SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room

AGENDA
September 27, 2022

OPEN SESSION (4:30 PM – 4:35 PM)

The Board of Directors will call the meeting to order at 4:30 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 4:35 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:00 P.M. or via Zoom: https://svmc.zoom.us/j/85249774335

Call to Order/Roll Call

I. **Approval of Agendas**
Recommended Action: Approve/Disapprove the Agenda as Presented/Amended

The Board Chairman may limit each presentation so that the matter may be concluded in the time allotted. Upon request of any Board member to extend the time for a matter, either a Board vote will be taken as to whether to extend the time allotted or the chair may extend the time on his own motion without a vote.

II. **Adjourn Open Session and go into Closed Session**

CLOSED SESSION

As provided in the Ralph M. Brown Act, Government Code Sections 54950 et seq., the Board of Directors may meet in closed session with members of the staff, district employees and its attorneys. These sessions are not open to the public and may not be attended by members of the public. The matters the Board will meet on in closed session are identified on the agenda or are those matters appropriately identified in open session as requiring immediate attention and arising after the posting of the agenda. Any public reports of action taken in the closed session will be made in accordance with Gov. Code Section 54957.1

III. **Closed Session Business**

A. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report (Time Limit – 5 minutes)

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): (Time Limit – 5 minutes)

1. Evaluation – Quality of Care/Peer Review/Credentials

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – June 2023 (Time Limit – 20 minutes)

D. Pursuant to Gov. Code Section 54956.9(d) (2), Conference with Legal Counsel about significant exposure to litigation involving a matter of compliance; privileged communication (1 Item) (Time Limit – 10 minutes)

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (2 Items). Estimated Date of Disclosure – February 2023 (Time Limit – 10 minutes)

F. Pursuant to Gov. Code Section 54957(b): Discussion Pertaining to Personnel: Public Employee Performance Evaluation (2 Items) (Time Limit – 15 minutes)

G. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1Item)

To the extent items on the Closed Session Agenda are not completed prior to the scheduled time for the Open Session to begin, the items will be deferred to the conclusion of the Open Session Agenda.

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION

V. Closed Session Action Taken

Pursuant to Gov. Code Section 54957.1; Action(s) to be taken Pursuant to Closed Session Discussion

A. Chief of Staff Report
Recommended Action: Information only; no action taken

B. Quality Review

1. Evaluation – Quality of Care/Peer Review/Credentials
   Recommended Action: Approve/Disapprove

2. Quality Division Update –Quality Report
   Recommended Action: Approve/Disapprove

C. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken

D. Conference with Legal Counsel
Recommended Action: Information only; no action taken

E. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken

F. Discussion Pertaining to Personnel
Recommended Action: Approve/Disapprove

G. Conference with Legal Counsel about recent work product
Recommended Action: Information only; no action taken

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment.

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items

are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If discussion is requested by any Board member(s) or any member of the public on any item addressed during public comment, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. August 23, 2022 Minutes of the Regular Meeting of the Board of Directors
Recommended Action: Approve/Disapprove August 23, 2022 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **August 2022 Financials**
Recommended Action: Approve/Disapprove

B. **Single Audit**
Recommended Action: Information only; no action taken

C. **Tree of Angels Request**
Recommended Action: Approve/Disapprove

D. **09.27.2022 Fiduciary Responsibility Delegation Charter – Retirement Plan Administration Committee**
Recommended Action: Approve/Disapprove

E. **09.27.2022.01 Amending the Composition and Signature Authority of the Retirement Plan Administration Committee**
Recommended Action: Approve/Disapprove

F. **Capital Budget Quarter 3 and Quarter 4**
Recommended Action: Approve/Disapprove

G. **Conflict of Interest Code Review**
Recommended Action: Adopt Conflict of Interest Code

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
September 27, 2022

XI. Announcements:

A. Regular Board of Directors Meeting – October 25, 2022 at 4:30pm

B. Ethics Training

C. Anti-Harassment Training

XII. Adjournment

SPECIAL NOTICE

Pursuant to Executive Order N-25-20 signed by Governor Newsom on March 12, 2020, and in an effort to protect public health and slow the rate of transmission of COVID-19, Sierra View Local Health Care District is allowing for electronic public participation at Regular Board Meetings. Public comments may be submitted to wwatts@sierra-view.com and will be read aloud during Public Comments as applicable, for Board consideration. Members of the public are encouraged to submit comments prior to 4:00 p.m. the day of the meeting to participate in said meeting.

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 5:00 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

Materials related to an item on this agenda submitted to the Board after distribution of the agenda packet, as well as the agenda packet itself, are available for public inspection/copying during normal business hours at the Administration Office of Sierra View Medical Center, 465 W. Putnam Ave., Porterville, CA 93257. Privileged and confidential closed session materials are/will be excluded until the Board votes to disclose said materials.

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Senior Leadership Team	9/27/2022
Board of Director's Approval	
_____ Bindusagar Reddy, MD, Chairman	9/27/2022 Date

SIERRA VIEW MEDICAL CENTER-
CONSENT AGENDA
September 27, 2022
BOARD OF DIRECTOR'S APPROVAL

The following Polices/Procedures/Protocols/Plans have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:

	Pages	Action
Policies:		Approve ↓
1. Authority in the Absence of the V.P. of Patient Care Services	1	
2. Conflict of Interest Code (Compliance with the Political Reform act of 1974	2-9	
3. Continuity of Operations Plan	10-12	
4. Demotion of Position to New Position	13	
5. Diet Manual & Therapeutic Diet Menus	14-15	
6. Dietary Accountability to Administration and Medical Staff	16-17	
7. Fire Safety Ansul System R102 Wet Chemical Fire	18	
8. Food Preparation	19-20	
9. Food Purchasing and Receiving	21-22	
10. Food Service Cleaning and Sanitation	23-24	
11. Food Service Corrugated Cardboard Management	25-26	
12. Job Titles	27-28	
13. Managing Construction	29-30	
14. Meal Discount	31-32	
15. Meal Trays	33-35	
16. Performance Improvement – Food and Nutrition	36	
17. Pre-Construction Risk Assessment Program	37-38	
18. Salary Grades and Ranges	39-41	
19. Security Management Plan	42-52	
20. Utility Systems Management Plan	53-63	
21. Vertical Transport System Elevator PM	64	

SUBJECT:	SECTION:
AUTHORITY IN THE ABSENCE OF THE V.P. OF PATIENT CARE SERVICES	***Leadership (LD)***

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide for continuity of ultimate decision authority and accountability within the Division of Nursing.

POLICY:

1. The Vice President of Patient Care Services (VPPCS) / Chief Nurse Executive has overall responsibility, accountability, and authority for directing all matters pertaining to Patient Care Services, including staffing patterns and patient care.

2. In the absence of the VPPCS/CNE, a designee will be appointed by the VPPCS/CNE as "Acting Chief Nurse Executive" and will be consulted on all nursing administrative matters.

3. The House Supervisor on duty during the hours when members of the senior nursing leaders (CNE and nursing directors) are not present is considered to be in charge of the hospital.

4. In the absence of nursing department directors, each director will appoint a designee to assume responsibility for their respective area(s).

AFFECTED AREAS/ PERSONNEL: *DIVISION OF NURSING*

REFERENCES:

- The Joint Commission (-2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- State of California. (2014). California Administrative Code Title XXII, 70211(c).

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
CONFLICT OF INTEREST CODE POLICY

PURPOSE:

The Political Reform Act, Government Code section 81000 et seq., requires state and local government agencies to adopt and promulgate Conflict-of-Interest Codes. The Fair Political Practices Commission (FPPC) has adopted a regulation, Title 2, California Code of Regulations, section 18730, which contains the terms of a standard Conflict-of-Interest Code, which can be incorporated by reference, and which may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act after public notice and hearings. Therefore, the terms of Title 2, California Code of Regulations, section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, along with the attached appendices in which officials and employees are designated and disclosure categories are set forth, are hereby incorporated by reference and constitute the Conflict-of-Interest Code of Sierra View Local Health Care District (SVLHCD). This policy reflects the law ~~as of September 1, 2020~~, which is subject to updates and revisions. The information stated in this policy is a summary of applicable law and is intended to be a helpful guide, however may not entirely describe each possible circumstance or scenario that may occur.

POLICY STATEMENT:

In addition to the Conflict of Interest and Disclosure Code approved and adopted by the Board of Directors, attached hereto as Exhibit 1 and made a part of this policy, all board members, senior management, leaders of the organized medical staff and employees of SVLHCD shall seek to promote, enhance and protect the best interests of SVLHCD and to avoid taking any actions which may be adverse to the best interest of SVLHCD or our patients.

AFFECTED AREAS/PERSONNEL: *INDIVIDUALS AS MAY BE DETERMINED BY THE BOARD OR CEO.*

DEFINITIONS:

For the purpose of this policy, the following definitions apply:

The definitions contained in the Political Reform Act of 1974, regulations of the Fair Political Practices Commission (Regulations 18110, et seq.), and any amendments to the Act or regulations, are incorporated by reference into this Conflict of Interest Code.

Disclosing member : The persons holding positions on Appendix A of the Conflict of Interest Code. It has been determined that these individuals make or participate in the making of decisions which may foreseeably have a material impact on economic interests.

Immediate Family member: For purposes of this Policy, an "immediate family member" of a disclosing member shall include spouse, parent, grandparents, grandchildren, daughter, son, step-daughter, step-son, siblings, step-parents, mothers and fathers-in-law, brother-in-law, sister-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such person.

GUIDELINES:

Under the Act, a disclosing member has a disqualifying conflict of interest in a decision if it is foreseeable that the decision will have a financial impact on his or her personal finances or other financial interests. In such cases, there is a risk of biased decision-making that could sacrifice the public's interest in favor of the disclosing member's private

financial interests. To avoid actual bias or the appearance of possible improprieties, the disclosing member is prohibited from participating in the decision.

DISQUALIFYING FINANCIAL INTERESTS:

There are five types of interests that may result in disqualification:

- **Business Entity.** SVLHCD will follow 2 CCR§ 18702.1 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member has (1) an investment of $25,000 or more in a business entity and no ownership or control of the business entity or (2) an investment of $2,000 or more in a business entity in which he or she is a director, officer, partner, trustee, employee, or manager.

- **Real Property.** SVLHCD will follow 2 CCR § 18702.2 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member has an interest in real property of $2,000 or more including leaseholds. (However, month-to-month leases are not considered real property interests.)

- **Income.** SVLHCD will follow 2 CCR § 18702.3 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member has received income or promised income aggregating to $500 or more in the previous 12 months, including the disclosing member's community property interest in the income of his or her spouse or registered domestic partner from any individual or entity.

- **Gifts.** SVLHCD will follow 2 CCR § 18702.4 to determine if a material conflict exists. Generally, a conflict exists if the disclosing member and/or his or her immediate family has/have received gifts aggregating to $500 or more in the previous 12 months from any individual or entity.

- **Personal Finances. SVLHCD will follow 2 CCR §18702.5 to determine if a material conflict exists. Generally, a conflict exists if** the disclosing member's personal finances are positively impacted by a decision, including his or her expenses, income, assets, or liabilities, as well as those of his or her immediate family in an amount of $500 or more in a 12 month period.

DISQUALIFYING FINANCIAL IMPACT OR EFFECT:

If a decision may have a financial impact or effect on any of the foregoing interests, a disclosing member is disqualified from a decision if the following two conditions are met:

- The financial impact or effect is foreseeable, and

- The financial impact or effect is significant enough to be considered material.

Generally, a financial impact or effect is presumed to be both foreseeable and material if the financial interest is "explicitly" or directly involved in the decision. A financial interest is explicitly involved in the decision whenever the interest is a named party in, or the subject of a decision before the District.

If the interest is "not explicitly involved" in the decision, a financial impact or effect is reasonably foreseeable if the effect can be recognized as a realistic possibility and more than hypothetical or theoretical. A financial effect need not be likely to occur to be considered reasonably foreseeable.

However, for interests "not explicitly involved" in the decision, different standards apply to determine whether a foreseeable effect on an interest will be material depending on the nature of the interest. The FPPC has adopted rules for deciding what kinds of financial effects are important enough to trigger a conflict of interest. These rules are called "materiality standards," that is, they are the standards that should be used for judging what kind of financial impacts resulting from decisions are considered material or important.

There are too many materiality standards to adequately review all of them here. To determine the applicable materiality standard, or to obtain more detailed information on conflicts, a disclosing member may consult the FPPC's guide to Recognizing Conflicts of Interest. Alternatively, the disclosing member shall inform the Compliance Officer (CO) or designee that he/she may require assistance from the District's counsel or the FPPC anytime the disclosing member has reason to believe a decision may have a financial impact or effect on his/her personal finances or other financial interests.

PROCEDURE:

A. The Board of Directors of SVLHCD is vested with ultimate authority and responsibility to determine the applicability of this policy to any set of facts that may arise and to determine any steps that should be taken to correct a situation deemed not in the best interests of SVLHCD including, if deemed appropriate, disciplinary action.

B. The CO or designee of SVLHCD will annually notify the individual holding one of the positions listed in Appendix A of the Conflict Code of the need to complete the Fair Political Practices Commission Form 700, maintained in Administration. The CO or designee will monitor and review all responses from recipients. If the CO or designee finds that the facts set forth in any particular response give rise to a potential conflict of interest contrary to this policy, the CO or designee will forward all information relating to any such potential conflict, together with any recommended course of action, to the CEO and the Board of Directors.

C. Additionally, any individual in the described positions, in accordance with the Political Reform Act of 1974, is required to file a Conflict of Interest Statement within 30 days after assuming the position, annually during the month of March each year, and within 30 days of leaving the position. It will be the responsibility of the Human Resources Department to notify the CO when employees are hired or terminate their employment in these positions.

D. The Conflict of Interest Code of SVLHCD is reviewed biennially and the Local Agency Biennial Notice is filed with the Board of Supervisors, County of Tulare.

REFERENCES:

- The Political Reform Act, Government Code section 81000 et seq (1974). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=81000.
- Regulations of the Fair Political Practices Commission (Regulations 18110, et seq.) (August 2015). http://www.fppc.ca.gov/content/dam/fppc/NS-Documents/LegalDiv/Conflicts%20of%20Interest/Conflicts-Guide-August-2015-Jan-2016-Edits.pdf.
- Title 2, CA Code of Regulations, Sections 18702.1 to 18702.5 (1992). https://govt.westlaw.com/calregs/Document/I217C89F0849E45F4AB521DCF019F4F41?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default).

- Title 2, CA Code of Regulations, section 18730 (1992). http://www.fppc.ca.gov/content/dam/fppc/NS-Documents/LegalDiv/Regulations/Index/Chapter7/Article2/18730.pdf.

Exhibit 1: Conflict of Interest Code and Appendices

CONFLICT-OF-INTEREST CODE SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The Political Reform Act (Government Code §§ 81000 *et seq.*) requires local government agencies to adopt and promulgate a conflict-of-interest code. This code is designed to ensure that board members and employees of this agency do not engage in government decision-making in which the officer or employee may have a personal financial interest. In addition, board members and decision-making employees designated in the agency's code[1] are required to file periodic public statements disclosing their personal economic interests (Form 700).[2]

The Fair Political Practices Commission has adopted a regulation that contains the terms of a model conflict-of-interest code. Therefore, the terms of 2 Cal. Code of Regs., Section 18730,[3] and any amendments to it duly adopted by the Fair Political Practices Commission, are hereby incorporated by this reference and, together with the attached APPENDIX A (DESIGNATED POSITIONS), and APPENDIX B (DISCLOSURE CATEGORIES), constitutes the conflict-of-interest code of this agency.[4]

Persons serving in designated positions (APPENDIX A) shall file periodic disclosure statements (Form 700) with this agency, as required by law, and pursuant to notice from this agency's filing officer. The disclosure statements shall be retained by the agency for no less than seven years, and shall be made available for public inspection and reproduction upon request.

Adopted by Agency: Meeting Date: _____

Approved by Tulare County Board of Supervisors: Meeting Date: _____

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[1] Government Code section 82019

[2] Government Code section 87302(b)

[3] Copy of Regulation as of date of adoption of this code attached hereto for convenience.

[4] Agency also has a conflict of interest policy that applies to all employees, a copy of which (as of the date of adoption of this resolution) is attached hereto for convenience.

SIERRA VIEW LOCAL HEALTH CARE DISTRICT APPENDIX A LIST OF DESIGNATED POSITIONS

Designated Position	Disclosure Categories
Board Member	Full Disclosure
Chief Executive Officer / President	Full Disclosure
Chief Financial Officer	Full Disclosure
Vice President of Patient Care Services & Chief Nurse Executive (CNE) AND Chief Academic Officer & Founding Designated Institutional Officer (DIO)	Full Disclosure (excluding interests in real property)
Vice President of Professional Services and Physician Recruitment	Full Disclosure
Vice President of Human Resources	Full Disclosure (excluding interests in real property)
Vice President of Quality and Regulatory Affairs	Full Disclosure (excluding interests in real property)
Director of Financial Strategy and Contracts Administrator	General Contracting A
Admin Director of IT/Infrastructure/Project Management	General Contracting A
Director of Materials Management and Business Development	General Contracting A
Director of Environmental Services	General Contracting A
Director of Facilities	General Contracting A
Director of Pharmacy	General Contracting A
General Counsel	Full Disclosure
Consultant	Full Disclosure *

*Consultants/New Positions are included in the list of designated positions and shall disclose pursuant to the broadest category in the code, subject to the following limitations:
The Chief Executive Officer or his or her designee may determine in writing that a particular consultant or new position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with disclosure requirements in this section. Such written determination shall include a description, a statement of the consultant's or new position's duties and, based upon that description, a statement of the extent of disclosures requirements. The CEO's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code. (Gov. Code Section 81008.) See APPENDIX B – Conflict of Interest Code Disclosure Categories

SIERRA VIEW LOCAL HEALTH CARE
DISTRICT APPENDIX B
DISCLOSURE CATEGORIES

1. Full Disclosure

All interests in real property located entirely or partly within the District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interests or option to acquire such interest in real property.

All investments, business positions, and sources of income, including gifts, loans and travel payments. *Intended for board members and high-level decision-making employees with broad duties)*

2. Full Disclosure (excluding interests in real property)

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

3. Interests in Real Property (only)

All interests in real property located entirely or partly within this Agency's jurisdiction or boundaries, or within two miles of this Agency's jurisdiction or boundaries or of any land owned or used by this Agency. Such interest include any leasehold ownership interest or option to acquire such interest in real property.

~~3.~~4. General Contracting (two options)

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like, including training or consulting services, of the type utilized by the ~~District~~Agency.

(Intended for employees whose duties and decisions involve contracting and purchasing for the entire ~~District~~ Agency)

B. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like including training or consulting services, of the type utilized by the employee's department or ~~agency~~area of authority.

(Intended for employees whose duties and decisions involve contracting and purchasing for a specific department or ~~agency of the District~~)area of authority.)

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5. Regulatory, Permit or Licensing Duties

All investments, business positions, and sources of income, including gifts, loans and travel payments, from sources that are subject to the regulatory, permit or licensing authority of, or have an application for a license or permit pending before, the employee's department or agency, or the County.

6. Grant/Service Providers/Agencies that Oversee Programs (two options)

A. All investments, business positions, and sources of income, including gifts, loans and travel payments, or income from a nonprofit organization, if the sources is of the type to receive grants or other monies from or through the specific department or agency of the county.

(Intended for employees whose duties and decisions involve awards of monies or grants to organizations or individuals)

B. All investments, business positions, and sources of income, including gifts, loans and travel payments, or income from a nonprofit organization, if the sources is of the type to offer or provide consulting, rehabilitative or educational services concerning the prevention, treatment or rehabilitation of persons.

(Intended for employees who also approves programs for rehabilitation services)

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SUBJECT: **CONTINUITY OF OPERATIONS PLAN**	SECTION: *Emergency Management* **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The Continuity of Operations Plan (COOP) is an extension of the Emergency Operations Plan that assesses the hazards or risks that may have an impact on business functionality in order to deliver essential or critical services. The COOP will provide guidance on how Sierra View Medical Center (SVMC) will continue to provide essential business functions and deliver essential or critical services.

POLICY:

A. Sierra View Medical Center will provide a Continuity of Operations Plan that will be utilized during a disaster response. The COOP will be used as a guide for:

1. Identifying and prioritizing services and functions that are considered essential or critical to maintain operations.
2. Providing alternative locations for business functions when the location of essential or critical service has been affected due to a disaster.
3. Outline the order of succession when a particular leadership or management role is unable to fulfill their function or duties.
4. Identify the delegation of authority for individuals to act on behalf of the hospital.
5. Recovery and return to normal operations.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS*

EQUIPMENT: N/A

PROCEDURE:

A. Activation & Relocation

1. The Chief Executive Officer (CEO) or HICS Incident Commander (IC) will determine full or partial COOP based on the severity of the event and level of threat.
2. Upon activation of or notification to activate the hospital's COOP, telephone, e-mail and other methods of communication designed by the hospital will be used to notify staff.
3. In all situations allowing for an alert, staff, Tulare County Health and Human Services, California Department of Public Health (CDPH), Central California Healthcare Coalition (CCHCC) and other key partners will be notified.
4. Relocation due to a partial or full evacuation will follow procedures found in the Evacuation Procedures policy and the Emergency Operations Plan.
5. Instructions for augmentation of staff can be found in the Authorization for Volunteer Caregivers During Disasters policy.

B. Alternate Facility Operations

1. Interoperable communications, or the ability for Sierra View Medical Center to communicate with individuals internal and external to the facility network is critical

during emergencies. Access to critical information systems that are used to accomplish essential functions during normal operations from the hospital should be assured at the alternate work site. The communication capabilities of the hospital can be found in the Disaster Communications policy.

2. Sierra View Medical Center will maintain the safety and security of medical records during an emergency and has the following policies in place to ensure this: Medical Records Security During Evacuation Procedures, Medical Records During a Mass Casualty Event and Medical Records Destroyed By Man-Made or Natural Disasters.
3. If relocation to an alternate worksite is necessary, the Director of Health Information Management (HIM) will ensure the needed equipment and records are transferred to the alternate worksite. Additional support may be needed from the hospital's Information Technology (IT) department.
4. Sierra View Medical Center's IT department will ensure that connectivity will exist at the alternate worksite and will provide systems and technical supports during a COOP activation.

C. Leadership

1. Order of succession for Senior Leadership is as follows:
   - **Chief Executive Officer** > Chief Financial Officer > Chief Nursing Officer
   - **Chief Financial Officer** > Admin Director of Revenue Cycle > Director of General Accounting
   - **Chief Nursing Officer >** Director of Acute Care and Nursing Excellence > Director of Surgical Services
   - **Vice President of Professional Services** > Admin Director of General Services > Admin Director of Imaging
   - **Vice President of Quality & Regulatory Affairs** > Director of Risk Management > Director of Care Continuum
   - **Vice President of Human Resources** > Human Resources Manager > Director of Marketing

   Sierra View Medical Center also maintains an updated Administrator on Call (AOC) list that is shared with hospital leadership.

2. Delegation of authority for Sierra View Medical Center would be scenario driven and would be found in the Shared Governance and Management Authority and Responsibility Matrix policy and the Purpose and Authority policy.

D. Recovery

1. Once the CEO or Incident Commander has determined that the emergency situation has ended and is unlikely to reoccur they will issue a COOP termination. Any plans to salvage, restore and recover the impacted facility will initiate upon approval from applicable local, state and federal emergency service authorities.
2. Sierra View Medical Center will follow the procedures identified in the Recovery From Disaster Response policy.

3. Once Sierra View Medical Center has returned to full normal operations, an After Action Review (AAR) will be conducted. The information will be used to improve the COOP during its annual review.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. EM.13.01.01 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **DEMOTION OF POSITION TO NEW POSITION**	SECTION: ***Human Resources*** **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

Sierra View Medical Center (SVMC) may at times need to reassign an employee to a position with lesser responsibilities, authority and overall impact on the organization as measured by their performance or business needs of the hospital. The employee's compensation will be adjusted to reflect work being performed if demoted to another position.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

Demotion means the reassignment of an employee from their current position to a new position with lesser duties, responsibilities, and authority. The employee will then move to a position with a lower pay grade assignment whether the personnel action is for performance or non-performance reasons related to the business needs of the hospital.

Compensation will be reduced by the amount necessary to maintain the same relationship to the minimum of the new salary range.

If the employee returns to his or her previous job assignment, the salary should not be reduced to an amount lower than the employee's original salary in that job.

The annual review date changes upon demotion. The new review date will be the effective date of the demotion. The employee's performance in the new position will be reviewed at ninety (90) days and then again at his or her next new annual review date.

Downgrade means the assignment of an employee to a lower pay grade based on reduced responsibilities or the restructuring of job duties in lieu of a new position.

The employee's salary shall be reviewed with the Human Resources department to set the appropriate salary in the new pay range.

REFERENCES:

- Equal Employment Opportunity Commission. Usa.gov (n.d.). Retrieved from https://www.usa.gov/federalagencies/equal-employment.
- DFEH | Department of Fair Employment & Housing (n.d.). Retrieved from https://www.dfeh.ca.gov.

CROSS REFERENCES:

- SALARY GRADES AND RANGES
- PERFORMANCE ACCOUNTABILITY AND COMMITMENT

SUBJECT: **DIET MANUAL & THERAPEUTIC DIET MENUS**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish a standard for therapeutic diets and non-therapeutic diets.

POLICY:

A current therapeutic diet manual is used for standardization of the diet orders, defining diets, and planning diets. The therapeutic diet manual must be approved by the dietitian and the medical staff. The publication or revision date of the approved therapeutic diet manual must not be more than five (5) years old. The therapeutic diet manual is available to all medical, nursing and food service personnel.

AFFECTED AREAS/PERSONNEL: *FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS*

DEFINITIONS:

Therapeutic diets: A diet ordered as part of the patient's treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

PROCEDURE:

1. The Clinical Nutrition Manager (CNM) will review the therapeutic diet manual annually.
2. The therapeutic diet manual will be updated a minimum of every five (5) years.
3. The CNM, Pharmacy & Therapeutics Committee, Medical Executive Committee (MEC) and the CEO/Board of Directors will approve the manual.
4. A diet manual is available for viewing on Sierra View Medical Center (SVMC) Employee Portal under "Nutrition Links" Sierra View Clinical Diet Manual and SVMC Interpretation of Diet Services will serve as a reference for medical and nursing personnel when ordering hospital-specific diets.
5. A hard copy of the therapeutic diet manual is kept in the Food & Nutrition Service (FNS) office and in the dietitian office. This serves as a guide for food service staff for special diet food preparation.
6. The nutritional adequacy is based on weekly average of each nutrient. Menus are designed to meet nutritional requirements specified in accordance with the Dietary Reference Intake (DRI) from the Food and Nutrition Board, Institute of Medicine, and National Academies of Science's guidelines. Nutritional adequacy is referenced to a male of 51-70 years of age, unless otherwise specified.
7. Any modified diets not outlined in the diet manual will be transcribed by the dietitian(s), using reputable nutrition references.
8. Due to limitations within the nutrient database, not all micronutrient values are available. Every effort will be made for adequate provision of these micronutrients.

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Centers for Medicare & Medicaid Services. State Operations Manual (Rev. 200, 02-21-20). A-0629 §482.28(b)(1). Retrieved from https://www.cms.gov/media/423601.

SUBJECT:	SECTION:
DIETARY ACCOUNTABILITY TO ADMINISTRATION AND MEDICAL STAFF	**Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

This policy shall delineate responsibilities for Food & Nutrition Service (FNS) Department. The FNS Director and/or the Clinical Nutrition Manager (CNM) will supervise food service operations.

POLICY:

The FNS Director and CNM are responsible to the Sierra View Medical Center (SVMC) administration & medical staff to uphold the standards, where applicable, for all federal, state and local regulatory agencies.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, ADMINISTRATION, MEDICAL STAFF*

PROCEDURE:

1. Under the direction of the FNS Director, the CNM is responsible for:

   a. Planning, coordinating, and managing patient/resident nutritional care activities complying with federal, state and local regulatory standards established by SVMC, regulatory agencies, and the patient/resident/customer.

   b. The CNM will collaborate with the FNS Director in monitoring patient food service to ensure the provision of high quality, nutritious food prepared in accordance with diet modification(s).

   c. The CNM will attend meetings between the FNS Director and Administration and assigned meetings as required.

   d. The CNM will provide written reports as required by Administration.

   e. The CNM will participate on any committees as required by administration, medical staff and any federal, state or local regulatory agency.

   f. The CNM will provide food in the quantity and quality to meet the nutritional needs of the patient in accordance with the physician's diet order, and provide a comprehensive nutrition care program including food and nutrition therapy in a timely, effective and efficient manner. The nutrition care program is integrated with nursing and other appropriate disciplines, as needed.

2. In compliance with A-0620, §482.28, the FNS Director shall be a full-time employee who is granted the authority and delegated responsibility by SVMC's governing body and medical staff for the operation of the FNS department. The authority and delegated responsibility includes the daily management of food service, implementing training programs for FNS staff and assuring the established policies and procedures are maintained that address at least the following:

   a. Safety practices for food handling.

   b. Emergency food supplies.

   c. Orientation, work assignments, supervision of work, and personnel performance.

   d. Menu planning, purchasing of foods and supplies, and retention of essential records.

   e. Service Quality Assurance & Performance Improvement (QAPI) program

   f. Plan, prepare and manage the Department's budget.

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
FIRE SAFETY ANSUL SYSTEM R102 WET CHEMICAL FIRE	**Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To outline preventative maintenance schedules for the fire suppression system and cleaning schedules for the exhaust ducts system.

POLICY:

Inspection and servicing of the kitchen hood fire extinguishing system, Ansul R102 Wet Chemical Fire, will be conducted by qualified personnel semi-annually. The grease exhaust duct system will be cleaned and chemically treated to retard the accumulation of grease quarterly. The manual pull stations will be inspected monthly to ensure the ring and tiepins are properly secured.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, ENGINEERING*

PROCEDURE:

1. The Engineering Department will perform preventative maintenance and inspect all actuation components, including the remote manual pull stations and actuators, etc., for proper operation using the manufacturers listed procedures.

2. The Engineering Department will inspect fusible links and automatic sprinkler heads at least annually to assure proper operation of the system. In addition, they will visually inspect the control cylinders and pressure gauges to determine if cylinders have been activated and assure no falling weights may activate the tension cable.

3. A contracted company will clean hoods, grease removal devices, ducts, and other apparatus and coat them with an approved fire retardant material. At no time will flammable solvents be utilized for cleaning.

4. Food service employees will clean hoods and vents a minimum of weekly. At no time will flammable solvents be utilized for cleaning.

5. In the event of the Ansul system failure, manual fire extinguishers will be utilized.

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance.

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **FOOD PREPARATION**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish safe principles for food preparation.

POLICY:

Employees will prepare food in a clean and safe manner to protect patients, residents, staff and visitors from food borne illness. Employees will prepare foods by methods that conserve nutrients, enhance flavor and maintain attractive appearance.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. Foods must be defrosted from the freezer using proper thawing methods. Frozen foods will be thawed under refrigeration. When frozen food needs to be thawed expeditiously, food may be thawed in a clean sink under running potable water.

2. The use of latex gloves is prohibited in food facilities and retail food establishments. Food employees shall use non-latex utensils, including scoops, forks, tongs, paper wrappers, gloves, or other implements, to assemble ready-to-eat food or to place ready-to-eat food on tableware or in other containers.

3. Single-use gloves shall be used for only one task, such as working with ready-to-eat food or with raw food of animal origin, used for no other purpose, and shall be discarded when damaged or soiled, or when interruptions in the food handling occur. Employees will wash hands and change gloves after any source of possible contamination.

4. Foods will be cooked to minimum temperature or greater:

   - Poultry/Ground Poultry 165°F
   - Casserole Dishes 165°F
   - Ground Meat & Eggs 155°F
   - Pork, Beef, Veal, Lamb 145°F
   - Fish 145°F
   - Vegetables & Grains 135 °F

5. Foods which are prepared and not served on the day of preparation will be cooled from 140°F - 70°F within two (2) hours and from 70°F - 41°F within the next four (4) hours, with a total cooling time not to exceed 6 hours. Foods that have not cooled to these guidelines must be

reheated to 165° and the cooling process repeated. If product does not meet the criteria on the second attempt, food must be discarded.

6. To cool food rapidly, leave all or partially uncovered during cooling period, separate food into smaller portions, place foods in shallow pans and place foods in refrigerator or use ice bath and stir frequently. Food may also be placed in the freezer for a short period of time.

7. Foods which are prepared and not served on the day of preparation are to be stored appropriately, covered, clearly identified and dated with the date of preparation. These foods will be used within 2 days.

8. All foods reheated will be heated to a minimum of 165°F. Foods may only be reheated once.

9. All hot foods will be held at 140°F or above. Cold foods will be held at 41°F or below.

10. All eggs will be pasteurized.

REFERENCES:

- California Retail Food Code. Revised January 2022
- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **FOOD PURCHASING AND RECEIVING**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To be utilized as guidelines for all purchasing and receiving food and supplies for the Food and Nutrition Service (FNS) Department.

POLICY:

All food items shall be purchased from reliable vendors that meet regulations specified by federal, state, and local health care agencies. Only high quality food products will be accepted when receiving deliveries.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. All food items shall be purchased from a reputable vendor.
2. All dairy and egg products shall be pasteurized.
3. Special request food items shall be purchased from a local supermarket.
4. Special nutritional supplements are purchased from a reputable vendor.
5. The quantity of foods shall be purchased to meet inventory and the planned menus' needs.
6. At the time of delivery, the food items shall be checked for accuracy against the invoice. Only quality food will be received. Products deemed unsatisfactory will be refused and returned for credit.
7. Items requiring refrigeration or those that are frozen will be put away immediately.
8. Dry storage items will be put away as soon as possible.
9. All empty boxes, crates and other packaging shall be disposed of immediately to eliminate potential harboring places for vermin. Original product packaging shall be retained for lot and manufacturing information identification needed for recall items.
10. Invoices are processed and sent to accounts payable weekly for payment.

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/regulations-and-guidance/regulations-and-guidance.html.

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- Food and Drug Administration (2022). Retail Food Protection. Retrieved from https://www.fda.gov/food/retail-food-protection/fda-food-code.

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SUBJECT: **FOOD SERVICE CLEANING AND SANITATION**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the protocol for clean and sanitary conditions in all Food and Nutrition Service (FNS) areas.

POLICY:

The FNS areas are maintained in a clean and sanitary condition. Assigned cleaning schedules will be posted in the kitchen.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, ENGINEERING DEPARTMENT, PATIENT CARE AREAS*

PROCEDURE:

1. FNS areas are kept clean and free from litter, rubbish and are protected from rodents, roaches, flies and other insects.

2. Utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas.

3. Plastic ware, china and glassware that are unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze are discarded.

4. Ice used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. Preventative maintenance for the ice machines are performed by the Engineering Department according to manufacturer's guidelines.

5. Kitchen waste not disposed of by mechanical means are kept in leak proof, nonabsorbent, tightly closed containers and are disposed of as frequently as necessary to prevent a nuisance, odor or unsightliness.

6. Cleaning schedules will be posted on the dry storage room door. FNS staff will initial upon assigned cleaning task completion. The FNS Director or designee will routinely check cleaning schedules and kitchen cleanliness.

7. Detailed cleaning will not be performed during food preparation and service periods.

8. Cleaning solutions are used in the proper concentration and dilution. All second container chemical spray bottles will be labeled with the manufacturer's label.

REFERENCES:

- California Department of Public Health (2021). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2021). Retrieved from https://www.cms.gov/Regulations-and-Guidance.

- The Joint Commission (2021). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **FOOD SERVICE CORRUGATED CARDBOARD MANAGEMENT**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose for this document is to define procedures for management, use and storage of corrugated cardboard boxes in the Food & Nutrition Service (FNS) department.

POLICY:

Food and supplies are purchased, received and stored in accordance to regulatory standards to maintain optimal nutritional composition and prevent all sources of contamination. FNS assures that all food and supplies are stored in accordance with the Food & Drug Administration (FDA) guidelines recommended for cardboard containers.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PATIENT CARE AREAS, PHYSICIANS, VOLUNTEERS*

PROCEDURE:

1. To retain information such as manufacturer's production data, expiration dates, ingredients and other vital information required for product recall, food and supplies are stored in the original cardboard packaging in compliance with the FDA 3-201.11; *21 Code of Federal Regulations (CFR) 101, 9 CFR 317*, unless original cardboard packaging is compromised.

2. Food & supply pallets are transferred directly from the delivery truck to the hall adjacent to the kitchen to be disassembled. Perishable items are delivered to appropriate areas within the kitchen. Shelf stable supplies are delivered to the storage room or staged in the hall adjacent to the kitchen area until time permits for appropriate storage. At no time are food and supplies left unattended on the external loading dock.

3. Products are rejected at delivery when packaging is compromised and easily assessed visually. All compromised cardboard packaging discovered subsequent to delivery exhibiting potential pest damage is removed immediately from the kitchen to eliminate potential pest propagation.

4. The storeroom is an integral part of the kitchen design and opens directly to the food preparation area. The storeroom is in close proximity to the delivery area. It has sufficient light and ventilation, and is of solid construction to discourage rodent and insect access. The storeroom is maintained at a comfortable temperature.

5. The storeroom floor, shelves and adjacent areas are cleaned and monitored daily. Sierra View Medical Center maintains a contracted pest control company. The pest control company monitors the kitchen areas monthly at a minimum and is available anytime for consultation.

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance

- The Joint Commission (2022). Hospital accreditation standards. LD.04.01.01., IC.02.02.01 EP 4. Joint Commission Resources. Oak Brook, IL.

- Food and Drug Administration 2022. FDA Food Code Version 2017 https://www.foodsafety.gov/keep/foodkeeperapp/index.html.

- Code of Federal Regulation 1011. CFR 21 CFR 101. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=101.

SUBJECT: **JOB TITLES**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide a concise and consistent method of developing job titles that reflects the appropriate responsibilities of all positions.

POLICY:

Human Resources shall maintain a current index of approved job titles to support the following activities:

- Salary administration - Salary grade and range structure
- Electronic reporting - Position control

The job code dictionary table will house each job title and each job code is assigned to a position number which makes up the department number and the job code.

Primary job titles shall represent the functional nature of the incumbent's position for which the employee works the majority of hours. Secondary job titles may be assigned as appropriate.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

Approval process for the introduction of new job titles or changed titles shall occur through the use of an electronic Position Control Form.

The Vice President for the incumbent's position approves the electronic Position Control Form for the purpose of this policy.

Job titles shall be standardized between work units and department whenever practical and will be managed through Human Resources.

Titling changes normally reflect increased or decreased responsibilities associated with revision of the corresponding position description.

New titles reflect organizational change, the introduction of new services or new job functions and are always accompanied with a new position description and competencies.

Secondary job titles are assigned when employee(s) are qualified to work in other positions that are not the majority of hours worked on a regular basis. For non-exempt staff, it is permissible to pay different rates of pay for different job titles.

Overtime will be paid according to Fair Labor Standards Act (F.L.S.A.) Please refer to the Overtime Policy. For exempt employees working in a secondary non-exempt position, please refer to the Exempt Staff Working Extra Shifts Policy.
Vacation/Holiday and Sick leave will be paid at the primary position's base rate of pay.

Should the employee work the majority of hours in his/her secondary position over a period of one year, the Director is responsible for submitting the proper electronic change notice, moving the secondary position to the primary.

Job titles are eliminated or inactivated when employee(s) are no longer assigned or occupying the title or positions are no longer budgeted. The Leader of the position approves the inactivation of the job title.

REFERENCES:

- California Public Sector Employment Law | Download Ebook. (n.d.) Retrieved from https://www.e-bookdownload.net/search/california-public-sector-employment-law.
- Fair Labor Standards Act of 1938. (Revised May 2011). Retrieved from https://www.dol.gov/whd/regs/statutes/fairlaborstandact.pdf.

CROSS REFERENCES:

- OVERTIME
- SALARY GRADES AND RANGES

SUBJECT:	SECTION:
MANAGING CONSTRUCTION	*Safety Management*
	Page 1 of 2

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing safe, effective care to our patients at all times. During construction and renovation activities, there are a number of issues that must be addressed by administrative, clinical, facilities management, project planning, and management staff to assure a safe and secure environment for all patients, visitors, physicians, staff and the general public during construction and renovation of the facilities.

POLICY:

All projects will be designed to promote better care for the patients and an increased safe environment for staff, physicians and the general public. Each project will be managed to ensure that the potential impact or disruption to patient care areas and the caregiver is kept to a minimum. Every effort will be used to minimize disruption of the construction process, but, in all cases, patient care considerations will have the highest priority. Patient care quality and patient safety will not be compromised.

During design and construction, or renovation, the appropriate guidelines and regulations will be followed, including, but not limited to, Guidelines for Design and Construction of Healthcare Facilities, 2014 edition, published by the American Society for Healthcare Engineering. All appropriate state and local regulations will be followed, including obtaining all permits, licenses and approvals and maintaining compliance with relevant regulations. Each proposed project will be carefully reviewed initially and at various phases to ensure the proper design, engineering, and construction methods are followed. In addition, any unique problems requiring special consideration during construction will be discussed and mitigation strategies will be developed to minimize the disruption to the care environment.

The organization's Master Plan and each Project Construction Plan must include a Pro Active Risk Assessment, including a Pre-construction Risk Assessment, developed to minimize the impact of construction on patient care, staff safety, and business operations. The Pre-Construction Risk Assessment will cover air quality, infection control, noise, vibration, utility systems, and emergency preparedness with Interim Life Safety Measures. The risk assessment process will be repeated as often as necessary to assure effective management of the issues listed and conducted by individuals with expertise and experience in each area.

Sierra View Medical Center is accredited by the Joint Commission. The Joint Commission requires documentation of the risk assessment, the plans developed to manage the impact of construction, and implementation of the plans. The facility will document compliance with the programs elements. Appropriate training will be provided to the staff involved, associated with, or adjacent to the project. Training will also be provided to all contractors to ensure all construction workers are appropriately trained in safety issues associated with the project and hospital policy.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

REFERENCES:

- The Joint Commission (2021). Hospital Accreditation Standards. EC.02.01.01. Joint Commission Resources. Oak Brook, IL.
- Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals, 2018 Edition.
- Office of Statewide Health Planning & Construction Facilities Development Division, CA. Title 24.
- California Department of Public Health CA. Title 22.
- Infection Control Construction Permit process
- Contractor's Handbook Training Program
- Construction Risk Assessment Program
- Construction "Safety Permit" Program

CROSS REFERENCES:

- Interim Life Safety (LSM) Policy

SUBJECT: **MEAL DISCOUNT**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish meal discount guidelines for personnel working.

POLICY:

Personnel who are working and wearing their Sierra View Medical Center (SVMC) badge will receive a meal discount when eating food from the café or coffee corner. The Food and Nutrition Service (FNS) Director is responsible to monitor department costs and present meal cost analysis to the Senior Leadership Team.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PHYSICIANS, VOLUNTEER LEAGUE, ON SITE SECURITY GUARDS & STUDENTS*

PROCEDURE:

1. Personnel must be wearing their SVMC badge and be on duty to receive discounted meal prices. Regular pricing will apply to employees without their badge and/or who are off-duty.

2. Items eligible for discount are established by the FNS Department, and pre-set and maintained in the Point of Sale (POS) computer software system.

3. Personnel (including, but not limited to, hospital staff, physicians, volunteers, security guards and students) are eligible for meal discounts.

4. Complimentary coffee and brewed tea made in the Café is provided for all personnel on duty at no charge.

5. Physicians in the emergency department, hospitalists, intensivists, volunteer league members and food service personnel are eligible for complimentary (free) meals. Convenient food items such as chips, energy drinks, bottled beverages, etc. are excluded and must be purchased. One meal per four (4) hour shift is permitted.

6. The café will charge for all to-go containers.

7. The café offers fountain soda refills with proof of receipt for the same day.

8. An appropriate charge for condiments and disposable products will be charged for customers utilizing these products for foods purchased off-site.

9. Bulk food purchases have the potential to deplete prepared food supplies for staff, visitors, physicians and volunteers working and will not be permitted.

10. Discounted pricing applies to personnel as specified above, and may not be extended to friends or family of qualifying personnel.

11. With the assistance of the FNS Director, the Senior Leadership Team will review meal cost analysis a minimum of annually and adjust prices as necessary.

SUBJECT: **MEAL TRAYS**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose of this policy is to establish the processes by which meal trays are ordered, prepared and delivered.

POLICY:

Meal trays for patients are prepared and served in accordance with the physician diet order. A minimum of three (3) meals are served daily with no more than fourteen (14) hours between the dinner meal and the breakfast meal. Patient tray line begins at 0700, 1130 and 1700.

AFFECTED PERSONNEL/AREAS: *FOOD & NUTRITION SERVICE (FNS), NURSING, PATIENT CARE AREAS*

PROCEDURE:

1. All food is prepared in the kitchen and served in accordance with the patient's diet order as determined by the physician.

2. Trays are appropriately identified with the patient's name, room number and diet order. Assembled trays are checked by the diet aide for accuracy.

3. FNS personnel transport trays to the patient units in enclosed or covered food carts. On the occasion trays are transported in open carts, all food items not under a protective dome are covered with plastic wrap or other type of covering.

4. Utilizing two (2) patient identifiers, FNS personnel distribute, retrieve and record meal trays for the acute care patients. Skilled nursing staff distributes, retrieve and record meal trays for long term care patients.

5. Prior to being served to the patient, nursing compares trays against the diet census sheet to assure patients are receiving the diet as ordered.

6. Isolation trays will be sent on re-usable dining wares unless otherwise specified by the physician order, nursing, or the FNS Director. Isolation trays will be delivered into, and retrieved from, the patient room by nursing staff, and will be cleaned by FNS using proper sanitation and disinfection procedures.

7. Patients placed on a "NPO" (nothing by mouth) tray hold will not receive a tray. The NPO order will be communicated through the electronic medical record system. A call will be placed to FNS for any NPO tray holds that occur within a half hour of meal periods.

8. Nursing will request a late tray for all patients admitted after the scheduled meal periods. A tray with hot food will be sent upon request when available. Hot food is available 0700-0930, 1130-

1400 and 1700-1900. Cold sandwiches are available from the kitchen between meal service and until 2000.

9. Nourishment rooms located on each unit have food available at all times for all patients.

10. Courtesy trays will be provided to breastfeeding mothers, one parent of a pediatric patient, caregivers of developmentally disabled patients and law enforcement officers assigned to guard a patient. Meals provided will be the same as the non-select regular diet for patients. The FNS director, nursing unit supervisor or dietitian will approve any exceptions.

11. Special lunch meals will be served on Thanksgiving Day and Christmas Day.

12. FNS personnel are responsible for recording meal intake. Nursing staff are responsible for recording meal intake if they remove the tray from the room. The percentage is determined according to the point system (information included in this policy).

PERCENTAGE MEAL/SNACK INTAKE - POINT SYSTEM

PERCENTAGE OF MEALS CONSUMED

Tray Items→		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
→	1	100	50	33	25	20	17	14	13	11	10	9
P	2	----	100	67	50	40	33	29	25	22	20	18
O	3	----	----	100	75	60	50	43	38	33	30	27
I	4	----	----	----	100	80	67	57	50	44	40	36
N	5	----	----	----	----	100	83	71	63	56	50	45
T	6	----	----	----	----	----	100	86	75	67	60	55
	7	----	----	----	----	----	----	100	88	78	70	64
T	8	----	----	----	----	----	----	----	100	89	80	73
O	9	----	----	----	----	----	----	----	----	100	90	82
T	10	----	----	----	----	----	----	----	----	----	100	91
A	11	----	----	----	----	----	----	----	----	----	----	100
L												

13. Points given for food/drink consumed (do not include coffee, tea, or water.):

    a. Less than ¼ - no point is given.

    b. ¼ to ½ - ½ point is given.

    c. ¾ or more - 1 point is given.

14. Process:

a. Visually inspect the patient's tray and add up the total number of food items on the tray.

b. Add up the points for the food eaten using the above guidelines. Round up to the next whole number if ½ or higher.

c. Use the chart to determine the meal percentage.

d. Document the percentage in the electronic medical record (EMR).

Examples:

Mr. Doe has the following items on his dinner tray: Coffee, juice, roast beef, mashed potatoes, carrots, salad, roll, dessert

- *Total number of items to count for meal %: 7 (The coffee does not count.)*
- *He consumes: ½ coffee, ½ potatoes, ¼ of salad, all of the beef, juice, carrots, and roll.*
- *Total points = 5*
- *Meal % = 71%*

REFERENCES:

- California Code of Regulations (2022). Title 22. § 70273(a)
  Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). 482.28(b)(2). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2022). Hospital accreditation standards. PC.02.01.03. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PERFORMANCE IMPROVEMENT - FOOD AND NUTRITION**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish protocol for measurable performance improvement.

POLICY:

The Food and Nutrition Service (FNS) Department demonstrates a consistent endeavor to deliver clinical care and food service that is optimal with available resources and consistent with achievable goals. In order to reach optimal service, the FNS department participates in the hospital performance improvement program. The program is designed to enhance clinical care and food service through the ongoing objective assessment of important aspects of FNS and the correction for improvement of the identified problems.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. The FNS Director and Clinical Nutrition Manager (CNM) are responsible for quality assurance /performance improvement (QAPI).

2. The FNS Director and/or CNM will identify QAPI opportunities, determine desired results, and develop measurable goals for resolution.

3. The collected data results will be presented to the Performance Improvement/Patient Safety Committee at least annually.

REFERENCES:

- California Department of Public Health (2022). Retrieved from https://www.cdph.ca.gov.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2022). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html.
- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PRE-CONSTRUCTION RISK ASSESSMENT PROGRAM**	SECTION: ***Safety Management*** **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To maintain a risk free environment during construction, renovation or demolition and continue to provide quality patient care services and a comfortable and safe environment for patients, staff, physicians and visitors.

POLICY:

Sierra View Medical Center (SVMC) is committed to protecting the health and safety of patients, staff, and visitors at all times. During construction, renovation and demolition, there are a number of issues that must be addressed by administrative, clinical, and facilities management staff. Appropriate members of the Sierra View Medical Center staff, will assess the potential impact of each construction, renovation, or demolition project on the ability of Sierra View Medical Center to meet the needs of patients and caregivers. The risks identified will be used to develop a plan designed to minimize disruption of Sierra View Medical Center patient care services and risks to Sierra View Medical Center patients, staff, physicians and visitors. Every effort will be made to minimize disruption related to the construction process. However, in all cases, care considerations will have the highest priority. Sierra View Medical Center will not compromise patient care quality or patient safety.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

PROCEDURE:

When demolition, renovation, modification, or other construction activities are planned, a team of qualified members selected from contractors, sub-contractors, Sierra View Medical Center safety, risk management, security, project management staff, infection control staff, and appropriate clinical department staff will assess the impact of the work on Sierra View Medical Center operations.

The assessment will consider the potential impact for the following:

- It will evaluate the potential disturbance from dust that could cause respiratory irritation, infections, or expose anyone to environmental hazards such as asbestos or hazardous chemicals.
- It will evaluate the impact of air quality from materials used in the construction process.
- It will evaluate the noise and vibration associated with construction operations and the potential for impact on the ability to provide patient care or perform normal business functions.
- It will evaluate the potential for disruption of utility services and communication systems.
- It will evaluate the impact on fire and life safety.

- It will evaluate the impact on Sierra View Medical Center security program and systems.
- It will evaluate the impact on emergency services. Each project will be carefully reviewed to determine if there are unique problems requiring special consideration during construction.

The risk assessment will be used to develop plans to minimize impact of construction on patient care and business operations of Sierra View Medical Center. In addition, appropriate emergency response procedures will be developed. The risk assessment process will be repeated as often as necessary to assure effective management of the issues listed throughout the life of each project, from the design phase up to and including the time of completion (occupancy & operation).

The Joint Commission required documentation of the risk assessment, the plans developed to manage the impact of construction, and implementation of the plans shall be maintained and readily available within the Engineering Services office. Regular reporting of all project assessments and ongoing activities will be communicated to the Safety Committee.

Sierra View Medical Center staff and contractor representatives will participate in the documentation of the compliance. Contractors are required to participate in the assessment, implementation, monitoring and enforcement of the plans. Contractor participation may include training of construction workers, supplying specialized equipment to create and maintain safe environmental conditions, monitoring construction staff behavior, enforcing safe work practices and maintaining diligent assurance of all necessary records and documentations.

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. EC.02.06 05 EP 2-3 Joint Commission Resources. Oak Brook, IL.
- Infection Control Permit
- Contractor's Handbook
- Hot Work Permit
- Project Risk Assessment Tool

SUBJECT: **SALARY GRADES AND RANGES**	SECTION: *Human Resources* **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the manner in which Sierra View Medical Center (SVMC) administers salary. This includes the assignment of wage pay grades and salary ranges which are established and administered for all positions at SVMC.

POLICY:

To ensure the fair and consistent practice of administering rates of pay, all non-exempt and exempt positions are classified into one of a series of pay grades and salary ranges.

Pay Grades –Jobs of approximate equal value, as determined by job content and evaluation methods, are grouped together. Pay grades are established as a tool for organization and management of the wage administration system.

Salary Ranges – Structures containing a reference to wage minimums and maximums for the pay grade. An employee's actual base hourly rate of pay falls within the salary range for their job classification. Employees shall not be paid less than the pay range minimum or more than the pay range maximum.

Wage Tiers – A one-dimensional expression of an actual base hourly rate of pay with no minimum or maximum wage range. Salaried tiers are not expressed as a salary range, and therefore their job titles are not listed with a grade and range reference. Tier wage structures are listed independently for grouping like positions.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES/CONTRACTORS*

PROCEDURE:

Comparison with wage surveys throughout the year ensures competitiveness and external equity for pay ranges and tiers. At times, market conditions may indicate a need to increase pay grades and tiers for certain positions.

SVMC shall participate in the California Hospital Association's (CHA) annual compensation survey and use published results to determine external wage competitiveness when appropriate. Comparative wage surveys from professional organizations may be used for job classifications that are not surveyed by the CHA. The Human Resources department shall direct the participation of the survey process. Specific external market conditions may require more frequent analysis for specific job classifications when responding to unusual market or staffing situations.

WAGE STRUCTURE:

1. The District maintains wage pay grades and salary range structures, defined as salary range minimums, midpoints and maximums. Individual positions are benchmarked to equivalent

salary grades reported by CHA's annual management and non-management compensation surveys.

2. Wage tier structures for designated non-exempt positions contain tiered sequences expressed as one-dimensional minimums.

3. The District's wage structures are publicly accessible and non-exempt wage structures are available to staff electronically on the hospital's intranet.

4. Wage actions affecting exempt and non-exempt positions and/or their respective wage structures may be based on the following considerations:

   - The District maintains wage grades and ranges for exempt and non-exempt positions.
   - Wage pay grades are represented by a number and separated by a spread of 5%. The spread between the salary range minimum and maximum is 40%.
   - Specific job classifications and their incumbents may be adjusted to maintain their relationship between existing salary range with CHA. .
   - When individual positions are adjusted to a higher grade and range, incumbents falling below the minimum are moved to the new grade minimum or adjusted within the new pay grade during salary administration.
   - Exempt and non-exempt positions lacking a survey comparison are benchmarked to similarly surveyed and ranked positions within the SVMC wage structure.
   - Labor market, competitive forces and the need to complete searches expeditiously determine exempt (management) pay grades and salary range designations.
   - When responding to unusual market or staffing situations, the President/Chief Executive Officer (CEO) may authorize establishment of pay ranges and tier structures outside of these guidelines.

MAKING SALARY OFFERS:

1. Department Directors are responsible for auditing their position control reports to ensure accuracy of position titles, position control numbers and wage pay grade and tier assignments.

2. Prior to making any wage offers to either external or internal candidates, Human Resources will review the department's internal wage equity.

3. All contingent offers of employment must be made by the Human Resources Department. Human Resources will determine the rate of pay and use a 2% increment increase for each year of experience as it relates to the position and internal equity.

4. Wage offers which exceed 50% of the incumbent's pay grade range require CEO approval.

REFERENCES:

- California Hospital Association – Annual Compensation Survey (Rep.). (n.d.). Retrieved from https://www.calhospital.org.

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SUBJECT:	SECTION:
SECURITY MANAGEMENT PLAN	*Security*
	Page 1 of 11

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. EXECUTIVE SUMMARY

Each environment of care poses unique security risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Security Management Program is designed to identify and manage the security risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. A security management program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for a Secure Environment describes the security risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the security of patients, staff, and other individuals coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Security Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. Security is a system made up of human assets and technology.

B. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, staff, and others coming to Sierra View Medical Center.

C. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing Sierra View Medical Center.

D. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.

E. Staff awareness of security is an essential part of an effective program. Sierra View Medical Center orients and trains all staff to the security program and to techniques for managing security risks related to work areas or daily activities.

III. OBJECTIVES

A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.

B. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.

C. Analyze security incidents and occurrences to identify root cause elements of them.

D. Conduct ongoing random security patrols in all areas of the hospital, affiliated medical practices, and outpatient facilities. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas and all patient care areas at least once per day.

E. Present reports of Environment of Care management activities to the Environmental Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The Safety/Security Officer coordinates the documentation and presentation of this information.

F. Assure that all departments have current organization-wide and department-specific procedures and controls designed to manage identified security risks.

G. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.

H. Assign qualified individuals to manage the program and to respond to immediate security threats.

I. Perform an annual evaluation of the management plan and of the scope, objectives performance and effectiveness of the security program.

J. Design and present security education and training to all new and current employees, volunteers, members of the medical staff, contract staff and others as appropriate.

K. Provide timely response to emergencies and requests for assistance.

L. Communicate with law enforcement and other civil authorities as needed.

M. Manage access to the grounds, buildings, and sensitive areas of Sierra View Medical Center.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Security Program from the Environmental Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety/Security Officer.

B. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leadership to assure budget and staffing resources are available to support the Security Program.

C. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Security program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address security issues and concerns. The Chief Executive Officer also collaborates with the Safety/Security Officer to develop a budget and operational objectives for the Security Program.

D. The Safety/Security Officer works under the general direction of the Chief Executive Officer or designee. The Safety Officer, in collaboration with the Environment of Care/Safety and Security Manager, is responsible for managing the Security Program. The Safety/Security Officer reports program findings to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.

E. Department Directors are responsible for orienting new staff members to the department and job and to task specific security procedures. The orientation and ongoing education and training emphasize patient safety. Department Directors are also responsible for participating in the reporting and investigation of incidents occurring in their departments.

F. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

V. ELEMENTS OF THE SECURITY PLAN

EC.01.01.01 EP1 – Appointment of Security Leadership

The Chief Executive Officer of Sierra View Medical Center appoints the Safety Officer, and selects a qualified individual capable of overseeing the development, implementation and monitoring of the security program.

The Safety Officer coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The Safety Officer job is defined by a job description. The Chief Executive Officer or designee evaluates the competence of the Safety/Security Officer annually.

The Safety Officer maintains a current knowledge of laws, regulations, and standards of security. The Safety Officer also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of Sierra View Medical Center.

The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate Incident Commander is appointed at the time that any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors, or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

EC.01.01.01 EP5 – Management Plan for a Secure Environment

The Security Management Program is described in this management plan. The Security Management Plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse security event.

EC.02.01.01 EP1 – Proactive Risk Assessment

The Safety Officer of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.

The Safety Officer works with Department Directors and Managers, the Patient Safety Officer, Risk Coordinator, the Administrative Director of Quality and Care and others as appropriate.

EC.02.01.01 EP3 – The hospital takes action to minimize or eliminate identified security risks in the physical environment

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.

LD.04.01.07 EP1 – Development and Management of Policies and Procedures

The Safety Officer follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job specific environmental safety procedures and controls.

The organization wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by Department Directors. The Department Directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job-related policies, procedures and controls. Department Directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The Safety Officer coordinates the reviews of procedures with department heads and other appropriate staff.

EC.02.01.01 EP7 – Identification of Patients, Staff, and Others Entering the Facility

The identification of staff is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.

The current systems in place at Sierra View Medical Center include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.

The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems. It also includes functional identification of patients who are fall risks, have allergies to medications or nutritional products, have DNR orders or Advance Directives, who are undergoing surgery, who are receiving blood or blood products, and who are security risks.

The identification of others entering Sierra View Medical Center is managed by the Security and Materials Management Departments. The Safety Officer, in collaboration with the Chief Executive Officer and other appropriate staff, manages the procedures for identification of contractors and visitors. The Director of Materials Management manages the procedures for identification of vendors. The Safety Officer takes appropriate action to remove unauthorized persons from areas and to prevent unwanted individuals from gaining access to Sierra View Medical Center.

Sierra View Medical Center requires all guests/visitors on Sierra View Medical Center premises to wear authorized colored identification wristbands indicating the date and the area or department they are visiting or rendering services from:

- White – Radiology/Lab
- Orange – Distinct Part Skilled Nursing Facility (DPSNF)
- Purple – Cath Lab
- Yellow – Emergency Department
- Blue – Post Anesthesia Care Unit (PACU)/Surgery
- Red – Intensive Care Unit (ICU)/Telemetry
- Green – Medical Surgical Unit
- Pink – Women's Services

EC.02.01.01 EP8 – Identification and Management of Security Sensitive Areas

The Safety Officer is responsible for identifying security sensitive areas, and controls access to and from the security sensitive areas.

The following areas have been designated as sensitive areas:

- Cashiers Window
- Emergency Department
- Human Resources
- Labor & Delivery
- Women's Services

- Pharmacy
- Information Services
- Health Information Management (HIM)
- Medication Rooms
- OTHERS as deemed necessary

Staff in each sensitive area participates in intensive training addressing the unique risks of the area and the procedures and controls in place to manage them. The Safety Officer assesses the need for reinforcement of department level education on an annual basis.

EC.02.01.01 EP9 – Management of Security Incidents Including an Infant or Pediatric Abduction

The Safety Officer has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Safety Officer or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.

The responding officers use appropriate written procedures and techniques, including use of force, to bring security incidents under control and to restore order.

The Safety Officer and the Vice President of Patient Care Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.

The Safety Officer and the Clinical Directors of Neonatal and Pediatric Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

EC.04.01.01 EP1 – EP11 – The hospital monitors conditions in the environment

The Administrative Director of Quality and Care coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Administrative Director of Quality and Care to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works

with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Administrative Director of Quality and Care and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Environment of Care Safety Committee Chairperson provides summary information related to incidents to the Chief Executive Officer and other leaders, including the Board of Directors, as appropriate.

The Safety Officer works with the Security Supervisor and the Safety Committee to collect information about Security deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

The Safety Officer and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of the Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of the Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Performance Improvement/Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule.

The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the Board of Directors, Senior Leadership or Quality and Patient Safety concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to the Board of Directors, Senior Leadership and Quality and Patient Safety leadership.

GOALS:

Work to reduce automobile theft to the 50th percentile in the Osborne Engineering benchmarking database. The current rate is in the 86th percentile.
Meet with On-Site Security to assess the current situation. Increase vehicle patrols throughout the facility parking lots.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, contract staff, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as contract staff, volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses the changes to the policies, procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Administrative Director of Quality and Care Management, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. In addition,

the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *BOARD OF DIRECTORS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTED SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. EC.01.01.01 EP5 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- WORKPLACE VIOLENCE PREVENTION PLAN

SUBJECT: **UTILITY SYSTEMS MANAGEMENT PLAN**	SECTION: **Page 1 of 11**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

I. EXECUTIVE SUMMARY

The Environment of Care and the range of patient care services provided to the patients served by Sierra View Medical Center present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria, including risks identified by outside sources such as the Joint Commission, is used to eliminate or reduce the probability of adverse patient outcomes.

The Utility Systems Management Plan describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The Management Plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center (SVMC), Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Clinical Lab, Wound Healing Center, Urology Clinic, Community Health Center, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.

B. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.

C. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

III. OBJECTIVES

Design, operate and maintain utility systems serving the buildings that house the healthcare services of Sierra View Medical Center to provide a safe, comfortable, appropriate environment that supports patient care and business operations.

Perform recommended maintenance to maximize system service life and reliability.

Manage the Utility Systems Management program to assure compliance with the Joint Commission requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Facilities Manager assures that an appropriate utility system maintenance program is implemented. The Facilities Manager also collaborates with the Safety Officer to develop reports of Utility Systems Management performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.

B. The Hospital's Board of Directors receives regular reports of the activities of the Utility Systems Management program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Facilities Manager and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leaders to assure budget and staffing resources are available to support the Utility Systems Management program.

C. The Hospital's Chief Executive Officer receives regular reports of the activities of the Utility Systems Management program. The Chief Executive Officer collaborates with the Facilities Manager and other appropriate staff to address utility system issues and concerns. The Chief Executive Officer collaborates with the Facilities Manager to develop a budget and operational objectives for the program.

D. The facility maintenance technicians, and selected outside service company staff, schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

E. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. PROCESSES OF THE UTILITY SYSTEMS PLAN

EC.01.01.01 EP9 – Plan for the Safe, Reliable, Effective Operation of Utility Systems

The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of Sierra View Medical Center may experience an adverse event while being monitored, diagnosed, or treated

with any type of medical equipment or being housed in an environment supported by the utility systems of Sierra View Medical Center.

EC.02.05.01 EP1 – Design and Installation of Utility Systems

The Facilities Manager works with qualified design professionals, project managers, and the intended end users of the space of Sierra View Medical Center to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of Sierra View Medical Center. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.

EC.02.05.01 EP3 –Developing an Inventory of Utility Systems and Equipment

All utility systems' components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.

EC.02.05.01 EP4 – Determining System Risk

The Facilities Manager identifies high-risk, operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. High-risk, operating components of utility system include life-support equipment.

EC.02.05.01 EP5 & EP6 – Inspection, Testing, and Maintenance Intervals

The Facilities Manager uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.

A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.

The Facilities Manager is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

EC.02.05.02 EP1 – Management of Water Systems

The Facilities Manager and the Manager of Infection Control are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.

Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.

The Facilities Manager and the Manager of Infection Control are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.

The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.

EC.02.05.01 EP15 & EP16 – Management of Ventilation Systems

The Facilities Manager and the Manager of Infection Control are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.

Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Maintenance.

The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum, flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.

Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Facilities Manager and Manager of Infection Control develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

EC.02.05.01 EP17 – Mapping of Utility Systems

The Facilities Manager is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawings, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations.

Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on disc or on the Intranet server of the hospital.

EC.02.05.01 EP9 – Labeling of Controls for System Shutdown and Recovery

The Facilities Manager is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.

The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.

EC.02.05.01 EP9 – 13 – Emergency Procedures

The Facilities Manager and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.

The Facilities Manager and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.

The resources must include, but are not limited to, information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.

Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All utility systems emergency procedures are reviewed annually.

EC.02.05.03 EP1 – 7 and EC.02.05.07 EP1 - 10 – Inspection, Testing, and Maintenance of Emergency Power Systems

The Facilities Manager is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. Sierra View Medical Center uses battery-powered lights, engine-

driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.

Each required battery-powered emergency lighting device is tested for 30 seconds each quarter and for 90 minutes annually.

The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that, if disrupted, would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.

The Facilities Manager is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.

Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and the essential electrical system is functional again.

Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by National Fire Protection Association (NFPA) 99, NFPA 101 and NFPA 110.

Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Facilities Manager, Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

EC.02.05.05 EP2 - Utility Systems Inventory and Initial Testing

The Facilities Manager establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by Sierra View Medical Center and leased or rented equipment.

The Facilities Manager is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

EC.02.05.05 EP4 - Testing of High Risk Equipment

The Facilities Manager assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.05 EP5 - Testing of Infection Control Support Equipment

The Facilities Manager assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.05 EP6 - Testing of Non-High Risk Equipment

The Facilities Manager assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.09 EP7 - Medical Gas System Testing

All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the current edition of NFPA 99.

UM.EC.02.05.09 EP10 - Modifying / Repairing Medical Gas Systems

When a new medical gas system is installed or an existing system is breached for any reason, the Facilities Manager coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Facilities Manager maintains a permanent record of all certification testing.

EC.02.05.09 EP11 - Labeling & Accessibility of Medical Gas Controls

The Facilities Manager is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.

In addition, the Facilities Manager is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled environmental tours. Deficiencies are reported to the appropriate manager for resolution.

EC.04.01.01 EP1 – 11 – The hospital monitors conditions in the environment

The Administrative Director of Quality and Care coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Administrative Director of Quality and Care to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Administrative Director of Quality and Care, who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Administrative Director of Quality and Care and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Senior Leaders, and the Board of Directors, as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra

View Medical Center. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each Environment of Care Management Plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, benchmarking programs, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities.

The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Environmental Safety/Security Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, Senior Leadership, the Board of Directors, Department Directors, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to

determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the Board of Directors, Senior Leadership, and Administrative Director of Quality and Care concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

Goals:

- Work with Precept Environmental to implement our Water Safety Plan.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their start date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and

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environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Administrative Director of Quality and Care Management, Manager of Infection Control, and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care Program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2022). Hospital accreditation standards. EC 01.01.01 EP9 Joint Commission Resources. Oak Brook, IL.

SUBJECT:	SECTION:
VERTICAL TRANSPORT SYSTEM, ELEVATOR PM	***Utility Management***

POLICY:

Sierra View Medical Center (SVMC) has a scheduled maintenance system which is used to schedule, monitor and document the testing and maintenance of the vertical and horizontal transport system at monthly intervals.

PROCEDURE:

ELEVATORS:

- The Engineering Department personnel will check the condition and operation of the elevators, to include the audible communication devices and fireman recall at the predetermined interval. All preventative and corrective maintenance is performed by Thyssenkrupp (vendor) under a full service contract.

- Thyssenkrupp checks and maintains all protective devices.

VERTICAL LIFTS (DUMBWAITERS):

- The Engineering Department personnel will check the condition and operation of the dumbwaiters at the predetermined interval. All preventative and corrective maintenance is performed by Thyssenkrupp (vendor) under a full service contract.

REFERENCES:

- The Joint Commission (2022). EC.02.03.05 EP 27 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

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MINUTES OF A REGULAR MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **August 23, 2022 at 4:30 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 4:35 p.m.

Directors Present: BEHL, LOMELI, REDDY, PANDYA
Directors Absent: SORRELLS
Others Present: Black Jill, Director of Financial Planning and Revenue Integrity, Blazar, Dan, Patient Experience Officer, Camacho, Lorena, Director of Enterprise Risk Management Canales, Tracy, VP of Human Resources, Marketing and Public Relations Dickson, Doug, Chief Financial Officer, Eckhoff, Richard, Community Member, Franer Julie, Admin Director of Patient Financial Services, Fuentes, Melissa, VP Quality and Regulatory Affairs, Gomez, Cindy, Director of Compliance, Hefner, Donna, President/Chief Executive Officer, Hirte, Todd, Contracts Administration, Hudson, Jeffery, VP Patient Care Services, CNE and DIO, Hurtado-Ziola, Nancy, Infection Prevention Manager, Pandya, Ela, Community Member, Parsons, Malynda, Marketing and Public Relations, Reed-Krase, Alex, Legal Counsel, Roberts, Silvia, Manager of Care Integration for Social Services and Case Management, Sandhu, Harpreet, MD, Chief of Staff, Wallace, Marcy, Director of Patient Access & Communication, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services,

I. Approval of Agenda:

Vice Chairman LOMELI motioned; to approve the Agenda. The motion was seconded by Chairman REDDY, and carried to approve the agenda with changes. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 4:40 p.m. to discuss the following items:

A. Pursuant to Evidence Code Section 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation- Quality of Care/Peer Review/Credentials

2. Quality Division Update

3. Risk Management Quarterly Report

4. Compliance Quarterly Report

C. Pursuant to Gov. Code Section 54956.9(d)(2); Conference with Legal Counsel about significant exposure to litigation involving a matter of compliance; privileged communication (1Item)

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – February 2023

E. Pursuant to Gov. Code Section 54956.9: Conference with Legal Counsel Regarding Anticipated Litigation (2 Items)

F. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item)

III. Open Session: Chairman REDDY adjourned Closed Session at 5:08 p.m., reconvening in Open Session at 5:14 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff, Harpreet Sandhu, M.D. Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review. Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Abstain
PANDYA	Yes

2. Quality Division Report.

Following review and discussion, it was moved by Chairman REDDY, seconded by Vice Chairman LOMELI, and carried to approve the Quality Division Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	Yes

3. Risk Management Quality Report.

Following review and discussion, it was moved by Chairman REDDY, seconded by Vice Chairman LOMELI, and carried to approve the Risk Management Quality Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	Yes

4. Compliance Report Quarter 2

Following review and discussion, it was moved by Chairman REDDY, seconded by Vice Chairman LOMELI and carried to approve the Compliance Report for Quarter 4. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	Yes

C. Conference with Legal Counsel. *Deferred to September 27, 2022 Regular Board of Directors meeting*

D. Discussion Regarding Trade Secret. This item was consolidated and discussed under Closed Session, Item B. 2.

E. Conference with Legal Counsel. Information only; no action taken

F. Conference with Legal Counsel. Information only; no action taken

IV. Public Comments

Initially None. At the conclusion of Agenda Item XII(D) a member of the public, Richard Eckoff, stated that he had misunderstood the agenda and thought item XII(D) would allow for public comment.

Due to the misunderstanding, it was motioned by Director PANDYA to return to agenda item IV to allow for public comment from Richard Eckhoff, Community Member, seconded by Vice Chairman LOMELI and carried to approve the additional Public Comment period. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	Yes

Public Comment:

Richard Eckhoff requested a copy of the July 26, 2022 minutesand informed the Board that he was not able to look at the Consent Agenda before the meeting.

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Chairman REDDY, seconded by Vice Chairman LOMELI, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director BEHL and seconded Vice Chairman LOMELI to approve the June 28, 2022 Minutes of the Regular Meeting of the Board of Directors. The motioned carried and the vote of the Board, is as follows:

REDDY	Yes
LOMELI	Yes

SORRELLS	Absent
BEHL	Yes
PANDYA	No

VII. Hospital CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View:

In the District:
Film Crew on site filming for their upcoming movie "Porterville"
Uber/Porterville TransPORT now available for SVMC patients

Service Line Update:
The Maternal Child Health Discharge Checklist was developed by the Patient Experience committee, led by Donna Cha, RN. The group working with Patient Experience identified a need to improve the communication around preparing mothers and families for discharge and to ensure they were educated on the first days at home with their newborn.
To date, for the months of June and July, for the patient satisfaction question regarding Discharge Communication, we have a perfect score on all 31 surveys returned. These scores indicate that the new practice put in place does have a positive effect on the patient's satisfaction while in the hospital. Phase Two to follow.

Foundation Events:
10/1/2022 A Night of Dueling Pianos - Sierra View Foundation kicked off its Marketing efforts for the upcoming Dueling Pianos battle that will take place at the Ramirez Home in Porterville. Funds raised will be donated to the hospital to purchase 20 WOWs (Workstations on Wheels) for various departments throughout the district. For sponsorship opportunities visit: sierra-view.com/duelingpianos

Employee Recognition and Engagement:
After working closely with Sierra View since 1984 when the district was contracted with Fridlund Lab and after more than 30 dedicated years with our organization, we are saying goodbye to the one and only, Laura Nielson, SVMC Laboratory Manager. Laura will be missed by all of her team but she will be spending much time with her loved ones, including her grandchildren who live nearby. She is also hopeful to get back into things such as hiking, traveling, baking, needlework, and crafts.

COVID 19 Public Health Emergency (PHE):
The Centers for Medicare & Medicaid Services (CMS) encouraging providers to prepare for end of PHE. Secretary Xavier Becerra extended PHE 10/15/22 will provide 60-day notice before ending. Roadmap to end Waivers and Flexibilities. SVMC will address the return to normal standards and operational practices. Anticipating PHE end on 1/11/2023.

VIII. Business Action Items

A. July 2022 Financials

Doug Dickson, CFO presented the Financials for July 2022. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $10,847,917. Supplemental Funds were $2,139,404. Total Operating Expenses were $14,320,238. $2, 045,770 gain from operations were $938,362.

Following review and discussion, it was moved by Vice Chair LOMELI, seconded by Director PANDYA and carried to approve the July 2022 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	Yes

Ela Pandya, Community Member spoke up to ask a question regarding professional fees. Legal Counsel advised that questions can be asked during the Public Comment section.

B. Investment Report

Doug Dickson, CFO presented the Investment Report. Approximately 9% of the total portfolio will turn over during the next 12 months. Investment yield is expected to be approximately 1.5% over the next twelve months. Quarter4 actual investment income was $546,845

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the investment report as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	No

C. GME Annual Institutional Review

Dr. Jeffery Hudson, VP Patient Care Services, Chief Nurse and Chief Academic Officer GME/DIO presented the GME Annual Institutional Review.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the investment report as presented. The vote of the Board by roll call is as follows:

REDDY	Yes
LOMELI	Yes
SORRELLS	Absent
BEHL	Yes
PANDYA	No

D. Comments from Public and Recording of Meetings

The SVLHCD Board prides itself on being an entity that not only encourages input and comment from the public, but readily seeks out means to encourage and increase public participation at Board Meetings. For example, the Board holds its meetings during evenings with the hope that more of the public can participate in meetings. Each Board meeting allows for a period for public comment. Recently, though not legally necessary, the Board has re-organized its agenda to better accommodate those members of the public that have been attending the Board meetings. At the July 26, 2022 meeting, the Board received a comment from a member of the public incorrectly alleging three problems with the June 28, 2022 meeting, which allegations the Board feels it cannot leave unaddressed.

1. The comment alleged that agenda item III. E was never taken up by the Board at the June 28, 2022 meeting. This is not correct. The agenda item was taken up by the Board, but only to the extent that prior to the Board taking any substantive action on the item, the Board voted to table to matter to the July 26, 2022 meeting. If the motion to table the item had not passed, then the Board would have proceeded with the item. This is a standard practice afforded to all Boards prior to taking up any item on the agenda.

2. The comment alleged that the Board did not allow for public comment. This is not correct. As with every meeting, the Board did allow for public comment during the period noticed on the June 28, 2022 agenda. No public comments were received in person, or by Zoom chat, email, facsimile, mail or message or any other method. Since agenda item III E. was tabled, no Public Comments relative to that specific item were allowed until after the item was taken up by the Board at the July 26, 2022 meeting. There is no requirement under the Brown Act for the Board to allow this additional pubic comment time. The Board allotted a specific public comment period for this item simply because it wished to hear from the Community on that particular item. It was in the Board's interest and the public interest to have public comments for that item heard at the same meeting the Board took up agenda item III E.

3. The comment complained about the continuity of recordings of meetings. There is no requirement under the Brown Act to record the meetings. Recordings

are done by SVLHCD for the convenience of the public and are created to the extent the Board's administrative resources make such recordings practical. The Board, by and through its administration, continues to work to improve this service for its constituents and hopes to continue to improve with each meeting.

At the end of the day, the Board is focused on serving the public. The Board hopes that as this agenda item makes clear, the Board takes comments from the public very seriously and will do its best to continue to address the public's concerns when any such concerns are voiced through the public comment period.

Information only; no action taken.

Director PANDYA motioned to bring this issue/complaint via Public Comment on the Agenda for next month. No second. Motion failed.

XIII. Announcements:

A. Regular Board of Directors Meeting – September 27, 2022

Adjournment: There being no further business, the meeting was adjourned 6:08 p.m.

Respectfully submitted,

Liberty Lomeli
Vice Chairman
SVLHCD Board of Directors
LL: ww

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FINANCIAL PACKAGE
August 2022

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
August 2022

Statistic	Aug-22 Actual	Aug-22 Budget	Aug-22 Over/ (Under)	Aug-22 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 22 YTD	Increase/ (Decrease) Aug-21	% Change
Utilization											
SNF Patient Days											
Total	110	75	35	46.7%	224	150	74	49.3%	143	81	56.6%
Medi-Cal	62	62	0	0.3%	124	137	(13)	-9.4%	143	(19)	-13.3%
Sub-Acute Patient Days											
Total	874	903	(29)	-3.2%	1,731	1,806	(75)	-4.2%	1,815	(84)	-4.6%
Medi-Cal	616	565	51	9.1%	1,207	1,136	71	6.2%	1,142	65	5.7%
Acute Patient Days	1,877	1,923	(46)	-2.4%	3,604	3,846	(242)	-6.3%	4,442	(838)	-18.9%
Acute Discharges	468	469	(1)	-0.2%	932	938	(6)	-0.6%	1,029	(97)	-9.4%
Medicare	168	179	(11)	-6.0%	340	347	(7)	-2.1%	382	(42)	-11.0%
Medi-Cal	243	214	29	13.8%	467	458	9	1.9%	503	(36)	-7.2%
Contract	54	72	(18)	-25.1%	118	124	(6)	-4.8%	136	(18)	-13.2%
Other	3	4	(1)	-17.8%	7	7	(0)	-4.0%	8	(1)	-12.5%
Average Length of Stay	4.01	4.10	(0.09)	-2.2%	3.87	4.10	(0.23)	-5.7%	4.32	(0.45)	-10.4%
Newborn Patient Days											
Medi-Cal	176	174	2	1.4%	354	347	7	1.9%	413	(59)	-14.3%
Other	29	39	(10)	-26.4%	58	79	(21)	-26.4%	88	(30)	-34.1%
Total	205	213	(8)	-3.8%	412	426	(14)	-3.3%	501	(89)	-17.8%
Total Deliveries	125	112	13	11.6%	246	224	22	9.8%	258	(12)	-4.7%
Medi-Cal %	84.55%	81.51%	3.04%	3.7%	84.71%	81.51%	3.20%	3.9%	83.27%	1.44%	1.7%
Case Mix Index											
Medicare	1.5293	1.6783	(0.1490)	-8.9%	1.5355	1.6783	(0.1428)	-8.5%	1.7011	(0.1656)	-9.7%
Medi-Cal	1.1357	1.2438	(0.1081)	-8.7%	1.1986	1.2438	(0.0452)	-3.6%	1.1677	0.0309	2.6%
Overall	1.2831	1.4431	(0.1600)	-11.1%	1.3316	1.4431	(0.1115)	-7.7%	1.3843	(0.0527)	-3.8%
Ancillary Services											
Inpatient											
Surgery Minutes	8,444	8,728	(284)	-3.3%	17,155	17,456	(301)	-1.7%	20,957	(3,802)	-18.1%
Surgery Cases	102	100	2	2.0%	203	200	3	1.5%	232	(29)	-12.5%
Imaging Procedures	1,514	1,231	283	23.0%	2,842	2,462	380	15.4%	3,084	(242)	-7.8%
Outpatient											
Surgery Minutes	13,589	13,010	579	4.5%	22,318	26,020	(3,702)	-14.2%	26,205	(3,887)	-14.8%
Surgery Cases	203	198	5	2.5%	334	396	(62)	-15.7%	378	(44)	-11.6%
Endoscopy Procedures	190	185	5	2.7%	315	370	(55)	-14.9%	376	(61)	-16.2%
Imaging Procedures	4,143	3,880	263	6.8%	7,884	7,760	124	1.6%	7,404	480	6.5%
MRI Procedures	306	290	16	5.5%	610	580	30	5.2%	636	(26)	-4.1%
CT Procedures	1,342	1,009	333	33.0%	2,454	2,018	436	21.6%	2,056	398	19.4%
Ultrasound Procedures	1,068	904	164	18.1%	2,026	1,808	218	12.1%	1,838	188	10.2%
Lab Tests	37,008	30,494	6,514	21.4%	70,755	60,988	9,767	16.0%	82,849	(12,094)	-14.6%
Dialysis	-	5	(5)	-100.0%	1	10	(9)	-90.0%	9	(8)	-88.9%

Sierra View Medical Center
Financial Statistics Summary Report
August 2022

	Aug-22				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 22 YTD	(Decrease) Aug-21	% Change
Cancer Treatment Center											
Chemo Treatments	1,808	1,794	14	0.8%	3,462	3,588	(126)	-3.5%	3,528	(66)	-1.9%
Radiation Treatments	1,798	1,817	(19)	-1.0%	2,923	3,634	(711)	-19.6%	2,875	48	1.7%
Cardiac Cath Lab											
Cath Lab IP Procedures	8	9	(1)	-11.1%	18	18	-	0.0%	20	(2)	-10.0%
Cath Lab OP Procedures	37	24	13	54.2%	61	48	13	27.1%	58	3	5.2%
Total Cardiac Cath Lab	45	33	12	36.4%	79	66	13	19.7%	78	1	1.3%
Outpatient Visits											
Emergency	3,502	3,249	253	7.8%	6,862	6,498	364	5.6%	6,552	310	4.7%
Total Outpatient	14,093	13,731	362	2.6%	26,173	27,462	(1,289)	-4.7%	25,741	432	1.7%
Staffing											
Paid FTE's	904.71	935.67	(30.96)	-3.3%	906.35	935.67	(29.32)	-3.1%	887.75	18.60	2.1%
Productive FTE's	769.63	804.83	(35.19)	-4.4%	760.06	804.83	(44.77)	-5.6%	751.46	8.60	1.1%
Paid FTE's/AOB	4.87	5.52	(0.65)	-11.8%	5.25	5.52	(0.27)	-4.9%	4.99	0.26	5.3%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	10,150	10,240	(90)	-0.9%	10,123	10,240	(117)	-1.1%	10,301	(179)	-1.7%
Cost/Adj.Patient Day	2,476	2,602	(127)	-4.9%	2,585	2,599	(15)	-0.6%	2,247	337	15.0%
Revenue/Adj. Discharge	50,673	52,250	(1,577)	-3.0%	49,047	52,250	(3,203)	-6.1%	58,765	(9,718)	-16.5%
Cost/Adj. Discharge	12,360	13,277	(918)	-6.9%	12,523	13,263	(740)	-5.6%	12,821	(298)	-2.3%
Adj. Discharge	1,153	1,029	124	12.0%	2,208	2,058	150	7.3%	1,934	275	14.2%
Net Op. Gain/(Loss) %	-13.25%	-8.75%	-4.50%	51.4%	-18.04%	-8.63%	-9.41%	109.0%	0	-18.96%	-2063.6%
Net Op. Gain/(Loss) $	(1,667,072)	(1,099,340)	(567,732)	51.6%	(4,227,215)	(2,169,019)	(2,058,196)	94.9%	229,917	(4,457,132)	-1938.6%
Gross Days In Accts Rec.	89.90	85.78	4.12	4.8%	89.90	85.78	4.12	4.8%	85.73	4.16	4.9%
Net Days In Accts. Rec.	68.19	66.37	1.82	2.7%	68.19	66.37	1.82	2.7%	67.68	0.52	0.8%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	AUG 2022	JUL 2022
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 13,190,642	$ 18,850,290
SHORT-TERM INVESTMENTS	2,336,681	3,948,711
ASSETS LIMITED AS TO USE	1,812,996	1,810,624
PATIENT ACCOUNTS RECEIVABLE	156,231,886	157,607,830
LESS UNCOLLECTIBLES	(23,701,522)	(23,224,763)
CONTRACTUAL ALLOWANCES	(104,342,138)	(105,879,940)
OTHER RECEIVABLES	10,806,490	9,602,461
INVENTORIES	3,912,226	3,992,469
PREPAID EXPENSES AND DEPOSITS	2,896,902	2,021,694
TOTAL CURRENT ASSETS	63,144,162	68,729,376
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	30,331,004	29,829,591
LONG-TERM INVESTMENTS	142,663,970	142,016,127
PROPERTY, PLANT AND EQUIPMENT, NET	91,291,694	90,892,204
INTANGIBLE RIGHT OF USE ASSETS	450,507	470,291
OTHER ASSETS:		
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,972,083	1,993,063
TOTAL ASSETS	$ 330,103,419	$ 334,180,651

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	AUG 2022	JUL 2022
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 289,983	$ 144,992
CURRENT MATURITIES OF BONDS PAYABLE	3,880,000	3,880,000
CURRENT MATURITIES OF LONG TERM DEBT	1,188,800	1,188,800
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	6,274,313	8,543,094
ACCRUED PAYROLL AND RELATED COSTS	9,167,186	8,366,345
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	4,029,415	4,092,491
LEASE LIABILITY - CURRENT	216,902	228,281
TOTAL CURRENT LIABILITIES	25,046,599	26,444,003
SELF-INSURANCE RESERVES	1,853,000	1,829,283
CAPITAL LEASE LIAB LT	2,777,770	2,859,779
BONDS PAYABLE, LESS CURR REQT	41,565,000	41,565,000
BOND PREMIUM LIABILITY - LT	4,053,961	4,118,867
LEASE LIABILITY - LT	233,605	242,010
OTHER NON CURRENT LIABILITIES	375,854	375,854
TOTAL LIABILITIES	75,905,788	77,434,795
UNRESTRICTED FUND	258,650,630	258,650,630
PROFIT OR (LOSS)	(4,452,999)	(1,904,773)
TOTAL LIABILITIES AND FUND BALANCE	$ 330,103,419	$ 334,180,651

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

AUG 2022 ACTUAL	AUG 2022 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,070,519	5,323,164	252,645	(5)%	INPATIENT - NURSING	9,906,479	10,646,328	739,849	(7)%
18,694,892	19,182,047	487,155	(3)%	INPATIENT - ANCILLARY	35,903,174	38,364,094	2,460,920	(6)%
23,765,411	24,505,211	739,800	(3)%	TOTAL INPATIENT REVENUE	45,809,653	49,010,422	3,200,769	(7)%
34,647,680	29,264,674	(5,383,006)	18%	OUTPATIENT - ANCILLARY	62,503,516	58,529,348	(3,974,168)	7%
58,413,091	53,769,885	(4,643,206)	9%	TOTAL PATIENT REVENUE	108,313,169	107,539,770	(773,399)	1%
				DEDUCTIONS FROM REVENUE				
(17,811,627)	(17,329,545)	482,082	3%	MEDICARE	(33,045,567)	(34,659,090)	(1,613,523)	(5)%
(20,396,376)	(17,147,544)	3,248,832	19%	MEDI-CAL	(38,243,598)	(34,295,088)	3,948,510	12%
(7,247,855)	(6,731,802)	516,053	8%	OTHER/CHARITY	(13,121,007)	(13,463,604)	(342,597)	(3)%
(11,620)	(10,496)	1,124	11%	DISCOUNTS & ALLOWANCES	(63,829)	(20,992)	42,837	204%
(787,670)	(482,709)	304,961	63%	BAD DEBTS	(1,192,788)	(965,418)	227,370	24%
(46,255,147)	(41,702,096)	4,553,051	11%	TOTAL DEDUCTIONS	(85,666,790)	(83,404,192)	2,262,598	3%
12,157,943	12,067,789	(90,154)	1%	NET SERVICE REVENUE	22,646,380	24,135,578	1,489,198	(6)%
422,532	496,384	73,852	(15)%	OTHER OPERATING REVENUE	782,012	992,769	210,757	(21)%
12,580,475	12,564,173	(16,302)	0%	TOTAL OPERATING REVENUE	23,428,392	25,128,347	1,699,955	(7)%
				***** OPERATING EXPENSE *****				
5,369,358	5,143,581	225,777	4%	SALARIES	10,307,607	10,258,473	49,134	1%
643,868	646,690	(2,823)	0%	S&W PTO	1,301,318	1,292,127	9,191	1%
1,299,152	1,428,293	(129,141)	(9)%	EMPLOYEE BENEFITS	2,585,188	2,857,822	(272,635)	(10)%
1,941,483	1,862,853	78,630	4%	PROFESSIONAL FEES	4,165,169	3,729,706	435,463	12%
860,419	745,842	114,577	15%	PURCHASED SERVICES	1,537,959	1,488,670	49,289	3%
2,257,771	2,011,068	246,703	12%	SUPPLIES & EXPENSES	4,092,954	4,022,003	70,951	2%
232,131	222,594	9,537	4%	MAINTENANCE & REPAIRS	433,521	443,694	(10,173)	(2)%
298,912	212,617	86,295	41%	UTILITIES	500,634	425,234	75,400	18%
51,887	45,029	6,858	15%	RENT/LEASE	90,566	90,058	508	1%
113,597	100,975	12,622	13%	INSURANCE	253,321	201,950	51,371	25%
821,966	874,731	(52,765)	(6)%	DEPRECIATION/AMORTIZATION	1,653,977	1,751,373	(97,397)	(6)%
357,003	369,240	(12,237)	(3)%	OTHER EXPENSE	733,394	736,256	(2,862)	0%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,247,547	13,663,513	584,034	4%	TOTAL OPERATING EXPENSE	27,655,607	27,297,366	358,241	1%
(1,667,072)	(1,099,340)	567,732	52%	NET GAIN/(LOSS) FROM OPERATIONS	(4,227,215)	(2,169,019)	2,058,196	95%
112,969	112,970	1	0%	DISTRICT TAXES	225,938	225,939	1	0%
244,992	169,712	(75,280)	44%	INVESTMENTS INCOME	650,069	339,424	(310,645)	92%
46,602	37,742	(8,860)	24%	OTHER NON OPERATING INCOME	89,475	75,483	(13,992)	19%
(84,040)	(84,840)	(800)	(1)%	INTEREST EXPENSE	(168,481)	(169,680)	(1,200)	(1)%
(28,245)	(50,587)	(22,342)	(44)%	NON-OPERATING EXPENSE	(132,379)	(101,177)	31,202	31%
292,279	184,997	(107,282)	58%	TOTAL NON-OPERATING INCOME	664,622	369,989	(294,633)	80%
(1,374,793)	(914,343)	460,450	50%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(3,562,593)	(1,799,030)	1,763,563	98%
(1,173,433)	0	1,173,433		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	(890,406)	0	890,406	
(2,548,226)	(914,343)	1,633,883	179%	NET GAIN/(LOSS)	(4,452,999)	(1,799,030)	2,653,969	148%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
08/31/22

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(1,667,072)	(4,227,215)
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation and amortization	821,966	1,653,977
Provision for bad debts	476,759	674,170
Changes in assets and liabilities:		
Patient accounts receivable	(161,856)	503,917
Other receivables	(1,204,029)	(2,449,699)
Inventories	80,243	33,269
Prepaid expenses and deposits	(875,208)	(621,654)
Advance refunding of bonds payable	20,980	41,960
Accounts payable and accrued expenses	(2,268,782)	(1,944,681)
Accrued payroll and related liabilities	800,841	1,244,408
Estimated third-party payor settlements	(63,076)	(126,152)
Self-insured program reserves	23,717	-
Total adjustments	(2,348,445)	(990,485)
Net cash provided by (used in) operating activities	(4,015,517)	(5,217,700)
Cash flows from noncapital financing activities:		
District tax revenues	112,969	225,938
Noncapital grants and contributions, net of other expenses	18,358	(43,221)
Net cash provided by (used in) noncapital financing activities	131,327	182,717
Cash flows from capital and related financing activities:		
Purchase of capital assets, net of disposals	(1,221,456)	(1,378,235)
Intangible right of use assets	19,784	39,526
Principal payments on debt borrowings	-	(3,715,000)
Interest payments	(3,954)	(960,468)
Net change in notes payable and lease liability	(101,793)	(203,460)
Net changes in assets limited as to use	(503,785)	3,674,404
Net cash provided by (used in) capital and related financing activities	(1,811,204)	(2,543,233)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(1,821,276)	(5,817,669)
Interest and dividends received from investments	244,992	650,069
Net cash provided by (used in) investing activities	(1,576,284)	(5,167,600)
Net increase (decrease) in cash and cash equivalents:	(7,271,678)	(12,745,816)
Cash and cash equivalents at beginning of month/year	22,799,001	28,273,139
Cash and cash equivalents at end of month	15,527,323	15,527,323

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
August 2022

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Sep-21	12,759,611	1,650,547	14,410,158
Oct-21	10,376,691	1,244,630	11,621,321
Nov-21	10,974,393	1,575,199	12,549,592
Dec-21	13,662,211	6,342,016	20,004,227
Jan-22	9,101,598	3,002,395	12,103,993
Feb-22	9,223,160	1,873,199	11,096,359
Mar-22	11,160,102	6,179,876	17,339,978
Apr-22	10,302,842	5,121,377	15,424,219
May-22	10,717,469	760,349	11,477,818
Jun-22	11,174,875	4,902,151	16,077,026
Jul-22	10,591,327	206,562	10,797,889
Aug-22	**11,384,869**	**198,928**	**11,583,797**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - cash receipts for Cafe and Coffee Corner sales, rebates, refunds, and receipts from miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues

- Medi-Cal OP Supplemental and DSH funds received
- Medi-Cal and Medi-Care Tentative Cost Settlements received for prior year
- Grants, IGT, & HQAF

August 2022 Summary of Other Activity:

78,577	Property Taxes
30,048	Tulare County First 5 4th Qtr 04/22 - 06/22
90,303	Miscellaneous
198,928	

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SIERRA VIEW
MEDICAL CENTER

September 2022

SVMC Board of Directors
Request for Financial Donation - SVMC's Tree of Angels for 2022

It is the time of year again for the Tree of Angels Committee to begin preparations for SVMC's Annual Tree of Angels. As you know, each year our staff unite together to help local families in our community in need to ensure they are able to receive in the joy and magic of the holiday season. Without the help and support of our hospital staff along with our financial partners, we could not make this special drive a reality. It truly is a gift both to the givers and the receivers alike.

In the past, we have been able to make this worthy cause possible because of SVMC's Board of Director's generosity and financial support. Last year, the Board committed to a $10,000 donation. We understand the current financial climate due to the pandemic and appreciate any donation amount the Board would be so generous to extend. We have committed to adopt 75 families this year.
Because of the generosity and commitment of the SVMC employees, and other local business donations, the committee believes we can fulfill our commitment to 75 families with a $10,000 donation from the Board.

On behalf of the Tree of Angels Committee, we want to thank you for your years of support and once again we are asking for a consideration of a financial donation in support of such a worthy cause. It is the Tree of Angels charitable event that allows SVMC's mission come alive through service and compassion, ultimately making a difference in the lives of our fellow neighbors.

In Service Together,

The Tree of Angel's Committee

465 West Putnam Avenue | Porterville, CA 93257
(559) 784-1110 | sierra-view.com

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SIERRA VIEW
MEDICAL CENTER

Sierra View Local Health Care District

Fiduciary Responsibility Delegation Charter

I. Purpose and Objectives

The purpose of this Fiduciary Responsibility Delegation Charter ("Charter") is to guide the **Sierra View Local Health Care District** ("Plan Sponsor") in executing its fiduciary responsibilities with respect to the following plan(s) (the "Plan").

Plan Name	Type
Sierra View Local Health Care District Money Purchase Pension Plan	401(a)
Sierra View Local Health Care District Employer 457 Deferred Compensation Plan	457(b)
Sierra View Management 401(a) Plan	401(a)

This Charter defines the fiduciary responsibility of the Plan Sponsor and the delegation of certain rights, powers and duties under the Plan to others as designated by the Plan Sponsor. Fiduciaries who fail to meet the responsibilities delineated herein may be personally liable for breach of fiduciary duty.

However, the Plan Sponsor indemnifies and holds harmless each member of the Retirement Plan Administration Committee (the "Committee") for an alleged breach of fiduciary duty, except in the case of the delegate's gross negligence or willful misconduct.

Consistent with ERISA, when applicable, the Plan Sponsor's objectives as they relate to fiduciary responsibility and maintenance and operation of the Plan are to:

a) Maintain the Plan for the exclusive benefit of participants while avoiding any prohibited transactions and/or conflicts of interest;

b) Exercise prudence in all respects while executing fiduciary responsibilities;

c) Diversify designated investment alternatives available to participants under the Plan; and,

d) Ensure conformity of the Plan's operations to the Plan document provisions and applicable law.

II. Fiduciary Authority and Responsibilities Under the Plan

The Plan Sponsor shall bear responsibility for delegating specific fiduciary duties. Certain fiduciary responsibilities shall be delegated by the Plan Sponsor's Board of [Directors/Trustees/Regents] (the "Board") to other persons under and pursuant to this Charter. The Board shall retain decision rights regarding any substantive changes to the Plan that may impact Plan costs, including changes to eligibility for benefits and/or changes in employer contributions.

III. Committee Membership

The Board hereby delegates certain functional fiduciary responsibilities to the Plan Sponsor's Retirement Plan Administration Committee (the "Committee"). The Board shall select Committee members.

a) The Committee's membership shall include Sierra View Local Health Care District employees in the following roles, or successor positions as confirmed by the Committee Chair:

   1. President/CEO as Committee Chair
   2. Chief Financial Officer
   3. Vice President of Human Resources

Commented [CF1]: Roles added per the resolution December 2014

b) The Committee will name a Chair from among the members of the Committee in the event the CEO position is vacant.

c) The Committee will name a Secretary, an employee who may, but need not be, a Committee member.

d) If any individual, who is a member of the Committee, ceases to be an employee, then the removal of the Committee member shall occur automatically and without any requirement for action by the Board or any notice to the individual.

e) Any employee will automatically be added to the Committee upon filling one of the roles above.

IV. Committee Procedures

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b) Majority Decisions. Any action of the Committee may be taken by a simple majority of those members qualified to vote, with or without the concurrence of the minority. In the event of a deadlock, the matter shall be decided by the Committee Chair.

c) Delegation to Act in Behalf of Committee. The Committee may delegate to one or more of its members to act on its behalf, to give notice in writing of any action taken by the Committee, and to contract for legal, recordkeeping, accounting, clerical, and other services to carry out the purposes of the Plan. The Committee may appoint such officers and/or subcommittees (the members of which need not be members of the Committee) with such powers as it shall determine and may authorize to execute or deliver on behalf of the Plan.

d) Committee Rules. Subject to the limitations of the Plan, the Committee shall from time to time establish rules for the administration of the Committee and the transaction of its business, including the times and places for holding meetings, the notices to be given with respect for such meetings and the number of members who shall constitute a quorum for the transaction of business.

e) Frequency of Meetings. Except to the extent that the Committee shall otherwise determine, meetings of the Committee shall be held at least once each semi-annual period.

f) Reports to the Board. Periodically, the Committee shall present a report to the Board. Such report shall include a summary of the activities of the Committee respecting the status of the administrative and investment activities of the Plan and such other information as the Committee or the Board deems advisable.

V. Plan Administrative Responsibilities

The Plan administrative responsibilities of the Committee shall include, but shall not be limited to, the following:

a) Require any person to furnish information for the proper administration of the Plan as a condition to receiving benefits.

b) Make and enforce rules and prescribe procedures for efficient Plan administration.

c) Maintain all records necessary for Plan administration, other than those maintained by the recordkeeper.

d) Interpret and construe the Plan and their related documents.

e) Determine guidelines for benefits payable and claims for benefits under the Plan.

f) Designate persons to carry out any fiduciary responsibilities of the Plan Administrator for the Plan.

g) Execute amendments to Plan documents and/or policies as may be required by changes in applicable law and/or regulation.

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i) Communicate the Plan's provisions to participants as required by applicable law and oversee information provided to participants on the nature and characteristics of the investment alternatives available in the Plan to assist participants with making prudent asset allocation decisions and provide such additional information to participants pursuant to the provisions of section 404(c) and 404(a)(5) of ERISA, as applicable.

j) Determine employee eligibility to participate in the Plan in accordance with applicable Plan document provisions.

k) Enroll participants in the Plan in accordance with applicable Plan document provisions.

l) Ensure the timely deposit of participant salary deferrals to the participants' separate accounts under the Plan.

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SIERRA VIEW MEDICAL CENTER

Sierra View Local Health Care District

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SIERRA VIEW
MEDICAL CENTER

Sierra View Local Health Care District

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SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS
RESOLUTION NO: 9-27-22/01 AMENDING THE COMPOSITION AND SIGNATURE AUTHORITY OF THE RETIREMENT PLAN ADMINISTRATION COMMITTEE

Upon motion by _____, seconded by _____, _____ directors being present, upon vote of _____ years and_____ nays, the Board of Directors of Sierra View Local Health Care District hereby resolve as follows:

RESOLVED: The composition of the Retirement Plan Administration Committee shall consist of the Sierra View Local Health Care District President/CEO as Chair, Chief Financial Officer, and Vice President of Human Resources, or their successor positions as confirmed by the Committee's Chair.

RESOLVED FURTHER: Signature authority for any documents, forms, and reports that require the signature of the Plan Administrator and relate to the administration of the retirement plans, is delegated to the Sierra View Local Health Care District President/CEO, Chief Financial Officer, or Vice President of Human Resources.

Board of Directors

Dated: _____ _____

Secretary

(Official Seal)

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SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
CONFLICT OF INTEREST CODE

The Political Reform Act (Government Code 81000 81000 *et seq.*) requires local government agencies to adopt and promulgate a conflict-of-interest code. This code is designed to ensure that board members and employees of the District do not engage in government decision-making in which the officer or employee may have a personal financial interest. In addition, board members and decision-making employees designated in the District's code are required to file periodic public statements disclosing their personal economic interests (Form 700).

The Fair Political Practices Commission has adopted a regulation that contains the terms of a model conflict-of -interest code. Therefore, the terms of Title 2, CA Code of Regulations, section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, are hereby incorporated by this reference and, together with the attached APPENDIX A (DESIGNATED POSITIONS), and APPENDIX B (DISCLOSURE CATEGORIES), constitutes the. Conflict of Interest Code of the District.

Persons serving in designated positions (APPENDIX A) shall file periodic disclosure statements (Form 700) with the District, as required by law and pursuant to notice from the District's filing officer. The disclosure statements shall be retained by the District for no less than seven years, and shall be made available for public inspection and reproduction upon request.

Adopted by Sierra View Local Health Care District:

Date:_____

Approved by Tulare County Board of Supervisors:

Date:_____

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT

APPENDIX A

LIST OF DESIGNATED POSITIONS

CONFLICT OF INTEREST CODE

Designated Position	Disclosure Categories
Board Member	Full Disclosure
Chief Executive Officer/President	Full Disclosure
Chief Financial Officer	Full Disclosure
Vice President of Patient Care Services & Chief Nurse Executive (CNE) AND Chief Academic Officer & Founding Designated Institutional Officer (DIO)	Full Disclosure (excluding interests in real property)
Vice President of Professional Services and Physician Recruitment	Full Disclosure
Vice President of Quality & Regulatory Affairs	Full Disclosure (excluding interests in real property)
Vice President of Human Resources	Full Disclosure (excluding interests in real property)
Director of Financial Strategy and Contracts Administrator	General Contracting A
Admin Director of IT/Infrastructure/Project Management	General Contracting A
Director of Materials Management and Business Development	General Contracting A
Director of Environmental Services	General Contracting A
Director of Facilities	General Contracting A
Director of Pharmacy	General Contracting A
General Counsel	Full Disclosure
Consultant	Full Disclosure *

*Consultants/New Positions are included in the list of designated positions and shall disclose pursuant to the broadest category in the code, subject to the following limitations:
The Chief Executive Officer or his or her designee may determine in writing that a particular consultant or new position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with disclosure requirements in this section. Such written determination shall include a description, a statement of the consultant's or new position's duties and, based upon that description, a statement of the extent of disclosures requirements. The CEO's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code. (Gov. Code Section 81008.) See APPENDIX B – Conflict of Interest Code Disclosure Categories

SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE
DISTRICT APPENDIX B
DISCLOSURE CATEGORIES

1. **Full Disclosure**

All interests in real property located entirely or partly within the District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interests or option to acquire such interest in real property.

All investments, business positions, and sources of income, including gifts, loans and travel payments. Intended for board members and high-level decision-making employees with broad duties)

2. **Full Disclosure (excluding interests in real property)**

All investments, business positions, ownership and sources of income, including gifts, loans and travel payments.

3. **Interests in Real Property (only)**

All interests in real property located entirely or partly within this Agency's jurisdiction or boundaries, or within two miles of this Agency's jurisdiction or boundaries or of any land owned or used by this Agency.

Such interest include any leasehold ownership interest or option to acquire such interest in real property.

4. **General Contracting (two options)**

A. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like, including training or consulting services, of the type utilized by the Agency.

(Intended for employees whose duties and decisions involve contracting and purchasing for the entire Agency)

B. All investments, business positions, ownership and sources of income, including gifts, loans and travel payments, from sources that provide, or have provided in the last two years, leased facilities, goods, supplies, materials, equipment, vehicles, machinery, services, or the like including training or consulting services, of the type utilized by the employee's department or area of authority.

(Intended for employees whose duties and decisions involve contracting and purchasing for a specific department or area of authority.)

5. **Regulatory, Permit or Licensing Duties**

All investments, business positions, and sources of income, including gifts, loans and travel payments, from sources that are subject to the regulatory, permit or licensing authority of, or have an application for a license or permit pending before, the employee's department or agency, or the County.

6. **Grant/Service Providers/Agencies that Oversee Programs (two options)**

A. All investments, business positions, and sources of income, including gifts, loans and travel payments, or income from a nonprofit organization, if the sources is of the type to receive grants or other monies from or through the specific department or agency of the county.

(Intended for employees whose duties and decisions involve awards of monies or grants to organizations or individuals)

B. All investments, business positions, and sources of income, including gifts, loans and travel payments, or income from a nonprofit organization, if the sources is of the type to offer or provide consulting, rehabilitative or educational services concerning the prevention, treatment or rehabilitation of persons.

(Intended for employees who also approves programs for rehabilitation services)

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