# ORIGINAL

# Parkridge West Hospital

# CN1611-039

BURR • • • FORMAN LLP

*results matter*

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November 15, 2016

Melanie M. Hill
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Andrew Jackson Building
Nashville, TN 37243-0200

Re: Parkridge West Hospital
Certificate of Need Application

Dear Ms. Hill:

Filed herewith is a Certificate of Need application for Parkridge West Hospital. Although I am the contact person and legal counsel for this project, I will be out of the office November 16-November 22. Therefore please direct all supplemental questions and other correspondence or phone calls to John Wellborn in my absence. Thank you for your assistance.

Sincerely yours,

Burr & Forman LLP

Jerry W. Taylor

cc: John Wellborn

**State of Tennessee**
**Health Services and Development Agency**
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
**www.tn.gov/hsda** Phone: 615-741-2364 Fax: 615-741-9884

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# CERTIFICATE OF NEED APPLICATION

## SECTION A: APPLICANT PROFILE

**1. *Name of Facility, Agency, or Institution***

Parkridge West Hospital
Name

1000 Highway 28
Street or Route

Marion
County

Jasper
City

TN
State

37347
Zip Code

Website address: http://parkridgewesthospital.com

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

**2. *Contact Person Available for Responses to Questions***

Jerry W. Taylor
Name

Attorney
Title

Burr & Forman, LLP
Company Name

jtaylor@burr.com
Email address

511 Union Street, Suite 2300
Street or Route

Nashville
City

TN
State

37219
Zip Code

Attorney
Association with Owner

615-724-3247
Phone Number

615-724-3248
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 the Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-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 signed and 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 applicant proposed to convert 8 currently unstaffed medical-surgical (med-surg) beds to adult psychiatric beds. The 8 additional adult psych beds will be located in the existing 20 bed Medicare certified psychiatric distinct par unit (DPU) in a freestanding building on the campus of Parkridge West Hospital.

There is not sufficient space in the existing facility for the new beds, so a "bump out" expansion consisting of approximately 3290 square feet will be constructed. In addition, approximately 8,520 square feet of the existing facility will be renovated.

**2) Ownership structure;**

Parkridge West Hospital is a satellite hospital of Parkridge Medical Center, and operates under its license. The corporate owner is Parkridge Medical Center, Inc. which is ultimately owned through several subsidiaries by HCA Holdings, Inc. An organizational chart is attached as Attachment Section A-4,A(2).

**3) Service area;**

The primary service area (PSA) consists of 5 counties in Tennessee: Bradley, Grundy, Hamilton, Marion and Sequatchie. These counties accounted for 81% of the Tennessee admissions in 2015, and 52% of total admissions. The secondary service area (SSA) consists of 2 counties in Alabama: Jackson and DeKalb. These counties accounted for 25.4% of the admissions to Parkridge West in 2015. Combined, the PSA and SSA counties accounted for 78% of the admissions to Parkridge West in 2015.

**4) Existing similar service providers;**

Five hospitals operate a total of 260 adult psychiatric beds in the PSA. A table reflecting the utilization of the adult psych beds in the PSA is attached as Attachment Section B, Need, 1, (9). In 2015 the average occupancy rate for adult psych beds in the PSA was 76.4%.

An additional 36 adult and geriatric psych beds were approved in Hamilton County for Erlanger Behavioral Health by CN1603-012A. According to the CON application for that project, these beds will serve a much wider geographic area than the 5 county PSA and the 2 county SSA and therefore should not be a significant factor in the need for the requested 8 beds.

**5) Project cost;**

The total estimated project cost not including the filing fee is $2,169,808. The largest single expenditure is construction and renovation cost of $1,517,600. The renovation cost per square foot is $70, which is below the 1st Quartile of costs approved by the HSDA. The new construction cost per square foot is $280, which is between the 1st Quartiel and 2nd Quartile of approved costs. The total cost per square foot is $128, which his below the 1st Quartile of approved costs.

**6) Funding;**

Funding is available through the cash reserves of the parent company, HCA Holdings, Inc.

**7) Financial Feasibility including when the proposal will realize a positive financial margin; and**

As reflected in the Projected Data Charts, the project is profitable from the outset -- both for the 8 additional beds and for the 28 bed unit.

**8) Staffing.**

The additional beds will not require any additional psychiatrists to be added to the medical staff. Parkridge West has an employed psychiatrist as its Medical Director, and 2 other psychiatrists in Parkridge Health System who do or can rotate through the Parkridge West unit.

This project will require 5.5 additional FTE non-physician staffing. HCA and Parkridge Health System have an effective recruiting program, and should be able to fill these positions as needed.

**B. <u>Rationale for Approval</u>**

**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;**

Parkridge West needs additional capacity to serve adult patients needing inpatient psychiatric care in the service area. Occupancy has been steadily rising since HCA acquired the facility in 1st Quarter 2014. YTD October 2016, the occupancy rate on the 20 bed unit is 87%. In 2015 occupancy was 81%. All of Parkridge West's psych beds are semi-private, so gender and age compatibility issues make the actual availability of beds even lower than an 80+% occupancy rate might otherwise suggest.

Many admissions have to be denied due lack of available beds at Parkridge West. YTD September 2016 171 admissions have been denied due solely to a lack of available beds.

Annualized, the number of such denials will be 228 in 2016. These denied admissions alone constitute 72% of the projected 315 Year 1 admissions.

The additional capacity will also allow Parkridge West to admit TennCare enrollees. Parkridge West is in network with all TennCare MCOs in the region. When HCA acquired the facility and began operating it effective March 1, 2014 the psychiatric distinct part unit (DPU) was not a credentialed TennCare provider. Because of this, and due to lack of capacity at Parkridge West, TennCare enrollees presenting to Parkridge West have been referred to its sister facility Parkridge Valley Adult and Senior Services. That facility has a large TennCare patient base.

The additional capacity sought in this application will allow Parkridge West to accept TennCare enrollees, and it will have the DPU credentialed by TennCare. Parkridge West is committed to being a TennCare provider and admitting TennCare enrollees in the future. In fact, 80% of the projected payer mix in Year 1 is TennCare.

**2) Economic Feasibility;**

The project is economically feasible. The cost of construction and renovation are reasonable, and the total cost per square foot of $128 is below the 1st Quartile of similar costs recently approved by the Agency. Funding is available through the cash reserves of the parent company, HCA Holdings, Inc. The project is profitable from the outset as reflected on the Projected Data Charts.

**3) Appropriate Quality Standards; and**

Parkridge West is licensed and monitored by the Tennessee Department of Health. Parkridge West is also accredited and monitored by the Joint Commission. It is in good standing with all licensing and accrediting agencies..

**4) Orderly Development to adequate and effective health care.**

Converting 8 currently unstaffed med-surg beds to highly utilized adult psych beds, rather than adding newly licensed beds to the area, is the most efficient and orderly development of health care resources.

The additional capacity will allow Parkridge West to serve patients who are currently being denied admission due to lack of an available bed. Through September of 2016, Parkridge West had to deny admission to 171 patients due to lack of a bed. Annualized, this will be 228 such denials in 2016. That is 72% of the projected admissions on to the new beds. The additional capacity will also allow the Parkridge West DPU to become a credentialed site by TennCare, and will allow TennCare enrollees to be served.

This project should not have a significant impact on existing providers. Most of the admissions being denied at Parkridge West are referred to its sister facility, Parkridge Valley.

Although an additional 36 adult and geriatric psych beds were approved in Hamilton County for Erlanger Behavioral Health by CN1603-012A, this project should not have a significant impact on the Erlanger Behavioral Health project. According to the CON application for that project, these beds will serve a much wider geographic area than the 5

county PSA and therefore should not be a significant factor in the need for the requested 8 beds.

## C. Consent Calendar Justification

**If Consent Calendar is requested, please provide the rationale for an expedited review.** N/A.

**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.**

## 4. SECTION A: PROJECT DETAILS

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

Parkridge Medical Center, Inc. — Name
423-698-6061 — Phone Number
One Park Plaza — Street or Route
Davidson — County
Nashville — City
TN — State
37203 — Zip Code

**B.** ***Type of Ownership of 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 | |
| D. | Corporation (For Profit) | X | 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 Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx.*** **Attachment Section A-4A.**

Corporate organizational documentation is attached as Attachment Section A-4A(1).

***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.***

Parkridge West Hospital is a satellite hospital of Parkridge Medical Center, and operates under its license. The corporate owner is Parkridge Medical Center, Inc. which is ultimately owned through several subsidiaries by HCA Holdings, Inc. An organizational chart is attached as Attachment Section A-4A(2).

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

N/A — Name

Street or Route

County

City

State

Zip Code

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.*** **Attachment Section A-5.**

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

| | | | | | |
|---|---|---|---|---|---|
| A. | Ownership | X | D. | Option to Lease | _____ |
| B. | Option to Purchase | _____ | 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.**

A copy of the Deed is attached as 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 1/2" x 11" sheet of white paper, single or double-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 highway that cross or border the site.**

A plot plan with the required information is attached as 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 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.**

A floor plan with the required information is attached as Attachment Section A-6B(2).

**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.**

Parkridge West Hospital is located at 1000 Hwy 28, a major thoroughfare. The hospital has

direct access and visibility from Interstate 24. Public transportation is not available in this community.

**7. Type of Institution** ***(Check as appropriate--more than one response may apply)***

| | | | | | |
|---|---|---|---|---|---|
| A. | Hospital (Specify)_____ | __X_ | 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. | Nonresidential Substitution-Based Treatment Center for Opiate Addiction | _____ |
| F. | Mental Health Hospital | _____ | | | |
| G. | Intellectual Disability Institutional Habilitation Facility ICF/IID | _____ | M. | Other (Specify)_____ _____ | _____ |

**Check appropriate lines(s).**

**8. Purpose of Review** ***(Check appropriate lines(s) – more than one response may apply)***

| | | | | | |
|---|---|---|---|---|---|
| A. | New Institution | _____ | F. | Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution,* ***Conversion****, Relocation]* | __X__ |
| B. | Modifying an ASTC with limitation still required per CON | _____ | | | |
| C. | Addition of MRI Unit | _____ | | | |
| D. | Pediatric MRI | _____ | | | |
| E. | Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify)_____ | _____ | G. | Satellite Emergency Dept. | _____ |
| | | | H. | Change of Location | _____ |
| | | | I. | Other (Specify)_____ _____ | _____ |

**9. Medicaid/TennCare, Medicare Participation**

**MCO Contracts [Check all that apply]**

**_X_AmeriGroup _X__United Healthcare Community Plan _X__BlueCare _X__TennCare Select**

***Medicare Provider Number*** 44S156 & 440156

***Medicaid Provider Number*** 0440156

***Certification Type*** Hospital

**If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?**

N/A. This is not a new facility.

**Medicare __Yes __No _X_N/A Medicaid/TennCare __Yes __No _X_N/A**

## 10. Bed Complement Data

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

| | Current Licensed | Beds Staffed | Beds Proposed | *Beds Approved | **Beds Exempted | TOTAL Beds at Completion |
|---|---|---|---|---|---|---|
| 1) Medical | 50 | 0 | -8 | 0 | 0 | 42 |
| 2) Surgical (included in Medical) | | | | | | |
| 3) ICU/CCU | | | | | | |
| 4) Obstetrical | | | | | | |
| 5) NICU | | | | | | |
| 6) Pediatric | | | | | | |
| 7) Adult Psychiatric | 20 | 20 | +8 | 0 | 0 | 28 |
| 8) Geriatric Psychiatric | | | | | | |
| 9) Child/Adolescent Psychiatric | | | | | | |
| 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 Medicare/Medicaid) | | | | | | |
| 18) Nursing Home – Licensed (non-certified) | | | | | | |
| 19) ICF/IID | | | | | | |
| 20) Residential Hospice | | | | | | |
| **TOTAL** | 70 | 20 | Net 0 | 0 | 0 | 70 |

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

**B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. Attachment Section A-10.**

HCA acquired and began operating Parkridge West effective March 1, 2014. Since that time, there has been strong and steady growth in utilization of the psychiatric inpatient beds. As of YTD 2016 the psych beds are occupied at an average rate of 87%. Parkridge West serves a significant number of patients from rural areas west of Hamilton County. The additional capacity will allow Parkridge West to better serve this population, and will improve access to care for this population.

Parkridge West is not currently staffing its 50 licensed medical-surgical beds. Converting 8 of the medical surgical beds to psychiatric better is a better and more efficient use of existing resources.

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

A completed chart is attached following this page.

## 12. Square Footage and Cost Per Square Footage Chart--Parkridge West Medical Center--Behavioral Health Unit

| Unit/Department | Existing Location | Existing SF | Temporary Location | Proposed Final Location | Proposed Final Square Footage | | |
|---|---|---|---|---|---|---|---|
| | | | | | Renovated | New | Total |
| Behavioral Health | Treatment Ctr | 8,520 | | Treatment Ctr | 8,520 | 3,290 | 11,810 |
| | | | | | | | 0 |
| | | | | | | | 0 |
| | | | | | | | 0 |
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| | | | | | | | 0 |
| | | | | | | | 0 |
| Unit/Dept GSF Subtotal | | 8,520 | | | 8,520 | 3,290 | 11,810 |
| Other GSF Subtotal | | | | | | | 0 |
| Total GSF | | 8,520 | | | 8,520 | 3,290 | 11,810 |
| Total Cost* | | | | | $596,400.00 | $921,200.00 | $1,517,600.00 |
| **Cost Per Square Foot | | | | | $70.00 | $280.00 | $128.50 |
| Cost per Square Foot is Within Which Range? (For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda) | | | | | _X_ Below 1st Quartile | ___ Below 1st Quartile | _X_ Below 1st Quartile |
| | | | | | ___ Between 1st and 2nd Quartile | _X__ Between 1st and 2nd Quartile | ___ 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.*

**ARCHITECT SHOULD ENTER COST PSF ONLY FOR NEW AND RENOVATED COLUMNS; THE TOTAL COST PSF COLUMN CALCULATES AUTOMATICALLY.**

## 13. MRI, PET, and/or Linear Accelerator

N/A.

1. **Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or**
2. **Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:**

**A. Complete the chart below for acquired equipment.**

| | | | |
|---|---|---|---|
| ☐ Linear Accelerator | Mev _____ | Types: ☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____ | |
| | Total Cost*: _____ | ☐ By Purchase<br>☐ By Lease Expected Useful Life (yrs) ___ | |
| | ☐ New ☐ Refurbished | ☐ If not new, how old? (yrs) _____ | |
| ☐ MRI | Tesla: ____ | Magnet: ☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____ | |
| | Total Cost*: _____ | ☐ By Purchase<br>☐ By Lease Expected Useful Life (yrs) ___ | |
| | ☐ New ☐ Refurbished | ☐ If not new, how old? (yrs) _____ | |
| ☐ PET | ☐ PET only ☐ PET/CT ☐ PET/MRI | | |
| | Total Cost*: _____ | ☐ By Purchase<br>☐ By Lease 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.**

**C. Compare 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.**

**D. Schedule of Operations:**

| Location | Days of Operation (*Sunday through Saturday*) | Hours of Operation (*example: 8 am – 3 pm*) |
|---|---|---|
| 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.**

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

## 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 or double 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)."***

### 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 Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.**

**Standards and Criteria for Psychiatric Inpatient Services**

**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".**

The bed need calculations are reflected in the table attached as Attachment Section B, Need, 1, (1). Although there is a surplus of adult psych beds in the service area, several extenuating circumstances should be taken into account rather than considering the bed need calculations in a vacuum.

Almost all of the bed surplus is in Hamilton County. Although Hamilton County is the county of residence of a large portion of Parkridge West's psychiatric patient base, a large portion of those Hamilton County patients reside in western or southern Hamilton County. These patents are as close to or closer to Parkridge West than to the Hamilton County providers. In addition, many patients prefer the smaller and less intimidating environment offered by Parkridge West than the larger Hamilton County hospitals. The additional capacity will improve accessibility and offer enhanced patient choice.

Approximately 63% of the psychiatric admissions at Parkridge West from the PSA originated from counties other than Hamilton. Rural counties Grundy, Sequatchie, and Marion are all Medically Underserved Areas (MUA) and Parkridge West is an important and local access point for psychiatric inpatient care. Portions of Bradley County, which is the other county in the Tennessee PSA, are likewise designated as an MUA. Bradley County is somewhat an anomaly, in that it is located to the east of Hamilton County, and 30 psych patients admitted to Parkridge West in 2015 traveled through Hamilton County, "passing" the Hamilton County providers, to seek and receive care at Parkridge West.

The secondary service area consists of Jackson County and DeKalb County, Alabama. In 2015, Parkridge West admitted 174 patients from these two counties for psychiatric care. That constitutes 25% of total admissions at Parkridge West. The applicant understands there are no inpatient psychiatric beds in DeKalb or Jackson Counties. The additional capacity will improve accessibility and offer enhanced patient choice for these Alabama residents as well.

Included in the bed need calculations are all 150 licensed beds at Moccasin Bend Mental Health Institute. However, in August of 2009 Moccasin Bend "closed" 25 of those 150 beds. The applicant understands those beds have now been re-opened, but it is not known when that occurred.

**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;**

Parkridge West will accept emergency involuntary admissions. The ALOS for Parkridge West was 9-10 days in 2015. If and to the extent "non-emergency indefinite admissions" means patients with stays significantly longer than 9-10 days, that population is not expected to be significant portion of the patient base.

**b. The extent to which the applicant serves or proposes to serve the TennCare population and the indigent population;**

Parkridge West is in network with all TennCare MCOs in the region. When HCA acquired the facility and began operating it effective March 1, 2014 the psychiatric distinct part unit (DPU) was not a credentialed TennCare provider. Because of this, and due to lack of capacity at Parkridge West, TennCare enrollees presenting to Parkridge West have been referred to its sister facility Parkridge Valley Adult and Senior Services. That facility has a large TennCare patient base.

The additional capacity sought in this application will allow Parkridge West to accept TennCare enrollees, and it will have the DPU credentialed by TennCare. Parkridge West is committed to being a TennCare provider and admitting TennCare enrollees in the future. In fact, 80% of the projected payer mix in Year 1 is TennCare.

**c. The number of beds designated as "specialty" beds (including units established to treat patients with specific diagnoses);**

The beds at Parkridge West will be designated as adult psychiatric beds. The beds will serve patients aged 18+.

**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;**

Parkridge West plans to implement IOP and/or partial hospitalization in 2017. A specific target date has not been set. Currently, patients needing these outpatient services are referred to Parkridge Valley, and/or other providers in the community.

**e. Psychiatric units for patients with intellectual disabilities;**

Whether the admission of an individual with intellectual disabilities is appropriate is determined on a case by case basis by the psychiatrist. The most important factors are whether or not the individual has the capacity and ability to meaningfully participate in therapies, and can manage his or her ADLs. If such an admission to Parkridge West is determined to be not appropriate, a transfer would be made to an appropriate provider, including but not limited to Moccasin Bend Mental Health Institute.

**f. Free standing psychiatric facility transfer agreements with medical inpatient facilities;**

Parkridge West is not a freestanding psychiatric facility; it is operated under the general hospital license of Parkridge Medical Center. Parkridge West is located adjacent to a full-service Emergency Department, and in addition, a hospitalist rounds daily through the Parkridge West psychiatric unit. However, in the event a transfer to a general hospital is necessary, such a transfer can be made to Parkridge Medical Center without the need for a transfer agreement.

**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**

Parkridge West does and will accept involuntary admissions, and patients with dual diagnoses. Please see the response to (f) above regard to patients with medical co-morbidities.

**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.**

Parkridge West is for short-stay acute patients diagnosed with a psychiatric condition. Staffing levels and patterns will be appropriate to meet the needs of the patient population..

**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.**

Not applicable to this project.

**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.**

Not applicable to this project; a crisis stabilization unit is available in Hamilton County..

**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.**

Attached as Attachment Section B, Need, 1, (3) is a bar graph from the TDMHSAS reflecting the relative incidence of mental illness among the nation, the State of Tennessee, and Region 3, which includes the PSA. The PSA has a much higher incidence of mental illness than the nation or state in 2010-2012, and a slightly higher incidence in 2010-2012.

**4. Planning Horizon: The applicant shall predict the need for psychiatric inpatient beds for the proposed first two years of operation.**

A two year planning horizon is used in this application.

**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.**

The primary service area consists of Bradley, Grundy, Hamilton, Marion, and Sequatchie Counties. Residents of these counties accounted for 82% of Tennessee psychiatric admissions to Parkridge West in 2015. All of the population segments mentioned above will have access to services.

Rural counties Grundy, Sequatchie, and Marion are all Medically Underserved Areas (MUA) and Parkridge West is an important and local access point for psychiatric inpatient care. Portions of Bradley County, which is the other county in the PSA, are likewise designated as an MUA.

The secondary service area consists of Jackson County and DeKalb County, Alabama. In 2015, Parkridge West admitted 174 patients from these two counties for psychiatric care. That constitutes 25% of total admissions at Parkridge West. The applicant understands there are no inpatient psychiatric beds in these two counties. The additional capacity will improve accessibility and offer enhanced patient choice for these Alabama residents as well.

**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.**

Parkridge West is in compliance with the access time for admissions to Psychiatric Inpatient Hospital Services.

**6. Composition of Services: Inpatient hospital services that provide only substance abuse 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.**

Parkridge West does not have a dedicated substance abuse unit or beds. Parkridge West does accept patients with a dual diagnosis of mental health and substance abuse.

Parkridge West does take into account concerns of geriatric patients in its treatment plans. Parkridge West does not accept adolescent patients.

Parkridge West does admit patients with medical co-morbidities. Parkridge West is located adjacent to a full-service Emergency Department, and in addition, a hospitalist rounds daily through the Parkridge West psychiatric unit. However, in the event the medical condition requires a transfer to a general hospital, such a transfer can be made to Parkridge Medical Center or another community provider.

**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.**

Parkridge West will serve patients 18 years of age and older. Children and adolescents will not be served.

**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.**

Rural counties Grundy, Sequatchie, and Marion are all Medically Underserved Areas (MUA) and Parkridge West is an important and local access point for psychiatric inpatient care. Portions of Bradley County, which is the other county in the PSA, are likewise designated as an MUA.

This project should have no negative impact on the state supported Moccasin Bend Mental Health Institute.

Parkridge West accepts both voluntary and involuntary admissions, and serves acute psychiatric patients. The ALOS for Parkridge West was 9-10 days in 2015 If and to the extent "long term patients" means patients with stays significantly longer than 9-10 days, that population is not expected to be significant portion of the patient base.

The projected Medicare and TennCare revenues in Year 1 for the 8 new beds are:

| | | |
|---|---|---|
| Medicare: | $102,164 | 9% |
| TennCare: | $908,120 | 80% |

**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.**

A table reflecting the utilization of Adult psychiatric beds operating in the PSA is attached as Attachment Section B, Need, 1, (9).

**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.**

Parkridge West has operated above 80% for the past two years it has owned the facility. The utilization rates are:

| | |
|---|---|
| 2016 YTD October: | 87% |
| 2015: | 81% |
| 2014: | 57% (Acquired by HCA in March, 2014) |

Parkridge West is financially stable. Financial information can be found in the Historical Data Chart in this application.

**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).**

Parkridge West is accredited by the Joint Commission. Appropriate age and gender separations are and will be observed and have been taken into account in patient rooms, bathrooms, and activity and recreation areas. Seclusion rooms are provided. Services are 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.**

Parkridge West is classified as an IMD. The projected TennCare revenue in Year 1 is $908,120. This should not have a significant impact on the TennCare budget.

**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.**

Parkridge West does admit patients with medical co-morbidities. Parkridge West is located adjacent to a full-service Emergency Department, and in addition, a hospitalist rounds daily through the Parkridge West psychiatric unit. However, in the event the medical condition requires a transfer to a general hospital, such a transfer can be made to Parkridge Medical Center or another community provider.

**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.**

The sources for data utilized in this application were the TDH, the TDMHSAS, and the Joint Annual Reports.

**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.**

A staffing chart is provided in response to Question Section B, Economic Feasibility, 8. This project will require 5.5 additional FTE staffing. HCA and Parkridge Health System have an effective recruiting program.

**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.**

Parkridge West is part of the Parkridge Health system which encompasses the 20 bed inpatient psychiatric facility located on the Parkridge West campus. Parkridge West works with local community providers to link patients to the appropriate level of care upon discharge. The community partnerships include Mountain Valley, the local mental health outpatient provider (who is currently not accepting new patients). It also works closely with Mountain Lakes in Scottsboro (Jackson County). They provide outpatient services, home visits and case management. Additional partnerships include emergency departments and the local crisis response team.

Parkridge West is involved in primary prevention initiatives through our speakers bureau comprised of the behavioral health leadership, therapists, nursing team and psychiatrists. All participants serve as speakers and presenters within the community to provide behavioral health education and prevention modalities.

**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.**

Parkridge West's services are equally available to all individuals in the service area who qualify for admission.

The primary service area consists of Bradley, Grundy, Hamilton, Marion, and Sequatchie Counties. Residents of these counties accounted for 82% of Tennessee psychiatric admissions to Parkridge West in 2015. All of the population segments mentioned above will have access to services.

Rural counties Grundy, Sequatchie, and Marion are all Medically Underserved Areas (MUA) and Parkridge West is an important and local access point for psychiatric inpatient care. Portions of Bradley County, which is the other county in the PSA, are likewise designated as an MUA.

**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.**

HCA Behavioral Health hospitals and units in acute care hospitals, including Parkridge West all have robust and highly effective quality improvement programs that include outcome and process monitoring systems. All HCA behavioral health hospitals and distinct part units are Joint Commission-accredited.

Copies of Responsive documents are attached as Attachment Section B, Need, 1, (18). Copies of Responsive documents are attached as Attachment Section B, Need, 1, (18). These same documents were submitted with a different recent application, so please disregard the "Supplemental #2" and dates at the top of each page.

**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.**

The applicant so agrees.

**[END OF RESPONSES TO STANDARDS AND CRITERIA IN STATE HEALTH PLAN]**

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

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 border states, if applicable. Attachment Section B - Need-3.**

**Please complete the following tables, if applicable:**

| PSA Counties | 2015 Discharges County Residents | % of Tennessee Discharges | % of Total Discharges |
|---|---|---|---|
| Bradley | 30 | 6.8% | 4.4% |
| Grundy | 28 | 6.4% | 4.1% |
| Hamilton | 161 | 36.6% | 23.5% |
| Marion | 87 | 19.8% | 12.7% |
| Sequatchie | 54 | 12.3% | 7.9% |
| Sub-Total PSA | 360 | 81.8% | 52.6% |
| **SSA Counties** | **2015 Discharges County Residents** | **% of Tennessee Discharges** | **% of Total Discharges** |
| DeKalb, Ala. | 44 | | 6.4% |
| Jackson, Ala. | 130 | | 19% |
| Sub-Total SSA | 174 | | 25.4% |
| TOTAL PSA & SSA | **534** | | **78%** |

A map of the proposed PSA is attached as Attachment Section B, Need, 3.

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

This description can best be ascertained by examining the data in the table attached as Attachment Section B, Need, 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 US 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**

The requested table reflecting population and demographics of the PSA is attached as Attachment Section B, Need, 4A. The data is based on a two year planning horizon, as directed by the applicable CON Standards and Criteria.

**B. 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 median age of the PSA (41.1) is slightly higher than that of the state as a whole (38.3). Parkridge West accepts all admission eligible patients 18 years of age and older.

The median household income of the PSA ($39,898) is lower than that of the state as a whole ($44,621). The percentage of the population of the PSA below the poverty level (20.8%) is higher than that of the state as a whole(17.8%). Parkridge West serves all individuals regardless of socio-economic status, and will be a TennCare provider.

As reflected in data from the TDMHSAS, attached as Attachment Section B, Need, 1, (3) the PSA has a much higher incidence of mental illness than the nation or state in 2010-2012, and a slightly higher incidence in 2010-2012.

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 include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.**

Five hospitals operate a total of 260 adult psychiatric beds in the PSA. A table reflecting the utilization of the adult psych beds in the PSA is attached as Attachment Section B, Need, 1 (9). In 2015 the average occupancy rate for adult psych beds in the PSA was 76.4%.

An additional 36 adult adult and geriatric psych beds were approved in Hamilton County by CN1603-012A. According to the CON application for that project, these beds will serve a much wider geographic area than the 5 county PSA and therefore should not be a significant factor in the need for the requested 8 beds.

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.**

A table reflecting historical and projected utilization is provided below. Current 20 bed Psychiatric unit cannot run at capacity due to patient acuity and gender issues in a unit that has semi-private rooms. Year to date October 2016 occupancy is 87%. The first year utilization of the new beds of 315 admissions is based in part on denials of admissions due to lack of an available bed. YTD September 2016 there were 171 such denials, which is 228 denied

admissions annualized. Assuming Parkridge had the capacity to accept these admissions, that would constitute 72% of the projected 315 admissions.

| PARKRIDGE WEST INPATIENT PSYCH BED UTILIZATION 2014-2016 | | | |
|---|---|---|---|
| **Year:** | **2014** | **2015** | **2016 (YTD 10/31/16)** |
| **Discharge 18-64** | 328 | 489 | 492 |
| **Days 18-64** | 3228 | 4969 | 4516 |
| **ALOS 18-64** | 9.84 | 10.16 | 9.18 |
| **Discharge 65+** | 85 | 79 | 60 |
| **Days 65+** | 957 | 945 | 815 |
| **ALOS 65+** | 11.26 | 11.96 | 13.58 |
| **Total Discharges** | 413 | 568 | 552 |
| **Total Days** | 4185 | 5914 | 5331 |
| **Occupancy Total Days** | 57.3% | 81.0% | 87.4% |

| PROJECTED UTILIZATION ON 8 NEW BEDS | | |
|---|---|---|
| **:** | **Year 1** | **Year 2** |
| **Adm. 65+** | 315 | 386 |
| **ALOS 65+** | 5.8 Days | 5.8 Days |
| **Patient Days** | 1,825 | 2,008 |
| **Occupancy** | 62.5% | 68.7% |

## 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 completed Project Cost Chart is attached following this page.

   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 (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.**

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

      A letter from the project architect is attached as Attachment Section B, Economic Feasibility, 1, E.

# PROJECT COST CHART

| | | | |
|---|---|---|---|
| A. | Construction and equipment acquired by purchase: | | |
| | 1. Architectural and Engineering Fees | | $ 132,200.00 |
| | 2. Legal, Administrative, Consultant Fees | | $ 33,000.00 |
| | 3. Acquisition of Site | | $ - |
| | 4. Preparation of Site (included in A,5) | | $ - |
| | 5. Total Construction Costs | | $ 1,517,600.00 |
| | 6. Contingency Fund | | $ 303,520.00 |
| | 7. Fixed Equipment (Not included in Construction Contract) | | $ - |
| | 8. Moveable Equipment (List all equipment over $50,000.00) | | $ 130,200.00 |
| | 9. Other (Specify) _____ | | _____ |
| 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 | | $ 53,288.00 |
| | 2. Underwriting Costs | | _____ |
| | 3. Reserve for One Year's Debt Service | | _____ |
| | 4. Other (Specify) _____ | | _____ |
| D. | Estimated Project Cost (A+B+C) | | $ 2,169,808.00 |
| E. | CON Filing Fee | | $ 15,000.00 |
| F. | Total Estimated Project Cost (D + E) | **TOTAL** | $ 2,184,808.00 |

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 Section B-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**

   A funding letter is attached as Attachment Section B, Economic Feasibility, 2.

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

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

   **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.***

   A completed Historical Data Chart for the entire facility is attached following this page. Also attached is a Historical Data Chart for the "Project Only." This is not for the 8 beds being requested; it is for the entire DPU, but not including the ED or outpatient utilization.

**HISTORICAL DATA CHART**

X Total Facility (Incl. ED & OP)
___ Project Only

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 (Month)

| | | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 5,331 Dischg Days | 6,247 Dischg Days | 7587 Dischg Days |
| B. | Revenue from Services to Patients | | | |
| | 1. Inpatient Services | 22,502,459 | 27,837,462 | 38,588,113 |
| | 2. Outpatient Services | 55,148,000 | 60,723,908 | 70,673,376 |
| | 3. Emergency Services (Included in OP) | - | - | - |
| | 4. Other Operating Revenue | 34,739 | 375,558 | 602,077 |
| | Specify: _____ | | | |
| | **Gross Operating Revenue** | 77,685,198 | 88,936,928 | 109,863,566 |
| C. | Deductions from Operating Revenue | | | |
| | 1. Contract Deductions | 64,419,928 | 66,371,173 | 77,716,206 |
| | 2. Provision for Charity Care | 168,556 | 620,543 | 776,585 |
| | 3. Provision for Bad Debt | 1,452,393 | 9,293,183 | 12,568,720 |
| | **Total Deductions** | 66,040,877 | 76,284,899 | 91,061,511 |
| **NET OPERATING REVENUE** | | 11,644,321 | 12,652,029 | 18,802,055 |
| D. | Operating Expenses | | | |
| | 1. Salaries and Wages | 3,697,931 | 5,172,971 | 7,248,929 |
| | a. Direct Patient Care | 2,645,138 | 1,837,982 | 2,553,136 |
| | b. Non-Patient Care | 1,052,793 | 3,334,989 | 4,695,793 |
| | 2. Physicians' Salaries and Wages | - | - | - |
| | 3. Supplies | 637,392 | 1,208,172 | 2,401,337 |
| | 4. Rent | 229,574 | 363,357 | 745,351 |
| | a. Paid to Affiliates | | | |
| | b. Paid to Non-Affiliates | 229,574 | 363,357 | 745,351 |
| | 5. Management Fees: | | | |
| | a. Fees to Affiliates | 769,197 | 1,018,669 | 666,823 |
| | b. Fees to Non-Alffiliates | - | - | - |
| | 6. Other Operating Expenses | 4,438,439 | 6,237,463 | 9,328,851 |
| | **Total Operating Expenses** | 9,772,533 | 14,000,632 | 20,391,291 |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | 1,871,788 | (1,348,603) | (1,589,236) |
| F. | Non-Operating Expenses | | | |
| | 1. Taxes (Income & Property) | 48,775 | (1,220,558) | (1,047,322) |
| | 2. Depreciation | 1,189,547 | 1,350,455 | 1,627,698 |
| | 3. Interest | 552,082 | 812,646 | 887,332 |
| | 4. Other Non-Operating Expenses | | | |
| | **Total Non-Operating Expenses** | 1,790,404 | 942,543 | 1,467,708 |
| **NET INCOME (LOSS)** | | 81,384 | (2,291,146) | (3,056,944) |
| G. | Other Deductions | | | |
| | 1. Annual Principal Debt Repayment | | | |
| | 2. Annual Capital Expediture | | | |
| | **Other Total Deductions** | - | - | - |
| | **NET BALANCE** | 81,384 | (2,291,146) | (3,056,944) |
| | **DEPRECIATION** | 1,189,547 | 1,350,455 | 1,627,698 |
| | **FREE CASH FLOW (Net Blance + Depreciation)** | 1,270,931 | (940,691) | (1,429,246) |

* Data for 1/1/16 through 10/31/16

** Data for 1/1/14 through 2/28/14 was provided by Capella for JAR completion. Parkridge purchased facility eff 3/1/14

HISTORICAL DATA CHART -- OTHER EXPENSES

X Total Facility (Incl. ED & OP)
___ Project Only

| OTHER EXPENSE CATEGORY | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|
| 1. Professional Services Contracts | 200,187 | 668,710 | 1,067,751 |
| 2. Contract Labor | 233,581 | 269,713 | 118,259 |
| 3. Imagng Interpretation Fees | - | - | - |
| 3. Employee Benefits | 968,176 | 1,196,752 | 1,977,000 |
| 5. Contract Services | 1,493,118 | 2,332,292 | 3,163,854 |
| 6. Repairs & Maintenance | 596,017 | 755,023 | 998,761 |
| 7. Utilities | 390,960 | 543,004 | 581,610 |
| 8. Insurance | 194,388 | 163,694 | 281,240 |
| 9. Other | 362,012 | 308,275 | 1,140,376 |
| TOTAL OTHER EXPENSES | 4,438,439 | 6,237,463 | 9,328,851 |

**HISTORICAL DATA CHART**

__ **Total Facility**
X **Project Only (20 Psych beds, no ED or OP)**

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 (Month)

| | | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 5,331 Dischg Days | 6,247 Dischg Days | 4,185 Dischg Days |
| B. | Revenue from Services to Patients | | | |
| | 1. Inpatient Services | 22,502,459 | 24,840,540 | 18,913,297 |
| | 2. Outpatient Services | | | - |
| | 3. Emergency Services | | | - |
| | 4. Other Operating Revenue | 34,739 | | - |
| | Specify: _____ | | | |
| | **Gross Operating Revenue** | 22,537,198 | 24,840,540 | 18,913,297 |
| C. | Deductions from Operating Revenue | | | |
| | 1. Contract Deductions | 17,267,632 | 19,389,449 | 15,453,115 |
| | 2. Provision for Charity Care | 59,250 | 84,463 | 11,075 |
| | 3. Provision for Bad Debt | 72,467 | 91,779 | 99,674 |
| | **Total Deductions** | 17,399,349 | 19,565,691 | 15,563,864 |
| **NET OPERATING REVENUE** | | 5,137,849 | 5,274,849 | 3,349,433 |
| D. | Operating Expenses | | | |
| | 1. Salaries and Wages | 1,781,009 | 1,959,092 | - |
| | a. Direct Patient Care | 1,129,089 | 1,031,929 | |
| | b. Non-Patient Care | 651,920 | 927,163 | |
| | 2. Physicians' Salaries and Wages | - | - | - |
| | 3. Supplies | 297,326 | 365,807 | |
| | 4. Rent | 59,047 | 184,759 | - |
| | a. Paid to Affiliates | | | |
| | b. Paid to Non-Affiliates | 59,047 | 184,759 | |
| | 5. Management Fees: | | | |
| | a. Fees to Affiliates | 308,271 | 316,491 | |
| | b. Fees to Non-Alffiliates | | | |
| | 6. Other Operating Expenses | 1,735,473 | 2,032,329 | - |
| | **Total Operating Expenses** | 4,181,126 | 4,858,478 | - |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | 956,723 | 416,371 | 3,349,433 |
| F. | Non-Operating Expenses | | | |
| | 1. Taxes | 25,174 | 53,046 | |
| | 2. Depreciation | | | |
| | 3. Interest | | | |
| | 4. Other Non-Operating Expenses | | | |
| | **Total Non-Operating Expenses** | 25,174 | 53,046 | - |
| **NET INCOME (LOSS)** | | 931,549 | 363,325 | 3,349,433 |
| G. | Other Deductions | | | |
| | 1. Annual Principal Debt Repayment | | | |
| | 2. Annual Capital Expediture | | | |
| | **Other Total Deductions** | - | - | - |
| | **NET BALANCE** | 931,549 | 363,325 | 3,349,433 |
| | **DEPRECIATION** | - | - | - |
| | **FREE CASH FLOW (Net Blance + Depreciation)** | 931,549 | 363,325 | 3,349,433 |

* Data for 1/1/16 through 10/31/16

** Expense data is not available. Purchased facility 3/1/14. Net Revenue data per JAR

**HISTORICAL DATA CHART -- OTHER EXPENSES**

__ **Total Facility**
X **Project Only (20 Psych beds, no ED or OP)**

| OTHER EXPENSE CATEGORY | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|
| 1. Professional Services Contracts | 131,141 | 130,139 | - |
| 2. Contract Labor | 109,337 | 107,666 | - |
| 3. Employee Benefits | 494,623 | 493,814 | - |
| 4. Contract Services | 471,799 | 731,786 | - |
| 5. Repairs & Maintenance | 134,537 | 140,265 | - |
| 6. Utilities | 213,965 | 249,661 | - |
| 7. Insurance | 100,329 | 70,094 | - |
| 8. Other | 79,742 | 108,904 | - |

4. **Complete Projected Data Charts on the following two 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.***

   Two Projected Data Charts -- one for the 8 beds only and one for the entire facility -- are attached following this page.

**PROJECTED DATA CHART**

___ **Total Facility**
X **Project Only** **(8 Psych beds)**

Give information for the last two (2) years for which complete data are available for the facility or agency. The fiscal year begins in January (Month)

| | | Year: 1 | Year: 2 | |
|---|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 1825 pt days | 2008 pt days | |
| B. | Revenue from Services to Patients | | | |
| | 1. Inpatient Services | $9,055,650 | $10,758,112 | |
| | 2. Outpatient Services | | | |
| | 3. Emergency Services | | | |
| | 4. Other Operating Revenue | | | |
| | Specify: _____ | | | |
| | **Gross Operating Revenue** | $9,055,650 | $10,758,112 | |
| C. | Deductions from Operating Revenue | | | |
| | 1. Contract Deductions | $7,852,744 | $9,422,194 | |
| | 2. Provision for Charity Care | $26,930 | $32,281 | |
| | 3. Provision for Bad Debt | $40,826 | $39,876 | |
| | **Total Deductions** | $7,920,500 | $9,494,351 | |
| **NET OPERATING REVENUE** | | $1,135,150 | $1,263,761 | |
| D. | Operating Expenses | | | |
| | 1. Salaries and Wages | $475,696 | $485,210 | |
| | a. Direct Patient Care | $475,696 | $485,210 | |
| | b. Non-Patient Care | $0 | $0 | |
| | 2. Physicians' Salaries and Wages | $0 | $0 | |
| | 3. Supplies | $64,477 | $71,782 | |
| | 4. Rent | $0 | $0 | |
| | a. Paid to Affiliates | $0 | $0 | |
| | b. Paid to Non-Affiliates | $0 | $0 | |
| | 5. Management Fees: | | | |
| | a. Fees to Affiliates | $68,109 | $75,826 | |
| | b. Fees to Non-Alffiliates | $0 | $0 | |
| | 6. Other Operating Expenses | $334,410 | $358,231 | |
| | **Total Operating Expenses** | $942,692 | $991,049 | |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | $192,458 | $272,712 | |
| F. | Non-Operating Expenses | | | |
| | 1. Taxes (Property) | $18,601 | $18,601 | |
| | 2. Depreciation | $116,729 | $116,729 | |
| | 3. Interest | | | |
| | 4. Other Non-Operating Expenses | | | |
| | **Total Non-Operating Expenses** | $135,330 | $135,330 | |
| **NET INCOME (LOSS)** | | $57,128 | $137,382 | |
| G. | Other Deductions | | | |
| | 1. Estimated Annual Principal Debt Repayment | $0 | $0 | |
| | 2. Annual Capital Expediture | $0 | $0 | |
| | **Other Total Deductions** | $0 | $0 | |
| | **NET BALANCE** | $57,128 | $137,382 | $80,254 |
| | **DEPRECIATION** | $116,729 | $116,729 | |
| | **FREE CASH FLOW (Net Balance + Depreciation)** | $173,857 | $254,111 | |

## PROJECTED DATA CHART -- OTHER EXPENSES

___ Total Facility
X Project Only

| OTHER EXPENSE CATEGORY | Year: 1 | Year: 2 |
|---|---|---|
| 1. Professional Services Contracts | 120749 | 132824 |
| 2. Contract Labor | 0 | 0 |
| 3. Benefits | 110549 | 112760 |
| 4. Contract Services | 59212 | 65693 |
| 5. Repairs & Maintenance | 5000 | 5000 |
| 6. Utilities | 24000 | 24480 |
| 7. Insurance | 10800 | 10800 |
| 8. Other | 4100 | 6674 |
| **TOTAL OTHER EXPENSES** | $334,410.00 | $358,231.00 |

**PROJECTED DATA CHART** **X Total Facility (28 Psych beds) Project Only**

Give information for the last two (2) years for which complete data are available for the facility or agency. The fiscal year begins in January (Month)

| | | Year: 1 | Year: 2 |
|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 8,222 Patient Days | 8,515 Patient Days |
| B. | Revenue from Services to Patients | | |
| | 1. Inpatient Services | $36,058,601 | $40,423,288 |
| | 2. Outpatient Services | | |
| | 3. Emergency Services | | |
| | 4. Other Operating Revenue | $41,687 | $42,521 |
| | Specify: | | |
| | **Gross Operating Revenue** | $36,100,288 | $40,465,809 |
| C. | Deductions from Operating Revenue | | |
| | 1. Contract Deductions | $28,573,902 | $32,502,422 |
| | 2. Provision for Charity Care | $98,030 | $106,936 |
| | 3. Provision for Bad Debt | $127,786 | $131,184 |
| | **Total Deductions** | $28,799,718 | $32,740,542 |
| **NET OPERATING REVENUE** | | $7,300,570 | $7,725,267 |
| D. | Operating Expenses | | |
| | 1. Salaries and Wages | $2,612,907 | $2,660,891 |
| | a. Direct Patient Care | $1,830,603 | $1,864,505 |
| | b. Non-Patient Care | $782,304 | $796,385 |
| | 2. Physicians' Salaries and Wages | $0 | $0 |
| | 3. Supplies | $421,268 | $435,709 |
| | 4. Rent | $70,856 | $71,565 |
| | a. Paid to Affiliates | $0 | $0 |
| | b. Paid to Non-Affiliates | $70,856 | $71,565 |
| | 5. Management Fees: | | |
| | a. Fees to Affiliates | $438,034 | $463,516 |
| | b. Fees to Non-Affiliates | $0 | $0 |
| | 6. Other Operating Expenses | $2,416,977 | $2,670,124 |
| | **Total Operating Expenses** | $5,960,042 | $6,301,804 |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | $1,340,528 | $1,423,463 |
| F. | Non-Operating Expenses | | |
| | 1. Taxes (Property) | $48,810 | $48,810 |
| | 2. Depreciation | $133,099 | $133,099 |
| | 3. Interest | | |
| | 4. Other Non-Operating Expenses | | |
| | **Total Non-Operating Expenses** | $181,909 | $181,909 |
| **NET INCOME (LOSS)** | | $1,158,619 | $1,241,554 |
| G. | Other Deductions | | |
| | 1. Estimated Annual Principal Debt Repayment | $0 | $0 |
| | 2. Annual Capital Expediture | $0 | $0 |
| | **Other Total Deductions** | $0 | $0 |
| | **NET BALANCE** | $1,158,619 | $1,241,554 |
| | **DEPRECIATION** | $133,099 | $133,099 |
| | **FREE CASH FLOW (Net Balance + Depreciation)** | $1,291,718 | $1,374,653 |

**PROJECTED DATA CHART -- OTHER EXPENSES**

**X Total Facility (28 Psych beds)**
**Project Only**

| OTHER EXPENSE CATEGORY | Year: 1 | Year: 2 |
|---|---|---|
| 1. Professional Services Contracts | 278,118 | $290,193 |
| 2. Contract Labor | 131,204 | $132,516 |
| 3. Employee Benefits | 704,097 | $718,179 |
| 4. Contract Services | 625,371 | $637,514 |
| 5. Repairs & Maintenance | 166,444 | $168,058 |
| 6. Utilities | 280,758 | $283,806 |
| 7. Insurance | 131,195 | $270,126 |
| 8. Other | 99,790 | $169,732 |
| **TOTAL OTHER EXPENSES** | 2,416,977 | 2,670,124 |

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.**

| | Previous Year (from Project Only HDC) | Current Year (from Project Only HDC) | Year One (from Project Only PDC) | Year Two (from Project Only PDC) | % Change (Current Year to Year 2) |
|---|---|---|---|---|---|
| **Gross Charge *(Gross Operating Revenue/Utilization Data)*** | **$3,97640 per discharge day** | **$4,227.70 per discharge day** | **$4,962 per patient day** | **$5,357 per patient day** | **26.7%** |
| **Deduction from Revenue *(Total Deductions/Utilization Data)*** | **$3,132.01 per discharge day** | **$3,263.81 per discharge day** | **$4,340 per patient day** | **$4,728.26 per patient day** | **44.9%** |
| **Average Net Charge *(Net Operating Revenue/Utilization Data)*** | **$844.38 per discharge day** | **$963.77 per discharge day** | **$622.00 per patient day** | **$629.36 per patient day** | **-34.7%** |

**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 current and proposed charges are reflected above. Although the average gross charge increases significantly from current year to Year 1, that is more than off-set by the significant increase in deductions. The reason for this is the proposed charges are based on a high TennCare patient mix, whereas the current charges are mostly Medicare and commercial payers.

**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).**

The most relevant comparison is to the recently approved Erlanger Behavioral Health project, CN1603-012A.

Erlanger Behavioral Health: $4,361 net revenue per admission (Year 1)

Parkridge West: $3,604 net revenue per admission (Year 1)

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. 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 Section B-Economic Feasibility-6A. NOTE: Publicly held entities only need to reference their SEC filings.**

As is reflected on the Historical Data Chart for the Total Facility, Parkridge West has improved its financial performance steadily since being acquired by HCA in 1st Q 2014, and is now operating profitably. Copies of the audited Financial Statements for HCA Holdings are attached as Attachment Section B, Economic Feasibility, 6, B.

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:**

| Year | 2nd Year previous to Current Year | 1st Year previous to Current Year | Current Year | Projected Year 1 | Projected Year 2 |
|---|---|---|---|---|---|
| Net Operating Margin Ratio | N/A (Data is not available, due to the acquisition of the hospital in 2014). | 13.9% | 18.6% | 18.4% | 18.4% |

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) 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.**

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 |

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 28 Beds:**

| Payor Source | Projected Gross Operating Revenue | As a % of total |
|---|---|---|
| Medicare/Medicare Managed Care | $16,678,333 | 46.2% |
| TennCare/Medicaid | $9,458,275 | 26.2% |
| Alabama Medicaid | $3,898,831 | 10.8% |
| Commercial/Other Managed Care | $5,451,143 | 15.1% |
| Self-Pay | $0 | 0% |
| Charity Care | $108,301 | .3% |
| Other (Specify) Champus, HIX | $505,404 | 1.4% |
| Total | $36,100,288 | 100% |

**Applicant's Projected Payor Mix, Year 1 8 Beds:**

| Payor Source | Projected Gross Operating Revenue | As a % of total |
|---|---|---|
| Medicare/Medicare Managed Care | $1,131,956 | 12.5% |
| TennCare/Medicaid | $7,244,520 | 80% |
| Alabama Medicaid | $262,614 | 2.9% |

| | | |
|---|---|---|
| Commercial/Other Managed Care | $371,282 | 4.1% |
| Self-Pay | $0 | 0% |
| Charity Care | $27,166 | .3% |
| Other (Specify) Champus, HIX | $18,111 | .2% |
| Total | $9,055,650 | 100% |

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 (FTEs) 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.**

| Position Classification | Existing FTEs 2016 | Projected FTEs Year 1 | Average Wage | Area Wide/State wide Average Wage |
|---|---|---|---|---|
| Direct Patient Care Positions | | | | |
| *Director* | 1.0 | 1.0 | $37.34 | $37.40 |
| *RN* | 12.6 | 14.7 | $27.45 | $27.00 |
| *Mental Health Tech* | 8.4 | 10.5 | $11.55 | $13.00 |
| *Social Worker* | 1.7 | 2.5 | $26.51 | $25.00 |
| *Recreation Therapist* | 1.0 | 1.5 | $24.10 | $18.00 |

| | | | | |
|---|---|---|---|---|
| Non-Patient Care Positions | | | | |
| *Unit Secretary* | 1.0 | 1.0 | $13.31 | $13.00 |
| *Position 2* | | | | |
| *Position "etc."* | | | | |
| Total Non-Patient Care Positions | | | | |
| Total Employees *(A+B)* | 25.7 | 31.2 | | |
| Contractual Staff | 0.0 | 0.0 | | |
| Total Staff *(A+B+C)* | 25.7 | 31.2 | | |

9. **Describe all alternatives to this project which 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.**

No less costly or more efficient alternatives were identified. Additional bed capacity is needed due to high utilization of the existing psych beds. Converting 8 currently unstaffed med-surg beds to psych beds rather than adding newly licensed beds is the most efficient use of resources.

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

No practical alternatives to new construction were identified. There is not sufficient space in the current facility to house the beds. The med-surge beds being converted are located in a physically separate building on the campus. It does not make clinical or economic sense to have the behavioral health unit split into different buildings.

## 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, contractual agreements for health services.**

No such arrangements are necessary. Any ancillary health care services required by Parkridge West can be accessed from within Parkridge Health System.

**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 and/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. <u>Positive Effects</u>**

The additional capacity will allow Parkridge West to serve patients who are currently being denied admission due to lack of an available bed. Through September of 2016, Parkridge West had to deny admission to 171 patients due to lack of a bed. Annualized, this will be 228 such denials in 2016. That is 72% of the projected admissions on to the new beds. The additional capacity will also allow the Parkridge West DPU to become a credentialed site by TennCare, and will allow TennCare enrollees to be served.

**B. <u>Negative Effects</u>**

This project should not have a significant impact on existing providers. Most of the admissions being denied at Parkridge West are referred to its sister facility, Parkridge Valley.

Although an additional 36 adult and geriatric psych beds were approved in Hamilton County by CN1603-012A, this project should not have a significant impact on the Erlanger Behavioral Health project. According to the CON application for that project, these beds will serve a much wider geographic area than the 5 county PSA and therefore should not be a significant factor in the need for the requested 8 beds.

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 Commission on Accreditation of Rehabilitation Facilities.**

   The additional beds will not require any additional psychiatrists to be added to the medical staff. Parkridge West has an employed psychiatrist as its Medical Director, and __ psychiatrists in Parkridge Health System who do or can rotate through the Parkridge West unit.

   This project will require 5.5 additional FTE non-physician staffing. HCA and Parkridge Health System have an effective recruiting program, and should be able to fill these positions as needed.

   **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.).**

   Parkridge Health System's behavioral health service line offers internships for students pursuing their education in social work, behavioral health, nursing and medicine at the bachelors level, masters level, mid-level practitioners and physicians. It also offers clinical rotations and a nurse residency program for nursing students and graduates interested in pursuing a career in behavioral health nursing and medicine. Additionally, Parkridge psychiatrists serve as preceptors for students pursuing their nurse practitioner license as well as residency opportunities for psychiatry students. These partnerships are with University of Tennessee at Chattanooga, Southern Adventist University, and Chattanooga State. Parkridge continues to explore additional institutional partnerships.

4. **Identify the type of licensure and certification requirements applicable and verify 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:** Tennessee Department of Health

   **Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):** Medicare psychiatric Distinct Part Unit.

   **Accreditation (i.e., Joint Commission, CARF, etc.):** 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.**

   Copies of these are attached as Attachment Section B, Orderly Development, 5A.

**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.**

Copies are attached as Attachment Section B, Orderly Development, 5B.

**C. Document and explain inspections within the last 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-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.**

None.

**1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.**

N/A.

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

The applicant has made a good faith effort to respond to this question regarding the entities identified in Attachment Section A-4 A(2) to the best of its knowledge, information and belief. Due to the breadth of the question and a lack of definition of key terms, the applicant cannot represent these responses are totally comprehensive, but no responsive information is being intentionally withheld. Because there is no central repository for the information sought, and because of the length of time some of the entities have been in existence, the applicant's responses are limited to the past 5 years as a reasonable look-back period.

**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 or 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 than 5%.**

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

We assume for the purpose of this question that "state licensure action" refers to facility licensure. Parkridge Medical Center, Inc. has not been subjected to Final Order or Judgment in a state licensure action regarding any of its hospitals. The other entities in the chain of ownership do not hold a hospital license.

**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;**

Parkridge Medical Center, Inc. has not been involved in civil litigation whereby a Civil Monetary Penalty was paid. We are not aware that any of the entities upstream from that entity as reflected in Attachment Section A-4 A(2) have been involved in civil litigation whereby a judgment or settlement was entered into resulting in the payment of a Civil Monetary Penalty.

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

Parkridge Medical Center, Inc., has not been involved in civil litigation whereby an Administrative Monetary Penalty was paid. We are not aware that any of the entities upstream from this entity as reflected in Attachment Section A-4 A(2) have been involved in civil litigation whereby a judgment or settlement was entered into resulting in the payment of an Administrative Monetary Penalty.

**5) Agreement to pay civil or administrative 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**

Please see the response to (3) and (4) above.

**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.**

Parkridge Medical Center, Inc. is a party in approximately 23 civil lawsuits, which is not unusual for a large health system.

Certain of the entities listed in Attachment Section A-4 A(2) may have been subject to an investigation, regulatory action or party to a civil action (broadly interpreting "civil action"). None of the entities in Attachment Section A-4 A(2) have been the subject of a criminal action.

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

Parkridge Medical Center entered into a corporate integrity agreement (CIA) with the Office of the Inspector General (OIG) on September 14, 2012. Parkridge is in full compliance with the terms of the CIA.

6. **Outstanding Projects:**

**A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and**

Parkridge Health system holds the following outstanding CON:

| Outstanding Projects | | | | | |
|---|---|---|---|---|---|
| CON Number | Project Name | Date Approved | *Annual Progress Report(s) | | Expiration Date |
| | | | Due Date | Date Filed | |
| CN1503-007 | Parkridge Medical Center | 6-24-2015 | 6-24-2016 | 7-4-2016 | 8-1-2020 |

*** 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.**

**B. Provide a brief description of the current progress, and status of each applicable outstanding CON.**

This is a large campus expansion and modernization project. It is on schedule, and should be completed within the period of validity of the CON. Annual Progress Reports will be submitted as they become due.

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

N/A. Parkridge West does not operate such equipment.

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)? _____**

No

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

N/A

C. **If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? _____**

N/A

**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.

## 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.**

   This appears to be a policy statement to which no response is necessary.

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

   This project will improve access to adult psychiatric beds in the eservice area.

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

Converting 8 currently unstaffed med-surg beds to adult psych beds to provide needed additional capacity for adult psych beds at Parkridge West is the most efficient use of heath resources.

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

Parkridge West is licensed and monitored by the Tennessee Department of Health. Parkridge West is also accredited ad monitored by the Joint Commission. Parkridge Wet is in good standing with all relevant licensing and accrediting agencies.

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

The additional beds will not require any additional psychiatrists to be added to the medical staff. Parkridge West has an employed psychiatrist as its Medical Director, and 2 other psychiatrists in Parkridge Health System who do or can rotate through the Parkridge West unit.

This project will require 5.5 additional FTE non-physician staffing. HCA and Parkridge Health System have an effective recruiting program, and should be able to fill these positions as needed.

## 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.**

A Publisher's Affidavit has been requested from the Chattanooga Times Free Press and will be submitted in a timely fashion.

## NOTIFICATION REQUIREMENTS

**(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)**

**Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of 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 state representative and senator representing the house district and senate 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.**

N/A.

## 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.**
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.**

N/A. An extended period of validity is not requested.

# 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 | | 02/17 |
| 2. Architectural and engineering contract signed | 14 | 03/17 |
| 3. Construction documents approved by the Tennessee Department of Health | 120 | 06/17 |
| 4. Construction contract signed | 120 | 06/17 |
| 5. Building permit secured | 134 | 06/17 |
| 6. Site preparation completed | 176 | 08/17 |
| 7. Building construction commenced | 190 | 09/17 |
| 8. Construction 40% complete | 310 | 01/18 |
| 9. Construction 80% complete | 370 | 03/18 |
| 10. Construction 100% complete (approved for occupancy) | 412 | 05/18 |
| 11. *Issuance of License | 426 | 06/18 |
| 12. *Issuance of Service | 426 | 06/18 |
| 13. Final Architectural Certification of Payment | 440 | 06/18 |
| 14. Final Project Report Form submitted (Form HR0055) | 454 | 06/18 |

***For projects that *DO NOT* involve construction or renovation, 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**

## List of Attachments

## Parkridge West Hospital

| | |
|---|---|
| Corporate organizational documentation | Attachment Section A-4A(1) |
| Ownership chart | Attachment Section A-4A(2) |
| Copy of the Deed | Attachment Section A-6A |
| Plot plan | Attachment Section A-6B(1) |
| Floor plan | Attachment Section A-6B(2) |
| Bed need calculations | Attachment Section B, Need, 1, (1) |
| TDMHSAS prevalence data | Attachment Section B, Need, 1, (3) |
| Adult psychiatric beds utilization in the PSA | Attachment Section B, Need, 1, (9) |
| HCA Behavioral Health surveys | Attachment Section B, Need, 1, (18) |
| Map of the proposed PSA | Attachment Section B, Need, 3 |
| Demographics of Population | Attachment Section B, Need, 4A |
| Letter from the project architect | Attachment Section B, Economic Feasibility, 1, E |
| Funding letter | Attachment Section B, Economic Feasibility, 2 |
| Audited Financial Statements | Attachment Section B, Economic Feasibility, 6, B |
| Current license/accreditation certification | Attachment Section B, Orderly Development, 5A |
| Survey & plan of correction | Attachment Section B, Orderly Development, 5B |

**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

# Filing Information

Name: **PARKRIDGE MEDICAL CENTER, INC.**

## General Information

| | | | |
|---|---|---|---|
| **SOS Control #** | **000023600** | Formation Locale: | TENNESSEE |
| Filing Type: | For-profit Corporation - Domestic 07/09/1970 4:30 PM | Date Formed: | 07/09/1970 |
| | | Fiscal Year Close | 12 |
| Status: | Active | | |
| Duration Term: | Perpetual | | |

**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

The following document(s) was/were filed in this office on the date(s) indicated below:

| Date Filed | Filing Description | Image # |
|---|---|---|
| 08/24/2016 | Assumed Name Renewal | B0265-7184 |
| Assumed Name Changed From: PARKRIDGE VALLEY HOSPITAL To: PARKRIDGE VALLEY HOSPITAL | | |
| Expiration Date Changed From: 10/05/2016 To: 08/24/2021 | | |
| 03/09/2016 | 2015 Annual Report | B0211-5742 |
| 03/17/2015 | 2014 Annual Report | B0062-8205 |
| 12/16/2014 | Assumed Name Renewal | B0029-1656 |
| Assumed Name Changed From: Parkridge Health System To: Parkridge Health System | | |
| Expiration Date Changed From: 01/08/2015 To: 12/16/2019 | | |
| 10/03/2014 | Assumed Name Renewal | B0003-7268 |
| Assumed Name Changed From: PARKRIDGE EAST HOSPITAL To: PARKRIDGE EAST HOSPITAL | | |
| Expiration Date Changed From: 10/12/2014 To: 10/03/2019 | | |
| 04/21/2014 | Assumed Name | 7333-0311 |
| New Assumed Name Changed From: No Value To: Parkridge West Hospital | | |
| 04/15/2014 | Assumed Name | 7330-1883 |
| New Assumed Name Changed From: No Value To: Parkridge West Hospital, A Facility of Parkridge Medical Center | | |
| 03/28/2014 | 2013 Annual Report | 7315-0498 |
| 03/11/2014 | Assumed Name | 7297-2287 |



**Attachment Section A-4A(1)**

CHARTER

OF

PARKRIDGE HOSPITAL, INC.

The undersigned natural persons, having capacity to contract and acting as the incorporators of a cor oration under the Tennessee General Corporation Act, adopt the following Charter for such corporation:

1. The name of the corporation is Parkridge Hospital, Inc.

2. The duration of the corporation is perpetual.

3. The address of the principal office of the corporation in the State of Tennessee shall be 242 25th Avenue, North, Nashville, County of Davidson.

4. The corporation is for profit.

5. The purposes for which the corporation is organized are:

(a) To own, manage and operate hospitals, nursing homes, clinics, and all other types of health-care or medically oriented facilities.

(b) To buy, sell and lease articles of commerce, and, in connection therewith, to own, manage and operate wholesale and retail sales outlets.

(c) To buy, sell, develop, and lease real estate.

(d) To provide consultation, advisory and management services to any business, whether corporation, trust, association, partnership, joint venture or proprietorship.

(e) To engage in any lawful businesses which are directly or indirectly related to the above purposes.

PM 2 52

6. The maximum number of shares which the corporation shall have the authority to issue is One Hundred Thousand (100,000) shares of Common Stock, par value of $1.00 per share.

7. The corporation will not commence business until the consideration of One Thousand Dollars ($1,000) has been received for the issuance of shares.

8. (a) The shareholders of this corporation shall have none of the preemptive rights set forth in the Tennessee General Corporation Act.

(b) The initial bylaws of this corporation shall be adopted by the incorporators hereof, and thereafter, the bylaws of this corporation may be amended, repealed or adopted by a majority of the members of the entire Board of Directors, or by the holders of a majority of the outstanding shares of capital stock.

(c) This corporation shall have the right and power to purchase and hold shares of its capital stock; provided, however, that such purchase, whether direct or indirect, shall be made only to the extent of unreserved and unrestricted capital surplus.

Dated July 9 , 1970.

Robert G. McCullough

Maclin P. Davis, Jr.

William E. Martin

RECEIVED
STATE OF TENNESSEE

2010 JAN -8 PM 3:14

6640.1387

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

# APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

For Office Use Only
SECRETARY OF STATE

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Parkridge Medical Center, Inc.

2. The state or country of incorporation is Tennessee

3. The corporation intends to transact business in Tennessee under an assumed corporate name.

4. The assumed corporate name the corporation proposes to use is
Parkridge Health System

[NOTE: The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

1/7/2010
Signature Date

Parkridge Medical Center, Inc.
Name of Corporation

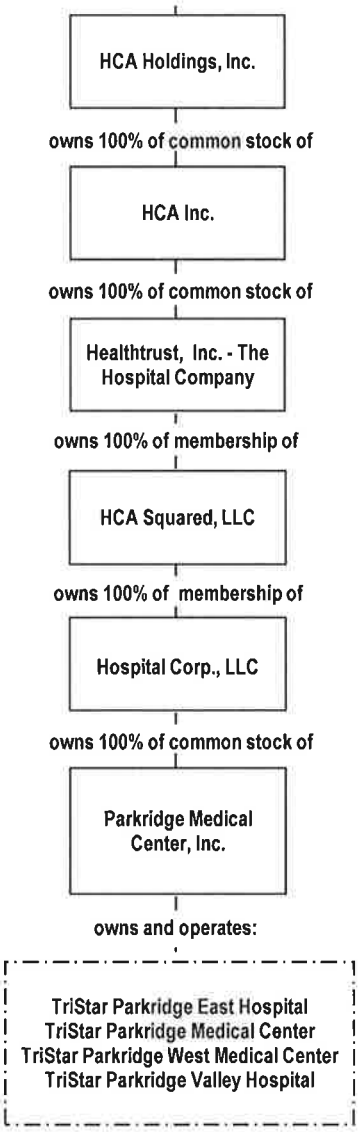
Vice President and Secretary
Signer's Capacity

Dora A. Blackwood
Signature

Dora A. Blackwood
Name (typed or printed)

SS-4402 (Rev. 4/01) Filing Fee: $20 RDA1720

TN008 - 12/12/2002 C T System Online


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 membership of
HCA Squared, LLC
owns 100% of membership of
Hospital Corp., LLC
owns 100% of common stock of
Parkridge Medical Center, Inc.
owns and operates:
TriStar Parkridge East Hospital
TriStar Parkridge Medical Center
TriStar Parkridge West Medical Center
TriStar Parkridge Valley Hospital

----------SPACE ABOVE THIS LINE FOR RECORDER'S USE----------

THIS INSTRUMENT PREPARED BY,
AND AFTER RECORDING RETURN TO:

King & Spalding LLP
Attention: Benjamin W. Middendorf
1180 Peachtree Street
Atlanta, Georgia 30309

BK/PG: 457/117-127
14000635

| 11 PGS:AL-WARRANTY DEED | |
|---|---|
| SANDRA BATCH 50510 03/03/2014 - 10:08:20 AM | |
| VALUE | 5374898.00 |
| MORTGAGE TAX | 0.00 |
| TRANSFER TAX | 19887.12 |
| RECORDING FEE | 55.00 |
| ARCHIVE FEE | 0.00 |
| DP FEE | 2.00 |
| REGISTER'S FEE | 1.00 |
| TOTAL AMOUNT | 19945.12 |

STATE OF TENNESSEE, MARION COUNTY
WINFRED HAGGARD
REGISTER OF DEEDS

## LIMITED WARRANTY DEED

**THIS INDENTURE**, made this 28th day of February, 2014, between **SP ACQUISITION CORP.**, a Tennessee corporation (hereinafter referred to as "Grantor"), and **PARKRIDGE MEDICAL CENTER, INC.**, a Tennessee corporation (hereinafter referred to as "Grantee"), having an address c/o HCA Corporate Real Estate, One Park Plaza, Nashville, Tennessee 37203, Attention: Ron Woods (the words "Grantor" and "Grantee" to include their respective heirs, legal representatives, successors and assigns where the context requires or permits);

W I T N E S S E T H: That,

**FOR AND IN CONSIDERATION OF** the sum of TEN AND NO/100 DOLLARS ($10.00) and other good and valuable consideration in hand paid at and before the sealing and delivery of these presents, the receipt and sufficiency whereof are hereby acknowledged, Grantor has granted, bargained, sold, aliened, conveyed and confirmed, and by these presents does hereby grant, bargain, sell, alien, convey and confirm unto Grantee, all that tract or parcel of land being more particularly described in Exhibit A, attached hereto and incorporated herein by this reference (hereinafter referred to as the "Land");

TOGETHER WITH all buildings, structures, fixtures and improvements thereon and all rights, members, easements, and appurtenances appertaining to the Land and all right, title, interest and estate of Grantor in and to any and all alleys, streets and rights-of-way adjacent to or abutting the Land; and

TOGETHER WITH all of Grantor's rights, powers, privileges and options, if any, as the "Declarant" under the following Declarations:

1. Declaration of Covenants, Restrictions and Easements, dated July 1, 2000, made by SP Acquisition Corp., as Declarant, and recorded in Book 282, at pages 491 *et seq.*, Register's Office of Marion County, Tennessee, as amended by instruments recorded in Book 291, page 1112, Book 303, page 538, Book 330, page 755 and Book 357, page 1153, aforesaid records;

2. Declaration of Restrictive Covenants, dated January 24, 2001, made by SP Acquisition Corp., as Declarant, and recorded in Book 291, page 1123, in the Register's Office for Marion County, Tennessee; and

3. Declaration of Easements, dated January 24, 2001, made by SP Acquisition Corp., as Declarant, and recorded in Book 291, page 1135, in the Register's Office for Marion County, Tennessee.

The Land, together with all of the foregoing described assets, properties, rights and interests, is herein called the "Property".

TO HAVE AND TO HOLD the Property, together with all and singular the rights, members and appurtenances thereof, to the same being, belonging or in any wise appertaining to the only proper use, benefit and behoof of Grantee, its successors and assigns, forever, IN FEE SIMPLE, subject to the Permitted Exceptions.

The conveyance effected hereby and the limited warranty of title contained herein are made expressly subject to those certain matters set forth in Exhibit B attached hereto and by this reference incorporated herein and made a part hereof (the "Permitted Exceptions").

And, except as to the Permitted Exceptions, Grantor will warrant and forever defend the right and title to the Property unto Grantee, its successors and assigns, against the claims of all persons claiming by, through or under Grantor, and no further.

IN WITNESS WHEREOF, Grantor has signed and sealed this deed, the date and year first above written.

**GRANTOR:**

**SP ACQUISITION CORP.,**
a Tennessee corporation

By: _____
Name: D. Andrew Slusser
Title: Vice President

STATE OF TENNESSEE

COUNTY OF Davidson

Personally appeared before me, the undersigned, a Notary Public having authority within the State and County aforesaid, D. Andrew Slusser, with whom I am personally acquainted, and who acknowledged that he executed the within instrument for the purposes therein contained, and who further acknowledged that he is the Vice President of SP ACQUISITION CORP., a Tennessee corporation, and is authorized by the corporation to execute this instrument on behalf of the corporation.

WITNESS my hand, at office, this 26 day of February, 2014.

Cindy Paragone
Notary Public

My Commission Expires: July 7, 2014

CINDY PARAGONE
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 7, 2014

| | |
|---|---|
| I, or we, hereby swear or affirm that, to the best of affiant's knowledge, information, and belief, the actual consideration for this transfer or value of the property transferred, whichever is greater, is $ 5,374,898.00 which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.<br><br>Affiant Name: D. Andrew Slusser | Subscribed and sworn to before me this 26 day of February, 2014.<br><br>Cindy Paragone<br>Notary Public<br><br>My commission expires: July 7, 2014<br><br>CINDY PARAGONE STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY My Commission Expires July 7, 2014 |

| | |
|---|---|
| **Property Address:**<br><br>980 Highway 28<br>Jasper, Tennessee | **Parcel I.D. Nos.:**<br><br>Tax Map 132, Parcels 65.01 and 65.03 |
| **Name and address of property owners:**<br>Parkridge Medical Center, Inc.<br>c/o HCA Corporate Real Estate<br>Attention: Ron Woods<br>One Park Plaza<br>Nashville, Tennessee 37203 | **Mail tax bills to:**<br><br>HCA Corporate Real Estate<br>Attention: Ron Woods<br>One Park Plaza<br>Nashville, Tennessee 37203 |

# EXHIBIT A

## LAND

**TRACT 1: (TAX MAP 132, PARCEL 65.01)**

BEING A CERTAIN TRACT OF LAND LOCATED ALONG THE SOUTH RIGHT OF WAY LINE OF INTERSTATE 24 AND THE EAST RIGHT OF WAY LINE OF TENNESSEE STATE HIGHWAY NO. 28 IN THE 2ND CIVIL DISTRICT OF MARION COUNTY, TENNESSEE AND BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

COMMENCING AT A TENNESSEE STATE HIGHWAY MONUMENT 150.3+ RIGHT OF STATION 48+10.72 OF THE STATE OF TENNESSEE HIGHWAY PROJECT NUMBER F-13(2) LOCATED AT THE NORTHERN MOST PROPERTY CORNER OF TRACT 2; ON THE RIGHT OF WAY LINE OF INTERSTATE 24, THENCE ALONG THE SAID R.O.W. LINE SOUTH 76 DEGREES 56 MINUTES 21 SECONDS EAST, A DISTANCE OF 106.52 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE SOUTH 13 DEGREES 12 MINUTES 36 SECONDS WEST, A DISTANCE OF 89.57 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE SOUTH 76 DEGREES 53 MINUTES 18 SECONDS EAST, A DISTANCE OF 499.71 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE NORTH 13 DEGREES 20 MINUTES 19 SECONDS EAST, A DISTANCE OF 99.87 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE SOUTH 78 DEGREES 14 MINUTES 51 SECONDS EAST, A DISTANCE OF 594.99 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE ALONG THE SEQUATCHIE RIVER AND T.V.A. BOUNDARY SOUTH 04 DEGREES 12 MINUTES 46 SECONDS EAST, A DISTANCE OF 880.72 FEET TO AN IRON PIN NEW;

THENCE ALONG THE SEQUATCHIE RIVER SOUTH 12 DEGREES 47 MINUTES 21 SECONDS EAST, A DISTANCE OF 145.00 FEET TO T.V.A MONUMENT #234;

THENCE ALONG THE SEQUATCHIE RIVER SOUTH 17 DEGREES 32 MINUTES 33 SECONDS EAST, A DISTANCE OF 254.33 FEET T.V.A. MONUMENT #235 THE TRUE POINT OF BEGINNING;

THENCE ALONG THE SEQUATCHIE RIVER SOUTH 17 DEGREES 13 MINUTES 41 SECONDS EAST, A DISTANCE OF 153.00 FEET TO T.V.A MONUMENT #236;

THENCE SOUTH 87 DEGREES 37 MINUTES 10 SECONDS WEST, A DISTANCE OF 159.89 FEET TO AN IRON PIN NEW;

THENCE SOUTH 86 DEGREES 04 MINUTES 38 SECONDS WEST, A DISTANCE OF 169.44 FEET TO AN IRON PIN NEW;

THENCE SOUTH 75 DEGREES 58 MINUTES 42 SECONDS WEST, A DISTANCE OF 167.89 FEET TO AN IRON PIN NEW;

THENCE SOUTH 68 DEGREES 08 MINUTES 07 SECONDS WEST, A DISTANCE OF 88.13 FEET TO AN IRON PIN NEW;

THENCE NORTH 19 DEGREES 01 MINUTES 50 SECONDS WEST, A DISTANCE OF 93.10 FEET TO AN IRON PIN NEW;

THENCE NORTH 50 DEGREES 51 MINUTES 50 SECONDS EAST, A DISTANCE OF 162.69 FEET TO AN IRON PIN NEW;

THENCE NORTH 75 DEGREES 58 MINUTES 42 SECONDS EAST, A DISTANCE OF 128.69 FEET TO AN IRON PIN NEW;

THENCE NORTH 86 DEGREES 04 MINUTES 38 SECONDS EAST, A DISTANCE OF 184.72 FEET TO AN IRON PIN NEW;

THENCE NORTH 88 DEGREES 28 MINUTES 30 SECONDS EAST, A DISTANCE OF 123.23 FEET TO THE POINT OF BEGINNING AND CONTAINING 83,091 SQUARE FEET OR 1.91 ACRES, MORE OR LESS.

TOGETHER WITH, ALL EASEMENTS, RIGHT, PRIVILEGES AND APPURTENANCES TO THE FOREGOING BELONGING.

TOGETHER WITH, ALL OF GRANTOR'S RIGHT UNDER THAT CERTAIN EASEMENT, DATED JULY 30, 1983, OF RECORD IN DEED BOOK 9-X, PAGE 533, REGARDING THE RELOCATION OF ANY ROAD CONSTRUCTED PURSUANT TO THE EASEMENT GRANTED IN SAID EASEMENT.

BEING THE SAME PROPERTY CONVEYED TO SP ACQUISITION CORP., A TENNESSEE CORPORATION, BY DEEDS OF RECORD IN BOOK 222, PAGE 198, REGISTER'S OFFICE FOR MARION COUNTY, TENNESSEE.

**TRACT 2: (TAX MAP 132, PARCEL 65.03)**

BEING A CERTAIN TRACT OF LAND LOCATED ALONG THE SOUTH RIGHT OF WAY LINE OF INTERSTATE 24 AND THE EAST RIGHT OF WAY LINE OF TENNESSEE STATE HIGHWAY NO. 28 IN THE 2ND CIVIL DISTRICT OF MARION COUNTY, TENNESSEE AND BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

BEGINNING WITH A TENNESSEE STATE HIGHWAY MONUMENT 150.3 RIGHT OF STATION 48+10.72 OF THE STATE OF TENNESSEE HIGHWAY PROJECT NUMBER F-13(2) LOCATED AT THE NORTHERN MOST PROPERTY CORNER; ON THE RIGHT OF WAY LINE OF INTERSTATE 24, THENCE ALONG THE SAID R.O.W. LINE SOUTH 76 DEGREES 56 MINUTES 21 SECONDS EAST, A DISTANCE OF 106.52 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE SOUTH 13 DEGREES 12 MINUTES 36 SECONDS WEST, A DISTANCE OF 89.57 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE SOUTH 76 DEGREE 53 MINUTES 18 SECONDS EAST, A DISTANCE OF 499.71 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE NORTH 13 DEGREES 20 MINUTES 19 SECONDS EAST, A DISTANCE OF 99.87 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE CONTINUING WITH SAID R.O.W. LINE SOUTH 78 DEGREES 14 MINUTES 51 SECONDS EAST, A DISTANCE OF 594.99 FEET TO AN INTERSTATE R/W MONUMENT;

THENCE ALONG THE SEQUATCHIE RIVER AND THE T.V.A. BOUNDARY SOUTH 04 DEGREES 12 MINUTES 46 SECONDS EAST, A DISTANCE OF 880.72 FEET TO AN IRON PIN NEW;

THENCE ALONG THE SEQUATCHIE RIVER SOUTH 12 DEGREES 47 MINUTES 21 SECONDS EAST, A DISTANCE OF 145.00 FEET TO TVA MONUMENT #234;

THENCE ALONG THE SEQUATCHIE RIVER SOUTH 17 DEGREES 32 MINUTES 33 SECONDS EAST, A DISTANCE OF 254.33 FEET TO TVA MONUMENT #235;

THENCE SOUTH 88 DEGREES 26 MINUTES 30 SECONDS WEST, A DISTANCE OF 123.23 FEET TO AN IRON PIN NEW;

THENCE SOUTH 86 DEGREES 04 MINUTES 38 SECONDS WEST, A DISTANCE OF 184.72 FEET TO AN IRON PIN NEW;

THENCE SOUTH 75 DEGREES 58 MINUTES 42 SECONDS WEST, A DISTANCE OF 128.69 FEET TO AN IRON PIN NEW;

THENCE SOUTH 50 DEGREES 51 MINUTES 50 SECONDS WEST, A DISTANCE OF 162.69 FEET TO AN IRON PIN NEW;

THENCE SOUTH 19 DEGREES 01 MINUTES 50 SECONDS EAST, A DISTANCE OF 93.10 FEET TO AN IRON PIN NEW;

THENCE SOUTH 60 DEGREES 31 MINUTES 08 SECONDS WEST, A DISTANCE OF 260.53 FEET TO AN IRON PIN NEW;

THENCE SOUTH 85 DEGREES 59 MINUTES 48 SECONDS WEST, A DISTANCE OF 87.43 FEET TO AN IRON PIN NEW IN THE NORTHERN R.O.W. LINE OF CHASEY SIMPSON ROAD (FORMERLY BROWDER SWITCH ROAD);

THENCE WITH SAID NORTHERN RIGHT-OF-WAY LINE, SOUTH 66 DEGREES 30 MINUTES 38 SECONDS WEST, A DISTANCE OF 226.64 FEET TO AN IRON PIN NEW;

THENCE SOUTH 89 DEGREES 10 MINUTES 03 SECONDS WEST, A DISTANCE OF 153.75 FEET TO AN IRON PIN NEW;

THENCE NORTH 73 DEGREES 30 MINUTES 18 SECONDS WEST, A DISTANCE OF 131.32 FEET TO AN IRON PIN NEW;

THENCE NORTH 77 DEGREES 56 MINUTES 30 SECONDS WEST, A DISTANCE OF 162.81 FEET TO AN IRON PIN NEW;

THENCE NORTH 81 DEGREES 18 MINUTES 54 SECONDS WEST, A DISTANCE OF 286.47 FEET TO AN IRON PIN NEW;

THENCE NORTH 75 DEGREES 17 MINUTES 25 SECONDS WEST, A DISTANCE OF 165.42 FEET TO AN IRON PIN NEW;

THENCE NORTH 68 DEGREES 59 MINUTES 59 SECONDS WEST, A DISTANCE OF 209.96 FEET TO AN IRON PIN NEW;

THENCE NORTH 66 DEGREES 37 MINUTES 45 SECONDS, A DISTANCE OF 75.77 FEET TO AN IRON PIN NEW;

THENCE LEAVING SAID RIGHT-OF-WAY OF CHASEY SIMPSON ROAD AND RUNNING WITH THE EASTERLY RIGHT-OF-WAY LINE OF STATE HIGHWAY 28 NORTH 27 DEGREES 10 MINUTES 36 SECONDS EAST, A DISTANCE OF 251.14 FEET TO AN IRON PIN NEW;

THE NORTH 66 DEGREES 45 MINUTES 44 SECONDS EAST, A DISTANCE OF 195.28 FEET TO AN IRON PIN NEW;

THENCE NORTH 27 DEGREES 05 MINUTES 34 SECONDS EAST, A DISTANCE OF 400.00 FEET TO AN IRON PIN NEW;

THENCE NORTH 00 DEGREES 31 MINUTES 40 SECONDS EAST, A DISTANCE OF 335.40 FEET TO A STATE HIGHWAY MONUMENT OLD;

THENCE NORTH 27 DEGREES 05 MINUTES 32 SECONDS EAST, A DISTANCE OF 810.80 FEET TO A POINT OF BEGINNING AND CONTAINING 2,749,278 SQUARE FEET OR 63.11 ACRES, MORE OR LESS.

TOGETHER WITH, ALL EASEMENTS, RIGHTS, PRIVILEGES AND APPURTENANCES TO THE FOREGOING BELONGING.

TOGETHER WITH, ALL OF GRANTOR'S RIGHT UNDER THAT CERTAIN WARRANTY DEED, DATED JULY 30, 1983, OF RECORD IN DEED BOOK 9-X, PAGE 531, REGARDING THE RELOCATION OF ANY ROAD CONSTRUCTED PURSUANT TO THE EASEMENT IN SAID WARRANTY DEED.

BEING THE SAME PROPERTY CONVEYED TO SP ACQUISITION CORP, A TENNESSEE CORPORATION, BY DEEDS OF RECORD IN BOOK 222, PAGE 193, REGISTER'S OFFICE FOR MARION COUNTY, TENNESSEE.

## EXHIBIT B

Permitted Exceptions

1. Terms and provisions of Memorandum of Lease by and between SP Acquisition Corp., a Tennessee corporation and Medical Office Buildings of Tennessee, LLC, a Delaware limited liability company of record in Book 282, page 565, in the Register's Office for Marion County, Tennessee; see also Assignment and Assumption of Ground Lease of record in Book 334, page 1190, and Book 367, page 1489, in the Register's Office for Marion County, Tennessee.

2. Terms and provisions of Memorandum of Lease by and between Grandview Psychiatric Associates, L.P., a Tennessee limited liability company and SP Acquisition Corp., a Tennessee corporation of record in Book 291, page 1182, in the Register's Office for Marion County, Tennessee.

3. Terms and provisions of Memorandum of Ground Lease by and between SP Acquisition Corp., a Tennessee corporation and Grandview Psychiatric Associates, L.P., a Tennessee limited liability company of record in Book 291, page 1177, in the Register's Office for Marion County, Tennessee.

4. Covenants, conditions, restrictions, reservations, and easements of record in Declaration of Covenants, Restrictions and Easements recorded in Book 282, page 491, as amended in Book 291, page 1112, Book 303, page 538, Book 330, page 755 and Book 357, page 1153, in the Register's Office for Marion County, Tennessee.

5. Covenants, conditions, restrictions, reservations, and easements of record in Declaration of Restrictive Covenants recorded in Book 291, page 1123, in the Register's Office for Marion County, Tennessee.

6. Declaration of Restrictions on Certain Properties of John E. Acuff, Sr. of record in Miscellaneous Book 14, page 215, in the Register's Office for Marion County, Tennessee.

7. Restrictive Covenants contained in deed of record in Book 222, page 193, in the Register's Office for Marion County, Tennessee.

8. Ingress/Egress Easement of record in Book 9X, page 533, in the Register's Office for Marion County, Tennessee.

9. Permanent easement rights for ingress/egress for road purposes in deed of record in Book 9X, page 531, in the Register's Office for Marion County, Tennessee.

10. Declaration of Easements of record in Book 291, page 1135, in the Register's Office for Marion County, Tennessee.

11. Lack of access to and from a controlled access highway, I-24.

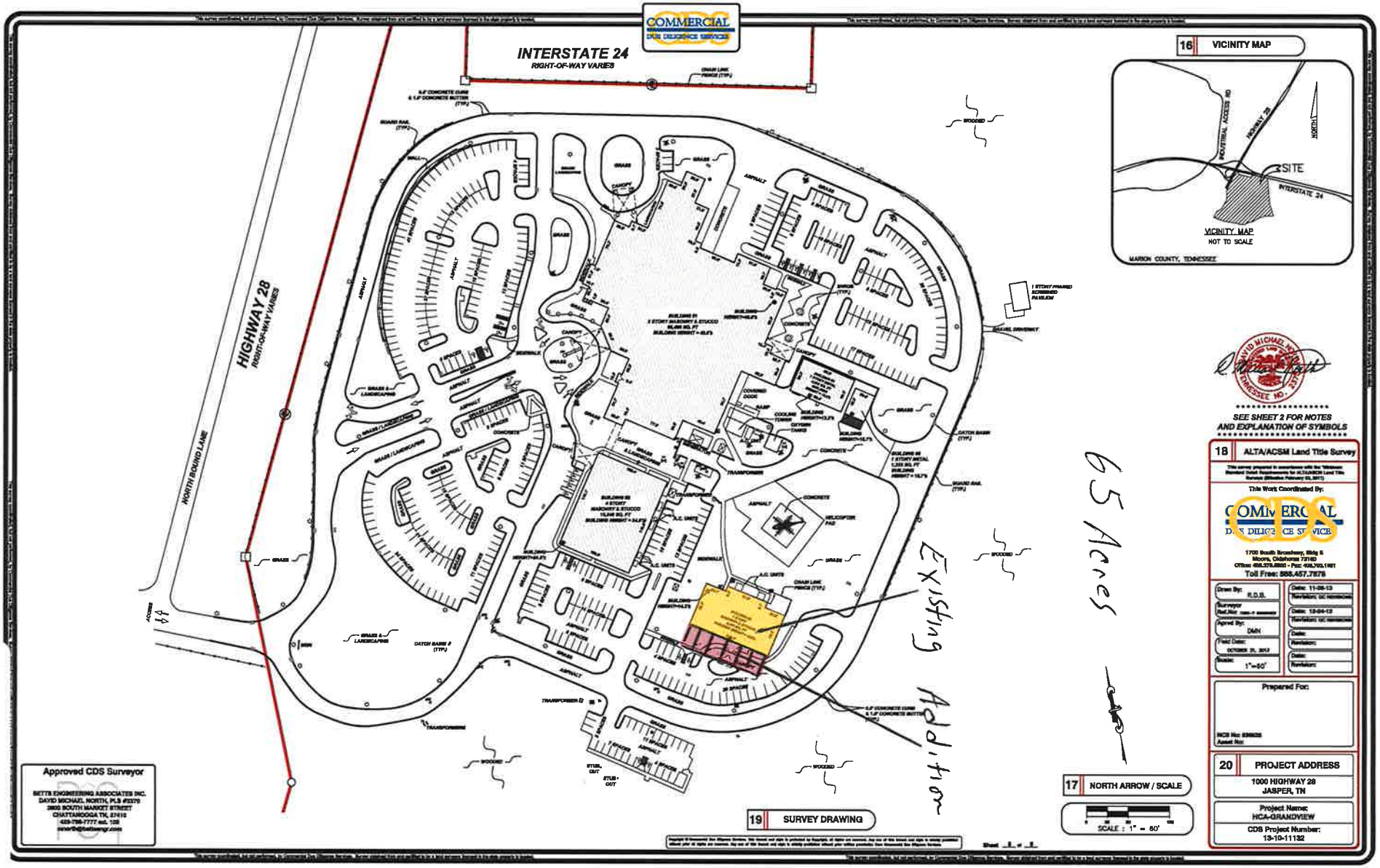
12. Easement for the flow of the waters of the Sequatchie River (or creek), and the rights of the public therein.

13. Rights of upper and lower riparian owners to the flow of the waters of the Sequatchie River (or creek), free from diminution or pollution.

14. Changes in the boundary of the land resulting from erosion or accretion caused by the flow of the Sequatchie River (or creek).

15. Any facts, rights, interests or claims that may exist or arise by reason of the following matters disclosed by an ALTA/ACSM survey made by Betts Engineering Associates, Inc. for Commercial Due Diligence Services on November 6, 2013, last revised December 24, 2013, designated Project Number 13-10-11132: (A) possible encroachment of fence onto Tract 2 of subject property (413.1' x 6.4'); (B) possible encroachment of fence on Tract 2 of subject property (97.9' x 0.2') and (C) possible encroachment of fence onto Tract 2 of subject property (62.2' x 3.9').

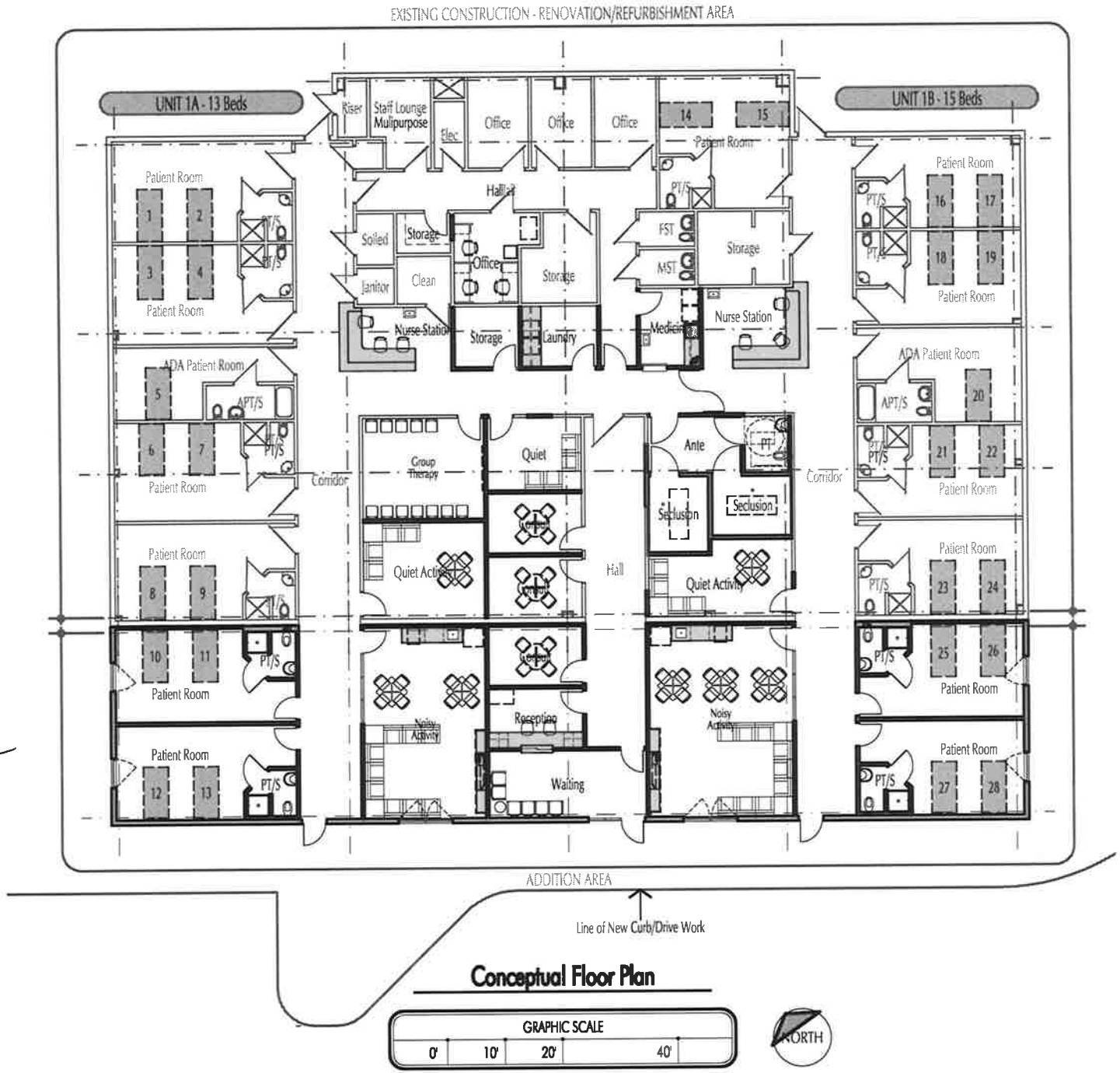
16. Taxes and assessments for 2014 and any subsequent years, not yet due and payable.




Attachment Section A-6B-(1)

Existing

Addition



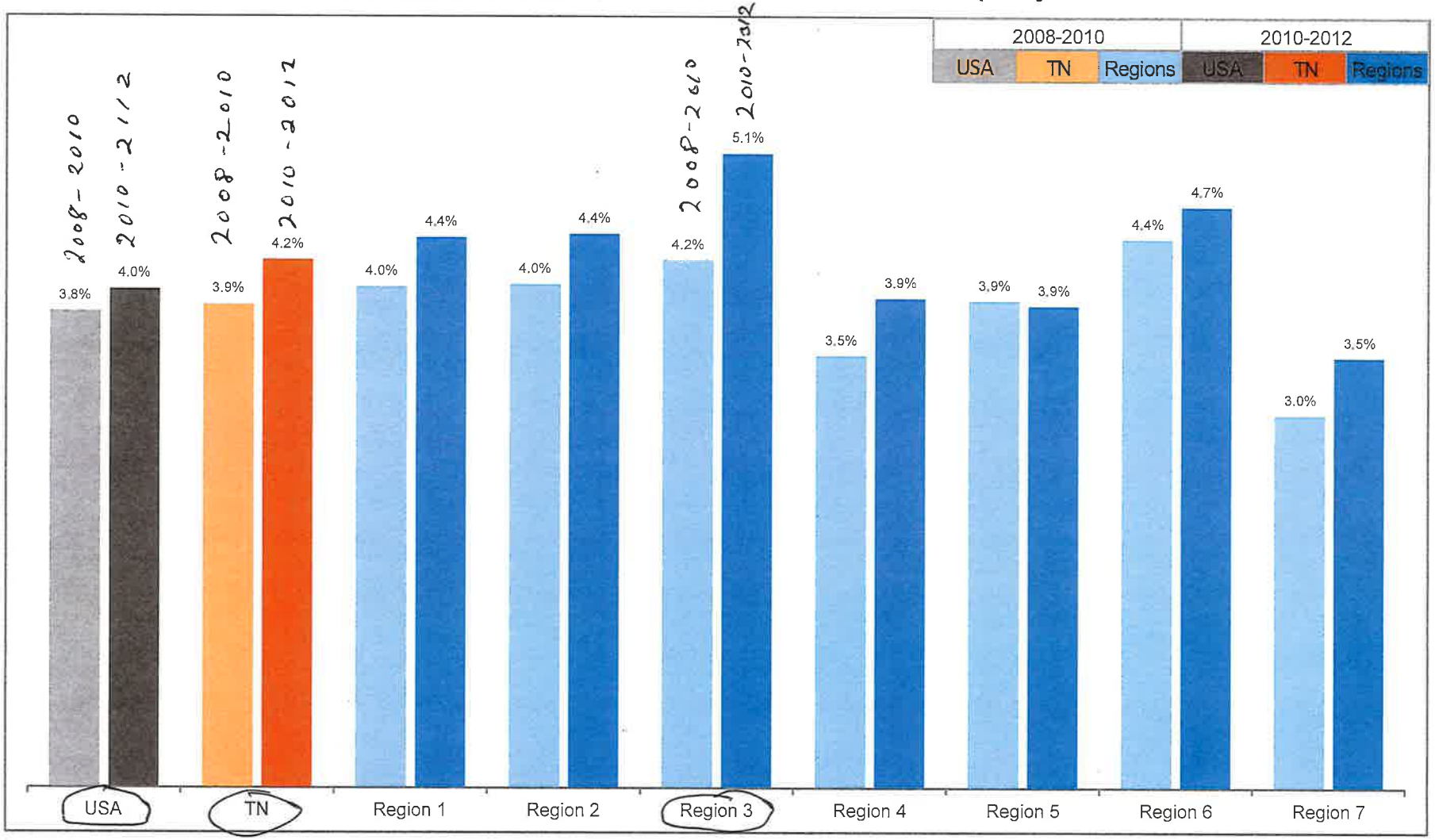

**Conceptual Floor Plan**

Attachment Section A-6B-(2)

| BED NEED CALCULATION 2016 & 2018 -- TENNESSEE PRIMARY SERVICE AREA | | | | | | |
|---|---|---|---|---|---|---|
| **Year: 2016** | | | | | | |
| **County** | 2016 Population Ages 18-64 | 2016 Population Ages 65+ | 2016 Total Population Ages 18+ | 2016 Gross Bed Need Population Ages 18+ | Existing Adult Psych Beds* | Net Adult Psych Bed Need |
| Bradley | 64,055 | 17,879 | 81,934 | 24.6 | 30 | -5.4 |
| Grundy | 7,567 | 3,021 | 10,588 | 3.2 | 0 | 3.2 |
| Hamilton | 217,501 | 61,073 | 278,574 | 83.6 | 266 | -182.4 |
| Marion | 16,911 | 5,763 | 22,674 | 6.8 | 20 | -13.2 |
| Sequatchie | 9,233 | 3,195 | 12,428 | 3.7 | 0 | 3.7 |
| **Totals** | 315,267 | 90,931 | 406,198 | 121.9 | 316 | -194.1 |
| | | | | | | |
| **Year: 2018** | | | | | | |
| **County** | 2018 Population Ages 18-64 | 2018 Population Ages 65+ | 2018 Total Population Ages 18+ | 2018 Gross Bed Need Population Ages 18+ | Existing Adult Psych Beds* | Net Adult Psych Bed Need |
| Bradley | 64,835 | 19,073 | 83,908 | 25.2 | 30 | -4.8 |
| Grundy | 7,432 | 3,163 | 10,595 | 3.2 | 0 | 3.2 |
| Hamilton | 218,256 | 65,201 | 283,457 | 85.0 | 266 | -181.0 |
| Marion | 16,634 | 6,170 | 22,804 | 6.8 | 20 | -13.2 |
| Sequatchie | 9,410 | 3,536 | 12,946 | 3.9 | 0 | 3.9 |
| **Totals** | 316,567 | 97,143 | 413,710 | 124.1 | 316 | -191.9 |

* Source: 2015 Joint Annual Reports. Numbers include beds designated as geriatic. Hamilton County totals include 36 new adult/geri beds granted by CN1603-012A.

## Percentage of adults with serious mental illness in the past year




Note: No data collected for 2006-2008.

Includes PSA



Attachment Section B, Need, 1, (3)

| UTILIZATION OF EXISTING ADULT PSYCHIATRIC BEDS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Year: 2015** | | | | | | | | |
| **Facility** | **County** | **Total Adult Psych Beds** | **Adult Admissions** | **ALOS** | **Days Age 18-64** | **Days Age 65+** | **Total Days** | **Occupancy on Total Adult Psych Beds** |
| Erlanger North | Hamilton | 12 | 249 | 14.3 | 142 | 3,407 | 3,549 | 81% |
| Parkridge Valley Adult | Hamilton | 48 | 1,602 | 6.5 | 7,879 | 2,494 | 10,373 | 59% |
| Parkridge West | Marion | 20 | 568 | 10.4 | 4,969 | 945 | 5,914 | 81% |
| Moccasin Bend MHI | Hamilton | 150 | 3,442 | 14.4 | 44,085 | 5,495 | 49,580 | 91% |
| Skyridge Westside | Bradley | 30 | 751 | 4.1 | 3,027 | 78 | 3,105 | 28% |
| **Totals** | | 260 | 6,612 | 11 | 60,102 | 12,419 | 72,521 | 76.4% |

| **Year: 2014** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Facility** | **County** | **Total Adult Psych Beds** | **Adult Admissions** | **ALOS** | **Days Age 18-64** | **Days Age 65+** | **Total Days** | **Occupancy on Total Adult Psych Beds** |
| Erlanger North | Hamilton | 12 | 262 | 13.8 | 188 | 3,440 | 3,628 | 83% |
| Parkridge Valley Adult | Hamilton | 48 | 1,594 | 6.4 | 7,382 | 2,860 | 10,242 | 58% |
| Parkridge West | Marion | 20 | 413 | 10.1 | 3,228 | 957 | 4,185 | 57% |
| Moccasin Bend MHI | Hamilton | 150 | 2,999 | 16.6 | 43,417 | 6,458 | 49,875 | 91% |
| Skyridge Westside | Bradley | 30 | 841 | 4.9 | 3,936 | 171 | 4,107 | 37% |
| **Totals** | | 260 | 6,109 | 11.8 | 58,151 | 13,886 | 72,037 | 75.9% |

SUPPLEMENTAL #2
November 1, 2016
1:26 pm

# JOINT COMMISSION AND
# DEPARTMENT OF HEALTH SURVEYS
# HCA PSYCHIATRIC FACILITIES IN TENNESSEE

Attachment Section B,
Need, 1, (18)

**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**

# Executive Summary

| Program(s) | Survey Date(s) |
| --- | --- |
| Hospital Accreditation<br>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 |

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**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 |

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**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 |

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**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.

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:**

| | | |
|---|---|---|
| | 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

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.**

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Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01

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.

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**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 |

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**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.

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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".**

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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.**

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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.**

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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.**

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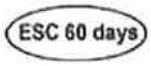
Chapter: Leadership

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)**

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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.**

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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)

4

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)

4

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:

**SUPPLEMENTAL #2**

**November 1, 2016**

**1:26 pm**

**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.**

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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.**

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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.**

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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 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.**

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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.**

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Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

ESC 45 days

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)

3

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.

4

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.**

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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.**

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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.**

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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):

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.**

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# 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.**

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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.**

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| | |
|---|---|
| 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.**

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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.**

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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.**

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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.**

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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).**

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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.**

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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.

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**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~~ 410-421 **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) |
|---|---|---|
| 445101 | 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 Bartl | | |

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<br>(i) Has in effect an agreement to participate as a hospital;<br>(ii) Is not excluded in its entirety from the prospective payment systems; and<br>(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?<br>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?<br>Does the unit meet any special licensing requirements of the state? | X | | |

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November 1, 2016
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| 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?<br>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)<br>Is treatment provided for physical illnesses requiring immediate attention?<br>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
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| 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?<br>1) Factual and historical information,<br>2) Social evaluation (baseline social functioning including strengths and weaknesses), and<br>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:<br>1) Chief complaints, reaction to hospitalization,<br>2) Past history of any psychiatric problems and treatment, including previous precipitating factors, diagnosis, and course of treatment, and<br>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.**<br>(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?<br>Is the treatment plan individualized?<br>Is there a primary diagnosis upon which the treatment interventions are based?<br>Are the treatment plan goals written in a manner that allows for changes in the patient's behavior to be measured?<br>Are the treatment plan goals relevant to the patient's condition?<br>Does the treatment team encourage the patient's active participation and responsibility for engaging in the treatment regimen?<br>For patients who have been secluded or restrained, have less restrictive interventions been considered prior to the use of seclusion or restraints?<br>What is the rationale for use of seclusion and/or restraints?<br>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?<br>Is the patient receiving all aspects of treatment to which the unit has committed itself, based on the assessment, evaluation, and plan of care?<br>Do the policies and procedures adequately direct staff on alternatives or less restrictive interventions prior to the use of seclusion and restraints?<br>Has the staff documented that less restrictive therapeutic interventions have been reviewed and/or attempted? | X | | |

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| 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:<br>1) the treatment plan<br>2) what the staff is doing to carry out the treatment plan, and<br>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?<br>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?<br>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?<br>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?<br>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 area is available due to being part of medical center.

SEPPLEMENTAL #2
November 1, 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
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 | | |

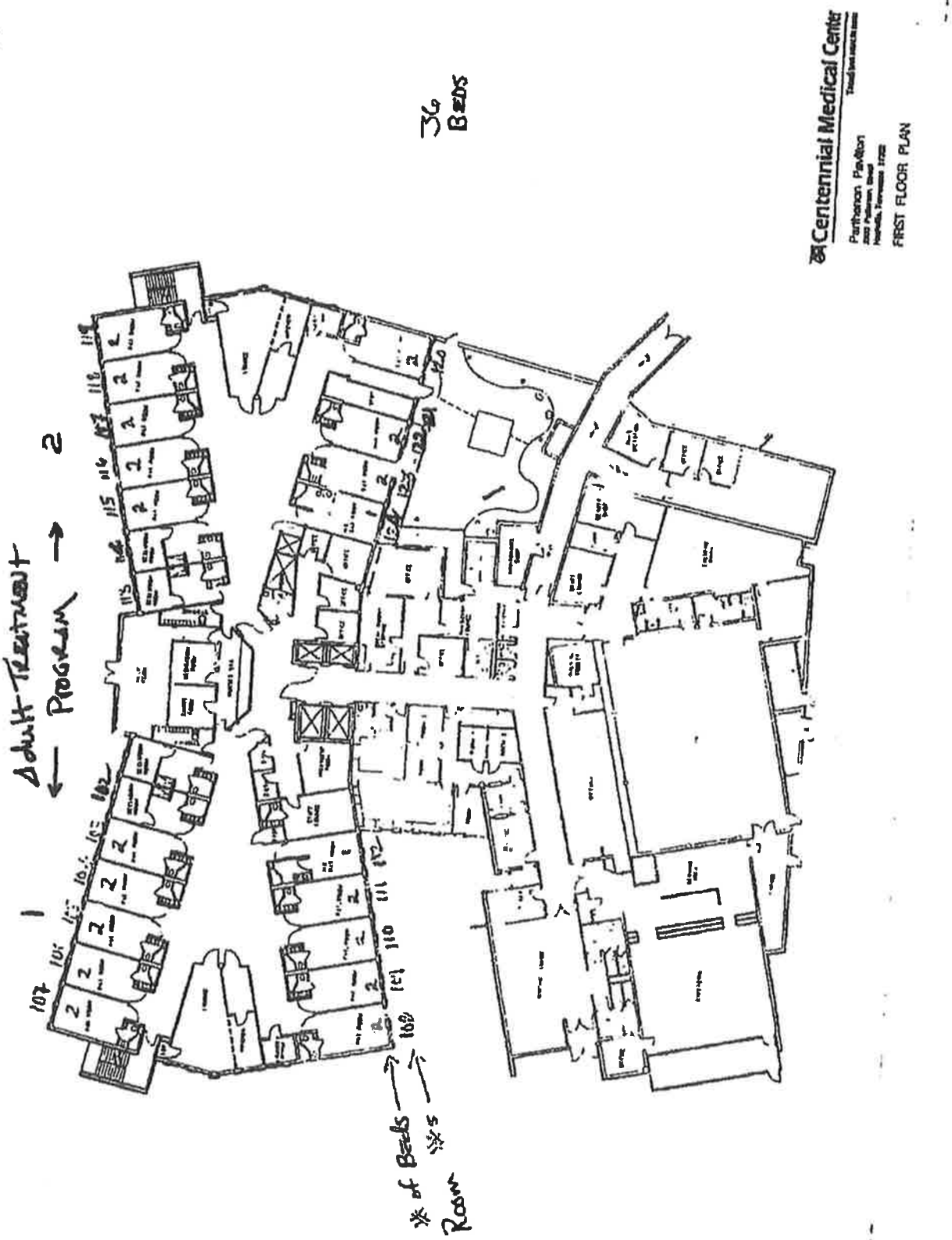
SUPPLEMENTAL #2
November 1, 2016
1:26 pm

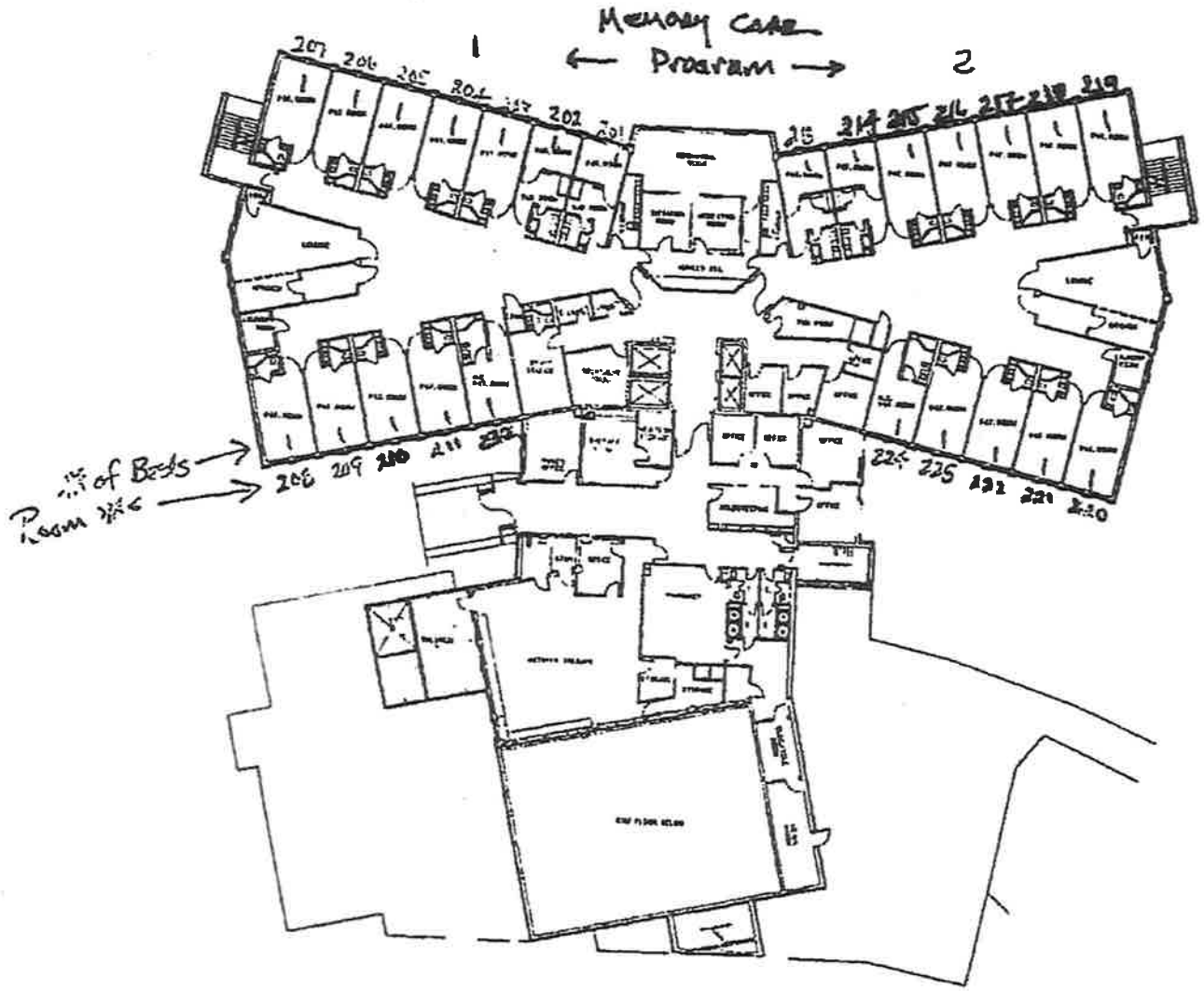
According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0358. The time required to complete this information collection is estimated 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

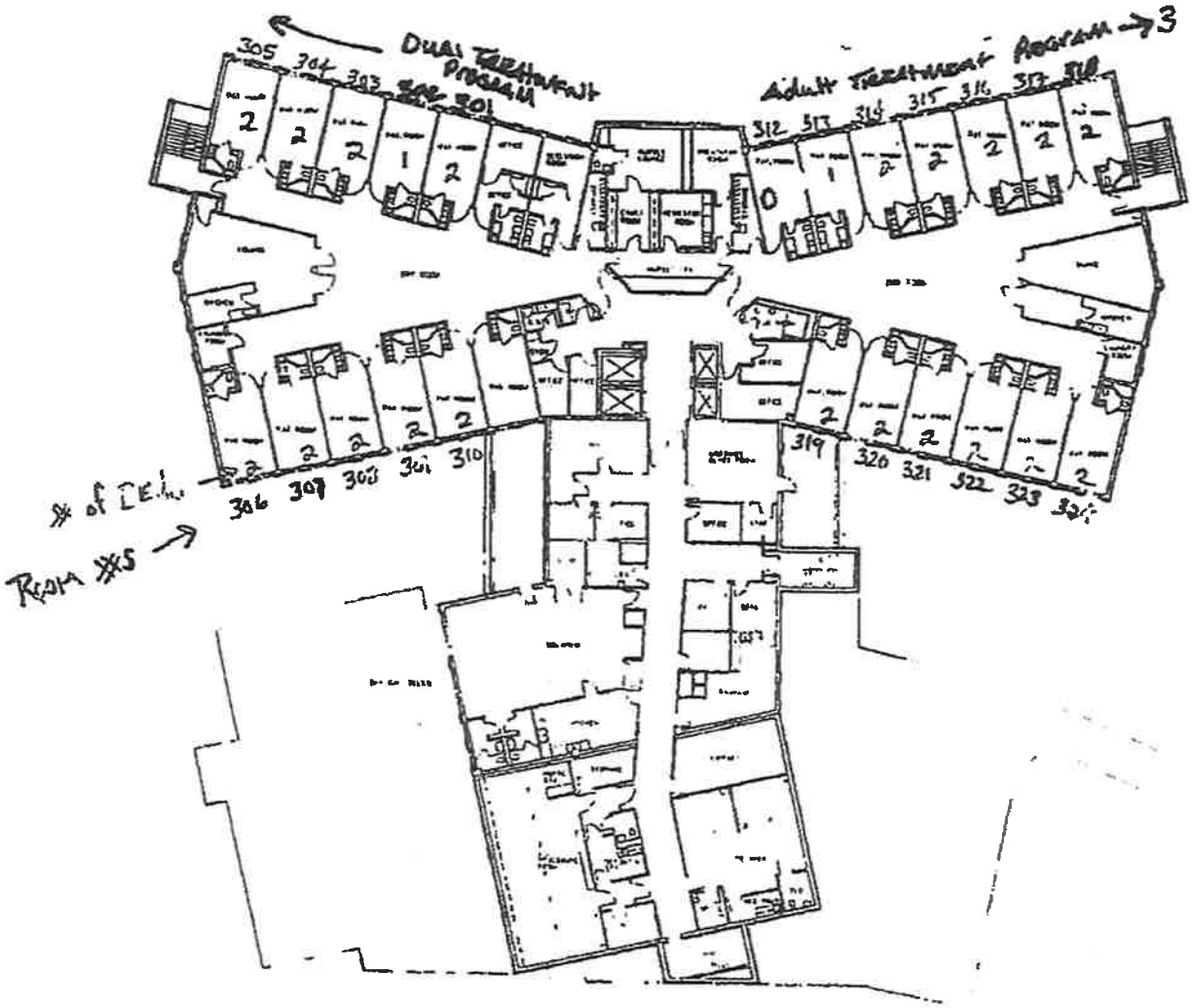
Parthenon Pavilion

SECOND FLOOR PLAN

November 2016

1:26 pm

SUPPLEMENTAL #2




42 Beds

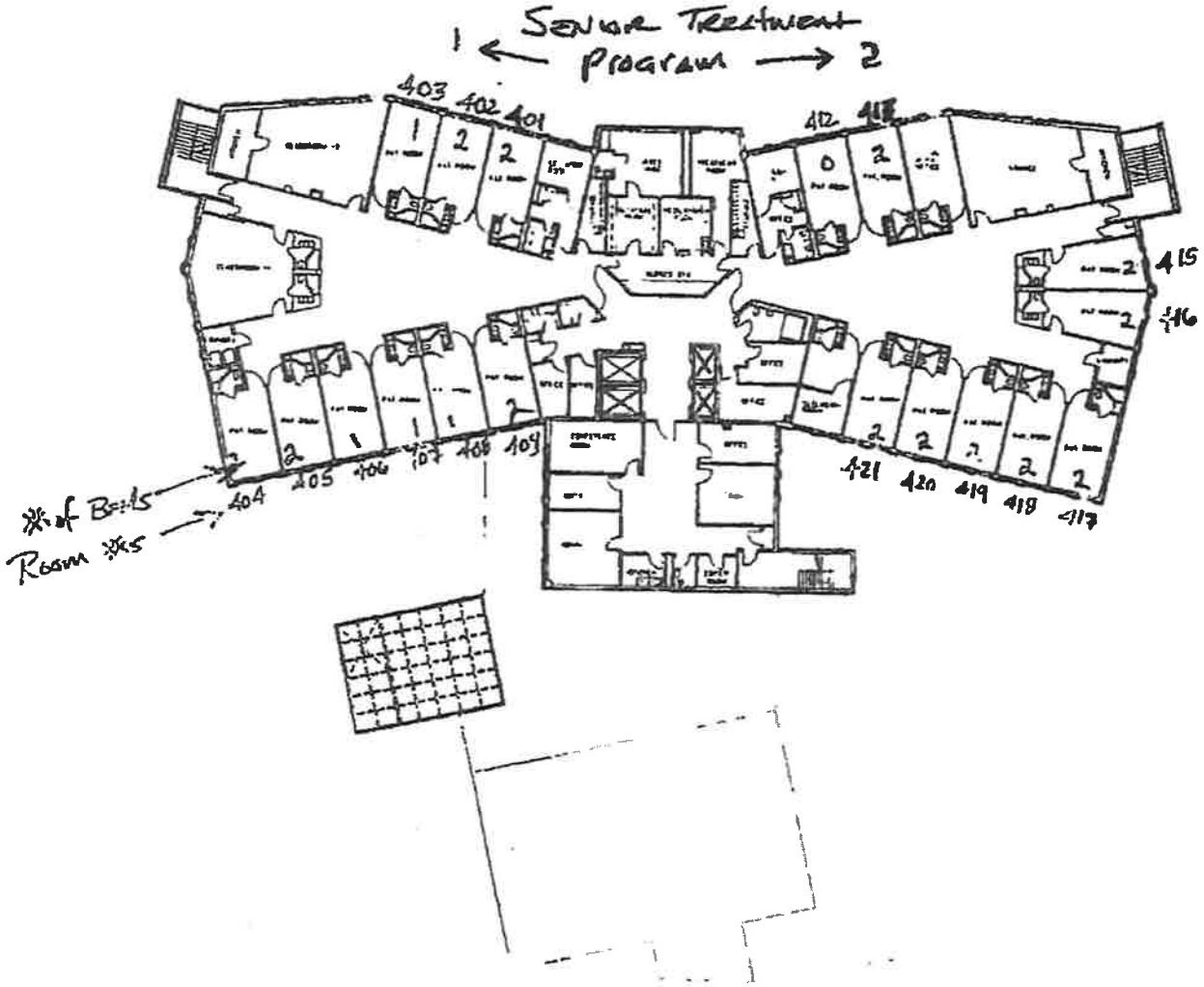
Centennial Medical Center

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 tjw

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>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<br>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<br><br>(3) Infection Control.<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>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.<br><br>The findings included:<br><br>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."<br><br>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 |
|---|---|
| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 630 | Continued From page 1<br><br>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..."<br><br>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.<br><br>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<br><br>(5) Medical Records.<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>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<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 688 | Continued From page 2<br>practitioner for 1 of 10 (Patient #44) patients reviewed from the mental health unit.<br><br>The findings included:<br><br>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.<br><br>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<br><br>(9) Food and Dietetic Services.<br><br>(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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING<br>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<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 742 | Continued From page 3<br><br>This Rule is not met as evidenced by:<br>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.<br><br>The findings included:<br><br>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."<br><br>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."<br><br>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."<br><br>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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 08/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 742 | Continued From page 4<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>3. During an interview on 6/28/11, at 12:00 PM, | H 742 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/29/2011 |

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|---|---|---|---|---|
| H 742 | Continued From page 5<br>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<br><br>(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.<br><br>(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:<br><br>9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:<br><br>(xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;<br><br>This Rule is not met as evidenced by:<br>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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/29/2011 |

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| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>NASHVILLE, TN 37203 |

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| H1137 | Continued From page 6<br>The findings included:<br><br>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..."<br><br>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..."<br><br>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.<br><br>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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING 03 - PARTHENON PAVILION<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 872 | 1200-8-1-.08 (2) Building Standards<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to maintain the physical condition of the hospital environment as required.<br><br>The findings include:<br><br>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.<br><br>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.<br><br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the | H 893 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING 03 - PARTHENON PAVILION<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/28/2011 |

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|---|---|---|---|---|
| H 893 | Continued From page 1<br><br>facility failed to maintain the heating, ventilation and the air-conditioning system as required.<br><br>The findings include:<br><br>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.<br><br>2. On 6/27/11 at 9:00 AM, observation within room 222's bathroom I revealed the exhaust fan unit was not working.<br><br>3. On 6/27/11 at 9:30 AM, observation within room 116 bathroom revealed the exhaust fan grille was missing.<br><br>4. On 6/27/11 at 9:32 AM, observation within room 115 revealed the exhaust fan unit was not working.<br><br>5. On 6/27/11 at 9:50 AM, observation within room 106 bathroom revealed the exhaust fan unit was not working.<br><br>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<br><br>(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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING 03 - PARTHENON PAVILION<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531138 | | 06/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>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 901 | Continued From page 2<br>codes or regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to comply with the applicable building and fire safety regulations as required.<br><br>The findings include:<br><br>Observations made by the surveyors during tour of the facility on 6/27/11 revealed the following:<br><br>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.<br><br>At 8:35 AM, within the 4th floor elevator room revealed an electrical junction box without a cover plate.<br><br>At 9:00 AM, within room 222 on the 2nd floor next to the entry door revealed a penetration in the smoke wall.<br><br>At 9:25 AM within the 2nd floor oxygen storage revealed an<br>unsecured oxygen cylinder.<br><br>At 9:26 AM within the second floor dictation room revealed the use of a multiple adapter.<br><br>2. At 8:00 AM, a conduit pipe not sealed above the ceiling in the engraving room of the 4th floor Penthouse.<br><br>At 8:04 AM, an open container of oily rags located in the 4th floor elevator mechanical room. | H 901 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING 03 - PARTHENON PAVILION<br>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<br>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 901 | Continued From page 3<br>At 8:24 AM, wall penetrations above the ceiling located on both elevator shafts on the 4th floor.<br><br>At 8:31 AM, wall penetrations above the ceiling located on the 1st and 3rd elevator shaft on the 3rd floor.<br><br>At 8:38 AM, electrical junction box cover missing above the ceiling at the administrator's office.<br><br>At 8:46 AM, wall penetration above the ceiling 3rd floor, West exit.<br><br>At 8:48 AM, conduit open and wall penetration above the ceiling 3rd floor adjacent room number 3.<br><br>At 8:54 AM, corridor doors would not close within the door frame at Dual Service Unit on the 3rd Floor.<br><br>At 9:08 AM, wall penetration above the connector door on the 2nd floor.<br><br>At 9:10 AM, electrical junction box cover missing and exposed wires above ceiling 2nd floor Senior Specialty Unit at environmental service closet<br><br>At 9:14 AM, permanent storage in corridor across Social Work office 2nd floor.<br><br>At 9:16 AM, wall penetrations above ceiling at the Neurological Psychiatric Unit (NPU) corridor doors.<br><br>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 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING 03 - PARTHENON PAVILION<br>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<br>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 901 | Continued From page 4<br>At 9:46 AM, fire wall penetrations above ceiling at elevators 3 & 4, and Intensive Treatment Program entrance on 1st floor.<br><br>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<br>A. BUILDING 04 - SARA CANNON<br>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<br>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 | 1200-8-1-.08 (23) Building Standards<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to maintain the heating ventilation and the air-conditioning system as required.<br><br>The findings include:<br><br>1. On 6/28/11 at 10:30 AM, observation within rooms 2305 and 2306 revealed the bathroom exhaust fans were not working.<br><br>2. On 6/28/11 at 10:45 AM, observation within the first floor area common restroom revealed the exhaust fan was not working.<br><br>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<br><br>(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<br>A. BUILDING 04 - SARA CANNON<br>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<br>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 901 | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to comply with the applicable building and fire safety regulations as required.<br><br>The findings include:<br><br>Observations made during a tour of the facility on 6/28/11 revealed the following<br><br>1. At 9:40 AM, observation within room 4322 revealed the Ground Fault Circuit Interrupter was loose in the wall.<br><br>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.<br><br>3. At 9:58 AM, observation within the 4322 bathroom revealed GFCI unit next to the sink did not trip when tested.<br><br>4. At 10:05 AM, observation within the north exit stair wings of Sarah Cannon Cancer Research Building revealed there were no sprinkler heads.<br><br>5. At 9:29 AM, storage of supplies and combustible trash crossover 4th floor.<br><br>6. At 9:33 AM, wall penetration above atrium plastic surgery entrance 4th floor.<br><br>7. At 9:36 AM, wall penetration and open conduit above ceiling - Operating Room (OR) entrance 4th floor.<br><br>8. At 9:39 AM, corridor storage OR 4th floor.<br><br>9. At 9:42 AM, dry wall not taped or mudded on | H 901 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION 1:26 pm<br>A. BUILDING 04 - SARA CANNON<br>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<br>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 901 | Continued From page 2<br>the med gas columns above ceiling adjacent to elevator 10 and 11 4th floor.<br><br>10. At 9:48 AM, wall penetrations above ceiling - inside wall and corridor wall conference room 4th floor.<br><br>11. At 9:52 AM, electrical control box doors open with loose wires exposed above ceiling at the staff lounge 4th floor.<br><br>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<br>A. BUILDING 02 - WOMENS HOSPITAL<br>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<br>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 871 | 1200-8-1-.08 (1) Building Standards<br><br>(1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient.<br><br>This Rule is not met as evidenced by:<br>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.<br><br>The findings include:<br><br>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.<br><br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, it was determined the facility failed to maintain the heating, ventilation and the air-conditioning system as required.<br><br>The findings include: | H 893 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02 - WOMENS HOSPITAL<br>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<br>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<br><br>1. On 6/27/11 at 2:30 PM, observation within the 7th floor resident bathrooms revealed the exhaust fans were not working.<br><br>2. On 6/28/11 at 7:40 AM, observation within resident room 6230 revealed the bathroom exhaust fan unit was not working.<br><br>3. On 6/28/11 at 8:50 AM, observation within the dietary dish washing area revealed the return grille was clogged with dirt.<br><br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to comply with applicable building and fire safety regulations as required.<br><br>The findings include:<br><br>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 1:26 pm<br>A. BUILDING 02 - WOMENS HOSPITAL<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/28/2011 |

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| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 901 | Continued From page 2<br>1. At 2:35 PM, wall penetration above ceiling Operating/Delivery room 6th floor.<br><br>Observations made during a tour of the facility on 6/28/11 revealed the following:<br><br>1. At 7:45 AM, penetration above door wall, OR entrance 5th floor.<br><br>2. At 7:59 AM, wall penetration above ceiling -10' from nursery door Well Baby Nursery 4th floor.<br><br>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.<br><br>4. At 8:26 AM, damper actuator pressed against duct work above corridor door 3220 3rd floor.<br><br>5. At 8:31 AM, corridor doors did not close during fire alarm activation - entrance medical-surgical unit 3rd floor.<br><br>6. At 8:50 AM, fire door blocked by storage - entrance to surgery 3rd floor.<br><br>7. At 8:56 AM, wall penetrations above ceiling located at back ED entrance 1st floor.<br><br>8. On 6/28/11 at 7:58 AM, observation by room 5216 revealed there was a penetration in the smoke wall.<br><br>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<br>A. BUILDING 02 - WOMENS HOSPITAL<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 901 | Continued From page 3<br>10. On 6/28/2011 at 8:15 AM, observation within the 3rd floor mechanical room revealed penetrations around the electricial conduits.<br><br>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.<br><br>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.<br><br>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<br>A. BUILDING 01 - MAIN BUILDING<br>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<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 872 | 1200-8-1-.08 (2) Building Standards<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to maintain the heating ventilation and the air-conditioning system as required.<br><br>The findings include:<br><br>1. On 6/27/11 at 11:00 AM, observation revealed the Operating Rooms numbers 6,11, and 12 doors had damaged finished veneers.<br><br>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<br><br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>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<br>A. BUILDING 01 - MAIN BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CENTENNIAL MEDICAL CENTER | 2300 PATTERSON STREET<br>NASHVILLE, TN 37203 |

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|---|---|---|---|---|
| H 901 | Continued From page 1<br>facility failed to comply with the life safety code as required.<br><br>The findings include:<br><br>Observations made during a tour of the facility on 6/27/11 revealed the following:<br><br>1. At 10:14 AM, fire wall penetration approximately 20 " x 12 " corridor wall 8th floor Cardiac Care Unit corridor adjacent to room 8229<br>2. At 11:21 AM, wall penetration above ceiling 2nd floor corridor Food Court entrance<br>3. At 11:23 AM, electrical junction box missing cover, exposed wires, Post Anesthesia Care Unit (PACU) corridor entrance 1st floor<br>4. At 11:25 AM, 2nd floor surgery and PACU storage in the corridors in 1st floor<br>5. At 11:29 AM, wall penetration above the door in PACU entrance, 1st floor<br>6. At 11:31 AM, wall penetration above door in PACU interior exit, 1st floor<br>7. At 11:35 AM, approximately 6 " x 6 " wall penetration above room number 3 in the Cardio Vascular Intensive Care Unit, 1st floor<br>8. At 11:40 AM, storage within 18" of the sprinkler, Central Sterile Supply, 1st floor<br>9. At 1:25 PM, conduit not sealed above the ceiling at the clean utility room in the Emergency Department 1st floor,<br>10. At 1:29 PM, fire wool removed from conduit above corridor door at cath lab/rehab 1st floor<br>11. At 1:31 PM, storage in corridor cath lab 1st floor<br>12. At 1:33 PM, wall penetration and conduit not sealed above ceiling - room 6 cath lab 1st floor<br>13. At 1:35 PM, conduit not sealed and wall penetration above ceiling - procedure room 5 cath lab 1st floor<br>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<br>A. BUILDING 01 - MAIN BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP531136 | | 06/28/2011 |

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|---|---|---|---|---|
| H 901 | Continued From page 2<br>procedure room 2 cath lab 1st floor<br>15. At 1:44 PM, storage of stretcher and supplies - corridor cath lab 1st floor<br>16. At 1:48 PM, wall penetration above ceiling - cath lab exit to ED 1st floor<br>17. At 2:00 PM, wall penetration above ceiling over door of cardiac ultrasound 1st floor<br>18. At 2:05 PM, smoke detectors covered - corridor noninvasive cardiology 1st floor<br>19. At 2:08 PM, 6" x6 "hole in smoke wall above door - morning admissions 1st floor<br><br>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<br>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.<br>You will have follow-up in the area(s) indicated below:<br>• 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 |

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**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 |

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**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 |

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**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 |

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**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 |

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**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.

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**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 |

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**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 |

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**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 |

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**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 |

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**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)

4

**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.

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**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.

3

**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.

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**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.

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**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.

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**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.

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**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.

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**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).

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**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.

**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.

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**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.

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**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.

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**Chapter:** Medication Management

**Program:** Hospital Accreditation

**Standard:** MM.03.01.01

ESC 60 days

**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.

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**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.

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**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):**

**SUPPLEMENTAL #2**
**November 1, 2016**
**1:26 pm**

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.

4

**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.

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| | |
|---|---|
| **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.

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**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.

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**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.

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**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.

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**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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oint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performa
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<br>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.<br>You will have follow-up in the area(s) indicated below:<br>• 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 |

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**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 |

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**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 |

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**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 |

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**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 |

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**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.

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**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 |

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**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 |

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**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 |

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**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 |

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**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.

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**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.

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**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.

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**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.

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**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.

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**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.

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**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).

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**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.
**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.

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**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.

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**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.

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**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.

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**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.

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**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.

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**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.

4

**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.

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|---|---|
| **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.

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**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.

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**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.

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**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.

# The Joint Commission Findings

**SUPPLEMENTAL #2**

**November 1, 2016**
**1:26 pm**

**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.

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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**

# 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 |

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**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.

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**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**

# 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 |

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**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 |

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**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 |

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**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.

**SUPPLEMENTAL #2**
**November 1, 2016**
**1:26 pm**

# Executive Summary

| Program(s) | Survey Date(s) |
|---|---|
| Hospital Accreditation<br>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.<br>You will have follow-up in the area(s) indicated below:<br>• 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 |

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**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 |

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**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 |

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**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:

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.**

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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.**

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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.**

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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.**

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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):

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.**

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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.**

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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

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

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.**

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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.**

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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

ESC 60 days

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

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:]

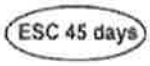
(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.
This Standard is NOT MET as evidenced by:

**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

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.**

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**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:** | 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.**

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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.**

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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.**

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**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) | 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 |

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**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.

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**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

Skyline Medical Center

TRISTAR 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

**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<br>**TNP 53123** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>C<br>**09/21/2011** |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br>**SKYLINE MEDICAL CENTER** | | STREET ADDRESS, CITY, STATE, SIP CODE<br>**3441 DICKERSON PIKE**<br>**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<br><br>(3) Infection Control<br><br>(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:<br><br>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<br><br>This Rule is not met as evidenced by:<br>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.<br><br>The findings included:<br>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:<br>Nurses performing finger stick blood sugars failed to clean the glucometer between patients to prevent the possibility of cross contamination of blood.<br><br>Corrective Action:<br>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."<br>Exhibit A<br><br>This deficiency was discussed at the Infection Prevention Committee on 9/21/11 with agreement on the policy revision, nursing education and random observations.<br><br>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.<br>Exhibit B and C<br><br>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.<br><br>Responsible Parties:<br>CNO, Clinical Directors<br><br>Compliance Monitoring:<br><br>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.<br>Exhibit D | 9/21/11<br><br>09/28/11<br><br>10/04/11 |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Title: Steve Otto CEO

(X6) Date: 10/11/11

STATE FORM 6899 C49B11

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TNP 53123 | A. BUILDING _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, SIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>Before being used again..."<br><br>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.<br><br>Nurse #1 obtained blood samples from the 2 Patients and failed to clean the glucometer between each patient use.<br><br>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 _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, SIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>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<br><br>(5) Medical Records<br><br>(k) All records must document the following:<br><br>8. Final diagnosis with completion of medical Records within thirty (30) days following discharge.<br><br>This Rule is not met as evidence by:<br>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.<br><br>The findings included:<br><br>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.<br><br>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:<br>Facility failed to ensure the medical records were completed within 30 days following the patient's discharge.<br><br>Corrective Action:<br>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.<br>Exhibit E (Example of Physician letter)<br><br>Responsible Parties:<br>Director of HIM and Health Information Management Service Center | |

Division of Health Services

PRINTED: 09/28/2011
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 _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3441 DICKERSON PIKE<br>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:<br>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. | |

Division of Health Services

PRINTED: 09/29/2011
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 _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, SIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>(9) Food Dietetic Services.<br><br>(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:<br>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.<br><br>Corrective Action:<br>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.<br>Exhibit F | 10/10/11 |
| | This Rule is not met as evidenced by:<br>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.<br>The findings included:<br>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.<br><br>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<br><br>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.<br><br>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.<br><br>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.<br><br>Responsible Parties:<br>CNO, Director Food & Nutrition Services<br><br>Compliance Monitoring:<br><br>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.<br>Exhibit G | 10/07/11<br><br>10/07/11 |

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 _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>1:13 PM revealed a food card with patient meal trays stored in the dirty utility/biohazard waste room<br><br>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.<br><br>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.<br><br>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.<br>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.<br><br>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 _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to comply with the life safety codes as required.<br><br>The findings included:<br><br>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.<br><br>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:<br>Facility failed to comply with the life safety codes as required.<br><br>Corrective Action:<br>The Plant Operations Department installed a door closure on the housekeeping door in the kitchen.<br><br>Responsible Parties:<br>Director Facilities Management<br><br>Compliance Monitoring:<br>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.<br><br>Corrective Action:<br>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.<br><br>Responsible Parties:<br>Director Facilities Management | 9/21/11<br><br>9/21/11<br><br>10/07/11<br><br>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 _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>**SKYLINE MEDICAL CENTER** | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**3441 DICKERSON PIKE**<br>**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<br><br>Continued page 2<br><br>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.<br><br>These findings were acknowledged by the director of facilities management during the exit interview on 9/20/11. | H 742 | Compliance Monitoring:<br>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.<br><br>Deficiency:<br>Facility failed to comply with the life safety codes as required.<br><br>Corrective Action:<br>The Plant Operations Department notified Simplex Grinnell of the need to inspect the hood suppression pipes in the kitchen over the cooking equipment.<br><br>Simplex Grinnell inspected the kitchen hood suppression pipes and changed them to cover the new kitchen appliances.<br><br>Responsible Parties:<br>Director Facilities Management<br><br>Compliance Monitoring:<br>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<br><br>9/29/11<br><br>10/07/11 |

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 _____<br>B. WING _____ | C<br>09/21/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to comply with the life safety codes as required.<br><br>The findings included:<br><br>Observation on 9/20/11 at 10:40 AM, revealed a penetration above the corridor doors in the smoke wall partition adjacent at 339.<br><br>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:<br>Facility failed to comply with the life safety codes as required.<br><br>Corrective Action:<br>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.<br>Exhibit H<br><br>Responsible Parties:<br>Director Facilities Management and Plant Operations Manager at Madison Campus<br><br>Compliance Monitoring:<br>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<br><br>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

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
Chief Executive Officer

Enclosures

SUPPLEMENTAL #2

November 1, 2016
1:26 pm

Division of Health Services

PRINTED: 09/20/2011
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 01- Main Building 01<br>B. WING | C<br>09/20/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to comply with the life safety codes as required.<br><br>The findings included:<br><br>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:<br>Facility failed to comply with the life safety codes as required.<br><br>Corrective Action:<br>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.<br>Exhibit I<br><br>Responsible Parties:<br>Director Facilities Management<br><br>Compliance Monitoring:<br>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<br><br>09/30/11<br><br>10/07/11<br><br>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<br>B. WING | C<br>09/20/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3441 DICKERSON PIKE<br>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<br>Continued page 2<br><br>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:<br>Facility failed to comply with the life safety codes as required.<br><br>Corrective Action:<br>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.<br><br>Responsible Parties:<br>Director Facilities Management, Director Food and Nutrition Services<br><br>Compliance Monitoring:<br>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<br><br>10/04/11<br><br>10/27/11<br><br>10/07/11<br><br>10/29/11 |

Division of Health Services

| 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<br><br>Continued page 3<br><br>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.<br><br>These findings were acknowledged by the director of facilities management during the exit interview on 9/20/11. | H 901 | Deficiency:<br>Facility failed to comply with the life safety codes as required.<br><br>Corrective Action:<br>The Plant Operations Department notified Simplex Grinnell of the need to inspect the hood suppression pipes in the kitchen over the new cooking equipment.<br><br>Simplex Grinnell inspected the kitchen hood suppression pipes and changed them to cover the new kitchen appliances.<br>Exhibit K<br><br>Responsible Parties:<br>Director Facilities Management<br><br>Compliance Monitoring:<br>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<br><br>9/29/11<br><br>10/07/11 |

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<br>B. WING | C<br>09/20/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SKYLINE MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3441 DICKERSON PIKE<br>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<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, it was determined the facility failed to comply with the life safety codes as required.<br><br>The findings included:<br><br>Observation on 9/20/11 at 10:40 AM, revealed a penetration above the corridor doors in the smoke wall partition adjacent at 339.<br><br>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:<br>Facility failed to comply with the life safety codes as required.<br><br>Corrective Action:<br>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.<br>Exhibit H<br><br>Responsible Parties:<br>Director Facilities Management and Plant Operations Manager at Madison Campus<br><br>Compliance Monitoring:<br>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<br><br>09/30/11<br><br>10/01/11 |

ivision of Health Care Facilities

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Title: CEO — (X6) Date: 10/3/11

IATE FORM 6899 C49B21

**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

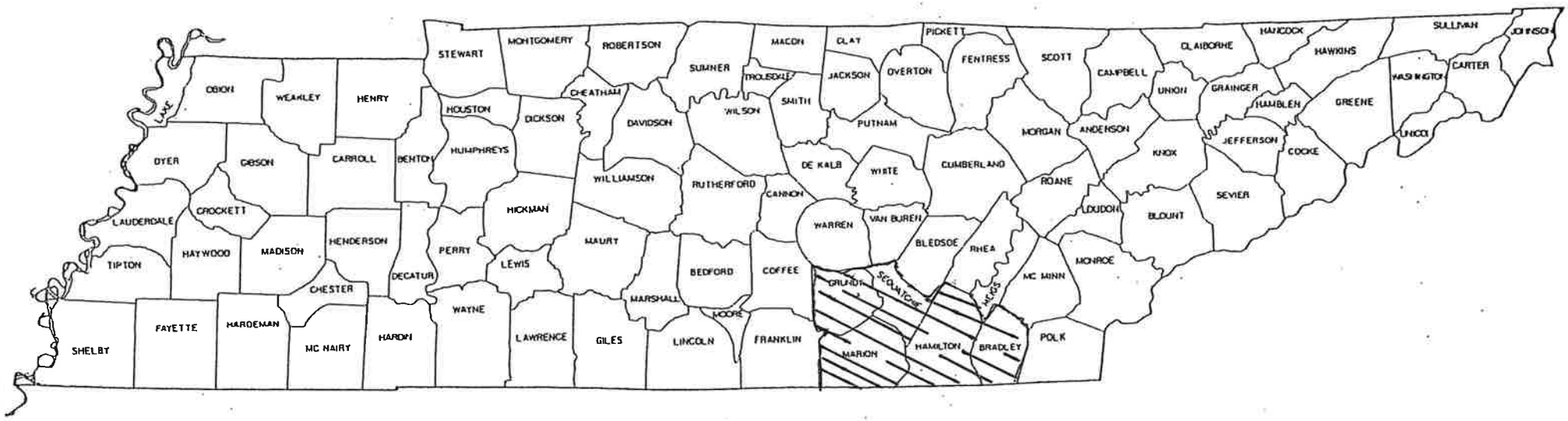
November 1, 2016
1:26 pm

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<br><br>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 | |




**Attachment Section B, Need, 3**

| Demographic Variable/ Geographic Area | Department of Health/Health Statistics | | | | | | | Bureau of the Census | | | | TennCare | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Population- Current Year | Total Population- Projected Year | Total Population-% Change | *Target Population- Current Year | *Target Population- Project Year | *Target Population-% Change | Target Population Projected Year as % of Total | Median Age | Median Household Income | Person Below Poverty Level | Person Below Poverty Level as % of Total | TennCare Enrollees | TennCare Enrollees as % of Total |
| Bradley County | 105,549 | 107,651 | 1.99% | 81,934 | 83,908 | 2.41% | 78% | 39 | $41,575 | N/A* | 19.8% | 23,405 | 22.2% |
| Grundy County | 13,470 | 13,379 | -0.68% | 10,588 | 10,595 | 0.07% | 79% | 42.7 | $26,856 | N/A* | 29.1% | 4,899 | 36.4% |
| Hamilton County | 356,156 | 362,471 | 1.77% | 278,574 | 283,457 | 1.75% | 78% | 39.4 | 47,880 | N/A* | 16.0% | 71,146 | 20.0% |
| Marion County | 28,585 | 28,627 | 0.15% | 22,674 | 22,804 | 0.57% | 80% | 42.9 | $40,998 | N/A* | 20.3% | 7,503 | 26.2% |
| Sequatchie County | 15,835 | 16,399 | 3.56% | 12,428 | 12,946 | 4.17% | 79% | 41.7 | $42,182 | N/A* | 18.6% | 4,175 | 26.4% |
| Primary Service Area Total | 519,595 | 528,527 | 1.72% | 406,198 | 413,710 | 1.85% | 78% | 41.1 (avg.) | $39,,898 (avg.) | N/A* | 20.8%(avg.) | 111,128 | 21.4% |
| State of TN Total | 6,812,005 | 6,962,031 | 2.20% | 5,241,318 | 5,368,064 | 2.42% | 77% | 38.3 | $44,621 | N/A* | 17.8% | 1,544,940 | 22.7% |

* The Census Bureau website doe not reflect toal population under Poverty Level. It only provides the % of total for the year 2014.

**Melanie M. Hill**
**Executive Director**
**Tennessee Health Services and Development Agency**
500 Deaderick Street, 9th Floor
Nashville, TN 37243

**RE: Behavioral Health Program Expansion**
**Parkridge West Medical Center Behavioral Health Unit**
**Jasper, Tennessee**

27 September 2016

Ms. Hill,

Per our recent conversation with John Wellborn, an attorney working with Parkridge West Medical Center Behavioral Health Unit on the Certificate of Need submission, we have prepared the following supporting documentation for your review.

I have reviewed the construction cost estimate provided by Parkridge West Medical Center Behavioral Health Unit in the CON Submission. Based on my experience and knowledge of the current healthcare market, it is my opinion that the projected cost of $1,517,600 appears to be reasonable for a project of this type and size. In my opinion, the project site is also suitable for construction of the proposed project.

The physical project 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 in this State. The standards include the following:

→ Guidelines for the Design and Construction of Health Care Facilities
→ Rules of the Tennessee Department of Health Board for Licensing Health Care Facilities
→ International Building Code
→ National Electrical Code
→ National Fire Protection Association (NFPA)
→ Americans with Disabilities Act (ADA)

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

Thank you.

Bradford P. Stengel, AIA
Architect
Tennessee Professional Architect License #00102523

TriStar Health.

TriStarHealth.com

110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

November 9, 2016

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, 9th floor
500 Deaderick Street
Nashville, TN 37243

RE: CON Application for Parkridge West Hospital

Dear Mrs. Hill:

Parkridge West Hospital is applying for a Certificate of Need to reclassify 8 medical beds to expand patient care capacity for the adult behavioral health unit located in Jasper, Tennessee.

As Chief Financial Officer of the TriStar Health System, the HCA Division office to which this facility belongs, I am writing to confirm that our parent company, HCA Holdings, Inc. will provide through TriStar the approximately $2,184,808 required to implement this project. HCA Inc.'s financial statements are provided in the CON application.

Sincerely,

C. Eric Lawson
Chief Financial Officer
TriStar Division of HCA

## REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
HCA Holdings, Inc.

We have audited the accompanying consolidated balance sheets of HCA Holdings, Inc. as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, stockholders' deficit, and cash flows for each of the three years in the period ended December 31, 2015. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of HCA Holdings, Inc. at December 31, 2015 and 2014, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, the Company changed its presentation of debt issuance costs as a result of the adoption of FASB Accounting Standards Update 2015-03, *Simplifying the Presentation of Debt Issuance Costs*, and the Company changed the classification of all deferred tax assets and liabilities to noncurrent on the December 31, 2015 consolidated balance sheet as a result of the adoption of FASB Accounting Standards Update 2015-17, *Balance Sheet Classification of Deferred Taxes*.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), HCA Holdings, Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 26, 2016 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 26, 2016

**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.

## HCA HOLDINGS, INC.
## CONSOLIDATED STATEMENTS OF STOCKHOLDERS' DEFICIT
## FOR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013
## (Dollars in millions)

| | Equity (Deficit) Attributable to HCA Holdings, Inc. | | | | | | |
|---|---|---|---|---|---|---|---|
| | Common Stock | | Capital in Excess of Par Value | Accumulated Other Comprehensive Loss | Retained Deficit | Equity Attributable to Noncontrolling Interests | Total |
| | Shares (in millions) | Par Value | | | | | |
| Balances, December 31, 2012 | 443.200 | $4 | $ 1,753 | $(457) | $(10,960) | $1,319 | $(8,341) |
| Comprehensive income | | | | 200 | 1,556 | 440 | 2,196 |
| Repurchase of common stock | (10.656) | | (500) | | | | (500) |
| Share-based benefit plans | 7.060 | | 139 | | | | 139 |
| Distributions | | | | | | (435) | (435) |
| Other | | — | (6) | | 1 | 18 | 13 |
| Balances, December 31, 2013 | 439.604 | 4 | 1,386 | (257) | (9,403) | 1,342 | (6,928) |
| Comprehensive income | | | | (66) | 1,875 | 498 | 2,307 |
| Repurchase of common stock | (28.583) | | (1,701) | | (49) | | (1,750) |
| Share-based benefit plans | 9.457 | | 321 | | | | 321 |
| Distributions | | | | | | (442) | (442) |
| Other | | — | (6) | | 2 | (2) | (6) |
| Balances, December 31, 2014 | 420.478 | 4 | — | (323) | (7,575) | 1,396 | (6,498) |
| Comprehensive income | | | | **58** | **2,129** | **567** | **2,754** |
| Repurchase of common stock | **(31.991)** | | **(505)** | | **(1,892)** | | **(2,397)** |
| Share-based benefit plans | **10.252** | | **523** | | | | **523** |
| Distributions | | | | | | **(495)** | **(495)** |
| Acquisition of entities with noncontrolling interests | | | | | | **85** | **85** |
| Other | | — | **(18)** | | | | **(18)** |
| Balances, December 31, 2015 | **398.739** | **$4** | **$ —** | **$(265)** | **$ (7,338)** | **$1,553** | **$(6,046)** |

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

## HCA HOLDINGS, INC.
## CONSOLIDATED STATEMENTS OF CASH FLOWS
## FOR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013
(Dollars in millions)

| | 2015 | 2014 | 2013 |
|---|---|---|---|
| **Cash flows from operating activities:** | | | |
| Net income | **$ 2,696** | $ 2,373 | $ 1,996 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | | |
| Increase (decrease) in cash from operating assets and liabilities: | | | |
| Accounts receivable | **(4,114)** | (3,645) | (4,395) |
| Provision for doubtful accounts | **3,913** | 3,169 | 3,858 |
| Accounts receivable, net | **(201)** | (476) | (537) |
| Inventories and other assets | **(314)** | (232) | (19) |
| Accounts payable and accrued expenses | **192** | 444 | 142 |
| Depreciation and amortization | **1,904** | 1,820 | 1,753 |
| Income taxes | **(160)** | (83) | 143 |
| Losses (gains) on sales of facilities | **5** | (29) | 10 |
| Losses on retirement of debt | **135** | 335 | 17 |
| Legal claim costs | **149** | 78 | — |
| Amortization of debt issuance costs | **35** | 42 | 55 |
| Share-based compensation | **239** | 163 | 113 |
| Other | **54** | 13 | 7 |
| Net cash provided by operating activities | **4,734** | 4,448 | 3,680 |
| **Cash flows from investing activities:** | | | |
| Purchase of property and equipment | **(2,375)** | (2,176) | (1,943) |
| Acquisition of hospitals and health care entities | **(351)** | (766) | (481) |
| Disposal of hospitals and health care entities | **73** | 51 | 33 |
| Change in investments | **63** | (37) | 36 |
| Other | **7** | 10 | 9 |
| Net cash used in investing activities | **(2,583)** | (2,918) | (2,346) |
| **Cash flows from financing activities:** | | | |
| Issuances of long-term debt | **5,548** | 5,502 | — |
| Net change in revolving bank credit facilities | **150** | 440 | 970 |
| Repayment of long-term debt | **(4,920)** | (5,164) | (1,662) |
| Distributions to noncontrolling interests | **(495)** | (442) | (435) |
| Payment of debt issuance costs | **(50)** | (73) | (5) |
| Repurchases of common stock | **(2,397)** | (1,750) | (500) |
| Income tax benefits | **235** | 134 | 113 |
| Other | **(47)** | (25) | (106) |
| Net cash used in financing activities | **(1,976)** | (1,378) | (1,625) |
| Change in cash and cash equivalents | **175** | 152 | (291) |
| Cash and cash equivalents at beginning of period | **566** | 414 | 705 |
| Cash and cash equivalents at end of period | **$ 741** | $ 566 | $ 414 |
| Interest payments | **$ 1,650** | $ 1,758 | $ 1,832 |
| Income tax payments, net | **$ 1,186** | $ 1,057 | $ 694 |

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

# Board for Licensing Health Care Facilities

State of Tennessee

0000000066

No. of Beds 0621

## DEPARTMENT OF HEALTH

*This is to certify, that a license is hereby granted by the State Department of Health to*

PARKRIDGE MEDICAL CENTER, INC. *to conduct and maintain a*

*Hospital* PARKRIDGE MEDICAL CENTER, INC.

*Located at* 2333 MCCALLIE AVENUE, CHATTANOOGA

*County of* HAMILTON *, Tennessee.*

*This license shall expire* FEBRUARY 20 *,* 2017 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

*In Witness Whereof, we have hereunto set our hand and seal of the State this* 3RD *day of* FEBRUARY *,* 2016 *.*

*In the Distinct Category(ies) of:* GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL

*By* Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

*By* John J. Dreyzehner, MD
COMMISSIONER

Attachment Section B, Orderly Development, 5A

# Parkridge Medical Center, Inc.

## Chattanooga, TN

has been Accredited by

## The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

The Joint Commission

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

July 23, 2014

Darrell Moore
President/CEO
Parkridge Medical Center, Inc.
2333 McCallie Avenue
Chattanooga, TN 37404

Joint Commission ID #: 7815
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 07/17/2014

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

Parkridge Medical Center, Inc.
2333 McCallie Avenue
Chattanooga, TN 37404

**Organization Identification Number: 7815**

**Program(s)**
Hospital Accreditation
Behavioral Health Care Accreditation

**Survey Date(s)**
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.<br>You will have follow-up in the area(s) indicated below:<br>• 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.

# The Joint Commission
# Summary of Findings

**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 |

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**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.

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**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 |

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**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 |

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**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 |

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**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 |

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# The Joint Commission
# Findings

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.04.01

**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.

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**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.04.03

**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.

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**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.

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**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.

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**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.

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**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.

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**Chapter:** Leadership

**Program:** Hospital Accreditation

**Standard:** LD.04.03.09

**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).

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**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.

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**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.

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**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.

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**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.

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**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.

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**Chapter:** Provision of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** PC.01.02.01

**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.

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**Chapter:** Provision of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** PC.01.03.01

**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.

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|---|---|
| **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.

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**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.

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# The Joint Commission
# Findings

**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.

**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.

# The Joint Commission
# Findings

**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.

**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF Hamilton

Melissa Arkin being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Agency Rules, and T.C.A. §68-11-1601, et seq., and that the responses to questions in this application or any other questions deemed appropriate by the Tennessee Health Services and Development Agency are true and complete.

Name

CEO Parkridge Valley
Title

Sworn to and subscribed before me this the 15th day of November, 2016 a Notary Public in and for Hamilton County, Tennessee.

Tiffany Richards
Notary Public

My Commission Expires: March 21, 2020.

TIFFANY RICHARDS
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

28512823 v1

**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

Jerry Taylor, Esq.
Burr and Forman
511 Union Street, Suite 2300
Nashville, TN 37219

RE: Certificate of Need Application -- Parkridge West Hospital - CN1611-039
The conversion of eight licensed medical surgical beds to eight adult psychiatric beds (for patients 18+) located at 1000 Highway 28, Jasper (Marion County), TN. If approved, the total Parkridge West Hospital adult psychiatric inpatient bed total will increase from 20 to 28. The estimated project cost is $2,184,808.

Dear Mr. Taylor:

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 Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, 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 Health, 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 Health 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):

(4) 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.

(5) 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: Trent Sansing, TDH/Health Statistics, PPA
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: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: December 1, 2016

RE: Certificate of Need Application
Parkridge West Hospital - CN1611-039

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: Jerry Taylor, Esq.

# LETTER OF INTENT
# TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Chattanooga Times Free Press which is a newspaper of general circulation in Marion County, Tennessee, on or before November 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. § 68-11-1601 *et seq.,* and the Rules of the Health Services and Development Agency, that Parkridge West Hospital, owned and managed by Parkridge Medical Center, Inc. intends to file an application for a Certificate of Need for the conversion of eight (8) licensed medical surgical beds to eight (8) adult psychiatric beds. The beds will be used to provide acute inpatient psychiatric services to individuals aged eighteen (18) years of age and older. No services are being initiated or discontinued; Parkridge West currently operates 20 licensed adult psychiatric beds. Parkridge West Hospital is located at 1000 Highway 28, Jasper, Marion County, Tennessee, 37347. Parkridge West Hospital is licensed as a general hospital by the Tennessee Department of Health, Board for Licensing Health Care Facilities. The total estimated project cost is $2,184,808.

The anticipated date of filing the application is November 15, 2016.

The contact person for this project is Jerry W. Taylor, Attorney who may be reached at: Burr & Forman, LLP, 511 Union Street, Suite 2300, Nashville, Tennessee, 37219, 615-724-3247; jtaylor@burr.com

Signature _____ Date 11-10-16

The published Letter of Intent contains the following statement: Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice 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.

==========

*

HF0051 (Revised 05/03/04 – all forms prior to this date are obsolete)

# Supplemental #1
# -ORIGINAL-

## PARKRIDGE WEST HOSPITAL

## CN1611-039

SUPPLEMENTAL #1
November 23, 2016
8:19 am

# SUPPLEMENTAL RESPONSES

# CERTIFICATE OF NEED APPLICATION

# FOR

# PARKRIDGE WEST HOSPITAL

## The Conversion of 8 Medical-Surgical Beds to 8 Psychiatric Beds

## Marion County, Tennessee

## Project No. CN1611-039

## November 23, 2016


**Contact Person:**

Jerry W. Taylor, Esq.
Burr & Forman, LLP
511 Union Street, Suite 2300
Nashville, Tennessee 37219
615-724-3247

1. **Section A. , Executive Summary, B. Rationale for Approval (1) Need**

**It is noted in September 2016 171 admissions were denied to Parkridge West Hospital's existing adult inpatient psychiatric unit solely because of a lack of beds. Of the 171 denied admissions, how many were committals? Also, where were the 171 admissions referred for treatment?**

During the nine month period January through September 2016, 171 admissions were denied due to lack of a bed. The applicant does not have data regarding the status of patients not admitted.

When beds are not available, Parkridge West routinely refers parties requesting admissions to Parkridge Valley in Hamilton County, absent a contrary choice of the patient. However, Parkridge West has no further information on where those 171 patients were in fact admitted.

**Please clarify the reason why TennCare will not credential the applicant's current 20 bed facility and why adding 8 additional beds will make a difference in a TennCare contract.**

TennCare has never declined to credential this facility. When the facility was acquired from another company in 2014, its principal psychiatrist was independent and did not participate in TennCare. Because Parkridge West was able to refer TennCare admissions requests to its sister hospital Parkridge Valley in Chattanooga, Parkridge West felt no need to request TennCare credentialing. However, in 2016 Parkridge West employed its principal psychiatrist as Medical Director. That physician will now participate in TennCare, and Parkridge West has initiated the credentialing process that will allow it to accept TennCare patients. This will go forward regardless of the decision on the 8 additional beds

**Please clarify if the applicant is contracted with Alabama Medicaid. If so, why is the applicant contracted with Alabama Medicaid and not Tennessee Medicaid/TennCare.**

The applicant is contracted with Alabama Medicaid because its principal psychiatrist (who did not contract with TennCare) has always contracted with Alabama Medicaid, making it feasible to admit those patients to Parkridge West. As explained immediately above, this was not the case with TennCare patients.

**Please discuss if all TennCare managed care companies have expressed interest in contracting with the applicant for inpatient behavioral health services.**

Parkridge West operates under the hospital license of Parkridge Medical Center. As one of its satellite hospitals, Parkridge West is in network and is contracted with all TennCare MCOs operating in the region. However, the Parkridge West DPU must still become credentialed by TennCare as discussed above.

**What was the 2015 payor mix for the current 20 bed adult psychiatric unit?**

Please see the table below.

| CY 2015 Payor Source for Existing 20-Bed Adult Unit | As a % of total |
|---|---|
| Medicare/Medicare Managed Care | 62.5% |
| TennCare/Medicaid | 0% |
| Alabama Medicaid | 14.6% |
| Commercial/Other Managed Care | 19.9% |
| Self-Pay | 0.9% |
| Charity Care | 0.2% |
| Other (Specify) Champus, HIX | 1.9% |
| Total | 100% |

2. **Section A., 6B (3) Public Transportation**

   **Please clarify if TennCare will provide transportation for TennCare enrollees needing inpatient treatment.**

   TennCare does provide transportation to its enrollees upon request. However, for a psychiatric admission, such transport may or may not be available as quickly as needed, particularly for an involuntary admission. For that reason, Parkridge West anticipates that TennCare enrollees will be arriving by ambulance and personal vehicle as well as by TennCare transport. This is the experience of Parkridge Valley in Chattanooga, the applicant's sister hospital which serves a large number of TennCare patients.

3. **Section A. , 10 (A) Bed Complement Data**

   **It is noted the applicant has 50 med/surg beds. However, please clarify why these beds are not staffed at Parkridge West Hospital. If approved, what are the plans for the remaining 44 med/surg beds?**

   If this application is approved, Parkridge West will have 42 med-surg beds, not 44. Parkridge West Hospital's previous medical staff, under prior ownership, was unable to support staffing its 50 med/surg beds at the time of its purchase by HCA. Through a reorganization of the campus, Parkridge West has reduced the services it offers, to focus on Emergency, Inpatient Behavioral Health, and select outpatient services. Parkridge West is committed to strengthening its medical staff, and returning needed services to the campus as the needs of the service area dictate.

4. **Section B, Need, Item I.a. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   **Please complete the following table to determine psychiatric bed need (1).**

   Please see the table below.

| Proposed Service Area | | | | | | | |
|---|---|---|---|---|---|---|---|
| Population 2018 | | Gross Need Pop. (30 beds/100,000) | | Current Licensed Beds | | Net Bed Need | |
| Adults 18-64 | Adults 65+ | Adults 18-64 | Adults 65+ | Adults 18-64 | Adults 65+ | Adults 18-64 | Adults 65+ |
| 316,567 | 97,143 | 95.0 | 29.1 | 316* | | -192* | |

** Licensed beds make no distinction between these age groups. Data is from the 2015 Joint Annual Reports and include beds designated as geriatric. Data include Hamilton County's recently approved 36 new adult/geri beds (CNI603-012A).*

**Please explain why the applicant will have one unit of 18+ patients instead of having two units comprised of the 18-64 and 65+ patients, respectively.**

The behavioral health current facility layout consists of two hallways with 10 patient beds in semi–private rooms. The hallways are separated by an area that is comprised of a nurse station, medication room and patient group and activity rooms. This project would increase the beds on each hall by 4 beds in 2 additional semi-private rooms.

Bed assignments are currently, and will continue to be, determined by gender, age, acuity and clinical program. Patients share rooms with patients of the same gender. Patients are then paired patients by age and clinical programming. Clinical programming may include individuals with dual diagnosis treatment, general psychiatric treatment, or geriatric specific treatment. Parkridge West does not have a specialized young adult (ages 18-25) program; however, their treatment is individualized within any special population that they may require.

**Please discuss how the applicant will address the programmatic and clinical needs of the geriatric population and the needs of the 18-25 age group in one inpatient psychiatric unit.**

Treatment programming is individualized for each patient according to their needs. Geriatric patients participate in general group therapy sessions as well as sessions and programming specific to their population. Recreational therapy is also specific to the geriatric population.

At this time there is not a specific treatment program for the young adult population. Their age specific individual treatment needs are met through the specific components in their treatment plan, during individual and family therapy, and recreational therapy. During group therapy the clinicians are trained to address and modify age specific aspects of the curriculum.

The Parkridge West clinical program primarily utilizes a group treatment model. Each patient's programming is further individualized in their treatment plan.

There are 2 designated group rooms and an outdoor recreation area. At completion of the project there will be 5 multipurpose activity rooms, which can be used for multiple types of therapies, and the outdoor recreation area. Clinicians use the different spaces to offer specific treatment to specific patient populations.

5. **Section B, Need, Item 2.j Crisis Stabilization Unit. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   **It is noted there is a crisis stabilization unit (CSU) in Hamilton County. What is a CSU? Who operates the Hamilton County CSU, how many beds are there, what is the population targeted?**

   A CSU offers 24/7/365 intensive, short-term stabilization for someone experiencing a mental health emergency who is willing to receive services. The CSU has "inpatient" beds for adults. Statewide, CSU's have a 3-day average length of stay. They do not charge for services. The CSU patient population tends to be uninsured. CSU services may include individual or family counseling and support, medication management and administration, stress management counseling, mental illness/substance abuse awareness and education; identification and development of patient support systems, and an individualized treatment plan.

   It is important to note that a CSU is accessible only through referral from a Mobile Crisis Service or Crisis Walk-In Center. Mobile Crisis Services send professional response teams to persons who are experiencing a mental health emergency; they may be accessed through a Statewide or local crisis telephone line. Their services may include telephonic service by trained crisis specialists, telehealth or face-to-face assessment, stabilization of symptoms, referral for additional services and treatment, and follow-up services.

   Crisis Walk-In Centers, as the name implies, are locations which offer face-to-face evaluations for persons experiencing a mental health emergency; they provide assessments, referrals, and follow-up services.

   For all of the Parkridge West service area counties in Tennessee, Volunteer Behavioral Health Care System (with principal offices at 413 Spring Street in Chattanooga) provides all three types of support (Mobile Crisis Teams, Mobile Walk-In Center; Crisis Stabilization Unit). Its CSU has 15 beds.

   Volunteer Behavioral Health Care System is a not-for-profit community-based provider of adult services, children and youth services, services for addiction and co-occurring disorders, crisis services, a Regional Intervention Program, and peer recovery.

6. **Section B, Need, Item 6. Composition of Services (Psychiatric Inpatient Services-Service Specific Criteria-)**

   **Please complete the following table of admissions by age category for Parkridge West in 2015.**

Please see the table below.

| Discharges 2015 | | | |
|---|---|---|---|
| Adults 18-65 | | Adults 65+ | |
| Voluntary | Involuntary | Voluntary | Involuntary |
| 239 | 250 | 21 | 58 |

**Please provide the projected utilization statistics for all 28 psychiatric inpatient beds.**

Please see the table below.

| PROJECTED UTILIZATION ON PROPOSED 28-BED UNIT | | |
|---|---|---|
| | Year 1 | Year 2 |
| Total Admissions | 962 | 1,044 |
| ALOS | 8.6 | 8.2 |
| Patient Days | 8,222 | 8,515 |
| Occupancy | 80.5% | 83.3% |

7. **Section B, Need, Item 9. Relationship to Existing Similar Services in the area. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   **Please clarify if the applicant's psychiatric adult inpatient services differ from similar services available in the service area.**

   Clinically, they do not. However, due to Parkridge West's location in a rural county, it provides accessibility advantages for persons living in rural areas west of Hamilton County.

8. **Section B, Need, Item 12. Institution for Mental Disease Classification. (Psychiatric Inpatient Services-Service Specific Criteria-)**

   **It is noted Parkridge West is classified as an IMD. Please clarify how this is possible since the applicant is licensed by the Department of Health and has licensed med/surg beds.**

   The applicant's response to question #12 on page 22 of the submitted application was incorrect. Parkridge West is not an IMD (Institution for Mental Disease). It cannot be an IMD because it is operated under the license of an acute care hospital.

9. **Section B, Need, Item 16. Community Linkage Plan. (Psychiatric Inpatient Services-Service Specific Criteria-)**

**SUPPLEMENTAL #1**

**November 23, 2016**
**8:19 am**

**It is noted there are no letters from providers in support of the application and detailing instances of unmet need for psychiatric inpatient services. Please clarify if support letters are forthcoming.**

Letters of support were inadvertently omitted from the filed application. Copies of these are attached following this response. Additional letters may be filed later under separate cover.

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Cleveland, TN 37311

**RE: Certificate of Need Application**
**Parkridge West Hospital 8 Bed Conversion**

Dear Ms. Hill,

On behalf of the Marion County Commissioner's Office, District 2, I am pleased to write this letter of support for Parkridge West Hospital's proposal to convert 8 medical surgical beds to 8 adult psychiatric beds. Parkridge West Hospital has been instrumental in providing valuable medical services to the community and is a respected community partner.

I believe they are in a unique position to improve behavioral health care access and impact the continued rise in behavioral healthcare needs in the community. I fully support the awarding of this CON to Parkridge West Hospital and look forward to working with them in this new capacity.

Sincerely,

Matt Blair
2nd District Comm.

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Nashville, TN 37243

**Re: Certificate of Need Application**
**Parkridge West Hospital Renovation and Expansion**

Dear Ms. Hill:

I am writing this letter to state my support of the Certificate of Need application submitted by Parkridge West Hospital as referenced above.

I am Paul Wayne Evans, Mayor of the Town of Jasper and I have worked with the professionals at Mountainview a number of years.

This facility has faithfully served mental health patients in our community and surrounding areas for the past 8 years. A renovation and bed expansion is needed for Mountainview to continue to serve this growing population. We know this facility runs near or at capacity and additional beds would reduce this problem.

I respectfully request this board grant approval for the bed addition and expansion project application for the reasons stated above.

Sincerely,

Paul W Evans
Mayor Jasper

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Nashville, TN 37243

**Re: Certificate of Need Application**
**Parkridge West Hospital 8 Bed Conversion**

Dear Ms. Hill:

I am writing this letter to state my support of the Certificate of Need application submitted by Parkridge West Hospital as referenced above.

Mountainview has faithfully served mental health patients in our community and surrounding areas since 2008. The conversion of 8 current medical/surgical beds to inpatient psychiatric beds is needed for Mountainview to continue to serve this growing population of individuals with behavioral health needs. I am aware that this facility runs near or at capacity and additional beds would increase the ability to serve our community and surrounding area.

I respectfully request this board grant approval for the 8 bed conversion.

Sincerely,

Marshall A Rains Jr
General Sessions Judge

**SUPPLEMENTAL #1**

**November 23, 2016**
**8:19 am**

# Parkridge West Hospital

*A Facility of Parkridge Medical Center* **PARKRIDGE HEALTH SYSTEM**

ParkridgeHealth.com
1000 Highway 28
Jasper, TN 37347
(423) 837-9500

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Nashville, TN 37243

**Re: Certificate of Need Application**
**Parkridge West Hospital 8 Bed Conversion**

Dear Ms. Hill:

I would like to take this opportunity on behalf of Parkridge West Hospital to garner support for a CON for additional beds.

Mountain View Treatment center has been an invaluable asset to this community as well as others since 2008 in providing outstanding in-patient service for severely mentally ill patients. Unfortunately, we have been running at full or near full capacity most of the time and have been unable to accommodate numerous Hospital and Crisis Response Team requests for hospital admissions.

If you would be kind enough to consider additional capacity of 8 psychiatric beds it would be greatly appreciated.

Sincerely,
Dr. Sarath Gangavarapu

Sarath Gangavarapu MD

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Nashville, TN 37243

**Re: Certificate of Need Application**
**Parkridge West Hospital 8 Bed Conversion**

Dear Ms. Hill:

I am writing this letter to state my support of the Certificate of Need application submitted by Parkridge West Hospital as referenced above.

Mountainview has faithfully served mental health patients in our community and surrounding areas since 2008. The conversion of 8 current medical/surgical beds to inpatient psychiatric beds is needed for Mountainview to continue to serve this growing population of individuals with behavioral health needs. I am aware that this facility runs near or at capacity and additional beds would increase the ability to serve our community and surrounding area.

I respectfully request this board grant approval for the 8 bed conversion.

Sincerely,

C. Nicole Campbell

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Nashville, TN 37243

**Re: Certificate of Need Application**
**Parkridge West Hospital Renovation and Expansion**

Dear Ms. Hill:

I am writing this letter to state my support of the Certificate of Need application submitted by Parkridge West Hospital as referenced above.

I am Billy Mason, Chief of Police for the Town of Jasper and I have worked with the professionals at Mountainview a number of years.

This facility has faithfully served mental health patients in our community and surrounding areas for the past 8 years. A renovation and bed expansion is needed for Mountainview to continue to serve this growing population. We know this facility runs near or at capacity and additional beds would reduce this problem.

I respectfully request this board grant approval for the bed addition and expansion project application for the reasons stated above.

Sincerely,

Billy Mason

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Cleveland, TN 37311

**RE: Certificate of Need Application**
**Parkridge West Hospital 8 Bed Conversion**

Dear Ms. Hill,

On behalf of the Marion County Commissioner's Office, District 4, I am pleased to write this letter of support for Parkridge West Hospital's proposal to convert 8 medical surgical beds to 8 adult psychiatric beds. Parkridge West Hospital has been instrumental in providing valuable medical services to the community and is a respected community partner.

I believe they are in a unique position to improve behavioral health care access and impact the continued rise in behavioral healthcare needs in the community. I fully support the awarding of this CON to Parkridge West Hospital and look forward to working with them in this new capacity.

Sincerely,

Ledger Mack Rice

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Cleveland, TN 37311

**RE: Certificate of Need Application**
**Parkridge West Hospital 8 Bed Conversion**

Dear Ms. Hill,

On behalf of the Marion County Commissioner's Office, District 3, I am pleased to write this letter of support for Parkridge West Hospital's proposal to convert 8 medical surgical beds to 8 adult psychiatric beds. Parkridge West Hospital has been instrumental in providing valuable medical services to the community and is a respected community partner.

I believe they are in a unique position to improve behavioral health care access and impact the continued rise in behavioral healthcare needs in the community. I fully support the awarding of this CON to Parkridge West Hospital and look forward to working with them in this new capacity.

Sincerely,

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

November 10, 2016

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Nashville, TN 37243

**Re: Certificate of Need Application**
**Parkridge West Hospital 8 Bed Conversion**

Dear Ms. Hill:

I am writing this letter to state my support of the Certificate of Need application submitted by Parkridge West Hospital as referenced above.

Mountainview has faithfully served mental health patients in our community and surrounding areas since 2008. The conversion of 8 current medical/surgical beds to inpatient psychiatric beds is needed for Mountainview to continue to serve this growing population of individuals with behavioral health needs. I am aware that this facility runs near or at capacity and additional beds would increase the ability to serve our community and surrounding area.

I respectfully request this board grant approval for the 8 bed conversion.

Sincerely,

Samuel F. Hudson
(423) 949-7900

**It is noted the local mental health outpatient provider of Mountain Valley is not accepting new patients. Why is the local mental health provider not accepting new patients? Who is Mountain Valley, what services do they offer, and who is their owner?**

Mountain Valley, an outpatient behavioral health provider, located in Japser, TN, is owned and operated by Volunteer Behavioral Health Care System. It has been the applicant's experience that Mountain Valley can be limited in its ability to accept new patient referrals due to maximum caseloads for their current resources.

**It is noted the applicant's payor mix is 80% TennCare and that mental health case management is a covered TennCare benefit. Please discuss how case management falls into the continuum of care in relation to inpatient psychiatric services. Does every TennCare patient discharged from Parkridge West's inpatient psychiatric unit offered case management services?**

Once Parkridge West obtains TennCare credentialing and admits TennCare patients, it will arrange a post-discharge follow-up appointment for each TennCare patient within seven days of discharge. However, post-discharge appointments and case management are not provided by the hospital. They are typically provided by either local Mental Health Centers or other private providers in the patients' home areas.

**10. Section B, Need Item 2**

**Please describe the relationship of this project to the applicant facility's long range development plans, if any, and how it relates to related previously approved projects of the applicant.**

Parkridge West has Intensive Outpatient and/or Partial Hospitalization (IOP/PHP) as part of the 2017 behavioral health growth plan. This will add a continuum of care for adults and will be available for individuals after discharge or as a therapeutic component that may prevent an inpatient admission. It is projected that the treatment focus will be general mental health and dual diagnosis. Specific geriatric IOP and PHP is under review as a potential specialty program.

**11. Section B, Need Item 3**

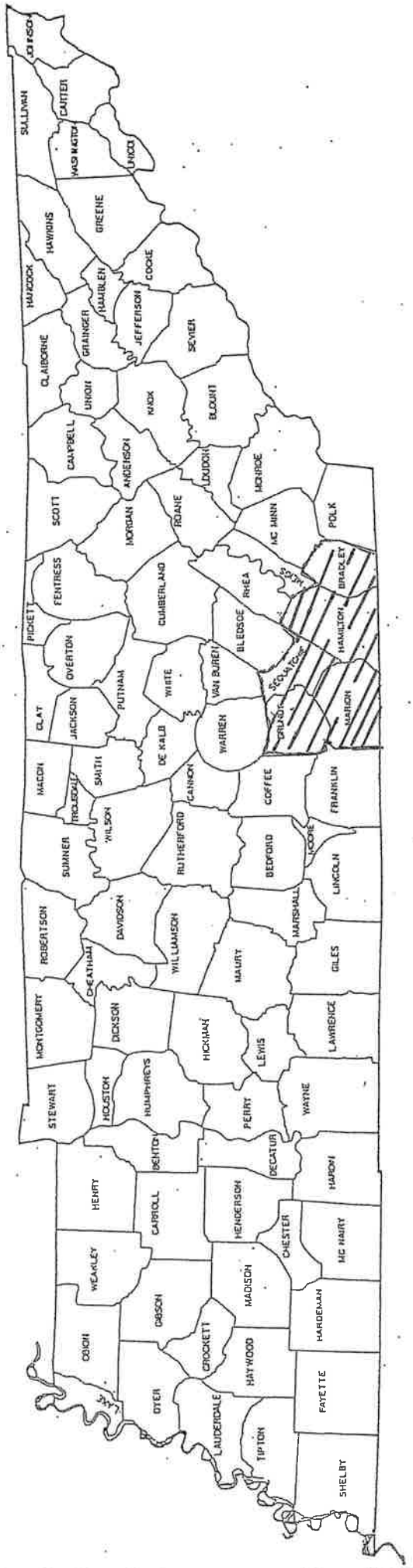
**The county level map of the proposed PSA could not be located. Please provide.**

The county level PSA map is Attachment Section B, Need, 3 in the filed application. A duplicate is attached following this response.

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**




Attachment Section B,
Need, 3

**SUPPLEMENTAL #1**

**November 23, 2016**
**8:19 am**

**12. Section B, Need Item 4.A**

**The referenced population table in Attachment Section B, Need, 4A could not be located. Please provide.**

This attachment was included in the filed application. A copy is attached following this response.

| Demographic Variable/ Geographic Area | Department of Health/Health Statistics | | | | | | | Bureau of the Census | | | | TennCare | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Population- Current Year | Total Population- Projected Year | Total Population-% Change | *Target Population- Current Year | *Target Population- Project Year | *Target Population-% Change | Target Population Projected Year as % of Total | Median Age | Median Household Income | Person Below Poverty Level | Person Below Poverty Level as % of Total | TennCare Enrollees | TennCare Enrollees as % of Total |
| Bradley County | 105,549 | 107,651 | 1.99% | 81,934 | 83,908 | 2.41% | 78% | 39 | $41,575 | N/A* | 19.8% | 23,405 | 22.2% |
| Grundy County | 13,470 | 13,379 | -0.68% | 10,588 | 10,595 | 0.07% | 79% | 42.7 | $26,856 | N/A* | 29.1% | 4,899 | 36.4% |
| Hamilton County | 356,156 | 362,471 | 1.77% | 278,574 | 283,457 | 1.75% | 78% | 39.4 | 47,880 | N/A* | 16.0% | 71,146 | 20.0% |
| Marion County | 28,585 | 28,627 | 0.15% | 22,674 | 22,804 | 0.57% | 80% | 42.9 | $40,998 | N/A* | 20.3% | 7,503 | 26.2% |
| Sequatchie County | 15,835 | 16,399 | 3.56% | 12,428 | 12,946 | 4.17% | 79% | 41.7 | $42,182 | N/A* | 18.6% | 4,175 | 26.4% |
| Primary Service Area Total | 519,595 | 528,527 | 1.72% | 406,198 | 413,710 | 1.85% | 78% | 41.1 (avg.) | $39,,898 (avg.) | N/A* | 20.8%(avg.) | 111,128 | 21.4% |
| State of TN Total | 6,812,005 | 6,962,031 | 2.20% | 5,241,318 | 5,368,064 | 2.42% | 77% | 38.3 | $44,621 | N/A* | 17.8% | 1,544,940 | 22.7% |

* The Census Bureau website doe not reflect toal population under Poverty Level. It only provides the % of total for the year 2014.

13. **Section C, Need, Item 6**

    **The table of the projected utilization on 8 new beds is noted. However, the table is for the 65+ population only. Is this correct since the applicant will serve 18+?**

    That projection table was mislabeled. Please see the corrected table provided above in response to Question 6.

14. **Section C. Economic Feasibility Item 3 and 4 (Historical and Projected Data Chart)**

    **The historical data chart for the existing 20 psych beds is noted. Please clarify the reason expense data is not available from March 1, 2014 to December 31, 2014.**

    The records maintained in the normal course of business do not segregate out the expense data for the psych unit only (not including the ED and outpatient). The applicant was able to segregate these expenses however, and revised Historical Data Charts are attached following this response.

    **Please remove the duplicate totals for salaries and wages and rent in the Historical and Projected Data Chart and submit new charts.**

    Revised Projected Data Charts are attached following this response.

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**

**HISTORICAL DATA CHART**

X Total Facility (20 beds incl. ED & OP)

___ Project Only

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 (Month)

| | | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 5,331 Dischg Days | 6,247 Dischg Days | 7587 Dischg Days |
| B. | Revenue from Services to Patients | | | |
| | 1. Inpatient Services | 22,502,459 | 27,837,462 | 38,588,113 |
| | 2. Outpatient Services | 55,148,000 | 60,723,908 | 70,673,376 |
| | 3. Emergency Services (incl. in Outpatient) | - | - | - |
| | 4. Other Operating Revenue | 34,739 | 375,558 | 602,077 |
| | Specify: | | | |
| | **Gross Operating Revenue** | 77,685,198 | 88,936,928 | 109,863,566 |
| C. | Deductions from Operating Revenue | | | |
| | 1. Contract Deductions | 64,419,928 | 66,371,173 | 77,716,206 |
| | 2. Provision for Charity Care | 168,556 | 620,543 | 776,585 |
| | 3. Provision for Bad Debt | 1,452,393 | 9,293,183 | 12,568,720 |
| | **Total Deductions** | 66,040,877 | 76,284,899 | 91,061,511 |
| **NET OPERATING REVENUE** | | 11,644,321 | 12,652,029 | 18,802,055 |
| D. | Operating Expenses | | | |
| | 1. Salaries and Wages | | | |
| | a. Direct Patient Care | 2,645,138 | 1,837,982 | 2,553,136 |
| | b. Non-Patient Care | 1,052,793 | 3,334,989 | 4,695,793 |
| | 2. Physicians' Salaries and Wages | - | - | - |
| | 3. Supplies | 637,392 | 1,208,172 | 2,401,337 |
| | 4. Rent | | | |
| | a. Paid to Affiliates | | | |
| | b. Paid to Non-Affiliates | 229,574 | 363,357 | 745,351 |
| | 5. Management Fees: | | | |
| | a. Fees to Affiliates | 769,197 | 1,018,669 | 666,823 |
| | b. Fees to Non-Alffiliates | - | - | - |
| | 6. Other Operating Expenses | 4,438,439 | 6,237,463 | 9,328,851 |
| | **Total Operating Expenses** | 9,772,533 | 14,000,632 | 20,391,291 |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | 1,871,788 | (1,348,603) | (1,589,236) |
| F. | Non-Operating Expenses | | | |
| | 1. Taxes (Income & Property) | 48,775 | (1,220,558) | (1,047,322) |
| | 2. Depreciation | 1,189,547 | 1,350,455 | 1,627,698 |
| | 3. Interest | 552,082 | 812,646 | 887,332 |
| | 4. Other Non-Operating Expenses | | | |
| | **Total Non-Operating Expenses** | 1,790,404 | 942,543 | 1,467,708 |
| **NET INCOME (LOSS)** | | 81,384 | (2,291,146) | (3,056,944) |
| G. | Other Deductions | | | |
| | 1. Annual Principal Debt Repayment | | | |
| | 2. Annual Capital Expediture | | | |
| | **Other Total Deductions** | - | - | - |
| | **NET BALANCE** | 81,384 | (2,291,146) | (3,056,944) |
| | **DEPRECIATION** | 1,189,547 | 1,350,455 | 1,627,698 |
| | **FREE CASH FLOW (Net Blance + Depreciation)** | 1,270,931 | (940,691) | (1,429,246) |

* Data for 1/1/16 through 10/31/16

** Data for 1/1/14 through 2/28/14 was provided by Capella for JAR completion. Parkridge purchased facility eff 3/1/14

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**

**HISTORICAL DATA CHART -- OTHER EXPENSES**

**X Total Facility (20 beds incl. ED & OP)**
**___ Project Only**

| OTHER EXPENSE CATEGORY | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|
| 1. Professional Services Contracts | 200,187 | 668,710 | 1,067,751 |
| 2. Contract Labor | 233,581 | 269,713 | 118,259 |
| 3. Imagng Interpretation Fees | - | - | - |
| 3. Employee Benefits | 968,176 | 1,196,752 | 1,977,000 |
| 5. Contract Services | 1,493,118 | 2,332,292 | 3,163,854 |
| 6. Repairs & Maintenance | 596,017 | 755,023 | 998,761 |
| 7. Utilities | 390,960 | 543,004 | 581,610 |
| 8. Insurance | 194,388 | 163,694 | 281,240 |
| 9. Other | 362,012 | 308,275 | 1,140,376 |
| **TOTAL OTHER EXPENSES** | 4,438,439 | 6,237,463 | 9,328,851 |

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**

HISTORICAL DATA CHART

__ Total Facility

X Project Only (20 beds, no ED or OP)

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 (Month)

| | | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 5,331 Dischg Days | 6,247 Dischg Days | 4,185 Dischg Days |
| B. | Revenue from Services to Patients | | | |
| | 1. Inpatient Services | 22,502,459 | 24,840,540 | 18,913,297 |
| | 2. Outpatient Services | | | - |
| | 3. Emergency Services | | | - |
| | 4. Other Operating Revenue | 34,739 | | - |
| | Specify: _____ | | | |
| | **Gross Operating Revenue** | 22,537,198 | 24,840,540 | 18,913,297 |
| C. | Deductions from Operating Revenue | | | |
| | 1. Contract Deductions | 17,267,632 | 19,389,449 | 15,453,115 |
| | 2. Provision for Charity Care | 59,250 | 84,463 | 11,075 |
| | 3. Provision for Bad Debt | 72,467 | 91,779 | 99,674 |
| | **Total Deductions** | 17,399,349 | 19,565,691 | 15,563,864 |
| **NET OPERATING REVENUE** | | 5,137,849 | 5,274,849 | 3,349,433 |
| D. | Operating Expenses | | | |
| | 1. Salaries and Wages | | | |
| | a. Direct Patient Care | 1,129,089 | 1,031,929 | 728,317 |
| | b. Non-Patient Care | 651,920 | 927,163 | 653,689 |
| | 2. Physicians' Salaries and Wages | - | - | - |
| | 3. Supplies | 297,326 | 365,807 | 436,008 |
| | 4. Rent | | | |
| | a. Paid to Affiliates | | | |
| | b. Paid to Non-Affiliates | 59,047 | 184,759 | 202,863 |
| | 5. Management Fees: | | | |
| | a. Fees to Affiliates | 308,271 | 316,491 | 91,133 |
| | b. Fees to Non-Alffiliates | | | |
| | 6. Other Operating Expenses | 1,735,473 | 2,032,329 | 982,083 |
| | **Total Operating Expenses** | 4,181,126 | 4,858,478 | 3,094,093 |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | 956,723 | 416,371 | 255,340 |
| F. | Non-Operating Expenses | | | |
| | 1. Taxes | 25,174 | 53,046 | 26,502 |
| | 2. Depreciation | | | |
| | 3. Interest | | | |
| | 4. Other Non-Operating Expenses | | | |
| | **Total Non-Operating Expenses** | 25,174 | 53,046 | 26,502 |
| **NET INCOME (LOSS)** | | 931,549 | 363,325 | 228,838 |
| G. | Other Deductions | | | |
| | 1. Annual Principal Debt Repayment | | | |
| | 2. Annual Capital Expediture | | | |
| | **Other Total Deductions** | - | - | - |
| | **NET BALANCE** | 931,549 | 363,325 | 228,838 |
| | **DEPRECIATION** | - | - | - |
| | **FREE CASH FLOW (Net Blance + Depreciation)** | 931,549 | 363,325 | 228,838 |

* Data for 1/1/16 through 10/31/16

** Expense data is for 10 months 3/1/14-12/31/14. Purchased facility 3/1/14. Net Revenue data per JAR for full year

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**

**HISTORICAL DATA CHART -- OTHER EXPENSES**

__ **Total Facility**

X **Project Only (20 beds, no ED or OP)**

| OTHER EXPENSE CATEGORY | Year: 2016 * | Year: 2015 | Year: 2014** |
|---|---|---|---|
| 1. Professional Services Contracts | 131,141 | 130,139 | 51,827 |
| 2. Contract Labor | 109,337 | 107,666 | 15,080 |
| 3. Employee Benefits | 494,623 | 493,814 | 306,884 |
| 4. Contract Services | 471,799 | 731,786 | 306,111 |
| 5. Repairs & Maintenance | 134,537 | 140,265 | 68,330 |
| 6. Utilities | 213,965 | 249,661 | 103,920 |
| 7. Insurance | 100,329 | 70,094 | 36,888 |
| 8. Other | 79,742 | 108,904 | 93,043 |

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**

**PROJECTED DATA CHART**

___ **Total Facility**
X **Project Only** **(8 new psych beds)**

Give information for the last two (2) years for which complete data are available for the facility or agency. The fiscal year begins in January (Month)

| | | Year: 1 | Year: 2 |
|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 1825 pt days | 2008 pt days |
| B. | Revenue from Services to Patients | | |
| | 1. Inpatient Services | $9,055,650 | $10,758,112 |
| | 2. Outpatient Services | | |
| | 3. Emergency Services | | |
| | 4. Other Operating Revenue | | |
| | Specify: _____ | | |
| | **Gross Operating Revenue** | $9,055,650 | $10,758,112 |
| C. | Deductions from Operating Revenue | | |
| | 1. Contract Deductions | $7,852,744 | $9,422,194 |
| | 2. Provision for Charity Care | $26,930 | $32,281 |
| | 3. Provision for Bad Debt | $40,826 | $39,876 |
| | **Total Deductions** | $7,920,500 | $9,494,351 |
| **NET OPERATING REVENUE** | | $1,135,150 | $1,263,761 |
| D. | Operating Expenses | | |
| | 1. Salaries and Wages | | |
| | a. Direct Patient Care | $475,696 | $485,210 |
| | b. Non-Patient Care | $0 | $0 |
| | 2. Physicians' Salaries and Wages | $0 | $0 |
| | 3. Supplies | $64,477 | $71,782 |
| | 4. Rent | $0 | $0 |
| | a. Paid to Affiliates | $0 | $0 |
| | b. Paid to Non-Affiliates | $0 | $0 |
| | 5. Management Fees: | | |
| | a. Fees to Affiliates | $68,109 | $75,826 |
| | b. Fees to Non-Alffiliates | $0 | $0 |
| | 6. Other Operating Expenses | $334,410 | $358,231 |
| | **Total Operating Expenses** | $942,692 | $991,049 |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | $192,458 | $272,712 |
| F. | Non-Operating Expenses | | |
| | 1. Taxes (Property) | $18,601 | $18,601 |
| | 2. Depreciation | $116,729 | $116,729 |
| | 3. Interest | | |
| | 4. Other Non-Operating Expenses | | |
| | **Total Non-Operating Expenses** | $135,330 | $135,330 |
| **NET INCOME (LOSS)** | | $57,128 | $137,382 |
| G. | Other Deductions | | |
| | 1. Estimated Annual Principal Debt Repayment | $0 | $0 |
| | 2. Annual Capital Expediture | $0 | $0 |
| | **Other Total Deductions** | $0 | $0 |
| | **NET BALANCE** | $57,128 | $137,382 |
| | **DEPRECIATION** | $116,729 | $116,729 |
| | **FREE CASH FLOW (Net Balance + Depreciation)** | $173,857 | $254,111 |

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**

**PROJECTED DATA CHART -- OTHER EXPENSES**

___ **Total Facility**
X **Project Only** **(8 new psych beds)**

| **OTHER EXPENSE CATEGORY** | Year: 1 | Year: 2 |
|---|---|---|
| 1. Professional Services Contracts | 120749 | 132824 |
| 2. Contract Labor | 0 | 0 |
| 3. Benefits | 110549 | 112760 |
| 4. Contract Services | 59212 | 65693 |
| 5. Repairs & Maintenance | 5000 | 5000 |
| 6. Utilities | 24000 | 24480 |
| 7. Insurance | 10800 | 10800 |
| 8. Other | 4100 | 6674 |
| **TOTAL OTHER EXPENSES** | $334,410.00 | $358,231.00 |

**SUPPLEMENTAL #1**

**November 23, 2016**

**8:19 am**

**PROJECTED DATA CHART** X **Total Facility (Approval beds, no ED or OP)**
**Project Only**

Give information for the last two (2) years for which complete data are available for the facility or agency. The fiscal year begins in January (Month)

| | | Year: 1 | Year: 2 |
|---|---|---|---|
| A. | Utilization/Occupancy Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) | 8,222 Pt.. Days | 8,515 Pt. days |
| | Dishcarges | 962 | 1044 |
| B. | Revenue from Services to Patients | | |
| | 1. Inpatient Services | $36,058,601 | $40,423,288 |
| | 2. Outpatient Services | | |
| | 3. Emergency Services | | |
| | 4. Other Operating Revenue | $41,687 | $42,521 |
| | Specify: | | |
| | **Gross Operating Revenue** | $36,100,288 | $40,465,809 |
| C. | Deductions from Operating Revenue | | |
| | 1. Contract Deductions | $28,573,902 | $32,502,422 |
| | 2. Provision for Charity Care | $98,030 | $106,936 |
| | 3. Provision for Bad Debt | $127,786 | $131,184 |
| | **Total Deductions** | $28,799,718 | $32,740,542 |
| **NET OPERATING REVENUE** | | $7,300,570 | $7,725,267 |
| D. | Operating Expenses | | |
| | 1. Salaries and Wages | | |
| | a. Direct Patient Care | $1,830,603 | $1,864,505 |
| | b. Non-Patient Care | $782,304 | $796,385 |
| | 2. Physicians' Salaries and Wages | $0 | $0 |
| | 3. Supplies | $421,268 | $435,709 |
| | 4. Rent | | |
| | a. Paid to Affiliates | $0 | $0 |
| | b. Paid to Non-Affiliates | $70,856 | $71,565 |
| | 5. Management Fees: | | |
| | a. Fees to Affiliates | $438,034 | $463,516 |
| | b. Fees to Non-Alffiliates | $0 | $0 |
| | 6. Other Operating Expenses | $2,416,977 | $2,670,124 |
| | **Total Operating Expenses** | $5,960,042 | $6,301,804 |
| E. | **Earnings Before Interest, Taxes, and Depreciation** | $1,340,528 | $1,423,463 |
| F. | Non-Operating Expenses | | |
| | 1. Taxes (Property) | $48,810 | $48,810 |
| | 2. Depreciation | $133,099 | $133,099 |
| | 3. Interest | | |
| | 4. Other Non-Operating Expenses | | |
| | **Total Non-Operating Expenses** | $181,909 | $181,909 |
| **NET INCOME (LOSS)** | | $1,158,619 | $1,241,554 |
| G. | Other Deductions | | |
| | 1. Estimated Annual Principal Debt Repayment | $0 | $0 |
| | 2. Annual Capital Expediture | $0 | $0 |
| | **Other Total Deductions** | $0 | $0 |
| | **NET BALANCE** | $1,158,619 | $1,241,554 |
| | **DEPRECIATION** | $133,099 | $133,099 |
| | **FREE CASH FLOW (Net Balance + Depreciation)** | $1,291,718 | $1,374,653 |

**PROJECTED DATA CHART -- OTHER EXPENSES** X **Total Facility (28 psych beds, no ED or OP)**
**Project Only**

| OTHER EXPENSE CATEGORY | Year: 1 | Year: 2 |
|---|---|---|
| 1. Professional Services Contracts | 278,118 | $290,193 |
| 2. Contract Labor | 131,204 | $132,516 |
| 3. Employee Benefits | 704,097 | $718,179 |
| 4. Contract Services | 625,371 | $637,514 |
| 5. Repairs & Maintenance | 166,444 | $168,058 |
| 6. Utilities | 280,758 | $283,806 |
| 7. Insurance | 131,195 | $270,126 |
| 8. Other | 99,790 | $169,732 |
| **TOTAL OTHER EXPENSES** | 2,416,977 | 2,670,124 |

**15. Section C, Economic Feasibility, Item 6.B. Net Operating Ratio.**

**The Net Operating Margin Ratio table is noted. However, the ratio of 13.9% for the 1st Year previous to current year appears to be incorrect. Please clarify.**

A corrected table is reflected below.

| Year | 2nd Year previous to Current Year | 1st Year previous to Current Year | Current Year | Projected Year 1 | Projected Year 2 |
|---|---|---|---|---|---|
| Net Operating Margin Ratio | N/A (Data is not available, due to the acquisition of the hospital in 2014). | 7.9% | 18.6% | 18.4% | 18.4% |

**16. Section C. Economic Feasibility Item 9**

**With Parkridge Valley operating under 60% occupancy, won't the proposed project have a significant impact on this facility? Why isn't the alternative of status quo a better option until such time that Parkridge Valley has attained optimal occupancy?**

The applicant's location in a rural county provides better access for nearby rural residents than Valley provides. It is important to continue to provide these services to the extent they are utilized and needed, in this rural location.

The proposed additional 8 beds will not have a significant impact on the Parkridge Valley campus. Because of its location just outside of Chattanooga, the surrounding community and clinical professionals desire to treat individuals closer to their home, and this expansion project will create that opportunity. Parkridge Valley has made steps toward attaining optimal occupancy by adding an additional Psychiatrist and additional recruitment of front-line staff which has incrementally increased staffing and attainable occupancy.

Adding capacity at Parkridge West will create an opportunity to serve additional patients who may be unable to go to Parkridge Valley due to staffing coverage and/or geographic location. The additional beds will decrease emergency department wait times, especially in that region, as it will increase Parkridge West's ability to accept these patients.

**17. Section C, Contribution to Orderly Development, Item 1**

**Please clarify if the applicant has a transfer agreement with Moccasin Bend Mental Health Institute.**

Parkridge West does not have a transfer agreement with MBMHI. The State has acuity transfer agreements with only three private hospitals in Eastern Tennessee. Patients at Parkridge West and Parkridge Valley that require the level of care provided by MBMHI are evaluated by the Crisis Response Team (CRT) to determine the necessity of a referral. Upon referral from the CRT, patients are entered into MBMHI's que and admitted based on MBMHI's available capacity.

**18. Section C, Contribution to Orderly Development, Item 4**

**The applicant's certification as a Medicare Psychiatric Distinct Part Unit is noted. Please define and briefly provide an overview of this certification.**

The Medicare DPU is a separately certified unit from the rest of the hospital. It is exempted from the Medicare Prospective Payment System.

**19. Section C, Contribution to Orderly Development, Item 5 B.7. and B.8**

**It is noted the applicant is under approximately 23 civil lawsuits. Please clarify is any of the civil lawsuits are associated with Parkridge West's existing inpatient psychiatric unit? If so, please describe.**

Parkridge Medical Center, Inc., is one of several plaintiffs in a lawsuit involving numerous healthcare providers and payor reimbursements. It is possible one or more claims at issue in that case relate to a patient treated at Parkridge West for psychiatric services; however we are unable at this time to determine whether any of the accounts at issue relate to inpatient psychiatric services at Parkridge West. Otherwise, none of the lawsuits relate to the existing inpatient psychiatric unit at Parkridge West.

**It is noted Parkridge Medical Center entered into a corporate integrity agreement (CIA) with the Office of Inspector General (OIG) on September 14, 2012. Please provide a brief overview of the CIA.**

Parkridge Medical Center, Inc., agreed to a five-year CIA as part of a settlement with the OIG relating to a lawsuit that pertained to fair market valuation of real estate. Parkridge is in full compliance with the CIA, and the CIA is not related to inpatient psychiatric services at Parkridge West.

**20. Section C, Contribution to Orderly Development, Item 8**

**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?**

Since acquiring the facility in March of 2014, Parkridge West has not experienced difficulties in filling vacant staff positions at the behavioral health unit in Jasper. Parkridge West anticipates that this will continue, regardless of what staffing issues may exist or may arise in Hamilton County. Increasing the psychiatric bed complement by 8 and adjusting the facility's layout will require an increase of staff ranging from 1 to 5 non-physician FTEs, depending on census. The moderate increase in program staffing at Parkridge West will not impact the two other Parkridge locations.

## 21. 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.**

A Publisher's Affidavit is attached following this response.

SUPPLEMENTAL #1

**November 23, 2016**

Account #: [redacted]
Company: PARKRIDGE WEST HOSPITAL
Client:
Ad number: 17391
PO#:
Note:

# AFFIDAVIT • STATE OF TENNESSEE • HAMILTON COUNTY

Before me personally appeared Jim Stevens, who being duly sworn that he is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

*Chattanooga Times Free Press: 11/10/16; TimesFreePress.com: 11/10/16.*

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $240.40. (Includes $10.00 Affidavit Charge).

Jim Stevens

Sworn to and subscribed before me this date: 11/17/2016

Martha M. Tiffin

My Commission Expires 08/13/2019

MARTHA M. TIFFIN
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF HAMILTON
My Comm. Expires August 13, 2019

Chattanooga
Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

SUPPLEMENTAL #1

# TRUE COPY OF PUBLISHED LEGAL AD

Chattanooga Times Free Press
November 23, 2016
8:19 am

## 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. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Parkridge West Hospital, owned and managed by Parkridge Medical Center, Inc. intends to file an application for a Certificate of Need for the conversion of eight (8) licensed medical surgical beds to eight (8) adult psychiatric beds. The beds will be used to provide acute inpatient psychiatric services to individuals aged eighteen (18) years of age and older. No services are being initiated or discontinued; Parkridge West currently operates 20 licensed adult psychiatric beds. Parkridge West Hospital is located at 1000 Highway 28, Jasper, Marion County, Tennessee, 37347. Parkridge West Hospital is licensed as a general hospital by the Tennessee Department of Health, Board for Licensing Health Care Facilities. The total estimated project cost is $2,184,808.

The anticipated date of filing the application is November 15, 2016.

The contact person for this project is Jerry W. Taylor, Attorney who may be reached at: Burr & Forman, LLP, 511 Union Street, Suite 2300, Nashville, Tennessee 37219, 615-724-3247.

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

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

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice 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.

17391-1

**SUPPLEMENTAL #1**
**November 23, 2016**
**8:19 am**

## AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Hamilton

NAME OF FACILITY: Parkridge West

I, Melissa Arkin, after first being duly sworn, state under oath that I am 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.

CEO
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 22 day of November, 2016, witness my hand at office in the County of Hamilton, State of Tennessee.

Tiffany Richards
NOTARY PUBLIC

My commission expires March 21, 2020, _____.

TIFFANY RICHARDS
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

HF-0043

Revised 7/02

# Supplemental #2
# -ORIGINAL-

## PARKRIDGE WEST HOSPITAL

## CN1611-039

SUPPLEMENTAL #2
November 29, 2016
9:41 am

# SECOND SUPPLEMENTAL RESPONSES

# CERTIFICATE OF NEED APPLICATION

# FOR

# PARKRIDGE WEST HOSPITAL

## The Conversion of 8 Medical-Surgical Beds to 8 Psychiatric Beds

## Marion County, Tennessee

## Project No. CN1611-039

## November 29, 2016

Contact Person:

Jerry W. Taylor, Esq.
Burr & Forman, LLP
511 Union Street, Suite 2300
Nashville, Tennessee 37219
615-724-3247

**13. Section C, Need, Item 6**

**The table of the projected utilization on 8 new beds is noted. However, the table is for the 65+ population only. Is this correct since the applicant will serve 18+?**

The referenced table in the application was mislabeled. A corrected table is reflected on Replacement Page R-27 following this response.

admissions annualized. Assuming Parkridge had the capacity to accept these admissions, that would constitute 72% of the projected 315 admissions.

| PARKRIDGE WEST INPATIENT PSYCH BED UTILIZATION 2014-2016 | | | |
|---|---|---|---|
| **Year:** | **2014** | **2015** | **2016 (YTD 10/31/16)** |
| **Discharge 18-64** | 328 | 489 | 492 |
| **Days 18-64** | 3228 | 4969 | 4516 |
| **ALOS 18-64** | 9.84 | 10.16 | 9.18 |
| **Discharge 65+** | 85 | 79 | 60 |
| **Days 65+** | 957 | 945 | 815 |
| **ALOS 65+** | 11.26 | 11.96 | 13.58 |
| **Total Discharges** | 413 | 568 | 552 |
| **Total Days** | 4185 | 5914 | 5331 |
| **Occupancy Total Days** | 57.3% | 81.0% | 87.4% |

| PROJECTED UTILIZATION ON 8 NEW BEDS | | |
|---|---|---|
| | **Year 1** | **Year 2** |
| **Adm. 18+** | 315 | 386 |
| **ALOS 18+** | 5.8 Days | 5.8 Days |
| **Patient Days** | 1,825 | 2,008 |
| **Occupancy** | 62.5% | 68.7% |

**SUPPLEMENTAL #2**
**November 29, 2016**
**9:41 am**

# AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

I, Jerry W. Taylor, after first being duly sworn, state under oath that I am 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.

Name

Sworn to and subscribed before me this the 28th day of November, 2016, a Notary Public in and for Davidson County Tennessee.

Notary Public

NANCY JOHNSON
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.
My Commission Expires MAR. 7, 2017

My Commission Expires: _____