

**UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

In re:

STEWARD HEALTH CARE SYSTEM LLC,
et al.,¹

Debtors.

Chapter 11

Case No. 24-90213 (CML)

(Jointly Administered)

**SECOND REPORT OF SUZANNE KOENIG, PATIENT CARE OMBUDSMAN,
FOR THE HOSPITALS AND FACILITIES LOCATED IN MASSACHUSETTS,
OHIO, PENNSYLVANIA, AND THE MIAMI-DADE FLORIDA LOCATIONS**

In accordance with section 333(b)(2) of title 11 of the United States Code, 11 U.S.C. §§ 101 *et seq.* (the “Bankruptcy Code”), Suzanne Koenig, solely in her capacity as the Patient Care Ombudsman (the “Ombudsman”) for the hospitals and facilities located in Massachusetts, Ohio, and Pennsylvania as well as the Miami-Dade Florida Locations,² that are part of the chapter 11 cases of the above-captioned debtors and debtors-in-possession (collectively, the “Debtors”), respectfully submits this second report (the “Report”) on the quality of patient care for the period from July 23, 2024 through and including the date hereof, September 20, 2024 (the “Report Period”).

¹ A complete list of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors’ claims and noticing agent at <https://restructuring.ra.kroll.com/Steward>. The Debtors’ service address for these chapter 11 cases is 1900 N. Pearl Street, Suite 2400, Dallas, Texas 75201.

² The “Miami-Dade Florida Locations” collectively refers to the Coral Gables Hospital located in Coral Gables, Florida; the Hialeah Hospital and the Palmetto General Hospital located in Hialeah, Florida; and the North Shore Medical Center located in Miami, Florida.

I. BACKGROUND

A. The Ombudsman’s Appointment and First Ombudsman Report

1. On May 6, 2024 (the “Petition Date”), each of the Debtors filed a voluntary petition for relief under chapter 11 of the Bankruptcy Code in the United States Bankruptcy Court for the Southern District of Texas (the “Court”).

2. On the Petition Date, the Court ordered the United States Trustee to appoint a patient care ombudsman pursuant to section 333 of the Bankruptcy Code. *See* docket entry at Docket No. 1. On May 20, 2024, the United States Trustee appointed the Ombudsman for the hospitals and healthcare facilities located in Massachusetts, Ohio, and Pennsylvania, and the Miami-Dade Florida Locations. *See Notice of Appointment of Patient Care Ombudsman Covering Massachusetts, Ohio, Pennsylvania, and Miami-Dade Florida Locations Under 11 U.S.C. § 333* [Docket No. 311] (the “Appointment Notice”). As set forth in section 333(a)(1) of the Bankruptcy Code and the Appointment Notice, the Ombudsman was appointed to, *inter alia*, monitor the quality of patient care provided to the Debtors’ patients at their hospitals and facilities located in Massachusetts, Ohio, and Pennsylvania, and the Miami-Dade Florida Locations.

3. On June 18, 2024, the Ombudsman filed applications to retain the law firm of Greenberg Traurig, LLP as her counsel and SAK Management Services, LLC *d/b/a* SAK Healthcare (“SAK”) as her medical operations advisor [Docket Nos. 891 and 892, respectively] (collectively, the “Applications”). On July 11, 2024, the Court entered orders granting the Applications [Docket Nos. 1561 and 1562, respectively].

4. On July 23, 2024, the Ombudsman filed her *First Report of Suzanne Koenig, as Patient Care Ombudsman, for the Hospitals and Facilities Located in Massachusetts, Ohio, Pennsylvania, and the Miami-Dade Florida Locations* [Docket No. 1659] and *Exhibits to First*

Report of Suzanne Koenig, as Patient Care Ombudsman, for the Hospitals and Facilities Located in Massachusetts, Ohio, Pennsylvania, and the Miami-Dade Florida Locations [Docket No. 1660] (collectively, the “First Ombudsman Report”). The First Ombudsman Report summarized the quality of patient care for the period from the appointment of the Ombudsman on May 20, 2024 through and including July 22, 2024.

B. Hospital Closures

5. The Debtors initiated a sale process for all of the hospitals. Unfortunately, the sale process was unsuccessful for Carney Hospital (“Carney”) and Nashoba Valley Medical Center (“Nashoba”) and as a result, the Debtors elected to cease operations thereat. The Court authorized the closures of Carney and Nashoba on August 22, 2024. *See Order (I) Approving Procedures Related to Facility Closures on a Final Basis and (II) Granting Related Relief* [Docket No. 2146].

6. The Ombudsman’s primary focus during this Report Period has been ensuring that patient safety and care was maintained during the closures of Carney and Nashoba, that patients were safely transferred or discharged prior to closure and that after closure, patients have access to their medical records. In furtherance of that, the Ombudsman filed three supplemental reports to keep the Court and other key constituencies apprised of patient safety and care during this closure period: (i) *Statement of Suzanne Koenig, as Patient Care Ombudsman, in Response to the Emergency Motion of Debtors for Entry of an Order (I) Approving (A) Funding from the Commonwealth of Massachusetts for the Planned Transition and Sale of Massachusetts Hospitals, (B) the Closure of Carney Hospital and Nashoba Valley Medical Center, and (C) Procedures Related to Facility Closures; and (II) Granting Related Relief* [Docket No. 1764] filed on July 30, 2024; (ii) *Supplemental Report of Suzanne Koenig, Patient Care Ombudsman, Relating to the Closure of Nashoba Valley Medical Center* [Docket No. 2204] filed on August 26, 2024; and

(iii) *Supplemental Report of Suzanne Koenig, Patient Care Ombudsman, Relating to the Closures of Nashoba Valley Medical Center and Carney Hospital* [Docket No. 2428] filed on September 10, 2024 (collectively, the “Supplemental Reports”). In her Supplemental Reports, the Ombudsman identified certain challenges that needed to be — and ultimately were — addressed during this closure period, including:

i. *Communication Between Corporate and Carney and Nashoba*

7. There initially appeared to be a lack of communication and coordination between the Debtors’ corporate offices and the leadership team and staff at the closing hospitals, particularly, Carney. At first, the senior leadership on the ground at Carney had few details regarding the closure process and steps. These communication and coordination issues, however, were remedied over time.

ii. *Staffing Concerns*

8. Senior leadership expressed concerns about maintaining necessary staffing through the closure process. Ultimately, because of the incentives offered by the teams at Carney and Nashoba and the staff’s dedication and genuine care for their coworkers, patients, and communities, staffing was maintained at a safe level through the closure process, with the rare exception of certain limited periods.

iii. *Communication with the Community/Access to Alternative Emergency Rooms and Hospitals*

9. Nashoba was the sole emergency department (“ED”) within a thirty-mile radius in a community with limited paramedics and emergency medical services (“EMS”) personnel. The Ombudsman was concerned about the limited availability of EMS personnel and the ability of the EDs in the surrounding communities to absorb former Nashoba patients. Additionally, on several occasions, Carney’s ED has received patients walking into the ED with gunshot and stab wounds.

10. The Ombudsman strongly encouraged the Debtors and other stakeholders to fund the cost of keeping an ambulance at Carney’s and Nashoba’s ED entrances for at least seven days post-closure in the event that critical patients, who were unaware of the ED closures, arrived needing emergency services. The Debtors arranged to have an ambulance located at each of the EDs for at least seven days, and these ambulances were used to assist patients arriving at these closed EDs (for example, Carney had at least nineteen ambulance transports to other hospitals from August 31st to September 5th).

iv. *Insufficient Detail in Closure Procedures*

11. The Ombudsman was initially concerned by the lack of specifics in the proposed closure procedures, but after further discussion with the Debtors, the Debtors, with input from the Ombudsman, developed a well-organized closure plan and the plan was implemented successfully.

12. Carney and Nashoba ceased all operations at 7:00 a.m. (prevailing Eastern Time) on August 31, 2024. From the Ombudsman’s perspective, the Debtors and the staff “on the ground” at Carney and Nashoba maintained patient care and safety throughout the closure process.

C. Sale of Remaining Massachusetts Hospitals, Ohio Hospitals, Pennsylvania and Florida Hospitals

13. With the closures of Carney and Nashoba, the Debtors’ remaining Massachusetts hospitals include Holy Family Hospital – Methuen campus (“Holy Family Methuen”), Holy Family Hospital – Haverhill campus (“Holy Family Haverhill,” and together with Holy Family Methuen, “Holy Family”), Saint Anne’s Hospital (“Saint Anne’s”), Morton Hospital (“Morton”), St. Elizabeth’s Medical Center (“SEMC”), and Good Samaritan Medical Center (“GSMC,” and together with Holy Family, Saint Anne’s, Morton, and SEMC, the “Remaining MA Hospitals”).

14. On September 13, 2024, the Court approved the sale transactions for all Remaining MA Hospitals, including: (i) the sale of Holy Family to LG Newcorp, Inc. and Lawrence General

Hospital, each a Massachusetts not-for-profit corporation; (ii) the sale of Saint Anne’s and Morton to Lifespan of Massachusetts; and (iii) the sale of SEMC and GSMC to BMC Health System, Inc. *See Order (I) Authorizing and Approving (A) the Sale of Steward Holy Family Hospital in Methuen and Steward Holy Family Hospital in Haverhill Free and Clear of Liens, Claims, Encumbrances, and Interests, and (B) the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases; and (II) Granting Related Relief*[Docket No. 2519]; *Order (I) Authorizing and Approving (A) the Sale of Saint Anne’s Hospital and Morton Hospital Free and Clear of Liens, Claims, Encumbrances, and Interests and (B) the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases; and (II) Granting Related Relief*[Docket No. 2520]; *Order (I) Authorizing and Approving (A) the Sale of the Debtors’ Assets Free and Clear of Liens, Claims, Encumbrances, and Interests and (B) the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases; and (II) Granting Related Relief*[Docket No. 2523].

15. On September 10, 2024, the Court entered a stipulation between certain Debtors and the Commonwealth of Pennsylvania (the “Commonwealth”), whereby the Commonwealth agreed to provide emergency funding for Sharon Regional Medical Center (“Sharon”) through the earlier of: (i) December 1, 2024, (ii) the sale or transfer of hospital operations to Meadville Medical Center, or another purchaser as approved by the Commonwealth, or (iii) delivery by the Commonwealth of a termination notice. *See Stipulation Regarding Funding by the Commonwealth of Pennsylvania for the Potential Transition and Sale of Sharon Regional Medical Center* [Docket No. 2422]. The goal is to keep Sharon operational for the benefit of its community until a sale can be consummated.

16. On September 18, 2024, the Court approved a global settlement between the Debtors and Medical Properties Trust (“MPT”) that results in, among other things, interim

managers being appointed for Hillside Rehabilitation Hospital, Trumbull Regional Medical Center, and the Miami-Dade Florida Locations. *See Final Order Approving (I) Global Settlement with Medical Properties Trust, Prepetition ABL/FILO Secured Parties, FILO Secured Parties, and Creditors' Committee, (II) Interim Management Procedures, and (III) Granting Related Relief* [Docket No. 2610] (the "Global Settlement"). Under the Global Settlement, the Debtors and MPT are to use good faith efforts to agree on a resolution with respect to Sharon as promptly as practicable.

17. During the next report period, the Ombudsman will focus on monitoring care and the transition of care as (a) the sales of the Remaining Massachusetts Hospitals close, (b) the interim managers begin providing care at Hillside Rehabilitation Hospital, Trumbull Regional Medical Center, and the Miami-Dade Florida Locations pending licensure approvals, and (c) the ongoing care provided by the Debtors at Sharon as well as the ongoing sale efforts relating to Sharon.

II. SUMMARY OF THE OMBUDSMAN'S MONITORING AND OBSERVATIONS

18. The following summarizes the Ombudsman's observations during the Report Period. Any observations regarding the hospitals are based upon the visits discussed in the individual reports and the observations and interviews conducted during those visits as well as phone calls and electronic mail communications conducted remotely with the staff at each of the hospitals and the Debtors' corporate team.

A. Executive Summary

19. The hospitals and facilities included in this Report are as follows (each a “Hospital,” and collectively, the “Hospitals”):³

Exhibit	Debtor	Facility Name	Address
A	Steward St. Elizabeth’s Medical Center of Boston, Inc.	St. Elizabeth’s Medical Center	736 Cambridge St. Brighton, MA 02135
B	Steward Holy Family Hospital, Inc.	Holy Family Hospital – Haverhill	140 Lincoln Ave. Haverhill, MA 01830
C	Steward Holy Family Hospital, Inc.	Holy Family Hospital – Methuen	70 East St. Methuen, MA 01844
D	Steward Good Samaritan Medical Center, Inc.	Good Samaritan Medical Center	235 N. Pearl St. Brockton, MA 02301
E	Nashoba Valley Medical Center, A Steward Family Hospital, Inc.	Nashoba Valley Medical Center	200 Groton Rd. Ayer, MA 01432
F	Morton Hospital, A Steward Family Hospital, Inc.	Morton Hospital	88 Washington St. Taunton, MA 02780
G	Steward St. Anne’s Hospital Corporation	Saint Anne’s Hospital	795 Middle St. Fall River, MA 02721
H	Steward Carney Hospital, Inc.	Carney Hospital	2100 Dorchester Ave. Dorchester, MA 02124
I	Steward Hillside Rehabilitation Hospital, Inc.	Hillside Rehabilitation Hospital	8747 Squires Ln. NE Warren, OH 44484
J	Steward Trumbull Memorial Hospital, Inc.	Trumbull Regional Medical Center	1350 E. Market St. Warren, OH 44482
K	Steward Sharon Regional Health System, Inc.	Sharon Regional Medical Center	740 E. State St. Sharon, PA 16146
L	Steward PGH, Inc.	Palmetto General Hospital	2001 W. 68 St. Hialeah, FL 33016
M	Steward NSMC, Inc.	North Shore Medical Center	1100 N.W. 95th St. Miami, FL 33150
N	Steward CGH, Inc.	Coral Gables Hospital	3100 Douglas Rd. Coral Gables, FL 33134
O	Steward HH, Inc.	Hialeah Hospital	651 E. 25th St. Hialeah, FL 33013

³ Norwood Hospital, formerly located at 800 Washington Street, Norwood, Massachusetts 02062, permanently closed before the Petition Date. Accordingly, Norwood Hospital is not included in this Report.

20. As described in further detail below, an individual report for each Hospital visited during this Report Period has been prepared and will be filed as Exhibits to this Report as reflected in the above chart.

B. Methodology

21. As noted in the Ombudsman’s first report, due to the number of Hospitals operated by the Debtors, the Ombudsman developed a standardized methodology to ensure consistency in reporting among the Ombudsman’s representatives visiting each location. Prior to the first visit following her appointment, the Ombudsman developed materials to ensure consistency with respect to representatives’ work under the statutory requirements of section 333 of the Bankruptcy Code, appropriate procedures for interviewing the professional staff and patients, and reiteration of privacy requirements mandated under the Health Insurance Portability and Accountability Act (“HIPAA”) as they apply to the Hospitals. The Ombudsman also created question guidelines and checklists to encompass the full scope of potential patient care concerns. The Ombudsman also determined the key areas and departments of each Hospital to be visited given their importance to patient care.

22. Each site visit included the Ombudsman and/or one SAK representative, who was a nurse by training. The visits to each Hospital ranged from approximately four to eight hours in length depending upon the size and complexity of the Hospital. During each visit, the Ombudsman and/or her representative met with the relevant Hospital’s leadership team, conducted a walk-through tour of each Hospital and its buildings, and interviewed key professional staff and patients where possible. The Ombudsman and her representatives also requested and reviewed Hospital records as part of this assessment process. Generally (and with the exception of Carney and Nashoba given that they were closing), the Ombudsman and/or her representative visited each

Hospital once during the Report Period with the Ombudsman and/or her representative conducting these visits on an unannounced basis.

23. Throughout the Report Period, the Ombudsman and her representatives have sought and obtained information from, and had open lines of communication with, the Debtors. For example, the Ombudsman receives regular staffing reports for the Hospitals and equipment repair updates from the Debtors' Hospitals. The Ombudsman had regular communications with the Debtors' corporate team and command center overseeing the closures. In addition, the Ombudsman had regular communications with the Commonwealth of Massachusetts concerning the closure and sales of the Massachusetts hospitals.

24. The Ombudsman and her SAK representatives dedicated a significant amount of time during this Report Period on addressing issues related to the closures of Carney and Nashoba, which included the filing of three Supplemental Reports. The Ombudsman and her representatives had numerous discussions with patients, nurses, doctors, and others impacted by the closures and regularly communicated with the Debtors' Command Center regarding the issues being raised.

25. The Ombudsman appreciates the cooperation and collaboration of all parties in interest in these cases to assist the Ombudsman in reviewing patient care.

C. Overall Impressions

26. While the individual Hospital Reports will provide a detailed analysis of each Hospital and patient care at the Hospitals, the Ombudsman did not observe any material issues impacting patient care requiring this Court's immediate attention. The Ombudsman did observe certain areas in which the Hospitals could improve the patient care experience and has discussed these issues with the Debtors. Below is a general summary of the Ombudsman's overall

impressions of care at the Hospitals and areas in which improvement can and has been made during the Report Period:

- The Ombudsman commends the staff at Carney and Nashoba for their dedication to the patients and the community in what was a difficult, emotional process as these Hospitals closed their doors on August 31, 2024. While there were some coordination and communication issues initially, overall, leadership developed and implemented a closure plan on a truncated timeframe that resulted in the safe discharge or transfer of all patients and cessation of operations. Patient care and safety was prioritized and maintained throughout the closure process.
- In order to alleviate some of the patient care issues resulting from Carney's closure, the Ombudsman was encouraged that the Debtors planned to reopen the closed behavioral health unit at GSMC.
- The Ombudsman relayed concerns to and discussed with the Debtors (a) the handling of pharmaceuticals, (b) decommissioning of nuclear waste, and (c) maintenance of and access to medical records post-closure of Nashoba and Carney.⁴ In the future, SEMC will handle medical record requests for Carney and Holy Family Methuen will handle medical record requests for Nashoba. The Ombudsman is still reviewing certain issues relating to medical records to ensure that patients will have access to their records and clear instructions as to how to obtain access to those records.

⁴ The medical records processes and procedures were not always made available to the Ombudsman.

- The Ombudsman did not observe any staffing issues that made her believe patients were in immediate danger or otherwise receiving unsafe care due to staffing issues. The Debtors are actively recruiting and filling vacant shifts with overtime, in-house travelers, and bonuses. The Debtors' staff are generally demonstrating a strong commitment to quality care. The Debtors' staffing levels appear to be sufficient based on the reporting provided to the Ombudsman throughout this Report Period.
- The Debtors have an engaged leadership team dedicated to providing excellent patient care and outcomes in the communities they serve through the Hospitals. The Debtors' leadership is dedicated to making improvements.
- The Ombudsman did not find any concerns related to procurement of adequate supplies, such as food and medical supplies, among other necessary items. Based on the Ombudsman's or her representative's observations during each of the visits, the supply rooms appeared to be stocked with enough supplies to provide safe patient care.
- While most of the Hospitals are still in need of repairs and new or repaired equipment, the Ombudsman has observed marked improvement since the First Ombudsman Report. The Debtors' leadership has implemented adequate temporary solutions, including the use of rental equipment, while permanent fixes are sought or pending the closing of various sale transactions. Often, the Debtors' staff must wait on the provision of funds to fix or replace the broken equipment, as many vendors are demanding

prepayment or cash on delivery. Although elevator status had improved over the past few weeks at SEMC, the hospital recently began experiencing an increase in elevator glitches, with six total elevators being nonfunctional. While the broken equipment is an ongoing issue that the Debtors must continue to fully resolve, the Ombudsman does not believe the security, safety, or care of the Hospitals' patients are presently at risk. The Hospital staff has been adept at problem solving while waiting for new equipment or repairs to be completed.

- The Ombudsman observed significant improvement in the kitchens that required attention during the last reporting period. Generally, the kitchens across the Hospitals were clean and organized, with minor exceptions. Relatedly, the kitchens that were previously chaotic had greatly improved their work processes, showing good flow with the meal prep line, labeling food with expiration dates, and taking food temperatures and documenting them in accordance with the Debtors' policy. Overall, meal prep and service has greatly improved.
- The patient census at many of the Hospitals has declined and appears to be partly related to negative press concerning the Debtors' Hospitals and these bankruptcy cases. The Ombudsman observed staff committed to providing excellent care to the patients and urges all parties in interest and the communities to continue supporting these Hospitals, many of which are critical to their localities. Indeed, the Ombudsman would hope to see no

additional closures given the significance of these Hospitals to their communities.

III. OMBUDSMAN'S MONITORING AND OBSERVATIONS BY HOSPITAL

27. The Ombudsman has detailed Reports on each of the Hospitals visited and assessed. Each Report includes observations of patient care with commentary about one or more areas of assessment, including an overview of each Hospital, regulatory compliance, patient interviews, risk management, medical records, infection control and protocols, emergency preparedness, discharge review, vendor relationships, maintenance, and environmental services.

IV. CONCLUSION

28. The Ombudsman has made her best efforts, within the time constraints, to conduct a comprehensive investigation of the quality of patient care at the Debtors' Hospitals. The Ombudsman is available to address any issues with this Court or other parties in interest. The Ombudsman will submit her next report within sixty days and will inform the Court if there are any critical concerns discovered prior to that time, as necessary. During the next reporting period, the Ombudsman will be focused on ensuring a smooth transition of the Hospitals expected to be taken over by new operators in the coming months.

Dated: September 20, 2024

**SUZANNE KOENIG, AS COURT
APPOINTED PATIENT CARE OMBUDSMAN**

By: /s/ Suzanne A. Koenig
Suzanne A. Koenig, solely in her capacity
as Patient Care Ombudsman

EXHIBIT A

ST. ELIZABETH MEDICAL CENTER

I. Elevator Update on August 20, 2024

On August 20, 2024, the Chief Operating Officer (“COO”) of St. Elizabeth Medical Center (“SEMC”) informed the Ombudsman that SEMC had been experiencing elevator issues over the past few days. SEMC had three nonfunctioning elevators in Seton Tower, leaving only one working elevator in that area, and two nonfunctioning elevators in CMP Tower, leaving only two working elevators in that area. The elevator company, Schindler, was onsite but ultimately unable to repair them. According to the Chief Nursing Officer (“CNO”), they were able to safely move patients throughout SEMC, although wait times had increased. The CNO stated that the transport department monitors elevator wait times, and the longest wait time to date was approximately twenty minutes.

Although the elevator status had improved over these past few months, these recent elevator glitches are concerning. The following chart shows the number of functional/nonfunctional elevators throughout the different areas of SEMC:

Unit	No. of Working Elevators	No. of Nonfunctional Elevators
Seton Tower	1	3
CMP Tower	2	2
SMC	3	0
Connell Intensive Care Unit (“ <u>ICU</u> ”)	2	0
Connell Emergency Department (“ <u>ED</u> ”)	1	1
Parking Garage	1	0

II. Unannounced Return Visit on August 22, 2024

The Ombudsman and her representative arrived at SEMC on August 22, 2024, for an unannounced return visit. The Ombudsman and her representative met with the President, the

COO, the CNO, and the Chief Medical Officer (“CMO”). They discussed, among other things, the ongoing issues with SEMC’s elevators, staffing, the closures of Carney Hospital (“Carney”) and Nashoba Valley Medical Center (“Nashoba”), and a recent patient care issue. The Ombudsman’s representative discussed a recent patient complaint with the CNO and the patient care issue with the CMO.

The Ombudsman and/or her representative toured the following areas: (a) kitchen department; (b) ED; (c) ICU; (d) Connell 6 (cardiac stepdown); and (e) 5 West (behavioral health). The Ombudsman also interviewed the emergency room physician responsible for physician coverage for all EDs in the Debtors’ network, who happened to be covering a physician shift at SEMC. The Ombudsman discussed with him physician coverage for all the Debtors’ hospitals and the impact and long-term consequences the closures of Carney and Nashoba have on their surrounding communities.

A. Kitchen Department

The Ombudsman toured the kitchen department with its manager. All equipment, shelves, and surrounding services were neat, clean, and free of debris. There were no open, unlabeled food containers noted in the general kitchen area. All food was labeled and stored in the freezers, coolers, and dry storage areas, as appropriate. Temperature logs were present on all coolers and freezers and were up-to-date with daily documentation. The Ombudsman observed the tray line and monitored temperatures as food was being served. All temperature readings ranged from 164 to 198 degrees. The food looked appetizing and well plated for patient nutrition and enjoyment.

B. ED

The Ombudsman's representative toured the ED with the CNO present. The ED consists of twenty-seven bays/rooms and five fast-track areas. Four of the rooms are used for behavioral health patients and are ligature free. The ED was clean, well lit, and spacious.

The ED consistently cares for approximately sixty to eighty patients per day. At the time of the visit, there were seventeen patients in the ED. According to the charge nurse, there were seven registered nurses (each an "RN"), three technicians, and one unit secretary working. The charge nurse stated that the ED occasionally has staffing challenges, however, such challenges are mostly related to vacations and sick calls and they are able to fill their vacancies by being creative. Staffing was appropriate for the number of patients presenting.

The charge nurse reported no supply issues. She stated that since the bankruptcy filing, they have not had any supply issues. The Ombudsman's representative reviewed all supply areas and found that supplies were ample. Emergency equipment was readily available and monitored per SEMC's protocols.

C. ICU

The Ombudsman's representative was given a tour of the ICU by the nursing director. The ICU holds twenty-eight patients. At the time of the visit, census was eighteen patients. According to the nursing director, there were seven employees on orientation with an additional five RNs starting their employment between September 2024 and October 2024.

The current acuity of the patients in the ICU was very high, with six patients requiring 1:1 nursing care (*i.e.*, one patient per RN). There were seventeen RNs working that day. In addition, there was a charge nurse and a resource nurse — each without patient assignments. The ICU has

24/7 physician coverage. Several teams from medicine, surgery, and cardiothoracic surgery were rounding on patients when the Ombudsman's representative arrived.

The nursing staff reporting no issues with staffing, which they attributed predominantly to the temporary closure of the ten-bed cardio-thoracic ICU ("CTICU"). The CTICU had closed for the summer, therefore the CTICU staff has been working in the ICU over the past few months. Staff also reported no issue in obtaining supplies necessary for patient care. Upon rounding, there were plenty of supplies in the patient areas.

D. Connell 6 (Cardiac Stepdown)

The Ombudsman's representative toured the sixteen-bed cardiac stepdown unit with the CNO present. The Ombudsman's representative interviewed two staff members. At the time of the visit, the cardiac stepdown unit had nine patients, including one patient awaiting discharge. The unit expected to receive two patients from the ICU.

The charge nurse stated that they usually have between three to four patients per RN, depending on the acuity of the patient. On the day of the visit, the unit was staffed with three RNs and a nursing assistant. The charge nurse believed they were appropriately staffed for the acuity of their patients. She reported no issues with staffing and supplies.

E. 5 West (Behavioral Health)

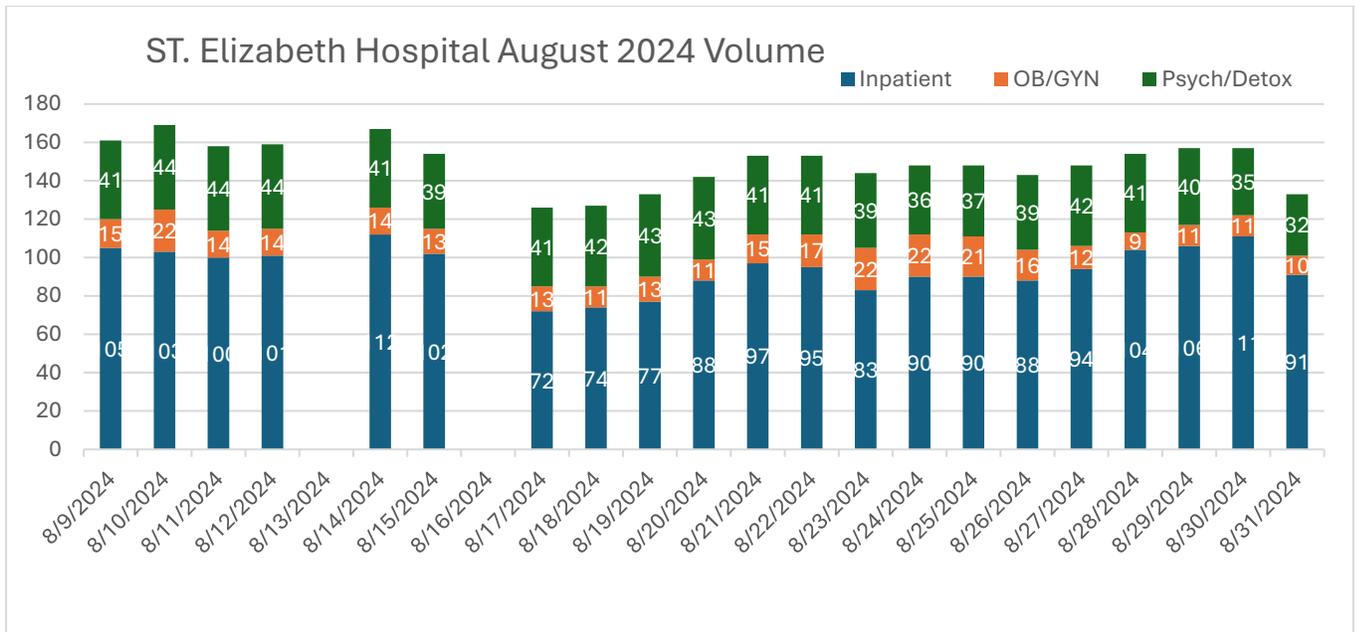
The Ombudsman's representative toured 5 West with the CNO present. 5 West is a thirty-bed adult psychiatric unit that is currently capped at eighteen patients due to the lack of social workers. The staff were excited to find out that two social workers and two occupational therapists have been hired from Carney and Nashoba and will begin working after the closures thereof.

The staff reported no issues with RN staffing, but they are aware that they need additional social workers. According to the staff, the current ratio of patients to social workers is ten patients per social worker. Staff reported no issues with supplies.

To minimize patient elopement, there are two sets of doors to enter and exit the unit that each require a special access badge. Safety rounds are performed, at minimum, every fifteen minutes. Beds are ligature free and very heavy with short cords.

F. Census

The following graphs show census volume at SEMC from August 9, 2024 through and including August 31, 2024 and September 1, 2024 through and including September 10, 2024, respectively:



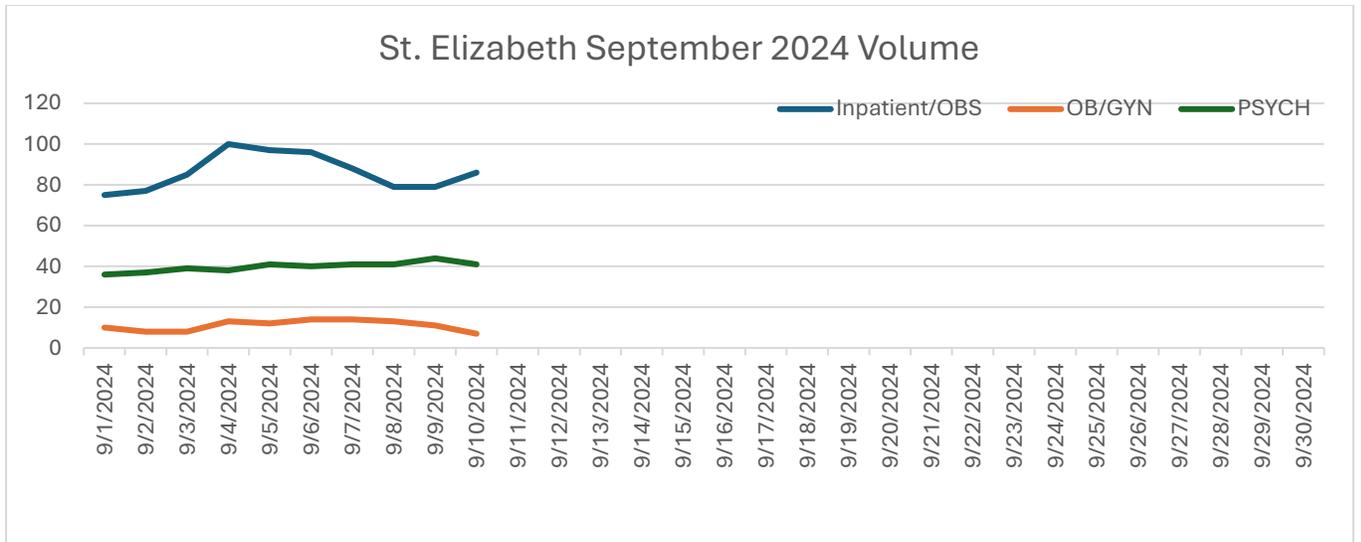


EXHIBIT B

HOLY FAMILY HOSPITAL – HAVERHILL CAMPUS

I. Return Visit on July 23, 2024

The Ombudsman’s representative arrived at Holy Family Hospital – Haverhill campus (“Holy Family Haverhill”) on July 23, 2024, for a return visit. The nursing supervisor greeted the Ombudsman’s representative and led them on a tour of Holy Family Haverhill, including the following areas: (a) emergency department (“ED”); (b) 4 West (medical/surgical/telemetry); and (c) adult behavioral unit (“ABU”). There were no surgical or endoscopy cases scheduled for that day.

A. ED

The Ombudsman’s representative, with the nursing supervisor present, toured the ED and interviewed two registered nurses (each an “RN”) who were at the nursing station. The ED has twenty patient stretchers and can flex up to twenty-four stretchers with four additional patients in the hallway. At the time of the visit, the ED was staffed with three RNs and census was eight patients.

ED staff reported no issues with supplies. The clean supply rooms were well stocked. The staff noted that their computed tomography (“CT”) scanner was down indefinitely. Patients requiring a CT scan had to be transferred to other hospitals. Holy Family Hospital – Methuen campus (“Holy Family Methuen”) is approximately twenty minutes away and was able to accommodate patients for CT scans.

B. 4 West (Medical/Surgical/Telemetry)

4 West is a thirty-five-bed medical/surgical/telemetry unit with a maximum of fourteen telemetry patients. At the time of the tour, there were nine patients total, and the unit was staffed with two RNs, one of which had been called in to pick up the shift as others had called in sick.

There is also one certified nursing assistant assigned as a 1:1 sitter for a patient who will be discharged that afternoon. The biggest challenge on this unit is with callouts. The nursing supervisor reports that much of her day is spent “plugging holes.”

The patient care area was clean and uncluttered. Call bells were quiet, but the two RNs working were steadily busy. One of the RNs reported that there were no supply or equipment issues.

C. ABU

The ABU is a locked seventeen-bed geriatric psychiatric unit with an average daily census of fifteen patients. On the day of the visit, census was thirteen patients, and the unit was staffed with three RNs and two certified nursing assistants/mental health technicians. The charge nurse and her colleagues were standing in the hallway with their computers on wheels and were documenting in patient charts. She stated that they have adequate staffing and supplies.

Several patients were calmly walking around the unit. There were no current issues with patients being agitated or on frequent monitoring checks. There is one patient who does try to escape the unit, but she was not present upon entry or exit of the unit.

D. Phone Call with the Director of Quality Management

During the tour of Holy Family Haverhill, the DQM (who covers both Holy Family Methuen and Holy Family Haverhill) was at Holy Family Methuen and called to speak with the Ombudsman’s representative. She apologized for being absent during the unannounced visit and offered to drive over to meet with the Ombudsman’s representative, which was unnecessary as the nursing supervisor had done an excellent job of leading the tour.

The DQM reported no recent concerns regarding patient safety or other areas of interest. The DQM agreed to correspond with the Ombudsman and her representatives via email or phone call until the next hospital tour if any patient safety issues arose.

II. Unannounced Return Visit on September 11, 2024

The Ombudsman and her representative returned to Holy Family Haverhill on September 11, 2024, for an unannounced return visit and was greeted by the Chief Nursing Officer (“CNO”), the nursing supervisor, and the manager of nursing operations. According to the leadership team, the magnetic resonance imaging (“MRI”) scanner has been nonoperational over the past three days. The helium required for the repair has been paid for in advance, and the team was waiting for the company to complete the repair. In the meantime, Holy Family Haverhill must transfer patients requiring an MRI to Holy Family Methuen.

The Ombudsman and/or her representative toured the following areas: (a) ED; (b) 4 West (medical/surgical/telemetry); (c) ABU; (d) kitchen department; and (e) pharmacy.

A. ED

The Ombudsman and her representative toured the ED, with the manager of nursing operations present, and interviewed the charge nurse and the ED physician. The ED has twenty rooms with the capacity to flex up using hallway stretchers or using double occupancy in two of the rooms. There are five rooms used for behavioral health patients. The average number of patients seen per day is between fifty and fifty-six.

At the time of the tour, there were seventeen patients in the ED and seven RNs assigned to the area. Staffing within the ED increases throughout the day and then gradually decreases in the evening as the patient census declines. Nursing staff reported no issues with supplies and staffing, although the ED physician stated that sometimes at night the department only has two RNs. Upon

inquiry, the charge nurse stated that the minimum nursing staff in the ED is three RNs. A review of the organizational staffing provided biweekly by the CNO confirmed that there were always, at minimum, three RNs working in the ED.

The supply areas were clean, organized, and well stocked. Emergency equipment was present and monitored as per Holy Family Haverhill's policy.

Quality metrics monitored in the ED are sepsis, Median Door to Doc Time ("Door to Doc Time"),¹ Left Without Being Seen, and patient satisfaction.

B. 4 West (Medical/Surgical/Telemetry)

Although 4 West has a bed capacity of thirty-five patients (as discussed *supra*), this area has been limited to a maximum of nine patients due to staffing levels. Census during the tour was nine patients with one expected discharge. As a result of the capped census, the ED often holds an admitted patient in the department until a bed at 4 West is available. On the day of the tour, 4 West was staffed with two RNs and two nursing assistants.

All patients were kept within the vicinity of the nurses' station, and the nurses were in the hallways documenting on their workstations. Staff reported no issues with supplies and staffing. Often the nursing supervisor will relieve the staff for lunch breaks when only two RNs are working.

According to the staff, quality metrics tracked for 4 West include nursing and physician documentation of restraints and reducing the number of invasive devices, such as Foley catheters and central lines. According to the manager of nursing operations, the device utilization rates have been declining in the department. The supply closets were clean, organized, and amply stocked.

¹ Door to Doc Time measures the arrival time of the patient to the time it takes a doctor to evaluate the patient.

C. ABU

As discussed *supra*, the ABU is a geriatric psychiatric unit that provides care for individuals that are fifty-five years of age or greater. Although the unit has the capacity to care for seventeen patients, the unit census has been limited to a maximum of eleven patients due to staffing. Consistently, census has remained at eleven patients. During the tour, the ABU was staffed with two RNs and three nursing assistants. One of the nursing assistants was assigned to a patient requiring constant observation and the others were performing fifteen-minute checks on all the patients.

At the time, staff reported no supply or staffing issues. The ABU was clean, well lit, and free of clutter. Patients were walking about the unit conversing with the staff, who were stationed in the hallway documenting.

D. Kitchen Department

The Ombudsman toured the kitchen which was noticeably different than it was during the Ombudsman's prior visit. The new kitchen manager had only been in place for three weeks prior to the return visit by the Ombudsman. and stated that he was short of staff to cover duties in the kitchen. The walls had spots, and the equipment was not as well maintained as the prior visit. The shelves were cluttered, and the floors had food particles strewn in different areas. The chemical closet was clean, and the eye wash station was close by. The refrigerators and freezers had corresponding temperature logs which were completed appropriately. Certain food items were not labeled and dated in the refrigerators and freezers. Small yogurt containers were not labeled and were opened in the refrigerator as well as a bowl of cookie dough was open, not covered and not labeled with an opened or expiration date. The kitchen equipment that was previously reported as

nonfunctioning continues to be broken, however, the staff remains able to work around the equipment issues and provide quality food service to the patients.

E. Pharmacy

The Ombudsman toured the pharmacy with the pharmacy director, who relayed a recent issue with compounding Phenylephrine due to the lack of funding. Funds recently have been released so the issue has been resolved.

III. Census

The following graphs show census volume at Holy Family Haverhill from August 10, 2024 through and including August 31, 2024 and September 1, 2024 through and including September 10, 2024, respectively:

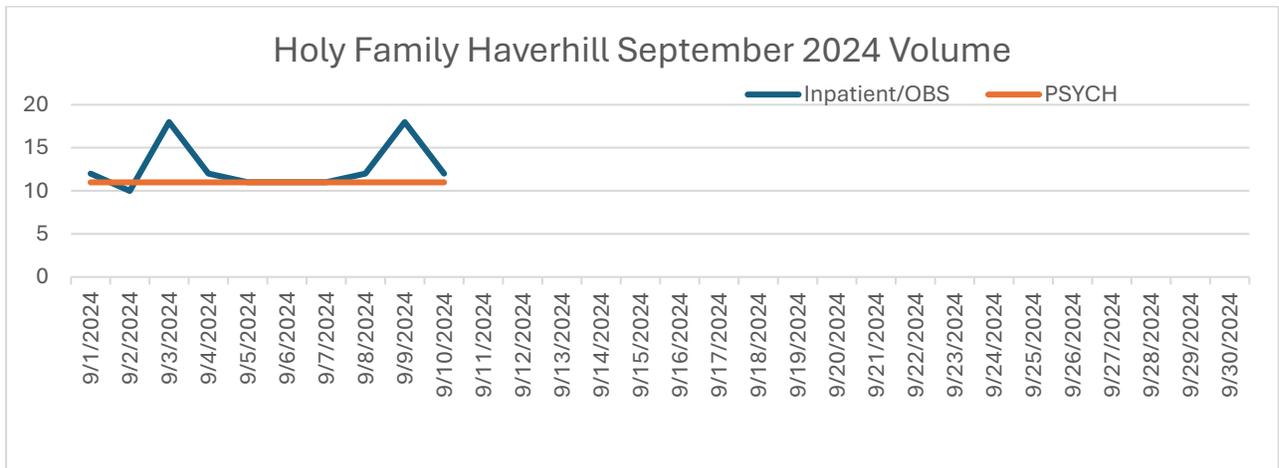
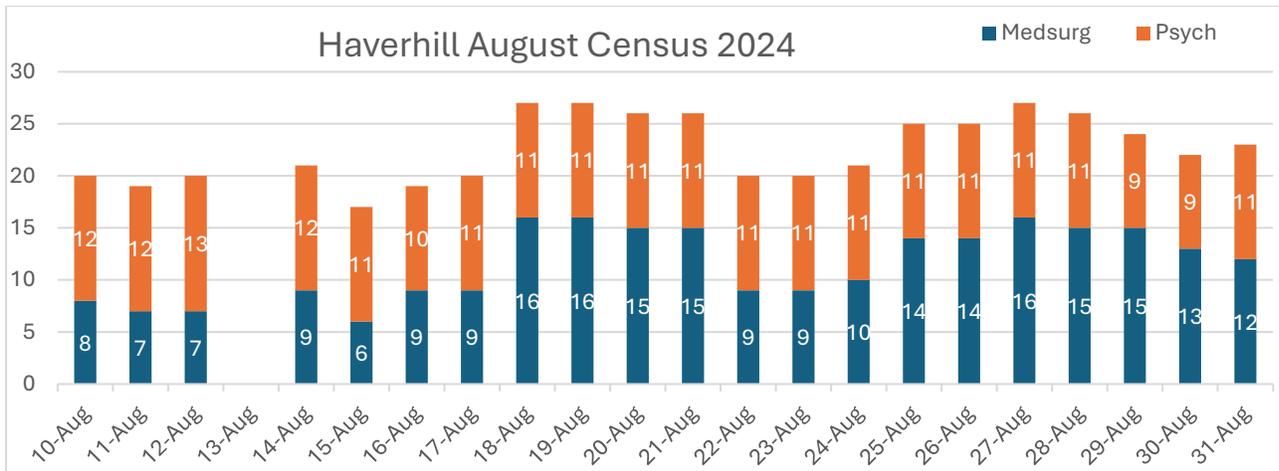


EXHIBIT C

HOLY FAMILY HOSPITAL – METHUEN CAMPUS

I. Return Visit on September 12, 2024

The Ombudsman and her representative arrived at Holy Family Hospital – Methuen Campus (“Holy Family Methuen”) on September 12, 2024, for an unannounced return visit. The Ombudsman and her representative were escorted to an administrative conference room where they met with the Chief Nursing Officer (“CNO”), the Chief Operating Officer, and the Quality Director (“QD”). The leadership team relayed that several employees from the shuttered Nashoba Valley Medical Center and Carney Hospital have been hired. With the new hires, the administrative team believes the adult psychiatric bed capacity will be increased from twelve to fourteen beds.

Recently, there have been a few significant resignations within hospital leadership. For example, the Director of Surgical Services and the Manager of Surgical Services that cover both campuses, Holy Family Methuen and Holy Family Hospital – Haverhill campus, submitted their resignations. Areas impacted by the resignations include the operating room, pre-admission testing, surgical services, post-anesthesia care unit, and obstetrics (“OB”) services. According to the CNO, they have discussed the potential effect of the resignations with the CNO of Lawrence General Hospital, which is acquiring Holy Family Methuen, and they have implemented a plan to minimize the overall impact until replacements can be found.

According to leadership, all equipment within Holy Family Methuen was functional on the day of the visit except for an oven in the kitchen.

The Ombudsman and/or her representative toured the following areas: (a) emergency department (“ED”); (b) OB services (birthing center), (c) intensive care unit (“ICU”), (d) medical-surgical telemetry, (e) kitchen department, and (f) materials management.

A. ED

The Ombudsman and her representative toured the ED. The ED handles approximately 100 to 120 patient visits every 24 hours. According to the charge nurse, the ED has a capacity of thirty-four beds, and at the time of the tour, there were twenty patients, of which five were psychiatric patients. The ED has four beds dedicated to the psychiatric population. According to staff, when the ED census is over capacity for psychiatric patients, they place each “overflow” patient in a room very close to the nurses’ station, perform frequent checks, and a nursing assistant is assigned to watch each patient.

At the time of the tour, the ED was staffed with seven registered nurses (each an “RN”), four nursing assistants, and one unit secretary. Staff nurses stated that the ED is staffed with a minimum of six RNs, which minimum staffing usually occurs overnight when the ED census typically drops.

Although the ED was not spacious, it was clean and free of clutter. Emergency equipment was present and monitored according to Holy Family Methuen’s policy on the day of the visit. At the time of the tour, all patients were in rooms and there were no hallway stretchers being utilized.

The staff was able to discuss what quality measures the ED monitors (including sepsis, Median Door to Doc time, and Left Without Being Seen); however, they were not sure about the most recent values.

B. OB Services – Birthing Center

While on the tour, census was four patients, of which three were laboring and one had delivered. The department is expecting one additional patient for a scheduled cesarian section (“c-section”). The department was staffed with six RNs, one scrub technician, one nursing

assistant, and one unit secretary. According to staff, the minimum RNs scheduled for this department is five.

Quality measures monitored are c-section rates, post-partum hemorrhage rates, inductions prior to thirty-nine weeks, and breast-feeding rates. To reduce harm to patients, the staff in this area perform practice drills on shoulder dystocia, post-partum hemorrhage, “Code Pink,” which is an infant abduction, and maternal hypertension.

Patient safety is a priority for this floor. For that reason, patients are extensively educated on never leaving the infant unattended, always placing the infant on its back, and never placing anything in the crib. Other safety features in this department include the Hugs® infant protection and security system (the “Hugs system”) and the staff wear special identification tags. The Hugs system will alert if an infant gets too close to an exit point.

C. ICU

Although the ICU has a capacity of sixteen patients, census during the tour was only four patients. According to the charge nurse, four RNs were assigned to the ICU at the time. The staff reported no shortages of staff and supplies. A review of the supply closet did not reveal any shortages. The shelves were clean, organized, and well stocked. Emergency equipment was readily available and monitored as per Holy Family Methuen’s policy.

Quality measures monitored in the ICU are the typical measures in all ICUs, such as central line infections, Foley catheter infections, hospital-acquired pressure ulcers, and restraints. The charge nurse stated that her greatest challenge is receiving more higher acuity patients to care for to “keep her skills sharp.”

D. Medical-Surgical Telemetry

The Ombudsman's representative met with the charge nurse of this eighteen-bed unit. According to the charge nurse, the current census was sixteen patients, and the unit was staffed with four RNs, two certified nursing assistants, and one unit secretary. The charge nurse stated that the typical patient to RN ratio is five to six patients per RN. The staff reported no supply and staffing issues.

The unit tour also included supply areas and dirty utility rooms. The supply areas were clean and amply stocked. Emergency equipment was readily available, clean, and monitored as per Holy Family Methuen's policy.

Quality measures monitored in this unit are pain assessment and reassessment, hand hygiene, and invasive devices.

E. Kitchen Department

The Ombudsman toured the kitchen with the manager present. All equipment, shelves, and surrounding services were neat, clean, and free of debris. There were no open, unlabeled food containers noted in the general kitchen area. All food was labeled and stored in the freezers, coolers, and dry storage areas, as appropriate, except for the pot roast and curly fries, which were stored in the cooler in an open bag and were not dated for expiration. Temperature logs were present on all coolers and freezers and were up-to-date with daily documentation. The Ombudsman observed the tray line and monitored temperatures as food was being served. All temperature readings ranged from 162 to 198 degrees. Three out of the kitchen's four ovens and the steamer were all nonfunctional.

F. Materials Management

The Ombudsman's representative toured the loading dock and materials management with the CNO present. The supply area was large, clean, and well organized. There were several code carts present. According to the employees, the carts have several color-coded locks that determine who stocked the carts with which supplies. The CNO stated that the employees in the department have improved and streamlined the code cart process. Supplies were ample. According to the employees, they are not aware of any shortages.

G. Quality Metrics

According to the QD and the CNO, the quality metrics monitored for Holy Family Methuen include central lines, Foley catheters, hand hygiene, and sepsis. Additional measures are ED metrics. The QD stated that Holy Family Methuen has had one central line infection and one Foley catheter infection in the last year, but she is unsure of the rate because that is reported by the infection control practitioner.

II. Serious Safety Events

Since the Ombudsman's first report, there has been one fall with injury and one patient that assaulted another patient in the psychiatric department.

A. Fall with Injury

A patient ("Patient A") had sustained a fall with injury. The Ombudsman's representative, who is an RN and a former CNO, reviewed Patient A's fall. Patient A was non-compliant and combative with a history of falls prior to admission. A bed alarm was placed on Patient A's bed so if she attempted to get up without assistance, an alarm would notify the staff. According to the record, Patient A was a known fall risk and had been educated several times that she must call for help.

On July 21, 2024, the charge nurse responded to the bed alarm and found Patient A on the floor. A rapid response was called. Patient A was examined, and no injuries were noted. As a result, Patient A was moved closer to the nurses’ station for closer observation and re-educated to call for help. Patient A was trained to use a walker by physical therapy and given a bedside commode.

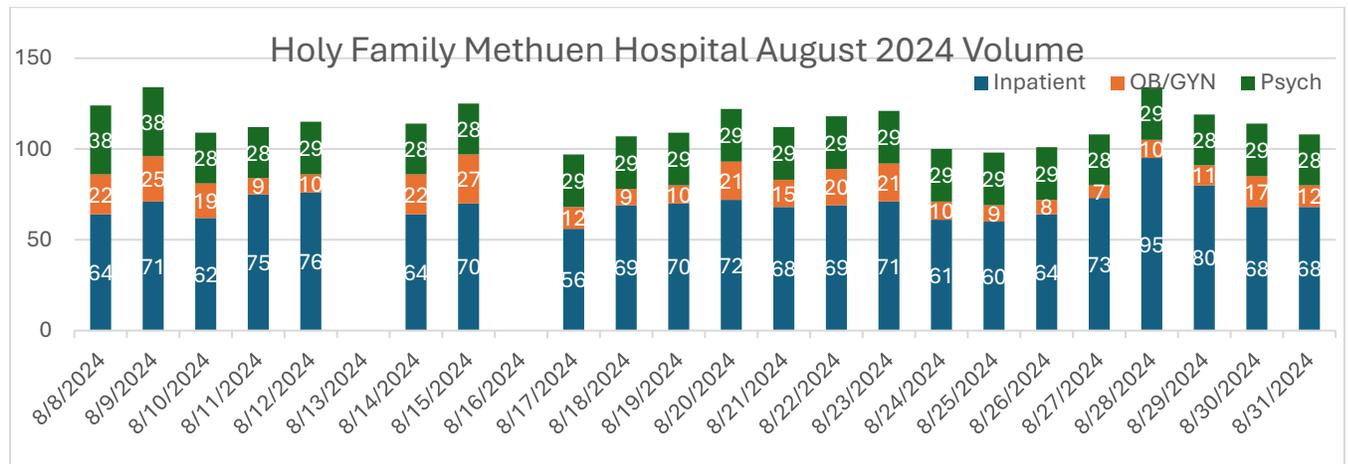
On July 23, 2024, while trying to assist Patient A to the bedside commode, Patient A pushed the nursing assistant away and proceeded to the bathroom. According to the notes, the nursing assistant attempted to assist Patient A out of the bathroom and was again pushed away, which is when Patient A fell and sustained injury.

B. Assault

A patient (“Patient B”) was being discharged from the adult psychiatric unit when he was assaulted by another patient. Patient B sustained a laceration to his left eye/cheek. His discharge continued, and Patient B left in stable condition.

III. Census

The following graphs show the census volume for Holy Family Methuen from August 8, 2024 through and including August 31, 2024 and September 1, 2024 through and including September 10, 2024, respectively:



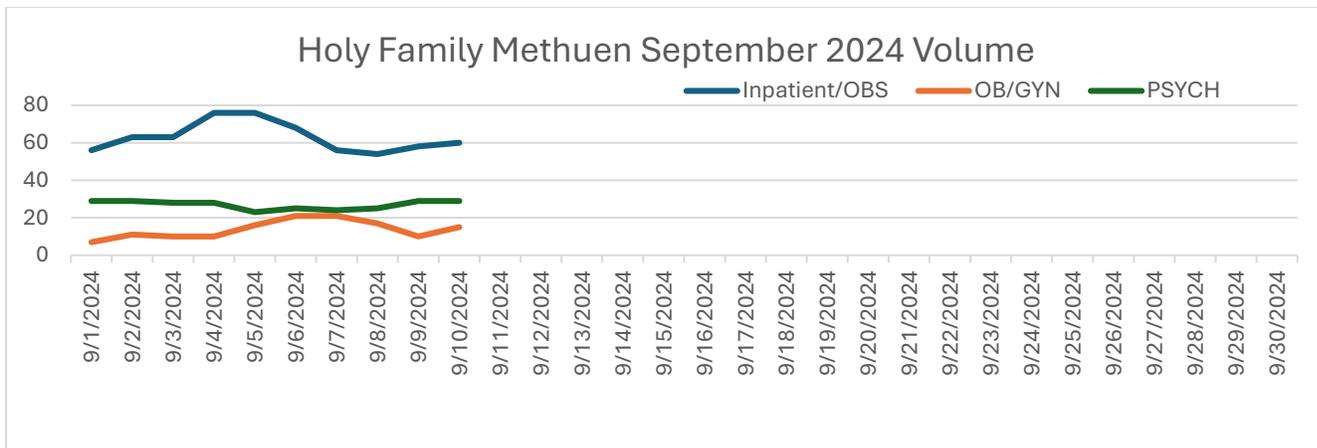


EXHIBIT D

GOOD SAMARITAN HOSPITAL

I. Return Visit on August 8, 2024

The Ombudsman and her representative returned to the Good Samaritan Medical Center (“GSMC”) on August 8, 2024 and were escorted to administration. A few of the administrative offices were closed due to plumbing leaks requiring mitigation and repairs. The Ombudsman and her representative met with the GSMC leadership team, including the President, the Chief Operating Officer (“COO”), the Chief Medical Officer (“CMO”), and the Chief Nursing Officer (“CNO”). According to the leadership team, the Debtors’ corporate human resources office is working closely with them to maintain communication with staff at Carney Hospital (“Carney”), which is closing on August 31, 2024, about current job openings at GSMC.

The leadership team assured the Ombudsman that all patients from Carney will be transferred to GSMC when Carney closes, except for behavioral health patients because Carney’s behavioral health unit is presently closed. According to the leadership team, the behavioral health beds were converted to medical/surgical overflow beds to accommodate the increased volume of patients needing critical care in the community when nearby Signature Healthcare Brockton Hospital (“Brockton”) (a non-Debtor hospital) temporarily closed. The Ombudsman suggested to the leadership team that GSMC consider reopening its behavioral health unit due to the increased need for behavioral healthcare in the community that will follow Carney’s closure. The leadership team expressed concerns regarding the ability to staff the behavioral health unit because other local hospitals are having issues recruiting psychiatric nurses, social workers, and the full complement of behavioral health teams. Nevertheless, on August 9, 2024, the CMO informed the Ombudsman that Carney’s behavioral health unit will re-open and the medical/surgical beds will be

decommissioned back to behavioral health beds to accommodate the patients requiring behavioral health services from Carney and the community at large.

According to the CMO, GSMC will receive the Graduate Medical Education (“GME”) training program from Carney, which will consist of thirty-one interns, residents, or fellows in addition to the attending teaching physicians. The residents will reside under the St. Elizabeth Medical Center’s (“SEMC”) GME license; however, they will train at GSMC. The residents and the attending teaching physicians are scheduled to tour GSMC on August 9, 2024. GSMC is currently locating space on its campus to build and accommodate the residents’ on-call rooms.

Although Brockton is tentatively scheduled to open next week its emergency department (“ED”), limited operating rooms (“OR”), intensive care unit (“ICU”), and medical/surgical areas, the leadership team is optimistic that they can continue to staff all GSMC’s units appropriately because they were able to sign many registered nurses (each an “RN”) to short-term per diem contracts through the end of September 2024. They also have signed an additional twenty-one RN positions from Elite Medical Staffing, offered staff incentives, and used travel RNs to cover any open shifts and staff shortages.

A. Tour

Following the meeting with the leadership team, the Ombudsman and her representative conducted a complete tour of GSMC:

- Kitchen Department. The kitchen department continues to show operational and sanitation improvement, which coincides with a change in dietary leadership that was requested of the contractor, Sodexo. Most equipment in the kitchen had been repaired, except for the steamer.

- ED. The current census of the ED was forty-seven patients in a forty-bed unit. Seven patients were in the hallway on stretchers. Fifteen of the patients reported to be behavioral health patients. The charge nurse stated that they were having a good day and this current census was much lower than usual. She reported no issues with staffing and supplies. A review of the supply closet did not reveal shortages.
- OR. According to the charge nurse in the OR, there were thirteen surgical cases scheduled for that day. One case was cancelled (the charge nurse did not know the reason the case was cancelled), and an additional case was added on for the evening. The charge nurse reported no issues with staffing and supplies.
- Additional Departments. The Ombudsman and her representative also toured 2A (cardiac telemetry), the ICU, 4A (medical/surgical), and labor and delivery. All areas reported no concerns regarding staffing or supplies. Each supply area was well stocked, clean, and orderly.

B. Quality

Staff nurses throughout GSMC stated that they continue to focus on quality care. All staff indicated that infection prevention is a main priority. Examples given by staff of measures taken to reduce infections were the removal of all invasive devices, such as central lines and Foley catheters, and frequent hand hygiene. Other quality metrics mentioned were quick identification and treatment of sepsis, rapid treatment of stroke patients, and reduction of falls.

II. Weekly Updates

The Ombudsman and her representative were invited to join a weekly telephone update with the GSMC staff.

The weekly updates began on August 9, 2024 and will continue through the transition process until a sale closing occurs. Updates from the administrative team will focus on, among other things: (a) a review of staffing, (b) the opening of GSMC's behavioral health unit, (c) transition of Carney's GME program to SEMC with training to be conducted at GSMC, and (d) the reopening of Brockton and the associated staffing concerns and condensed volume of patients requiring care. Attendance at the weekly updates will include the President, CMO, COO, and the Ombudsman and her representative.

III. Staffing

Biweekly staffing patterns are provided by the CNO and reviewed by the Ombudsman's representative, who was a former CNO and is an RN. The staffing information provided enumerates time periods of four hours in each unit, census levels of each unit, and the number of personnel (*e.g.*, RNs, nursing assistants, technicians, and unit secretaries) assigned to the unit. In addition, the CNO notes any variances to the staffing guidelines either positive or negative.

A review of the data provided shows that GSMC increases and decreases staff based on the number of patients present on each unit at the current time. According to the Ombudsman's representative, nurse to patient ratios are appropriate for the inpatient units given the acuity of the patients. The Ombudsman's representative noted that RN shortages rarely occurred. ED staffing ranged from eight RNs to seventeen RNs, fluctuating based on the time of day and the number of patients receiving care in the ED. While touring the departments, including the ED, staff members that were interviewed did not report any instances of the ED being short-staffed.

IV. Census

The census on August 8, 2024 was reported to be 138 patients. According to the CNO, GSMC is staffed to care for 154 patients.

The following charts depict the census volume from August 8, 2024 through and including August 31, 2024 and September 1, 2024 through and including September 10, 2024, respectively.

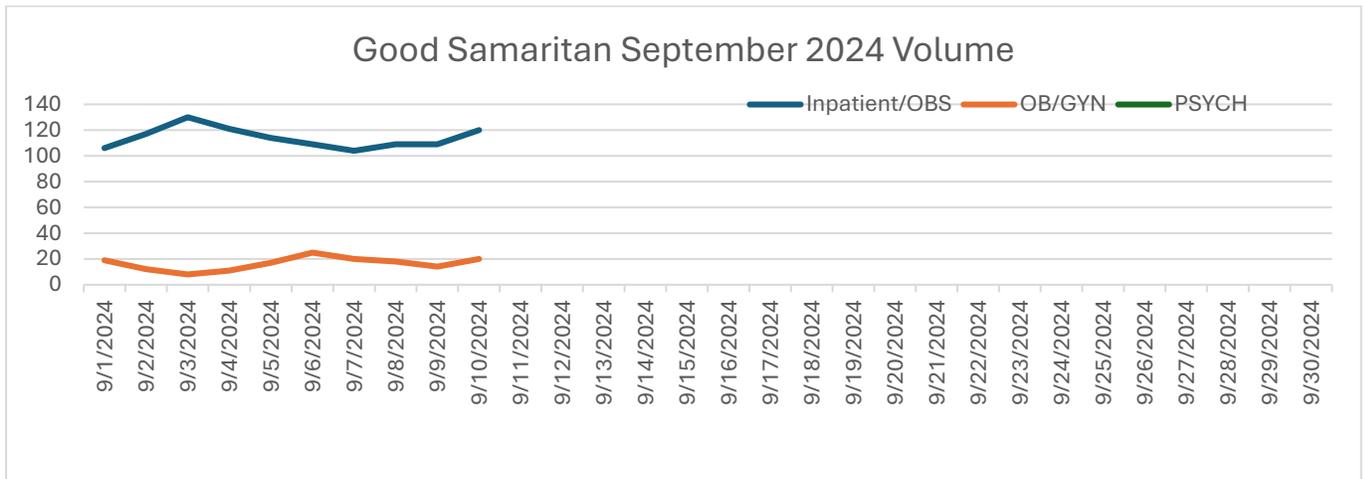
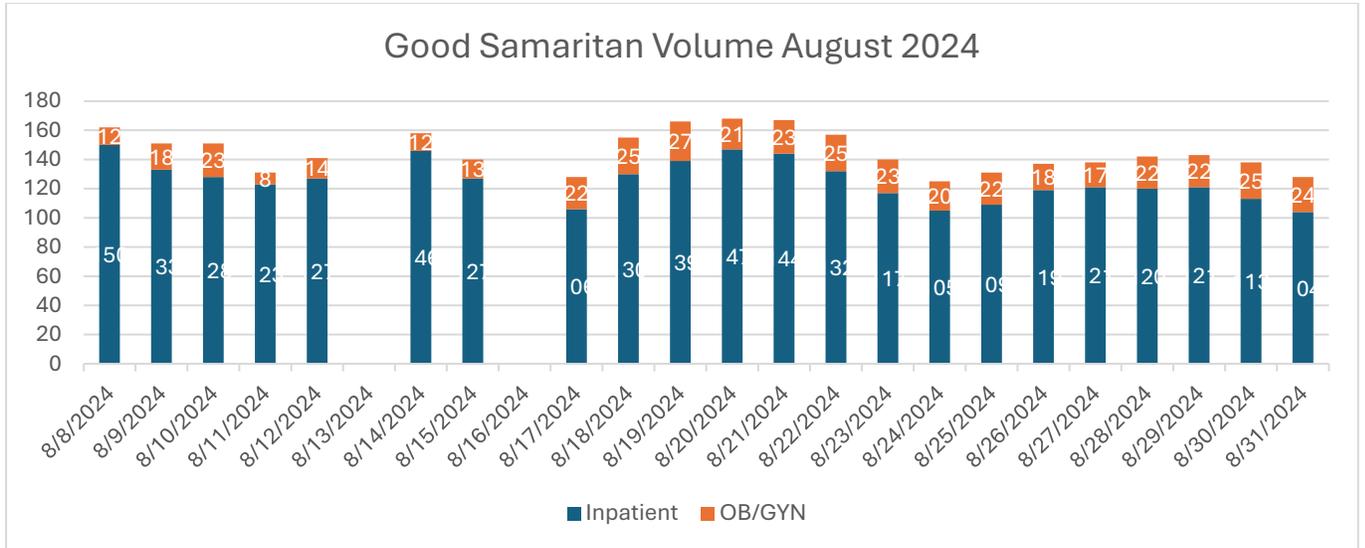


EXHIBIT E

NASHOBA VALLEY MEDICAL CENTER

I. Unannounced Return Visit on July 23, 2024

The Ombudsman’s representative arrived at Nashoba Valley Medical Center (“Nashoba”) for an unannounced return visit on July 23, 2024. On the day of the visit, census at Nashoba was thirty-three patients. Upon arrival, the Ombudsman’s representative was greeted by the nursing supervisor.

The Ombudsman’s representative toured the following areas: (a) emergency department (“ED”); (b) intensive care unit (“ICU”); (c) ACU (medical/surgical/telemetry unit); and (d) geriatric psychiatry (“geri-psych”) unit. The Ombudsman’s representative also interviewed the Director of Quality Management (“DQM”).

A. ED

The tour consisted of a walk around the ED, with an interview at the nursing station. Three registered nurses (each an “RN”), a unit clerk, and an additional nursing assistant were working. The charge nurse confirmed that from 11:00 p.m. until 7:00 a.m., there are still only two RNs working. She stated that a few nights ago, a patient safety report was entered for “unsafe staffing.” She explained that during the day, there are usually four to five RNs working and occasionally there is another nurse on call from 11:00 a.m. until 7:00 p.m. According to staff, they increase RN staff throughout the day to coincide with their typical busy times. She said that overnight, if more help is needed, they call the nursing supervisor and she/he or another unit nurse will float to help, however, they are not trained in the level of care required for ED patients and as such, they will work as “task” nurses and cannot take a patient load.

At the time of the tour, there were only two patients in the ED. One was a pediatric hold, as an inpatient bed (at another facility) had not been identified yet. The charge nurse reported no problems with having adequate supplies and equipment to take care of patients.

B. ICU

The ICU has six beds. On the day of the visit, census was three patients, of which two were ready for discharge to rehab but beds had not yet been secured for them. The ICU was staffed with two RNs at the time. The staff indicated that they had adequate supplies but are unhappy that people sometimes take supplies from ICU rather than going to central supply. This is a continued problem from the Ombudsman's initial visit in June 2024. An inspection of the supply room showed an adequate amount of supplies. The intensivist was also on the unit finishing rounds. He is a pulmonologist by training, which is typical in most ICUs.

C. ACU (Medical/Surgical/Telemetry Unit)

The ACU is a medical/surgical telemetry unit with a typical census of approximately twelve to fifteen patients. Census on the day of the tour was thirteen patients. The staff was expecting a patient admission from the ED later that the morning. According to the charge nurse, the ACU was staffed with three RNs and two certified nursing assistants. The staff indicated that they had adequate supplies. An inspection of the supply area did not reveal any shortages.

D. Geri-Psych Unit

The geri-psych unit is a twenty-bed locked behavioral health unit that is capped at eighteen beds because of staffing. At the time of the tour, census was seventeen patients, and the unit was staffed with four RNs plus mental health technicians/certified nursing assistants and a unit secretary. The nursing supervisor shared that the unit's staffing was "a little tight today," as they were staffed for only sixteen patients. Accommodating the extra patient was appropriate as they

had less acuity on the unit compared to other days. The doors are double locked: *i.e.*, a person must enter through a first door into an anteroom that must shut prior to the main door opening. The patients were calmly milling about the unit, and there were no visibly anxious patients.

E. Interview with the DQM

The Ombudsman’s representative met with the DQM at Nashoba. The DQM stated that things were going well from a quality perspective. She shared that the staff were “all on edge” about Nashoba’s uncertain future. The staff really love Nashoba and would not want to leave. She shared that there were two recent serious safety events that involved patient falls with injury. No permanent injuries or deaths occurred as a result of the falls, and staffing was not a contributing factor in the events.

II. Unannounced Return Visit on August 7, 2024

The Ombudsman and her representative arrived at Nashoba on August 7, 2024, for an unannounced return visit. There were several staff members congregated at the information desk requesting visitors and staff sign a petition to “Save the Hospital” and pins stating the same were being distributed to be worn by both patients and staff. While in the lobby, the Ombudsman and her representative were greeted by the DQM and taken to an administrative conference room where a meeting was held with the Chief Executive Officer, Chief Operating Officer (“COO”), and the DQM. The Chief Nursing Officer was out sick.

The leadership team shared that they were notified of Nashoba’s closure on July 26, 2024. The team was preparing for the closure by, among other things, sending letters to the mammography patients to schedule procedures elsewhere.¹ The team relayed that emergency

¹ Mammography patients had been scheduled thirteen months in advance.

medical services (“EMS”) had purposely been sending patients to other hospitals to “show the community what it will be like when the hospital closes.”

MassHire was onsite helping employees with job referrals, labor market information, resume writing, and basic information on career building. Employee Assistance Program was also onsite, and leadership had therapy dogs for staff. The Ombudsman reviewed a robust schedule of events being held for staff to assist with finding post-closure employment and provide emotional support (such as “Tea for the Soul” with the chaplain).

The Ombudsman and/or her representative toured the following units with the DQM present: (a) ACU (medical/surgical/telemetry floor); (b) materials management; (c) kitchen department; (d) operating room (“OR”); (e) pharmacy; (f) geri-psych unit; (g) ED; and (h) ICU. The following chart details census volume at the time of the tour was as follows:

Unit	Census on 8/7/2024
ACU (Medical/Surgical/Telemetry)	6 patients
Geri-Psych Unit	6 patients
ICU	0 patients
ED	17 patients
OR	10 cataract cases

The patient with the longest length of stay is in the geri-psych unit and has been at Nashoba for approximately ten months.

Each patient care area stated that they did not have any concerns with supplies or staffing but were extremely concerned about the closure’s impact on the community. The staff in each patient care area (including the OR) expressed fear that people may die due to the lack of emergency services in the area and the lack of public transportation. Nashoba Valley, Massachusetts is an area comprised of ten towns, and there is no public transportation available for the aging community. Staff nurses have been reaching out to the Council of the Aging and

EMS to try to stop the closure. Several staff members stated that they would relinquish their own jobs if it meant saving Nashoba.

According to the leadership team, they are trying to make sure they have enough stock for three days. A tour of materials management revealed an abundance of supplies.

Leadership in the kitchen department is relatively new. The new leadership stated that the prior person took a promotion within their company. Unlike at the prior visit, the outside refrigerator and freezer were disorganized and messy. The inside refrigerator that had been nonfunctional for some time was leaking and a towel was soaking up the drainage. The refrigerator and freezer logs were performed per Nashoba's policy. The dry supplies were ample. Open boxes were dated.

During the interview with the pharmacy director, she stated that staffing was a little rough last week, however, the current week was okay. The pharmacy director indicated no pharmaceutical supply issues.

III. The Closure of Nashoba

A detailed summary of the closure of Nashoba is set forth in the *Supplemental Report of Suzanne Koenig, Patient Care Ombudsman, Relating to the Closure of Nashoba Valley Medical Center* [Docket No. 2204] and the *Supplemental Report of Suzanne Koenig, Patient Care Ombudsman, Relating to the Closure of Nashoba Valley Medical Center and Carney Hospital* [Docket No. 2428] (collectively, the "Closure Reports"). For brevity's sake, all information set forth in the Closure Reports is fully incorporated herein by reference. Nashoba ceased operations on August 31, 2024. From the Ombudsman's perspective, the Debtors and the staff "on the ground" at Nashoba maintained patient care and safety throughout the closure process.

IV. Revisit to Shuttered Nashoba on September 12, 2024

The Ombudsman and her representative returned to Nashoba on September 12, 2024, to assess the post-closure process. As reported by the COO, the marquee was covered, the doors were locked, and signage was posted in several languages stating that Nashoba is permanently closed. To gain entrance, security must be notified. Each person that enters must sign the visitor log that tracks entrance and departure times.

The Ombudsman and her representative toured the following areas with security and the Senior Director of Environmental Management from CREF present: (a) ED; (b) laboratory; (c) OR; (d) ACU (medical/surgical/telemetry); (e) central supply; and (f) kitchen department.

Supplies within the OR were in the process of being collected. Most supplies were on wire carts, which were placed in the hallways. One medication, Ropivacaine 0.5% 150mg/30 ml, was found on a table. The medication was given to the CREF representative for proper disposal, and the Ombudsman notified Nashoba's COO.

A significant number of paraffin blocks and microscopic slides were remaining in Nashoba.² According to the CREF representative, the remaining paraffin blocks and microscopic slides are being sent to storage, while others have already been destroyed.

One blood specimen was in the laboratory refrigerator. The specimen was to be sent for a d-dimer test and did have protected health information (“PHI”) on the label. Written on the laboratory request slip was: “Lab result will take too long, patient sent for a CAT scan. Cancel test.” The specimen was given to the CREF representative for appropriate disposal. No other specimens were found in any other refrigerator within the laboratory. No further PHI was located

² Paraffin blocks and microscopic slides are used in pathology to store and process tissue samples for diagnosis, treatment, and research. The College of American Pathologists and the Joint Commission recommend storing paraffin blocks and microscopic slides for up to ten years.

while touring the remaining inpatient areas, including the ED. Supplies were being gathered and secured by Centurion, and the environment is being secured by CREF.

The Ombudsman and her representative did not find perishable products within the kitchen. The freezers, refrigerators, and dry storage areas were empty.

Except for security and the CREF representative, the Ombudsman and her representative did not see any other persons while rounding. According to the security escort, there is always a minimum of two security employees onsite.

EXHIBIT F

MORTON HOSPITAL

I. Return Visit on July 22, 2024

The Ombudsman's representative made a return visit to Morton Hospital ("Morton") on July 22, 2024. The Director of Quality and Director of Inpatient Nursing met the Ombudsman's representative in the lobby and led the group to a conference room. The Chief Nursing Officer ("CNO") joined the group in the conference room. Morton is licensed for 144 patients, with 18 of the beds allotted for level 4 detox. Morton has an average daily census of approximately 120 to 130 patients. On the day of this visit, census was 115 patients.

A discussion ensued regarding Morton's overall status. The group commended how, despite the uncertainty surrounding Morton's future, Morton has excellent employee engagement. Morton's turnover rate is less than eight percent. The CNO shared that their volume increased by thirty-three percent before the COVID pandemic and that they have not seen a decrease in patient volume since then. The leadership team stated that their operating room ("OR") has remained busy, with approximately eighty-two percent block utilization.¹

Leadership shared that some of the staff who came to work at Morton will be returning to Brockton Hospital ("Brockton"), which was temporarily closed over the past approximately year and a half as a result of a fire. The nursing leadership team stated that they are doing fine with the transition and planned accordingly for the staffing needs. They mentioned that Good Samaritan Medical Center had "leased" staff from Brockton, whereas Morton had hired such staff directly. Many staff decided to maintain a *pro re nata* ("PRN") position at Morton while returning to Brockton. The leadership team reports that they have hired several new registered nurses (each an "RN") and anticipate a smooth transition.

¹ Block utilization is the percent of surgeons who have an assigned time block having scheduled cases during that time.

Regarding their overall ability to acquire necessary equipment and supplies, leadership shared that they hired a new facilities manager approximately three to four months ago. Leadership reports that this new facilities manager pays attention to detail and plans in advance to ensure that Morton has everything needed to run smoothly. There is one ice machine that is nonfunctional, but the repair process is underway. They report no other equipment outages at this time.

The Ombudsman's representative toured: (a) S1 (cardiac telemetry) department; (b) the pharmacy; (c) central sterile supply/sterile processing department ("SPD"); (d) materials management department; and (e) the kitchen department.

A. S1 (Cardiac Telemetry)

The Ombudsman's representative toured the unit with the nursing director present. S1 is a thirty-bed cardiac telemetry unit. At the time of the visit, census on the unit was twenty-four patients. The charge nurse stated that they had seven RNs currently working on the unit. They staff with a four patients per RN ratio. An RN may have a maximum of five patients if such RN is assigned a combination of medical/surgical and telemetry patients. The charge nurse stated that the unit generally does not have issues with staffing. The nursing director reported that four of her day shift RNs have returned to Brockton full-time, but they have adequate staffing, as most stayed on to work PRN. They also use bonuses and incentives to attract RNs to pick up on call or extra shifts.

The Ombudsman's representative also toured multiple supply areas. All were neat, well organized, and adequately stocked. There are several nursing stations throughout the unit to allow for easier viewing of the central monitoring system.

B. Pharmacy

The Ombudsman’s representative toured the pharmacy with the department manager present. The space is small but well organized. Multiple pharmacists and technicians were busy working. The manager stated that they have no issues obtaining medications that were ordered to take care of their patients. Even national backorders have not been much of an issue lately, as they plan to order sufficient medications for their patients. The manager mentioned that Cardinal is their main supplier, and there are no problems obtaining necessary supplies.

The compounding room is tucked away in the back of the department and is currently not in use. This pharmacy is a Level II compounding pharmacy. It is typically used only for antibiotics or simple total parenteral nutrition mixtures. Occasionally, the pharmacy does prepare methotrexate, but it is rare. They have a routine cleaning schedule that includes at least daily cleaning and weekly deep cleaning of the space.

C. Central Sterile Supply/SPD

The Ombudsman’s representative toured central sterile supply/SPD. In this space, SPD is connected to a central storage room. The “clean” side of SPD is separated from the “dirty” side of the department. Once the equipment is processed, it is stored neatly and in an organized manner. Several OR case carts were available for case preparation. Three to four spare code carts were also stocked and ready for deployment to the next department that needed one.

D. Materials Management Department

A tour of the materials management department began with an introduction of three staff members who were busy unpacking boxes, as a truck had just arrived. The team discussed how they prepare in advance for cases to ensure they have all necessary materials. Specifically, every day at 1:00 p.m., the materials management team meets with multiple key stakeholders to ensure

they are ready for procedures that are scheduled to occur in the next three to four days. They mentioned that the surgeons at Morton are very engaged in problem solving and working with the hospital supply staff to streamline the products they need from the available options. The Steward Health System meets as a group (*i.e.*, representatives from the Debtors' hospitals) to be proactive in converting to use the same items, which are those available from their principal supplier, Medline. When the department has a problem with backorders or in the past with credit holds, the subject matter experts are consulted for planning on how to proceed.

E. Kitchen Department

The Ombudsman's representative toured the kitchen department with the kitchen manager and the Sodexo regional director present. The team had recently finished lunch service and was starting to prepare dinner. The space was neat, clean, and orderly. The staff discussed how they had been busy reorganizing the space after the loss of a key member of their team, who oversaw receiving, storage of supplies, and supply management. He was the staff member who passed away unexpectedly only a week before the Ombudsman's initial visit. There was significant improvement in the kitchen since the Ombudsman's prior visit, as there was no clutter, no unlabeled food items present, and overall, the space was set up with a good flow. The tray line was organized and ideal for tray preparation.

The dry storage room is located just across the hall from the kitchen. It was not a large space, but it was organized and neat. The manager shared that a lot of work had gone into redesigning the room for optimal storage.

II. Return Visit on August 21, 2024

The Ombudsman's representative arrived at Morton on August 21, 2024 for a return visit and was greeted by the CNO/Chief Operating Officer ("COO") in the lobby. The Ombudsman's

representative was escorted to a conference room in administration where a meeting occurred with the President/Chief Financial Officer (“CFO”) and CNO/COO. Census on the day of the visit for inpatient/observation was 102 plus 19 geriatric psychiatry patients and 8 level 4 detox patients, for an aggregate 130 patients. According to leadership, Morton is licensed for 144 patients.

According to the President/CFO, Morton’s census has grown steadily since the COVID pandemic while other organizations have struggled to build their volume. She credits this growth to the community efforts put forth by her team. The team developed a growth strategy in early 2019 to increase their presence in the community by attending and supporting local events such as baseball games and health fairs. They involved their bedside staff in the events so the community could meet the individuals that may be caring for them in the future. The leadership team stated that when the COVID pandemic hit their community, Morton became the main hospital in the community to receive and care for COVID patients. The community rallied around Morton and since that time, their volume has increased every year.

The leadership team has been recruiting new physicians with specialties in bariatrics and gastrointestinal. Surgeons currently utilize eighty-five percent of the OR block time. Additional services that are being offered soon include the inspire device used by ears, nose, and throat physicians for sleep apnea.

Despite there being a net gain of approximately 200 new hires over the last year, Morton’s greatest challenge at this time is staffing. According to the leadership team, they are not losing very many staff, however, the volume of patients has grown faster than they can hire. It has been especially difficult covering summer vacations and FMLA leaves. The leadership team has recently increased staff incentives to pick up extra time by paying two times their wages.

According to the leadership team, equipment requiring repairs or replacement include:

- The bone density machine, which requires a part costing approximately \$50,000 but will return a profit of approximately \$400,000 per year;
- A new HVAC system is needed in the intensive care unit;
- The kitchen department requires a new fryer; and
- One of the freezers in the kitchen department will need to be replaced soon, according to the kitchen manager.

The hospital is not experiencing any elevator issues or supply shortages.

The Ombudsman's representative toured: (a) elder behavioral health services ("EBHS"); (b) S1 (cardiac telemetry), (c) the emergency department ("ED"), and (d) the kitchen department.

A. EBHS

EBHS is licensed for nineteen patients. According to the charge nurse, the unit is consistently at capacity. On the day of the visit, two patients were being discharged and two patients were being admitted. At the time of the visit, EBHS was staffed with four RNs and three nursing assistants. The charge nurse stated that there are also two attending physicians and a nurse practitioner providing care for the patients. The charge nurse stated that she has been working in EBHS since it opened over thirty years ago. She reported no supplies or staffing issues.

The beds in this area are heavy, ligature free, low to the ground, and have very short cords to plug into the wall for electricity. Many patients were sitting in chairs in the hallway or walking around the unit. In an effort to prevent elopement, the area is locked and requires special identification to enter. Upon entry, the door must close before a second locked door can be opened. EBHS recently accepted two long-term patients from other organizations that are closing in the

area. One of the patients has settled into her surroundings without issue, however, the second patient has been acting increasingly violent towards the staff.

B. S1 (Cardiac Telemetry)

The Ombudsman's representative toured the unit with the Senior Director of Patient Care Services present. As mentioned *supra*, S1 is a thirty-bed cardiac telemetry unit. On the day of the visit, the unit had a census of twenty patients. The Ombudsman's representative spoke with the flow nurse and the unit secretary. At the time, S1 was staffed with five RNs, two nursing assistants, and a unit clerk/secretary. According to the staff, their usual patient load is four patients per RN, but occasionally they may have five patients. The staff stated that they have a combination of cardiac and medical/surgical patients. Assignments are made based on acuity.

The cardiac monitors are watched by the nursing staff. The monitors can be seen throughout the unit. There are several hallway monitors and a central monitoring station at two different nurses' stations. Patients are categorized as a "T1" or "T2." If a patient is a T1, the RN must travel with the patient to various procedures. Patients who are a T2 can travel without a monitor. Telemetry monitoring is discussed daily on PULSE rounds.

The staff reported no issues with receiving supplies. A review of the supply closets showed a well-stocked, well-organized supply area. Other closets showed an ample supply of transport monitors, vital sign machines, and intravenous ("IV") poles. All the equipment in the supply closets appeared to be clean.

C. ED

The Ombudsman's representative toured the ED with the Senior Director of Patient Care Services present. The Ombudsman's representative spoke with the charge nurse and the nurse manager of the ED. The ED consists of forty-two rooms and approximately twenty hallway

stretchers. There is a separate eight-bed section of the ED specifically used for behavioral health patients. The charge nurse stated that they consistently have a higher capacity of behavioral health patients, and they frequently reuse regular ED rooms for these patients. When the ED is over capacity with behavioral health patients, extra staff is utilized to make fifteen-minute rounds. At present, there are fourteen behavioral health patients boarding in the ED.

Current census in the ED was sixty-eight total patients. The average number of patients the ED cares for in a twenty-four-hour period is 122 for the month of July 2024. At the time of the visit, the ED was staffed with fourteen RNs, four ED technicians, and one unit clerk. According to the director, there were approximately twelve to fifteen patients waiting for inpatient beds. A few of the patients that had been waiting for inpatient beds were discharged. The longest timeframe for a patient holding in the ED for an inpatient bed is fifty-two hours.

Although the ED was at capacity, the noise level was very low. The ED is well stocked with supplies, and the area is clean and orderly.

D. Kitchen Department

The Ombudsman's representative toured the kitchen department with the Senior Director of Patient Care Services and the kitchen manager present. The kitchen manager is employed by Sodexo. The team was beginning their dinner preparations. All employees were wearing appropriate hair coverings (including facial hair coverings).

The Ombudsman's representative toured all the refrigerators and freezers, dry storage, the preparation area, and the dish cleaner. All refrigerators and freezers had corresponding temperature logs. The manager stated that when a temperature is showing as out of range, the refrigerator is immediately removed from service. All food in the refrigerator was labeled with dates and times. The area was neat and free of clutter. The dry storage area was organized, and

all opened items were labeled with dates and times. The pots and pans were clean and shiny. The dish cleaner was in a separate area and is in working order.

The chemical closet was clean, and the eye wash station was close by. According to the leadership team, the station is routinely checked by maintenance. The log above the station indicated that it has been routinely checked and was due for an inspection at the end of the week.

The ice machine that was nonfunctioning during the prior visit is now functional. Two refrigerators are nonfunctional but such outage does not impact the preparation and service of meals to patients because there are other refrigerators that accommodate the supplies.

The manager stated that she did have staffing issues and has hired two new employees that are starting at next month's orientation.

E. Overall Impression

Morton leadership is aware of their metrics and tracks them diligently. They have implemented many strategies to increase their growth and have a solid plan moving forward. They are optimistic about the new ownership.

The nursing leadership rounds consistently on staff throughout the building. All staff seemed to know the CNO/COO, and she was able to address staff by name. The staff was pleasant and cooperative. The leadership team has an open-door policy and encourages staff to ask questions and offer suggestions. The leadership team was open and honest with questions and is interested in hearing best practices.

The following graphs show census from August 8, 2024 through and including August 31, 2024 and September 1, 2024 through and including September 10, 2024, respectively:

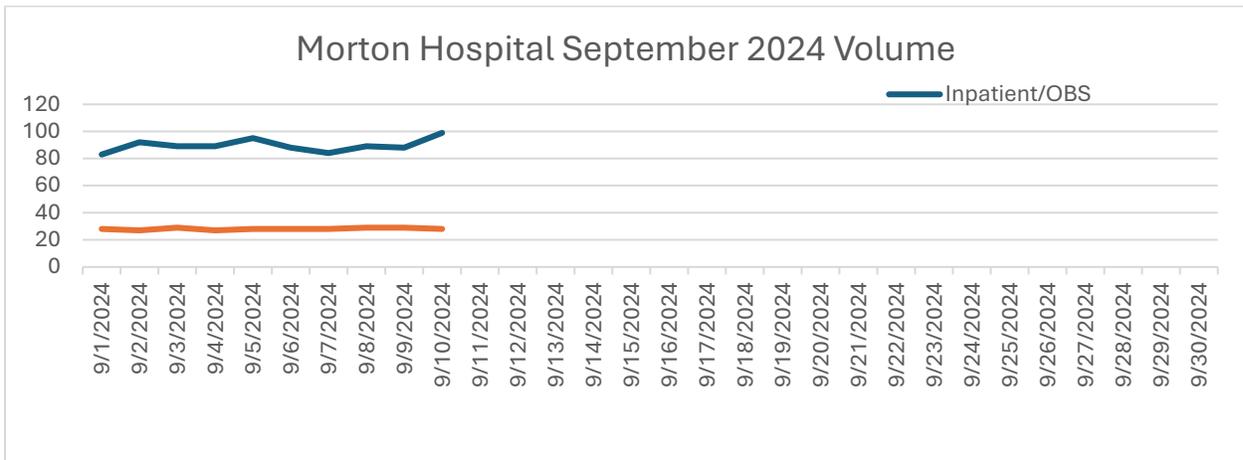
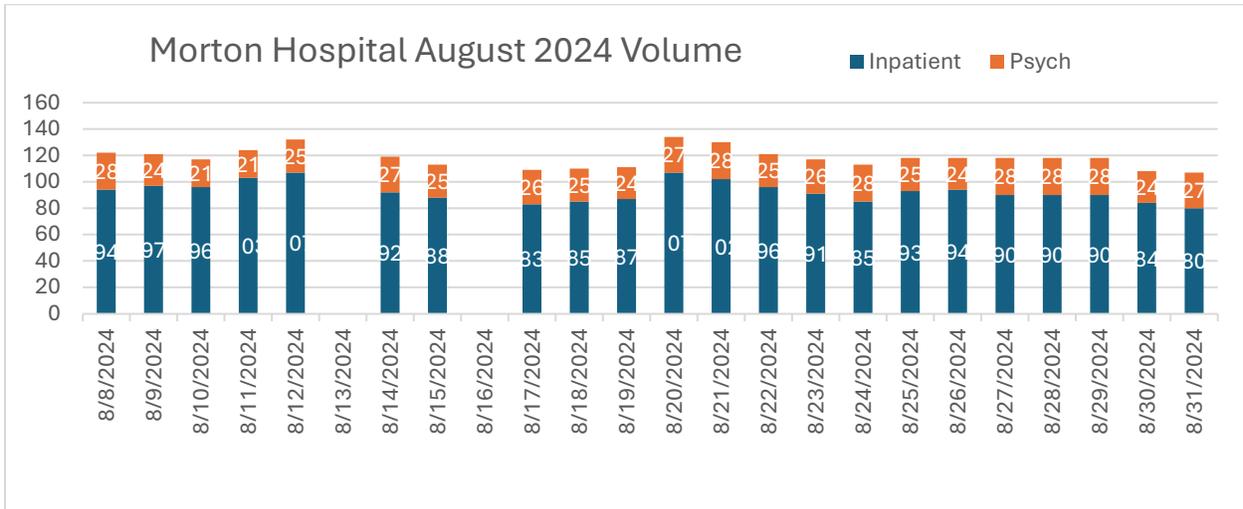


EXHIBIT G

ST. ANNE'S HOSPITAL

I. Unannounced Return Visit on July 22, 2024

The Ombudsman's representative returned to St. Anne's Hospital ("St. Anne's") on July 22, 2024. The Director of Inpatient Nursing greeted the Ombudsman's representative in the lobby and then escorted her to the administrative offices. The Ombudsman's representative met with St. Anne's President, the Chief Operating Officer, and the Chief Nursing Officer ("CNO") to discuss the areas that will be visited on this unannounced, routine return visit.

The leadership team reports that St. Anne's census has gradually risen to approximately 120 to 130 patients per day, which is an increase in volume from the Ombudsman's initial visit. On the day of the return visit, census was 135 patients in addition to two patient admissions who were still in the emergency department ("ED"). The leadership team stated that they recently onboarded fifty-five new employees and an additional ten new employees were presently in orientation on the day of the return visit.

The CNO accompanied the Ombudsman's representative on a tour of several departments, including: (a) the kitchen department; (b) four medical/surgical/telemetry units (St. Theresa's, St. Mary's, Sacred Heart, and St. James); (c) the operating room ("OR"); and (d) the supply departments, including bulk supply and central sterile supply, where the sterile processing department ("SPD") is located.

A. Kitchen Department

The Ombudsman's representative toured the kitchen with the CNO and the kitchen manager, who is employed by Sodexo. The kitchen department was clean and organized. The eyewash station was in an area where chemicals are used and thus could be quickly and easily accessed, if needed. There was a slight amount of paper debris noted on the floor, which was likely

related to breakfast service which had ended recently. There were also many corrugated cardboard boxes located in the food preparation spaces. The manager explained that they are working diligently to reduce/remove the cardboard in this space. Two tiles had gaping holes. The manager stated that he had submitted a ticket for replacement. He explained that these holes were caused by the high humidity from the dish machine and that he will continue to research how to remove the water vapor to keep humidity levels down.

The kitchen manager shared certain changes they implemented since the Ombudsman's initial visit. The department obtained an additional steam table, which was ready to be placed in service. It was reallocated from a recently closed sister hospital and has a value of approximately \$40,000. They also made alterations to the current steam table to include a heating lamp over the top of the food trays. The manager stated that this will ensure patient trays leave the kitchen at the appropriate temperature. The staff on the patient floors are now checking temperature readings of the food on the trays prior to serving the patient to ensure the meal is warm.

All open items in the coolers and freezer were sealed and labeled appropriately with expiration dates. Temperature logs were present on all coolers and freezers and the documentation was all current.

B. Medical/Surgical/Telemetry Units (St. Theresa's, St. Mary's, Sacred Heart, and St. James)

The following chart details the different medical/surgical/telemetry units that the Ombudsman's representative toured at St. Anne's:

Unit Name	Description	No. of Licensed Beds	Census on 7/22/2024
St. Theresa's	General Surgical Unit	26	17 patients, with 10 to 11 post-operative patients expected after discharges and room turnover are completed
St. Mary's	General Medical Unit	25	25 patients
Sacred Heart	Telemetry Unit	25	25 patients
St. James	General Medical Unit	18	18 patients

The nursing units for St. Theresa's, St. Mary's, and Sacred Heart are in the pavilion building and are the newest patient care areas. They are organized in a pod design, where five to six patient rooms are centered around a nursing station. The CNO shared that this is a patient-centered approach, although the design can lead to the nursing staff feeling isolated at times — usually at night or when a newer staff member is working. They do have the option of using a more central nursing station if needed.

Patient rooms were spacious and clean. Hallways were free of clutter. Patient care equipment was clean. A review of the supply closet did not indicate any shortages. Each of these units has a flow RN who admits and discharges the patients.

C. OR

The Ombudsman's representative toured the OR (specifically, the control desk area) with the CNO present. There were eighteen cases scheduled that day. The charge nurse stated that over the weekend, OR suites seven and eight had an HVAC outage. All sterile wrapped equipment and trays were removed and sent to SPD (see below) to be reprocessed. The sterile disposable packed items were relocated from the OR suites to a temperature and humidity stable area. She said that overall, they had no losses and both OR suites' HVAC systems were now functioning properly and

could be used for cases. According to the charge nurse, there are currently no supply or equipment shortages.

D. Supply Departments

St. Anne's' supply departments consist of a bulk supply room, central sterile supply, and the SPD.

i. Bulk Supply Room

The space is a large warehouse-type room that is neat and well-organized. The receiving dock is located in the bulk supply room. Several staff members were busy checking invoices and unpacking boxes. The room was full of various equipment and supplies. The team shared that they have had no problems getting requested items and the ability to obtain supplies had improved since the bankruptcy filing. There are still certain items that are more difficult to get, but this is typically related to backordered or high demand items.

ii. Central Sterile Supply

Overall, central sterile supply is a clean and organized space that is quite full. In this area, sterile blue-wrapped supplies and equipment are stored for later use in the OR. Central sterile supply is also responsible for preparing the OR case carts for scheduled cases. The staff in this department stated that they were busy and everything was going well. This increase in work was likely due to the reprocessing of equipment from the HVAC outage over the weekend in OR suites seven and eight. They did not have any items they were unable to get or have repaired if needed.

iii. SPD

Off the main space of central sterile supply is the SPD decontamination room; the SPD clean/sterilizing room; and the sterile tray storage room. The flow is logical for a sterile supply department and there is ample space for storage. SPD is also responsible for cleaning and

restocking code carts as needed. About eight to nine code carts were present in the department. The staff member explained their process for tracking expiring items in the code cart to ensure they are ready to go when needed during an emergency event.

The following chart details the nonfunctioning equipment as of July 22, 2024:

JULY 22, 2024 SAINT ANNE'S HOSPITAL				
BIOMEDICAL DEVICE	PROBLEM	STATUS	LOCATION	7/22 UPDATE
WASHER/FLEXIBLE ENDOSCOPE	LOSING DISINFECTION SOLUTION	Awaiting onsite evaluation to determine repair options. Expected completion date 7/19/24	OFF-SITE DARTMOUTH ASC	Repaired and returned to service 7/18/24
WASHER/FLEXIBLE ENDOSCOPE	WATER DILUTING	Awaiting onsite evaluation to determine repair options. Expected completion date 7/19/24	OFF SITE DARTMOUTH ASC	Repaired and returned to service 7/18/24
ICU ROOM 4 MONITOR HOUSING	DAMAGED AND END OF LIFE	Removed from wall mount //15 for patient Safety.Requires Monitor upgrade, awaiting quote to submit for pre-payment. Expected completion	ICU	Awaiting parts to finish repair. Parts must be pre-paid, awaiting payment to process order. Expected completion date unknown.
ICU ROOM 8 MONITOR	NEED TO REPLACE	7/15. Requires Monitor upgrade, awaiting quote to submit for pre-payment. Expected completion date	ICU	Awaiting parts to finish repair. Parts must be pre-paid, awaiting payment to process order. Expected completion date unknown.
STERILIZING UNITS/ STEAM	AUTOCLAVE FAILING TO OPEN DOOR	Awaiting parts to finish repair. Expected completion 7/19/24	OFF SITE DARTMOUTH ASC	Repaired and returned to service 7/18/24
TABLES/ OPERATING	LOOSE POWER ENTRY ASSEMBLY	Awaiting parts to finish repair. Parts must be pre-paid, awaiting payment to process order. Expected completion date unknown.	OFF SITE DARTMOUTH ASC	Awaiting parts to finish repair. Parts must be pre-paid, awaiting payment to process order. Expected completion date unknown.
TABLES/ OPERATING	STAFF HAVING DIFFICULTY WITH LOCK	Awaiting onsite evaluation to determine repair options. Expected completion date 7/22/24	OFF-SITE ATTLEBORO ASC	Service Scheduled for 7/23/24
MRI PATIENT MONITOR	ECG NOT WORKING	Fiber Optic Cable needed. Reached out to sister hospitals to inquire about available F/O Cable, none available at this time. Reached out to additional Sent in to OEM for factory repair. Awaiting quote to request po to finalize repair. Expected completion date	MRI	Parts unavailable. Device removed from service. Awaiting Rental Monitor to place in department. ETA 7/26/24
SCANNING SYSTEM ULTRASONIC	UNABLE TO BOOT UP	Awaiting quote to request po to finalize repair. Expected completion date	MAIN OR	Parts unavailable. Device removed from service. Awaiting Rental Monitor to place in department. ETA 7/26/24
FACILITIES	PROBLEM	STATUS	LOCATION	
Automatic Transfer Switch # 2	Returns normal power from emergency power	Completion scheduled for next week	West Mechanical Room	Scheduled for 7/31
Automatic Transfer Switch # 3	Returns normal power from emergency power	Completion scheduled for next week	West Mechanical Room	Awaiting Material
Boiler # 2 oil heater	Required for backup system for redundancy	Quote \$25k, no date scheduled	Boiler Room	Quote \$25k, no date scheduled
Vacuum Pump System	Current pump is a rental, no redundancy	Quote \$73k; no date scheduled	OFF SITE DARTMOUTH ASC	Quote \$73k; no date scheduled
Pneumatic Heating System	Provides heat to patient areas in East Building	Quote \$68k;no date scheduled	East Building	Quote \$68k;no date scheduled
V1 Vault Chiller	8 ton water sourced chiller for Linac Machine	Not quoted yet	Hudner Oncology	Not quoted yet
Building EMS (Temps and Humidity)	Remote access to the buildings control system	Quote \$120k; no date scheduled	Main Campus and off-sites	Waiting for offsite quotes
Nurse call system	Nurse call replacement in East/North Bldg	Quote \$800k; no date scheduled; 4 Patient rooms closed	East and North Buildings	Quote \$800k; no date scheduled; 4 Patient rooms closed
Roof Top Unit compressor	System is only running at 75% capacity	Not quoted yet	OFF-SITE ATTLEBORO ASC	Awaiting quote from Limbach Mechanical (new vendor)

II. Unannounced Return Visit on August 21, 2024

The Ombudsman's representative made an unannounced return visit to St. Anne's on August 21, 2024. The Ombudsman's representative had a brief meeting with the President and the CNO.

The leadership team stated that census on the day of the visit was 124 patients. The leadership team believes census is a bit lower than during the prior visit because two major surgeons (in orthopedics and neurology) were on vacation.

The President stated that two elevators were currently down. They are waiting for parts and were hopeful that Schindler would be able to repair it on the day of the visit. The second elevator was taken out of service that morning because it was not stopping level. Neither of the nonfunctioning elevators is impacting patient care or the way patients are transported throughout the building.

The Ombudsman's representative toured the following departments with the CNO: (a) ED; (b) geriatric psychiatric ("geri-psych") department; (c) Sacred Heart (Telemetry Unit), (d) intensive care unit ("ICU"); and (e) the kitchen department.

A. ED

The Ombudsman's representative toured the ED with the CNO present. The waiting room is large and being monitored by the triage nurse. Upon entry to the ED, registration clerks and security are readily available. The ED is well lit and clean with ample seating.

As discussed *supra*, the ED consists of twenty-seven beds plus hallway stretchers if needed. At the time of the tour, there were twenty-five patients in the ED, of which ten were psychiatric patients, six were in the psychiatric holding area, and four were in the core ED requiring frequent checks. According to the charge nurse, the ED was staffed that day with eleven RNs, seven

technicians, and one unit clerk (secretary). The charge nurse reported that there were no recent issues with staffing and supplies. A tour of the supply areas did not reveal any shortages.

Emergency equipment, such as code carts, pediatric code carts, and central line carts were present and monitored per St. Anne's' policy. The hallways were clear and free of clutter. At the time of the visit, there were no patients on stretchers in the hallway.

B. Geri-Psych Department

The Ombudsman's representative toured the geri-psych department with the CNO present. The department is a sixteen-bed locked unit dedicated to caring for geriatric patients with mental health issues. On the day of the visit, there were sixteen patients. The staff were pleasant and talkative. The staff stated that they are always at capacity and anytime they have a patient discharged, there is always an admission waiting for the empty bed. At the time of the tour, the geri-psych department was staffed with four RNs and four certified nursing assistants. According to the staff, they are not having issues with staffing or supplies.

The area was clean. Most patients were up either in chairs or walking in the hall. The rooms were at a comfortable temperature. According to the CNO, the air handler/chiller needs repair. As a result, there are temporary coolers in the hall common spaces within the department. Senior leadership is in the process of getting a quote for the repair. The CNO stated that the patient rooms are unaffected and have remained cool.

C. Sacred Heart (Telemetry Unit)

The Ombudsman's representative toured Sacred Heart, a twenty-five bed telemetry unit (as discussed *supra*) with the CNO present. The current census was nineteen patients. At the time, Sacred Heart was staffed with eight RNs, three nursing assistants, and one unit clerk. According to the flow nurse, which is an RN assigned to admit and discharge patients, they were expecting

one admission that day. The flow nurse stated they were not experiencing shortages of staff or supplies.

The patient rooms were spacious and clean. Emergency gases are present at the head of the bed. The hallways were free of equipment and clutter. Patient care equipment was clean. Emergency equipment was monitored per St. Anne's' policy. Supply rooms were well stocked.

D. ICU

The Ombudsman's representative toured the ICU with the CNO present. The ICU has capacity for twelve patients. On the day of the visit, census was five patients. The ICU was expecting three admissions and one patient to be transferred to Brigham and Women's Hospital via helicopter. At present, the unit educator has three ED orientees to learn about central line insertions. According to the staff, there are no issues with supplies or staffing. The ICU was staffed with four RNs at the time of the visit.

E. Kitchen Department

The kitchen manager, who is employed by Sodexo, gave the Ombudsman's representative a tour of the kitchen department with the CNO present. The kitchen equipment was clean and well organized. According to the manager, all equipment in the kitchen is functioning as expected. All open items in the coolers and freezers were labeled appropriately with dates and times. The temperature of each refrigerator and freezer were being monitored per St. Anne's' policy. There was a ceiling leak that was in the process of being repaired in the dish room.

F. Equipment Update

Recent equipment repairs include: endoscopes, ICU room four monitor, OR table locks, MRI table monitor, ATS switch #3, and a roof top compressor. Several other repairs are in process,

such as ICU room eight monitor, sterilizing units (parts ordered), ultrasonic scanning system (payment sent), and ATS switch #2.

G. Census

The following graphs show St. Anne’s’ census volume from August 8, 2024 through and including August 31, 2024 and September 1, 2024 through and including September 10, 2024, respectively:

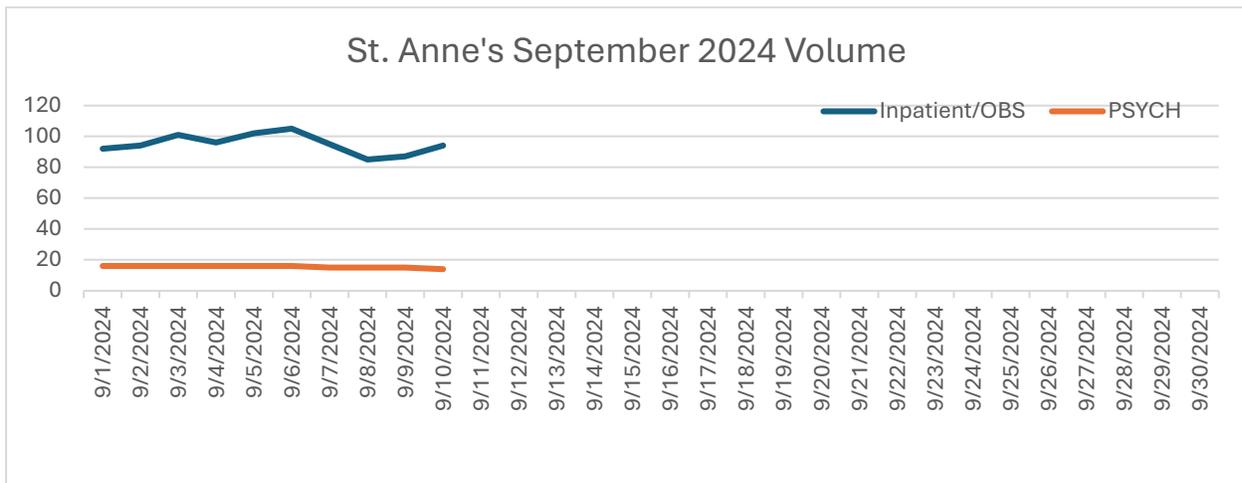
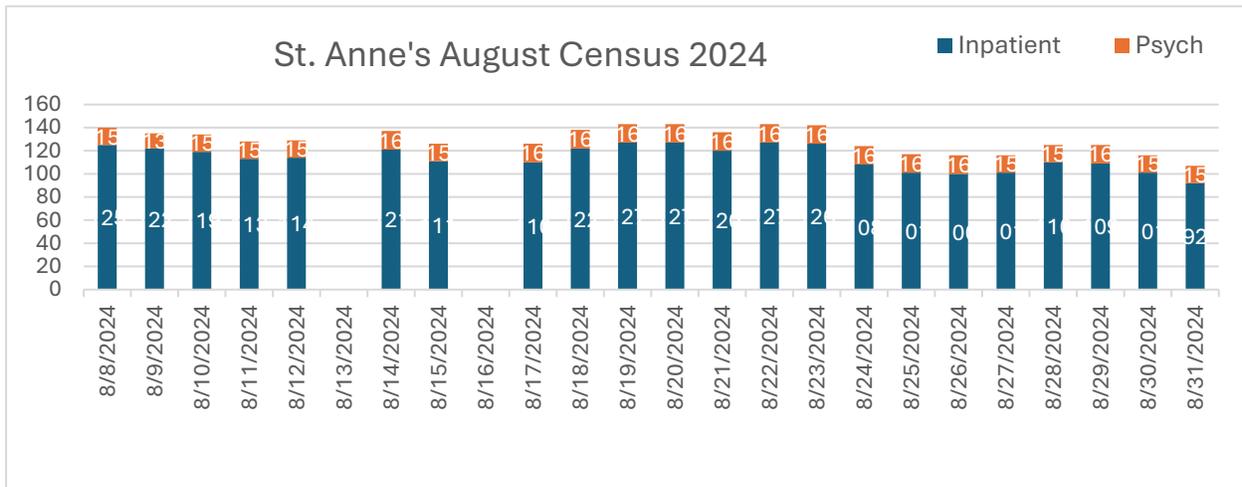


EXHIBIT H

CARNEY HOSPITAL

I. Unannounced Return Visit to Carney Hospital on July 30, 2024

On July 30, 2024, the Ombudsman and her representatives made an unannounced follow-up visit to Carney Hospital (“Carney”) to observe patient care during Carney’s closure process, as further detailed in the *Statement of Suzanne Koenig, as Patient Care Ombudsman, in Response to the Emergency Motion of Debtors for Entry of an Order (I) Approving (A) Funding from the Commonwealth of Massachusetts for the Planned Transition and Sale of Massachusetts Hospitals, (B) the Closure of Carney Hospital and Nashoba Valley Medical Center, and (C) Procedures Related to Facility Closures; and (II) Granting Related Relief* [Docket No. 1764] (the “July 30th Statement”) and the *Supplemental Report of Suzanne Koenig, Patient Care Ombudsman, Relating to the Closures of Nashoba Valley Medical Center and Carney Hospital* [Docket No. 2428] (“September 10th Supplemental Report”).¹

Upon arrival, they met with Carney’s President/Chief Executive Officer (the “President”), Chief Nursing Officer (“CNO”), and Director of Quality Management (“DQM”). Afterwards, the Ombudsman and her representatives visited several departments, including the Intensive Care Unit (“ICU”), the Emergency Department (“ED”), the Med-Surgery/Telemetry Unit (3NE), certain behavioral health departments, rehab services, the Post-Anesthesia Care Unit (“PACU”), the kitchen department, and human resources. In addition, the Ombudsman and her representatives interviewed the medical director of the ED and three patients.

A. ICU

The Ombudsman’s representative toured the ICU with the CNO present. On the day of the visit, the ICU had two patients and was staffed with two registered nurses (each an “RN”) and one

¹ In the interest of brevity, this Report incorporates the Ombudsman’s July 30th Statement and September 10th Supplemental Report by reference as if fully restated herein.

unit secretary. The RNs informed the Ombudsman's representative that there are no issues with staffing or supplies. The Ombudsman's representative inspected the supplies and did not observe any noticeable shortages.

B. ED

The Ombudsman's representative toured the ED with the CNO present. At the time of the visit, the ED had eighteen patients, including four behavioral health patients, and was staffed with seven RNs, three nursing assistants, and one unit secretary.

In the past two hours, the ED had three "Code Silvers," which is a response initiated to alert staff to a psychiatric emergency. The staff informed the Ombudsman's representative that Carney is no longer admitting psychiatric patients and is transferring all psychiatric admissions to other hospitals.

There were no reported staff or supply issues. The staff relayed concerns about community members being unaware of Carney's closure and coming to the ED with critical medical needs, such as a gunshot wound or stabbing. Staff informed the Ombudsman's representative that although Carney is not a designated trauma center, the ED nevertheless receives walk-ins with severe injuries. Several patients echoed concerns over where to obtain emergency care going forward.

C. Med-Surgery/Telemetry Unit (3NE)

The Ombudsman's representative toured the med-surgery/telemetry unit with the CNO present. On the day of the site visit, the unit had thirteen patients and was staffed with three RNs, one nursing assistant, and one unit clerk. The charge nurse stated that the med-surgery/telemetry unit is not having issues with supplies or staffing.

D. Behavioral Health Departments

The Ombudsman and her representative toured certain of Carney's behavioral health departments — specifically, the adult psychiatry and the older adult psychiatry units — with the DQM present. Carney also has an adolescent psychiatry unit, which had five patients at the time of the site visit. These departments surround and are separated by a central nursing station. According to the staff, the behavioral health departments are no longer taking admissions. Both the adult psychiatry and the older adult psychiatry units were adequately staffed, and the staff present on the day of the visit stated that they have sufficient supplies and equipment to care for their patients. The Ombudsman and her representative observed that the environment was clean and had no concerns regarding patient safety. Patients were up and about and appeared calm in their environment.

Adult Psychiatry Unit. At the time of the visit, the adult psychiatry unit had thirteen patients admitted and was staffed with two RNs and two technicians. The Ombudsman and her representative interviewed the charge nurse of the adult psychiatry unit at the central nursing department.

Older Adult Psychiatry Unit. The older adult psychiatry unit had ten patients and was staffed with two RNs and three technicians, with one such technician assigned to a 1:1 patient.

E. Rehab Services

The Ombudsman's representative, with the DQM present, interviewed the director of the rehab services department. The director relayed that the department was doing fine with the financial constraints, that they are staying very busy with patient care, and that there were no problems with equipment or supplies.

F. PACU

The Ombudsman's representative toured PACU with the DQM. Five RNs were present in PACU at the time. The RNs shared that they have sufficient supplies and equipment to safely care for patients.

G. Kitchen Department

The Ombudsman's representative toured the kitchen department with the contracted director for Sodexo present. The visit consisted of a tour through the kitchen and storage spaces for the dietary department. The Ombudsman's representative observed that the overall appearance was clean and tidy with ample workspace for staff. The kitchen staff were busy either cleaning the department for the night or preparing late trays and trays that would be taken to the ED for patients who are admitted overnight.

During the prior visit, the staff reported several broken or unavailable equipment, including the steamer, two top ovens, the plate warmer, two sinks, and the steam table. The director reported that since the last visit, the ovens had been repaired, but the steam table repair had been canceled given the upcoming closure of Carney.

H. Interview with the Director of Human Resources

The Ombudsman and her representative interviewed the Director of Human Resources (the "HR Director") with the DQM present. The HR Director stated that she is the only employee remaining in her department and is committed to working until Carney closes. The HR Director told the Ombudsman and her representative that Carney may close on August 31, 2024. She relayed that she did not have advance notice that Carney was ceasing operations.

II. Return Visit to Carney on July 31, 2024

On July 31, 2024, the Ombudsman and her representatives returned to Carney to assist the internal leadership team and the corporate team with the closure process (the “July 31st In-Person Meeting”). Specifically, the Ombudsman and her representatives met with the President, CNO, DQM, Carney’s Chief Medical Officer (“CMO”), the Regional DQM, the Regional Infection Control Practitioner, the Regional Risk Manager, and the Corporate CMO.

The Corporate CMO opened the meeting with apologies regarding the communication issues that occurred with Carney’s leadership team. He shared that they held an emergency meeting on July 26, 2024 to discuss, among other things, patient safety, securing “landing spots” for employees (there are approximately 1,250 staff between Carney and Nashoba Valley Hospital (“Nashoba Valley”)), the transition and storage of medical records, and the plans for the physical plants. He anticipated finalizing closure plans within the next twenty-four to forty-eight hours. The Corporate CMO conveyed that they are working on talking points and are engaged with the media and government officials.

The Ombudsman and her team shared that they would assist with further development and implementation of the closure plan with a focus on the safe transition of care for patients. The Ombudsman’s representative shared her closure plan that guided the successful, safe closure of a large teaching hospital in Pennsylvania. The plan included details regarding, among other things: storage of and access to medical records; disposition of pharmaceuticals; closure of units; patient transfers and transfer agreements; disposal and handling of biomedical hazardous and radioactive waste; payments to vendors; coordination with emergency medical services (“EMS”) and removal of hospital road signs; security measures post-closure; disposal of food supplies; communication plans; cessation of ambulatory programs; disposal and handling of medical gases; storage of

personnel files; psychiatric care closure; lab closure; radiology closure; FAQs; timelines; securing adjoining buildings; and credentialing files.

The Ombudsman stressed that she has safely and successfully overseen or assisted in the closure of numerous hospitals and medical facilities and that she is available to help in any way she can. The Ombudsman emphasized that her ultimate concern is for patient safety and assisting the closing hospitals develop a closure plan that ensures appropriate and safe patient care.

III. Steward Command Center Meeting on July 31, 2024

The Ombudsman and her representatives attended the initial Steward Command Center meeting via teleconference on July 31, 2024 (the “July 31st Teleconference”). The attendees included members of Carney’s senior leadership (including the President, CNO, and DQM), Regional Human Resources, Regional Quality, Corporate Quality, Chief Operating Officer of Steward Medical Group, Senior Director of Quality and Regulatory, Vice President of Steward Healthcare, and Director of Marketing.

The Ombudsman expressed disappointment over the general lack of communication with and inclusion of the Carney leadership team regarding the closure. To date, there had not been any town hall meetings with Carney’s staff and the Carney leadership team did not have any FAQs from corporate that could help them answer the staff’s questions.

The Ombudsman requested daily updates regarding the closure, census, length of stay, and timelines.

IV. Return Visit to Carney on August 8, 2024

On August 8, 2024, the Ombudsman and her representative visited Carney to follow up on the closure process. Although there was no administrative leadership onsite due to a medical emergency of the CNO, the President was available by phone. There was a Corporate HR Director

temporarily stationed at Carney. At the time of the Ombudsman’s visit (approximately 2:00 p.m.), the Corporate HR Director was unavailable.

The DQM stated that Carney was not experiencing issues with supplies or staffing. She did, however, express that theft is presently a major issue, with pictures being stolen off the walls, crosses are missing, and half of the Sodexo food order is unaccounted for. DQM assured that security is aware of the situation. Since the July 31st In-Person Meeting, the Carney leadership team developed a “Pre-Closure Action Item” list that was shared with the Ombudsman and her representative. They also shared a closure plan.

The census as of the date of this return visit was as follows:

Unit	Census
Med-Surgical/Telemetry (3NE)	13
Adult Psychiatry	3
Older Adult Psychiatry	9 ²
Adolescent Psychiatry	0
ICU	0
ED	13

The September 10th Supplemental Report includes graphs that depict (a) the census volume decrease over the month of August and (b) the ED usage through August 31, 2024. *See* September 10th Supplemental Report, at pgs. 4-5.

V. Summary of Closure Process

The Ombudsman and her team met with the Steward Command Center weekly to discuss patient census, medical records issues, transition of staff to other organizations (including job

² At the time, corporate was continuing to work with Massachusetts to place these remaining psychiatry patients.

fairs), placement of long-term psychiatric patients, and the impact of the closures on the communities. The Ombudsman received daily reports from the Steward Command Center to review patient care issues, staffing, sick calls, and census. In addition, the Ombudsman sought out daily reports from the CNOs, Presidents, and Chief Operating Officers at each of the closing hospitals regarding patient care issues or organizational failure.

VI. Development of Closure Plan and Timeline; Town Hall Meetings; and Final Command Center Statements

At the outset of the closure process, there was not a well-organized plan in place. However, over time and with the input from the Ombudsman and her team, the Debtors ultimately developed a clear and specific closure plan and ceased operations at Carney on August 31, 2024 in a manner that ensured patient care and safety. The September 10th Supplemental Report details the closure plan and its successful implementation (including the Debtors hosting town hall meetings and adopting the Ombudsman’s suggestion to fund an ambulance at Carney’s entrance for at least seven days post-closure in the event that critical patients, who were unaware of the ED closure, arrived needing emergency services). *See* September 10th Supplemental Report, at pgs. 3-9. In the interest of brevity, such information is incorporated fully herein by reference.

From the Ombudsman’s perspective, the Debtors and the staff “on the ground” at Carney maintained patient care and safety throughout the closure process. The Ombudsman will ensure that patients have clear instructions as to how to access their historical patient records, which are critical to the continuum of care.

EXHIBIT I

HILLSIDE REHABILITATION HOSPITAL

I. Cooling Tower Malfunction on August 8, 2024

On August 8, 2024, the staff at Hillside Rehabilitation Hospital (“Hillside”) noticed the cooling tower had failed, causing certain areas in the building to become increasingly warm. The Ombudsman was informed of this situation on August 11, 2024. Based on discussions with Hillside, patient care areas impacted by the cooling tower failure were Centers 1 and 2. All patients were immediately relocated from Centers 1 and 2 to Center 3, which was unaffected. Other areas impacted by the cooling tower failure included case management, the sleep lab, the kitchen department, laboratory services, and the pharmacy. Temperatures on patient care floors were monitored and maintained. Sleep lab cases were cancelled until the situation was resolved. A spot cooler was placed in the pharmacy and central supply department, where temperatures were always maintained. There were no patient complaints.

According to the Director of Facilities (the “DF”), on August 12, 2024, rental gear was in route to provide cooling to the affected areas at Hillside, and they planned to immediately begin the installation process to switch the cooling system to the rental equipment once the rental gear arrived. On August 13, 2024, a rental chiller was onsite, and the process to install was underway. On August 14, 2024, Hillside completed the installation of the rental chiller. All temperatures were within the appropriate range. Hillside staff continued to monitor temperature and humidity in the pharmacy, lab, central supply department, and any areas that may have patients to ensure proper temperatures were maintained.

The DF stated that pharmacy temperatures are monitored 24/7 electronically and that he programmed an alarm to notify him if there was a two-degree change so that he would be aware of any increasing temperatures and be able to act quickly to resolve the issue. Other employees

that also receive such alarm include Hillside's Chief Executive Officer, the Regional DF, the pharmacy director, security, and maintenance.

II. Return Visit on August 13, 2024

The Ombudsman and her representative arrived at Hillside on August 13, 2023, for an unannounced return visit. They were greeted by the Risk Manager and Quality Director (the "DQ") who informed them that the Director of Nursing was no longer employed at Hillside and the Chief Administrative Officer was on vacation.

The Ombudsman and her representative toured (a) the kitchen department, (b) Centers 1, 2, and 3, (c) the pharmacy, and (d) the central supply department.

A. Kitchen Department

The Ombudsman and her representative toured the kitchen department. Since the Ombudsman's prior visit, new thermometers had been purchased so accurate temperatures could be maintained. The dietary manager informed the Ombudsman that they are no longer using the hot box to maintain food temperatures as it was not functioning and required repair. The steamer, oven, and roasters were used instead to maintain proper temperature readings for the food.

The kitchen was noticeably cleaner than it was at the Ombudsman's prior visit, as unnecessary items were removed so that floors, shelves, and equipment were easier to maintain and keep clean. The floors were clean. New Swiffers were purchased to clean underneath shelving. The shelves were decluttered. The pots and pans were well organized and shined.

The refrigerator inspection showed that most items were dated and covered, except the food preparation for dinner did not have dates. The Ombudsman reminded the manager that all food, including the current prepared food, should be dated if stored in the refrigerator. The freezer rental unit continues to be located outdoors.

The manager stated that there were a few items that were not stored in the proper areas because they were presently short staffed due to a planned vacation and an unexpected FMLA, and therefore they could not properly unload a delivery received earlier that day. According to the manager, a part-time employee was recently hired and will begin work soon. The manager planned to put the rest of the items away shortly after the Ombudsman's visit. The refrigerator and freezer logs were inspected and found to have been completed daily and within normal range. The Ombudsman monitored the food temperatures on the tray line prior to the afternoon meal and all food temperatures were in compliance with the regulations.

B. Centers 1, 2, and 3

The Ombudsman's representative toured the patient care areas. Centers 1 and 2 were presently closed and not occupied by patients because of the increased temperatures from the failed cooling tower. The temperature-sensitive supplies had been removed. All patient care information had been relocated to Center 3. The DQ stated that they were going to take this opportunity to strip and clean the floors.

The Ombudsman's representative also toured Center 3. At the time, census was twenty-four patients. According to staff, the patient to registered nurse (each an "RN") ratio depends on the number of certified nursing assistants that are working that day. During the Ombudsman's visit, the ratio was four patients per RN. Staff stated that each RN can have as many as seven patients. Staff stated that there are no problems securing sufficient supplies to care for patients. The patient care area was clean and organized. Throughout the day, there were no patient care complaints regarding care, and all patients interviewed said the temperatures in their rooms and throughout Hillside were comfortable.

C. Central Supply Department

The Ombudsman toured the central supply department and noted that there were enough supplies stored in the warehouse as well as on patient care floors.

D. Pharmacy

The Ombudsman toured the pharmacy with the department manager present. The space is small but well organized. There was one pharmacist working on the day of the visit. The manager stated that there are no issues obtaining the medications needed to care for the patients. Even national backorders have not been much of an issue lately, as they plan to order sufficient medications for their patients. The manager mentioned that Cardinal is their main supplier, and there are likewise no problems obtaining necessary supplies.

The compounding room is tucked away in the back of the department and is currently not in use because the sleeves for the gloves are no longer attainable and the filter for the compounder is the incorrect size. Any medication needing to be compounded is obtained from Trumbull Regional Medical Center.

III. Closure of Hillside

On August 20, 2024, a Worker Adjustment and Retraining Notification was sent to employees notifying them that the Debtors plan to close Hillside. Originally, Hillside had planned to stop admissions as of August 27, 2024. However, after that notice, these plans have changed given the settlement reached with MPT and the new operator identified for this hospital.

IV. Census

Below are charts depicting the census through September 12, 2024:

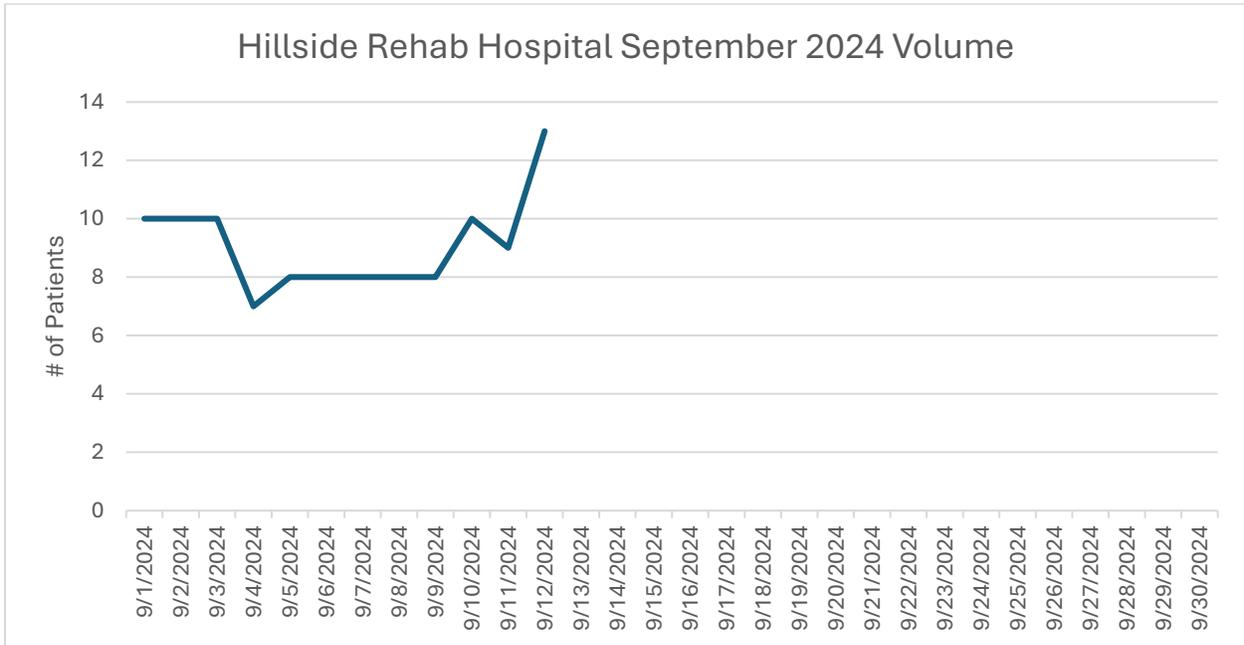
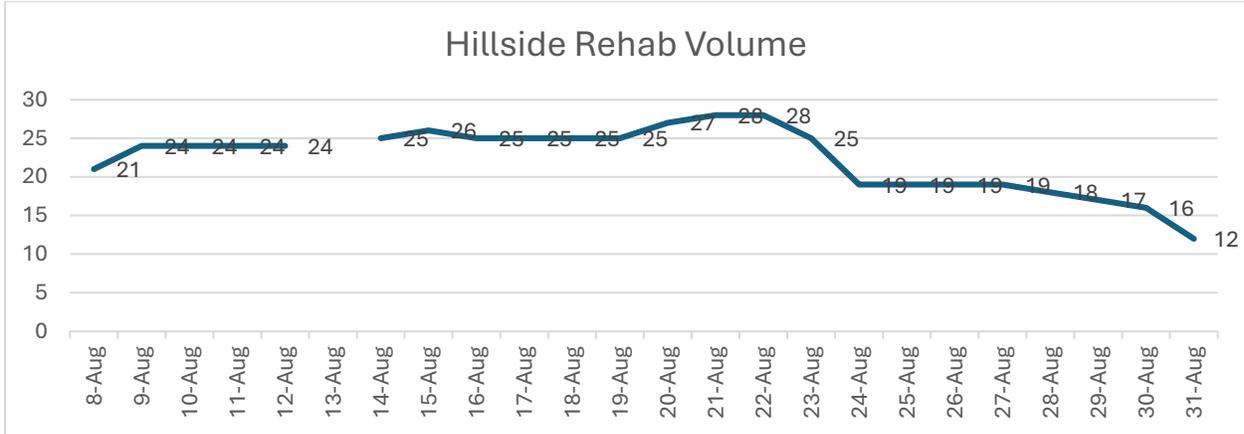


EXHIBIT J

TRUMBULL REGIONAL MEDICAL CENTER

I. Unannounced Return Visit on August 14, 2024

The Ombudsman and her representative arrived at Trumbull Regional Medical Center (“TRMC”) for an unannounced return visit on August 14, 2024, at approximately 8:00 a.m. (prevailing Eastern Time) and were escorted to administration by the Director of Human Resources. Upon entry into the administrative suite, the Ombudsman and her representative met with the Chief Medical Officer (“CMO”), the Regional Chief Nursing Officer (“Regional CNO”), TRMC’s Chief Nursing Officer (“CNO”), and other individuals in the administrative conference room.

The leadership team expressed the following concerns:

1. Potential closure of TRMC.
2. Vendors requiring prepayment. According to the CMO, individuals/areas most impacted by the vendor issues are the orthopedic surgeons and the cardiac catheterization lab. The CMO stated that they are cautious about scheduling only cases that they know they can perform safely and for which they have the supplies readily available.
3. Loss of specialties, such as urology and gastrointestinal.
4. TRMC has experienced a decrease in patient volume.
5. TRMC’s residency program consists of approximately sixty to seventy residents covering family practice, internal medicine, and surgery. There is a concern of orphaning residents if TRMC closes.

At the time of the visit, census was sixty-four patients, of which nineteen were behavioral health. According to staff, private physicians have spent a great deal of time convincing patients

that TRMC remains open and continues to provide excellent care. Staff throughout TRMC stated that many patients are surprised at the outstanding care they are receiving because TRMC has received bad publicity.

The Ombudsman and/or her representative toured the following areas: (a) emergency department (“ED”); (b) intensive care unit (“ICU”); (c) adult mental health unit; (d) geriatric mental health unit; (e) medical-surgical/telemetry (4-East and 6-East), and (f) kitchen department.

A. ED

The tour consisted of a walk around the ED with the CNO present and an interview with the staff. TRMC’s ED has thirty beds. On the day of the visit, there were seventeen patients in the ED. According to the staff, the volume has decreased to about forty to sixty visits per day. Staff reported no issues with supplies and staffing. At the time, the ED was staffed with six registered nurses (each an “RN”), two ED technicians, and a unit clerk. The designated behavioral health area in the ED had one behavioral health patient awaiting placement.

The waiting room was empty. The ED was clean. Emergency equipment was present and monitored appropriately.

B. ICU

The ICU has eighteen beds. On the day of the visit, census was six patients, and the ICU was staffed with four RNs. The patient to RN ratio continues to be one to two patients per RN, depending on the acuity of the patients. According to staff, there was an abundant number of RNs to care for the current census. Several of the RNs were sent to other areas within TRMC to be “helping hands.”

Staff reported no issues with supplies. An inspection of the supply area did not reveal any shortages.

The temperature in the ICU was comfortable. The portable air conditioning unit was still present but turned off. The unit was clean and uncluttered.

C. Adult Mental Health Unit

On the day of the visit, census in the adult mental health unit was nine patients, which is half the volume it was during the Ombudsman's prior visit. The psychiatric intensive care unit area was empty. Staffing for the adult mental health unit remained unchanged from the Ombudsman's prior visit: there were two RNs and a technician/aide. Patients were walking about the unit.

The unit was clean. Although the carpet was still extensively stained, it no longer smelled of urine. According to the CNO, a quote has been obtained to remove the carpet and they are awaiting approval and funds.

D. Geriatric Mental Health Unit

At the time of the tour, census in the geriatric mental health unit was ten patients, and the unit was staffed with two RNs. The unit's bed capacity is sixteen. Staff reported no issues with staffing and supplies. The area remains clean.

E. Medical-Surgical/Telemetry (4-East and 6-East)

4-East and 6-East are both medical-surgical/telemetry units, each with a bed capacity of thirty. 6-East has remote telemetry. The telemetry monitors on 4-East and 6-East are monitored by a monitor technician located on the 4th floor.

i. 4-East

On the day of the visit, census was sixteen patients. 4-East was staffed with four RNs, one licensed practical nurse, one "Helping Hands," which is an ICU nurse that was floated to this area, two nursing assistants, and a secretary. The charge nurse does not have a patient assignment.

Physicians, RNs, case management, and others were performing pulse rounds to discuss patient care and discharge planning.

Staff nurses reported no issues with staffing and supplies. The supply closets were organized, clean, and full of supplies. The area was robust with activity, and the Ombudsman's representative observed call bells being answered quickly.

ii. 6-East

On the day of the visit, census was twenty patients. 6-East was staffed by five RNs, with two of the five RNs being reassigned to 6-East from the ICU, two nursing assistants, and one unit clerk. The charge nurse had taken an assignment and was being assisted by the two RNs who were relocated from the ICU. Staff nurses reported no issues with supplies or staffing.

F. Kitchen Department

The Ombudsman toured the kitchen department, which was noticeably cleaner than it was during the Ombudsman's prior visit. The walls and equipment were sparkling, and the shelves were decluttered. The pots and pans were clean, shiny, and well maintained throughout the kitchen. The chemical closet was clean, and the eye wash station was close by. In addition, there was significant improvement in the operational flow of the work processes. Overall, the space was set up with a good flow.

The refrigerators and freezers had corresponding temperature logs. The food was labeled and dated in the refrigerators and freezers, and the walk-in refrigerator doors were fixed to shut and seal tightly. The kitchen equipment that was previously reported as nonfunctioning continues to be broken, however, the staff remains able to work around the equipment issues and provide quality food service to the patients.

G. Staffing

Based on charge nurse interviews and a review of recent staffing patterns, TRMC continues to staff the inpatient and ED according to acceptable industry standards. ICU RNs are in a patient to RN ratio of one to two patients per RN, depending on acuity. Medical-surgical/telemetry was staffed one RN per five patients. The ED was similarly staffed at one RN per four to five patients, depending on acuity.

H. Quality Metrics

Staff throughout TRMC were aware of quality metrics that their unit is monitoring, such as reducing central lines and Foley catheters, improving sepsis core measures, and hand hygiene. ED staff mentioned they are monitoring measures such as strokes, myocardial infarction, and sepsis. The quality metrics TRMC is measuring are comparable to those monitored by other similar hospitals.

II. Call with TRMC'S President on August 27, 2024

The Ombudsman had a call with TRMC's President on August 27, 2024. The President stated that TRMC was given a closure notice, with a closure date of September 21, 2024. Employees received a Worker Adjustment and Retraining Notification on August 20, 2024. Behavioral health admissions were halted on August 26, 2024, and all elective admissions were stopped on August 27, 2024. Given the settlement reached with MPT and the new operator identified for this hospital, these closure efforts have stopped.

III. Census

The below graph depicts the census volume decreasing as a result of the expected closure in August:

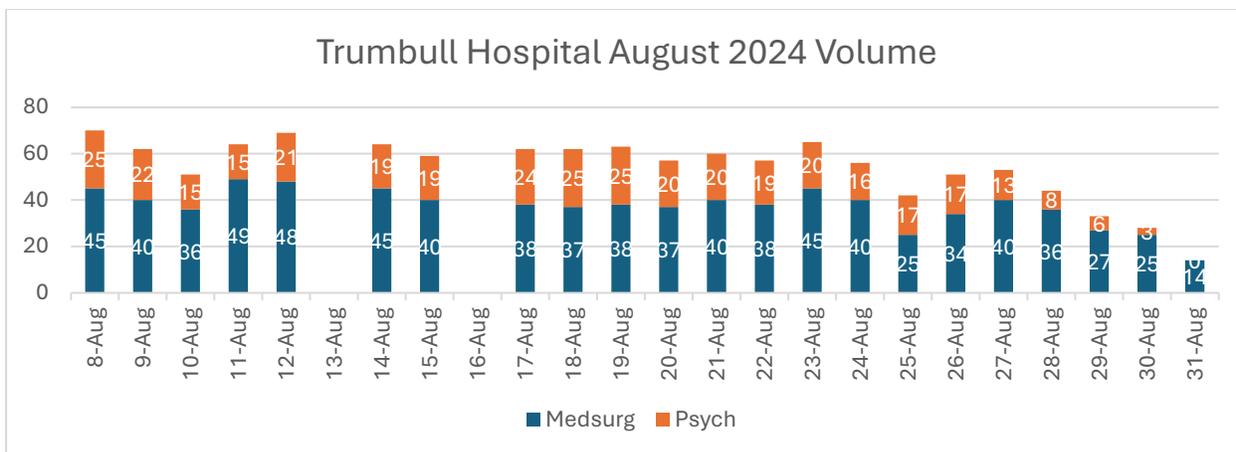


EXHIBIT K

SHARON REGIONAL MEDICAL CENTER

I. Unannounced Return Visit on August 14, 2024

The Ombudsman and her representative arrived at Sharon Regional Medical Center (“SRMC”) on August 14, 2024 and were escorted to administration to meet with SRMC’s President and the Regional Director of Quality (the “Regional DQ”). The leadership team expressed concern over the potential closure of SRMC and the future of the Resident Education Program for students, residents, and fellows. According to the leadership team, they were told by the Debtors’ corporate office that if no qualifying bids were received soon, SRMC would have to close. The leadership team explained that the census is down due to the loss of physician practices serving SRMC and the negative publicity about a potential closure and the Debtors generally. On the day of the visit, the census was fifty-one total patients, including thirty-six inpatients and fifteen behavioral health patients. The inpatient census is lower than it was at the Ombudsman’s prior visit.

The Ombudsman and/or her representative toured the following areas: same day surgery unit, 6 West, 4 West, 5 West, intensive care unit (“ICU”), cardiovascular unit (“CVU”), the emergency department (“ED”), central supply, and the kitchen department. A conversation occurred with a family member of a patient who also worked in the cardiac catheterization lab (“cath lab”).

A. Same Day Surgery Unit

The same day surgery unit was clean, well lit, and the corridors were free of clutter. According to the staff, they are not having issues with supplies or staffing. The staff’s sole concern was low patient volume. The staff explained that they have not been busy because two of their major surgeons were on vacation and they lost several surgeons over the past few weeks.

B. 6 West and 4 West

Both 6 West and 4 West are closed due to low patient volume. The most recent closure was 4 West, which closed approximately four days prior to the Ombudsman's visit. The areas were clean and well lit. The Ombudsman's representative suggested removing supplies and the pyxis machines if the areas are not going to reopen.

C. 5 West

5 West is a medical-surgical telemetry floor that had a census of twenty-six patients. On the day of the tour, there were six registered nurses (each an "RN"), one licensed practical nurse, three nursing assistants, and one unit clerk assigned to 5 West. Staff reported no issues with staffing and supplies. The area was clean and uncluttered.

D. ICU

The ICU's capacity is twelve patients. On the day of the visit, census was five patients. There were two RNs caring for five patients. The unit manager was also present and able to assist if needed. One of the staff RNs was questioned about her caseload caring for three patients. According to her, her assignment was telemetry, which is lower than ICU acuity. Staff reported no issues with staffing and supplies. The ICU was quiet without much activity occurring, and the area was clean and calm.

Quality measures in this ICU are similar to ICUs nationally. Quality projects for the ICU include the typical reduction of infection from invasive devices such as central lines and Foley catheters.

E. CVU

The CVU has a capacity of nine patients. On the day of the visit, the census was five patients, however, one of the patients was being discharged home. Three RNs were in the CVU,

except one of the three RNs was on orientation. According to the preceptor, the orientee is a very experienced ICU RN who only needs to be oriented to the computer system and SRMC's specific policies. The staff RNs reported no issues with staffing and supplies. The only concerns relayed related to SRMC's uncertain future.

A cath lab RN came out of the lab to tell the Ombudsman's representative that a relative was the patient being discharged from the CVU. The RN stated that SRMC saved this person's life. The patient lives only ten minutes away. The patient presented to the ED with shortness of breath. It was determined that the patient had a very large blood clot in the lung and the cath lab successfully removed it. The cath lab RN believes that if SRMC had closed, his relative likely would not have survived given the distance to the next closest hospital.

F. ED

The ED has twenty-one beds. The ED typically handles fifty patients per day. On the day of the tour, the ED had eight patients. The ED was staffed with six RNs, one ED technician, one patient sitter, one medic, and one unit clerk. The staff reported no staffing and supply issues. A review of the supply closet did not indicate shortages of equipment or supplies. The ED continues to be clean and uncluttered.

G. Central Supply

The Ombudsman toured the central supply department with a central supply technician present. The space was neat and well organized. The technician assured the Ombudsman that there were no issues obtaining routine supplies, however, there are continuing issues obtaining orthopedic supplies for total knee and hip replacement surgeries that are physician preference items. All surgeries are pre-planned and many supplies are pre-paid so there will be no delays in obtaining the necessary supplies/equipment.

H. Kitchen Department

The Ombudsman toured the kitchen department with the director and the manager of the department present. The kitchen was clean, uncluttered, and no debris was noted in any space other than where current food preparation was underway. The kitchen area is small but well designed and organized to optimize space. The dry food storage areas were neat, clean, and organized. All food was labeled appropriately and stored in sealed containers. Temperature logs were present on all coolers and freezers and were up-to-date with monitoring documentation. The Ombudsman observed the tray line and noted that temperatures were taken and documented. All temperatures were within guidelines. The Ombudsman reviewed the temperature log that is used by staff to record temperatures on a daily basis, which are taken after preparation and before plating. All temperatures taken were within guidelines.

I. Physical Plant

According to the leadership team, since the last visit, two elevators remain non-functioning (one patient elevator and one service elevator) and a 300-ton chiller has been purchased, which is awaiting installation. The President and Regional DQ informed the Ombudsman that on August 13, 2024, the breast biopsy machine potentially malfunctioned and was immediately taken out of service. The maintenance department notified the vendor, who immediately arrived onsite. Upon examination, the vendor determined that the biopsy machine had falsely alarmed.

II. Census

The following charts depict the census volume from August 8, 2024 through and including August 31, 2024 and September 1, 2024 through and including September 10, 2024, respectively.

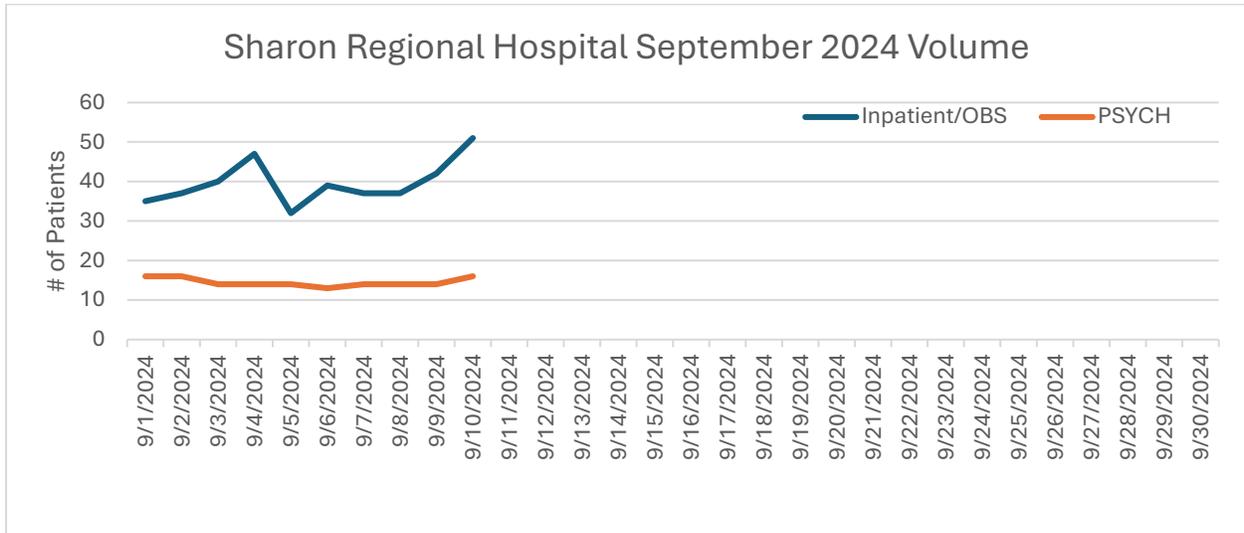
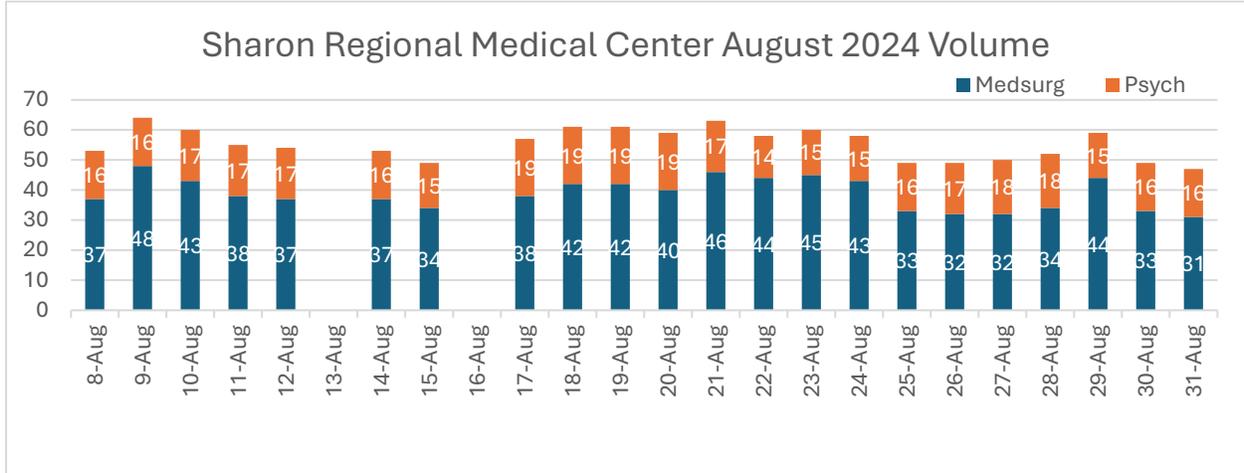


EXHIBIT L

PALMETTO GENERAL HOSPITAL

I. Unannounced Return Visit on September 7, 2024

The Ombudsman and her representative arrived at Palmetto General Hospital (“Palmetto”) on September 7, 2024. The Ombudsman and her representative had an initial meeting with the Chief Operating Officer, Chief Nursing Officer (“CNO”), A-CNO, and the Director of Quality. Palmetto has 378 licensed beds with a current census of 201 patients, which is Palmetto’s typical average daily census.

The senior leadership team shared that Palmetto recently lost a prominent cardio-thoracic surgeon because of the restructuring; however, they remained positive given that other surgeons did not leave with this surgeon and given that Palmetto is interviewing new cardio-thoracic surgeons to the departed physician.

Leadership stated that many previous supply issues have been resolved post-petition. The team also shared that the cardiac catheterization lab, which was closed during the Ombudsman’s prior visit, is expected to reopen in approximately three weeks. Additional improvements covered in the meeting included:

- All elevators were repaired and fully functioning, except for one service elevator (*i.e.*, eight of Palmetto’s nine elevators are fully operational).
- The ovens in the kitchen department were repaired by a new vendor.

The Ombudsman and/or her representative toured the following areas: (a) emergency department (“ED”); (b) intensive care units (“ICU”) – medical intensive care unit (“MICU”), coronary care unit (“CCU”), neurological intensive care unit (“Neuro ICU”); (c) 5th floor stepdown unit; (d) postpartum and nursery units; (e) kitchen/dietary department and (f) case management. The infection control practitioner and the ED medical director were interviewed.

A. ED

The ED has forty-one beds and can flex into an overflow area if needed. The area that can be flexed was previously used for the pediatric ED. At the time of the visit, there were twelve patients in the ED. According to the charge nurse, staffing fluctuates depending on the time of day. As the day progresses, the ED gets busier and, as such, requires additional staff. However, at any given time, there are five registered nurses (each an “RN”) staffed. The charge nurse also stated that a triage nurse and a charge nurse who do not carry assignments are always staffed to accommodate emergencies.

Proper emergency equipment was readily available. A pediatric code cart, baby warmer, and an adult code cart were all present within the ED. The charge nurse reported no issues with staffing and supplies. The supply room had ample supplies. The supplies were kept in a large locked pyxis dispensing cabinet.

The charge nurse relayed that the ED is working to improve certain quality metrics, including “repeating lactate levels for patients with sepsis and stroke core measures.” According to the A-CNO and an emergency room physician, Left Without Being Seen is less than one percent and Median Door to Doc Time (“Door to Doc Time”)¹ is under five minutes.

B. ICUs: MICU, CCU, and Neuro ICU

The following chart details the ICUs’ capacity and census and staffing numbers on the day of the Ombudsman’s visit:

Unit	Capacity	Census on 9/7/2024	Staffing on 9/7/2024
MICU	11 Beds	10 Patients	- 5 RNs - Shares a secretary with the CCU

¹ Door to Doc Time measures the arrival time of the patient to the time it takes a doctor to evaluate the patient.

Unit	Capacity	Census on 9/7/2024	Staffing on 9/7/2024
CCU	18 Beds	17 Patients	- 10 RNs - Shares a secretary with the MICU
Neuro ICU	8 Beds	8 Patients	- 4 RNs - 1 secretary

All charge nurses in the ICUs stated that the patient to RN ratio is two patients per RN; however, an RN may only have one patient if such patient has a high acuity.

Physician staffing in the ICUs follows an intensivist model with resident, fellows, and nurse practitioners. The ICUs have inhouse coverage 24/7. Patient rounds occur with a multidisciplinary team of individuals including the intensivist, fellow, RNs, infection control practitioner, and respiratory therapy. During these rounds, patient care issues are discussed, such as the need for invasive devices.

Each ICU was able to discuss what quality measures their unit was working to improve. These measures included infection reduction by reducing invasive lines, such as Foley catheters and central lines, and reducing pressure injuries.

While touring the Neuro ICU, a stroke alert was activated in the ED. The Ombudsman's representative inquired how a stroke alert is handled when the Neuro ICU is at capacity. According to the staff, they always know the available ICU beds, and they will either transfer a patient out of the Neuro ICU to a floor bed or temporarily use a bed in another ICU unit. According to the A-CNO, there is a process called "bed ahead." All floor staff at Palmetto know which bed and RN is available to accept a patient when necessary. A Neuro ICU RN stated that it takes only approximately five to ten minutes to make a bed available. She stated that the floor who accepts the patient never pushes back in emergency situations.

The RNs in charge reported no supply issues. A review of the supply carts in the ICUs did not reveal any shortages. The supplies are kept in a dispensing type of machine. When a supply is removed, a trigger is sent to central supply so replenishment can occur. All the supply rooms were clean and uncluttered. Patient care rooms are large and located around the central station. Rooms are all private.

C. 5th Floor Stepdown Unit

According to the charge nurse, patients in this unit have suffered from cardiac and stroke events. The current capacity of the 5th floor stepdown unit is forty-seven patients. At the time of the visit, census was thirty-five patients. The 5th floor stepdown unit was staffed with ten RNs, three nursing assistants, one telemetry technician, and one assistant nurse manager. Typically, there are four patients per RN.

To ensure patient satisfaction and quality care, nurse leaders round on every patient each day. The charge nurse developed a rounding tool to inquire about responsiveness of staff. Patients are given the opportunity to ask questions and to reward/recognize staff members. If any staff member is mentioned during rounds, such member is given immediate feedback.

Similar to other units, the quality measures that staff were working to improve included reduction of infections and invasive devices. The 5th floor stepdown unit has excellent metrics. It has been 395 days since a patient on this unit had a central line infection, three years since a methicillin-resistant *Staphylococcus aureus* infection, and 461 days since a *Clostridium difficile* infection.

D. Postpartum and Nursery Units

According to the staff, there are fourteen rooms for patients. To stay attractive in the competitive marketplace, all rooms are semi-private, however, they strive to keep all rooms private

whenever possible. The staffing model used in the unit is couplet care (a couplet is one mother and her infant). The patient/RN ratio is generally three couplets per RN. On the day of the visit, there were fourteen couplets. Seven RNs and a charge nurse work exclusively in the nursery.

Infant safety is a primary concern of the staff. Measures the unit employs to increase safety include the Hug® infant tracking and protection system. The system requires infants to wear special identification tags that alarm if the infant is too close to an exit door or elevator. Recently, a “Code Pink” drill was performed to ensure the staff and others throughout Palmetto can handle an attempted abduction. Other safety drills include post-partum hemorrhage.

Goals specific to this department include increasing breastfeeding rates and compliance with education hours. Staff educate new mothers to lay the infant on their back when sleeping, however, the training is often met with resistance from the new moms because of their lack of experience.

Staff stated that they have never had issues with supplies like other departments in Palmetto may have had prior to the bankruptcy filing.

E. Kitchen/Dietary Department

The Ombudsman toured the kitchen department with the new kitchen manager, who began at Palmetto only three weeks ago. However, he has many years of experience in kitchen management. He recently moved to the area and chose to work at Palmetto.

The kitchen was clean, uncluttered, and no debris was noted in any space other than where current food preparation was underway. The kitchen is large and well-organized to optimize the space. The dry food storage areas were neat, clean, and organized. All food was labeled and appropriately stored in sealed containers. Temperature logs were present on all coolers and freezers and were up-to-date with monitoring documentation.

The Ombudsman observed the tray line, and temperature readings were taken and documented. Temperatures readings were considered too low according to proper safety guidelines. The steam table water levels were also too low to maintain the proper temperature reading in the steam well. Hot water needed to be added to the steam well at appropriate levels. Several food items had to be reheated to travel to the floors and still maintain the proper temperature readings necessary to serve the patients.

The kitchen manager stated that the dish machine was broken, and food had to be transferred to the units on paper plates. It appears that the dishwasher may be sensitive and does not consistently work. The below chart details additional broken equipment in the kitchen department and the action taken with respect thereto:

Broken Equipment in the Kitchen area			
Equipment	Model	Status	Action Taken
Hobart Dishwasher	FT900S	Obsolete. It does not build the required temperature.	Plant operations team waiting for parts (specifically, steam traps and heat exchanger) and awaiting payment for the vendor, A-1 Industrial.
Traulsen Heat/Cold cabinet	RRI 2-32 LPUT	Obsolete. Neither cold nor hot side works. It needs new heat elements and a refrigeration unit.	Waiting on a visit from repair company, Expert Repairs. They are scheduled for 9/12/2024. Expert Repairs requires prepayment.
Bakers Pride Doble stack oven	GDCO11G	Does not turn on.	Scheduled on the same visit from Expert Repairs on 9/12/2024.
Marathoner doble stack oven	No model information	Obsolete. No parts are available.	Is being decommissioned, removed, and discarded on 9/9/2024.

F. Case Management

The case management team provided an example of a difficult discharge that they are working through. In fact, other providers refused to accommodate the patient and her family.

Patient Jane Doe ("Patient Doe"), whose length of stay was over 650 days, has advanced amyotrophic lateral sclerosis and is chronically ventilated via a tracheostomy. Patient Doe had a feeding tube ("PEG tube") placed through a percutaneous endoscopic gastrostomy that required multiple replacements over the past approximately two years, with her PEG tube most recently being replaced on July 29, 2024.

Patient Doe has no legal status in the United States. Patient Doe's daughter had been reluctant to cooperate with Palmetto in securing legal status for Patient Doe due to her lack of funds. Palmetto provided multiple resources to Patient Doe's daughter, such as: Guardianship Assistance; Dade Legal Aid, Catholic Charities Legal Services Miami; CABA Pro Bono Legal Services; and St. Thomas University Human Rights Institute. However, none of these institutions could assist Patient Doe until her daughter has power of attorney and can act as Patient Doe's representative.

The last meeting with Patient Doe's daughter took place on August 19, 2024, and Palmetto provided her with a form to file for guardianship of her mother. On August 26, 2024, Patient Doe's daughter received a follow-up call and she stated that she sought legal help to complete the form.

The case management team referred Patient Doe to Jackson Rehabilitation Care ("Jackson Rehab") and Jackson Memorial Long-Term Care Center ("Jackson Long-Term") for placement. Jackson Rehab responded that they were unable to accommodate Patient Doe's needs given her condition. An admissions liaison from Jackson Long-Term stated that the facility did accept

patients with tracheotomies and PEG tubes. However, Jackson Long-Term only accepts patients from other Jackson Health System facilities.

The team also requested quotes from Victoria Nursing and Rehabilitation Center (“Victoria”) and Unity Health (“Unity”). Admissions at Victoria provided the following:

- Their daily rate is \$1,000.00, and they have a letter of agreement (“LOA”) with Palmetto.
- If Patient Doe needs to be transferred out of the facility via 9-1-1, Jackson Memorial Hospital will pay for Patient Doe’s stay. Once Patient Doe is transferred back to Victoria, Palmetto will have to resume paying for Patient Doe’s stay.

The admissions department at Unity stated that they could do an LOA if Patient Doe met the criteria and requested that the most updated clinical information be sent to finalize a quote. They estimated that the quote will be approximately \$1,000.00 per day. The case management team will continue to follow up with Patient Doe’s daughter and obtain the final quote from Unity.

EXHIBIT M

NORTH SHORE MEDICAL CENTER

I. Return Visit on September 4, 2024

The Ombudsman and her representative arrived at North Shore Medical Center (“NSMC”) on September 4, 2024 for a return visit and were greeted in the lobby by the chief nursing officer (“CNO”). The CNO escorted the Ombudsman and her representative to the administrative suites where a meeting was held with NSMC’s President and the CNO. The leadership team shared that NSMC recently passed its Joint Commission Survey and that presently, Florida Agency for Healthcare Administration — Florida’s licensing and certification agency — was at NSMC performing a life safety inspection.

Although NSMC is licensed for 337 beds, on the day of the visit, the census was only 72 patients. The CNO expressed concerns regarding staffing and the lack of applicants for vacant positions. She stated that NSMC recently had six registered nurses (each an “RN”) resign. Human resources provided a resignation report to the Ombudsman’s representative.

As census and volume levels decrease, NSMC has been closing units with low patient occupancy levels. Certain departments have been eliminated, including obstetrics and gynecology. Other areas, such as tower 2 and the stepdown unit, have been shut down. The stepdown unit was closed approximately four months ago. Patients requiring a stepdown level of care are treated in the intensive care unit (“ICU”) and cared for by the stepdown nurses who were relocated to the ICU. The forensic unit (“FU”) currently does not have any patients. The CNO surmised that the lack of patients in the FU could be related to the expiring forensic contract, which terminates October 1, 2024. She expressed concern that the FU may also permanently close as a result. The CNO stated that cable television services had been discontinued and that many patients had voiced their displeasure regarding overnight stays at NSMC as a result.

The Ombudsman and her representative toured the ICU, emergency department (“ED”), the operating room (“OR”), post-anesthesia care unit (“PACU”), central supply, and the kitchen department.

A. ICU

The bed capacity for the ICU is twenty-two. On the day of the visit, there were eleven patients in the ICU, with four such patients requiring stepdown level of care. According to the charge nurse, there were five RNs staffed that day. Average patient to RN ratio for the ICU level of care patients was generally two patients per RN, but this fluctuated based on acuity. For example, one patient was receiving 1:1 nursing care. During the interview with the ICU RNs, they expressed concern about the lack of staff available beyond themselves. Training to become an ICU RN can last up to three months, however, when an RN resigns, only two weeks’ advanced notice is required.

The ICU RNs reported no issues with supplies. A review of the supply areas showed adequate levels. The ICU was clean, bright, and the hallways were clear of unnecessary equipment. Critical equipment, such as code carts, were present and inventoried per NSMC’s policy, which had adequate supplies.

B. ED

The ED consists of twenty-eight beds. On the tour, there were fifteen patients in the ED. According to the charge nurse, there are no supply issues, and they are staffed well. She stated that when they are short on personnel for a shift, someone will fill in and work overtime.

Since the prior visit, one of the behavioral rooms had been converted to a medication room. The manager plans to move the pyxis machine¹ into the newly-created room, thereby creating more

¹ A pyxis machine is an automated dispensing machine that provides secure medication storage along with electronic tracking of the use of narcotics and other controlled medications.

space at the nurse's station. One behavioral health room remains available for patient use. According to the director, the ED receives very few behavioral health patients.

The ED is bright and clean. Emergency equipment was readily available and monitored per NSMC's policy. The ED metrics continue to meet quality standards with the Left Without Being Seen ("LWBS") rate being approximately one percent and the Median Door to Doc Time ("Door to Doc Time")² being approximately eight to ten minutes.

C. OR/PACU

According to the OR staff, surgery volume is currently down because of a loss of surgeons and vacation season. Presently, the OR was running only three rooms due to staff availability. The PACU did not have any patients at the time of the tour. Staff reported no supply issues. During the time the Ombudsman and her representative were making their rounds, there were only three patients remaining on the "OR Board." According to the manager, most of the cases were completed earlier in the day.

D. Central Supply

The Ombudsman was greeted by the department manager on the day of the visit. The manager reported having sufficient supplies and equipment to support NSMC's operations. Surgeries are planned in advance so supplies can be obtained by preplanning for pre-payment and, in certain cases, Palmetto Hospital assists in securing supplies that are difficult to obtain. The department was neat, and there were no concerns noted.

² Door to Doc Time measures the arrival time of the patient to the time it takes a doctor to evaluate the patient.

E. Kitchen Department

The Ombudsman toured the kitchen with the kitchen manager. The kitchen was neat, organized, and clean, including all equipment, shelves, and surrounding surfaces. In the dry storage area, there were no opened, unlabeled food containers noted.

According to the kitchen manager, coolers and freezers are inspected daily, and all food items are labeled with orange stickers to indicate expiration dates. Temperature logs were present on all coolers and freezers and were up-to-date with monitoring documentation, except two freezers were missing the current date temperature readings.

The manager appeared knowledgeable with safety practices and took pride in his work. A large white tracking board was present on the wall, which listed the number of trays required per meal and the types of diets needed for each meal on that current date.

F. Quality Measures

Quality measures for NSMC are consistent with similar hospitals nationally. An example of some of the measures are sepsis, central line infections, Foley catheter infections, reduction of falls, hand hygiene, LWBS, Door to Doc Time, methicillin-resistant *Staphylococcus aureus* infections, and *clostridium difficile* infections. The staff are familiar with the quality measures and are actively working to provide excellent quality care.

G. Physical Plant

The following equipment was nonfunctioning:

- Two chillers;
- One boiler;
- A lift pump station; and
- Four elevators.

On the day of the tour, NSMC was renting a 250-ton Carrier chiller, a 550-ton Trane chiller, and a lift pump station from United Rental.

EXHIBIT N

CORAL GABLES HOSPITAL

I. Return Visit on September 5, 2024

The Ombudsman and her representative arrived at Coral Gables Hospital (“Coral Gables”) on September 5, 2024, for a return visit. The Ombudsman and her representative were escorted to the administrative suites where they met with certain of Coral Gables’ leadership, including the President, the Director of Inpatient Services, and the Director of Quality. Coral Gables is licensed for 245 beds. On the day of the visit, census was forty-eight patients and there were seventeen operating room cases scheduled.

According to the leadership team, specialty services offered at Coral Gables include urology, gynecology, robotics, gender affirming surgery, and orthopedics. The team is proud of their Center of Excellence Award for Advanced Orthopedics in both hip and knee replacements. In 2021, 2022, and 2023, Coral Gables also received a Healthgrades Patient Safety Excellence Award.

The Ombudsman and/or her representative toured the following departments: (a) emergency department (“ED”), (b) medical-surgical/telemetry (2nd and 4th floors) and surgical stepdown (3rd floor); (c) intensive care unit (“ICU”); (d) central supply department; and (e) kitchen department.

A. ED

ED staff stated that census was currently five patients. Staffing patterns remain consistent with other EDs with staggered staffing patterns, increasing as the typical patient volume increases throughout the day and then decreasing in late evening as census decreases. Staff reported no issues with staffing and supplies. A review of the supply areas did not reveal shortages. Emergency equipment was present and monitored per Coral Gables’ policy.

Quality metrics in the ED continue to far exceed national standards for Left Without Being Seen (“LWBS”), with a rate of 0.7% year to date, and Median Door to Doc Time (“Door to Doc Time”),¹ which is approximately eight minutes year to date. Acceptable standards for LWBS are less than two percent and Door to Doc Time is thirty minutes.

B. Medical-Surgical/Telemetry (2nd and 4th Floors) and Surgical Stepdown (3rd Floor)

On the day of the visit, census, staffing, and other metrics for medical-surgical/telemetry (2nd and 4th floors) and the surgical stepdown (3rd floor) are detailed in the following chart:

Unit	No. of Beds	Average Daily Census	Census on 9/5/24	Staffing on 9/5/24
2 nd Floor Medical-Surgical Telemetry	68	20	15	- 3 registered nurses (each an “ <u>RN</u> ”) - 1 charge nurse without patient assignment - 2 nursing assistants - 1 secretary
3 rd Floor Surgical Stepdown	27	—	8	- 2 RNs - 1 charge nurse without patient assignment - 1 nursing assistant
4 th Floor Medical-Surgical Telemetry	67	20	17	- 4 RNs - 1 charge nurse without patient assignment - 2 nursing assistants - 1 secretary

¹ Door to Doc Time measures the arrival time of the patient to the time it takes a doctor to evaluate the patient.

The medical-surgical/telemetry floors continue to have a 5:1 patient to RN ratio that is typical compared to other similar units. The charge nurses do not take a patient assignment unless necessary. On each unit, the charge nurses reported no issues with supplies or staffing.

The patient care areas were clean, and the hallways were free of clutter. Emergency equipment was present and checked per Coral Gables' policy, except the top drawer on the 4th floor code cart, which was located near the elevator, was able to be opened when gently pulled upon — all other drawers remained locked. The code cart was immediately taken out of service and sent to the central supply department for replacement and repair.

Quality metrics continue to be monitored such as pain assessment, reduction of falls, and reduction of invasive devices, such as Foley catheters and central lines. Call bells were answered quickly, and patient rounds are conducted hourly.

C. ICU

The ICU is comprised of sixteen private rooms. The average daily census is six patients, however, on the day of the tour, the ICU only had four patients. Typically, there is one RN per two patients. At the time, there were three RNs working in the ICU. The ICU also has a charge nurse that does not take patient assignments. The ICU nurses attend all rapid responses and in-house cardiac arrests.

The charge nurse reported no issues with staffing and supplies. The supply room was well organized and adequately stocked. The ICU was clean and free of clutter. Emergency equipment was present and monitored daily for functionality. RNs are aware of quality measures and work hard to reduce infections from invasive devices.

D. Central Supply Department

The Ombudsman toured the central supply department with the department manager present. The area was organized, and it appeared to be full of supplies needed for patient floors, surgery, and other hospital areas. The manager stated that, currently, Coral Gables has been able to obtain all necessary supplies. Surgeries are scheduled well in advance to ensure all items can be pre-paid if necessary. All patient floors had enough supplies in their supply rooms.

E. Kitchen Department

The Ombudsman toured the kitchen department with the kitchen director and chef present. The kitchen was clean and uncluttered. Despite its small size, the kitchen is managed appropriately. The main icemaker remained nonfunctional, but staff were able to obtain ice from other machines. The hot box was also nonfunctional, so alternative heating procedures were used to maintain food temperatures prior to meal service. All equipment, shelves, and surrounding surfaces were neat, clean, and free of debris. There were no open, unlabeled food containers noted in the general kitchen area. All food was labeled and stored in the freezers, coolers, and dry storage areas, as appropriate. Temperature logs were present on all coolers and freezers and were up-to-date with daily documentation. The Ombudsman observed the tray line and monitored temperatures as food was being served. All temperature readings ranged from 166 to 198 degrees. The food looked appetizing and well plated for patient nutrition and enjoyment.

F. Patient Interview

The Ombudsman interviewed a patient who was being discharged after a surgical procedure performed at Coral Gables. The patient had stayed at Coral Gables several days after surgery to recover. The patient stated that everyone involved in the care plan, including the

medical and nursing staff, was helpful. The patient was completely satisfied with the overall care received during the stay.

G. Staffing

There were no licensed nurse openings at the time of the Ombudsman's visit, however, there were two surgical technician openings. Coral Gables functions as a tight-knit community with a senior leadership team that is actively engaged, creating an environment where nurses feel motivated to work.

H. Physicians

The Ombudsman and her representative interviewed the department director of general surgery. He felt very strongly about the positive environment and overall care provided to his patients at Coral Gables compared to other hospitals in the geographic area. He stated that he tries to bring as many of his patients to Coral Gables to perform his surgeries because he trusts the licensed staff to follow directions and his outcomes are positive. He relayed that he has spoken to doctors in the community and that they will return to Coral Gables once there is further clarity as to the hospital's future and the sale is completed. He felt strongly that patient volume will increase as Coral Gables is very needed in the community.

I. Physical Plant

At the time of the visit, non-functioning equipment included:

- The boiler;
- One chiller;
- An icemaker;
- The hot box; and
- One cooler.

A rented portable boiler and chiller were on property. As discussed *supra*, the kitchen department is using alternative equipment already on-hand to handle the day-to-day issues.

EXHIBIT O

HIALEAH HOSPITAL

I. Unannounced Return Visit on September 5, 2024

The Ombudsman and her representative arrived at Hialeah Hospital (“Hialeah”) on September 5, 2024, for an unannounced return visit. The Chief Nursing Officer (“CNO”) quickly greeted the Ombudsman and her representative and escorted them to the administrative conference room, where the Ombudsman conducted an opening conference.

Hialeah is licensed for 356 beds with an average daily census of 105 to 155 patients. At the time of the Ombudsman’s visit, census was 101 patients. The administrative team believes the lower census is related to the recent holiday and physician vacations. Hialeah is a certified stroke center and a Center of Excellence for Bariatric Surgery.

The President stated that Hialeah continues to exceed expectations for the Geometric Length of Stay (“GMLOS”). The GMLOS rate has been maintained at 3.61 days, below the expected 3.67 days. The success of decreasing the GMLOS was attributed to pulse rounds that are held twice a day. Another success story communicated to the Ombudsman’s team was the “ED Academy.” There has been a 100% retention rate of new emergency department (“ED”) registered nurses (each an “RN”) that attended the “ED Academy.” Currently, there is not another “ED Academy” scheduled because there are only two vacancies in the ED.

The Ombudsman and/or her representative toured the following departments: (a) ED; (b) telemetry units (2nd and 3rd floors); (c) intensive care unit (“ICU”); and (d) kitchen department.

A. ED

The ED continues to be under construction, which is causing the department to be constrained. An infection control barrier is in place. Nevertheless, census remains constant at approximately ninety-five patients per day. At the time of the visit, the ED had nineteen patients.

According to the charge nurse, there were six RNs and two ED technicians working. More RNs are scheduled to arrive as the day progresses.

Throughout the ED, emergency equipment was clean and readily available. The equipment was being monitored and checked according to Hialeah's policy. Supplies have not been an issue according to staff, and the supply areas were clean, organized, and well stocked.

Metrics for the ED continue to exceed standards. Median Door to Doc Time is approximately five minutes and less than 0.1% of patients leave the department prior to being seen by a doctor.

B. Telemetry Units (2nd and 3rd Floors)

The following chart provides information regarding the capacity, census and staffing at the time of the tour of the telemetry units:

Unit	Capacity	Census on 9/5/2024	Staffing on 9/5/2024
2 nd Floor Medical-Surgical/Telemetry	71 Beds	37 Patients	- 7 RNs - 3 Nursing Assistants - 1 Unit Secretary
3 rd Floor Telemetry	58 Beds	34 Patients	- 7 RNs - 3 Nursing Assistants - 1 Unit Secretary

i. Staffing

In general, the patient care ratio for the telemetry RNs is five patients per RN, although an RN may occasionally have six patients. The charge nurse usually remains without a patient assignment. The patient to nurse ratio is similar to other like units. The telemetry monitors are watched by a monitor technician that is located on the third floor.

ii. Supplies

Each telemetry floor was well stocked with supplies. The supply areas were clean and free of clutter. Linen carts were well stocked and covered. Emergency equipment was clean and checked per Hialeah's policy. Since the telemetry units are large and each floor has several hallways, the carts were located at convenient and easily-accessible areas throughout the units.

iii. Quality Measures

The quality measures remained consistent since the prior visit: reduction of infection by reducing invasive devices; hand hygiene compliance by monitoring approximately 200 observations per month; and fall reduction by education of patients to "Call, Don't Fall," using bed alarms and a sitter if needed.

While interviewing the charge nurse on the second floor, a bed alarm alerted. The unit secretary quickly announced the alert over the intercom system with the statement: "Bed alarm in room (*omitted*)." Very quickly, approximately five employees ran to the patient's room, including the A-CNO and charge nurse. The secretary did an excellent job quickly recognizing that a patient needed help and then notifying the staff. This employee was a recent "employee of the quarter" for Hialeah.

C. ICU

The ICU has thirteen licensed beds. Census on the day of the visit was seven patients. There are four RNs caring for the patients and an additional RN in charge without a patient assignment. According to the staff, the usual ratio in the ICU is one RN per two patients, but RNs with higher acuity patients may only have one patient. Physician coverage for the ICU has remained unchanged from the prior visit.

Staff nurses reported no nursing or supply shortages. The nurse manager also reported no recent issues with supplies. The supply area looked to be fully stocked. Emergency equipment was readily available and monitored per Hialeah's policy.

Quality measures that are tracked in this ICU are the typical measures that all ICUs track nationally (e.g., reducing infections from central lines and Foley catheters and reduction of pressure injuries).

D. Kitchen Department

The Ombudsman toured the kitchen with the director. The storage of food was organized and neat. There were no opened, unlabeled food containers noted. Bowls, pots, pans, and other items were neatly stacked and were clean and orderly without debris, which was all similar from the prior visit.

The equipment that is currently out of order included a warmer that went down a few days prior to the Ombudsman's initial visit in July 2024. Four of the six ovens remained nonoperational. The coolers and freezers were repaired. Temperature logs were present on all coolers and freezers on the day of the visit and were up-to-date with monitoring documentation.

The staff had gathered in the line prep area just prior to starting the tray prep line. Temperature levels were recorded on food items prior to plating and transporting the meals to the floors. After review, the Ombudsman requested several items be re-tested as there was not enough water in the steam wells to keep the steamer temperatures elevated, so the food temperatures were not high enough to meet the standard guidelines. These food items were reheated and then returned to the tray line. All temperatures ranged from 160 to 182 degrees for hot food after reheating.

E. Development of “ALFI App”

According to a report from the Chief Operating Officer, during the last quarter of 2023, Hialeah decided to address readmissions. Hialeah is uniquely challenged due to having 107 assisted living facilities (each an “ALF”) in its service area. Indeed, the number of ALF patients in Hialeah’s surrounding community was much higher than that of its sister hospitals and corporate-wide facilities. The administrative team realized that there were no medical personnel at ALFs at certain times of the day, and the level of clinical competence widely varied. Medication reconciliation, follow-up visits, and communication were a true challenge.

The team got together weekly and openly discussed the challenges. They concluded that redundant communication was needed at every step of the patient care process. The challenge was making it easy, accessible, intuitive, meaningful, and effective. The administrative team partnered with patient access, ED, inpatient, pharmacy, rehab, and charge nurses to create a spreadsheet with all the necessary data points. The document, however, was unworkable as it was too busy and did not provide any way of measuring progress without having to number crunch. The team enlisted Hialeah’s emergency medical services liaison, who converted the spreadsheet into an application. While it required several modifications, the application ultimately proved intuitive and flowed to the levels of care and communication with documented proof of contact with the ALFs.

On November 1, 2023, Hialeah launched the “ALFI app,” and it continued to evolve, garnering the attention of the Debtors’ corporate office for the value it provided. With the application, Hialeah addressed fifteen to twenty percent of its patients four to five times during their admission, with constant communication with their ALFs, increasing the number of residents sent to Hialeah. Subsequently, the number of senior nursing facility patients admitted to Hialeah also increased. The ALFI app was ultimately integrated into Hialeah’s electronic medical records.

It is accessible as an icon on Hialeah's desktops, allowing staff to readily see all of the ALF patients and how communication to the ALF is flowing. Concerns have decreased, relationships have improved, and issues are quickly addressed. The positive impact of the ALFI app on patient care is a testament to Hialeah's collective efforts.