000 not $1,001,000. Please clarify.

That was a typographical error; the A&E fees are 7% of line A.5. Attached following this page is a corrected Project Cost Chart.

b. If the proposed project will be funded through cash reserves, please clarify the reason there is an assignment of $586,181 in the Project Costs Chart for interim financing.

HCA and other companies that self-fund projects impute "construction interest" to the project's capital costs paid out during the construction period, to equate to costs of capital that would be paid to a commercial lender were loan financing used for the construction period.

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PROJECT COST CHART-- TRISTA MAURY REGIONAL BEHAVIORAL HEALTHCARE

A. Construction and equipment acquired by purchase:

1.	Architectural and Engineering Fees	7% of A5	$ 1,001,000
2.	Legal, Administrative, Consultant Fees (Excl CON Filing Fee)		75,000
3.	Acquisition of Site		850,000
4.	Preparation of Site		1,960,000
5.	Total Construction Cost		14,300,000
6.	Contingency Fund	10% of A5	1,430,000
7.	Fixed Equipment (Not included in Construction Contract)		638,000
8.	Moveable Equipment (List all equipment over $50,000 as separate attachment)		1,098,250
9.	Other (Specify) Information Technology Systems and Misc		2,000,000

B. Acquisition by gift, donation, or lease:

1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify)	
5.	Other (Specify)	

C. Financing Costs and Fees:

1.	Interim Financing	586,181
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	

D. Estimated Project Cost (A+B+C) 23,938,431

E. CON Filing Fee 95,000

F. Total Estimated Project Cost (D+E) **TOTAL $** 24,033,431

Actual Capital Cost 24,033,431
Section B FMV 0

12. Section C. Economic Feasibility Item 2 Funding

The funding letter from Maury Regional stating Maury Regional is a 49% member of the LLC and is funding $12,000,000 to the proposed project is noted. However, Maury Regional is not a member of the applicant LLC. Please provide a funding letter from TriStar Health (on company letterhead with signature) that states TriStar Health will fund the entire project since they are the only member of the LLC at this time.

TriStar will not fund the whole project; it will fund only its 51% share. This has to be viewed in light of the applicant's commitment to partner with Maury Regional Hospital on the project or not to do the project at all. It would contradict the application to provide a letter assuring the HSDA that HCA would fund all of the capital cost. Attached following this page is a funding letter from HCA for its 51% of the capital cost.

13. Section C. Economic Feasibility Item 3 and 4 (Historical and Projected Data Chart)

Please complete the breakout of D.6 Other Operating Expenses located on page 43 and submit a replacement page.

Attached after this page is a replacement Projected Data Chart. The applicant has moved benefits into the salary line on the first page of that chart and recalculated the free cash flow section on page 2 of the chart. Also attached is revised page 45R, with the ratios stated as percentages.

14. Section C, Economic Feasibility, Item 5.C.

The table identifying the project's average gross charge in comparison to Rolling Hills and TrustPoint is noted. However, please clarify the reason the gross charge of the applicant would be over twice the amount charged by Rolling Hills and TrustPoint Hospital.

The gross charges for this proposed hospital are tentative for CY2019 and CY2020 charges. They will be set in further consultation with Maury Regional Medical Center, during project implementation. Note that this project's estimated charges are several years in the future, whereas we have only two-year-old comparative data from the existing hospitals you. Some annual inflation in those hospitals' charges is to be expected by 2019, narrowing the gap. But more significantly, HCA will negotiate major discounts from its gross charges --with both payors and inadequately insured patients.

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

TriStar Health

TriStarHealth.com
110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

October 12, 2016

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application for TriStar Maury Regional Behavioral Healthcare
Columbia, Maury County

Dear Mrs. Hill:

TriStar Maury Behavioral Healthcare, LLC is applying for a Certificate of Need to develop a 60-bed mental health hospital in Columbia. Through a wholly-owned subsidiary, Maury County Behavioral Health, LLC, HCA currently is the sole owner of the LLC filing the application. However, the application contemplates that an affiliate of Maury Regional Hospital (a public nonprofit entity) will acquire 49% membership interest in the applicant LLC in the near future. HCA and Maury Regional have planned this as a joint venture over the past two years.

The estimated project cost is $24,033,041. As the prospective 51% owner of the applicant LLC, HCA's share of this cost will be $12,256,851.

As Chief Financial Officer of TriStar Health, the HCA Division Office for Middle Tennessee, I am writing to confirm that HCA, Inc. will provide through TriStar Health the $12,256,851 in funding required to implement HCA's future share of the project cost. HCA, Inc.'s financial statements are provided in the application.

Sincerely,

C. Eric Lawson, CFO
Tristar Health

PROJECTED DATA CHART – MAURY PSYCHIATRIC HOSPITAL

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

			Year 2019	Year 2020
A.	Utilization Data	Discharges	1,352	1,830
	(Specify unit or measure)	Bed Days	11,630	15,739
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 46,925,000	$ 60,831,000
	2. Outpatient Services		2,870,000	5,264,000
	3. Emergency Services			
	4. Other Operating Revenue			
	(Specify) See notes page			
		Gross Operating Revenue	$ 49,795,000	$ 66,095,000
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments		$ 36,301,000	$ 49,032,000
	2. Provision for Charity Care		1,159,000	1,502,500
	3. Provisions for Bad Debt		1,159,000	1,502,500
		Total Deductions	$ 38,619,000	$ 52,037,000
NET OPERATING REVENUE			$ 11,176,000	$ 14,058,000
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Clinical		$ 5,998,000	6,742,000
	b. Non-Clinical		666,000	750,000
	2. Physicians Salaries and Wages			
	3. Supplies		871,000	843,000
	4. Rent			
	c. Paid to Affiliates			
	d. Paid to Non-Affiliates			
	5. Management Fees			
	a. Paid to Affiliates		447,040	562,320
	b. Paid to Non-Affiliates			
	6. Other Operating Expenses	See notes page	1,976,000	2,076,000
		Total Operating Expenses	$ 9,958,040	$ 10,973,320
E.	**Earnings Before Interest, Taxes, and Depreciation**		$ 1,217,960	$ 3,084,680
F.	Non-Operating Expenses			
	1. Taxes		$ 281,000	$ 1,058,000
	2. Depreciation		950,000	950,000
	3. Interest			
	4. Other Non-Operating Expenses			
		Total Non-Operating Expenses	$ 1,231,000	$ 2,008,000
NET INCOME (LOSS)			$ (13,040)	$ 1,076,680

Chart Continues Onto Next Page

SUPPLEMENTAL #1

October 28, 2016
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	Year 2019	Year 2020
NET INCOME (LOSS)	$ (13,040)	$ 1,076,680
G. Other Deductions		
1. Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$ 0	$ 0
NET BALANCE	$ (13,040)	$ 1,076,680
DEPRECIATION	$ 950,000	950,000
FREE CASH FLOW (Net Balance + Depreciation)	$ 936,960	$ 2,026,680

X TOTAL FACILITY
X PROJECT ONLY

PROJECTED DATA CHART -- OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2019	Year 2020
1. Professional Services Contract	$ 238,000	238,000
2. Contract Services	447,000	562,000
3. Repairs & Maintenance	60,000	60,000
4. Utilities	275,000	275,000
5. Insurance	309,000	379,000
6. Other	647,000	562,000
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14		
15.		
Total Other Expenses	$ 1,976,000	$ 2,076,000

6.A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved.

As shown in the Projected Data Chart, the hospital is expected to reach a positive cash flow its first year of operation and thereafter. Financial viability as calculated by the HSDA chart indicates a positive operating margin in Year Two, which will continue as census increases. The financial strength of the two owning organizations--HCA Holdings, Inc. and Maury Regional Hospital-- are shown in their financial statements provided in Attachment Section B-Economic Feasibility-6A, which document that these organizations have sufficient financial resources to support the hospital in its startup months, until viability is achieved.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project.

Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. NOTE: Publicly held entities only need to reference their SEC filings.

See Attachment Section B-Economic Feasibility-6A.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

	2nd Yr Previous to Current Yr	1st Yr Previous to Current Yr	Current Yr	Projected Yr 1	Projected Yr 2
Net Operating Margin Ratio	N/A	N/A	N/A	10.9%	21.94%

As indicated on that same table, these three hospitals will be receiving actual payments (net revenue per stay and per day) that are closely aligned with one another.

15. Section C. Economic Feasibility, Item 7

Please complete the table of the applicant's payor mix and submit a replacement page for page 47.

Attached after this page is revised page 47R.

16. Section C, Contribution to Orderly Development, Item 1

The transfer agreement with Maury Regional Hospital is noted. What other transfer agreements or contractual agreements is the applicant considering?

None others at this time; but by the time the project is implemented, the applicant would expect to have additional transfer agreements, possibly with MTMHI, TriStar Skyline at Madison, TriStar Valley Hospital in Chattanooga, and Tristar Centennial Medical Center in Nashville, to name a few.

17. Section C, Contribution to Orderly Development, Item 2

a. What is the distance from the applicant to Rolling Hills Hospital (Williamson County), TrustPoint Hospital (Rutherford County), and Centennial Medical Center (Davidson County)?

The distance and drive time data shown on Table A-6B(3) in the submitted application (following page 13) indicate that Columbia itself is 2.7 miles and 5 minutes' drive time from the project site. Below is Google Map's estimate of drive times from this project site to TrustPoint and Centennial.

Distances and Drive Times from This Project to Two Behavioral Care Providers Outside the Service Area			
From Project to Trustpoint		From Project to Centennial	
Miles	Minutes	Miles	Minutes
29.5 miles	34 min.	50.3 miles	59 minutes

Source: Google Maps on 10-27-16, at 4 pm.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1		
Payor Source	**Projected Gross Operating Revenue**	**As a Percent of Total Revenue**
Medicare/Medicare Managed Care	$20,764,515	41.7%
TennCare/Medicaid	$12,448,750	25.0%
Commercial/Other Managed Care	$12,747,520	25.6%
Self-Pay	$1,244,875	2.5%
Charity Care	$1,244,875	2.5%
Other	$1,344,465	2.7%
Total	$49,795,000	100.0%

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTE) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Please see Table C-Economic Feasibility-8 on the following page. The Medical Director's qualifications are documented in the Attachment "Miscellaneous". He will be interim Medical Director for the project during project development and staff recruitment. A permanent Medical Director has not been named at this time.

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Table C-Economic Feasibility-8: TriStar Maury Regional Behavioral Healthcare
Projected Staffing

Position Classification	Existing FTEs (N/A)	Projected FTEs (Yr 1)	Average Wage (Contractual Rate)	Areawide / Statewide Average Wage
A. Direct Patient Care Positions				
Chief Nursing Officer (CNO)		1.00		
Nurse Manager		2.00		
Nurse Supervisor		2.00		
Nurse		26.74		
Mental Health Technician		12.60		
Activity Therapist		2.80		
Social Worker		5.60		
Total Direct Patient Care Positions		**52.74**		
B. Non-Patient Care Positions				
CEO		1.00		
CFO		1.00		
Pharmacy		4.20		
Dietary		8.40		
Unit Secretary		3.00		
Administrative Assistant		2.00		
Case Management/Utilization Review		4.20		
Plant Operations		3.00		
Security		4.20		
Environmental Services		8.40		
Total Non-Patient Care Positions		**39.40**		
Total Employees (A + B)		**30.00**		
C. Contractual Staff				
Medical Director		1.00		
Total Contractual Staff		**1.00**		
Total Staff (A+B+C)		**93.14**		

Primary Service Area	TriStar Maury Reg. Behavioral HealthCare	Rolling Hills Hospital	TriStar Maury Reg. Behavioral HealthCare Projected Admissions in Year Two
Bedford		x	
Giles	x	x	174
Hickman	x		167
Lawrence	x	x	254
Lewis	x		76
Lincoln	x	x	207
Marshall	x	x	207
Maury	x	x	547
Moore	x		41
Perry	x		48
Wayne	x		109
Rutherford		x	
Williamson		x	
Total			**1,830**

Source: *CN1312-051A, Rolling Hills Hospital and CN1610-036, TriStar Maury Regional Behavioral Healthcare*

b. Please describe the effects of competition and/or duplication as a result of this proposal when half of the applicant's proposed service area overlaps with Rolling Hills Hospital and those five counties represent 1,389 admissions, or 75% of all admissions projected by the applicant in Year 2. Please refer to the table above.

By four years from today (2020), the applicant believes that the project service area counties will have much more demand for psychiatric admissions than is indicated by 2014-2015 admissions to behavioral health hospital beds. It is important not to expect patients and families to drive such long distances out of the area. It is not reasonable for the sheriff's departments to allocate scarce man-hours to transport patients to and from Middle Tennessee Mental Health Institute or Rolling Hills, or other faraway providers. There needs to be a short-term acute care resource for this service area's residents, closer to their homes.

The applicant concedes that the impact of the project on Rolling Hills will initially be adverse, but Rolling Hills' admissions will recover swiftly, with its location in one of America's fastest-growing urban areas, and the population's growing awareness of the availability of help with behavioral issues.

c. Please clarify if an 80% market share is realistic in the proposed 10 County service area. Does Rolling Hills or TrustPoint, sole mental health providers in their counties, have such market share? What is patient origin by county for TrustPoint and Rolling Hills.

The applicant does believe in its admissions projections, due to the stature of Maury Regional Medical Center in the service area, and to HCA's own long experience in serving behavioral health needs in Nashville, Madison, and Chattanooga. However, the "market" in CY2014 and CY2015 reflected only actual admissions--it did not include those who are going without inpatient care for a variety of reasons. The actual need for these services, in the opinion of the applicant, is much larger than indicated by actual admissions which constitute "the market" for projection purposes.

Attached after page 16 of this letter is patient origin information reported by Trustpoint and Rolling Hills, in their 2014 Joint Annual Reports.

18. Section C, Contribution to Orderly Development, Item 8

a. Please indicate if a Board Certified Psychiatrist specializing in Pediatrics is available to provide medical services to patients ages 13-17 if this application is approved.

There are two Board-certified psychiatrists in place in Columbia, who will be the project's first medical staff. They are Board-certified but do not yet have a specialty in Child Psychiatry. A third psychiatrist will be recruited during implementation of the project. That third psychiatrist hopefully will have a specialty in Child Psychiatry. With this project admitting only teenagers and adults, not children ages 0-12, the existing staff are viewed as highly competent to provide high quality care to teenagers and to adults. Please see the outstanding resume of Dr. Poling, in the Attachments.

b. In review of recent applications for Psychiatric Inpatient Facilities, it appeared empty beds were the result of shortages in psychiatric staff. Why will this project not have the same issues?

This is in Middle Tennessee, within an hour's drive of Nashville, and recruitment of staff to this region is expected to be easier in this region than in Chattanooga. Not only is the greater Nashville area a burgeoning health care center; over the next three years many new behavioral healthcare professionals will be graduated from Middle Tennessee educational programs. HCA operates its own program to help general acute care nurses transition to behavioral health nurses, and provides behavioral health

residencies for behavioral health RN's at TriStar Centennial and TriStar Skyline at Madison. HCA also operates a robust recruitment program including media advertising, personal recruitment calls, etc. with area-specific goals.

c. The table (Table B-Need-12) on page 48 is noted. Please complete the last two columns of the table and submit a replacement page 48.

The applicant cannot complete the last two columns of the table until Monday, October 31. It will be submitted under separate cover. However, to show the positions and FTE's of the project, a partially completed table is attached after this page.

19. Proof of Publication
Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Attached at the end of this submittal.

20. Affidavit
A signed and notarized affidavit must be submitted with each filing of an application and supplemental information. An affidavit was not included with this application. Please submit a completed affidavit for the original application and one for the supplemental information. Please note there is an affidavit form for the original filing and a separate form for supplemental responses.

Both are attached after this page.

Additional Materials Submitted: After this page are the responses to the State Health Plan CON review criteria for inpatient psychiatric beds, an additional support letter from a local physician, and an article of general interest on the topic of lack of beds for psychiatric patients.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn
Consultant

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

STATE HEALTH PLAN CON REVIEW CRITERIA FOR INPATIENT PSYCHIATRIC SERVICES

STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA
FOR
PSYCHIATRIC INPATIENT SERVICES

Standards and Criteria

1. Determination of Need: The population-based estimate of the total need for psychiatric inpatient services is a guideline of 30 beds per 100,000 general population, using population estimates prepared by the TDH and applying the applicable data in the Joint Annual Report (JAR). These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by the TDH in the JAR. For adult programs, the age group of 18-64 years shall be used in calculating the estimated total number of beds needed; additionally, if an applicant proposes a geriatric psychiatric unit, the age range 65+ shall be used. For child inpatients, the age group is 12 and under, and if the program is for adolescents, the age group of 13-17 shall be used. The HSDA may take into consideration data provided by the applicant justifying the need for additional beds that would exceed the guideline of 30 beds per 100,000 general population. Special consideration may be given to applicants seeking to serve child, adolescent, and geriatric inpatients. Applicants may demonstrate limited access to services for these specific age groups that supports exceeding the guideline of 30 beds per 100,000 general population. An applicant seeking to exceed this guideline shall utilize TDH and TDMHSAS data to justify this projected need and support the request by addressing the factors listed under the criteria "Additional Factors".

Rationale: Many communities in Tennessee have unique needs for inpatient psychiatric beds. The above formula functions as a "base criteria" that allows applicants to provide evidence supporting a need for a higher number of beds in the proposed service area. The HSDA may take into account all evidence provided and approve applications that request beds that exceed the 30 beds per 100,000 guideline when needed. An analysis of admissions and discharges by age category performed by the HSDA suggests there may be limited access for inpatients under the age of 18 and inpatients aged 65 and over. However, the applicable JAR form does not provide occupancy rates by age category. Health Planning believes developing determination of need formulas specific to each age category is not possible at this time due to these limitations in available data. The current need formula is to be utilized as a guideline allowing applicants the opportunity to apply to serve the unique needs of the intended service area.

Response:

Table B-Need-4A(2) in this application shows several population cohorts compiled from projections of the Tennessee Department of Health. This project will serve primarily adolescents and adults, ages 13-69. The applicant does not plan to offer a formal geropsychiatric unit or program because four "adult" programs limited almost entirely to geropsychiatric patients already exist in service area hospitals, and are underutilized. The applicant's adult program may occasionally admit an adult age 65 through 69--but this will be rare.

The State Health Plan uses a planning standard of 30 beds per 100,000 population, making no distinctions between use rates by age. The 30-bed standard is to be applied to children age 0-13, to adolescents age 13-17, and to adults age 18 and older--again, making no distinction between geriatric and non-geriatric adults. However, this project will not serve all adults; it serves adolescents and adults up to age 69--leaving the geriatric population to be served by the four existing geropsychiatric programs in area hospitals. The Guidelines should be applied taking that into account.

To reasonably apply the bed need planning Guideline to this specific project, the applicant has projected bed need by three separate age cohorts in Table B-Need-A1 below. The population projections are from the current Tennessee Department of Health population projections. Population estimates and projections by county, service area, and the target cohort of 13-69 years are shown in Table B-Need-4A(2) in a later section of this application.

Table B-Need-A1: Service Area Behavioral Acute Care Bed Need
CY2020
Applying Guidelines for Growth Planning Standard

Age Cohort Used	*Ages 13-69*	*Ages 13-64*	*Ages 65 +*
Service Area Population 2020	221,097	200,672	63,191
Bed Need @ 30 beds / 100,000	66.3	60.2	19.0
Behavioral Beds Available *	0*	0*	54*
Net Bed Need (Surplus)	66.3	60.2	(-35)

** All 54 existing beds are "adult" from a licensure standpoint. They are at Hillside Hospital (14), Lincoln Medical Center (10); Perry Community Hospital (14); and THM (16). However, from a health planning standpoint they are available almost exclusively to geropsychiatric patients.*

From the applicant's perspective, the Guideline when properly applied indicates a need for 66.3 acute behavioral beds in the service area, because the area has no hospital beds at all that are used to serve any significant numbers of adolescents and non-geriatric adults. When applied to the more restrictive age cohort of 13-64 years of age, the Guideline still shows a need for 60.2 acute behavioral beds. The Guideline also indicates that there are more geriatric beds in the area than are needed for the elderly 65+ population; and this may be one factor in the 56.1% collective occupancy reported by the area's four acute geropsychiatric care programs.

In conclusion, reasonable application of the Guideline planning standard to the populations served by this project, taking into account the complete unavailability of existing beds for non-geriatric patients, indicates a need for the proposed project.

2. Additional Factors: An applicant shall address the following factors:

a. The willingness of the applicant to accept emergency involuntary and non-emergency indefinite admissions;

Response:

The applicant intends to accept emergency involuntary admissions, but not emergency indefinite admissions requiring a long length of stay.

b. The extent to which the applicant serves or proposes to serve the TennCare population and the indigent population;

Response:

The applicant will serve both the TennCare and the indigent population, as projected in the responses to the payor mix question in this application, and in its Projected Data Chart.

c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);

Response:

The beds in the application are designated as adult (34) or adolescent (18), without further specialty designations.

d. The ability of the applicant to provide a continuum of care such as outpatient, intensive outpatient treatment (IOP), partial hospitalization, or refer to providers that do;

Response:

The project, as shown on its architectural floor plan, has provided space for outpatient programs of care that will include IOP. A partial hospitalization program is not planned at this time. The applicant is already coordinating the prospect of post-discharge care with the local Centerstone Mental Health Center in Columbia, which has written a support letter.

e. Psychiatric units for patients with intellectual disabilities;

Response:

To be admitted, a patient must demonstrate sufficient cognitive abilities to participate in both individual and group therapy. The facility's psychiatrists and clinical teams will make that judgment using a Behavioral Health Assessment, not an arbitrary IQ standard.

f. Free standing psychiatric facility transfer agreements with medical inpatient facilities;

Response:

The Attachments to the application included a transfer agreement with Maury Regional Medical Center, the service area's largest hospital. More will be sought when the project is under development, if CON approval is granted.

g. The willingness of the provider to provide inpatient psychiatric services to all populations (including those requiring hospitalization on an involuntary basis, individuals with co-occurring substance use disorders, and patients with comorbid medical conditions); and

Response:

The applicant will provide short-term acute inpatient care to patients requiring hospitalization on an involuntary basis, individuals with co-occurring substance abuse issues, and patients with comorbid medical conditions.

h. The applicant shall detail how the treatment program and staffing patterns align with the treatment needs of the patients in accordance with the expected length of stay of the patient population.

Response:

The facility is for short-stay acute patients diagnosed with a psychiatric condition. In question 15 below, the applicant has attached a staffing matrix that illustrates normative clinical staffing at varying levels of census for the short-stay patient.

i. Special consideration shall be given to an inpatient provider that has been specially contracted by the TDMHSAS to provide services to uninsured patients in a region that would have previously been served by a state operated mental health hospital that has closed.

Response:

Not applicable to this service area or to this proposed new provider.

j. Special consideration shall be given to a service area that does not have a crisis stabilization unit available as an alternative to inpatient psychiatric care.

Response:

The service area has no crisis stabilization unit available as an alternative to inpatient psychiatric care. Centerstone Community Mental Health Center, located in Columbia/Maury County, has a mobile crisis team that Maury Regional's ED can telephone to come assess a patient. The applicant understands that this team can mobilize to any of the ten service area counties. The State of Tennessee also maintains a Statewide Crisis Phone Line (855-CRISIS-1) that can activate Centerstone's team, or a mobile crisis team from Youth Villages, another community-based provider of mental health services for children and youth that is a contractor for TDMHSAS.

3. Incidence and Prevalence: The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

Rationale: The rate of incidence and prevalence of mental illness in the service area may indicate a need for a higher number of psychiatric inpatient beds in the designated area.

Response:

The applicant has consulted with planning staff at the TDMHSAS, who knew of no source of such data that could be used to project need for inpatient psychiatric beds.

Attached at the end of this letter are materials concerning the incidence or prevalence data for this region, published by TDMHSAS.

4. Planning Horizon: The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.

Rationale: The Division believes that projecting need two years into the future is more likely to accurately reflect the coming trends and less likely to overstate potential future need.

Response:

The projections of need in this application are for CY2020, which is the second year of operation of the proposed hospital.

5. Establishment of Service Area: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The proposal's sensitivity and responsiveness to the special needs of the service area shall be considered, including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, other medically underserved populations, and those who need services involuntarily. The applicant may also include information on patient origination and geography and transportation lines that may inform the determination of need for additional services in the region.

Applicants should be aware of the Bureau of TennCare's access requirement table, found under "Access to Behavioral Health Services" on pages 93-94 at http://www.tn.gov/assets/entities/tenncare/attachments/operationalprotocol.pdf.

Rationale: In many cases it is likely that a proposed psychiatric facility's service area could draw more significantly from only a portion of a county. When available, the Division would encourage the use of sub-county level data that are available to the general public (including utilization, demographic, etc.) to better inform the HSDA in making its decisions. Because psychiatric patients often select a facility based on the proximity of caregivers and family members, as well as the proximity of the facility, factors other than travel time maybe considered by the HSDA. Additionally, geography and transportation lines may limit access to services and necessitate the availability of additional psychiatric inpatient beds in specific service areas.

Response:

The defined service area includes ten counties surrounding Columbia, none of which currently provides needed inpatient acute hospitalization for the patient age groups (adolescents and non-geriatric elderly adults) that this project will serve. The service area

does not contain any major metropolitan areas where sub-county utilization patterns might be relevant. Therefore the applicant does not consider it helpful to utilize sub-county level data to establish the need for the project.

As drive time tables in the application demonstrate (see page 14 and 26), the residents of these ten counties are all within appropriate and reasonable drive times of Columbia, where this project will be located. The six counties containing approximately 85% of the target service area population have an average drive time to the site of approximately 36 minutes. Nine of the ten area county seats are 63 minutes' or less drive time of the site.

This is a rural area of significant extent. There are no public transportation systems available in the area, which could provide access to the project from counties adjoining Maury County.

6. Composition of Services: Inpatient hospital services that provide only substance use services shall be considered separately from psychiatric services in a CON application; inpatient hospital services that address co-occurring substance use/mental health needs shall be considered collectively with psychiatric services. Providers shall also take into account concerns of special populations (including, e.g., supervision of adolescents, specialized geriatric, and patients with comorbid medical conditions).

The composition of population served, mix of populations, and charity care are often affected by status of insurance, TennCare, Medicare, or TriCare; additionally, some facilities are eligible for Disproportionate Share Hospital payments based on the amount of charity care provided, while others are not. Such considerations may also result in a prescribed length of stay.

Rationale: Because patients with psychiatric conditions often experience co-morbid conditions, it is important that providers be capable of addressing such patients' potential medical needs. The accessibility of psychiatric services to various populations and for appropriate lengths of stay are important considerations for the HSDA when reviewing psychiatric inpatient services applications.

Response:

The hospital will admit patients with a primary diagnosis of need for short-term acute inpatient psychiatric care, and this will include patients with co-occurring substance abuse treatment needs. The hospital will seek TennCare and Alabama Medicaid contracts and will serve indigents as indicated in the application's Projected Data Chart and payor mix data.

Patients with co-morbid medical conditions will be treated by the proposed hospital's physician staff to the extent appropriate. If they need care not available from the proposed hospital's staff, they will be referred to Maury Regional Medical Center physicians (or another hospital of their choice) prior to admission for psychiatric care.

7. Patient Age Categorization: Patients should generally be categorized as children (0-12), adolescents (13-17), adults (18-64), or geriatrics (65+). While an adult inpatient psychiatric service can appropriately serve adults of any age, an applicant shall indicate if they plan to only serve a portion of the adult population so that the determination of need may be based on that age-limited population. Applicants shall be clear regarding the age range they intend to serve; given the small number of hospitals who serve younger children (12 and under), special consideration shall be given to applicants serving this age group. Applicants shall specify how patient care will be specialized in order to appropriately care for the chosen patient category.

Rationale: Based on stakeholder input, the Division has categorized the patient population into children, adolescents, adults, and geriatric. Each age category may require unique care.

Response:

This application categorizes its patient populations as adolescents ages 13-17, and adults ages 18-64--with an occasional patient of 65 to 69 years of age. The adolescent population's 18 beds and outdoors areas will be separated from the adult population's 42 beds and outdoor areas, as shown on the architectural plans for the facility. Separation of the two groups during the day (individual and group therapies; dining; recreation) is accomplished by scheduling their use of common spaces.

8. Services to High-Need Populations: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are involuntarily committed, uninsured, or low-income.

Response:

The hospital will accept involuntary commitments, low-income TennCare patients, and patients without insurance or the means to pay for care (as indicated in the Projected Data Chart).

9. Relationship to Existing Applicable Plans; Underserved Area and Populations: The proposal's relationships to underserved geographic areas and underserved population groups shall also be a significant consideration. The impact of the proposal on similar services in the community supported by state appropriations shall be assessed and considered; the applicant's proposal as to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, shall also be assessed and considered. The degree of projected financial participation in the Medicare and TennCare programs shall be considered.

Response:

This service area is a long drive from behavioral health providers in Nashville, Franklin and Murfreesboro. It is clearly underserved, having no acute care behavioral beds at all for adolescents (ages 13-17) and adults (ages18-64). The project can have no adverse impact on State-funded hospital beds, which are already operating at high occupancy.

The hospital will participate in both Medicare and TennCare/Medicaid, although very few Medicare-age patients are anticipated because the programs will focus on adolescents and adults ages 13-69. The hospital will offer short-term acute care and outpatient care, but will not serve patients requiring chronic, long-term hospital stays.

Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall also include how the applicant's services may differ from existing services (e.g., specialized treatment of an age-limited group, acceptance of involuntary admissions, and differentiation by payor mix). Accessibility to specific special need groups shall also be discussed in the application.

Rationale: Based on stakeholder input, a number of factors, including occupancy, shall be considered in the context of general utilization trends. Additionally, several factors may be necessary to consider when determining occupancy including staffed beds verses licensed beds, the target patient population, and the operation of specialty units.

Response:

The application has discussed at length the services available in the service area, and trends in occupancy and utilization of those services. The area has four acute inpatient geropsychiatric units but no inpatient programs for adolescents (ages13-17) or adults (ages

18-64). Their last reported combined utilization (2014 Jar's) was 39.5%, with occupancies ranging from 5.6% to 74.2%. Please see page 35R of the application for utilization details.

10. Expansion of Established Facility: Applicants seeking to add beds to an existing facility shall provide documentation detailing the sustainability of the existing facility. This documentation shall include financials, and utilization rates. A facility seeking approval for expansion should have maintained an occupancy rate for all licensed beds of at least 80 percent for the previous year. The HSDA may take into consideration evidence provided by the applicant supporting the need for the expansion or addition of services without the applicant meeting the 80 percent threshold. Additionally, the applicant shall provide evidence that the existing facility was built and operates, in terms of plans, service area, and populations served, in accordance with the original project proposal.

Rationale: Based on stakeholder input, the implementation of an 80 percent threshold for the approval may serve as an indicator of economic feasibility for the expansion of the facility. The 80 percent occupancy requirement may limit an applicant's ability to add specialty services that require separation from other units. Examples include geriatric psychiatry, services for patients with co-occurring mental health needs and substance use disorders. Additionally, the majority of the programs in the state are currently operating under this threshold. The communities these programs serve may have needs that require an expansion of services. An applicant may provide evidence of the economic feasibility of expansion despite not operating at or above 80 percent of capacity.

Response:

Not applicable.

11. Licensure and Quality Considerations: Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH and/or the TDMHSAS. The applicant shall also demonstrate its accreditation status with the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or other applicable accrediting agency. Such compliance shall provide assurances that applicants are making appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems, and children who need quiet space). Applicants shall also make appropriate accommodations so that patients are separated by gender in regards to sleeping as well as bathing arrangements. Additionally, the applicant shall indicate how it would provide culturally competent services in the service area (e.g., for veterans, the Hispanic population, and LBGT population).

Response:

This is a new facility so there need be no compliance issues. The proposed hospital will be developed and operated in full compliance with State licensure

requirements, and will seek Joint Commission accreditation. Appropriate age and gender separations will be observed and have been taken into account in the architectural design of patient rooms, bathrooms, and activity and recreation areas. Seclusion rooms are provided. Services will be provided with cultural sensitivity to all patients. Translation services will be available telephonically.

12. Institution for Mental Disease Classification: It shall also be taken into consideration whether the facility is or will be classified as an Institution for Mental Disease (IMD). The criteria and formula involve not just the total number of beds, but the average daily census (ADC) of the inpatient psychiatric beds in relation to the ADC of the facility. When a facility is classified as an IMD, the cost of patient care for Bureau of TennCare enrollees aged 21-64 will be reimbursed using 100 percent state funds, with no matching federal funds provided; consequently, this potential impact shall be addressed in any CON application for inpatient psychiatric beds.

Response:

This hospital will not have an IMD classification.

13. Continuum of Care: Free standing inpatient psychiatric facilities typically provide only basic acute medical care following admission. This practice has been reinforced by Tenn. Code Ann. § 33-4-104, which requires treatment at a hospital or by a physician for a physical disorder prior to admission if the disorder requires immediate medical care and the admitting facility cannot appropriately provide the medical care. It is essential, whether prior to admission or during admission, that a process be in place to provide for or to allow referral for appropriate and adequate medical care. However, it is not effective, appropriate, or efficient to provide the complete array of medical services in an inpatient psychiatric setting.

Response:

The proposed hospital will provide only appropriate and limited medical care upon admission; patients with additional medical needs will be referred to medical staff of Maury Regional Medical Center, one of the partnering providers in this project, or to medical staff at another facility of the patient's choice.

14. Data Usage: The TDH and the TDMHSAS data on the current supply and utilization of licensed and CON-approved psychiatric inpatient beds shall be the data sources employed hereunder, unless otherwise noted. The TDMHSAS and the TDH Division of Health Licensure and Regulation have data on the current number of licensed beds. The applicable TDH JAR provides data on the number

of beds in operation. Applicants should utilize data from both sources in order to provide an accurate bed inventory.

Rationale: Using these sources for data is the only way to ensure consistency across the evaluation of all applications. Data provided by the TDH and the TDMHSAS shall be relied upon as the primary sources of data for CON psychiatric inpatient services applications. Each data source has specific caveats. Requiring the use of both licensed beds and operating beds will provide a more comprehensive bed inventory analysis.

Response:

The statistical data required for this application have been obtained from the Tennessee Department of Health's most current county-level population projections, Licensure reports, and Joint Annual Reports. The applicant is not aware that additional bed utilization data from TDMHSAS is needed for this particular project.

15. Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed Service Area. Each applicant shall outline planned staffing patterns including the number and type of physicians. Additionally, the applicant shall address what kinds of shifts are intended to be utilized (e.g., 8 hour, 12 hour, or Baylor plan). Each unit is required to be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times. This staffing level is the minimum necessary to provide safe care. The applicant shall state how the proposed staffing plan will lead to quality care of the patient population served by the project.

However, when considering applications for expansions of existing facilities, the HSDA may determine whether the existing facility's staff would continue without significant change and thus would be sufficient to meet this standard without a demonstration of efforts to recruit new staff.

Response:

Detailed staffing plans by shift are premature until the hospital has been approved and begins its staff recruitment. As a general rule, these behavioral health hospitals staff one Board-certified psychiatrist to 15 patients. There are two Columbia psychiatrists already available to Maury Regional and HCA; and upon approval of the project HCA will begin recruiting a third. Shifts might be 12 hours for certain clinical persons, and 8 hours for others. A staffing pattern is very complex. To illustrate that, attached following this page is a staffing matrix HCA has provided as an example of clinical staffing guidelines for behavioral units, as their census changes.

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

As the Table C-Economic Feasibility-8 in the application shows, the hospital will have approximately 27 nurses, plus additional clinical persons, employed in Year One. The patient census that year will average 31.3 patients. So the project will exceed the minimum clinical staffing set forth in criterion #15.

Recruitment is always challenging but always seems to work out, in time. This is especially true here, when there will be so much time between the CON decision and the opening of the hospital in late 2018. HCA has a very robust and successful human resources recruiting team in its corporate office in Nashville.

Moreover, in this project HCA will be partnered with a subregional hospital of high quality and reputation. The two organizations are confident that they can attract the staff required to provide these patients with the highest quality of care.

The staffing matrix for clinical employees begins on the next page, 13a.

Staffing Matrix - 8 Hours Shifts

Hospital New Hospital
Dept #

Type of Nursing Unit: Psychiatric (Adult)

1.00 Discharge/Transfer/Obs Factor

Unit Census
Average Low 21
Average High 31

1.0 FTE = 8 Productive Man-Hours

Hospital New Hospital
Dept # 0

Type of Nursing Unit: Psychiatr

FTE By Shift and Skillmix - 8 Hr Shifts

Day								Evening							Night							24 Hour Total		HPPD	PLUS
Unit Census		RN	MHT	CM	SW / AT	US		Total Staff		RN	MHT	CM	SW / AT	US		Total Staff		RN	MHT	CM	SW / AT	US		Total Staff	Total Staff	Total Hours 24 hours	HPPD total	PLUS Hrs/UOS
1		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	60.00	60.00
2		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	30.00	30.00
3		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	20.00	20.00
4		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	15.00	15.00
5		1.00	1.00	0.50	1.00	1.00		4.5		1.00	1.00					2.0		1.00	1.00					2.0	8.5	68.0	13.60	13.60
6		1.00	1.00	0.50	1.00	1.00		4.5		1.00	1.00					2.0		1.00	1.00					2.0	8.5	68.0	11.33	11.33
7		2.00	1.00	0.50	1.50	1.00		6.0		2.00	1.00					3.0		1.00	1.00					2.0	11.0	88.0	12.57	12.57
8		2.00	1.00	1.00	1.50	1.00		6.5		2.00	1.00					3.0		2.00	1.00					3.0	12.5	100.0	12.50	12.50
9		2.00	1.00	1.00	2.00	1.00		7.0		2.00	1.00					3.0		2.00	1.00					3.0	13.0	104.0	11.56	11.56
10		2.00	1.00	1.00	2.50	1.00		7.5		2.00	1.00					3.0		2.00	1.00					3.0	13.5	108.0	10.80	10.80
11		2.00	1.00	1.00	2.50	1.00		7.5		2.00	1.00					3.0		2.00	1.00					3.0	13.5	108.0	9.82	9.82
12		2.00	1.00	1.00	2.50	1.00		7.5		2.00	1.00					3.0		2.00	1.00					3.0	13.5	108.0	9.00	9.00
13		3.00	2.00	1.00	2.50	1.00		9.5		3.00	1.00					4.0		3.00	2.00					5.0	18.5	148.0	11.38	11.38
14		3.00	2.00	1.00	3.00	1.00		10.0		3.00	1.00					4.0		3.00	2.00					5.0	19.0	152.0	10.86	10.86
15		3.00	2.00	1.00	3.00	1.00		10.0		3.00	1.00					4.0		3.00	2.00					5.0	19.0	152.0	10.13	10.13
16		3.00	2.00	2.00	3.00	1.00		11.0		3.00	2.00					5.0		3.00	2.00					5.0	21.0	168.0	10.50	10.50
17		3.00	2.00	2.00	3.00	1.00		11.0		3.00	2.00					5.0		3.00	2.00					5.0	21.0	168.0	9.88	9.88
18		3.00	2.00	2.00	3.00	1.00		11.0		3.00	2.00					5.0		3.00	2.00					5.0	21.0	168.0	9.33	9.33
19		4.00	2.00	2.00	3.50	1.00		12.5		4.00	2.00					6.0		4.00	2.00					6.0	24.5	196.0	10.32	10.32
20		4.00	2.00	2.00	3.50	1.00		12.5		4.00	2.00					6.0		4.00	2.00					6.0	24.5	196.0	9.80	9.80
21		4.00	2.00	2.00	4.00	1.00		13.0		4.00	2.00					6.0		4.00	2.00					6.0	25.0	200.0	9.52	9.52
22		4.00	2.00	2.00	4.00	1.00		13.0		4.00	2.00					6.0		4.00	2.00					6.0	25.0	200.0	9.09	9.09
23		4.00	2.00	2.00	4.00	1.00		13.0		4.00	2.00					6.0		4.00	2.00					6.0	25.0	200.0	8.70	8.70
24		4.00	2.00	2.00	4.00	1.00		13.0		4.00	2.00					6.0		4.00	2.00					6.0	25.0	200.0	8.33	8.33
25		5.00	2.00	2.00	4.50	2.00		15.5		5.00	2.00					7.0		5.00	2.00					7.0	29.5	236.0	9.44	9.44
26		5.00	2.00	2.00	4.50	2.00		15.5		5.00	2.00					7.0		5.00	2.00					7.0	29.5	236.0	9.08	9.08
27		5.00	2.00	2.00	4.50	2.00		15.5		5.00	2.00					7.0		5.00	2.00					7.0	29.5	236.0	8.74	8.74
28		5.00	2.00	2.00	4.50	2.00		15.5		5.00	2.00					7.0		5.00	2.00					7.0	29.5	236.0	8.43	8.43
29		5.00	2.00	2.00	4.50	2.00		15.5		5.00	2.00					7.0		5.00	2.00					7.0	29.5	236.0	8.14	8.14
30		5.00	2.00	2.00	4.50	2.00		15.5		5.00	2.00					7.0		5.00	2.00					7.0	29.5	236.0	7.87	7.87
31		6.00	2.00	3.00	5.00	2.00		18.0		6.00	2.00					8.0		6.00	2.00					8.0	34.0	272.0	8.77	8.77
32		6.00	2.00	3.00	5.00	2.00		18.0		6.00	2.00					8.0		6.00	2.00					8.0	34.0	272.0	8.50	8.50
33		6.00	2.00	3.00	5.00	2.00		18.0		6.00	2.00					8.0		6.00	2.00					8.0	34.0	272.0	8.24	8.24
34		6.00	2.00	3.00	5.00	2.00		18.0		6.00	2.00					8.0		6.00	2.00					8.0	34.0	272.0	8.00	8.00
35		6.00	2.00	3.00	5.00	2.00		18.0		6.00	2.00					8.0		6.00	2.00					8.0	34.0	272.0	7.77	7.77
36		6.00	3.00	3.00	5.50	2.00		19.5		6.00	3.00					9.0		6.00	3.00					9.0	37.5	300.0	8.33	8.33
37		7.00	3.00	3.00	5.50	2.00		20.5		7.00	3.00					10.0		7.00	3.00					10.0	40.5	324.0	8.76	8.76
38		7.00	3.00	3.00	5.50	2.00		20.5		7.00	3.00					10.0		7.00	3.00					10.0	40.5	324.0	8.53	8.53
39		7.00	3.00	3.00	5.50	2.00		20.5		7.00	3.00					10.0		7.00	3.00					10.0	40.5	324.0	8.31	8.31
40		7.00	3.00	3.00	6.00	2.00		21.0		7.00	3.00					10.0		7.00	3.00					10.0	41.0	328.0	8.20	8.20
41		7.00	4.00	3.00	6.00	2.00		22.0		7.00	4.00					11.0		7.00	4.00					11.0	44.0	352.0	8.59	8.59
42		7.00	4.00	3.00	6.00	2.00		22.0		7.00	4.00					11.0		7.00	4.00					11.0	44.0	352.0	8.38	8.38
43		8.00	4.00	3.00	6.00	2.00		23.0		8.00	4.00					12.0		8.00	4.00					12.0	47.0	376.0	8.74	8.74
44		8.00	4.00	3.00	6.00	2.00		23.0		8.00	4.00					12.0		8.00	4.00					12.0	47.0	376.0	8.55	8.55
45		8.00	4.00	3.00	6.00	2.00		23.0		8.00	4.00					12.0		8.00	4.00					12.0	47.0	376.0	8.36	8.36
46		8.00	4.00	4.00	6.50	2.00		24.5		8.00	4.00					12.0		8.00	4.00					12.0	48.5	388.0	8.43	8.43
47		8.00	4.00	4.00	6.50	2.00		24.5		8.00	4.00					12.0		8.00	4.00					12.0	48.5	388.0	8.26	8.26
48		8.00	4.00	4.00	6.50	2.00		24.5		8.00	4.00					12.0		8.00	4.00					12.0	48.5	388.0	8.08	8.08

Variable MH/UOS	8.74
Fixed MH/UOS	0.22
Total MH/UOS	8.96

Day				
Unit Census		RN	MHT	CM
1		29%	40%	20%
2		29%	40%	20%
3		29%	40%	20%
4		29%	40%	20%
5		22%	40%	20%
6		22%	40%	20%
7		33%	33%	17%
8		31%	29%	29%
9		29%	25%	25%
10		27%	22%	22%
11		27%	22%	22%
12		27%	22%	22%
13		32%	36%	18%
14		30%	33%	17%
15		30%	33%	17%
16		27%	29%	29%
17		27%	29%	29%
18		27%	29%	29%
19		32%	27%	27%
20		32%	27%	27%
21		31%	25%	25%
22		31%	25%	25%
23		31%	25%	25%
24		31%	25%	25%
25		32%	24%	24%
26		32%	24%	24%
27		32%	24%	24%
28		32%	24%	24%
29		32%	24%	24%
30		32%	24%	24%
31		33%	20%	30%
32		33%	20%	30%
33		33%	20%	30%
34		33%	20%	30%
35		33%	20%	30%
36		31%	26%	26%
37		34%	26%	26%
38		34%	26%	26%
39		34%	26%	26%
40		33%	25%	25%
41		32%	31%	23%
42		32%	31%	23%
43		35%	31%	23%
44		35%	31%	[illegible]
45		35%	31%	[illegible]
46		33%	28%	[illegible]
47		33%	28%	28%
48		33%	28%	[illegible]

	NA	32%	24%	25%
		CN	RN	LPN

Day (Avera

* Averages are based on average high/lo
Note - Skillmix % for RN, LPN, and TC a

Day - Indirect Patient Care **

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
MGR	8.00	8.00	8.00	8.00	8.00		
OTH							
OTH							
Total	8.0	8.0	8.0	8.0	8.0	0.0	0.0

** Enter hours by Day, example: 8 hours

Even. - Indirect Patient Care **

Mon	Tue	Wed	Thu	Fri	Sat	Sun
0.0	0.0	0.0	0.0	0.0	0.0	0.0

** Enter hours by Day, example: 8 hours

Night - Indirect Patient Care **

Mon	Tue	Wed	Thu	Fri	Sat	Sun
0.0	0.0	0.0	0.0	0.0	0.0	0.0

** Enter hours by Day, example: 8 hours

NOTES:

RN	RN
MHT	Mental Health Tech
CM	Case Management
SW/AT	Social Work / Activity Therapy
US	Unit Secretary

* Discharge/Transfer Factor is based on historical rate of transfers, discharges, and observation hours used to calculate department's unit of service.

10/28/16
Page 1 of 2

October 28, 2016

SUPPLEMENTAL #1

Staffing Matrix - 8 Hours Shifts

ic (Adult)

Note: Patient to Licensed Staff Ratio does not include Charge Nurse

Skill Mix % and Patient Ratio by Shift

			Evening							Night						
SW / AT	US	Pat / Lic Staff Ratio		RN	MHT	CM	SW / AT	US	Pat / Lic Staff Ratio		RN	MHT	CM	SW / AT	US	Pat / Lic Staff Ratio
40%	0%	1.0		50%	100%	0%	0%	0%	1.0		50%	100%	0%	0%	0%	1.0
40%	0%	2.0		50%	100%	0%	0%	0%	2.0		50%	100%	0%	0%	0%	2.0
40%	0%	3.0		50%	100%	0%	0%	0%	3.0		50%	100%	0%	0%	0%	3.0
40%	0%	4.0		50%	100%	0%	0%	0%	4.0		50%	100%	0%	0%	0%	4.0
40%	22%	5.0		50%	100%	0%	0%	0%	5.0		50%	100%	0%	0%	0%	5.0
40%	22%	6.0		50%	100%	0%	0%	0%	6.0		50%	100%	0%	0%	0%	6.0
50%	17%	3.5		67%	100%	0%	0%	0%	3.5		50%	100%	0%	0%	0%	7.0
43%	15%	4.0		67%	100%	0%	0%	0%	4.0		67%	100%	0%	0%	0%	4.0
50%	14%	4.5		67%	100%	0%	0%	0%	4.5		67%	100%	0%	0%	0%	4.5
56%	13%	5.0		67%	100%	0%	0%	0%	5.0		67%	100%	0%	0%	0%	5.0
56%	13%	5.5		67%	100%	0%	0%	0%	5.5		67%	100%	0%	0%	0%	5.5
56%	13%	6.0		67%	100%	0%	0%	0%	6.0		67%	100%	0%	0%	0%	6.0
45%	11%	4.3		75%	100%	0%	0%	0%	4.3		60%	100%	0%	0%	0%	4.3
50%	10%	4.7		75%	100%	0%	0%	0%	4.7		60%	100%	0%	0%	0%	4.7
50%	10%	5.0		75%	100%	0%	0%	0%	5.0		60%	100%	0%	0%	0%	5.0
43%	9%	5.3		60%	100%	0%	0%	0%	5.3		60%	100%	0%	0%	0%	5.3
43%	9%	5.7		60%	100%	0%	0%	0%	5.7		60%	100%	0%	0%	0%	5.7
43%	9%	6.0		60%	100%	0%	0%	0%	6.0		60%	100%	0%	0%	0%	6.0
47%	8%	4.8		67%	100%	0%	0%	0%	4.8		67%	100%	0%	0%	0%	4.8
47%	8%	5.0		67%	100%	0%	0%	0%	5.0		67%	100%	0%	0%	0%	5.0
50%	8%	5.3		67%	100%	0%	0%	0%	5.3		67%	100%	0%	0%	0%	5.3
50%	8%	5.5		67%	100%	0%	0%	0%	5.5		67%	100%	0%	0%	0%	5.5
50%	8%	5.8		67%	100%	0%	0%	0%	5.8		67%	100%	0%	0%	0%	5.8
50%	8%	6.0		67%	100%	0%	0%	0%	6.0		67%	100%	0%	0%	0%	6.0
53%	13%	5.0		71%	100%	0%	0%	0%	5.0		71%	100%	0%	0%	0%	5.0
53%	13%	5.2		71%	100%	0%	0%	0%	5.2		71%	100%	0%	0%	0%	5.2
53%	13%	5.4		71%	100%	0%	0%	0%	5.4		71%	100%	0%	0%	0%	5.4
53%	13%	5.6		71%	100%	0%	0%	0%	5.6		71%	100%	0%	0%	0%	5.6
53%	13%	5.8		71%	100%	0%	0%	0%	5.8		71%	100%	0%	0%	0%	5.8
53%	13%	6.0		71%	100%	0%	0%	0%	6.0		71%	100%	0%	0%	0%	6.0
50%	11%	5.2		75%	100%	0%	0%	0%	5.2		75%	100%	0%	0%	0%	5.2
50%	11%	5.3		75%	100%	0%	0%	0%	5.3		75%	100%	0%	0%	0%	5.3
50%	11%	5.5		75%	100%	0%	0%	0%	5.5		75%	100%	0%	0%	0%	5.5
50%	11%	5.7		75%	100%	0%	0%	0%	5.7		75%	100%	0%	0%	0%	5.7
50%	11%	5.8		75%	100%	0%	0%	0%	5.8		75%	100%	0%	0%	0%	5.8
48%	10%	6.0		67%	100%	0%	0%	0%	6.0		67%	100%	0%	0%	0%	6.0
48%	10%	5.3		70%	100%	0%	0%	0%	5.3		70%	100%	0%	0%	0%	5.3
48%	10%	5.4		70%	100%	0%	0%	0%	5.4		70%	100%	0%	0%	0%	5.4
48%	10%	5.6		70%	100%	0%	0%	0%	5.6		70%	100%	0%	0%	0%	5.6
50%	10%	5.7		70%	100%	0%	0%	0%	5.7		70%	100%	0%	0%	0%	5.7
46%	9%	5.9		64%	100%	0%	0%	0%	5.9		64%	100%	0%	0%	0%	5.9
46%	9%	6.0		64%	100%	0%	0%	0%	6.0		64%	100%	0%	0%	0%	6.0
46%	9%	5.4		67%	100%	0%	0%	0%	5.4		67%	100%	0%	0%	0%	5.4
46%	9%	5.5		67%	100%	0%	0%	0%	5.5		67%	100%	0%	0%	0%	5.5
46%	9%	5.6		67%	100%	0%	0%	0%	5.6		67%	100%	0%	0%	0%	5.6
45%	8%	5.8		67%	100%	0%	0%	0%	5.8		67%	100%	0%	0%	0%	5.8
45%	8%	5.9		67%	100%	0%	0%	0%	5.9		67%	100%	0%	0%	0%	5.9
45%	8%	6.0		67%	100%	0%	0%	0%	6.0		67%	100%	0%	0%	0%	6.0

52%	11%	5.52	NA	70%	100%	NA	NA	NA	5.52	NA	70%	100%	NA	NA	NA	5.52
TC	US	Pat / Lic Staff Ratio		CN	RN	LPN	TC	US	Pat / Lic Staff Ratio		CN	RN	LPN	TC	US	Pat / Lic Staff Ratio
age*)				**Evening** (Average*)							**Night** (Average*)					

ow unit census entered in Staffing Matrix
are a percentage of direct patient care man-hours: CN and US are a percentage of total man-hours.

13b

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

Staffing Matrix - 8 Hours Shifts

Hospital New Hospital
Dept #

Type of Nursing Unit: Psychiatric (Adolescent)

1.00 Discharge/Transfer/Obs Factor

Unit Census

Average Low	8
Average High	13

1.0 FTE = 8 Productive Man-Hours

FTE By Shift and Skillmix - 8 Hr Shifts

	Day							Evening							Night							24 Hour Total		HPPD
Unit Census		RN	MHT	CM	SW / AT	US		Total Staff		RN	MHT	CM	SW / AT	US		Total Staff		RN	MHT	CM	SW / AT	US		Total Staff	Total Staff	Total Hours 24 hours	HPPD total
1		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	60.00
2		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	30.00
3		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	20.00
4		1.00	1.00	0.50	1.00	0.00		3.5		1.00	1.00					2.0		1.00	1.00					2.0	7.5	60.0	15.00
5		1.00	1.00	0.50	1.00	1.00		4.5		1.00	1.00					2.0		1.00	1.00					2.0	8.5	68.0	13.60
6		1.00	1.00	0.50	1.00	1.00		4.5		1.00	1.00					2.0		1.00	1.00					2.0	8.5	68.0	11.33
7		2.00	1.00	0.50	1.00	1.00		5.5		2.00	1.00					3.0		1.00	1.00					2.0	10.5	84.0	12.00
8		2.00	1.00	1.00	1.50	1.00		6.5		2.00	1.00					3.0		2.00	1.00					3.0	12.5	100.0	12.50
9		2.00	1.00	1.00	1.50	1.00		6.5		2.00	1.00					3.0		2.00	1.00					3.0	12.5	100.0	11.11
10		2.00	1.00	1.00	1.50	1.00		6.5		2.00	1.00					3.0		2.00	1.00					3.0	12.5	100.0	10.00
11		2.00	1.00	1.00	1.50	1.00		6.5		2.00	1.00					3.0		2.00	1.00					3.0	12.5	100.0	9.09
12		2.00	1.00	1.00	1.50	1.00		6.5		2.00	1.00					3.0		2.00	1.00					3.0	12.5	100.0	8.33
13		2.00	2.00	1.00	1.50	1.00		7.5		2.00	2.00					4.0		2.00	2.00					4.0	15.5	124.0	9.54
14		2.00	2.00	1.00	1.50	1.00		7.5		2.00	2.00					4.0		2.00	2.00					4.0	15.5	124.0	8.86
15		2.00	2.00	1.00	1.50	1.00		7.5		2.00	2.00					4.0		2.00	2.00					4.0	15.5	124.0	8.27
16		3.00	2.00	1.50	1.50	1.00		9.0		3.00	2.00					5.0		2.00	2.00					4.0	18.0	144.0	9.00
17		3.00	2.00	1.50	2.00	1.00		9.5		3.00	2.00					5.0		2.00	2.00					4.0	18.5	148.0	8.71
18		3.00	2.00	1.50	2.00	1.00		9.5		3.00	2.00					5.0		2.00	2.00					4.0	18.5	148.0	8.22
																										Variable MH/UOS	

Day - Indirect Patient Care **

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
MGR	8.00	8.00	8.00	8.00	8.00		
OTH							
OTH							
Total	8.0	8.0	8.0	8.0	8.0	0.0	0.0

** Enter hours by Day, example: 8 hours

Even. - Indirect Patient Care **

Mon	Tue	Wed	Thu	Fri	Sat	Sun
0.0	0.0	0.0	0.0	0.0	0.0	0.0

** Enter hours by Day, example: 8 hours

Night - Indirect Patient Care **

Mon	Tue	Wed	Thu	Fri	Sat	Sun
0.0	0.0	0.0	0.0	0.0	0.0	0.0

** Enter hours by Day, example: 8 hours

Fixed MH/UOS

Total MH/UOS

RN	RN
MHT	Mental Health Tech
CM	Case Management
SW/AT	Social Work / Activity Therapy
US	Unit Secretary

NOTES:

* Discharge/Transfer Factor is based on historical rate of transfers, discharges, and observation hours used to calculate department's unit of service.

SUPPLEMENTAL #1

October 28, 2016

2:44 pm

Staffing Matrix - 8 Hours Shifts

Hospital New Hospital
Dept # 0

Type of Nursing Unit: Psychiatric (Adolescent)

Note: Patient to Licensed Staff Ratio does not include Charge Nurse

Skill Mix % and Patient Ratio by Shift

PLUS		Day							Evening							Night						
PLUS Hrs/UOS	Unit Census		RN	MHT	CM	SW / AT	US	Pat / Lic Staff Ratio		RN	MHT	CM	SW / AT	US	Pat / Lic Staff Ratio		RN	MHT	CM	SW / AT	US	Pat / Lic Staff Ratio
60.00	1		29%	40%	20%	40%	0%	1.0		50%	100%	0%	0%	0%	1.0		50%	100%	0%	0%	0%	1.0
30.00	2		29%	40%	20%	40%	0%	2.0		50%	100%	0%	0%	0%	2.0		50%	100%	0%	0%	0%	2.0
20.00	3		29%	40%	20%	40%	0%	3.0		50%	100%	0%	0%	0%	3.0		50%	100%	0%	0%	0%	3.0
15.00	4		29%	40%	20%	40%	0%	4.0		50%	100%	0%	0%	0%	4.0		50%	100%	0%	0%	0%	4.0
13.60	5		22%	40%	20%	40%	22%	5.0		50%	100%	0%	0%	0%	5.0		50%	100%	0%	0%	0%	5.0
11.33	6		22%	40%	20%	40%	22%	6.0		50%	100%	0%	0%	0%	6.0		50%	100%	0%	0%	0%	6.0
12.00	7		36%	40%	20%	40%	18%	3.5		67%	100%	0%	0%	0%	3.5		50%	100%	0%	0%	0%	7.0
12.50	8		31%	29%	29%	43%	15%	4.0		67%	100%	0%	0%	0%	4.0		67%	100%	0%	0%	0%	4.0
11.11	9		31%	29%	29%	43%	15%	4.5		67%	100%	0%	0%	0%	4.5		67%	100%	0%	0%	0%	4.5
10.00	10		31%	29%	29%	43%	15%	5.0		67%	100%	0%	0%	0%	5.0		67%	100%	0%	0%	0%	5.0
9.09	11		31%	29%	29%	43%	15%	5.5		67%	100%	0%	0%	0%	5.5		67%	100%	0%	0%	0%	5.5
8.33	12		31%	29%	29%	43%	15%	6.0		67%	100%	0%	0%	0%	6.0		67%	100%	0%	0%	0%	6.0
9.54	13		27%	44%	22%	33%	13%	6.5		50%	100%	0%	0%	0%	6.5		50%	100%	0%	0%	0%	6.5
8.86	14		27%	44%	22%	33%	13%	7.0		50%	100%	0%	0%	0%	7.0		50%	100%	0%	0%	0%	7.0
8.27	15		27%	44%	22%	33%	13%	7.5		50%	100%	0%	0%	0%	7.5		50%	100%	0%	0%	0%	7.5
9.00	16		33%	40%	30%	30%	11%	5.3		60%	100%	0%	0%	0%	5.3		50%	100%	0%	0%	0%	8.0
8.71	17		32%	36%	27%	36%	11%	5.7		60%	100%	0%	0%	0%	5.7		50%	100%	0%	0%	0%	8.5
8.22	18		32%	36%	27%	36%	11%	6.0		60%	100%	0%	0%	0%	6.0		50%	100%	0%	0%	0%	9.0
10.10																						
0.54		NA	30%	31%	28%	41%	15%	5.25	NA	64%	100%	NA	NA	NA	5.25	NA	64%	100%	NA	NA	NA	5.25
10.64			CN	RN	LPN	TC	US	Pat / Lic Staff Ratio		CN	RN	LPN	TC	US	Pat / Lic Staff Ratio		CN	RN	LPN	TC	US	Pat / Lic Staff Ratio
		Day (Average*)							**Evening** (Average*)							**Night** (Average*)						

* Averages are based on average high/low unit census entered in Staffing Matrix
Note - Skillmix % for RN, LPN, and TC are a percentage of direct patient care man-hours: CN and US are a percentage of total man-hours.

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

13d

16. Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care (e.g., agreements between freestanding psychiatric facilities and acute care hospitals, linkages with providers of outpatient, intensive outpatient, and/or partial hospitalization services). If they are provided, letters from providers (e.g., physicians, mobile crisis teams, and/or managed care organizations) in support of an application shall detail specific instances of unmet need for psychiatric inpatient services. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of Inpatient Psychiatric Bed usage.

Rationale: The Division recognizes that participation in community linkage plans is an important element in the provision of quality psychiatric inpatient services; therefore, it is important for applicants to demonstrate such connections with other community providers. The 2014 update to the State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion". The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

Response:

The Centerstone Mental Health Center in Columbia is one of the service area's most important resources for behavioral healthcare. Centerstone has provided its letter of support for this application. The applicant and Centerstone will closely coordinate post-discharge and outpatient care for these patients, to assure that they will have an optimal continuum of appropriate care. Other behavioral health organizations and practitioners in the Columbia area have also been very supportive of this project and willing to work closely with Maury Regional Medical Center in this endeavor.f4q

17. Access: The applicant must demonstrate an ability and willingness to serve equally all of the patients related to the application of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed service area.

Response:

The service area currently has no inpatient beds for any adolescents or adults ages 13-64, who need acute inpatient psychiatric care. The State Health Plan bed need methodology indicates a need for the 60 proposed mental health hospital beds for inpatient care of these age groups.

18. Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

Rationale: This section supports the State Health Plan's Fourth Principle for Achieving Better Health regarding quality of care.

Response:

HCA Behavioral Health hospitals and units, and Maury Regional Medical Center, both have robust and highly effective quality improvement programs that include outcome and process monitoring systems. All HCA behavioral health hospitals are Joint Commission-accredited.

The requested surveys will be submitted before the end of the month, under separate cover.

19. Data Requirements: Applicants shall agree to provide the TDH, the TDMHSAS, and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services at the applicant's facility and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response:

The applicant so agrees.

SUPPLEMENTAL #1

October 28, 2016
2:44 pm

DMHSAS PREVALENCE AND INCIDENCE DATA (TO BE SUBMITTED UNDER SEPARATE COVER)

SUPPLEMENTAL #1

October 28, 2016

2:44 pm

PATIENT ORIGIN REPORTED BY ROLLING HILLS HOSPITAL AND TRUSTPOINT 2014 JOINT ANNUAL REPORTS

State ID 75254

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2014

SCHEDULE A - IDENTIFICATION*

1. Name of Hospital Trustpoint Hospital — Federal Tax I.D. # 20-5850135
   Did your facility name change during the reporting period? ○ YES ◉ NO
   County Rutherford
2. Address of Facility — Street 1009 N. Thompson Lane; City Murfreesboro; State Tennessee; Zip 37129-
3. Telephone Number (615) 867-1111 (Area Code Number)
4. Name of Chief Executive Officer Jeffrey (First Name) Woods (Last Name)
   Signature of Chief Executive Officer _____
5. Name of person(s) coordinating form completion Courtney Bohannon & Lee Smith
   Telephone Number if different than above (615) 867-1111 (Area Code Number)
6. 96 Office Use Only
7. Reporting period used for this facility:
   Beginning Date 01/01/2014 Ending Date 12/31/2014
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ○ YES ◉ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1			☐	○	○	○
2			☐	○	○	○
3			☐	○	○	○
4			☐	○	○	○
5			☐	○	○	○

PH-0958 (Rev. 06/14)

* Refer to Instructions for Completing JAR-H_yy

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ○ or Discharges and Discharge Patient Days ◉

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson	0	0
02	Bedford	151	1,420
03	Benton	1	1
04	Bledsoe	0	0
05	Blount	0	0
06	Bradley	1	5
07	Campbell	0	0
08	Cannon	56	527
09	Carroll	0	0
10	Carter	0	0
11	Cheatham	3	19
12	Chester	0	0
13	Claiborne	0	0
14	Clay	3	44
15	Cocke	0	0
16	Coffee	138	1,296
17	Crockett	0	0
18	Cumberland	5	28
19	Davidson	250	2,176
20	Decatur	0	0
21	DeKalb	13	129
22	Dickson	25	207
23	Dyer	0	0
24	Fayette	0	0
25	Fentress	1	19
26	Franklin	48	329
27	Gibson	0	0
28	Giles	10	69

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger	0	0
30	Greene	0	0
31	Grundy	14	120
32	Hamblen	0	0
33	Hamilton	17	153
34	Hancock	0	0
35	Hardeman	0	0
36	Hardin	3	33
37	Hawkins	0	0
38	Haywood	0	0
39	Henderson	0	0
40	Henry	0	0
41	Hickman	6	27
42	Houston	2	7
43	Humphreys	10	66
44	Jackson	1	3
45	Jefferson	0	0
46	Johnson	0	0
47	Knox	5	37
48	Lake	0	0
49	Lauderdale	0	0
50	Lawrence	23	164
51	Lewis	3	42
52	Lincoln	18	154
53	Loudon	0	0
54	McMinn	3	54
55	McNairy	0	0
56	Macon	5	28
57	Madison	2	29
58	Marion	1	19
59	Marshall	40	301
60	Maury	32	239
61	Meigs	0	0
62	Monroe	0	0

SUPPLEMENTAL #1
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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery	44	393
64	Moore	3	30
65	Morgan	0	0
66	Obion	0	0
67	Overton	1	3
68	Perry	0	0
69	Pickett	1	6
70	Polk	1	13
71	Putnam	20	164
72	Rhea	0	0
73	Roane	0	0
74	Robertson	10	80
75	Rutherford	1,129	9,791
76	Scott	1	11
77	Sequatchie	0	0
78	Sevier	0	0
79	Shelby	3	16
80	Smith	10	51
81	Stewart	1	5
82	Sullivan	0	0
83	Sumner	33	271
84	Tipton	1	5
85	Trousdale	5	29
86	Unicoi	0	0
87	Union	0	0
88	Van Buren	2	24
89	Warren	53	424
90	Washington	0	0
91	Wayne	2	7
92	Weakley	0	0
93	White	6	51
94	Williamson	71	659
95	Wilson	57	606
96	TN County Unknown	0	0
	Tennessee Total	2,344	20,384

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1) Madison	5	104
2) Morgan	3	29
Other Alabama Counties	9	110
Alabama Total	17	243
GEORGIA COUNTIES: (Specify)		
1) Catoosa	2	6
2) Cobb	2	15
Other Georgia Counties	5	31
Georgia Total	9	52
MISSISSIPPI COUNTIES: (Specify)		
1) Oktibbeha	1	9
2)	0	0
Other Mississippi Counties	0	0
Mississippi Total	1	9
ARKANSAS COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Arkansas Counties	0	0
Arkansas Total	0	0
MISSOURI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Missouri Counties	0	0
Missouri Total	0	0

SUPPLEMENTAL #1
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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1) Christian	6	56
2) Todd	2	37
Other Kentucky Counties	4	51
Kentucky Total	12	144
VIRGINIA COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Virginia Counties	4	17
Virginia Total	4	17
NORTH CAROLINA COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other North Carolina Counties	1	6
North Carolina Total	1	6
OTHER STATES: (Specify)		
1) Texas	5	46
2) Florida	4	27
All Other States and Countries	21	167
RESIDENCE UNKNOWN:	0	0
GRAND TOTAL	2,418	21,095

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State ID 94404

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2014

SCHEDULE A - IDENTIFICATION*

1. Name of Hospital Rolling Hills Hospital — Federal Tax I.D. # 20-5566098
   Did your facility name change during the reporting period? ○ YES ◉ NO
   County Williamson
2. Address of Facility — Street 2014 Quail Hollow Circle; City Franklin; State Tennessee; Zip 37067-
3. Telephone Number (615) 628-5700 (Area Code Number)
4. Name of Chief Executive Officer Richard (First Name) Clark (Last Name)
   Signature of Chief Executive Officer _____
5. Name of person(s) coordinating form completion Chris Leonard
   Telephone Number if different than above (615) 628-5710 (Area Code Number)
6. 85 Office Use Only
7. Reporting period used for this facility:
   Beginning Date 01/01/2014 Ending Date 12/31/2014
8. 365 Office Use Only
9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ○ YES ◉ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1			☐	○	○	○
2			☐	○	○	○
3			☐	○	○	○
4			☐	○	○	○
5			☐	○	○	○

PH-0958 (Rev. 06/14)

* Refer to Instructions for Completing JAR-H_yy

RDA 1530

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State ID 94404

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting

Admissions and Inpatient Days ◉ or Discharges and Discharge Patient Days ○

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
01	Anderson	1	8
02	Bedford	41	316
03	Benton	0	0
04	Bledsoe	0	0
05	Blount	0	0
06	Bradley	0	0
07	Campbell	1	8
08	Cannon	9	69
09	Carroll	1	8
10	Carter	0	0
11	Cheatham	14	108
12	Chester	0	0
13	Claiborne	0	0
14	Clay	0	0
15	Cocke	0	0
16	Coffee	97	747
17	Crockett	1	8
18	Cumberland	4	31
19	Davidson	805	6,199
20	Decatur	0	0
21	DeKalb	6	46
22	Dickson	52	400
23	Dyer	0	0
24	Fayette	0	0
25	Fentress	2	15
26	Franklin	60	462
27	Gibson	0	0
28	Giles	41	316

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger	0	0
30	Greene	0	0
31	Grundy	2	15
32	Hamblen	1	8
33	Hamilton	1	8
34	Hancock	0	0
35	Hardeman	0	0
36	Hardin	3	23
37	Hawkins	0	0
38	Haywood	0	0
39	Henderson	3	23
40	Henry	2	15
41	Hickman	37	285
42	Houston	2	15
43	Humphreys	9	69
44	Jackson	0	0
45	Jefferson	0	0
46	Johnson	0	0
47	Knox	7	54
48	Lake	0	0
49	Lauderdale	0	0
50	Lawrence	67	516
51	Lewis	11	85
52	Lincoln	18	139
53	Loudon	0	0
54	McMinn	0	0
55	McNairy	0	0
56	Macon	4	31
57	Madison	2	15
58	Marion	0	0
59	Marshall	47	362
60	Maury	398	3,065
61	Meigs	0	0
62	Monroe	0	0

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5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery	73	566
64	Moore	0	0
65	Morgan	0	0
66	Obion	1	8
67	Overton	0	0
68	Perry	3	23
69	Pickett	0	0
70	Polk	0	0
71	Putnam	53	411
72	Rhea	0	0
73	Roane	1	8
74	Robertson	27	209
75	Rutherford	272	2,108
76	Scott	0	0
77	Sequatchie	0	0
78	Sevier	0	0
79	Shelby	0	0
80	Smith	9	70
81	Stewart	2	15
82	Sullivan	0	0
83	Sumner	66	512
84	Tipton	0	0
85	Trousdale	0	0
86	Unicoi	0	0
87	Union	0	0
88	Van Buren	0	0
89	Warren	11	85
90	Washington	0	0
91	Wayne	16	124
92	Weakley	0	0
93	White	3	23
94	Williamson	797	6,247
95	Wilson	79	612
96	TN County Unknown	0	0
	Tennessee Total	3,162	24,490

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1)	11	85
2)	0	0
Other Alabama Counties	0	0
Alabama Total	11	85
GEORGIA COUNTIES: (Specify)		
1)	1	8
2)	0	0
Other Georgia Counties	0	0
Georgia Total	1	8
MISSISSIPPI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Mississippi Counties	0	0
Mississippi Total	0	0
ARKANSAS COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Arkansas Counties	0	0
Arkansas Total	0	0
MISSOURI COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Missouri Counties	0	0
Missouri Total	0	0

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5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1)	9	67
2)	0	0
Other Kentucky Counties	0	0
Kentucky Total	9	67
VIRGINIA COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other Virginia Counties	0	0
Virginia Total	0	0
NORTH CAROLINA COUNTIES: (Specify)		
1)	0	0
2)	0	0
Other North Carolina Counties	0	0
North Carolina Total	0	0
OTHER STATES: (Specify)		
1) New York	1	8
2) Florida	1	8
All Other States and Countries	0	0
RESIDENCE UNKNOWN:	0	0
GRAND TOTAL	3,185	24,666

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OTHER MISCELLANEOUS ATTACHMENTS

SUPPLEMENTAL #1

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NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Maury Regional Behavioral Healthcare, (a proposed mental health hospital), to be owned by TriStar Maury Behavioral Healthcare, LLC (a limited liability company), and to be managed by Maury County Behavioral Health, LLC (a limited liability company), intends to file an application for Certificate of Need to establish a mental health hospital for adolescent and adult patients, located on the east side of North James Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike, in Columbia, Tennessee 38401. The estimated project cost is $24,400,000.

The project will seek licensure by the Tennessee Department of Mental Health and Substance Abuse Services as a 60-bed mental health hospital. The project does not initiate or discontinue any other health service and it will not affect any other facility's licensed bed complements.

The anticipated date of filing the application is on or before October 14, 2016. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Tennessee Health Services
and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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secured by a promissory note incorporated by reference in said Deed of Trust; and

WHEREAS, default has been made in the payment of said indebtedness, and the holder and owner of said note has instructed the undersigned to foreclose said deed of trust.

WHEREAS, the Trustee named in said deed of trust being unable to act, and the owner and holder of said note has appointed the undersigned as Successor Trustee by instrument recorded in Book R2392, Page 956, Register's Office of Maury County, Tennessee.

NOW THEREFORE, by virtue of the authority vested in me as Successor Trustee under said instrument, I will, on the 13th day of October, 2016 at 11 :00 a.m., offer for sale and sell, in front of the south door of the Maury County Courthouse in Columbia, Tennessee, to the last, highest and best bidder, for cash in hand and in bar of the equity of redemption, statutory right of redemption, homestead and all other exemptions of every kind but subject to building restrictions and any unpaid taxes or assessments, if any, the following described tract of land situated in Maury County, Tennessee, more particularly described as follows:

Located in the Fourth (4th) Civil District of Maury County, Tennessee, and being more particularly described as follows:

Lot 23 of Stonehenge Subdivision, Section 1 as shown by a map of record in Plat Book P14, Page 239, Register's Office of Maury County, Tennessee.

Included herewith is an easement across Lot 22 of the Stonehenge Subdivision Section 1 for the use of an existing driveway that encroaches from Lot 23 onto Lot 22.

Being the same property conveyed to Jonathan Hoath and Angela Hoath by deed of record in Book R2006, Page 1307, Register's Office of Maury County, Tennessee.

This property is shown on the tax records of Maury County as Map 91, Parcel 49.28, and has the address of 1309 Standing Stone Circle, Columbia, Tennessee 38401

This Property is to be sold **AS IS WHERE IS**, without representations or warranties of any kind whatsoever, whether express or implied. Without limiting the foregoing, THE PROPERTY IS TO BE SOLD WITHOUT ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR USE OR PURPOSE.

The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. This is an attempt to collect a debt and any information obtained will be used for that purpose.

Thomas M. Hutto, Successor Trustee
LAWWELL, DALE & GRAHAM
By: Thomas M. Hutto
805 S. Garden Street
P.O. Box 1017
Columbia, TN 38402-1017
(931)388-2822

FHG COLUMBIA

854 W. James Campbell Blvd., Suite 301
Columbia, Tennessee 38401
O 931.388.8779 F 931.540.0518

FHGMedical.com

October 6, 2016

OCT 17 2016

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
500 Deaderick St., Suite 850
Nashville, TN 37243

Dear Ms. Hill:

I am writing in support of the certificate of need application submitted by TriStar HCA and Maury Regional Medical Center for the establishment of a 60-bed behavioral health hospital in Columbia, TN.

I am a practicing family physician in Maury County and have been for the past 37 years. During that time, I have had multiple patients that have required psychiatric services requiring transportation or admission to Nashville Hospitals. This oftentimes has proven to be great difficulty and inconvenience. In discussions with the administration at Maury Regional Medical Center, there have been multiple patients who have required boarding in the emergency department awaiting disposition and transfer to an appropriate facility. Currently there are no adult or adolescent psychiatric beds located in the service area of Maury County or surrounding service area. There is a geriatric psychiatric hospital in Columbia, which does serve the purpose for that particular population. This project is in conjunction with TriStar HCA, which currently provides psychiatric services in Nashville, TN and they are very supportive of this joint venture.

Please consider this application and feel free to contact me at 931-380-0075 if you have any further questions.

Sincerely,

Charles A. Ball, M.D.

CAB/sa

Advertisement

SUPPLEMENTAL #1

OPTUM
WHEN WE HAVE THE TOOLS TO PREDICT
IT'S AMAZING WHAT WE CAN PREVENT
We combine technology, data and expertise to power modern health care.
LEARN MORE

ER wait times, length of stay far longer for psychiatric patients

By Maria Castellucci | October 17, 2016

Psychiatric patients wait disproportionately longer in emergency departments before receiving treatment and experience longer stays compared to other medical patients, according to reports released Monday by the American College of Emergency Physicians (http://newsroom.acep.org/2016-10-17-Waits-for-Care-and-Hospital-Beds-Growing-Dramatically-for-Psychiatric-Emergency-Patients) .

The three separate studies examined how emergency rooms care for patients with psychiatric conditions compared to other patients by looking at ER wait times and length of stay.

One of the reports, a survey from the ACEP of 1,700 emergency medicine physicians, found 48% of doctors say psychiatric patients are held in their emergency department waiting for an inpatient bed at least once a day. Almost 21% said patients wait up to two to five days for an inpatient psychiatric bed. Additionally, 57% of doctors reported increased wait times and boarding for children with psychiatric conditions.

At the same time, only 16.9% of physicians reported they had a psychiatrist on-call to respond to psychiatric emergencies in the ER and more than 10% reported they had no one on-call to respond to emergencies.

Dr. Rebecca Parker, president of the ACEP, called the results "troubling." She said a decline in outpatient resources as well as a "severe shortage" of psychiatric beds available at inpatient facilities has led to longer wait times.

About 52% of surveyed emergency physicians said they have experienced cutbacks to mental health resources in the last year in the communities they serve. Yet, the need for psychiatric services hasn't diminished. Three quarters of surveyed emergency physicians report treating psychiatric patients who require hospitalization at least once a shift.

"(A decline in resources) is exerting pressure on emergency departments and its most vulnerable patients," Parker said. "The emergency department has become a dumping ground for patients who have been abandoned by every other part of the healthcare system."

A decrease in psychiatric beds began in the 1960s when institutions were closed and psychiatric patients were moved from inpatient care to outpatient care. As a result, state and county psychiatric beds nationwide between 1970 and 2006 decreased from 400,000 to about 50,000 beds. That decline has continued. A report found state psychiatric beds nationwide from 2005 to 2010 fell by 14% from 50,509 to 43,318.

Another study presented by ACEP found 23% of psychiatric patients had emergency department visits that were longer than six hours, compared to 10% of other medical patients. In addition, 7% of psychiatric patients had an emergency department stay that was longer than 12 hours versus only 2.3% of other medical visits.

The study also found that about 22% of psychiatric patients were uninsured and 4.6% were seen in the same emergency department within 72 hours of their initial discharge.

The figures came from an analysis of 2001 to 2011 data from the National Hospital Ambulatory Medical Care Survey by the Centers for Disease Control and Prevention.

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In a separate study that looked at the same data from the National Hospital Ambulatory Medical Care Survey, patients with bipolar disorder, psychosis and depression had increased odds of staying in the ER for 24 hours or longer than other patients.

Dr. Suzanne Lippert, lead author of the studies and a clinical assistant professor of emergency medicine at Stanford University, said that although she doesn't have clinical evidence that extended wait times negatively effects patient care she said it's obvious to assume that patients likely suffer further under such conditions.

Parker at the ACEP added that the issue contributes to ER crowding, causing other medical patients to wait longer for care as well.

Parker said more funding and resources need to be allocated to address mental health inadequacies. She said lawmakers, particularly the Senate, have an opportunity to address gaps in care through legislation. "Comprehensive mental health reform is what we need, and we need it now."

RELATED CONTENT

Bedding, not boarding: Psychiatric patients boarded in hospital EDs create crisis for patient care and hospital finances (http://www.modernhealthcare.com/article/20131116/MAGAZINE/311169992)

Could technology be the answer to the crisis facing psychiatric patients in EDs? (http://www.modernhealthcare.com/article/20160220/MAGAZINE/302209964)

Maria Castellucci

Maria Castellucci is a general assignment reporter covering spot news for Modern Healthcare's website and print edition. She writes about finances, acquisitions and other healthcare topics in markets across the country. Castellucci is a graduate of Columbia College Chicago and started working at Modern Healthcare in September 2015.

Tags: **Clinical Practice**, **Emergency Medicine**, **Hospitals**, **Patient Care**, **Physicians**, **Providers**, **Safety and Quality**, **Safety**

Advertisement

SUPPLEMENTAL #1
October 28, 2016
2:44 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:
TriStar Murray Regional Behavioral Health

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

John R Wellborn
Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 28th day of October, 2016, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043

Revised 7/02

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

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2:44 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

SIGNATURE/TITLE
CONSULTANT

Sworn to and subscribed before me this 28th day of October (Month), 2016 (Year) a Notary

Public in and for the County/State of DAVIDSON

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

NOTARY PUBLIC

My commission expires July 2 (Month/Day), 2018 (Year).

Supplemental #2
-Original-

TriStar Maury Regional Behavioral Healthcare

CN1610-036

DSG Development Support Group

October 31, 2016

Phillip M. Earhart, Health Services Development Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application CN1610-036
TriStar Maury Regional Behavioral Healthcare

Dear Mr. Earhart:

This letter responds to your questions in the second supplemental request you sent after lunch today. They are provided in triplicate, with affidavit.

1. **Section A. , Executive Summary, (A) Overview**

a. The support letter dated September 2016 from Rodney Poling, MD mentions Maury Regional Medical Center inpatient psychiatric unit closed in 1997. Please indicate the type of inpatient unit, ages served, number of licensed beds, and the reason the unit closed.

These are records almost 19 years old and are not readily available. However, Dr. Poling, who was in charge of the unit at the time, tells the applicant that there was a 14-bed psychiatric inpatient unit serving primarily adults 18+ but occasionally admitting older teenagers. The hospital also had a dedicated 11-bed substance abuse unit serving the same ages. The beds for both units were converted to skilled nursing beds which at the time were more strongly needed for area patients.

b. It is noted children in state custody will not be admitted to the adolescent unit. If so, where will those patients in the proposed service area receive inpatient psychiatric treatment?

The State usually has contracts with large providers with longer-stay programs, such as those at TriStar Parkview. This facility would likely develop referral relationships with that facility and others across the State.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

2. Incidence and Prevalence

Please provide the referenced materials concerning incidence and prevalence data for this region, published by TDMHSAS. In addition, please discuss how the data concludes the need for psychiatric inpatient beds in the proposed service area.

Please see these additions at the end of this letter prior to the hospital survey data.

3. Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-)
12. Institution for Mental Disease Classification

Please discuss reasons why this hospital will not have an IMD classification.

This was a misunderstanding. Psychiatric facilities operated under general hospital licenses (such as TriStar's Parthenon, Valley, and Madison units) cannot be IMD's. However, as a freestanding facility, this hospital will be classified as an IMD, as is Rolling Hills Hospital. Fortunately, Tennessee's "managed Medicaid" system (TennCare) makes us exempt from the IMD exclusion from Medicaid.

4. Section B, Need, Item l.a. (Psychiatric Inpatient Services-Service Specific Criteria-) Quality Control and Monitoring

Please submit the referenced surveys and information on quality improvement programs of psychiatric programs owned by the applicant.

They are attached at the end of this letter due to their bulk.

5. Section B, Need Item 3

Page 31R is noted. However, the second table on page 31R of the projected admissions to the project in 2020 calculates to 1,722, not 1,830. Please clarify.

Revised page 31R-2 is attached after this page.

6. Section C. Economic Feasibility Item 2 Funding

a. Please provide a funding letter from TriStar Health (on company letterhead with signature) that states TriStar Health will fund the entire project since they are the only member of the LLC at this time.

Attached following this page.

3. (Continued) Please complete the following tables, if applicable:

Primary Service Area Counties	Estimated CY2015 Cases Age 13-64 in TN Acute Psychiatric Units	% of Total Admissions That Were Reported to THA
Giles	102	9.7%
Hickman	152	14.4%
Lawrence	146	13.9%
Lewis	27	2.6%
Lincoln	105	10.0%
Marshall	99	9.4%
Maury	353	33.5%
Moore	5	0.5%
Perry	29	2.8%
Wayne	36	3.4%
Totals	1,054	100.0%

Source: THA Database.
Note: This includes only the 1,054 cases reported to the THA by age group; three other hospitals admitted an estimated 995 additional service area cases, whose origin by county can not be accurately determined from their JAR's.

Primary Service Area Counties	Projected Admissions To The Project in CY2020 (Year Two) Alphabetic By County	% of Total Admissions
Giles	172	9.4%
Hickman	168	9.2%
Lawrence	254	13.9%
Lewis	75	4.1%
Lincoln	206	11.2%
Marshall	207	11.3%
Maury	549	30.0%
Moore	41	2.3%
Perry	47	2.5%
Wayne	111	6.1%
Totals	1830	100.0%

Source: Admissions projected in proportion to counties' percentages of the target population.

SUPPLEMENTAL #2
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TriStar Health.
TriStarHealth.com
110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

October 31, 2016

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application for TriStar Maury Regional Behavioral Healthcare
Columbia, Maury County

Dear Mrs. Hill:

TriStar Maury Behavioral Healthcare, LLC is applying for a Certificate of Need to develop a 60-bed mental health hospital in Columbia. Through a wholly-owned subsidiary, Maury County Behavioral Health, LLC, HCA currently is the sole owner of the LLC filing the application. The estimated project cost is $24,033,041. As Chief Financial Office of TriStar Health, the HCA Division Office for Middle Tennessee, I am writing to confirm that HCA, Inc. is able to provide through TriStar Health the $24,033,041 of funding needed to implement the project. HCA's financial statements are provided in the application.

However, the application states that an affiliate of Maury Regional Hospital (a public nonprofit entity) will acquire 49% membership in the applicant LLC in the near future, and will provide 49% of the capital costs required for the project. Maury Regional has submitted a funding commitment letter for its share of the project cost.

As stated in the application and in supplemental information submitted, the project will not be implemented until the JV is definitively completed and funding is in place from both parties. HCA does not expect to remain as sole owner, and has stated its willingness to accept a condition on the CON to that effect.

Sincerely,

C. Eric Lawson, CFO
TriStar Health

b. The table (Table B-Need-12) on page 48 is noted. Please complete the last two columns of the table and submit a replacement page 48.

A completed staffing table, revised Page 48R, is provided following this page.

Additional Item From the Applicant

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt/Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Table C-Economic Feasibility-8: TriStar Maury Regional Behavioral Healthcare
Projected Staffing--Revised on First Supplemental Responses

Position Classification	Existing FTEs (N/A)	Projected FTEs (Yr 1)	Estimated Mean Hourly Wage (Contractual Rate)	Areawide Hourly Mean For The MSA That Includes Maury County
A. Direct Patient Care Positions				
Chief Nursing Officer (CNO)		1.00	$59	$40.15 (NP)
Nurse Manager		2.00	$39	40.15 (NP)
Nurse Supervisor		2.00	$32	$28.50
Nurse		26.74	$27	$28.50
Mental Health Technician		12.60	$13	$18.60
Activity Therapist		2.80	$24	Est $21.20
Social Worker		5.60	$26	$11.60-$30.39
Total Direct Patient Care Positions		**52.74**		
B. Non-Patient Care Positions				
CEO		1.00	$85	$79.40
CFO		1.00	$75	$0.80
Pharmacy		4.20	$37	$57.80
Dietary		8.40	$16	$14.60
Unit Secretary		3.00	$15	$15.75
Administrative Assistant		2.00	$24	$22.80
Case Management/Utilization Review		4.20	$26	$17.90
Plant Operations		3.00	$25	$19.85
Security		4.20	$14	$13.65
Environmental Services		8.40	$17	$17.10
Total Non-Patient Care Positions		**39.40**		
Total Employees (A + B)		**30.00**		
C. Contractual Staff				
Psychiatrist, Medical Directors*		1.00	$140	Not Available
Total Contractual Staff		**1.00**		
Total Staff (A+B+C)		**93.14**		

Source: Tennessee Dept of Labor and Workforce Development. Used MSA that includes Davidson, Rutherford and Maury Cos.
**Note: Will be more than one Medical Director, the 1.0 FTE is cumulative.*

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The Capitalization Ratio is reflected below. Although the traditional Capitalization Ratio is negative, this does not accurately reflect the financial standing of HCA. This is because the 2006 merger and related transactions were accounted for as a "recapitalization" of HCA Inc. rather than a "sale", and therefore the Company's liabilities currently exceed its assets on its books. A more accurate depiction of the Company's financial standing is the Value of Equity calculation, also reflected below.

HCA Capitalization Ratio:

Long Term Debt	31,225,000,000
Debt + Equity	(23,462,000,000)
	X 100
Traditional Capitalization Ratio	(133.09)

More accurate to use Fair Value of Equity (shares outstanding x market price)

Shares outstanding at 9/30/16	$	376,140,814
Closing Market price 9/30/16	$	75.63
Market Cap	$	28,447,529,763
Debt + Equity (using Market Cap)		59,672,529,763
Alternative Capitalization Ratio		0.52

STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA
FOR PSYCHIATRIC INPATIENT SERVICES

ADDITION TO FIRST SUPPLEMENTAL RESPONSES FILED OCTOBER 28

Review Criterion 3: Incidence and Prevalence: The applicant shall provide information on the rate of incidence and prevalence of mental illness and substance use within the proposed service area in comparison to the statewide rate. Data from the TDMHSAS or the Substance Abuse and Mental Health Services Administration (SAMHSA) shall be utilized to determine the rate. This comparison may be used by the HSDA staff in review of the application as verification of need in the proposed service area.

Rationale: The rate of incidence and prevalence of mental illness in the service area may indicate a need for a higher number of psychiatric inpatient beds in the designated area.

Response:

DHMSAS data does not appear to allow projection of any specific inpatient bed need numbers. For that, the applicant has relied on the bed need planning methodology in these same State Health Plan criteria.

However, the Department annually publishes very detailed Needs Assessments of the prevalence of serious mental health conditions, by planning region in the State. This project is located in Region #5. Selected pages from the Department's most current Annual Assessment are provided below. These pages show two things, among others:

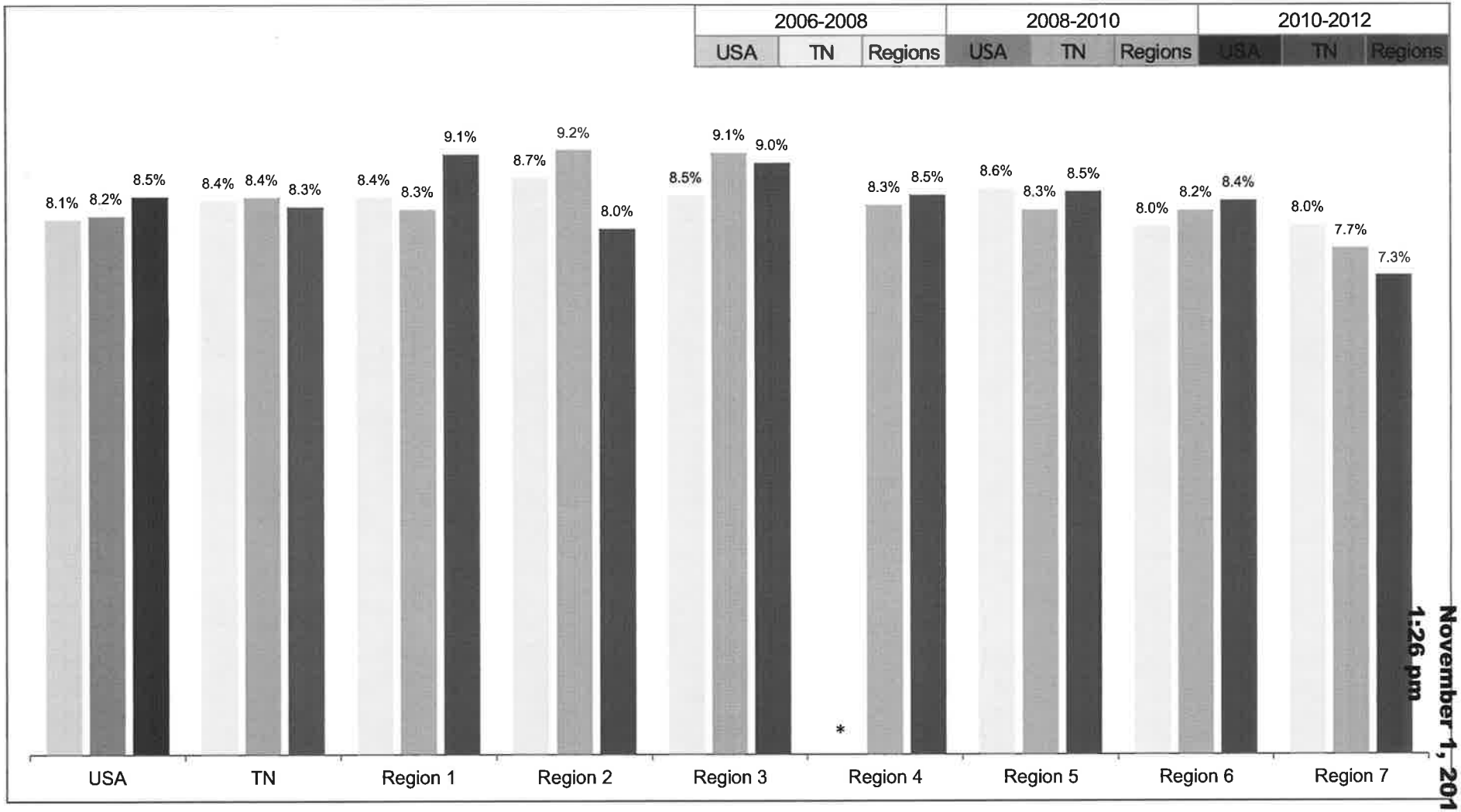
They indicate that for the measurement period of 2010-2012, 8.3% of Region 5 youth ages 12-17 had major depressive episodes "in the past year". This was close to the State's rate of 8.3%.

In addition, the Department's data captures State and national admissions rates to State Psychiatric Hospitals, Other Inpatient Settings, Residential Treatment Centers, and Community Programs. It appears that Tennessee admits a higher proportion of total admissions to its State facilities than is the case nationally--1.20 vs. 0.82 nationally. Yet Tennessee admits a much smaller proportion of its total admissions to non-State hospitals ("Other Inpatient:") than is the case nationally--0.79 compared to the national rate of 1.41. This may support the need for more psychiatric hospitals in Tennesssee.

Youth ages 12 – 17

Major Depressive Episode

Percentage of youth who had at least one major depressive episode in the past year



Note: *=Low precision; no estimate reported.

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Estimated number of youth who had at least one major depressive episode in the past year

County	2006-2008	2008-2010	2010-2012	County	2006-2008	2008-2010	2010-2012	County	2006-2008	2008-2010	2010-2012
REGION 1	**3,091**	**3,025**	**3,326**	Jackson	76	82	80	Perry	55	53	55
Carter	335	328	361	Macon	161	173	170	Robertson	479	462	477
Greene	445	436	479	Marion	179	193	190	Rutherford	1,920	1,850	1,911
Hancock	47	46	50	McMinn	356	382	376	Stewart	96	92	95
Hawkins	370	362	398	Meigs	75	81	79	Sumner	1,209	1,165	1,204
Johnson	98	96	106	Overton	151	162	160	Trousdale	61	59	61
Sullivan	976	955	1,050	Pickett	26	28	28	Wayne	106	102	105
Unicoi	106	104	114	Polk	115	124	122	Williamson	1,608	1,550	1,600
Washington	714	699	768	Putnam	438	471	463	Wilson	833	803	830
REGION 2	**7,757**	**8,130**	**7,082**	Rhea	204	219	215	**REGION 6**	**4,148**	**4,272**	**4,350**
Anderson	505	529	461	Sequatchie	96	103	101	Benton	100	103	105
Blount	848	889	775	Smith	138	148	146	Carroll	175	180	184
Campbell	268	281	245	Van Buren	35	38	37	Chester	117	121	123
Claiborne	215	225	196	Warren	265	285	280	Crockett	95	98	100
Cocke	235	246	215	White	170	183	180	Decatur	68	70	71
Grainger	155	163	142	**REGION 4**	*	**3,331**	**3,391**	Dyer	271	279	284
Hamblen	428	449	391	Davidson	*	3,331	3,391	Fayette	231	238	242
Jefferson	354	371	324	**REGION 5**	**11,321**	**10,911**	**11,268**	Gibson	346	356	363
Knox	2,716	2,847	2,480	Bedford	336	324	334	Hardeman	162	167	170
Loudon	305	320	278	Cannon	96	93	96	Hardin	165	170	173
Monroe	298	312	272	Cheatham	302	291	301	Haywood	136	140	143
Morgan	147	154	135	Coffee	372	359	370	Henderson	187	193	196
Roane	362	380	331	Dickson	367	353	365	Henry	193	199	202
Scott	168	176	153	Franklin	268	258	267	Lake	37	38	38
Sevier	620	650	566	Giles	194	187	194	Lauderdale	177	182	186
Union	132	138	120	Hickman	174	168	173	Madison	624	643	655
REGION 3	**5,999**	**6,445**	**6,339**	Houston	60	58	60	McNairy	173	179	182
Bledsoe	90	97	95	Humphreys	133	128	132	Obion	208	214	218
Bradley	649	697	686	Lawrence	302	291	301	Tipton	490	504	513
Clay	48	51	51	Lewis	89	85	88	Weakley	193	199	202
Cumberland	320	344	338	Lincoln	225	217	224	**REGION 7**	**6,853**	**6,554**	**6,204**
DeKalb	124	133	131	Marshall	219	211	218	Shelby	6,853	6,554	6,204
Fentress	124	134	131	Maury	538	519	536	**TN**	**42,495**	**42,495**	**41,989**
Grundy	93	100	98	Montgomery	1,231	1,186	1,225				
Hamilton	2,063	2,216	2,180	Moore	47	45	47				

Note: Population estimate based on National Surveys on Drug Use and Health (2006-2008, 2008-2010, 2010-2012) and 2010 Census, United States Census Bureau; *=Low precision; no estimate reported.

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APPROPRIATENESS DOMAIN: NUMBER OF ADMISSIONS DURING THE YEAR TO STATE HOSPITAL INPATIENT AND COMMUNITY-BASED PROGRAMS, FY 2015

STATE: Tennessee

Setting	Demographic	State			US			Admission Rate		States Reporting
		Admissions During Year	Total Served At Start of Year	Total Served During Year	Admissions During Year	Total Served At Start of Year	Total Served During Year	State	US	
State Psychiatric Hospitals	Total	9,508	348	7,928	113,158	39,165	136,244	1.20	0.83	51
	Children	1	-	1	9,454	1,322	9,929	1.00	0.95	31
	Adults	9,507	348	7,927	103,703	37,841	126,134	1.20	0.82	51
	Age NA	-	-	-	1	2	1	-	1.00	1
Other Inpatient	Total	14,212	508	17,273	459,065	39,137	313,432	0.82	1.46	35
	Children	3,109	89	3,247	76,166	2,445	41,213	0.96	1.85	29
	Adults	11,103	419	14,026	382,787	36,591	271,768	0.79	1.41	35
	Age NA	-	-	-	112	101	157	-	0.71	6
Residential Treatment Centers	Total	4,532	458	3,351	66,378	10,969	38,260	1.35	1.73	37
	Children	919	288	1,277	46,200	4,930	15,035	0.72	3.07	36
	Adults	3,613	170	2,074	20,136	6,033	20,763	1.74	0.97	27
	Age NA	-	-	-	42	6	36	-	1.17	2
Community Programs	Total	1,738,972	63,504	263,308	18,221,792	3,735,705	6,580,114	6.60	2.77	49
	Children	482,260	15,664	65,441	7,382,437	954,254	1,845,495	7.37	4.00	49
	Adults	1,256,712	47,840	197,867	10,824,986	2,778,279	4,728,407	6.35	2.29	49
	Age NA	-	-	-	14,369	3,172	5,867	-	2.45	16

Note:

Admission Rate= number of admissions divided by total served during the year

US Admissions During Year uses data from states reporting data only. States are only included in "US Total Served" if they also reported data on admissions.

US Total Served During Year is calculated using data in URS Table 3.

This table uses data from URS Table3 and 6.

Table 3 State Notes:

Age	None
Overall	TN does not provide state psychiatric hospital beds for children, ages 0-17. Data include: TennCare (Medicaid); TDMHSAS Behavioral Health Safety Net; non-Medicaid crisis; state and private psychiatric hospitals. See General Notes.
Gender	None

Table 6 State Notes:

Hospital	TN does not provide state psychiatric hospital beds for children, ages 0-17.
Other Inpatient	Data include: TennCare (Medicaid).
Residential	Data include: TennCare (Medicaid).
Community	Data include: TennCare (Medicaid).
Overall	Hospital data: age is determined at admission. Community data: age determined at midpoint of the reporting year. See General Notes.

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

Review Criterion 18. Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. An applicant that owns or administers other psychiatric facilities shall provide information on their surveys and their quality improvement programs at those facilities, whether they are located in Tennessee or not.

Rationale: This section supports the State Health Plan's Fourth Principle for Achieving Better Health regarding quality of care.

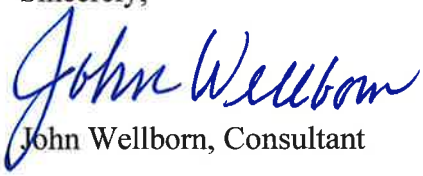
Response:

HCA Behavioral Health hospitals and units in acute care hospitals, and Maury Regional Medical Center, all have robust and highly effective quality improvement programs that include outcome and process monitoring systems. It is a Joint Commission requirement for accreditation; and all HCA behavioral health hospitals and units within HCA general acute care hospitals are Joint Commission-accredited.

Representative Joint Commission and Tennessee Department of Health surveys are attached at the end of this letter because of their bulk.

We hope this meets your needs for supplemental information on the project. Please `contact me if you have additional questions.

Sincerely,



John Wellborn, Consultant

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:
Tri Star Maury Regional Behavioral Health

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 31st day of October, 2016, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043

Revised 7/02

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

JOINT COMMISSION AND DEPARTMENT OF HEALTH SURVEYS HCA PSYCHIATRIC FACILITIES IN TENNESSEE

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

TRISTAR CENTENNIAL MEDICAL CENTER
(INCLUDES PARTHENON PAVILION)

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

Official Accreditation Report

TriStar Centennial Medical Center
2300 Patterson Street
Nashville, TN 37203

Organization Identification Number: 7888

Unannounced Full Event: 9/13/2016 - 9/16/2016

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Executive Summary

Program(s)	**Survey Date(s)**
Hospital Accreditation Behavioral Health Care Accreditation	09/13/2016-09/16/2016

Hospital Accreditation :

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 45 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.
- Evidence of Standards Compliance (ESC)

Behavioral Health Care Accreditation :

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. (*Please Note: if your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.*) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. (*Please Note: if your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.*) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site (For those with a Preliminary Denial of Accreditation decision: DIRECT and INDIRECT Impact Standards Compliance are due within 45 days):

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.09	EP1,EP3
	IC.02.02.01	EP2
	LS.02.01.20	EP1
	MM.03.01.03	EP2
	MM.04.01.01	EP13
	PC.01.03.01	EP1,EP5
	PC.02.01.03	EP1,EP7
	PC.02.01.11	EP2
	RI.01.03.01	EP11

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP19
	EC.02.05.01	EP1
	EC.02.06.01	EP1
	IC.02.01.01	EP1
	LD.01.03.01	EP2

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: 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.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP1, EP5	Standard
§482.23(c)(3)	A-0406	HAP - MM.04.01.01/EP13	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP - EC.02.05.01/EP1

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.06.01/EP1	Standard
§482.41(b)(6)	A-0713	HAP - EC.02.02.01/EP19	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.05.09/EP1, EP3	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP4, EP9, LS.02.01.20/EP1, LS.02.01.30/EP11, EP18, LS.02.01.35/EP6	Standard

---

CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - IC.02.01.01/EP1

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

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Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

	LS.02.01.10	EP4,EP9
	LS.02.01.30	EP11,EP18
	LS.02.01.35	EP6
	PC.01.02.01	EP2
	RC.01.01.01	EP19
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.02.01.05	EP4

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

ESC 60 days

Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has procedures for the proper routine storage and prompt disposal of trash.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 19
§482.41(b)(6) - (A-0713) - (6) The hospital must have procedures for the proper routine storage and prompt disposal of trash.
This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at TriStar Centennial Medical Center (330 23rd Avenue North, Nashville, TN) site for the Hospital deemed service.
During tracer activity in the Endoscopy procedure room, it was observed that the sharps disposal/ container had a wide square opening and considered as unsecured. It was open and contained wasted syringes and vials, some with leftover Propofol. They could easily be retrieved from the bin with the potential risk for retrieval and/ or diversion.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01

ESC 60 days

Standard Text: The hospital manages risks associated with its utility systems.

Element(s) of Performance:

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Condition

Corresponds to: HAP - IC.02.02.01/EP2

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP: §482.57 **Tag:** A-1151 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.57 Condition of Participation: Respiratory Care Services

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care services.

CoP Standard	Tag	Corresponds to	Deficiency
§482.57(b)(3)	A-1163	HAP - PC.02.01.03/EP1	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

---

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 1 of 12 medical gas and vacuum area alarm panel checks in the Women's & Children's Hospital, an area alarm panel was not labeled to indicate the area(s) served as required by NFPA 99-2012, 5.1.9.1 (7) and (13). An alarm panel in the 8th floor corridor was labeled "Education Room"; however, NICU staff were not aware of an Education Room. Upon further investigation, it was determined this alarm panel was for the NICU Suite "D".

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 4 of 10 medical gas and vacuum area alarm panel checks in the Tower, the area alarm panels were not labeled to indicate the area(s) served as required by NFPA 99-2012, 5.1.9.1 (7) and (13). The Tower 5th floor Neuro and Cardio ICU, and 4th floor MSICU, had two (2) unlabeled medical gas and vacuum area alarm panels each (4 total). Staff were not sure which rooms were monitored by each panel.

EP 3
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 1 of 27 medical gas and vacuum zone shutoff valve checks in the Women's & Children's Hospital, the zone valves did not clearly identify what the valves control as required by NFPA 99-2012, 5.1.4.8.8 and 5.1.11.2. The zone shutoff valves at the 8th floor NICU nurse station were labeled "Education Room"; however, NICU staff were not aware of an Education Room. Upon further investigation, it was determined these zone valves were for the NICU Suite "D".

Chapter: Environment of Care

1. The hospital designs and installs utility systems that meet patient care and operational needs. (See also EC.02.06.05, EP 1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41 - (A-0700) - §482.41 Condition of Participation: Condition of Participation: Physical Environment
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 1 of 10 electrical panel checks in the Women's & Children's Hospital, openings were observed in the front panel cover. Electrical panel EQLC in the 2nd floor electrical room had eight (8) openings in the panel cover where the knockouts or circuit breakers had been removed and not covered with a filler plate, thus exposing the inside of the electrical panel.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Element(s) of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)

Scoring Category : A
Score : Insufficient Compliance

Program: Hospital Accreditation

Standard: EC.02.06.01

ESC 60 days

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

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:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
Six (6) unsecured "H" sized nitrous oxide compressed gas cylinders were observed standing upright at the manifold in the Women's & Children's Hospital 8th floor mechanical room. A securing chain was present, but was not in use. This was corrected at the time of the observation.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
Relocatable power taps (RPTs) inside ORs 1 and 9 in the Women's and Children's Hospital were used for patient-care related electrical equipment. The RPTs were observed on the floor, and thus were not permanently attached to the equipment assembly as required by NFPA 99-2012, 10.2.3.6 (1).

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
An unsecured "H" sized carbon dioxide compressed gas cylinder was observed standing upright in the Women's & Children's Hospital main kitchen storage room.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
A relocatable power tap (RPT) inside CVOR 5 in the Tower was used for patient-care related electrical equipment. The RPT was observed on the floor, and thus was not permanently attached to the equipment assembly as required by NFPA 99-2012, 10.2.3.6 (1).

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

ESC 60 days

Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at Centennial Imaging Center (356 24th Avenue North, Nashville, TN) site for the Hospital deemed service.
In 2 of 2 mosquito hemostats observed in the IV start room, both were out of their sterile packaging and in need of reprocessing. The instruments were removed while the surveyor was onsite.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

ESC 45 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.51 - (A-0940) - §482.51 Condition of Participation: Condition of Participation: Surgical Services
This Condition is NOT MET as evidenced by:

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 2 of 2 soiled instrument trays, it was identified that the majority of the hinged instruments in both trays were in the closed position. The tray contents had been sprayed and were visibly moist, but there was also obvious bio-burden on the surfaces of many of the unopened instruments. This practice was inconsistent with AAMI guidelines which the organization identified as their evidence-based guidelines for sterilization and high level disinfection. Re-education of staff in process during survey.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
Sprayed circumcision instruments were observed in the closed and hinged positions in the dirty instrument container awaiting transport to sterile processing for cleaning and sterilization. This was not consistent with current AMMI guidelines used by the organization as their evidenced based guidelines for instrument sterilization and high level disinfection. Re-education in process during survey.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 2 of 2 tracers conducted, instruments were observed that had been in the operating room, but had not been used. These instruments were observed to not be sprayed with a pre-enzymatic cleaner and were not in open, unhinged positions as required by AAMI guidelines (Organization's selected evidenced based guidelines). Leaders agreed that the instruments were not sprayed and not in the open, unhinged position. Re-education of staff in process.

Observed in Tracer Visit at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The enzymatic cleaning solution used for manually cleaning instruments prior to placement in the instrument washer was mixed with hydrogen peroxide which was not consistent with the manufacturer's guidelines or the organization's procedure. This practice was immediately stopped and corrected onsite through re-education of staff member on correct process.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
While on tracer activity in the Endoscopy suite, the process for high level disinfection of endoscopes used for gastroscopes, colonoscopes, and duodenoscopes was observed. As part of the manual cleaning, the tech used a toothbrush to clean the ports, and, if present, the elevator mechanisms of the duodenoscopes. While a disposable brush was also used, this toothbrush was used on multiples scopes each day, stored in a detergent solution between scope cleanings, and disinfected at the end of each day. According to the CMS bulletin of 4/3/2015 related to the outbreaks of CRE involving duodenoscopes, brushes used in the cleaning of such scopes should either be disposable, or if used for multiple cleanings, disinfected after each use. This was discussed with the Vice president of perioperative services, among other leadership. They agreed that this practice of cleaning duodenoscopes did not conform to current guidelines. The organization immediately took all five duodenoscopes out service pending reprocessing, and provided photographic evidence of this. The organization also took immediate action and discontinued the use of reusable brushes and will retrain the tech. it should be noted that the organization was already doing random cultures of the duodenoscopes and did not have any positive CRE colonizers.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During tracer activity in the Endoscopy Suite, it was observed that the logs documenting the controls done on the endoscopes processed in the Metavator machines did not record the lot# of the control strips. This is required by AAMI, the organization's source for evidence based guidelines.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.01.03.01

Standard Text: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Element(s) of Performance:

2. The governing body provides for organization management and planning.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.12 - (A-0043) - §482.12 Condition of Participation: Governing Body
This Condition is NOT MET as evidenced by:

Observed in Auto Score for CLD at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews: §482.51 - (A-0940), §482.12 - (A-0043)

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)

Scoring Category : A
Score : Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 2 of 18 fire rated door checks in the Women's & Children's Hospital, the fire protection rating label was illegible. The cross-corridor door pair in the 2-hour fire rated wall in the 3rd floor corridor by patient room 3217 had fire protection rating labels that were painted, so it was not possible to verify these doors had a 90-minute fire rating.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The door to the Tower 4 East exit passageway was located in a 2-hour fire rated wall; however, this door had a 45-minute fire protection rating.

EP 9
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 1 of 3 fire rated wall checks, a penetration was not sealed. A 1/2-inch electrical conduit that penetrated the 2-hour fire rated wall in the Women's & Children's Hospital 3rd floor corridor by patient room 3217 was not sealed with an approved fire stop system.

Observed in Building Tour at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site for the Hospital deemed service.
Four 4-inch electrical conduits that penetrated the 2-hour fire rated floor assembly inside the 2nd floor mechanical room in the Parthenon Pavilion were not sealed with an approved fire stop system. The mechanical room walls were not fire rated as indicated by the Life Safety Code drawings.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

ESC 45 days

Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The doors to the East, West, and North stairwells on the 8th floor in the Women's & Children's Hospital were indicated as an exit and were locked in the direction of egress. A card swipe was required to egress. These doors were locked for security purposes; however, the locked units did not have a total (complete) smoke detection system throughout the locked space, nor could the locked doors be remotely unlocked from a constantly attended location within the locked space, as required by NFPA 101-2012, 19.2.2.2.5.2 (2).

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The doors to the East and North stairwells on the 7th floor in the Women's & Children's Hospital were indicated as an exit and were locked in the direction of egress. A card swipe was required to egress. These doors were locked for security purposes; however, the locked units did not have a total (complete) smoke detection system throughout the locked space, nor could the locked doors be remotely unlocked from a constantly attended location within the locked space, as required by NFPA 101-2012, 19.2.2.2.5.2 (2).

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The doors to the East, West, and North stairwells on the 6th floor in the Women's & Children's Hospital were indicated as an exit and were locked in the direction of egress. A card swipe was required to egress. These doors were locked for security purposes; however, the locked units did not have a total (complete) smoke detection system throughout the locked space, nor could the locked doors be remotely unlocked from a constantly attended location within the locked space, as required by NFPA 101-2012, 19.2.2.2.5.2 (2).

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The door to Stair "C" (West) on the Women's & Children's Hospital 7th floor was indicated as an exit and was locked in the direction of egress. This door was equipped with a delayed egress magnetic lock; however, there was no "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign on the door adjacent to the releasing device as required by NFPA 101-2012, 7.2.1.6.1.1(4).

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The cross-corridor door pair by the CVICU on the 3rd floor in the Tower was indicated as an exit and was locked in the direction of egress. This door was equipped with a delayed egress magnetic lock; however, there was no "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign on the door adjacent to the releasing device as required by NFPA 101-2012, 7.2.1.6.1.1(4).

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

ESC 60 days

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door.
(For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Partial Compliance

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The gap between the meeting edges of the corridor door pair to OR 8 in the Women's & Children's Hospital was 1/4-inch. This OR was not located in a suite.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The corridor door to patient room 8127 in the Tower did not latch due to a latch malfunction (latch stuck in the retracted position).

EP 18
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 1 of 10 smoke barrier wall checks in the Women's & Children's Hospital, the smoke barrier wall was not continuous to the deck. The smoke barrier wall in the 8th floor staff lounge stopped approximately 4-inches above the suspended ceiling, resulting in an approximate 24-inch gap between the head-of-wall and the roof deck. This wall was indicated on the Life Safety Code drawings as a smoke barrier wall.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 1 of 10 smoke barrier wall checks in the Women's & Children's Hospital, penetrations were not sealed. Two 1/2-inch holes through the smoke barrier wall in the 7 East NICU Suite "B" were not sealed.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 3 of 9 smoke barrier wall checks in the Tower, holes and penetrations were not sealed. An 8-inch by 12-inch hole in the smoke barrier wall above the ceiling in the 5th floor Neuro ICU men's locker room, a 3-inch drain that penetrated the smoke barrier wall in the 4th floor MSICU classroom, and three 1/2-inch flexible conduits that penetrated the smoke barrier wall in the 2nd floor PICU family waiting room, were not sealed.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

ESC 60 days

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 6
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
An obstructed fire sprinkler was observed in the Women's & Children's Hospital 5th floor clean utility room where a Pyxis machine was located directly below a sprinkler with only 15-inches clearance below the deflector.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
An obstructed fire sprinkler was observed in the Women's & Children's Hospital gift shop storage room where a storage shelf was located directly below a sprinkler with only 10-inches clearance below the deflector.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
An obstructed fire sprinkler was observed in the Tower 3rd floor Pharmacy storage room where a storage shelf was located directly below a sprinkler with only 10-inches clearance below the deflector.

Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
An obstructed fire sprinkler was observed in the Tower 2nd floor main kitchen dry storage room where a reach-in refrigerator was located directly below a sprinkler with only 8-inches clearance below the deflector.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.03

ESC 45 days

Standard Text: The hospital safely manages emergency medications.

Element(s) of Performance:

2. Emergency medications and their associated supplies are readily accessible in patient care areas. (See also PC.03.01.01, EP 8)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.

During tracer activities in the Operating Room, the amount of Dantrolene in the malignant Hyperthermia cart was noted to be insufficient for emergency use. There were 6 vials of 20 mg each present in the cart. The MHAUS recommends that the organization have at least 36 to 40 vials available. While the guidelines recognize that part of this supply can be available in another area of the organization, as long as it is obtainable within 10 minutes, it specifies that the initial dosage of 2.5 mg/kg be available "immediately". Assuming a 100 kg patient, this would require immediate access to 250 mg, or 12.5 vials. This issue was discussed on site with the organization, which had a well thought out plan for Dantrolene storage, and corrected the deficient cart storage while we were on site.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.04.01.01

Standard Text: Medication orders are clear and accurate.

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 13
§482.23(c)(3) - (A-0406) - (3) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During individual tracer in the PICU, an implemented Precedex titration order was written in the patient's chart as follows: 0.8 mcg/kg/hour, RASS -2. The order was incomplete as to desired frequency, maximum dose/ rate for titration.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 2 of 2 tracers conducted, on the 7 South Med- Psych unit, therapeutic duplications were found in medication orders. In the first patient, acetaminophen 650 mg was ordered as needed for fever or pain of a scale of 1-5, and tramadol was ordered as needed for pain. In the second patient, acetaminophen 650 mg was ordered both rectally and orally every 4 hours as needed for pain. In both cases, hospital policy regarding how to write orders was not followed.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.01

ESC 60 days

Standard Text: The hospital assesses and reassesses its patients.

Element(s) of Performance:

2. The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. (See also PC.01.02.07, EP 1)
Note: Examples of criteria could include those that identify when a nutritional, functional, or pain assessment should be performed for patients who are at risk.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

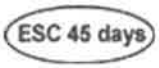
EP 2

Observed in Individual Tracer at TriStar Centennial Medical Center (330 23rd Avenue North, Nashville, TN) site.
A pediatric assessment was performed on an adult patient in the pediatric outpatient infusion center. There was no process in place for an adult assessment as evidenced by the clinical documentation and staff interview.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01



Standard Text: The hospital plans the patient's care.

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)

Scoring Category : C
Score : Insufficient Compliance

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.23(b)(4) - (A-0396) - (4) 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:

Observed in Individual Tracer at TriStar Centennial Medical Center (330 23rd Avenue North, Nashville, TN) site for the Hospital deemed service.
During record review there was no evidence that the patient's plan of care, which includes having measurable goals and timeframes, had been established related to the assessed needs of a post renal transplant patient.

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
During review of a nursing admission assessment, it was determined that there was no assessment information documented regarding the patient's wound status or the patient's Braden scale score. Staff interview confirmed that the patient had a sternal incision and was at risk for skin breakdown.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 2 of 2 tracers conducted, it was observed that there were no target dates assigned to the interventions in the nursing care plans

EP 5
§482.23(b)(4) - (A-0396) - (4) 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:

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During review of the nursing plan of care for a patient that had undergone mitral valve replacement and coronary artery bypass surgery, it was noted that time frames for achievement of established goals or resolution of identified problems were not documented in the plan of care. Participants in the tracer activity did indicate that the organization intended to add enhancements to the electronic medical record in the coming year to include the addition of time frames in the nursing plan of care.

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
During tracer review, there were no target dates for expected completion of goals entered on the plan of care so that evaluation of progress toward goal achievement could be measured.

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
The nursing plan of care for a surgical patient did not include target dates for goal achievement. Organization leaders acknowledged that the inclusion of target dates in the plans of care was not a current available field for staff to use. However, the organization was planning an upgrade in the next four months to allow inclusion of target dates.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 2 of 2 tracers conducted, there were no target dates assigned to the interventions observed that were entered in the nursing care plans.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.03

Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *
Note: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
- Responsible for the care of the patient
- Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
- Acting within his or her scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services
Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Scoring Category : A
Score : Insufficient Compliance

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.57(b)(3) - (A-1163) - (3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 1 of 2 protocol orders reviewed in the CCU, order parameters associated with the protocol were not documented in the medical record. An order had been written to initiate the ventilator weaning protocol, but the procedures of a sedation holiday, ventilator setting changes, and assessment criteria were not included with the protocol.

EP 7

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
Physician orders for a nicardipine titratable infusion were not followed as prescribed in the most recent order. Specifically, the order was written to begin the cardine infusion at 2.5 milligrams per hour and titrate by increments of 2.5 milligrams every 15 minutes to a goal systolic blood pressure 160-180 and diastolic blood pressure 90-105. The infusion was started at 3 milligrams per hour and increased by increments of 2 milligrams. Systolic blood pressures recorded over a twelve hour period were less than 160 in at least 50 percent of documented blood pressure values.

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
A patient received a dose of intravenous acetaminophen that was not indicated according to the most recent physician order. Specifically, the acetaminophen was prescribed to be administered if maximum dosing had been achieved for opioid medication or ketorolac. At the time the acetaminophen was given, the patient had not received any opioid medication and did not have orders for ketorolac.

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
The titration of the Pitocin drip was not consistent with the most current physician orders. The drip was to be initiated at one milli-units and increased by one milli-units every 15 minutes; the drip was initiated at two milli-units and increased by two milli-units every 30 minutes. During clarification with the organization, it was identified that the medication was obtained from the Pyxis by override. The titration of the Pitocin drip was not consistent with the most current physician orders. During clarification with the organization, it was identified that the medication was obtained from the Pyxis by override.

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.
Vital signs were not done according to the physician's order for vital signs every 15 minutes for two hours and then every 30 minutes for two hours. At least one set of 15 minutes and one set of 30 minutes vital signs were not taken timely as ordered by the physician.

Program: Hospital Accreditation

Standard: PC.02.01.11

ESC 45 days

Standard Text: Resuscitation services are available throughout the hospital.

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2

Observed in Tracer Activities at TriStar Centennial Medical Center (330 23rd Avenue North, Nashville, TN) site.
During tracer activity, individual electrodes (buttons) were observed in a bin/ container, out of the original packaging and not labeled with a revised expiration date. The electrodes stay fresh for approximately 45 days in the open bag, as per manufacturers IFU.

Observed in Tracer Activities at Centennial Imaging Center (356 24th Avenue North, Nashville, TN) site.
During tracer activity in the Diagnostic Imaging Center it was noted that the time displayed on the defibrillator monitor and printout was inaccurate. The printout was 1324 and the actual time was 1341 hours. Department staff/ leadership confirmed that the defibrillator printout would be used in the medical record as evidence of documentation should the defibrillator be used on a patient.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.

In 2 of 2 defibrillators checked, it was identified that the time displayed on the defibrillator monitor and printout was inaccurate by approximately one hour. Clinical staff and unit leadership present during the tracer verified that the defibrillator printouts were retained in the medical record as a component of the documentation to sequence resuscitation events.

Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site.

In 2 of 4 packages of opened electrode, were observed without new expiration dates after opening. Per manufacturer's guidelines, opened electrode pads were useable for 45 days after package was opened.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street, Nashville, TN) site for the Hospital deemed service.
In 2 of 4 medical record documents reviewed, it was noted that the time at which each medical record entry was signed and dated did not include the time. Specifically, the informed consent for anesthesia and a post-operative anesthesia record were not timed.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01

ESC 45 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Element(s) of Performance:

11. The informed consent process includes a discussion about reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 11

Observed in Individual Tracer at TriStar Centennial Medical Center (330 23rd Avenue North, Nashville, TN) site.
During a review of the patient's informed consent or pre-procedure records, there was no evidence of documentation that the physician informed the patient of the potential risks and benefits of the procedure, alternative treatments, and the possibility of a blood transfusion, as required by the HCO's policy.

Chapter: Care, Treatment, and Services

Program: Behavioral Health Care Accreditation

Standard: CTS.02.01.05

Standard Text: For organizations providing care, treatment, or services in non–24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual's need for a medical history and physical examination.
Note 1: This standard does not apply to foster care and therapeutic foster care. (See also CTS.02.04.01, EP 1)
Note 2: This standard does not apply to organizations that provide physical examinations to all individuals served as a matter of policy or to comply with law and regulation.

Element(s) of Performance:

4. For organizations providing care, treatment, or services in non–24-hour settings: The organization determines whether the date of the individual's most recent physical examination exceeds one year. If the date exceeds one year, a medical history and physical examination is performed.
Note: Securing the individual's agreement to receive a medical history and physical examination may be undertaken as a process, and the organization may incorporate this process into the individual's plan for care, treatment, or services. If performing a medical history and physical examination is not within the organization's scope of services, it may refer the individual to another organization. (Refer to CTS.03.01.07, EPs 1-3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

EP 4

Observed in Individual Tracer at Parthenon Pavilion (2401 Parman Street, Nashville, TN) site.
Upon review of assessment documentation for a client in the trauma focused intensive outpatient program, it was observed that the organization failed to determine whether the date of this client's last history and physical examination exceeded one year. The program collected information about the client's primary care physician if they have one; however, did not collect any additional information about the last history and physical examination. A new tool had been created; however, not yet implemented which collected information about the date of the individual's last history and physical examination.

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	IC.02.01.01	EP2
	IC.02.02.01	EP4
	LS.02.01.20	EP13,EP14
	LS.02.01.30	EP2,EP25
	LS.02.01.35	EP3,EP5,EP14
	MM.03.01.01	EP2
	NPSG.03.06.01	EP4
	RC.01.01.01	EP7
	RC.02.01.01	EP2,EP21
	RC.02.03.07	EP4
	RI.01.01.03	EP2
Program:	Behavioral Health Care Accreditation Program	
Standards:	NPSG.15.01.01	EP1

Opportunities for Improvement – Detail

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:

2. The hospital uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4)
Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.
Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Tracer Activities at TriStar Centennial Medical Center (330 23rd Avenue North,Nashville,TN) site.

During tracer activity in the Outpatient Endoscopy Center it was noted that a tube of lubricating jelly used for intubation was being re-used. During staff interview, it was confirmed that these tubes were meant to be single-use only. The tube was discarded while the surveyor was onsite.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. During tracer activity in the 7 south med- Psych unit, it was observed that the bottom shelves of wire storage racks in the clean utility room did not have a barrier protection, exposing the items on it to possible contamination during cleaning of the floor.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category : C
Score : Satisfactory Compliance

14. Exit access doors and exit doors are free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit. (For full text and any exceptions, refer to NFPA 101-2000: 7.5.2.2)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP13
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. The exit access corridor by the dinning room on the 2nd floor in the Women's & Children's Hospital was obstructed by nine (9) large clean linen carts stored along one side in the corridor such that the 8-foot corridor was reduced down to 5-feet clearance.
EP14
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. A door pair marked as an exit at the entry to the 8th floor C-Section ORs in the Women's & Children's Hospital had a sign on the door that stated "Authorized Personnel Only". Doors marked as an "Exit" and "Authorized Personnel Only" is contradictory and confuses the direction of egress.

Chapter:	Life Safety
Program:	Hospital Accreditation
Standard:	LS.02.01.30
Standard Text:	The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following:
Boiler/fuel-fired heater rooms
- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
Central/bulk laundries larger than 100 square feet
- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)
- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of

smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99 -1999: 10-10.2.2)
Maintenance repair shops
- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)
- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Paint shops that are not severe hazard areas
- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Soiled linen rooms
- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-

rated doors.
Storage rooms
- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Trash collection rooms
- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Scoring Category : C
Score : Satisfactory Compliance

25. The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2000: 18/19.3.
Note: See The Joint Commission's website (http://www.jointcommission.org/life_safety_code_information__resources/) for alcohol-based hand rub (ABHR) requirements, including permissible volumes of ABHR gel and foam within a single smoke compartment.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. The exit access corridor by the dining room on the 2nd floor in the Women's & Children's Hospital contained nine (9) large clean linen carts stored in a row in the corridor, which exceeded 50 square feet of combustibles storage that was not located in a room protected as a hazardous area.
EP25
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. The alcohol-based hand-rub dispenser in the Women's & Children's Hospital 7 East NICU by bay #30 was not installed in accordance with NFPA 101-2012, 19.3.2.6 (8)(a) as this dispensed was installed directly above an electrical outlet.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

14. The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2000: 18/19.3.5.

Scoring Category : C
Score : Satisfactory Compliance

3. Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.3)

Scoring Category : C
Score : Satisfactory Compliance

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP14
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. The pizza oven under the vent hood in the Tower food court was not covered by the automatic fire extinguishing system as all four (4) discharge nozzles had been inadvertently moved (pipe rotated) away from the oven. The discharge nozzles were directed at the area in front of the vent hood.
EP3
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. A disconnected fire sprinkler hanger was observed above the ceiling in the Tower 5th floor Neuro ICU men's locker room where the sprinkler hanger had become disconnected from the anchor in the roof deck. This was corrected at the time of the observation.
EP5
Observed in Building Tour at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. The fire sprinkler head in patient room 4215 on the 4th floor in the Women's & Children's Hospital was heavily loaded with foreign materials (dust/dirt/lint). This sprinkler was located directly above the patient bed.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.01

Standard Text: The hospital safely stores medications.

Element(s) of Performance:

2. The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.
Note: This element of performance is also applicable to sample medications.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Tracer Activities at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site. During Tracer Activities in the Operating Room, it was observed that a refrigerator containing medications did not have any record of temperatures being checked on the weekends. In addition, the feature noting the range of temperatures on the thermometer was inaccurate, stating that the temperatures had ranged from 50 to 86 degrees over an unknown period. The top range of the allowable refrigerator temperatures was 46 degrees, and the current temperature was 38 degrees.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.06.01

Standard Text: Maintain and communicate accurate patient medication information.

Element(s) of Performance:

4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Individual Tracer at TriStar Centennial Medical Center (330 23rd Avenue North,Nashville,TN) site.
During record review of the medications ordered for a post kidney transplant patient it was noted that the provider ordered for Protonix be discontinued and changed to Pepcid. There was no evidence of documentation to show that this written information was provided to the patient/ family at the end of the outpatient encounter.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Element(s) of Performance:

7. The medical record contains information that documents the course and result of the patient's care, treatment, and services.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP7
Observed in Tracer Activities at Centennial Imaging Center (356 24th Avenue North,Nashville,TN) site.
During staff interview in the Diagnostic Imaging department, it was discovered that when a peripheral IV is inserted and discontinued, an IV assessment is not documented. Examples of documentation include, but is not limited to the following: insertion site, type of catheter, patency, assessment for infiltration/ phlebitis, condition of catheter upon removal, and how the patient tolerated the procedure.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.01.01

Standard Text: The medical record contains information that reflects the patient's care, treatment, and services.

Element(s) of Performance:

2. The medical record contains the following clinical information:
- The reason(s) for admission for care, treatment, and services
- The patient's initial diagnosis, diagnostic impression(s), or condition(s)
- Any findings of assessments and reassessments (See also PC.01.02.01, EP 1; PC.03.01.03, EPs 1 and 8)
- Any allergies to food
- Any allergies to medications
- Any conclusions or impressions drawn from the patient's medical history and physical examination
- Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.
- Any consultation reports
- Any observations relevant to care, treatment, and services
- The patient's response to care, treatment, and services
- Any emergency care, treatment, and services provided to the patient before his or her arrival
- Any progress notes
- All orders
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, and route
- Any access site for medication, administration devices used, and rate of administration
- Any adverse drug reactions
- Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EPs 1 and 23)
- Results of diagnostic and therapeutic tests and procedures
- Any medications dispensed or prescribed on discharge
- Discharge diagnosis
- Discharge plan and discharge planning evaluation (See also PC.01.02.03, EP 6)

Scoring Category : C
Score : Satisfactory Compliance

21. The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following:
- The time and means of arrival
- Indication that the patient left against medical advice, when applicable
- Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services
- A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Individual Tracer at TriStar Centennial Medical Center (2300 Patterson Street,Nashville,TN) site.
During individual tracer it was observed that the urine output for a dialysis patient was inadvertently documented as 2800 ml. Clarification with staff indicated an entry error, and should have been entered as 2500 ml.
EP21
Observed in Individual Tracer at TriStar Centennial Medical Center (330 23rd Avenue North,Nashville,TN) site.
During an individual tracer it was observed that the medical record of a discharged patient did not contain information that the physician order was implemented by staff in relation to the change of medication (Protonix was discontinued and changed to Pepcid).

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.03.07

Standard Text: Qualified staff receive and record verbal orders.

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Individual Tracer at Parthenon Pavilion (2401 Parman Street,Nashville,TN) site.
During tracer activity on the dual treatment program (DTP) inpatient unit, it was observed that a telephone order for an alcohol detox protocol was ordered on 09/10/16 and had not yet been authenticated by the prescriber on the date of survey, 09/14/16. Per organization policy, a telephone order should be authenticated within 24 hours; therefore, this telephone order authentication did not occur per the time frame specified by the organization.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.01.03

Standard Text: The hospital respects the patient's right to receive information in a manner he or she understands.

Element(s) of Performance:

2. The hospital provides language interpreting and translation services. (See also HR.01.02.01, EP 1; PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5) Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Individual Tracer at TriStar Centennial Medical Center (330 23rd Avenue North,Nashville,TN) site.
During an individual tracer it was observed that there was no evidence of documentation for interpretation or language services provided during the pre-admission (pre-endoscopy) call to a Spanish speaking patient.

Chapter: National Patient Safety Goals

Program: Behavioral Health Care Accreditation

Standard: NPSG.15.01.01

Standard Text: Identify individuals at risk for suicide.

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1

Observed in Individual Tracer at Parthenon Pavilion (2401 Parman Street,Nashville,TN) site.
Upon review of assessment documentation for a client in the intensive outpatient program, it was observed that the program did not conduct a risk assessment including specific characteristics of the individual served and environmental features that may decrease the risk for suicide. If a client is a direct admit into this program from the community, a more complete and comprehensive suicide risk assessment was conducted using both risk and protective factors. If a client was admitted into the program from the organization's inpatient unit (as was the case for this client), the more comprehensive suicide risk assessment tool was not utilized. For those patients admitted from inpatient, the organization assessed whether the client had current suicide ideation, plan, or intent. A risk assessment utilizing risk and protective factors was not being utilized upon admission for all patients.

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305-3608

February 3, 2016

Administrator
Tristar Centennial Medical Center
2300 Patterson Street
Nashville, TN 37203

Dear Administrator:

Enclosed is the **Psychiatric Unit Criteria Work Sheet** that you will need to fill out in order for your **psychiatric unit** to continue to be PPS exempt. Also enclosed is an **attestation form** you will need to complete and submit to this office. The Administrator **must sign** the attestation form. Along with the **Self-Attestation form** and the **Psychiatric Unit Criteria Work Sheet**, you will need to **send a floor plan of the psychiatric unit showing room numbers and a list of the room numbers showing how many beds are in each room.**

These completed forms will be your PPS survey this year. If you have any questions, please do not hesitate to call our office at (731) 984-9684.

If your fiscal year ending date has changed, please let us know. The fiscal year ending date is what determines when your PPS is due.

Sincerely,

P. Diane Carter

P. Diane Carter
Interim Regional Administrator

SJ/tf

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

ATTESTATION STATEMENT FOR EXCULSION FROM PPS FOR FISCAL YEAR BEGINNING: 01/01/2016

Mrs. P. Diane Carter
Interim Regional Administrator
West Tennessee Health Care Facilities
2975 C Highway 45 Bypass
Jackson, TN 38305

Dear Mrs. Carter:

This attestation must be signed by the Administrator/Chief Executive Officer of the hospital (including hospitals with excluded units).

Attention: Read the following carefully before signing.

STATEMENTS OR ENTRIES GENERALLY: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both. (18 U.S.C., Sec. 1001)

Based upon my personal knowledge and belief, I attest that the responses on the attached prospective payment system (PPS) exclusion worksheets are true and correct, and that **Tristar Centennial Medical Center Psychiatric Unit** currently meets and will continue to meet the applicable requirements for exclusion from PPS for the period beginning **January 1, 2016 to December 31, 2016** as set out in Subpart B of 42 CFR Part 412. I agree that if the hospital unit fails to meet any of these requirements between the date of attestation and the first day of the hospital's fiscal year, I will notify Mrs. Pat Bendert, Centers for Medicare & Medicaid Services, The Atlanta Federal Center, 61 Forsyth Street, 4T20, Atlanta GA 30323 of the change immediately in order to permit a valid determination of distinct part status prior to the beginning of the fiscal year. The unit is located in the **Tristar Centennial Medical Center, 230 Patterson Street, Nashville, TN 37203** 103-112, 115-120, 123-124, 201-204 ~~301-310, 312-324, 401-406, 412-415, 418-421~~ **psychiatric room numbers.** See copies of the attached **floor plan** for the **Psychiatric Unit.** The unit consists of 101,029* **square feet in the Psychiatric Unit.**

This is square footage of the psychiatric hospital and includes, non patient care areas

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

I understand that the Centers for Medicare & Medicaid Services (CMS) or its representative has the right to conduct an on-site survey at any time to validate whether the statements made on the attached work sheet are true.

_____
Signature – Administrator/Chief Executive Officer of the Hospital

_____
Title

_____
Date

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

Form Approved
OMB No. 0938-0358

PSYCHIATRIC UNIT CRITERIA WORK SHEET

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE UNIT	FACILITY NAME AND ADDRESS (CITY, STATE, ZIP CODE)
445161	103-124, 201-224, 301-324, 401-407, 413-421	Parthenon Pavilion at Centennial Medical Center 2300 Patterson St. Nashville, TN 37203
NUMBER OF BEDS IN THE UNIT: 132	SURVEY DATE:	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD: 01/01/2016 (MM DD YYYY) to 12/31/2016 (MM DD YYYY)		
VERIFIED BY: Allen Barl		

ALL CRITERIA MUST BE MET FOR EXCLUSION FROM MEDICARE'S HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS)

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
	§412.25 Excluded Hospital Units: Common Requirements				
A1105	(a) Basis for exclusion. In order to be excluded from the prospective payment system, a psychiatric unit must meet the requirements under §412.25(a) and (b) which include:				
A1106	(1) Be part of an institution that (i) Has in effect an agreement to participate as a hospital; (ii) Is not excluded in its entirety from the prospective payment systems; and (iii) Has enough beds that are not excluded from the prospective payment systems to permit the provision of adequate cost information, as required by §413.24(c)	Has the state agency (SA) verified with the CMS Regional Office (RO) that the hospital has a current agreement to participate in the Medicare program and to ensure that the hospital is not already excluded in its entirety from PPS, such as a psychiatric hospital?	X		
A1107	(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.	Are the same admission criteria being applied to all patients?	X		
A1108	(3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.	Are the psychiatric unit medical records separate from other hospital records? Are the records readily available for review?	X		
A1109	(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.	Does the hospital have a policy ensuring prompt transfer of information to the unit?	X		
A1110	(5) Meet applicable State licensure laws.	Has the unit verified current active licensure of its professional staff? Does the unit meet any special licensing requirements of the state?	X		

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1111	(6) Have utilization review standards applicable for the type of care offered in the unit.	Does the hospital have a utilization review plan that includes psychiatric services?	X		
A1112	(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds.	Is the area containing the psychiatric unit beds separate from the beds in the other units of the hospital?	X		
	§412.27 Excluded Psychiatric Units: Additional Requirements:				
A1120	(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately on in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification.		X		
A1121	(b) Furnish, through the use of qualified personnel, psychological services, social work, psychiatric nursing, occupational therapy, and recreational therapy.		X		
A1122	(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:		X		
A1130	(1) **Development of Assessment/Diagnostic Data.** Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.		X		
A1131	(i) The identification data must include the inpatient's legal status.	Legal status is defined by state statutes and dictates the circumstances under which the patient was admitted and/or is being treated (i.e. voluntary, involuntary, committed by court)	X		
A1132	(ii) A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.	Is the diagnosis written in DSM nomenclature? If the diagnosis is absent, is there written justification for the omission? (for example, the patient was psychotic on admission and not accompanied by family) Is treatment provided for physical illnesses requiring immediate attention? Is there an evaluation and treatment plan for identified physical illnesses that may impact the patient's psychiatric outcome?	X		

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1133	(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.	The records should include who, what, where, when, and why the patient was admitted to the facility.	X		
A1134	(iv) The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.	Does the assessment include the following components? 1) Factual and historical information, 2) Social evaluation (baseline social functioning including strengths and weaknesses), and 3) Conclusions and Recommendations (in anticipation of social work's role in treatment and discharge planning).	X		
A1135	(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.	At a minimum, the screening neurological exam includes a detailed description of gross testing for cranial nerves II through XII.	X		
A1140	(2) **Psychiatric Evaluation.** Each inpatient must receive a psychiatric evaluation that must:	The psychiatric evaluation must include the following components: 1) Chief complaints, reaction to hospitalization, 2) Past history of any psychiatric problems and treatment, including previous precipitating factors, diagnosis, and course of treatment, and 3) Past family, educational, vocational, occupational, and social history.	X		
A1141	(i) Be completed within 60 hours of admission;		X		
A1142	(ii) Include a medical history;	Does the evaluation include any medical conditions that may impact the patient's recovery/remission?	X		
A1143	(iii) Contain a record of mental status;	Does the mental status record describe the appearance, behavior, emotional response, verbalization, thought content, and cognition of the patient?	X		
A1144	(iv) Note the onset of illness and the circumstances leading to admission;	Are the identified problems related to the patient's need for admission?	X		

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1145	(v) Describe attitudes and behavior;	Does the problem statement describe the behavior(s) which require modification in order for the patient to function in a less restrictive environment?	X		
A1146	(vi) Estimate intellectual functioning, memory functioning, and orientation; and		X		
A1147	(vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.	For the purposes of this regulation, words such as "youth", "pretty", "social security income" and "has a car" do not represent assets.	X		
A1150	(3) **Treatment Plan.** (i) Each inpatient must have an additional comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and	Is the treatment plan a result of collaboration between the patient and the treatment team? Is the treatment plan individualized? Is there a primary diagnosis upon which the treatment interventions are based? Are the treatment plan goals written in a manner that allows for changes in the patient's behavior to be measured? Are the treatment plan goals relevant to the patient's condition? Does the treatment team encourage the patient's active participation and responsibility for engaging in the treatment regimen? For patients who have been secluded or restrained, have less restrictive interventions been considered prior to the use of seclusion or restraints? What is the rationale for use of seclusion and/or restraints? If the use of seclusion and/or restraints is a frequent occurrence, does the treatment plan document alternative interventions to address and treat negative patient behavior?	X		
A1151	(ii) The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.	Does the patient require 24 hour specialized psychiatric care? Is the patient receiving all aspects of treatment to which the unit has committed itself, based on the assessment, evaluation, and plan of care? Do the policies and procedures adequately direct staff on alternatives or less restrictive interventions prior to the use of seclusion and restraints? Has the staff documented that less restrictive therapeutic interventions have been reviewed and/ or attempted?	X		

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1160	(4) **Recording Progress.** Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities.	Does the content of the treatment notes and progress notes relate to: 1) the treatment plan 2) what the staff is doing to carry out the treatment plan, and 3) the patient's response?	X		
A1161	The frequency of progress notes is determined by the condition of the inpatient and must be recorded at least weekly for the first two months and at least once a month thereafter;		X		
A1162	and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.		X		
A1165	(5) **Discharge Planning and Discharge Summary.** The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or after care as well as a brief summary of the patient's condition on discharge.	Does the discharge planning process include the participation of the multidisciplinary staff and the patient? Are the details of the discharge plan communicated to the post-hospital treatment entity?	X		
A1170	(d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures, and engage in discharge planning, as follows:		X		
A1171	(1) **Personnel.** The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to –		X		
A1172	(i) Evaluate inpatients;	Is there adequate staff to ensure that admission work-ups are completed in a timely manner?	X		
A1173	(ii) Formulate written, individualized, comprehensive treatment plans;	Are all members of the treatment team able to contribute their data and perspectives toward formulation of the treatment plan?	X		

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1174	(iii) Provide active treatment measures; and	Is the distribution of staff consistent with particular patient needs? Is staffing sufficient to carry out treatment plans?	X		
A1175	(iv) Engage in discharge planning.	Does the record indicate that staff has participated in discharge planning? Are staff aware of discharge plans for the patients they are working with?	X		
A1180	(2) **Director of Inpatient Psychiatric Services; Medical Staff.** Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.		X		
A1181	(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.		X		
A1182	(ii) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	Are there appropriate professional staff available to provide necessary medical and treatment services? Does the unit have policies and procedures to direct medical and direct care staff in situations when patients become agitated and aggressive, posing a potential threat to self or others?	X		

Number of Physicians

SPECIALTY	FULL-TIME (A)	PART-TIME (B)	CONSULTING (C)
Psychiatry	11 Regularly admitting		
Neurology			
Other*	Internal Medicine MD and 3.5 Nurse practioners provide H&P's and ongoing medical care		
Other*			
*Specify			

We have an open medical staff with 11 regularly admitting psychiatrist. Board certification is required within 5 years of Eligibility. We contract with medical group to provide H&P's and provide medical coverage to our pts. also have psychology n eurology, plus almost all medical speciality areas available due to being part of medical center.

SUPPLEMENTAL #2
November 3, 2016
1:26 pm

Form CMS-437 (04/06)

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1183	(3) **Nursing Services.** The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.		X		
A1184	(i) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric and mental health nursing, or its equivalent, from a school of nursing accredited by the National League of Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.		X		
A1185	(ii) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.		X		

Number of Nursing Personnel Assigned to Unit *(Full-Time Equivalents)*
(A) R.N.S. 74.3 (B) L.P.N.S. 0 (C) AIDES 41.9

Day of Survey-Number of Nursing Personnel *(Full-Time Equivalents)*

SHIFT	R.N.	L.P.N.	AIDES	OTHER
Day	27	0	10	6
Evening	24	0	12	
Night	17	0	7	

4 unit secretaries and 2 managers

Average bed-size of adult patient ward ____ beds

R.N. Duty Roster *(Full-time Equivalent)* — For at least one complete week

SHIFT	SUN.	MON.	TUES.	WED.	THURS.	FRI.	SAT.
Day	20	18	19	21	23	18	20
Evening	22	20	21	24	23	20	21
Night	15	15	15	14	16	15	15
Relief							

SUPPLEMENTAL #2
November 1, 2016
:26 pm

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
A1186	(4) **Psychological Services.** The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures.	Are the patients in need of psychological therapy or testing receiving those services in a timely manner, and with sufficient intensity?	X		
A1187	(5) **Social Services.** There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished.	Does the social services director periodically audit the quality of social work services?	X		
A1188	The services must be furnished in accordance with accepted standards of practice and established policies and procedures.		X		
A1189	Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.		X		
A1190	(6) **Therapeutic Activities.** The unit must provide a therapeutic activities program.		X		
A1191	(i) The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychological functioning.	Has the unit ensured consistent availability and provision of individualized therapeutic activities and rehabilitative services based on patient's needs?	X		
A1192	(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.	Are there clearly defined monitoring and evaluation mechanisms to conduct consistent and timely review of the quality and appropriateness of therapeutic and rehabilitative services?	X		

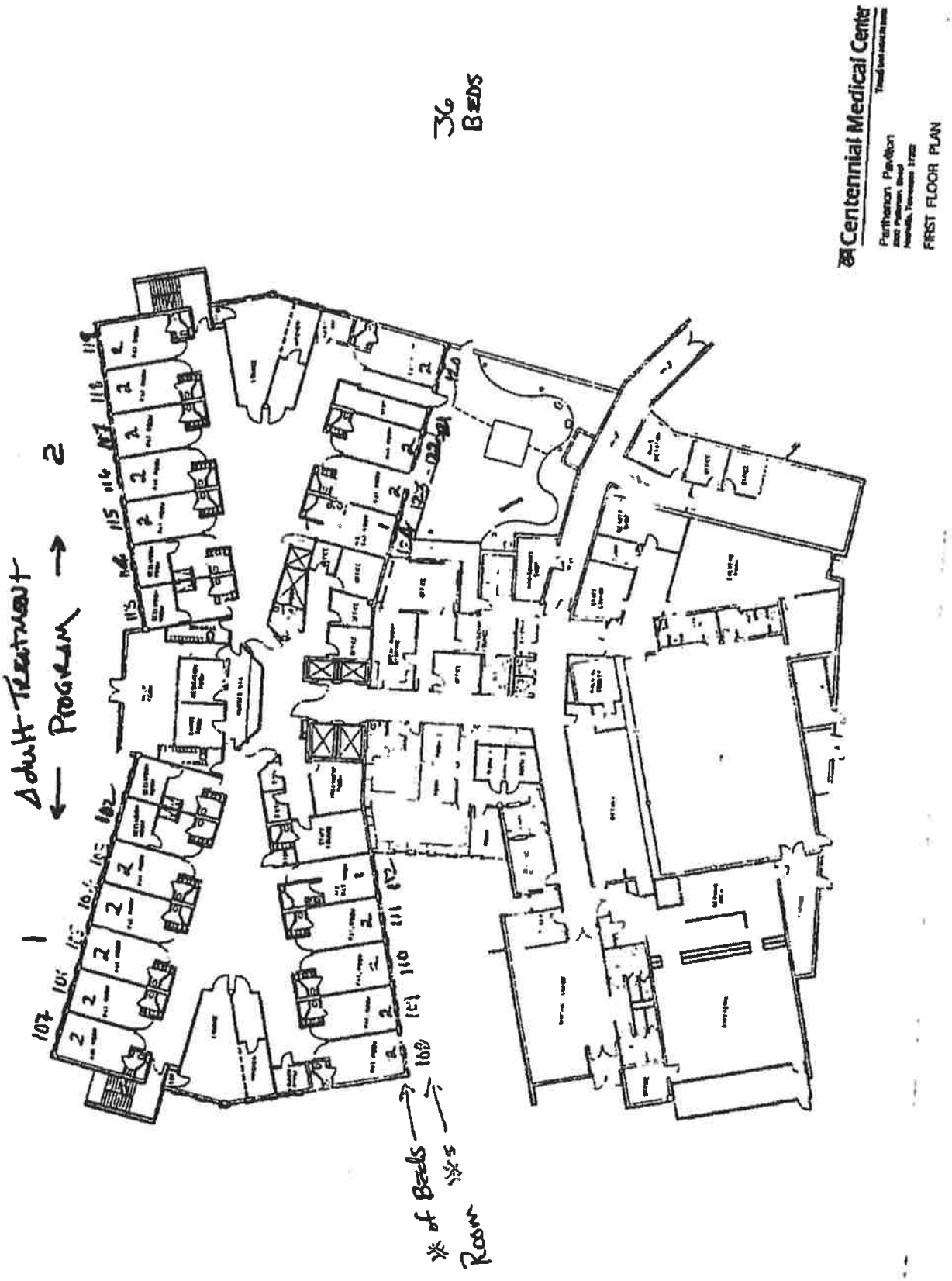
SUPPLEMENTAL #2
November 1, 2016
1:26 pm

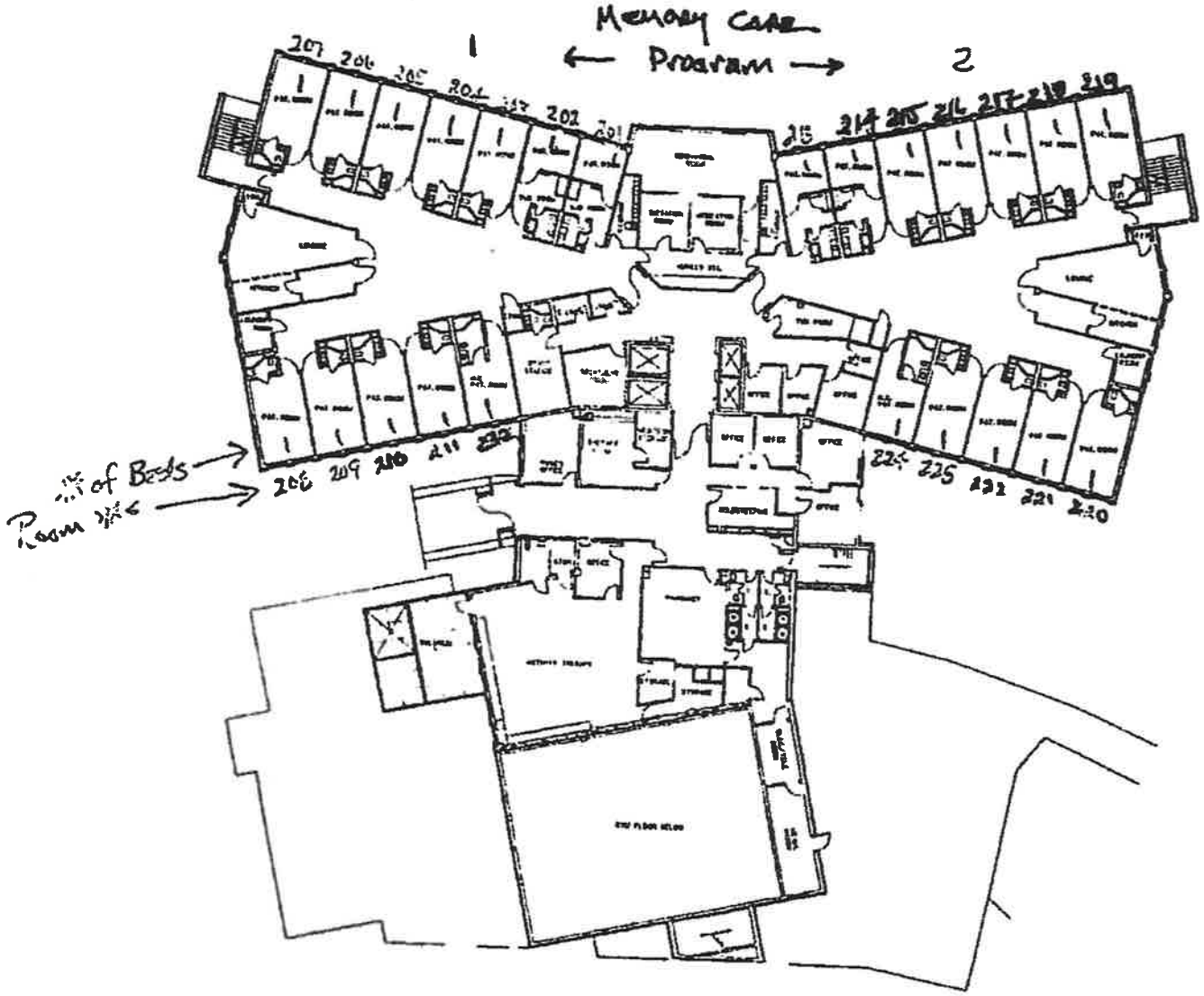
According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0358. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

SUPPLEMENTAL #2

November 1, 2016

1:26 pm





Centennial Medical Cent

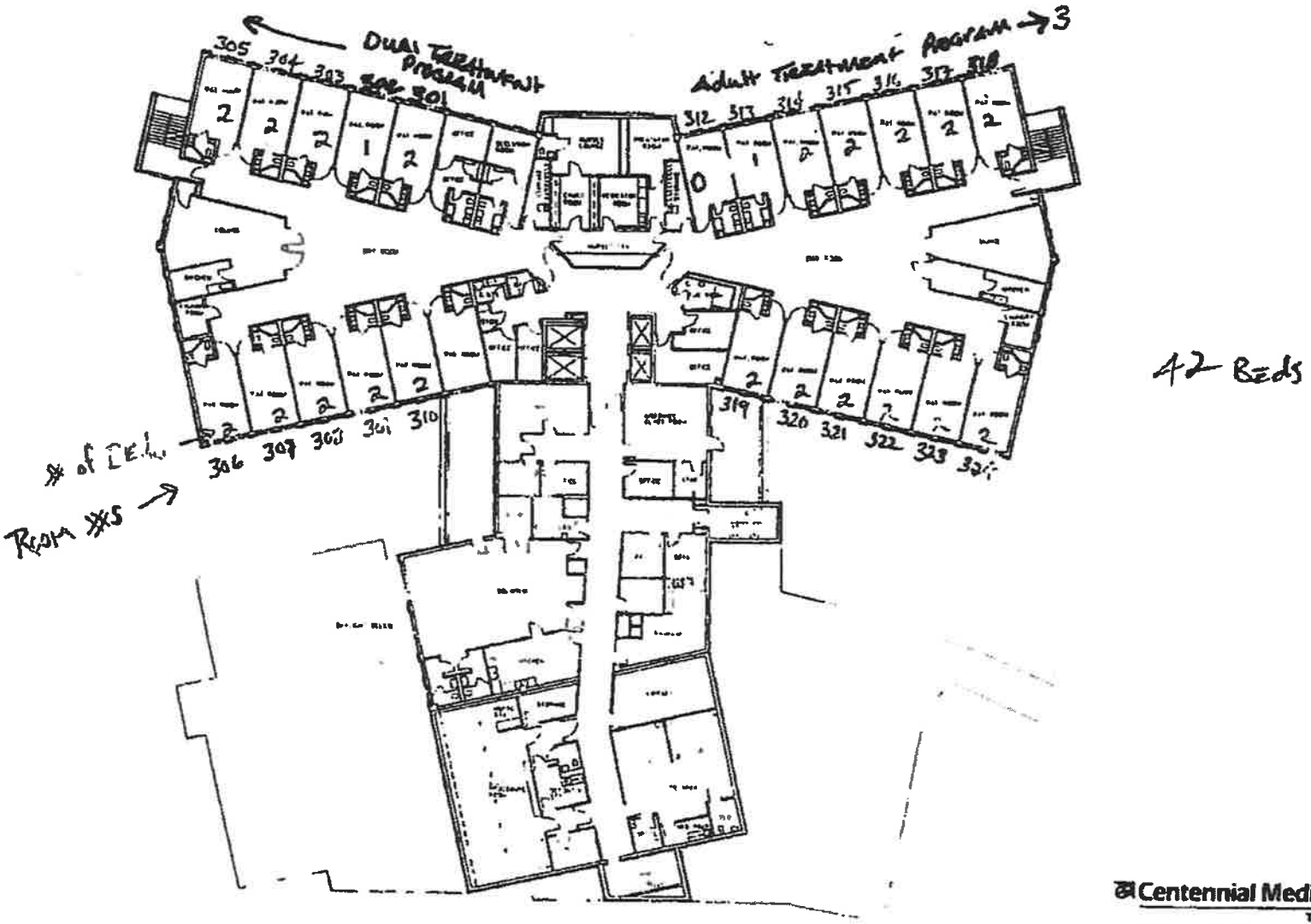
Parthenon Pavilion

SECOND FLOOR PLAN

November 2016

1:26 pm

SUPPLEMENTAL #2



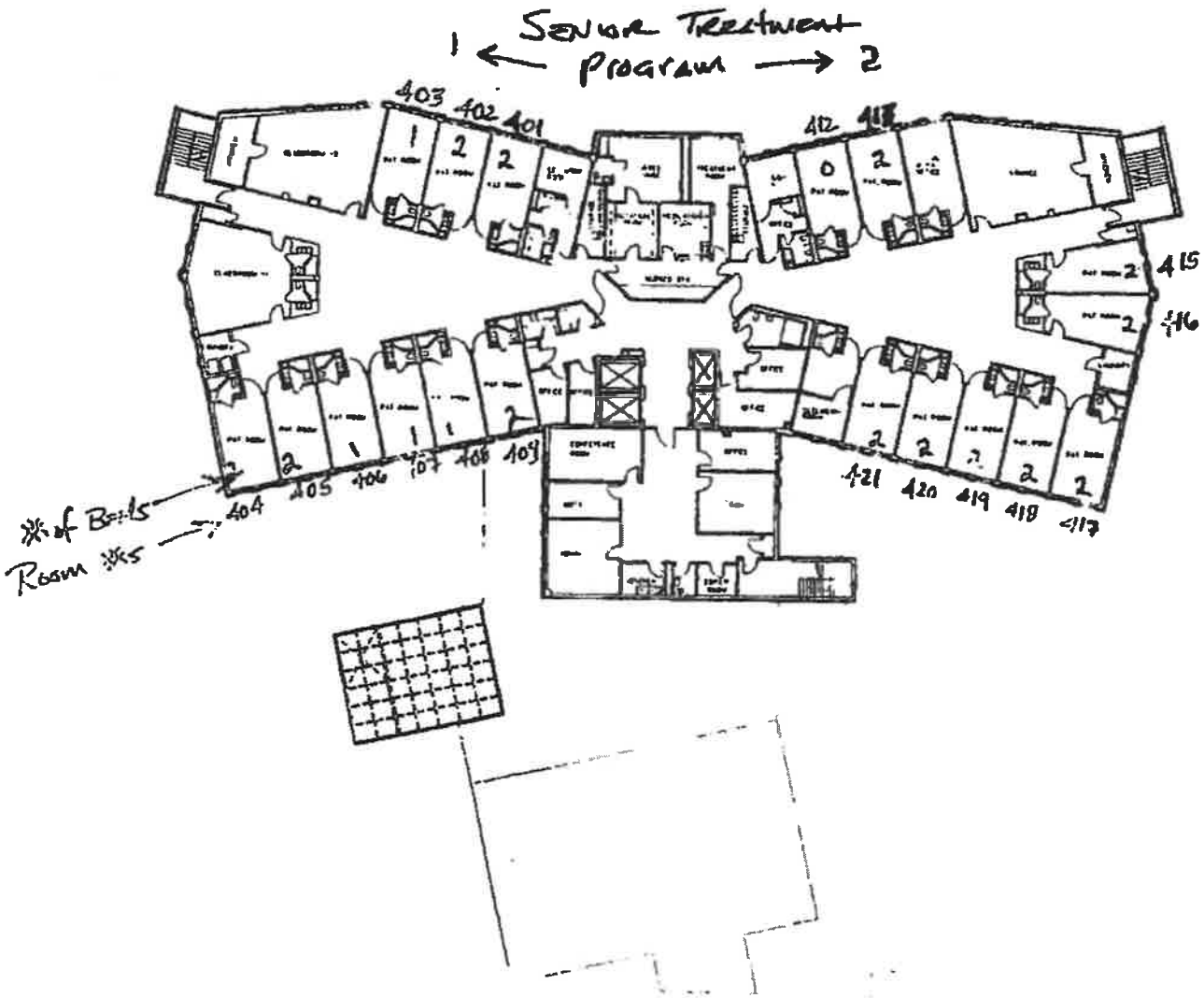
Centennial Medical Center

Parthenon Pavilion

THIRD FLOOR PLAN

November 1, 2016
1:26 pm

SUPPLEMENTAL #2



30 Beds

Centennial Medical Cer

Parthenon Pavilion

FOURTH FLOOR PLAN

November 1, 2016

1:26 pm

SUPPLEMENTAL #2

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

RECEIVED

JUL 11 2011

CENTENNIAL MEDICAL CENTER
ADMINISTRATION

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305-3608

July 7, 2011

Administrator
Centennial Medical Center
2300 Patterson Street
Nashville, TN 37203

RE: Licensure Surveys

Dear Administrator:

Enclosed is the statement of deficiencies for the licensure surveys completed at your facility on **June 27 - 29, 2011**. Based upon 1200-8-1, you are asked to submit an acceptable plan of correction for achieving compliance with completion dates and signature within **ten (10) days from the date of this letter.**

Please address each deficiency separately with positive and specific statements advising this office of a plan of correction that includes acceptable time schedule, which will lead to the correction of the cited deficiencies. **Enter on the right side of the State Form, opposite the deficiencies**, your planned action to correct the deficiencies and the expected completion date. The completion date can be no longer than **45 days from the day of survey**. Before the plan can be considered "acceptable," it must be signed and dated by the administrator

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-984-9710.

Sincerely,

P. Diane Carter

P. Diane Carter, RN. LNCC
Public Health Consultant Nurse 2

PDC/tjw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	TNP531136		06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL MEDICAL CENTER	2300 PATTERSON STREET NASHVILLE, TN 37203

(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
H 630	1200-8-1-.06 (3)(a) Basic Hospital Functions (3) Infection Control. (a) The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases. This Rule is not met as evidenced by: Based on policy review and interview, it was determined the facility failed to provide a sanitary environment to avoid sources of infections by failing to follow their policy for cleaning of glucose monitors in 3 of 28 (Tower Holding Surgical Area, Well Baby Nursery and Sarah Cannon Intensive Care Unit) nurses stations where glucose monitors were housed. The findings included: 1. Review of the hospital policy for cleaning glucose monitors revealed, "... The CDC recommends that glucose monitors that are used on more than a single person be disinfected after each use ... clean the outside of the monitor with a PDI Super Sani-Cloth Wipe." 2. During an interview on 6/27/11 at 11:00 AM in the Tower Holding Surgical Area, the Director of Surgical Services stated the same glucose monitor may be used to check 10 to 20 different patient's blood glucose in a 24 hour period. She stated the glucose monitor was cleaned at least every shift and would be cleaned between patients if blood was observed on the glucometer.	H 630		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	TNP531136		06/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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H 630	Continued From page 1 3. During an interview in the Well Baby Nursery on 6/27/11 at 12:05 PM, Nurse #1 was asked how often she cleaned the glucose monitor. Nurse #1 stated, "...only once a shift with Sani Wipes..." 4. During an interview on 6/28/11 at 8:50AM in the Sarah Cannon Intensive Care Unit, the Charge Nurse (CN) stated glucose monitors were used for multi patient use and were wiped off every day. She stated she was not sure if there were designated days the monitors were cleaned. The CN said the monitors were cleaned with a wet wash cloth or a Sani-Wipe. She also stated the monitor would be cleaned after use on a patient known to have an infection. 5. During an interview on 6/29/11 at 10:45 AM, the Risk Manager stated the glucose monitors should be cleaned following the hospital policy.	H 630		
H 688	1200-8-1-.06 (5)(a) Basic Hospital Functions (5) Medical Records. (a) The hospital shall comply with the Tennessee Medical Records Act, T.C.A. §68-11-301, et seq. A hospital shall transfer copies of patient medical records in a timely manner to requesting practitioners and facilities. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure medical records were transferred in a timely manner to a requesting	H 688		

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H 688	Continued From page 2 practitioner for 1 of 10 (Patient #44) patients reviewed from the mental health unit. The findings included: Medical record review for Patient #44 documented an admission date of 5/28/10 and a discharge date of 6/6/10. The medical record documented "Authorization for Use and Disclosure of Protected Health Information (PHI) Release of Psychaitric Information" dated 5/31/10 and 6/1/10 to two different practitioners. There was no documentation the requested health information had been transferred to the requesting practitioners. During an interview in the Massey Conference Room on 6/29/11 at 11:23 AM the Patient Advocate stated, "...spoke with the social worker...[she] shredded the confirmations [of medical record sent out via fax] from 2009 and 2010 last week..."	H 688		
H 742	1200-8-1-.06 (9)(i) Basic Hospital Functions (9) Food and Dietetic Services. (i) Food shall be protected from sources of contamination whether in storage or while being prepared, served and/or transported. Perishable foods shall be stored at such temperatures as to prevent spoilage. Potentially hazardous foods shall be maintained at safe temperatures as defined in the current " U.S. Public Health Service Food Service Sanitation Manual " .	H 742		

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H 742	Continued From page 3 This Rule is not met as evidenced by: Based on policy review, observations, and interview, it was determined the facility failed to protect food from sources of contamination while being prepared or served and failed to maintain potentially hazardous foods at safe temperatures according to facility policy. The findings included: 1. Review of facility policy for jewelry revealed the following documentation: "Jewelry should be conservative and discreet. Large dangling earrings are a safety issue and are not permitted. Post earrings are acceptable." Review of facility policy for food preparation revealed the following documentation: "No soiled cloths, boxes, cartons, or other items that may contaminate should be placed on food preparation surfaces. Red buckets with sanitation solution will be in each location." The policy also documented, "Keep it hot at 140 degrees or above...or don't keep it." Review of facility hand washing policy documented: "Dry hands with a clean disposable (or single use) towel being careful to avoid touching the faucet handles or towel holder with clean hands. Turn the faucet off using the towel as a barrier between your hands and the faucet handle. Discard the used towel in a trash can lined with a fluid-resistant bag. Trash cans with foot-pedal operated lids are preferable." 2. Initial observations in the facility kitchen on 6/28/11 at 9:30 AM revealed two hand washing sinks which did not have the required trash container to discard paper towels without contaminating the workers hands. The dietary	H 742		

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H 742	Continued From page 4 employee who washed her hands deposited the paper towels in a kitchen trash can by opening the top of the trash can recontaminating her hands. There were two open trash cans containing paper and food debris in the kitchen area by the three compartment sink. Observations in the facility kitchen on 6/28/11 at 10:15 AM, revealed numerous soiled rags left on the kitchen preparation tables rather than the red buckets with sanitizer solution which were available. A dietary employee was wearing hoop earrings. Observations in the facility refrigerator on 6/28/11at 10:45 AM, revealed the shelled eggs were not covered to prevent contamination and/or cracks in the porous shells. At 10:50 AM, sausage patties were observed left out on a kitchen counter at room temperature. Observations in the facility kitchen on 6/28/11 at 12:00 PM, revealed prepared food on the tray line ready to be served. The dietary employees, who would be serving food on the tray line, changed their plastic gloves, opened the trash can cover with their clean gloved hand and deposited the soiled gloves in the trash can recontaminating their hands. A dietary employee was wearing a large barrette on top of her hair net. Other dietary employees were wearing earrings that looked like large diamond studs. Observations at 12:15 PM, during meal service, revealed the holding temperature of the ground meat on the tray line was at 116 degrees Fahrenheit (F) rather than the required 140 degrees F. 3. During an interview on 6/28/11, at 12:00 PM,	H 742		

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H 742	Continued From page 5 the Food Services Director confirmed the earrings were not allowed and stated the only allowed jewelry was a wedding band, a watch and post earrings.	H 742		
H1137	1200-8-1-.11 (8)(a)9.(xx) Records and Reports (8) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient. (a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to: 9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include: (xx) patient abuse, patient neglect, or misappropriation of resident/patient funds; This Rule is not met as evidenced by: Based on policy review, medical record review, and interview, the facility failed to ensure it reported identified abuse to the Department of Health for 1 of 6 (Patients #46) sampled patients.	H1137		

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H1137	Continued From page 6 The findings included: 1. Review of facility policy "Alleged or Suspected Abuse (Child and/or Adult)" revised 4/04 documented "...C. Notifying the appropriate authorities... 6. If applicable, a UIRS (Unusual Incident Reporting System) report is filed with the State of Tennessee..." Review of facility policy "External Agency Reporting" revised 5/07 documented "...PROCEDURE... 2. When the incident or accident has, or could be expected to have, resulted in the death of a patient, life-threatening injury or illness to a patient, or the abuse of a patient, the matter shall be reported to the Department in a timely manner and, in no case, later than seven (7) business days after the incident or accident..." 2. Review of the facility investigation of a witnessed allegation of abuse for Patient #46 documented an occurrence date of 6/19/08. The facility investigation did not document the incident was reported to the Department of Health within 7 days. 3. During an interview in the Massey Conference Room on 6/28/11 at 1:20 PM the Patient Advocate of the facility stated, "...at that time [2008], we reported to APS [Adult Protective Services]...we began the online UIRS reporting in 2009..."	H1137		

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H 872	1200-8-1-.08 (2) Building Standards (2) 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 Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the physical condition of the hospital environment as required. The findings include: 1. On 6/27/11 at 9:20 AM, observation within the 2nd floor soiled utility room of the Pavilion building revealed the veneer finish on the entry fire door was damaged by push carts. 2. On 6/27/11 at 9:40 AM observation within the 2nd floor Nurses Station medical room revealed the entry door was damaged by push carts. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11.	H 872		
H 893	1200-8-1-.08 (23) Building Standards (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observations, it was determined the	H 893		

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H 893	Continued From page 1 facility failed to maintain the heating, ventilation and the air-conditioning system as required. The findings include: 1. On 6/27/11 at 8:50 AM, observation within resident rooms 303, 305, 313 bathrooms revealed the exhaust fan grilles were not working when tested. 2. On 6/27/11 at 9:00 AM, observation within room 222's bathroom I revealed the exhaust fan unit was not working. 3. On 6/27/11 at 9:30 AM, observation within room 116 bathroom revealed the exhaust fan grille was missing. 4. On 6/27/11 at 9:32 AM, observation within room 115 revealed the exhaust fan unit was not working. 5. On 6/27/11 at 9:50 AM, observation within room 106 bathroom revealed the exhaust fan unit was not working. These findings were acknowledged by the Administrator and verified by the Maintenance Director. These findings were corrected prior to the exit interview on 6/28/11.	H 893		
H 901	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new	H 901		

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H 901	Continued From page 2 codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the applicable building and fire safety regulations as required. The findings include: Observations made by the surveyors during tour of the facility on 6/27/11 revealed the following: 1. At 8:30 AM, within the 4th floor air handling room ceiling area revealed there was an opened 12 " x12 " electrical junction box with wires without a cover plate. At 8:35 AM, within the 4th floor elevator room revealed an electrical junction box without a cover plate. At 9:00 AM, within room 222 on the 2nd floor next to the entry door revealed a penetration in the smoke wall. At 9:25 AM within the 2nd floor oxygen storage revealed an unsecured oxygen cylinder. At 9:26 AM within the second floor dictation room revealed the use of a multiple adapter. 2. At 8:00 AM, a conduit pipe not sealed above the ceiling in the engraving room of the 4th floor Penthouse. At 8:04 AM, an open container of oily rags located in the 4th floor elevator mechanical room.	H 901		

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H 901	Continued From page 3 At 8:24 AM, wall penetrations above the ceiling located on both elevator shafts on the 4th floor. At 8:31 AM, wall penetrations above the ceiling located on the 1st and 3rd elevator shaft on the 3rd floor. At 8:38 AM, electrical junction box cover missing above the ceiling at the administrator's office. At 8:46 AM, wall penetration above the ceiling 3rd floor, West exit. At 8:48 AM, conduit open and wall penetration above the ceiling 3rd floor adjacent room number 3. At 8:54 AM, corridor doors would not close within the door frame at Dual Service Unit on the 3rd Floor. At 9:08 AM, wall penetration above the connector door on the 2nd floor. At 9:10 AM, electrical junction box cover missing and exposed wires above ceiling 2nd floor Senior Specialty Unit at environmental service closet At 9:14 AM, permanent storage in corridor across Social Work office 2nd floor. At 9:16 AM, wall penetrations above ceiling at the Neurological Psychiatric Unit (NPU) corridor doors. At 9:20 AM, dry wall tape and screws not mudded on 1hour fire wall, open junction box with exposed wires above the ceiling on the NPU over the environmental service closet.	H 901		

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H 901	Continued From page 4 At 9:46 AM, fire wall penetrations above ceiling at elevators 3 & 4, and Intensive Treatment Program entrance on 1st floor. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11.	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 1:26 pm A. BUILDING 04 - SARA CANNON B. WING	(X3) DATE SURVEY COMPLETED
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H 893	1200-8-1-.08 (23) Building Standards (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the heating ventilation and the air-conditioning system as required. The findings include: 1. On 6/28/11 at 10:30 AM, observation within rooms 2305 and 2306 revealed the bathroom exhaust fans were not working. 2. On 6/28/11 at 10:45 AM, observation within the first floor area common restroom revealed the exhaust fan was not working. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the survey exit on 6/28/11.	H 893		
H 901	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - SARA CANNON B. WING	(X3) DATE SURVEY COMPLETED
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H 901	Continued From page 1 This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the applicable building and fire safety regulations as required. The findings include: Observations made during a tour of the facility on 6/28/11 revealed the following 1. At 9:40 AM, observation within room 4322 revealed the Ground Fault Circuit Interrupter was loose in the wall. 2. At 9:54 AM, observation within the 4th floor revealed the corridor egress doors next to the nurses station did not close to latch when tested. 3. At 9:58 AM, observation within the 4322 bathroom revealed GFCI unit next to the sink did not trip when tested. 4. At 10:05 AM, observation within the north exit stair wings of Sarah Cannon Cancer Research Building revealed there were no sprinkler heads. 5. At 9:29 AM, storage of supplies and combustible trash crossover 4th floor. 6. At 9:33 AM, wall penetration above atrium plastic surgery entrance 4th floor. 7. At 9:36 AM, wall penetration and open conduit above ceiling - Operating Room (OR) entrance 4th floor. 8. At 9:39 AM, corridor storage OR 4th floor. 9. At 9:42 AM, dry wall not taped or mudded on	H 901		

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H 901	Continued From page 2 the med gas columns above ceiling adjacent to elevator 10 and 11 4th floor. 10. At 9:48 AM, wall penetrations above ceiling - inside wall and corridor wall conference room 4th floor. 11. At 9:52 AM, electrical control box doors open with loose wires exposed above ceiling at the staff lounge 4th floor. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11.	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 1:26 pm A. BUILDING 02 - WOMENS HOSPITAL B. WING	(X3) DATE SURVEY COMPLETED
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H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the overall hospital environment for the safety of both staff and patient as required. The findings include: On 6/28/11 at 10:10 AM, observation within the 3rd floor janitor's closet revealed one of the acoustic ceiling tiles was water damaged. This finding was acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11.	H 871		
H 893	1200-8-1-.08 (23) Building Standards (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the heating, ventilation and the air-conditioning system as required. The findings include:	H 893		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WOMENS HOSPITAL B. WING	(X3) DATE SURVEY COMPLETED
	TNP531136		06/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL MEDICAL CENTER	2300 PATTERSON STREET NASHVILLE, TN 37203

(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
H 893	Continued From page 1 1. On 6/27/11 at 2:30 PM, observation within the 7th floor resident bathrooms revealed the exhaust fans were not working. 2. On 6/28/11 at 7:40 AM, observation within resident room 6230 revealed the bathroom exhaust fan unit was not working. 3. On 6/28/11 at 8:50 AM, observation within the dietary dish washing area revealed the return grille was clogged with dirt. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11. The deficiencies were corrected prior to the Exit interview on 6/28/11.	H 893		
H 901	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with applicable building and fire safety regulations as required. The findings include: Observations made during a tour of the facility on 6/27/11 revealed the following:	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WOMENS HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED
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H 901	Continued From page 2 1. At 2:35 PM, wall penetration above ceiling Operating/Delivery room 6th floor. Observations made during a tour of the facility on 6/28/11 revealed the following: 1. At 7:45 AM, penetration above door wall, OR entrance 5th floor. 2. At 7:59 AM, wall penetration above ceiling -10' from nursery door Well Baby Nursery 4th floor. 3. At 8:17 AM, wall penetration above ceiling left and right columns at elevator 3 and 4 on the 3rd floor; wall penetration above ceiling left and right columns at elevator 1 and 2 on the 3rd floor; smoke detector within 3' of diffuser elevator lobby 3rd floor. 4. At 8:26 AM, damper actuator pressed against duct work above corridor door 3220 3rd floor. 5. At 8:31 AM, corridor doors did not close during fire alarm activation - entrance medical-surgical unit 3rd floor. 6. At 8:50 AM, fire door blocked by storage - entrance to surgery 3rd floor. 7. At 8:56 AM, wall penetrations above ceiling located at back ED entrance 1st floor. 8. On 6/28/11 at 7:58 AM, observation by room 5216 revealed there was a penetration in the smoke wall. 9. On 6/28/11 at 7:55 AM, observation within the 6th floor nurses station area revealed an unsecured oxygen cylinder was being used.	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 1:26 pm A. BUILDING 02 - WOMENS HOSPITAL B. WING	(X3) DATE SURVEY COMPLETED
	TNP531136		06/28/2011

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H 901	Continued From page 3 10. On 6/28/2011 at 8:15 AM, observation within the 3rd floor mechanical room revealed penetrations around the electricial conduits. 11. On 6/28/11 at 8:42 AM, observation within the dietary dining room revealed the exit was blocked with dining tables and chairs. 12. On 6/28/11 at 8:55 AM, observation within the sprinkler riser room of the Women's Hospital building revealed there were only five extra sprinklers in the spare box. These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11.	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 1:26 pm A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	TNP531136		06/28/2011

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H 872	1200-8-1-.08 (2) Building Standards (2) 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 Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the heating ventilation and the air-conditioning system as required. The findings include: 1. On 6/27/11 at 11:00 AM, observation revealed the Operating Rooms numbers 6,11, and 12 doors had damaged finished veneers. 2. On 6/27/11 at 2:20 PM, observation within the Microbiology room on the 2nd floor revealed the exhaust fan grille was dirty These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11.	H 872		
H 901	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 1:26 pm A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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H 901	Continued From page 1 facility failed to comply with the life safety code as required. The findings include: Observations made during a tour of the facility on 6/27/11 revealed the following: 1. At 10:14 AM, fire wall penetration approximately 20 " x 12 " corridor wall 8th floor Cardiac Care Unit corridor adjacent to room 8229 2. At 11:21 AM, wall penetration above ceiling 2nd floor corridor Food Court entrance 3. At 11:23 AM, electrical junction box missing cover, exposed wires, Post Anesthesia Care Unit (PACU) corridor entrance 1st floor 4. At 11:25 AM, 2nd floor surgery and PACU storage in the corridors in 1st floor 5. At 11:29 AM, wall penetration above the door in PACU entrance, 1st floor 6. At 11:31 AM, wall penetration above door in PACU interior exit, 1st floor 7. At 11:35 AM, approximately 6 " x 6 " wall penetration above room number 3 in the Cardio Vascular Intensive Care Unit, 1st floor 8. At 11:40 AM, storage within 18" of the sprinkler, Central Sterile Supply, 1st floor 9. At 1:25 PM, conduit not sealed above the ceiling at the clean utility room in the Emergency Department 1st floor, 10. At 1:29 PM, fire wool removed from conduit above corridor door at cath lab/rehab 1st floor 11. At 1:31 PM, storage in corridor cath lab 1st floor 12. At 1:33 PM, wall penetration and conduit not sealed above ceiling - room 6 cath lab 1st floor 13. At 1:35 PM, conduit not sealed and wall penetration above ceiling - procedure room 5 cath lab 1st floor 14. At 1:42 PM, wall penetration above ceiling -	H 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 1:26 pm A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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H 901	Continued From page 2 procedure room 2 cath lab 1st floor 15. At 1:44 PM, storage of stretcher and supplies - corridor cath lab 1st floor 16. At 1:48 PM, wall penetration above ceiling - cath lab exit to ED 1st floor 17. At 2:00 PM, wall penetration above ceiling over door of cardiac ultrasound 1st floor 18. At 2:05 PM, smoke detectors covered - corridor noninvasive cardiology 1st floor 19. At 2:08 PM, 6" x6 "hole in smoke wall above door - morning admissions 1st floor These findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 6/28/11.	H 901		

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

TRISTAR PARKRIDGE MEDICAL CENTER
(INCLUDES VALLEY WEST)

The Joint Commission

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Parkridge Medical Center, Inc.
2333 McCallie Avenue
Chattanooga, TN 37404

Organization Identification Number: 7815

Program(s)	**Survey Date(s)**
Hospital Accreditation Behavioral Health Care Accreditation	05/13/2014-05/16/2014

Executive Summary

Hospital Accreditation :	As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report. You will have follow-up in the area(s) indicated below: • Evidence of Standards Compliance (ESC)
Behavioral Health Care Accreditation :	As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.04.03	EP5
	EC.02.05.07	EP4,EP6
	NPSG.15.01.01	EP1
	PC.01.02.01	EP23
	PC.02.01.03	EP1,EP7
	PC.02.01.11	EP2
	PC.03.01.07	EP7

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.04.01	EP4
	IC.01.05.01	EP1
	IC.02.01.01	EP1
	IC.02.02.01	EP4
	LD.04.03.09	EP4
	LS.02.01.10	EP4
	LS.02.01.30	EP11
	MM.03.01.01	EP8
	MS.03.01.01	EP16,EP17
	PC.01.03.01	EP5
	RC.01.01.01	EP19
	TS.03.01.01	EP1

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(c)(2)	A-0144	HAP - IC.02.01.01/EP1	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: 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.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP5	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(2)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(3)	A-0505	HAP - MM.03.01.01/EP8	Standard

CoP: §482.26 **Tag:** A-0528 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.26 Condition of Participation: Radiologic Services

The hospital must maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

CoP Standard	Tag	Corresponds to	Deficiency
§482.26(c)(2)	A-0547	HAP - MS.03.01.01/EP16	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP5, EC.02.05.07/EP4, EP6	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP4, LS.02.01.30/EP11	Standard

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - IC.02.01.01/EP1, IC.02.02.01/EP4

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - IC.02.02.01/EP4, IC.01.05.01/EP1	Standard

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CoP: §482.52 **Tag:** A-1000 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.52(b)(3)	A-1005	HAP - PC.03.01.07/EP7	Standard

CoP: §482.53 **Tag:** A-1026 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.53 Condition of Participation: Nuclear Medicine Services

If the hospital provides nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice.

CoP Standard	Tag	Corresponds to	Deficiency
§482.53(a)(2)	A-1029	HAP - MS.03.01.01/EP17	Standard

CoP: §482.56 **Tag:** A-1123 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.56 Condition of Participation: Rehabilitation Services

If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.

CoP Standard	Tag	Corresponds to	Deficiency
§482.56(b)	A-1132	HAP - PC.02.01.03/EP1, EP7	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. The governing body (or the persons legally responsible for the conduct of the hospital and carrying out the functions specified in this part that pertain to the governing body) must include a member, or members, of the hospital's medical staff.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(e)	A-0083	HAP - LD.04.03.09/EP4	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.01

ESC 60 days

Standard Text: The hospital manages medical equipment risks.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

4. The hospital identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current hospital experience. (See also EC.02.04.03, EPs 2 and 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The two hydroculators for hot packs and cold packs were not being cleaned every two weeks as recommended by the manufacturer's guidelines. The organization did not have a cleaning log for either machine and explained that equipment had been cleaned around every quarter. During the survey the organization had begun the process of developing a cleaning scheduling and educating the staff on the new every two week cleaning schedule.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.03

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains medical equipment.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

5. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The vendor policy for water culture acceptability was not consistent with the current AAMI levels of less than 100. The vendor the acceptable level for water cultures at the time of survey was less than 200.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.07

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains emergency power systems.
Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. At least monthly, the hospital tests each emergency generator under load for at least 30 continuous minutes. The completion dates of the tests are documented.

Scoring Category : A
Score : Insufficient Compliance

6. At least monthly, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Parkridge Valley Hospital - Adult and Senior Campus (7351 Courage Way, Chattanooga, TN) site for the Hospital deemed service.
During the document review of the generator located at the Parkridge Valley Adult Campus, it was noted that from July 2013 to January 13, 2014, the generator was tested for a duration of less than 30 minutes each month. The hospital was in compliance after January 13, 2014 for the generator's 30 minute run time.

EP 6
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Parkridge Valley Hospital - Adult and Senior Campus (7351 Courage Way, Chattanooga, TN) site for the Hospital deemed service.
During the document review of the generator located at the Parkridge Valley Adult Campus, it was noted that there were three automatic transfer switches. During the months of July, August and September 2013, only the initiating transfer switch was documented as being exercised on a monthly basis. There was no notation that the other two transfer switches had been exercised.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.01.05.01

ESC 60 days

Standard Text: The hospital has an infection prevention and control plan.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the operating room, it was noted that a surgeon in the sterile field had "gowned" and "gloved" in a sterile manner, was wearing an operating room hat, but had his mask below his chin and beard. After the time out had been completed and before the procedure (direct laryngoscopy and laryngeal biopsy) had begun, he raised his mask to cover his mouth, nose and beard. This technique does not comply with AORN standards which the hospital uses as its standard for sterile technique

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in radiology, during a CT guided biopsy of a lung mass, it was noted that the radiologist, before performing the procedure, "scrubbed", then used his cleaned hands to put on his hat, his mask, open his sterile gown. He then put on his gown and sterile gloves for the procedure. This technique does not comply with AORN standards which the hospital uses as its standard for sterile technique.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

Standard Text: The hospital implements its infection prevention and control plan.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.13(c)(2) - (A-0144) - (2) The patient has the right to receive care in a safe setting.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
In the OR it was found that on two procedure door jambs that each had multiple scratches and scrapes down to bare metal providing a surface for potential infections. In the cysto room it was noted there was a hole in the wall that also provided a surface for potential infections.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the central sterile storage area it was noted that the back of the sterilizer could be accessed from a door in sterile storage. When the door was opened it was noted that the floor under and around the sterilizer was wet and there was water dripping from the pipes. It was also noted that the brass like floor grate was corroded green and had rust. Plant operations responded immediately, cleaned the water and fixed the leaking pipes.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the Ultrasound and Mammography area it was found that the vaginal probe cleaning area was checked daily first thing in the morning to see if the room had a negative pressure. Per documentation it was noted that the pressure was negative daily for the last few months. However, at the time of survey the room was neutral and not negative due to the fact that the staff kept the door open during the day. This did not allow the room to maintain negative pressure.

Observed in Individual Tracer at Parkridge Valley Hospital - Adult and Senior Campus (7351 Courage Way, Chattanooga, TN) site for the Hospital deemed service.
For a patient on the senior unit, who was admitted 28 days prior to this review, it was noted that the patient was admitted with lice and scabies. When the staff was asked if infection control had been informed of this it was stated that they were notified. On further review with the ICP it was found that this report had not been submitted.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the operating room area, it was noted that a bronchoscopy was being performed in operating room 2. When a tissue (kleenex) was held at the base of the closed door between room 2 and the hall, the tissue blew away from the door, showing that the room 2 pressure was positive compared with the hall pressure. (consistent with the finding with the room pressure monitors earlier that day). During bronchoscopy, the room pressure should be negative compared with the hall pressure so that possible airborne contaminants would not be blown out into a clean area.

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The return air vents in two operating rooms in use were noted to be coated with a matted layer of dust. The matted layer of dust was demonstrated to the staff in unoccupied room 8 by scrubbing off a section of the layered dust with a damp paper towel.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01 ESC 60 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the Radiology suite, it was noted that a wire supply cart in one of the procedure rooms did not have an impervious bottom. The open structure would allow dirt and debris from the floor to contaminate items stored on the bottom shelf.

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The Pharmacy IV Infusion prep room has three open bottom wire carts two of which had cardboard and plastic medication boxes stored on the bottom shelf.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.03.09

ESC 60 days

Standard Text: Care, treatment, and services provided through contractual agreement are provided safely and effectively.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
Note 1: In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the 'Medical Staff' (MS) chapter.
Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:
- Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.12(e) - (A-0083) - §482.12(e) Standard: Contracted Services

The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
A review of contracts by the surveyor and a discussion with the Market Director of Quality revealed that leaders had not monitored contracted services by establishing expectations for the performance of the contracted services. Specifically the contract with Surgery Pharmacy Services, Inc. did not include performance expectations nor did the contract with DCI (dialysis services).

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 1st floor at the 2-hour separation between the hospital and medical office building that the door frame had 8 small, unprotected holes.

Observed in Building Tour at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – Main, it was observed on the 3rd floor at the 2-hour separation between the hospital and the Diagnostic Center that the 90-minute rated door did not have two floor catches for the lower latching mechanisms.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

ESC 60 days

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 2nd floor at the elevator lobby that the corridor's double doors had a gap of approximately ¼- inches.

Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 2nd floor at the back door to the ICU that the corridor's double doors had a gap of approximately ¼- inches.

Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 2nd floor at the back door to the ICU that the double doors did not have positive latching.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.03.01.01

Standard Text: The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.

Scoring Category : A
Score : Insufficient Compliance

17. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 16
§482.26(c)(2) - (A-0547) - (2) Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.
This Standard is NOT MET as evidenced by:
Observed in Credentialing and Privileging at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The HCO did not have documentation that the medical staff had determined the qualifications of the radiology staff who use equipment and administer procedures.

EP 17
§482.53(a)(2) - (A-1029) - (2) The qualifications, training, functions and responsibilities of the nuclear medicine personnel must be specified by the service director and approved by the medical staff.
This Standard is NOT MET as evidenced by:
Observed in Credentialing and Privileging at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The HCO could not provide documentation that the qualifications, training, functions and responsibilities of the nuclear medicine personnel are specified by the service director and approved by the medical staff.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.01

Standard Text: The hospital safely stores medications.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

8. The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 8
§482.25(b)(3) - (A-0505) - (3) Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the Radiology suite it was noted that a locked cabinet containing "rescue" drugs (for resuscitation if needed during stress testing) contained a vial of esmolol (10 mg/ml; 10 ml) that had expired.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the clean utility room of the MICU it was noted that the expiration date of several IV bags of D5 normal saline, 500 ml, had passed. The bags were still on the shelf available for use.(beyond their expiration date).

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the operating room area, it was noted in a code cart in the hall that several bags of IV (intra venous) fluids in the cart had expired dates. These included the following: lactated ringers 1000 ml expired 11-13; D5 1000 ml expired 1-14; D5W 500 ml expired 3-14.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the MRI suite it was noted that several IV bags of 0.9% NaCl were beyond their expiration dates.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.15.01.01

ESC 45 days

Standard Text: Identify patients at risk for suicide.
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Intensive Outpatient Program (2775 Executive Park, Cleveland, TN) site.
While reviewing the case record of an adult IOP client from the Cleveland site it was noted that the completed assessment did not draw any conclusions about the individual's risk of self-harm despite a suicide gesture that precipitated a recent psychiatric hospitalization.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
While reviewing the case record of an adult IOP client from the Cleveland clinic it was noted that the individual's completed suicide risk assessment did not address environmental factors that could impact on the individual's relative risk of self-harm. Nor did the assessment result in any specific conclusions about the level of risk,if any, posed by the individual.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
While reviewing the case record of an 18yr old male PHP client at the Courage Way site, it was noted that the completed suicide risk assessment did not address the impact of external factors, if any, on the individual's risk of suicide. It was noted in the record that the individual had contemplated jumping off a cliff and may have experienced hallucinations. Yet, neither were mentioned in the risk assessment.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.01

ESC 45 days

Standard Text: The hospital assesses and reassesses its patients.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires. (See also PC.01.01.01, EP 24)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 23
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The FIM scores for a post surgical patient were not entered during the initial therapy evaluation as required by hospital policy

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
While conducting tracer activities on the Telemetry Unit it was determined that during patient assessments the hospital had not gathered the data and information it required. Specifically, although the patient had been admitted through the Emergency Department with numerous health problems including two wounds on his left lower leg, there was no indication that the wounds had been assessed during the initial nursing assessment conducted when the patient was admitted to the unit. The wound component of the record had been left blank. Hospital policy PC-POL/PRO-3.040.001 states that skin and wound assessments are completed minimally on admission, every shift and as needed according to the patient's needs.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

ESC 60 days

Standard Text: The hospital plans the patient's care.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.23(b)(4) - (A-0396) - (4) 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:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
While reviewing the medical record of a patient on 4 West the surveyor noted that the nursing care plan included goals as well as the settings and services to meet those goals, however there were no timeframes identified for meeting the goals.

Observed in Record Review at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During a review of the nursing care plan in the Parkridge East NICU and an interview with nursing staff it was determined that the patient centered careplan did not include time frames within which the goals were to be achieved.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
While reviewing the written plan of care the surveyor determined that not all goals had not been based upon time frames within which they were to be achieved. Although the goals were appropriate to the settings and services required to meet them, several of them did not include a time frame. Additionally, no goals had been added to the plan for Respiratory Services although the patient was on continuous oxygen and received aerosolized medications to reduce respiratory symptoms.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
64 year old female admitted 5/6/14 for Degenerative Joint Disc Disease. For lumbar fusion. On POD 2 patient developed Acute Kidney injury secondary to Vancomycin. Patient started on dialysis. The nursing POC had problem goals but did not have patient or incident specific time frames associated with these goals.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
SICU: 77 year old female admitted to treat her recurrent bladder tumor. Coronary artery disease and bundle branch block was found during evaluation. The patient coded and was suspected to have aspirated some pills. The nursing POC had problem goals but did not have patient or incident specific time frames associated with these goals.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.02.01.03 ESC 45 days
Standard Text:	The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
Primary Priority Focus Area:	Assessment and Care/Services

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *
Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Scoring Category : A
Score : Insufficient Compliance

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.56(b) - (A-1132) - §482.56(b) Standard: Delivery of Services

Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the MRI suite, it was noted that an intubated patient had undergone an MRI scan which lasted about six hours about a month earlier. The patient was identified. On discussion with the nurse who had monitored the patient during this procedure it was learned that, although, in the ICU, the intubated patient had been receiving propofol sedation according to pump titration protocol, the pump could not be used in the MRI area and the ICU nurse had to count drops and titrate the rate of the propofol infusion up and down to keep the patient at the requested level of sedation. There was no protocol for this action which was beyond the scope of the orders.

EP 7
§482.56(b) - (A-1132) - §482.56(b) Standard: Delivery of Services

Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During review of a medical record related to tracer activity on 2 W the surveyor determined that the hospital had not provided care, treatment and services as ordered. The physician order included "routine wound care", however there was no clinical protocol or reference that described the components of routine wound care. Documentation by the nurse providing wound care indicated that Mepilex and curlex were used to dress the wound.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.11

ESC 45 days

Standard Text: Resuscitation services are available throughout the hospital.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served.
Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EPs 2 and 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Grandview Medical Center (1000 Highway 28, Jasper, TN) site.
In the ED main trauma room it was noted that two crash cart defibrillators and one T1Zoll Adult defibrillator were not checked on May 5.

Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The documentation log was incomplete for the emergency crash cart used for the open heart patients. The log had no documentation of the crash cart being checked on the weekday of 5/6/14 or the weekend of 5/4/14.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.01.07

ESC 45 days

Standard Text: The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

7. For hospitals that use Joint Commission accreditation for deemed status purposes: A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7
§482.52(b)(3) - (A-1005) - [The policies must ensure that the following are provided for each patient:]

(3) A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity on 4 East, in the chart of a patient who had undergone a right total hip replacement, it was noted that there was no 48 hour post operative anesthesia note as required by hospital policy. The surgery had been performed greater than 48 hours before this surveyor looked at the patient's chart.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity on a post surgical floor, in the chart of a patient who had undergone an incision and drainage of his left ankle, it was noted that there was no 48 hour post operative anesthesia note as required by hospital policy. The surgery had been performed greater than three days before this surveyor looked at the patient's chart.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity on 4 East, in the chart of a patient who had undergone a right total hip replacement, it was noted that the immediate post operative note by the surgeon was signed, dated, but not timed as required by hospital policy and CMS. There were several other entries in this medical chart (Medicare order form; order for PCA [patient controlled analgesia}; physician progress note) that were dated but not timed.

§482.24(c)(2) - (A-0450) - (2) 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:
Observed in Record Review at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
While review the medical record of a patient receiving services on 4 West it was noted that the anesthesia Resident had not entered the time of authentication on the post anesthesia evaluation.

Observed in Record Review at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
While reviewing the medical record of an oncology patient receiving services on 4 W it was noted that physician orders for blood cultures and an echo cardiogram did not include the time that the physician had authenticated the orders.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
77 year old female admitted to treat her recurrent bladder tumor. Coronary artery disease and bundle branch block was found during evaluation. The patient coded and was suspected to have aspirated some pills. The chart had two orders by Provider A on 5/10/14 and 5/12/14 that were signed but not timed and Provider B on 5/4/14 had two orders and 5/5/14 had a single order that were signed but not timed.

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.01.01

Standard Text: The hospital uses standardized procedures for managing tissues.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

1. The hospital assigns responsibility to one or more individuals for overseeing the acquisition, receipt, storage, and issuance of tissues throughout the hospital.
Note: Responsibility for this oversight involves coordinating efforts to provide standardized practices throughout the hospital. A hospital may have a centralized process (one department responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital) or a decentralized process (multiple departments responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Grandview Medical Center (1000 Highway 28, Jasper, TN) site.
During a tissue tracer in the OR it was noted that no specific individual had been assigned the responsibility for the acquisition, receipt, storage and issuance of tissues. Materials management received a request to order the tissue and they received the tissue and took the tissue to the OR. There was documentation that the tissue was received but there was no specific documentation for the process to manage the receipt, temperature, integrity, storage, and issuance of the tissue.

SUPPLEMENTAL #2

November 1, 2016

1:26 pm

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Behavioral Health Care Accreditation Program

August 12, 2016

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #7887
Print/Reprint Date: 08/15/2016

Mark R. Chassin, MD, FACP, MPP, MP
President

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lual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

The Joint Commission

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

November 19, 2014

Darrell Moore
President/CEO
Parkridge Medical Center, Inc.
2333 McCallie Avenue
Chattanooga, TN 37404

Joint Commission ID #: 7815
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 11/19/2014

Dear Mr. Moore:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning May 17, 2014. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Parkridge Medical Center, Inc.
2333 McCallie Avenue
Chattanooga, TN 37404

Organization Identification Number: 7815

Program(s)	**Survey Date(s)**
Hospital Accreditation Behavioral Health Care Accreditation	05/13/2014-05/16/2014

Executive Summary

Hospital Accreditation :	As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report. You will have follow-up in the area(s) indicated below: • Evidence of Standards Compliance (ESC)
Behavioral Health Care Accreditation :	As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.04.03	EP5
	EC.02.05.07	EP4,EP6
	NPSG.15.01.01	EP1
	PC.01.02.01	EP23
	PC.02.01.03	EP1,EP7
	PC.02.01.11	EP2
	PC.03.01.07	EP7

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.04.01	EP4
	IC.01.05.01	EP1
	IC.02.01.01	EP1
	IC.02.02.01	EP4
	LD.04.03.09	EP4
	LS.02.01.10	EP4
	LS.02.01.30	EP11
	MM.03.01.01	EP8
	MS.03.01.01	EP16,EP17
	PC.01.03.01	EP5
	RC.01.01.01	EP19
	TS.03.01.01	EP1

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(c)(2)	A-0144	HAP - IC.02.01.01/EP1	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: 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.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP5	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(2)	A-0450	HAP - RC.01.01.01/EP19	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(3)	A-0505	HAP - MM.03.01.01/EP8	Standard

CoP: §482.26 **Tag:** A-0528 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.26 Condition of Participation: Radiologic Services

The hospital must maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

CoP Standard	Tag	Corresponds to	Deficiency
§482.26(c)(2)	A-0547	HAP - MS.03.01.01/EP16	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP5, EC.02.05.07/EP4, EP6	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP4, LS.02.01.30/EP11	Standard

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - IC.02.01.01/EP1, IC.02.02.01/EP4

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - IC.02.02.01/EP4, IC.01.05.01/EP1	Standard

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CoP: §482.52 **Tag:** A-1000 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.52(b)(3)	A-1005	HAP - PC.03.01.07/EP7	Standard

CoP: §482.53 **Tag:** A-1026 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.53 Condition of Participation: Nuclear Medicine Services

If the hospital provides nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice.

CoP Standard	Tag	Corresponds to	Deficiency
§482.53(a)(2)	A-1029	HAP - MS.03.01.01/EP17	Standard

CoP: §482.56 **Tag:** A-1123 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.56 Condition of Participation: Rehabilitation Services

If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.

CoP Standard	Tag	Corresponds to	Deficiency
§482.56(b)	A-1132	HAP - PC.02.01.03/EP1, EP7	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. The governing body (or the persons legally responsible for the conduct of the hospital and carrying out the functions specified in this part that pertain to the governing body) must include a member, or members, of the hospital's medical staff.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(e)	A-0083	HAP - LD.04.03.09/EP4	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.01

ESC 60 days

Standard Text: The hospital manages medical equipment risks.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

4. The hospital identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current hospital experience. (See also EC.02.04.03, EPs 2 and 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The two hydroculators for hot packs and cold packs were not being cleaned every two weeks as recommended by the manufacturer's guidelines. The organization did not have a cleaning log for either machine and explained that equipment had been cleaned around every quarter. During the survey the organization had begun the process of developing a cleaning scheduling and educating the staff on the new every two week cleaning schedule.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.03

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains medical equipment.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

5. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The vendor policy for water culture acceptability was not consistent with the current AAMI levels of less than 100. The vendor the acceptable level for water cultures at the time of survey was less than 200.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.07

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains emergency power systems.
Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. At least monthly, the hospital tests each emergency generator under load for at least 30 continuous minutes. The completion dates of the tests are documented.

Scoring Category : A
Score : Insufficient Compliance

6. At least monthly, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Parkridge Valley Hospital - Adult and Senior Campus (7351 Courage Way, Chattanooga, TN) site for the Hospital deemed service.
During the document review of the generator located at the Parkridge Valley Adult Campus, it was noted that from July 2013 to January 13, 2014, the generator was tested for a duration of less than 30 minutes each month. The hospital was in compliance after January 13, 2014 for the generator's 30 minute run time.

EP 6
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Parkridge Valley Hospital - Adult and Senior Campus (7351 Courage Way, Chattanooga, TN) site for the Hospital deemed service.
During the document review of the generator located at the Parkridge Valley Adult Campus, it was noted that there were three automatic transfer switches. During the months of July, August and September 2013, only the initiating transfer switch was documented as being exercised on a monthly basis. There was no notation that the other two transfer switches had been exercised.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.01.05.01

ESC 60 days

Standard Text: The hospital has an infection prevention and control plan.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the operating room, it was noted that a surgeon in the sterile field had "gowned" and "gloved" in a sterile manner, was wearing an operating room hat, but had his mask below his chin and beard. After the time out had been completed and before the procedure (direct laryngoscopy and laryngeal biopsy) had begun, he raised his mask to cover his mouth, nose and beard. This technique does not comply with AORN standards which the hospital uses as its standard for sterile technique

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in radiology, during a CT guided biopsy of a lung mass, it was noted that the radiologist, before performing the procedure, "scrubbed", then used his cleaned hands to put on his hat, his mask, open his sterile gown. He then put on his gown and sterile gloves for the procedure. This technique does not comply with AORN standards which the hospital uses as its standard for sterile technique.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

Standard Text: The hospital implements its infection prevention and control plan.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.13(c)(2) - (A-0144) - (2) The patient has the right to receive care in a safe setting.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
In the OR it was found that on two procedure door jambs that each had multiple scratches and scrapes down to bare metal providing a surface for potential infections. In the cysto room it was noted there was a hole in the wall that also provided a surface for potential infections.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the central sterile storage area it was noted that the back of the sterilizer could be accessed from a door in sterile storage. When the door was opened it was noted that the floor under and around the sterilizer was wet and there was water dripping from the pipes. It was also noted that the brass like floor grate was corroded green and had rust. Plant operations responded immediately, cleaned the water and fixed the leaking pipes.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
In the Ultrasound and Mammography area it was found that the vaginal probe cleaning area was checked daily first thing in the morning to see if the room had a negative pressure. Per documentation it was noted that the pressure was negative daily for the last few months. However, at the time of survey the room was neutral and not negative due to the fact that the staff kept the door open during the day. This did not allow the room to maintain negative pressure.

Observed in Individual Tracer at Parkridge Valley Hospital - Adult and Senior Campus (7351 Courage Way, Chattanooga, TN) site for the Hospital deemed service.
For a patient on the senior unit, who was admitted 28 days prior to this review, it was noted that the patient was admitted with lice and scabies. When the staff was asked if infection control had been informed of this it was stated that they were notified. On further review with the ICP it was found that this report had not been submitted.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the operating room area, it was noted that a bronchoscopy was being performed in operating room 2. When a tissue (kleenex) was held at the base of the closed door between room 2 and the hall, the tissue blew away from the door, showing that the room 2 pressure was positive compared with the hall pressure. (consistent with the finding with the room pressure monitors earlier that day). During bronchoscopy, the room pressure should be negative compared with the hall pressure so that possible airborne contaminants would not be blown out into a clean area.

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The return air vents in two operating rooms in use were noted to be coated with a matted layer of dust. The matted layer of dust was demonstrated to the staff in unoccupied room 8 by scrubbing off a section of the layered dust with a damp paper towel.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01 ESC 60 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the Radiology suite, it was noted that a wire supply cart in one of the procedure rooms did not have an impervious bottom. The open structure would allow dirt and debris from the floor to contaminate items stored on the bottom shelf.

§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The Pharmacy IV Infusion prep room has three open bottom wire carts two of which had cardboard and plastic medication boxes stored on the bottom shelf.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.03.09

ESC 60 days

Standard Text: Care, treatment, and services provided through contractual agreement are provided safely and effectively.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
Note 1: In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the 'Medical Staff' (MS) chapter.
Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:
- Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.12(e) - (A-0083) - §482.12(e) Standard: Contracted Services

The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
A review of contracts by the surveyor and a discussion with the Market Director of Quality revealed that leaders had not monitored contracted services by establishing expectations for the performance of the contracted services. Specifically the contract with Surgery Pharmacy Services, Inc. did not include performance expectations nor did the contract with DCI (dialysis services).

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 1st floor at the 2-hour separation between the hospital and medical office building that the door frame had 8 small, unprotected holes.

Observed in Building Tour at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – Main, it was observed on the 3rd floor at the 2-hour separation between the hospital and the Diagnostic Center that the 90-minute rated door did not have two floor catches for the lower latching mechanisms.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

ESC 60 days

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 2nd floor at the elevator lobby that the corridor's double doors had a gap of approximately ¼- inches.

Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 2nd floor at the back door to the ICU that the corridor's double doors had a gap of approximately ¼- inches.

Observed in Building Tour at Grandview Medical Center (1000 Highway 28, Jasper, TN) site for the Hospital deemed service.
During the building tour of the Parkridge Medical Center – West, it was observed on the 2nd floor at the back door to the ICU that the double doors did not have positive latching.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.03.01.01

ESC 60 days

Standard Text: The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.

Scoring Category : A
Score : Insufficient Compliance

17. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 16
§482.26(c)(2) - (A-0547) - (2) Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.
This Standard is NOT MET as evidenced by:
Observed in Credentialing and Privileging at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The HCO did not have documentation that the medical staff had determined the qualifications of the radiology staff who use equipment and administer procedures.

EP 17
§482.53(a)(2) - (A-1029) - (2) The qualifications, training, functions and responsibilities of the nuclear medicine personnel must be specified by the service director and approved by the medical staff.
This Standard is NOT MET as evidenced by:
Observed in Credentialing and Privileging at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
The HCO could not provide documentation that the qualifications, training, functions and responsibilities of the nuclear medicine personnel are specified by the service director and approved by the medical staff.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.01

Standard Text: The hospital safely stores medications.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

8. The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 8
§482.25(b)(3) - (A-0505) - (3) Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the Radiology suite it was noted that a locked cabinet containing "rescue" drugs (for resuscitation if needed during stress testing) contained a vial of esmolol (10 mg/ml; 10 ml) that had expired.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the clean utility room of the MICU it was noted that the expiration date of several IV bags of D5 normal saline, 500 ml, had passed. The bags were still on the shelf available for use.(beyond their expiration date).

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the operating room area, it was noted in a code cart in the hall that several bags of IV (intra venous) fluids in the cart had expired dates. These included the following: lactated ringers 1000 ml expired 11-13; D5 1000 ml expired 1-14; D5W 500 ml expired 3-14.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the MRI suite it was noted that several IV bags of 0.9% NaCl were beyond their expiration dates.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.15.01.01

Standard Text: Identify patients at risk for suicide.
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Intensive Outpatient Program (2775 Executive Park, Cleveland, TN) site.
While reviewing the case record of an adult IOP client from the Cleveland site it was noted that the completed assessment did not draw any conclusions about the individual's risk of self-harm despite a suicide gesture that precipitated a recent psychiatric hospitalization.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
While reviewing the case record of an adult IOP client from the Cleveland clinic it was noted that the individual's completed suicide risk assessment did not address environmental factors that could impact on the individual's relative risk of self-harm. Nor did the assessment result in any specific conclusions about the level of risk,if any, posed by the individual.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
While reviewing the case record of an 18yr old male PHP client at the Courage Way site, it was noted that the completed suicide risk assessment did not address the impact of external factors, if any, on the individual's risk of suicide. It was noted in the record that the individual had contemplated jumping off a cliff and may have experienced hallucinations. Yet, neither were mentioned in the risk assessment.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.01

ESC 45 days

Standard Text: The hospital assesses and reassesses its patients.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

23. During patient assessments and reassessments, the hospital gathers the data and information it requires. (See also PC.01.01.01, EP 24)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 23
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The FIM scores for a post surgical patient were not entered during the initial therapy evaluation as required by hospital policy

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site.
While conducting tracer activities on the Telemetry Unit it was determined that during patient assessments the hospital had not gathered the data and information it required. Specifically, although the patient had been admitted through the Emergency Department with numerous health problems including two wounds on his left lower leg, there was no indication that the wounds had been assessed during the initial nursing assessment conducted when the patient was admitted to the unit. The wound component of the record had been left blank. Hospital policy PC-POL/PRO-3.040.001 states that skin and wound assessments are completed minimally on admission, every shift and as needed according to the patient's needs.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

ESC 60 days

Standard Text: The hospital plans the patient's care.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.23(b)(4) - (A-0396) - (4) 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:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
While reviewing the medical record of a patient on 4 West the surveyor noted that the nursing care plan included goals as well as the settings and services to meet those goals, however there were no timeframes identified for meeting the goals.

Observed in Record Review at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During a review of the nursing care plan in the Parkridge East NICU and an interview with nursing staff it was determined that the patient centered careplan did not include time frames within which the goals were to be achieved.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
While reviewing the written plan of care the surveyor determined that not all goals had not been based upon time frames within which they were to be achieved. Although the goals were appropriate to the settings and services required to meet them, several of them did not include a time frame. Additionally, no goals had been added to the plan for Respiratory Services although the patient was on continuous oxygen and received aerosolized medications to reduce respiratory symptoms.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
64 year old female admitted 5/6/14 for Degenerative Joint Disc Disease. For lumbar fusion. On POD 2 patient developed Acute Kidney injury secondary to Vancomycin. Patient started on dialysis. The nursing POC had problem goals but did not have patient or incident specific time frames associated with these goals.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
SICU: 77 year old female admitted to treat her recurrent bladder tumor. Coronary artery disease and bundle branch block was found during evaluation. The patient coded and was suspected to have aspirated some pills. The nursing POC had problem goals but did not have patient or incident specific time frames associated with these goals.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.03 ESC 45 days

Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *
Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

Scoring Category : A
Score : Insufficient Compliance

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.56(b) - (A-1132) - §482.56(b) Standard: Delivery of Services

Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity in the MRI suite, it was noted that an intubated patient had undergone an MRI scan which lasted about six hours about a month earlier. The patient was identified. On discussion with the nurse who had monitored the patient during this procedure it was learned that, although, in the ICU, the intubated patient had been receiving propofol sedation according to pump titration protocol, the pump could not be used in the MRI area and the ICU nurse had to count drops and titrate the rate of the propofol infusion up and down to keep the patient at the requested level of sedation. There was no protocol for this action which was beyond the scope of the orders.

EP 7
§482.56(b) - (A-1132) - §482.56(b) Standard: Delivery of Services

Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During review of a medical record related to tracer activity on 2 W the surveyor determined that the hospital had not provided care, treatment and services as ordered. The physician order included "routine wound care", however there was no clinical protocol or reference that described the components of routine wound care. Documentation by the nurse providing wound care indicated that Mepilex and curlex were used to dress the wound.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.11

ESC 45 days

Standard Text: Resuscitation services are available throughout the hospital.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

2. Resuscitation equipment is available for use based on the needs of the population served.
Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EPs 2 and 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Grandview Medical Center (1000 Highway 28, Jasper, TN) site.
In the ED main trauma room it was noted that two crash cart defibrillators and one T1Zoll Adult defibrillator were not checked on May 5.

Observed in Tracer Activities at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site.
The documentation log was incomplete for the emergency crash cart used for the open heart patients. The log had no documentation of the crash cart being checked on the weekday of 5/6/14 or the weekend of 5/4/14.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.01.07

ESC 45 days

Standard Text: The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

7. For hospitals that use Joint Commission accreditation for deemed status purposes: A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7
§482.52(b)(3) - (A-1005) - [The policies must ensure that the following are provided for each patient:]

(3) A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity on 4 East, in the chart of a patient who had undergone a right total hip replacement, it was noted that there was no 48 hour post operative anesthesia note as required by hospital policy. The surgery had been performed greater than 48 hours before this surveyor looked at the patient's chart.

Observed in Individual Tracer at Parkridge East Hospital (941 Spring Creek Road, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity on a post surgical floor, in the chart of a patient who had undergone an incision and drainage of his left ankle, it was noted that there was no 48 hour post operative anesthesia note as required by hospital policy. The surgery had been performed greater than three days before this surveyor looked at the patient's chart.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C

Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
During tracer activity on 4 East, in the chart of a patient who had undergone a right total hip replacement, it was noted that the immediate post operative note by the surgeon was signed, dated, but not timed as required by hospital policy and CMS. There were several other entries in this medical chart (Medicare order form; order for PCA [patient controlled analgesia}; physician progress note) that were dated but not timed.

§482.24(c)(2) - (A-0450) - (2) 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:
Observed in Record Review at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
While review the medical record of a patient receiving services on 4 West it was noted that the anesthesia Resident had not entered the time of authentication on the post anesthesia evaluation.

Observed in Record Review at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
While reviewing the medical record of an oncology patient receiving services on 4 W it was noted that physician orders for blood cultures and an echo cardiogram did not include the time that the physician had authenticated the orders.

Observed in Individual Tracer at Parkridge Medical Center (2333 McCallie Avenue, Chattanooga, TN) site for the Hospital deemed service.
77 year old female admitted to treat her recurrent bladder tumor. Coronary artery disease and bundle branch block was found during evaluation. The patient coded and was suspected to have aspirated some pills. The chart had two orders by Provider A on 5/10/14 and 5/12/14 that were signed but not timed and Provider B on 5/4/14 had two orders and 5/5/14 had a single order that were signed but not timed.

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.01.01

ESC 60 days

Standard Text: The hospital uses standardized procedures for managing tissues.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

1. The hospital assigns responsibility to one or more individuals for overseeing the acquisition, receipt, storage, and issuance of tissues throughout the hospital.
Note: Responsibility for this oversight involves coordinating efforts to provide standardized practices throughout the hospital. A hospital may have a centralized process (one department responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital) or a decentralized process (multiple departments responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Grandview Medical Center (1000 Highway 28, Jasper, TN) site.
During a tissue tracer in the OR it was noted that no specific individual had been assigned the responsibility for the acquisition, receipt, storage and issuance of tissues. Materials management received a request to order the tissue and they received the tissue and took the tissue to the OR. There was documentation that the tissue was received but there was no specific documentation for the process to manage the receipt, temperature, integrity, storage, and issuance of the tissue.

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

TRISTAR SKYLINE MEDICAL CENTER
(INCLUDES MADISON BEHAVIORAL HEALTH)

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

Official Accreditation Report

TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

Organization Identification Number: 7887

Evidence of Standards Compliance (60 Day) Submitted: 10/24/2016

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Executive Summary

Program(s)	**Submit Date**
Hospital Accreditation	10/24/2016

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Program	Standard	Level of Compliance
HAP	EC.02.01.01	Compliant
HAP	EC.02.02.01	Compliant
HAP	EC.02.04.03	Compliant
HAP	EC.02.06.01	Compliant
HAP	IC.01.05.01	Compliant
HAP	IC.02.01.01	Compliant
HAP	LS.02.01.10	Compliant
HAP	LS.02.01.30	Compliant
HAP	LS.02.01.35	Compliant
HAP	LS.02.01.70	Compliant
HAP	MS.12.01.01	Compliant
HAP	PC.01.02.01	Compliant
HAP	RC.01.01.01	Compliant
HAP	RI.01.03.01	Compliant
HAP	TS.03.02.01	Compliant
HAP	WT.05.01.01	Compliant

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Compliant
§482.24(c)(4)(v)	A-0466	HAP - RI.01.03.01/EP13	Compliant

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.02.01/EP12, EC.02.06.01/EP1	Compliant
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP3	Compliant
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP5, EP9, LS.02.01.30/EP2, EP11, EP23, LS.02.01.35/EP4, EP6, LS.02.01.70/EP1	Compliant

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Compliant

Corresponds to: HAP - IC.02.01.01/EP1

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

Official Accreditation Report

TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

Organization Identification Number: 7887

Evidence of Standards Compliance (45 Day) Submitted: 9/26/2016

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Executive Summary

Program(s)	**Submit Date**
Hospital Accreditation	9/26/2016

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Program	Standard	Level of Compliance
HAP	EC.02.05.01	Compliant
HAP	EC.02.05.05	Compliant
HAP	EC.02.05.09	Compliant
HAP	IC.02.02.01	Compliant
HAP	LS.02.01.20	Compliant
HAP	MM.04.01.01	Compliant
HAP	PC.02.01.03	Compliant
HAP	PC.02.02.03	Compliant
HAP	PC.03.05.11	Compliant
HAP	RC.02.01.03	Compliant
HAP	TS.03.01.01	Compliant

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(14)	A-0182	HAP - PC.03.05.11/EP1	Compliant

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.23 Condition of Participation: 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.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(3)	A-0406	HAP - MM.04.01.01/EP13	Compliant

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.05.05/EP3, EC.02.05.09/EP1	Compliant
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP1, EP32	Compliant

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Compliant

Corresponds to: HAP - EC.02.05.01/EP15

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP Standard	Tag	Corresponds to	Deficiency
§482.42(a)	A-0748	HAP - IC.02.02.01/EP2	Compliant

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(6)	A-0959	HAP - RC.02.01.03/EP7	Compliant

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Official Accreditation Report

TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

Organization Identification Number: 7887

Unannounced Full Event: 8/9/2016 - 8/12/2016

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. (*Please Note: if your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.*) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation Behavioral Health Care Accreditation	08/09/2016-08/12/2016

Hospital Accreditation :	As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report. You will have follow-up in the area(s) indicated below: • Evidence of Standards Compliance (ESC)
Behavioral Health Care Accreditation :	As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. (*Please Note: if your survey event resulted in a Preliminary Denial of Accreditation status, your timeframe for ESC completion will be 45 days.*) The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site (For those with a Preliminary Denial of Accreditation decision: DIRECT and INDIRECT Impact Standards Compliance are due within 45 days):

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.01	EP15
	EC.02.05.05	EP3
	EC.02.05.09	EP1
	IC.02.02.01	EP2
	LS.02.01.20	EP1,EP32
	MM.04.01.01	EP13
	PC.02.01.03	EP7
	PC.02.02.03	EP11
	PC.03.05.11	EP1
	RC.02.01.03	EP7
	TS.03.01.01	EP5,EP6,EP7

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.01.01	EP14
	EC.02.02.01	EP12
	EC.02.04.03	EP3

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

EC.02.06.01	EP1
IC.01.05.01	EP1
IC.02.01.01	EP1
LS.02.01.10	EP5,EP9
LS.02.01.30	EP2,EP11,EP23
LS.02.01.35	EP4,EP6
LS.02.01.70	EP1
MS.12.01.01	EP2
PC.01.02.01	EP1
RC.01.01.01	EP19
RI.01.03.01	EP13
TS.03.02.01	EP7
WT.05.01.01	EP4

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(14)	A-0182	HAP - PC.03.05.11/EP1	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: 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.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(3)	A-0406	HAP - MM.04.01.01/EP13	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(4)(v)	A-0466	HAP - RI.01.03.01/EP13	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.02.01/EP12, EC.02.06.01/EP1	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP3, EC.02.05.05/EP3, EC.02.05.09/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP5, EP9, LS.02.01.20/EP1, EP32, LS.02.01.30/EP2, EP11, EP23, LS.02.01.35/EP4, EP6, LS.02.01.70/EP1	Standard

CoP: §482.42 **Tag:** A-0747 **Deficiency:** Standard

Corresponds to: HAP - IC.02.01.01/EP1, EC.02.05.01/EP15

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP Standard	Tag	Corresponds to	Deficiency
§482.42(a)	A-0748	HAP - IC.02.02.01/EP2	Standard

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(6)	A-0959	HAP - RC.02.01.03/EP7	Standard

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.01.01

ESC 60 days

Standard Text: The hospital manages safety and security risks.

Element(s) of Performance:

14. The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following:
- Patients who may experience claustrophobia, anxiety, or emotional distress
- Patients who may require urgent or emergent medical care
- Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel)
- Ferromagnetic objects entering the MRI environment
- Acoustic noise

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 14

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. The fire extinguisher immediately adjacent to the MRI control rooms had ferrous components, including the pull pin, top handle, and wire that attached the inspection tag to the extinguisher, as determined by a magnet MRI staff use to check equipment. These ferrous items would present a hazard in a magnetic environment.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

ESC 60 days

Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

12. The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * (See also IC.02.01.01, EP 6)
Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 12
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

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:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
During the building tour in the Ultrasound department it was noted that staff would discard, into a general trash receptacle, used protective coverings and other supplies utilized in the performance of transvaginal ultrasounds. As these used supplies would possess potentially-infectious material, from the performance of the transvaginal ultrasound, such contaminated supplies need to be discarded into a biohazard-labeled container.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
During a demonstration of the reprocessing of transvaginal ultrasound probes it was noted that the used (potentially infectious) probes were transported from the procedure room to the reprocessing room without being placed in a closed, covered, biohazard-labeled container.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.03

ESC 60 days

Standard Text: The hospital inspects, tests, and maintains medical equipment.

Element(s) of Performance:

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3. The hospital inspects, tests, and maintains non–high-risk equipment identified on the medical equipment inventory. These activities are documented. (See also EC.02.04.01, EPs 2 and 4)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 3
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
During the building tour it was noted that a Viking Hoyer Lift did not possess a preventative maintenance sticker and was subsequently found to have not been listed on the organization's Preventative Maintenance spread sheet. As such, it was not undergoing required preventative maintenance.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
During the building tour it was noted that two hand-held pulse oximetry units did not possess a preventative maintenance sticker and were subsequently found to have not been listed on the organization's PM spread sheet of non-critical medical equipment. As such, they were not undergoing required preventative maintenance.

Observed in Tracer Activities at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
Preventative maintenance documentation was requested on the Madonna Elliptical machine located in the Inpatient Rehabilitation gym. It was learned that this piece of equipment was not on the medical equipment inventory and had not had entry testing or PMs. This was corrected on-site as soon as the issue was identified.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.05.01

ESC 45 days

Standard Text: The hospital manages risks associated with its utility systems.
Element(s) of Performance:

15. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, relative humidity, and temperature. (See also EC.02.06.01, EP 13 and EC.02.06.05, EP 1)
Note: Areas designed for control of airborne contaminants include spaces such as all classes of operating rooms, special procedure rooms that require a sterile field, caesarean delivery rooms, rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, airborne infection isolation rooms, rooms for patients with pulmonary or laryngeal tuberculosis, bronchoscopy treatment rooms), patients in 'protective environment' rooms (for example, rooms for patients receiving bone marrow transplants), laboratories, pharmacies, sterile supply/processing rooms, and other sterile spaces. For further information, refer to Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 15
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 1 of 3 pressure differential checks, the appropriate pressure relationship was not observed. The central sterile processing sterile storage room on the 1st floor was observed to have a strong negative pressure relationship with respect to the corridor as determined by a tissue flutter test at the entry door to this room. The cause was determined to be related to an incorrect VAV setting. The hospital was able to correct this deficiency during the survey and the correct pressure differential (positive) for this area was verified.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.05.05

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains utility systems.
Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.

Element(s) of Performance:

3. The hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2 and 4)
Note: High-risk utility system components includes life-support utility system components.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
The electric fire pump at the Madison Campus was not properly maintained as indicated by heavy corrosion at the pump base and casing. The in-board packing gland drain cup was not draining and thus standing water was observed in the drain cup and pump base. This was one of two fire pumps at this location that served 95% of the hospital.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems.
Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Element(s) of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 2 of 12 medical gas and vacuum area alarm panel checks, alarm panels were not labeled to indicate the room(s) served. Two (2) medical gas and vacuum area alarm panels at the OR nurse station each monitored oxygen, medical air, vacuum, nitrous, nitrogen, and carbon dioxide; however, both panels were only labeled "Surgery", and not the specific ORs each panel monitored. Twelve ORs were present.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01

ESC 60 days

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

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:

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
During the building tour in the Geri-Psych unit it was noted that a relocatable power tap (RPT) was in use within 6 feet of patient-care activities. While the organization did possess the CMS waiver allowing use of RPTs, the organization was not following all of the requirements associated with that waiver such as ensuring that any unused receptacles were covered.

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
During tracer activity and tour of the surgical suite, access to an electrical panel in operating room # 5 was noted to be obstructed by several pieces of equipment positioned directly in front of the panel. This saturation was immediately corrected when observed.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
An unsecured "H" sized helium cylinder was observed standing upright in the gift shop storage room.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.01.05.01

ESC 60 days

Standard Text: The hospital has an infection prevention and control plan.

Element(s) of Performance:

1. When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

SUPPLEMENTAL #2

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EP 1

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. During tracer activity and tour of the surgical suite and sterile processing areas, it was noted that the organization was using open wire baskets to contain instruments that required immediate use sterilization. The scrub nurse had to come out of the operating room into the central corridor (a "sub sterile" storage area) to retrieve the basket from the sterilizer and then return to the sterile field in the OR. Current AAMI and ST-79 recommendations were that instruments requiring immediate use sterilization should be processed in closed containers that can be brought into the OR by a circulating nurse and opened on a back table adjacent to the sterile field. This would obviate the need for the scrub nurse to compromise sterility by exiting the operative field to go into the adjacent room to retrieve the pan.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

ESC 60 days

Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
The edge of the mat covering the physical therapy treatment table in the Inpatient Rehabilitation gym was worn along an full side of the table exposing the fabric underlining. This prevented adequate cleaning of the table between patient use.

Observed in Tracer Activities at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
A rolling seat in the Physical Therapy gym on 3rd floor had tears in the covering exposing the foam padding beneath. This prevented adequate cleaning of this item located in a patient care setting.

Observed in Tracer Activities at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 27 of 31 opportunities to document the final rinse temperature for the main kitchen dishwasher dinner cycles for the month of May, the temperature was missing or below the required 180 degrees. There was no evidence of corrective action taken other than education of the responsible staff member.

Observed in Tracer Activities at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 9 of 30 opportunities to document the final rinse temperature for the main kitchen dishwasher dinner cycle for the month of June, the final rinse temperature was below the required 180 degrees with no documentation of corrective action taken.

Observed in Tracer Activities at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 19 of 31 opportunities to document the final rinse temperature for the main kitchen dishwasher dinner cycle for the month of July, the temperature did not meet the required 180 degrees. No documentation of any corrective action was present.

Chapter:	Infection Prevention and Control
Program:	Hospital Accreditation
Standard:	IC.02.02.01 ESC 45 days
Standard Text:	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.
Element(s) of Performance:	

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.42(a) - (A-0748) - §482.42(a) Standard: Organization and Policies

(a) Standard: Organization and policies. A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. 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:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
During the building tour in the Wound Care Center it was noted that reusable surgical instruments did not receive pre-cleaning, to include application of an enzymatic cleaning agent; had not been stored prior to transport in an open state (if applicable) and remained wet until transported to central sterile; and were not transported to central sterile in a closed, covered, biohazard-labeled container.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
During the building tour in the Sleep Center it was noted that reusable medical equipment was not transported to central sterile for reprocessing in a closed, covered, biohazard-labeled container.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
During the building tour in the Sleep Center it was noted that reusable medical equipment was being cleaned with a reusable brush. This brush did not undergo cleaning at the end of each day (or discarded) but was simply stored in a cabinet for future use.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10

ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)

Scoring Category : C
Score : Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 2 of 33 fire rated door checks, improper hardware was installed on the fire rated door. The 90-minute fire rated door to Stair #2 on the 5th floor and Stair #4 on the 1st floor did not have approved fire exit hardware as required by NFPA 101-2012, 7.2.1.7.2. These doors were equipped with panic hardware with a dog-down feature to retract the latch and thus disable the door's positive latch function.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 1 of 33 fire rated door checks, the door did not close completely. One door leaf of the 90-minute fire rated door pair by Radiology Room #6 on the 1st floor did not close completely due to the door binding on the door frame.

EP 9
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 2 of 5 fire barrier wall checks, penetrations were not properly sealed with an approved fire stop system. An electrical back box had become dislodged from the 4-hour fire rated occupancy separation wall on 6 West, resulting in a 4-inch hole in this wall. A 3/4-inch cable sleeve had become dislodged from the 2-hour fire rated wall at Stair #2 on 2 West, resulting in a hole in this wall.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

Scoring Category : A
Score : Insufficient Compliance

32. The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101 -2000: 18/19.2.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
The door to Stair #4 on the 3rd floor was indicated as an exit and was locked in the direction of egress. This door was equipped with a delayed egress magnetic lock; however, there was no "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign on the door adjacent to the releasing device as required by NFPA 101-2012, 7.2.1.6.1.1(4).

EP 32

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
The door to Stair #1 on the 3rd floor was indicated as an exit and was locked in the direction of egress. This door was equipped with a delayed egress magnetic lock. The "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign on the door was not on a contrasting background as required by NFPA 101-2012, 7.2.1.6.1.1(4). The sign had red letters with a transparent background on a cherry wood door.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
The door to Stair #2 on the 3rd floor was indicated as an exit and was locked in the direction of egress. This door was equipped with a delayed egress magnetic lock. The "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign on the door was not on a contrasting background as required by NFPA 101-2012, 7.2.1.6.1.1(4). The sign had red letters with a transparent background on a cherry wood door.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
The door to Stair #3 on the 3rd floor was indicated as an exit and was locked in the direction of egress. This door was equipped with a delayed egress magnetic lock. The "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign on the door was not on a contrasting background as required by NFPA 101-2012, 7.2.1.6.1.1(4). The sign had red letters with a transparent background on a cherry wood door.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

ESC 60 days

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following:
Boiler/fuel-fired heater rooms

- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.

Central/bulk laundries larger than 100 square feet
- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.

Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)
- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.

Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)
- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)

Maintenance repair shops
- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at

least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)
- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Paint shops that are not severe hazard areas
- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Soiled linen rooms
- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Storage rooms
- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
Trash collection rooms
- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Scoring Category : C
Score : Insufficient Compliance

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door.
(For full text and any exceptions, refer to NFPA 101 -2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Partial Compliance

23. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 2
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
In 3 of 25 hazardous rooms, checked during the building tour, it was noted that ceiling tiles were missing. This could compromise the effectiveness of the fire suppression system in these rooms.

Observed in Tracer Activities at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
In three instances in the Geri-Psych unit it was noted that escutcheon plates in hazardous rooms had gaps of greater than 1/8 inch. This could compromise the functionality of the associated sprinkler in the event of a fire.

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
The corridor door to the 3rd floor Acute "B" kitchen at the Madison Campus was a dutch door that did not have an astragal, rabbet, or bevel at the meeting edges of the upper and lower leaves as required by NFPA 101-2012, 19.3.6.3.13(2). In addition, the gap was greater than 1/8-inch.

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
The corridor door to the 1st floor Geriatric Psych unit medication room at the Madison Campus was a dutch door that did not have an astragal, rabbet, or bevel at the meeting edges of the upper and lower leaves as required by NFPA 101-2012, 19.3.6.3.13(2). In addition, the gap was greater than 1/8-inch.

EP 23

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 3 of 29 smoke barrier door checks, the gap between meeting edges of door pairs was greater than 1/8-inch. The smoke barrier door pair in the 1st floor OR corridor across from the nurse station had a 3/8-inch gap, to OR #12 had a 1/4-inch gap, and across from the darkroom had a 3/8-inch gap, between the meeting edges of the door pair.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

ESC 60 days

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)

Scoring Category : C
Score : Partial Compliance

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
The fire sprinkler pipe above the ceiling in the 4 West corridor by the entry to MOB was used to support the suspended ceiling grid. The grid was attached to the sprinkler pipe with a wire. This wire was disconnected from the sprinkler pipe at the time of the observation.

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
The fire sprinkler pipe above the ceiling in the 1st floor OR corridor was used to support electrical conduit. The conduit was attached to the sprinkler pipe with a rod and clamp. This rod and clamp were disconnected from the sprinkler pipe at the time of the observation.

EP 6
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
Two (2) obstructed fire sprinklers were observed in the ER nurse station where CareFusion equipment was located directly below these sprinklers with less than 18-inches clearance below the deflector (13-inches clear).

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
Fire sprinklers were observed in the Madison Campus Plant Ops area where equipment shelves were located directly below these sprinklers with less than 18-inches clearance below the deflector (5-inches clear).

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.70

Standard Text: The hospital provides and maintains operating features that conform to fire and smoke prevention requirements.

Element(s) of Performance:

1. The hospital prohibits all combustible decorations that are not flame retardant. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.7.5.4)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 3 of 5 locations surveyed, it was noted that seasonal decorations lacked evidence that they were fire retardant.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.12.01.01

Standard Text: All licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education.

Element(s) of Performance:

2. These activities relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2

Observed in Regulatory Review at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. In 2 of 4 physician files reviewed for documentation of education on the organizations restraint policy, no evidence of the training was found in the file.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.04.01.01

ESC 45 days

Standard Text: Medication orders are clear and accurate.

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 13
§482.23(c)(3) - (A-0406) - (3) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
In 3 of 4 patient records reviewed, on the Adolescent and Acute-B units it was noted that the orders for medications contained two or more medications ordered for the identical therapeutic indication. Examples consisted of both MOM and Colace ordered prn for constipation; Tylenol ordered for pain of 1-3 and Motrin ordered prn for pain (therefore could be administer for a pain level of 1-3); Cogentin ordered both PO and IM prn for EPS; Phenergan ordered both po and rectal prn for vomiting; and, Motrin ordered prn for pain (could be administered for back pain) with Methyl Salicylate ordered prn for back pain.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.01

Standard Text: The hospital assesses and reassesses its patients.

Element(s) of Performance:

1. The hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. (See also RC.02.01.01, EP 2)
Note 1: In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.
Note 2: Assessment and reassessment information includes the patient's perception of the effectiveness of, and any side effects related to, his or her medication(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. During individual. tracer activity in the Emergency Department the record of a patient who had been admitted with exacerbation of COPD and in respiratory distress was reviewed. The initial nursing assessment did not include documentation of an evaluation of the patient's breath sounds as provided in the computer assessment. Nursing staff accompanying the surveyor agreed that this documentation field should have been completed.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.03

ESC 45 days

Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Element(s) of Performance:

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. The medical record of an ICU patient on continuous IV sedation with propofol was reviewed. The physician's order called for the drip to start at 5 mcg/kg/min and to titrate by 5 mcgs every 5 minutes to a Richmond Agitation Sedation Score (RASS) of -1. The drip was initiated at 25 mcg/kg/min, and on three occasions during a 48 hour period reviewed, the drip was titrated by more than 5 mcg/kg/min. Those instances showed a documented change in drip rate of 25 mcg, 15 mcg, and 15 mcg. Additionally, on two of those occasions there was no indication for the rate change as the RASS was documented at the goal of -1 before the drip rate was adjusted.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.02.03

ESC 45 days

Standard Text: The hospital makes food and nutrition products available to its patients.

Element(s) of Performance:

11. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11

Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. In 4 of 9 days in the month of August 2016, it was noted that the recorded temperature for the patient-nutrition refrigerator exceeded the maximum allowed temperature and there was no documented evidence of any corrective action having occurred as is required by the hospital instructions located on the temperature log.

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site. During the building tour on the Adolescent unit it was noted that the temperature log for the patient-nutrition freezer was documented as being out of range on 2 of 9 days in the month of August 2016 with no evidence that corrective action, as proscribed by the temperature log, had occurred.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.05.11

ESC 45 days

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.
Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.
Note 2: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.13(e)(14) - (A-0182) - (14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) as soon as possible after the completion of the 1 hour face-to-face evaluation. This Standard is NOT MET as evidenced by:

Observed in Regulatory Review at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 2 of 2 closed medical records reviewed for patients who had been in restraints for violent behavior, there was no documentation within the record of the face-to-face assessment.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 3 of 3 patient records reviewed, during tracer activities in the Wound Care unit it was noted that medical forms (such as consents) were signed by patients and/or staff but were lacking the time when they were signed.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.01.03

Standard Text: The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

Element(s) of Performance:

7. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 7
§482.51(b)(6) - (A-0959) - (6) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.
This Standard is NOT MET as evidenced by:

Observed in Record Review at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site for the Hospital deemed service.
In 2 of 4 patient records reviewed, regarding surgical procedures performed by podiatrists, there was no immediate post procedure progress note documented following the operation as required by medical staff policy.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01

ESC 60 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Element(s) of Performance:

13. Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery. (See also RC.02.01.01, EP 4)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 13
§482.24(c)(4)(v) - (A-0466) - [All records must document the following, as appropriate:]

(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site for the Hospital deemed service.
In 2 of 2 patient records reviewed, it was noted that for patients admitted to the Geri-Psych unit informed consent documents had not been completed by the 8th day of hospitalization and treatment.

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.01.01

Standard Text: The hospital uses standardized procedures for managing tissues.

Element(s) of Performance:

5. The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.

Scoring Category : A
Score : Insufficient Compliance

6. The hospital documents the receipt of all tissues. (See also TS.03.02.01, EPs 3 and 6)

Scoring Category : C
Score : Insufficient Compliance

7. The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. (See also TS.03.02.01, EP 6)
Note 1: If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame.
Note 2: Tissues requiring no greater control than 'ambient temperature' (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 5

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. In 3 of 3 patient records reviewed, of patients who had received biological tissue that needed to be reconstituted prior to use there was no documentation of the reconstitution agent, its lot number nor its expiration date.

EP 6

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. In 3 of 3 patient records reviewed, of patients who had received biological tissue there was no documentation of the receipt of the respective tissue products by the organization (date, time, manner of receipt) subsequently used on the patients.

EP 7

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. In 3 of 3 patient records reviewed, there was no documentation, for the tissues utilized on these patients, of verification at the time of receipt that the package integrity had been met and that transport temperature range was controlled and acceptable for tissues requiring a controlled environment.

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.02.01

ESC 60 days

Standard Text: The hospital traces all tissues bi-directionally.

Element(s) of Performance:

7. The hospital completes and returns tissue usage information cards requested by the tissue supplier. *

Footnote *: According to the Health Insurance Portability and Accountability Act (HIPAA) regulations regarding protected health information, 'A covered entity may disclose protected health information for public health activities or other purposes to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for the following purposes:
- To track products if the disclosure is made to a person required or directed by the FDA to track the product
- To enable product recalls, repairs or replacement (including locating and notifying individuals who have received products of product recalls, withdrawals, or other problems' (Refer to 45 CFR 164.512(b)(1)(iii)(B) and (C))

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7

Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike, Nashville, TN) site. In 3 of 3 patient records reviewed, there was no documentation that the organization had completed and returned the tissue usage information cards requested by the tissue supplier or in another way had notified the tissue procurement organization of which patient had received the specific lot of tissue.

Chapter: Waived Testing

Program: Hospital Accreditation

Standard: WT.05.01.01

ESC 60 days

Standard Text: The hospital maintains records for waived testing.

Element(s) of Performance:

4. Individual test results for waived testing are associated with quality control results and instrument records.
Note: A formal log is not required, but a functional audit trail is maintained that allows retrieval of individual test results and their association with quality control and instrument records.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4

Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive, Madison, TN) site. During the building tour on the Geri-Psych unit it was noted that the quality control analytes possessed dates that were either unreadable or were showing that the analyte was expired. As such, any individual test results performed in association with the expired analytes could not be verified as to quality.

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.03.01	EP1
	HR.01.02.05	EP5
	IC.02.02.01	EP4
	LS.02.01.20	EP13
	LS.02.01.34	EP4
	LS.02.01.35	EP5,EP14
	LS.02.01.50	EP9
	MM.03.01.01	EP2
	MM.05.01.07	EP2
	PC.01.02.03	EP5
	RC.02.01.03	EP3,EP5
Program:	Behavioral Health Care Accreditation Program	
Standards:	CTS.03.01.03	EP1

Opportunities for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.03.01
Standard Text: The hospital manages fire risks.

Element(s) of Performance:

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive,Madison,TN) site.
In 1of 3 above ceiling checks, an open electrical junction box with exposed electrical wires was observed.
An open junction box was observed above the ceiling in the Madison Campus 3rd floor Acute A Day Room.
This was corrected at the time of the observation.

Chapter: Human Resources
Program: Hospital Accreditation
Standard: HR.01.02.05
Standard Text: The hospital verifies staff qualifications.

Element(s) of Performance:

5. Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in HR File Review at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site.
In 1of 9 HR health files reviewed for staff required to have annual fit testing, documentation showed that no testing had been done since October of 2014 for a contracted EVS employee. The review date was in August of 2016.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site. During tracer activity in the surgical suite, an empty operating room was visited. The room was ready for an upcoming case. An endotracheal tube as noted on the anesthesia cart under a green towel. The peel pack had been opened, and a syringe had been attached to the air vent. Hospital policy was that equipment should be "readily available but not opened" prior to a case. It was not clear when the tube had been opened or when the next anticipated case would occur. The tube should not have been stored opened prior to use.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101 -2000: 7.1.10.1)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP13
Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site. The exit access corridor at the back of the ORs was obstructed by surgical equipment and supplies stored on both sides along the entire length of the corridor such that an 8-foot corridor was reduced to 5-foot clearance.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.34

Standard Text: The hospital provides and maintains fire alarm systems.

Element(s) of Performance:

4. The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2000: 18/19.3.4.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site. During the building tour in the Radiation Oncology unit it was noted that access to the emergency fire pull station, located in the patient waiting room, was blocked with patient seating furniture.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

14. The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2000: 18/19.3.5.

Scoring Category : C
Score : Satisfactory Compliance

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP14
Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive,Madison,TN) site.
Fire sprinkler heads in wrong orientation were observed in the the Madison Campus kitchen where three (3) pendant sprinkler heads were installed in the upright position.
EP5
Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive,Madison,TN) site.
The cafeteria at the Madison Campus had a concealed fire sprinkler cover plate by the soda fountain that was caulked to the ceiling tile, and thus covered the air gap between the ceiling and the cover plate. This air gap is necessary for proper operation of the sprinkler and must not be covered or sealed.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.50

Standard Text: The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

9. All linen and waste chute inlet and discharge service doors have both self-closing and positive latching devices.
Note: Discharge doors may be held open with fusible links or electrical hold-open devices. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.5.4.1 and 8.2.3.2.3.1; NFPA 82-1999: 3-2.2.9)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP9
Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive,Madison,TN) site.
In 1of 3 linen chute door checks, the chute door was obstructed. A tall linen cart was located at the mouth of the soiled linen chute discharge such that it would block the discharge door, normally held open by a fusible link, from closing and latching if the door was released. The cart was removed at the time of the observation.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.01

Standard Text: The hospital safely stores medications.

Element(s) of Performance:

2. The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.
Note: This element of performance is also applicable to sample medications.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Building Tour at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site. During the building tour in the Imaging department it was noted that oral Barium Contrast solution for patient-care use was stored in a refrigerator at 35-40 degrees F. The manufacturer's instructions for use stated that this product is to be stored at a temperature of 68-77 degrees F.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.07

Standard Text: The hospital safely prepares medications.

Element(s) of Performance:

2. Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Building Tour at Skyline Madison Campus (500 Hospital Drive,Madison,TN) site.
During the building tour on the Geri-Psych unit it was noted that a Silent Knight pill crusher that was utilized to crush medications for patients on this unit was contaminated with dirt/dust and possessed residue of crushed medications. This would increase the risk of infectious disease transmission and the risk of medication cross-contamination to subsequent patients who would have their medications crushed in this piece of medical equipment.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.03

Standard Text: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Element(s) of Performance:

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Individual Tracer at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site. During individual tracer activity on the 7th floor unit, the record of a patient who had undergone a spinal operation two days previously was reviewed. The record contained an H&P which had been documented by a physician assistant at an earlier outpatient encounter within the previous 30 days. The physician's preoperative update note was incomplete because it only stated that there had been "no change". There was no attestation to a concurrent examination on which to base the fact that there had been no change in the patient's clinic condition since the previous exam.

Chapter:	Record of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	RC.02.01.03
Standard Text:	The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

Element(s) of Performance:

3. The patient's medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed. (See also PC.01.02.03, EPs 4 and 5)

Scoring Category : C
Score : Satisfactory Compliance

5. An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital.
Note 2: If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP3
Observed in Record Review at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site. In 1of 4 patient records reviewed, focused on patients who underwent surgical procedures by a podiatrist, there was no preoperative H&P documented in the clinical record. The form for that purpose had been left blank.
EP5
Observed in Record Review at TriStar Skyline Medical Center (3441 Dickerson Pike,Nashville,TN) site. During review of the record of a patient who underwent a surgical procedure by a podiatrist on 4/27, it was noted that the surgeon had not dictated the full operative note until 5/9, twelve days following the procedure. In addition, the record was missing an immediate post procedure progress note which was required by medical staff policy.

Chapter: Care, Treatment, and Services

Program: Behavioral Health Care Accreditation

Standard: CTS.03.01.03

Standard Text: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Element(s) of Performance:

1. The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Individual Tracer at Skyline Madison Campus (500 Hospital Drive,Madison,TN) site.
While conducting a tracer, it was noted that the problem list had sleep as a major problem for the patient. This was not addressed on the treatment plan either as an active treatment focus or if the problem was being referred or deferred. Other issues were noted in the treatment plan that were not on the problem list such as hypertension. However, other parts of the record indicated the patient was on medication for hypertension and appeared to be at an acceptable range.

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

October 25, 2016

Re: # 7887
CCN: #440006
Program: Hospital
Accreditation Expiration Date: August 13, 2019

Steve Otto
Chief Executive Officer
TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, Tennessee 37207

Dear Mr. Otto:

This letter confirms that your August 09, 2016 - August 12, 2016 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on September 26, 2016 and October 24, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of August 13, 2016.

The Joint Commission is also recommending your organization for continued Medicare certification effective August 13, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Skyline Madison Campus
500 Hospital Drive, Madison, TN, 37115

TriStar Skyline Medical Center
3441 Dickerson Pike, Nashville, TN, 37207

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

October 25, 2016

Steve Otto, MBA
Chief Executive Officer

TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

Joint Commission ID #: 7887
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 10/25/2016

Dear Mr. Otto:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Hospitals**

This accreditation cycle is effective beginning August 13, 2016 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Official Accreditation Report

TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

Organization Identification Number: 7887

Evidence of Standards Compliance (60 Day) Submitted: 10/24/2016

Executive Summary

Program(s)
Hospital Accreditation

Submit Date
10/24/2016

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Program	Standard	Level of Compliance
HAP	EC.02.01.01	Compliant
HAP	EC.02.02.01	Compliant
HAP	EC.02.04.03	Compliant
HAP	EC.02.06.01	Compliant
HAP	IC.01.05.01	Compliant
HAP	IC.02.01.01	Compliant
HAP	LS.02.01.10	Compliant
HAP	LS.02.01.30	Compliant
HAP	LS.02.01.35	Compliant
HAP	LS.02.01.70	Compliant
HAP	MS.12.01.01	Compliant
HAP	PC.01.02.01	Compliant
HAP	RC.01.01.01	Compliant
HAP	RI.01.03.01	Compliant
HAP	TS.03.02.01	Compliant
HAP	WT.05.01.01	Compliant

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Compliant
§482.24(c)(4)(v)	A-0466	HAP - RI.01.03.01/EP13	Compliant

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.02.01/EP12, EC.02.06.01/EP1	Compliant
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP3	Compliant
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP5, EP9, LS.02.01.30/EP2, EP11, EP23, LS.02.01.35/EP4, EP6, LS.02.01.70/EP1	Compliant

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Compliant

Corresponds to: HAP - IC.02.01.01/EP1

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

SUPPLEMENTAL #2
November 10, 2011
1:26 pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305-3608

September 26, 2011

Mr. Steve Otto, Administrator
Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

RE: Licensure Surveys

Dear Mr. Otto:

Enclosed is the statement of deficiencies for the licensure surveys completed at your facility on **September 19 - 21, 2011**. Based upon 1200-8-1, you are asked to submit an acceptable plan of correction for achieving compliance with completion dates and signature within **ten (10) days from the date of this letter.**

Please address each deficiency separately with positive and specific statements advising this office of a plan of correction that includes acceptable time schedule, which will lead to the correction of the cited deficiencies. **Enter on the right side of the State Form, opposite the deficiencies**, your planned action to correct the deficiencies and the expected completion date. The completion date can be no longer than **45 days from the day of survey**. Before the plan can be considered "acceptable," it must be signed and dated by the administrator

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-984-9710.

Sincerely,

P Diane Carter

P. Diane Carter, RN. LNCC
Public Health Consultant Nurse 2

PDC/tjw

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

Skyline Medical Center

TRI STAR HEALTH SYSTEM

October 10, 2011

Ms. P. Diane Carter
Public Health Consultant Nurse 2
State of Tennessee Department of Health
West Tennessee Health Care Facilities
2975C Highway 45 Bypass
Jackson, Tennessee 38305-3608

Re: Skyline Medical Center
Licensure Survey

Dear Ms. Carter:

Enclosed is Skyline Medical Center's plan of corrective action in response to your letter dated September 26, 2011. This letter and its attachments describe the numerous actions the hospital has taken to ensure compliance with each of the deficiencies cited and provides credible evidence of full compliance.

Skyline Medical Center is committed to the care of human life and we strive to deliver high quality healthcare in the communities we serve. If you require additional information or if I can be of assistance, please do not hesitate to call me at 615-769-7114.

Sincerely,

Steve Otto

Steve Otto
Chief Executive Officer

Enclosures

3441 Dickerson Pike • Nashville, TN 37207 • 615-769-2000
www.tristarhealth.com

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Division of Health Services

PRINTED 09/22/2011
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER **SKYLINE MEDICAL CENTER**		STREET ADDRESS, CITY, STATE, SIP CODE **3441 DICKERSON PIKE** **NASHVILLE, TN 37207**	

(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
H637	1200-8-1-.06 (3)(b)7. Basic Hospital Functions (3) Infection Control (b) The chief executive officer or administrator Shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develop guidelines and techniques for the prevention, surveillance, control and reporting of hospital infections. Duties of the committee shall include the establishment of: 7. Formal provisions to educate and orient all appropriate personnel in the practice of aseptic techniques such as hand washing and scrubbing practices, proper grooming, masking and dressing care techniques, disinfecting and sterilizing techniques and the handling and storage of patient care equipment and supplies; and This Rule is not met as evidenced by: Based on policy review, observation and interview, it was determined 1 of 1 (Nurse #1) nurses observed performing finger stick blood sugars failed to clean the glucometer between patients to prevent the possibility of cross contamination of blood. The findings included: 1. Review of facility's "EXPOSURE CONTROL PLAN FOR BLOODBORNE PATHOGENS" policy documented, "...E...Re-usuable, contaminated PPE [personal protective equipment] or equipment is cleaned with a designated disinfectant per manufacturer's recommendations, rinsed and thoroughly dried	H 637	Deficiency: Nurses performing finger stick blood sugars failed to clean the glucometer between patients to prevent the possibility of cross contamination of blood. Corrective Action: The policy title "Roche Accucheck Glucose Testing" was revised to include a notation that "After each patient testing event, the meter is wiped down with an approved antiseptic towel or cleaner." Exhibit A This deficiency was discussed at the Infection Prevention Committee on 9/21/11 with agreement on the policy revision, nursing education and random observations. A label has been developed and has been placed on each accucheck glucose machine. The label alerts the staff to "Clean with Super Sani-cloth." Another label is on the outside lid of the blood glucose box to clean if it becomes contaminated. Exhibit B and C Clinical staff has been educated on the revised policy and expectations that the accucheck glucose monitoring equipment will be cleaned with a disinfectant wipe after each patient use via staffing huddles, Leadership Lunch and Learn on 10/3/11, and through nursing rounds. Responsible Parties: CNO, Clinical Directors Compliance Monitoring: Each clinical unit will conduct 10 random observations per month to validate compliance with the cleaning of the accucheck glucose monitoring equipment after each patient use. The Quality Department has designed a form for the observations. At the end of the month, this form will be returned to the Quality Department for analysis and aggregation of data on the Nursing dashboards. The data will be presented quarterly to the Infection Prevention Committee, Performance Improvement/ Patient Safety Council, forwarded to the Medical Executive Committee and Board of Trustees for their review, input and recommendations. Exhibit D	9/21/11 09/28/11 10/04/11

Division of Health Care Facilities

Title (X6) Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Steve Otto CFO 10/11/11

STATE FORM 6899 C49B11 If continuation sheet 1 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
H637	Continued From page 1 Before being used again…" 2. Observations during tour on 9/20/11 at 11:00 AM, revealed Nurse #1 entered room 631 with a Glucometer that was not observed clean before entering the room. The nurse placed the glucometer on the paitent's counter beside the bed without placing a barrier between the glucometer and the counter. She placed a blood glucose test strip into the glucometer, stuck the patient's finger to obtain a drop of blood, placed the patient's blood sample onto the test strip and the glucometer after completing the procedure. Nurse #1 proceeded to room 630 patient in Contact isolation, she enter the room with the Glucometer that still was not observed cleaned Before entering the room. Nurse #1 placed the Glucometer on the patient's over bed table without a barrier between the glucometer and the over bed table. She placed a blood glucose test strip into the glucometer, struck the patient's finger to obtain a drop of blood , placed patients blood sample onto the test strip and the glucometer displayed the patient's blood glucose reading. Nurse #1 failed to clean the glucometer after completing the procedure. Nurse #1 transported the glucometer to the docking station at the nurses' desk and docked the machine. Nurse #1 obtained blood samples from the 2 Patients and failed to clean the glucometer between each patient use. 3. During an interview in the 6th floor nurses' Station on 9/20/11 at 11:10, Nurse #1 stated, "…no, I did not clean it [glucometer] after using it…"	H 637	Any variance in practice will be immediately reported to the unit Clinical Director for follow up with the staff involved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
H637	Continued From page 2 During an interview in the 6th floor nurses' station On 9/20/11 at 11:15 AM, the Clinical Coordinator For the Medical Surgical unit stated, "…I expect nursing to clean the machine after using it…"	H 637		
H707	1200-8-1-.06 (5)(k)8. Basic Hospital Functions (5) Medical Records (k) All records must document the following: 8. Final diagnosis with completion of medical Records within thirty (30) days following discharge. This Rule is not met as evidence by: Based on review of the delinquent medical record report and interview, it was determined the facility failed to ensure the medical records were completed within 30 days following the patient's discharge. The findings included: 1. Review of the most current delinquent medical records report revealed the following number of medical records were incomplete greater than 30 days after discharge: 1 for March 2011, 1 for May 2011, 3 for June 2011, 9 for July 2011 and 114 For August 2011. 2. During an interview on 9/20/11 at 2:55 PM, the Medical Records Department Supervisor verified The above findings as correct.	H 707	Deficiency: Facility failed to ensure the medical records were completed within 30 days following the patient's discharge. Corrective Action: The Director HIM will monitor a report that details the age and delinquency in a patient's medical record on a weekly basis. Any physicians with a patient medical record delinquency that are incomplete 21 days or more after patient discharge will be notified by certified letter of the incomplete record and a time frame for completion that complies with the Medical Staff By-Laws/Rules and Regulations. The expectation is that all patient records will be completed by the end of the specified timeframe. If the physician fails to complete the specific patient record within the timeframe designated, the physician will be placed on medical record suspension until the records are complete. Physician suspension are reported at the Health Information Management Committee, then forwarded to the Performance Improvement/Patient Safety Council, Medical Executive Committee and Board of Trustees for review, input and recommendations. Consistent variances in physician medical record delinquency will be forwarded to the Peer Review Committee for further review and action. Exhibit E (Example of Physician letter) Responsible Parties: Director of HIM and Health Information Management Service Center	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
	Continued From page 3			
H707		H 707	Compliance Monitoring: The Health Information Service Center will receive and review a weekly report regarding medical record delinquencies compliance within the 30 day timeframe. If variances are found, the Health Information Service Center will notify the facility HIM Director to ensure the delinquency information is correct. If the physicians have delinquencies past the 30 day timeframe, they will verify the physician has been suspended per the Medical Staff By-Laws/Rules and Regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER TNP 53123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/21/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
H 742	Continued From page 4	H 742		
H 742	1200-8-1-.06 (9)(i) Basic Hospital Functions (9) Food Dietetic Services. (i) Food shall be protected from sources of contamination whether in storage or while being prepared, served and/or transported. Perishable foods shall be stored at such temperatures as to prevent spoilage. Potentially hazardous foods shall be maintained at safe temperatures as defined in a current "U.S. Public Health Service Food Service Sanitation Manual:.		Deficiency: Facility failed to prevent the potential spread of infection by storing meal trays on a cart in a dirty utility room with biohazard waste on patient care floors. Corrective Action: No meal trays will be placed in the biohazard room. Signs have been developed and placed on the door of the biohazard door to alert the staff not to place any trays in the room. The catering to you associates will pick up all trays from the patient rooms. If a patient is not through eating at that time, the disposable items will be left in the patient room. Exhibit F	10/10/11
	This Rule is not met as evidenced by: Based on observation and interview, the facility failed to prevent the potential spread of infection By storing meal trays on a cart in a dirty utility room with the biohazard waste on 6 of 6 (Patient #2, 3, 4, 5 6 and 7) patient care floors. The findings included: 1. Observations on the second floor on 9/20/11 at 1:20 PM revealed food cart with patient meal trays stored in the dirty utility/biohazard waste room. 2. Observations on the third floor on 9/20/11 at 1:10 PM revealed a food card with patient meal trays stored in the dirty utility/biohazard waste room 3. Observations on the fourth floor on 9/20/11 at 1:10 PM revealed food cart with patient meal trays stored in the dirty utility/biohazard waste room. 4. Observation on the fifth floor on 9/20/11 at		Clinical and dietary staff was educated on this new practice via e-mail to all clinical directors, communication books and discussion with staff. This deficiency was also discussed at the Infection Prevention Committee on 9/21/11 with agreement to set up a meeting to discuss the plan of action. Responsible Parties: CNO, Director Food & Nutrition Services Compliance Monitoring: A form has been developed for monitoring the biohazard room to validate compliance with the new practice and that no meal trays are being stored there for pick up by the dietary department. The Infection Prevention Practitioners will be monitoring the process when they conduct their rounds. The results of the monitoring will be presented quarterly to the Infection Prevention Committee, Performance Improvement/Patient Safety Council, Medical Executive Committee and Board of Trustees for their review, input and recommendations. Exhibit G	10/07/11 10/07/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
H 742	Continued From page 4 1:13 PM revealed a food card with patient meal trays stored in the dirty utility/biohazard waste room 5. Observations on the sixth floor on 9/20/11 at 1:10 PM revealed food cart with patient meal trays stored in the dirty utility/biohazard waste room. 6. Observations on the seventh floor on 9/20/11 at 10:15 AM revealed food cart with patient meal trays stored in the dirty utility/biohazard waste room. 7. During an interview on the sixth floor on 9/20/11 at 10:10 AM, the Clinical Coordinator for the Medical/Surgical (Med/Surg) unit confirmed the patient meal trays were stored in the dirty utility/biohazard waste room on the sixth and seventh floor. During an interview on the fifth floor on 9/20/11 at 1:15 PM the Quality Director confirmed the patient meal trays were stored in the dirty utility/biohazard waste room on the fourth and fifth floors. During an interview on the fourth floor on 9/20/11 at 1:20 PM the Clinical Manager of the Acute Inpatient Rehabilitation Unit (second and third floors) confirmed the patient meal trays were stored in the dirty utility/biohazard waste room.	H 742	Any variance in practice will be forwarded to the Clinical Director for immediate follow up with staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER **SKYLINE MEDICAL CENTER**		STREET ADDRESS, CITY, STATE, SIP CODE **3441 DICKERSON PIKE** **NASHVILLE, TN 37207**	

(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
	H 901 1200-8-1-09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the life safety codes as required. The findings included: 1. Observation of the kitchen on 9/19/11 at 1:22 PM, revealed the housekeeping door did not have a door closure causing the closet not maintaining a negative air pressure. 2. Observation of the kitchen on 9/19/11 at 1:26 PM, revealed the paper goods storage room door was wedged open with a rubber door stop.	H 742	Deficiency: Facility failed to comply with the life safety codes as required. Corrective Action: The Plant Operations Department installed a door closure on the housekeeping door in the kitchen. Responsible Parties: Director Facilities Management Compliance Monitoring: Plant Operations has set up a re-occurring work order that will cause an inspection to be done by the Director of Facilities Management once per week beginning immediately and continuing for 4 months. If no issues are found, doors will be checked during normal EOC rounds semi-annually. Corrective Action: The Plant Operations Department inspected the door and validated the door had no closure difficulties. The rubber wedge was removed. The Director Food & Nutrition Services was notified at that time to not have the door propped open with any objects. Responsible Parties: Director Facilities Management	9/21/11 9/21/11 10/07/11 09/21/11

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Division of Health Services

PRINTED: 09/22/2011
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER **SKYLINE MEDICAL CENTER**		STREET ADDRESS, CITY, STATE, SIP CODE **3441 DICKERSON PIKE** **NASHVILLE, TN 37207**	

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	H 901 1200-8-1-09 (1) Life Safety Continued page 2	H 742	Compliance Monitoring: Plant Operations has set up a re-occurring work order that will cause an inspection to be done by the Director of Facilities Management once per week beginning immediately and continuing for 4 months. If no issues are found, doors will be checked during normal EOC rounds semi-annually.	
	3. Observation of the kitchen on 9/19/11 at 1:30 PM, revealed kitchen hood suppression fore extinguishing nozzles were not centered over the cooking equipment. These findings were acknowledged by the director of facilities management during the exit interview on 9/20/11.		Deficiency: Facility failed to comply with the life safety codes as required. Corrective Action: The Plant Operations Department notified Simplex Grinnell of the need to inspect the hood suppression pipes in the kitchen over the cooking equipment. Simplex Grinnell inspected the kitchen hood suppression pipes and changed them to cover the new kitchen appliances. Responsible Parties: Director Facilities Management Compliance Monitoring: The Director of Facilities Management and Chief Quality & Patient Safety Officer inspected the hood suppression pipes in the kitchen and found them appropriately placed covering the cooking equipment.	09/21/11 9/29/11 10/07/11

vision of Health Care Facilities — Title — (X6) Date

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING _____ B. WING _____	C 09/21/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

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	H 901 1200-8-1-09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the life safety codes as required. The findings included: Observation on 9/20/11 at 10:40 AM, revealed a penetration above the corridor doors in the smoke wall partition adjacent at 339. This findings was acknowledged by the director of facilities management and the plant operations manager during the exit interview on 9/20/11.	H 901	Deficiency: Facility failed to comply with the life safety codes as required. Corrective Action: The penetration was sealed at the time it was found. Skyline Medical Center has a "No Pass, No Pay" policy that details the process to ensure all fire/smoke wall penetrations complies with state and national fire code requirements. Owner's representative (Plant Operations, Biomedical or Information Systems) will conduct an inspection of all new penetrations after the work is completed to ensure they are sealed. Exhibit H Responsible Parties: Director Facilities Management and Plant Operations Manager at Madison Campus Compliance Monitoring: The Director Facilities Management and Plant Operations Manager (Madison Campus) conduct quarterly fire barrier inspections. If penetrations are found, they are sealed at the time of the inspection.	09/20/11 10/01/11

SUPPLEMENTAL #2

November 1, 2011 2011
1:26 pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305

October 24, 2011

Mr. Steve Otto, Administrator
Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

RE: Fire Safety Licensure Survey

Dear Mr. Otto:

On **September 20, 2011**, a fire safety licensure survey was completed at your facility. Your plan of correction has been reviewed and found to be ***unacceptable***. Your responses must explain what you are doing to ensure compliance with regulations and completion dates.

I am enclosing copy of the statement of deficiencies. The plan of correction should be returned to this office **ten (10) days from the date of this letter**. An acceptable plan of correction is required in order for this office to recommend that your facility be licensed.

Please address each deficiency separately with positive and specific statements advising this office of plan of correction, which includes acceptable time schedules, which will lead to the correction of the cited deficiencies. ***Enter on THE RIGHT SIDE OF THE STATE FORM, opposite the deficiencies, your planned action to correct each deficiency and the expected completion date.*** The completion date can be no longer than 45 days from the day of survey. Before the plan can be considered "acceptable," ***it MUST BE SIGNED AND DATED by the administrator.***

Your plan of correction must contain the following:

- How each deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-984-9710.

Sincerely
P. Diane Carter
P. Diane Carter, RN, LNCC
Public Health Nurse Consultant 2

PDC/tjw tjw

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Skyline Medical Center

TRISTAR HEALTH SYSTEM

November 2, 2011

Ms. P. Diane Carter
Public Health Consultant Nurse 2
State of Tennessee Department of Health
West Tennessee Health Care Facilities
2975C Highway 45 Bypass
Jackson, Tennessee 38305-3608

Re: Skyline Medical Center
Licensure Survey-Fire Safety

Dear Ms. Carter,

Enclosed is Skyline Medical Center's revised plan of corrective action in response to your letter dated October 24, 2011. We hope this letter and its attachments expand the description of the numerous actions the hospital has taken to ensure compliance with each of the fire safety deficiencies cited and provides credible evidence of full compliance.

If you require additional information of if I can be of assistance, please do not hesitate to call me at 615-769-7114.

Sincerely,

Steve Otto

Steve Otto
Chief Executive Officer

Enclosures

3441 Dickerson Pike – Nashville, TN 37207 – 615-769-2000
www.tristarhealth.com

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Division of Health Services

PRINTED: 09/22/2011
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER TNP 53123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01- Main Building 01 B. WING	(X3) DATE SURVEY COMPLETED C 09/20/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
	H 901 1200-8-1-09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the life safety codes as required. The findings included: 1. Observation of the kitchen on 9/19/11 at 1:22 PM, revealed the housekeeping door did not have a door closure causing the closet not maintaining a negative air pressure.	H 901	Deficiency: Facility failed to comply with the life safety codes as required. Corrective Action: The Plant Operations Department installed a door closure on the housekeeping door in the kitchen. Inspection by the Director Facilities Management on 9/22/11 noted the housekeeping door to latch securely. The Director of Food and Nutrition Services was notified the door was to remain closed at all times. A sign stating "We must keep this door closed at all times" was placed on the door to alert FNS staff. The Director of Food & Nutrition Services also communicated this to the staff utilizing the housekeeping area in a 1:1 conversation. Exhibit I Responsible Parties: Director Facilities Management Compliance Monitoring: Plant Operations has set up a re-occurring work order that will cause an inspection to be done by the Director of Facilities Management once per week beginning immediately and continuing for 4 months. If no issues are found, doors will be checked during normal EOC rounds semi-annually. Any door found not closed during rounding will be communicated to the Director of Food & Nutrition Services for immediate follow-up. The Director Food & Nutrition Services is also performing daily monitoring to ensure the door is latched securely. The audits will daily for 2 months. If no issues are noted, the observation of compliance will change to the monthly surveillance rounding. The audits will be reported to the Environment of Care Committee quarterly, forwarded to the Performance Improvement Council, Medical Executive Committee and Board of Trustees for their review, input and recommendations as needed.	9/21/11 09/30/11 10/07/11 10/29/11

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Division of Health Services

PRINTED: 09/21/2011
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER TNP 53123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01- Main Building 01 B. WING	(X3) DATE SURVEY COMPLETED C 09/20/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
	H 901 1200-8-1-09 (1) Life Safety Continued page 2 2. Observation of the kitchen on 9/19/11 at 1:26 PM, revealed the paper goods storage room door was wedged open with a rubber door stop.	H901	Deficiency: Facility failed to comply with the life safety codes as required. Corrective Action: The Plant Operations Department inspected the door that was wedged open and validated the door had no closure difficulties; therefore the rubber wedge was removed. The Director Food & Nutrition Services was notified at that time to not have the door propped open with any objects. The Director of Food and Nutrition Services communicated with the staff at a special meeting the importance of not propping any doors open at any time, especially rubber door stops. This door is in the kitchen is able to be left open, so the Plant Operations Department installed a "magnetic door hinge" which allows this to happen. The door has the ability to release to the closed position in case of fire. This was checked by the Director Facilities Management and Chief Quality & Patient Safety Officer during their weekly rounds. Responsible Parties: Director Facilities Management, Director Food and Nutrition Services Compliance Monitoring: Plant Operations has set up a re-occurring work order that will cause an inspection to be done by the Director of Facilities Management once per week beginning immediately and continuing for 4 months. If no issues are found, doors will be checked during normal EOC rounds semi-annually. Doors found propped open will be communicated to the Director of Food & Nutrition Services for immediate follow-up. The Director of Food and Nutrition Services is also performing daily monitoring to validate that no doors are propped open with any objects for 2 months. If no issues are noted, the observation of compliance will change to the monthly surveillance rounding. The audit results will be reported quarterly at the Environment of care Committee, Performance Improvement/Patient Safety Council, Medical Executive Committee and Board of Trustees for their review, input and recommendations as needed.	09/21/11 10/04/11 10/27/11 10/07/11 10/29/11

Division of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING 01- Main Building 01 B. WING	C 09/20/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

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	H 901 1200-8-1-09 (1) Life Safety Continued page 3 3. Observation of the kitchen on 9/19/11 at 1:30 PM, revealed kitchen hood suppression fore extinguishing nozzles were not centered over the cooking equipment. These findings were acknowledged by the director of facilities management during the exit interview on 9/20/11.	H 901	Deficiency: Facility failed to comply with the life safety codes as required. Corrective Action: The Plant Operations Department notified Simplex Grinnell of the need to inspect the hood suppression pipes in the kitchen over the new cooking equipment. Simplex Grinnell inspected the kitchen hood suppression pipes and changed them to cover the new kitchen appliances. Exhibit K Responsible Parties: Director Facilities Management Compliance Monitoring: The Director of Facilities Management and Chief Quality & Patient Safety Officer inspected the hood suppression pipes in the kitchen and found them appropriately placed covering the cooking equipment. These suppression pipes are permanently placed and cannot be adjusted by any kitchen staff. Simplex Grinnell has a biannual maintenance already scheduled to inspect the suppression hood nozzles, hood exhaust fans, etc. The last inspection was on 6/23/11 therefore the next inspection is scheduled for 12/2011. If any issues are found during an inspection, they are corrected at that time. Documentation of the inspections is kept in the Plant Operations Department. Any deficiencies in the inspections for the next 2 years will be reported to the Environment of Care Committee, Performance Improvement/Patient Safety Council, Medical Executive Committee and Board of Trustees for review, input and recommendations as needed.	09/21/11 9/29/11 10/07/11

SUPPLEMENTAL #2

November 1, 2016

1:26 pm

Division of Health Services

PRINTED: 09/22/2011
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP 53123	A. BUILDING 02-Madison Campus B. WING	C 09/20/2011
NAME OF PROVIDER OR SUPPLIER SKYLINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, SIP CODE 3441 DICKERSON PIKE NASHVILLE, TN 37207	

(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
	H 901 1200-8-1-09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the life safety codes as required. The findings included: Observation on 9/20/11 at 10:40 AM, revealed a penetration above the corridor doors in the smoke wall partition adjacent at 339. This findings was acknowledged by the director of facilities management and the plant operations manager during the exit interview on 9/20/11.	H 901	Deficiency: Facility failed to comply with the life safety codes as required. Corrective Action: The penetration was sealed at the time it was found. Skyline Medical Center has a "No Pass, No Pay" policy that details the process to ensure all fire/smoke wall penetrations complies with state and national fire code requirements. The policy was reviewed by the Director Facilities Management and no changes were needed. Upon completion of the contractors work, the contractor fills out the No Pass No Pay form (included on the policy) and gives the completed form to the Plant Operations Department. Owner's representative (Plant Operations, Biomedical or Information Systems) conducts an inspection of all new penetrations to ensure they are sealed. If the penetrations are not sealed, the contractor is made aware and payment is held until the penetrations are sealed and the work is re-inspected. Exhibit H Responsible Parties: Director Facilities Management and Plant Operations Manager at Madison Campus Compliance Monitoring: The Director Facilities Management and Plant Operations Manager (Madison Campus) conduct quarterly fire barrier inspections. If penetrations are found, they are sealed at the time of the inspection. Penetrations are reported as part of the surveillance to the Environment of Care Committee quarterly, forwarded to the Performance Improvement Council, Medical Executive Committee and Board of Trustees for their review, input and recommendations as needed. As noted above, the hospital is monitoring every outside contractor work and sealing of penetrations during each visit to the facility. Non-compliance results in no pay to the contractor until a re-inspection is done and passed.	09/20/11 09/30/11 10/01/11

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGWAY 45 BYPASS
JACKSON, TENNESSEE 38305
731-984-9684

November 8, 2011

Mr. Steve Otto, Administrator
Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

Dear Mr. Otto:

On **November 4, 2011,** our office completed a revisit to verify that your facility had achieved and maintained compliance. Based on our revisit, we found that your facility had demonstrated compliance with deficiencies cited on the **fire safety licensure survey** completed on **September 20, 2011.**

If this office may be of any assistance to you, please call 731-984-9710.

Sincerely,

P. Diane Carter

P. Diane Carter, RN, LNCC
Public Health Nurse Consultant 2

PDC/tjw

SUPPLEMENTAL #2
November 1, 2016
1:26 pm OCT - 4 2011

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305-3608
731-984-9684

September 26, 2011

Administrator
Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207

RE: PECU Licensure Survey

Dear Administrator:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey conducted at your facility on **September 21, 2011. The attached form is for your files.**

If this office may be of any assistance to you, please do not hesitate to call (731) 984-9710.

Sincerely,

P. Diane Carter

P. Diane Carter, RN, LNCC
Public Health Nurse Consultant 2

PDC/tjw

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

PRINTED: 09/22/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53123	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/21/2011
NAME OF PROVIDER OR SUPPLIER: SKYLINE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 3441 DICKERSON PIKE NASHVILLE, TN 37207		

(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
P 002	1200-8-30 No Deficiencies Based on policy review, medical record review, observation, and interviews, the facility complied with the regulations for a Primary Pediatric Emergency Care Facility. No deficiencies were cited during the annual licensure survey conducted 9/19/11 - 9/21/11.	P 002	COPY	