SIERRA VIEW
MEDICAL CENTER

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

AGENDA
November 28, 2023

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:30 P.M. In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

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 (5:01 PM)

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

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9(b)(3)(F): Conference with Legal Counsel, significant exposure to litigation; & Gov. Code Section 54962; Health and Safety Code Section 32106(b); Cal. Civ. Code § 3426.1(d): Discussion Regarding Trade Secrets (1 Item) Estimated Date of Disclosure – March 2025

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

E. 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)

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)

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 (5:30 PM)

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 Report as Given

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

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

D. Discussion Regarding Trade Secret and Strategic Planning
Recommended Action: Information only; no action taken

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

F. Conference with Legal Counsel
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. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. 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 th e Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

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.

SIERRA VIEW MEDICAL CENTER

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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. **October 24, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove October 24, 2023 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. **Porterville Adult School**
Recommended Action: Information only; no action taken

B. **October 2023 Financials**
Recommended Action: Approve/Disapprove Report as Given

C. **Investment Report**
Recommended Action: Approve/Disapprove Report as Given

D. **Retirement Planning Advisory Committee Report**
Recommended Action: Approve/Disapprove Report as Given

XI. Announcements:

A. Regular Board of Directors Meeting – December 19, 2023 at 5:00 p.m.

XII. Adjournment

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. – 4:30 p.m. Such request must be made at least 48 hours prior to the meeting.

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
November 28, 2023

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.

SUBJECT: **SKIN CARE TIPS FOR NURSING ASSISTANTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose is to assure skin integrity is maintained.

POLICY:

Sierra View Medical Center (SVMC) will utilize protocols for skin care to promote resident comfort and to provide preventive skin care measures.

AFFECTED PERSONNEL/AREAS: *CNAs*

PROCEDURE:

A. INCONTINENT:

1. Check residents at least every 2 hours for wetness. Change as needed. Make a point to check incontinent residents between other duties.
2. Wash perineal area and dry at each change.
3. Use diaper or padding under resident in bed or up in chair; not up between legs. Do not layer incontinent pads between resident and pressure relief devices.
4. Check for redness and report it to the licensed nurse.
5. Toilet residents that are up in chairs at least every 2 hours or according to individualized toileting schedule.

B. CONTACTURES:

1. Practice gentle handling of area; move slowly so you do not hurt the resident.
2. Wash skin gently with wash cloth, dry well and pat with a soft cloth.
3. Check resident's fingernails, and trim if needed so they do not cut into the palms of hands. Check for redness, and report it to the nurse.

C. PRESSURE INJURIES:

1. Turn resident every 2 hours or more often as needed.
2. Do not leave resident on reddened area longer than to bathe or feed.
3. If incontinent, change as soon as wet, wash and dry.
4. Do not rub reddened area.

5. Any change in skin condition should be reported to the nurse.

D. SKIN:

1. Never rub. Only pat to wash and to dry.
2. Dress slowly, so cloth does not pull skin.
3. Be careful during transfers.
4. Use lotion to keep skin lubricated.

E. SKIN FOLDS:

1. Wash and dry under every skin fold.
2. If a patient is obese, padding may be needed under breast or stomach.
3. If redness is found, report it to the licensed nurse.

F. GENERAL:

1. Tuck linen loosely over residents and pressure relief devices.

REFERENCES:

- California Code of Regulations (2021). Title 22. §72315 (5) (6). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

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Senior Leadership Team	11/28/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	11/28/2023

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
November 28, 2023
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. Asbestos	1-3	
2. Closed Office Coverage, Notices, Signage	4-5	
3. Disruption of Services	6-7	
4. Extreme Temperatures	8-9	
5. Infant Child Abduction Procedures Code Pink and Purple	10-11	
6. Interim Life safety Measures (ILSM) Risk Assessment Matrix – Construction	12-14	
7. Mandatory Provider Cards	15-17	
8. Public Information	18-19	
9. Recording Hours Worked	20-22	
10. Sick Leave	23-26	
11. Staff Call-In	27-28	
12. Surge Capacity Plan	29-32	
13. Theft of Property	33-34	
14. Use of Temporary Tents, Canopies and Membrane Structures	35	
15. Vacation/Holiday Leave	36-42	
Forms:		
1. Physician Urology Office Note	43	
2. Request to Amend Protected Health Information	44-45	

SUBJECT: **ASBESTOS**	SECTION: *Hazardous Materials and Waste Mgt* **Page 1 of 3**

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

PURPOSE:

To provide guidance and safety processes to be considered during remodeling, construction or maintenance in areas of Sierra View Medical Center that may expose employees and occupants to Asbestos.

POLICY:

Asbestos-containing materials include:

- Thermal insulation used on hot water and steam pipes, boilers, hot water tanks and other storage tanks. Frequently, the mudded or mastic coating at cloth or canvas joints contain asbestos even if the tank does not.
- Flooring materials may be in the form of asphalt/asbestos tile, vinyl/asbestos tile or resilient flooring, i.e., linoleum 9 x 9 floor tiles usually contain asbestos. These flooring materials were generally used for hospital flooring in the sixties and seventies. Asbestos tile may be found under carpeting.
- Adhesives used in flooring adhesives.
- Acoustical plaster used in hospital ceilings (lobbies, corridors, patient rooms, auditoriums, meeting rooms, offices, etc.)
- Fireproofing sprayed on structural steel and steel frame buildings. Fireproofing is found throughout hospital ceilings and is out of sight.
- Roof tar and flashing may contain asbestos. Prior to the 1980s, built up roofs used asbestos-containing felts.
- Drywall joint compounds can be found throughout buildings.
- Miscellaneous materials including asbestos cement boards used as panels in service areas, ductwork and as firestops in plenum spaces, fire doors, cooling tower panels, window glazing/caulking, mastics/adhesives, fume hood liners, boiler fire brick or gasketing, etc.

Asbestos construction work is divided into four categories by the Occupational Safety and Health Administration (OSHA). They include:

- Class I - removal of thermal insulation and sprayed on or trouted on surfacing asbestos containing materials.
- Class II - removal of other types of asbestos-containing materials, i.e., roofing and flooring.
- Class III - repair and maintenance where asbestos-containing materials may be disturbed.

- Class IV - cleaning and custodial activities including vacuuming contaminated carpets, mopping floors and dusting.

Environmental Protection Agency (EPA) requires all friable asbestos-containing materials be removed prior to a building being demolished and it may require the removal before renovations. Depending on the size of the project, the Environmental Protection Agency (EPA) or the state must be notified prior to a building being renovated or demolished.

EPA classifies asbestos-containing materials into three categories.

- Category I - non-friable asbestos containing materials; including flooring, roofing and gasket materials.
- Category II - non-friable asbestos containing materials includes any non-friable materials not in Category I which cannot become friable upon renovation or demolition.
- Regulated Asbestos Containing Materials including friable asbestos (spray applied and thermal materials) and Category I and II materials which are subject to becoming friable during renovation or demolition.

ABATEMENT:

The EPA has instituted four asbestos abatement options which include:

- Operation and maintenance programs, which include the routine management of asbestos-containing materials.
  - A written program must be in place that includes notification of personnel and occupants who may come in contact with asbestos-containing materials, labeling to prevent unintentional disturbance of the material, and work practices for maintenance activities to limit the disturbance of material.
- Sealing the asbestos-containing materials by encapsulation with an impenetrable barrier which will inhibit fiber release.
- Enclosure of asbestos-containing materials, so fibers are not able to contaminate occupied areas.
- Removal of the asbestos-containing materials.

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

PROCEDURE:

- Material sampling is required of all thermal system insulation and surfacing materials. This includes floor tile installed prior to 1980, which must be presumed to contain asbestos. The samplings must be

performed by an accredited Asbestos Handling Emergency Response Action inspector. A minimum of three samplings must be taken in all applicable areas from each material.

- OSHA instituted a permissible exposure limit to regulate work exposure limit to an airborne level of 0.1 f/cc (fibers per cubic centimeter) as an eight hour time weighted average.

- OSHA requires a "competent person" to conduct an initial exposure assessment. All Class I work is assumed to exceed the limits until monitoring documentation can prove otherwise. All Class I and II projects shall be monitored on a daily basis. The following shall be identified during the assessment.
  - Identify if there is a hazard.
  - Identify the risk of exposure. The four components that affect risk potential are friability, condition, location and air movement.
- Warning labels shall be posted to all asbestos-containing materials at accessible locations.
- Floor tiles containing asbestos must not be sanded. Stripping of unwaxed or unfinished floor tiles that contain or are presumed to contain asbestos is prohibited.
- Engineering Department and Environmental Services personnel that work in areas known or presumed to contain asbestos must attend an asbestos-awareness training class annually. Personnel who clean up or remove asbestos are required to attend additional training.
- A medical surveillance program shall be in place for all personnel exposed to asbestos concentrations that exceed the exposure limits or short-term exposure limits. Personnel exposure monitoring records shall be maintained for 30 years.
- Contractors shall be notified that asbestos-containing materials may be encountered during the project prior to bidding. The contractor shall be supplied with the name of a "competent person" to call if asbestos-containing materials are disturbed or damaged during the project.

REFERENCES:

- Occupational Safety and Health Administration (OSHA) (n.d.). Retrieved from www.osha.gov.
- Environmental Protection Agency (EPA) (n.d.). Retrieved from www.epa.gov.
- Title 8 Section 1529. Asbestos. Retrieved from https://www.dir.ca.gov/title8/1529.html.

SUBJECT:	SECTION:
CLOSED OFFICE COVERAGE, NOTICES, SIGNAGE	***Multi – Specialty Clinic***

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

PURPOSE:

To ensure proper, timely communication of both planned and unplanned changes in the clinic's operating schedule.

POLICY:

Clinic staff will post signs and/or notices when both planned and unplanned changes in the Clinic's posted operating schedule occur.

AFFECTED PERSONNEL/AREAS: *MULTI-SPECIALTY CLINIC AND MEDICAL STAFF*

PROCEDURE:

A. Telephone coverage

1. During the course of regular Clinic hours, if the telephone is not being answered by Clinic staff, the phones will be forwarded to a contracted, professional answering service.

2. Clinic Leadership or designee will forward the after-hours schedule to the contracted, professional answering service by the 20th of the month for the following month.

3. Clinic Leadership or designee will set telephone system to call forwarding at the end of the business day or whenever usual operations schedule is amended, both planned and unplanned.

B. After-hours schedule

1. Clinic physicians will collaborate to determine who is on after-hours coverage during the course of each month and will communicate this information to Clinic Leadership or designee prior to the 20th of the month for the upcoming month.

2. Clinic Leadership or designee will ensure the after-hours schedule is compiled, forwarded to, and received by the contracted, professional answering service in a timely manner.

C. Planned closing/change of schedule

1. If a Clinic closing is planned (i.e.: holiday, vacation), advance notice of the closing will be posted, using the attached format, at least one week prior to the planned closing.

2. Notice will include instructions to be followed in the case of a medical emergency.

D. Unplanned closing/change of schedule

1. If an unplanned closing or change of schedule occurs (i.e., power failure, medical emergency at the hospital requiring the physician, other emergency), notice will be posted immediately to advise patients, guests, vendors, and delivery personnel.

2. Notice will include instructions to be followed in the case of a medical emergency.

3. Upon re-opening the Clinic, all notices will be removed and appropriately disposed.

REFERENCES:

- The Joint Commission, PC.04.01.01, Hospital, Provision of Care, Treatment, and Services

CROSS REFERENCES:

- BUSINESS HOURS – MULTI-SPECIALTY CLINIC

SUBJECT: **DISRUPTION OF SERVICES**	SECTION: ***Resource Management and Preparation*** **Page 1 of 2**

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

POLICY:

In the event that disruption of services should occur, as a result of an internal or external situation, Sierra View Medical Center shall exercise a plan to provide for the safety and welfare of patients, visitors, and staff.

Alternative sources for provision of essential utilities shall be identified and planned for in order to maintain the hospital's ability to provide for patient care when essential utilities are disrupted.

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

PROCEDURE:

AUTHORITY:

The Chief Executive Officer or Administrator On-Call will be notified immediately of any actual or anticipated disruption of services that impairs the facility's ability to deliver safe care. They will report to the hospital immediately to assume responsibility for evaluating the situation and determining an appropriate course of action including possible evacuation, transfer, or relocation of patients.

Department Leaders may be recalled to the hospital to participate in the response to the incident.

REPORTING:

The Chief Executive Officer or Administrator On-Call shall be responsible for informing the Department of Health Services, by telephone, immediately upon being notified of the disruption of services or the need to discontinue services due to earthquake, fire, power outage, or other calamity that causes damage to the facility or threatens the safety or welfare of patients.

BED LIMITATION:

1 Transfers of patients from this facility to another because of lack of beds or staff will not occur until all measures to accommodate the patient have been exhausted and documented.

2 Decisions to limit admissions will be made by the CEO, in consultation with the Chief of Staff, after evaluation of all efforts to accommodate the patients.

PHYSICIAN NOTIFICATION:

Physicians shall be notified if a decision is made to restrict admissions and when the closure of the facility or portions of the service are imminent. Staff will determine from the physician whether in-patients currently in the facility may be discharged or may require transfer to another facility.

ESSENTIAL SERVICES AND UTILITIES:

Contingency plans are in place to address management of loss of essential utilities and services including power, water, Medical gases, and sewer.

1. If the interrupted service has been due to loss of electricity, the on-duty Engineering Department personnel shall proceed immediately to the emergency generator to ensure that on hand associated systems are operating satisfactorily. When proper operation has been verified, he/she shall then inform the Administrative Director of General Services or designee, and notify the CEO or designee.

2. Appropriate utility companies shall be notified by the Facilities Manager without delay when their services are required to repair or assist with returning services to proper functioning levels. See "*Essential Services Phone Reference List*".

REFERENCES:

- The Joint Commission (2023). EM.12.01.01 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Title 22: Section 70741, 70743, 70745, 70746

SUBJECT: **EXTREME TEMPERATURES**	SECTION: *Special Circumstances* **Page 1 of 2**

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

PURPOSE:

To provide guidance and safety processes to be considered during periods of extreme ambient temperatures. Sierra View Medical Center is located in the southern San Joaquin Valley in the State of California. Summer ambient temperatures often exceed 100 degrees F*.

POLICY:

During periods of extreme ambient temperatures special precautions will be implemented for employees who must work outside and are subjected to extreme heat.

Any time ambient temperatures exceed 80 degrees F*, Cal OSHA programs will be followed for worker safety within the "Heat Illness Prevention" guidelines. Examples of program elements include frequent break periods in shaded areas or inside conditioned buildings. Employees will have available for their use Ice, Water and other consumable fluids to control dehydration and heat stroke symptoms.

To prevent against physical plant equipment failures, the Facilities Manager will consistently evaluate physical plant systems for proper operation and reliability to ensure uninterrupted operation for the safety of all those who inhabit the facilities during summer months. Engineering will have policies and procedures including equipment checks and periodic maintenance of all HVAC systems to ensure proper operation and reliability. When equipment failures occur, refer to the Disruption of Services policies and procedures in the Environment of Care Policy & Procedure Manual.

Sierra View Medical Center follows an "All Hazards Approach" to emergencies by referring to and following the programs contained within the Emergency Operations Procedure manual and the Emergency Operations Plan.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

When necessary, the Safety Officer will take actions to ensure the safety of employees, patients, medical staff, volunteers, students and the general public who access the District's facilities due to temperature extremes within the facilities of Sierra View Medical Center due to equipment malfunction and failure.

Employees who must work in extremely hot conditions will follow the safety programs put into place by Employee Health for their protection from dehydration and heat stroke conditions.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EM.12.02.11 Joint Commission Resources. Oak Brook, IL.
- Cal OSHA "Heat Illness Prevention" eTool (April 2018). Retrieved from https://www.dir.ca.gov/dosh/etools/08-006/.

CROSS REFERENCES:

- Disruption of Services

SUBJECT:	SECTION:
INFANT/CHILD ABDUCTION PROCEDURES - CODE PINK & CODE PURPLE	***Security Management***

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

PURPOSE:

To ensure that all hospital personnel and outside agencies are notified appropriately, with the goal of being able to locate, return and reunite the infant or child with the family as quickly as possible.

POLICY:

At no time should anyone without a valid need to know be told that an infant or pediatric patient is missing. The Chief Executive Officer (CEO) or designee and the police will make that determination. No hospital employee or volunteer is authorized to make a public statement concerning this incident or to communicate with any member of the media without prior clearance from the CEO or designee.

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

PROCEDURE:

1. When staff has suspicion an infant or pediatric patient is missing, the staff will immediately notify PBX and call a Code Pink (infant abduction) or Code Purple (child abduction) by providing the location of the abduction and description of the patient. Upon hearing the Code Pink/Purple announcement, all staff will immediately check their areas and initiate searches to locate the infant or pediatric patient.

2. Search the mother's room and the nursery or patient room as appropriate. Care will be given to protect the crime scene where the abduction occurred to preserve any evidence.

3. Nursing administration will notify the CEO, Administrator on Call, Risk Management, and the Safety Officer.

4. Nursing administration will begin keeping a log of the event.

5. Communications will implement the following actions:

    a. Contact Security, Maintenance and Housekeeping by radio and notify same of the floor or area affected by the Code Pink/Code Purple and provide a basic description of the missing patient. Security, Maintenance and Housekeeping will secure all hospital exits and stop the flow of traffic. Guests attempting to leave the hospital will be asked to cooperate until the police arrive.

    b. Dial 911 and report incident to the police, asking them not to broadcast the information over the radio.

    c. Maintain a policy of NO information to any inquiries about this patient or the incident.

6. The director of the affected department and staff will implement the following actions:

    a. Inform the parents of the abduction once it has been confirmed.

    b. If a newborn abduction has occurred, place all babies in the mother's room unless contraindicated.

    c. Provide supportive services to the mother and family of the abducted infant, as indicated.

    d. All staff will remain until released by the police department.

7. The CEO or designee will implement the following actions:

    a. Develop a plan that meets the specific needs of this incident and act as a facility liaison with the police department to ensure cooperation with any needed activities, i.e. complete hospital search, questioning of staff and visitors.

    b. Distribute to staff a standardized response to any phone or in person inquiries.

    c. In collaborating with the CEO, Vice President of Patient Care Services and affected nursing manager, implement plan to inform other patients of this incident and ensure additional nursing staff and patient care services as needed.

    d. Clear any public communication statements.

8. All staff, patients, visitors and vendors shall be detained for possible questioning by police.

9. Observe the description, clothes, vehicle license number and direction of any person or persons observed fleeing the facility. This information shall be forwarded to the police immediately. Video camera footage will be retrieved by Security in order to search for possible suspects and to review the incident.

REFERENCES:

- The Joint Commission (2023). EC.02.01.01 EP9 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Abduction of Newborn/ Code Pink – MCH Response

SUBJECT:	SECTION:
INTERIM LIFE SAFETY MEASURES (ILSM) RISK ASSESSMENT MATRIX - CONSTRUCTION	***Life Safety Management*** **Page 1 of 3**

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

POLICY:

Sierra View Medical Center (SVMC) will institute and document Interim Life Safety Measures (ILSM) to temporarily compensate for hazards posed to buildings and grounds during construction.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

The Administrative Director of General Services will evaluate identified Life Safety Code deficiencies and construction activities to decide when and to what extent one or more of the following are applicable activities utilizing the attached Interim Life Safety Measures Risk Assessment Matrix (Attachment A):

- All exits will be unobstructed and useable. All personnel will receive training if alternative exits must be designated. Buildings or areas under construction will maintain escape facilities for construction workers at all times. The means of egress in the construction area will be inspected for reliability daily.
- Ensure free and unobstructed access to the Emergency Department/services for emergency forces and ensure that vehicles, materials, etc., are not blocking access routes.
- Fire alarm, detection and suppression must be in good working order. If any fire system is impaired, a temporary but equivalent system shall be provided and must be inspected and tested monthly.
- When the fire alarm system or automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the Hospital shall notify the local fire department and implement fire watches in an occupied building.
- Temporary construction partitions must be smoke tight and built of noncombustible or limited combustible materials that will not contribute to the development or spread of a fire.
- Additional firefighting equipment and training for personnel on its use will be conducted in the affected areas.
- Smoking shall be prohibited in or adjacent to all construction area and throughout the hospital buildings.
- Develop and encourage storage, housekeeping and debris removal practices that reduce the building's flammable and combustible fire load to the lowest level necessary for daily operations. All flammable liquids will be properly stored.
- Conduct a minimum of two fire drills per shift per quarter in affected areas.

- A specific assignment for fire watches when cutting and/or brazing torches are being used or when interruptions are made in the fire warning system.
- Increase hazard surveillance rounds of grounds, buildings and equipment, paying special attention to construction areas, construction storage, field offices and excavations both during and after hours.
- Train personnel to compensate for impaired structural or compartmentalization features of fire safety.
- Conduct hospital-wide safety education programs to ensure awareness of Life Safety Code deficiencies, construction hazards and interim life safety measures, only when the entire facility is compromised.
- The Administrative Director of General Services will implement a prioritized work order program to ensure timely correction of Life Safety Code deficiencies.
- The Administrative Director of General Services will coordinate Interim Life Safety Measures (ILSM) between the Safety Officer, Environment of Care Manager, Fire Marshal, Infection Control, Directors of affected areas, Contractors and the Fire Department.
- The Environment of Care Manager will ensure that all Interim Life Safety Measures (ILSM) are documented and that reports are submitted to the Safety Committee on a quarterly basis.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. LS.01.02.01 Joint Commission Resources. Oak Brook, IL.
- SVMC Interim Life Safety Measures Risk Assessment Matrix

ATTACHMENT A

Sierra View Medical Center
Interim Life Safety Measures Risk Assessment

Existing Significant Life Safety Code Deficiencies as a Result of Construction	Interim Life Safety Measures														
	1) Ensuring Egress	2) Emergency Forces Access	3) Emergency Forces Notification	4) Ensuring Operational Life Safety Systems	5) Implementing a Fire Watch	6) Temporary Construction Barriers	7) Additional Fire Fighting Equipment	8) Prohibiting Smoking	9) Controlling Combustible Loading	10) Conducting 2 Fire Drills Per Shift in All Areas	11) Conducting 2 Fire Drills Per Shift in Local Area	12 Increased Hazard Surveillance	13) Training of personnel in affected areas	14) Conducting Facility Wide Training on Life Safety	15) Conducting Additional Training of Incident Response Team
Code Deficiencies															
Patient room door latching problem															
Lacking a code complying smoke barrier															
Fire exit stairs discharge properly															
Excessive travel distance to an approved exit															
Lack of two remote exits															
Non conforming building construction type															
Improperly protected vertical openings															
Large penetrations in fire barriers															
Corridor walls do not extend to the structure															
Hazardous areas not properly protected															
Construction Related Issues															
Blocking off an approved exit															
Rerouting of traffic to the emergency room															
Major renovation of an occupied floor															
Replacing fire alarm system (out of service)															
Installing a sprinkler system (out of service)															
Significantly modifying smoke or fire barrier walls															
Adding an addition to an existing structure															
Maintenance and Testing															
Taking a fire alarm system out-of-service															
Taking a sprinkler system out-of-service															
Disconnecting alarm devices															

Project / Department _____ **ILSM Implemented** **Yes** _____ **No** _____

Signature _____ **Department** _____ **Date** _____

SUBJECT: **MANDATORY PROVIDER CARDS**	SECTION:

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

PURPOSE:

To define the requirements and procedures of Sierra View Medical Center (SVMC) mandatory provider cards validation process.

DEFINITIONS:

1. Provider card: Given to participant who takes and passes an American Heart Association provider course or other course required for hospital employees in specific job roles.

POLICY:

All clinical staff will hold, obtain and/or maintain current provider cards appropriate to each area in the hospital. (For licenses, registrations and certifications required to perform services, please see LICENSURE, REGISTRATION, CERTIFICATION Policy.)

AFFECTED PERSONNEL/AREAS:

ALL EMPLOYEES, INDIVIDUAL CONTRACTORS AND EMPLOYEES OF CONTRACTORS

PROCEDURE:

A. All required provider cards must be presented at the time of employment, unless otherwise clarified by the job description.

B. All life-support provider cards (basic and advanced) must be from the American Heart Association (AHA).

Note: An AHA Basic Life Support for Healthcare Providers (BLS) provider card is required for clinical staff in all patient care areas and must be obtained prior to hands-on patient care. All other required AHA provider cards must be obtained within 6 months of assignment to department.

C. Annually, provider cards are verified online with the appropriate issuing agencies, and a photocopy of the provider card along with the verification documentation will be placed in the employee's personnel file. PLEASE NOTE: E-CARDS must be claimed by the employee prior to the old card expiration date. Once that is complete. HR is not able to pull verification until this has been done.

D. It is the employee's responsibility to maintain current required provider cards and to provide a copy of the card or E-CARD # to their Department Director and Human Resources prior to the expiration date.

   1. A copy of the provider card or verification will be maintained in each staff member's personnel file.

   2. The Education Department will maintain evidence of completion in SVMC's learning management system.

3. For AHA courses offered at SVMC:

   a. AHA provider cards will be presented to successful course attendees via E-Card.

   b. Lost AHA provider cards can be printed through your E-Card account.

E. Employees will work with their Department Directors to schedule their attendance and participation in mandatory provider classes.

1. Attendance at training/education is mandatory when attendance is required as a condition of employment and/or continued employment.

Attendance at scheduled mandatory training/education is treated as scheduled work time and time and attendance rules apply to course attendance. Due to limited availability of seats available for each class, it is imperative for staff to inform Education Department if they will not be attending so they can re-assign the seat to another staff member.

   a. Employees must call to notify the Education Department and the Department/ Staffing office at least 48 hours in advance or as soon as is reasonably possible when they are unable to attend a scheduled class day. Failure to notify the Education Department of an absence to a mandatory training/education class within the guidelines stated above will be subject to disciplinary action based on the Attendance & Punctuality Policy.

2. Time and materials for mandatory provider card training/education is compensable when completed at SVMC. Every effort should be made to avoid overtime when scheduling mandatory courses.

   a. Should the employee who is required to hold a provider card choose to take the training course outside of SVMC when the facility has scheduled courses on the calendar, the time and materials are not compensable or reimbursable.

   b. Mandatory training that is not available through SVMC and must be taken off-site is compensable at the employee's base rate of pay.

   c. Computers are available at SVMC for staff use. Time spent completing mandatory training that is computer-based is compensable time and must be completed on-site at SVMC.

   d. Employees who work for more than one organization and choose to complete the training at their other place of employment will not be paid by SVMC to complete off-site training when that training is also on the calendar at SVMC.

e. Employees who are on a Medical Leave of Absence when training is available or mandatory must be cleared by their Physician to participate. Please contact Human Resources to work through this process.

F. Staff failing to maintain or acquire the required provider cards within the expected time-frame will:

1. Be removed from their department work schedule

2. Placed on an unpaid disciplinary suspension up to a maximum of a two week period

   a. Documented Suspension will be placed in their employment file

   b. Vac-Hol will not be available during the unpaid suspension period

3. If the provider card is renewed sooner than the two week period, and proof is provided to the Human Resources department, the employee can then return to work.

4. It becomes the employee's responsibility to find courses that satisfy the mandatory training requirement when she/he does not take a SVMC-provided course within the established timeframe.

5. Failure to obtain the required provider cards within the two (2) week Administrative Leave period will result in termination of employment with the Hospital.

H. Documentation:

1. Staff participation at provider classes at SVMC is documented with attendance rosters signed by the employee, and testing completed by the employee and validated by the instructor when appropriate.

2. The Education Department will notify Human Resources (HR) once an employee has completed the class. The employee must then CLAIM their E-Card prior to expiration date of the old card. Once that is completed, HR will then print off E-Card for HR records. If the employee receives training from outside of SVMC, the employee will need to bring in a copy of the card to HR, or the E-Card # will need to be provided to HR in order to print. This too must be done prior to expiration date of the old card.

I. Provider Card Requirement for each department and position:

6. Refer to the employee's job description.

CROSS REFERENCES:

- LICENSURE, REGISTRATION, CERTIFICATION
- ATTENDANCE AND PUNCTUALITY

SUBJECT:	SECTION:
PUBLIC INFORMATION	***Public Information***
	Page 1 of 2

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

POLICY:

Sierra View Medical Center (SVMC) will provide appropriate communication of information on the presence and status of disaster victims to relatives, authorities, and news media within the guidelines of patient confidentiality.

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

PROCEDURE:

1. The role of Public Information Officer (PIO) will usually be assigned to the Community Relations and Marketing staff member working in the Command Center.

2. The Public Information Officer will obtain updated victim lists periodically throughout the disaster response.

3. All news releases and reports will be issued by the Public Information Officer only.

4. News media will remain in the room assigned by the PIO in the conference room area. News media will not be allowed access to triage or treatment areas without escort authorized by the Public Information Officer.

5. Efforts will be made to coordinate family inquiries with victim lists, and assisting families in locating loved ones.

6. Families and visitors will be assisted to a holding area in the lobby or other area determined by the Command Center. Assistants will be assigned to provide a caring atmosphere and to meet the needs of concerned persons for information and comfort during waiting periods. Families may need to interact with Social Services, physicians, and clergy. A log will be maintained of all visitors and the name of the victim they are wanting to locate or visit.

7. The Red Cross may respond with requests for information about the welfare of individuals in disaster-stricken areas.

    a. The Disaster Health Service of the Red Cross is responsible for obtaining verified information on ill, injured, hospitalized and dead for inquiry purposes.

    b. These requests are handled by Disaster Welfare Inquiry (DWI) workers. Information for DWI will include victim's name, age, sex, diagnosis and condition, pre-disaster address, and present location of the victim.

    c. Information from the Victim Lists will be used to complete the *Disaster Welfare Inquiry* form by the Public Information Officer in the Command Center.

d. The Red Cross does not release casualty lists publicly or notify families unless requested to do so by public officials.

8. VIP (Very Important Person):

a. An event that occurs, which would cause admittance of a person for treatment for injury or illness and that person being of high public interest, could require the hospital to activate part of the disaster plan:

- Seal off a room or section and restrict entry.
- Implement a modified security plan providing support for security personnel accompanying the VIP.
- Public Information releases to the news media and the required support of additional communications with approval of the VIP or security representatives.

REFERENCES:

- The Joint Commission (2023). EM.12.02.01 EP2 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- California Code of Regulations (2019). Title 22. § 70741, 70743, 70745, 70746. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **RECORDING HOURS WORKED**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide standard guidelines for the accurate documentation of all hours worked by employees in order to ensure full compliance with Wage and Hour Guidelines as well as other relevant state and federal statutes.

POLICY:

Exempt Employees:

Employees who work in a position designated as exempt under the Fair Labor Standards Act (FLSA) are exempt from overtime payments under federal law. To qualify as an exempt employee, he/she must be paid on a salary basis and must qualify for exempt status under applicable federal and state law. Should the exempt employee work on a holiday, all hours worked must be approved by their Vice-President. Please refer to HR Policies: Exempt Employee Compensation, Holiday Pay and Vacation/Holiday. Their individual schedules may vary based on the needs of the department, but all full-time exempt employees are expected to work a minimum of forty hours per week. The hospital will follow the provisions of the Federal Fair Labor Standards Act (FLSA) and applicable California wage statutes to establish a "salaried" exempt status for Executive, Professional, or Administrative employees who are classified as exempt from the overtime provisions. For pay practices for exempt employees who work extra shifts, refer to HR Policy: Exempt Staff Working Extra Shifts.

Non-Exempt Employees:

Federal Wage and Hour laws require that non-exempt employees be paid for every hour they are "suffered or permitted" to work. Time sheets are considered to be legal documentation and, as such, must accurately reflect all hours worked and all non-productive hours (Education, Orientation, In-service, etc.) utilized by each employee. Non-exempt employees will be expected to accurately record all hours worked utilizing the timekeeping system. For purposes of overtime computation, hours worked will include actual hours worked and other approved hours.

All productive hours worked or non-productive hours utilized by employees to complete their daily time commitments will be accurately recorded and approved on a daily basis.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

PROCEDURE:

CLOCKING IN AND OUT

1. Employees have the option of using the computer or time clock to clock in/out.

2. Employees will be considered tardy if they clock-in eight (8) or more minutes after their scheduled shift start time.

Failure to follow this procedure or instructions/counseling will result in disciplinary action.

EMPLOYEE REVIEW OF TIME RECORDS

1. Employees are responsible for the accuracy of their timecards. Responsibilities include using time clocks and computers to accurately record hours worked, pay code hours such as Vacation/Holiday, late or missed meal and rest breaks, and any hours transferred to other departments and/or secondary job codes. Employees are required to review and attest to the accuracy of all hours and totals as presented on their time cards on a daily basis.

2. Any earning adjustments received by Payroll after the close of the prior pay period due to error by employees will be corrected in the next pay period. Any discrepancies with time sheets must be directed to the employee's immediate supervisor for correction.

3. Any earning adjustments received by Payroll after the close of the prior pay period due to error by department leadership or the District will be processed as soon as practical.

LEADERSHIP REVIEW OF TIME RECORDS

The Director or Manager will review and approve time cards each week, certifying that the hours were properly recorded, are accurate and that each employee is entitled to compensation accordingly. As part of the time card review, leaders are responsible for ensuring their staff are getting all meal and rest breaks by reviewing the attestation completed by the employee indicating they had a late or missed meal or rest period. If the attestation by the employee results in a meal/rest penalty, leaders will need to discuss this with their staff members and submit a Payroll Earnings Adjustment Request form as necessary.

It is the responsibility of the Director or Manager to review and approve the previous pay period time cards by 10:00 a.m. on payroll Mondays. Failure to ensure accurate documentation of hours worked and/or edits could result in disciplinary action.

FALSIFICATION OF RECORDS PROHIBITED

Employees approving inaccurate data about their hours on their time cards will be grounds for immediate disciplinary action, up to and including termination.

Clocking in for another employee's time is prohibited and will be grounds for immediate disciplinary action, up to and including termination.

HOURS WORKED

A paid ten(10) minute rest period is provided for every 4 hours of work. For additional details, please refer to HR Policy: Meal and Break Periods.

Payment for time worked will be calculated by the minute as recorded in the timekeeping system. There will be no rounding of time by fifteen minute increments. Early clock ins prior to an employee's scheduled shift and/or late clock outs at the end of an employee's scheduled shift that result in overtime is

prohibited unless approved by their leader. Any pattern of intentionally gaining unapproved time will result in disciplinary action.

PRE OR POST-SHIFT ACTIVITIES

Any activity that non-exempt employees are required to perform before they can begin their jobs or before they can leave the premises must, by law, be considered time worked. Such activities may include, but are not limited to:

- Changing clothes (when such changes must be made on premises);
- Setting up a work station;
- Mandatory showers or scrub-downs; and cleanup activities.

VOLUNTEERED TIME – (Non-exempt)

Non-exempt employees are prohibited from volunteering to work before or after scheduled shifts performing substantially the same type of duties for which they would normally be compensated.

DIRECTOR RESPONSIBILITY FOR ADMINISTRATION OF SALARY POLICIES

Managers and Directors may not unilaterally create, promise or implement agreements with employees involving wages, premiums, or recording of time, or otherwise modify or exceed the hospital's wage and salary policies. Wage practices and benefits defined by exempt or non-exempt status will not be altered.

REFERENCES:

- Fair Labor Standards Act
- California Labor Code and Industrial Welfare Commission

CROSS REFERENCES:

- OVERTIME
- HOLIDAY PAY
- EXEMPT STAFF WORKING EXTRA SHIFTS
- MEAL AND BREAK PERIODS
- EXEMPT EMPLOYEE COMPENSATION

SUBJECT: **SICK LEAVE**	SECTION: *Human Resources* **Page 1 of 4**

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

PURPOSE:

To define the purpose and scope of Sick Leave benefits provided at Sierra View Medical Center (SVMC).

POLICY:

SICK LEAVE ACCRUALS

All Employees: The Hospital will provide each employee with a lump sum of five (5) days of protected sick leave at the beginning of each 12-month period (employee's date of hire). An employee is not eligible to begin using any protected sick leave until the 91st day of employment with the Hospital. Unused days do not carry over to the following year.

PERMITTED USE OF SICK LEAVE

Sierra View Medical Center allows employees to utilize available paid sick leave for the following circumstances:

- Diagnosis, care, or treatment of an existing health condition, or preventative care for an employee or an employee's designated person, family member, as defined as employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, and siblings. "Family Member "means any of the following:
    - A child, which for purposes of this policy means a biological, adopted or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis; this definition of child is applicable regardless of age or dependency status.
    - A biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child.
    - Spouse
    - Registered domestic partner
    - Grandparent
    - Grandchild
    - Sibling

- Designated Person means the following:

Under the California Family Rights Act (CFRA) and California Healthy Workplaces Health Families Act (HWHFA) an employee will be able to identify a designated person for whom they want to use leave when they request unpaid CFRA or HWHFA.
For an employee who is a victim of domestic violence, sexual assault or stalking, as specified.

- To obtain any relief or services related to being a victim of domestic violence, sexual assault, or stalking, including the following with appropriate certification of the need for such services:

- A temporary restraining order or restraining order.
- Other injunctive relief to help ensure the health, safety or welfare of themselves or their children.
- To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking.
- To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking.

- To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking.
- To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

TERMS AND CONDITIONS

- An employee shall provide reasonable advance notification of their need to use available accrued sick leave to their supervisor if the need for such sick leave use is foreseeable (e.g., doctor's appointment scheduled in advance). If the need for such sick leave use is unforeseeable (*e.g.*, employee is ill at time of shift), the employee shall provide notice of the need for the leave to their supervisor as soon as is practicable.
  - If the absence is foreseeable, the employee's time sheet must be completed in advance of the absence. If the absence is unforeseen, the employee must complete their time sheet upon return from the absence. If the absence extends beyond the close of the payroll period, it is the employee's responsibility to request sick leave be added to the time sheet at the time the absence is reported. If sick leave is not noted on the time sheet, the absence is considered an unexcused absence. The employee is required to approve/attest the sick leave entry on the time sheet upon return.
- Departments may require an employee who uses available sick leave hours from their sick leave bank to do so with a minimum increment of two hours.
- Sick leave use will not be counted as an absence occurrence or used as a basis for disciplining an employee for absenteeism. However, if an employee does not have any sick leave hours to use for an absence, the absence will be counted as a full occurrence under the Attendance and Punctuality policy. In a declared emergency/disaster related to a medical situation like a pandemic, a physician's note will be required after the third day of work missed not protected under sick leave.

- An employee will not receive compensation for unused sick leave upon termination, resignation, retirement or other separation from employment from the Hospital.

  Employees rehired by the Hospital within 12 months from date of separation, shall receive upon new hire date, 5 days of protected sick leave to be used on or after their 91st day of re-employment.

- Sick leave will not be considered hours worked for purposes of overtime calculation.

- Any available sick leave must be used simultaneously with an employee's FMLA/CFRA leave and may be used on Pregnancy Disability Leave (PDL) leave.

REQUIRED RECORD KEEPING:

As part of a department's routine process of receiving information from employees who call in sick, procedures need to be in place to inquire about the following:

- Whether the sick day is due to a covered reason under this policy.

- If the sick day is used to care for a covered person as listed above, what is that person's relationship to the employee? (Mother, child, etc.)

- Whether the illness is a serious health condition that also may be covered under FMLA/CFRA/PDL. Employees do not need to disclose a diagnosis. If the illness qualifies as a serious health condition, employees should be directed to contact Human Resources. Directors/Managers must notify Human Resources once they learn an employee/employee's family member may have a qualifying illness/serious health condition, so the employee may be informed of leaves available to them.

CAUTION: The scope of the questions must be limited, to protect the confidentiality of medical information of an employee or family member's health condition. For example, the department cannot ask the employee to reveal what the specific health condition is.

A Leave of Absence does not need to be requested unless the employee will be absent for more than three (3) continuous work days and the absence qualifies as an FMLA/CFRA, PDL or other medical leaves.

An employee taking sick leave is not required to submit a doctor's note.

REFERENCES:

- Dir. (n.d.). Healthy Workplace Healthy Family Act of 2014 (AB 1522). Retrieved August 25, 2020, from https://www.dir.ca.gov/dlse/ab1522.html.

- California Code of Regulations (2020). Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Family and Medical Leave Act. (n.d.). Retrieved August 25, 2020, from https://www.dol.gov/agencies/whd/fmla.

- California Family Rights Act - DFEH. (n.d.). Retrieved August 25, 2020, from https://www.dfeh.ca.gov/wp-content/uploads/sites/32/2019/08/DFEH_CFRA_Pamphlet.pdf.

- California, S. (n.d.). PDL, CFRA, NPLA, and FMLA Requirements and Obligations. Retrieved August 25, 2020, from https://www.dfeh.ca.gov/employment/pdl-cfra-npla-fmla/.

CROSS REFERENCES:

- Reasonable Accommodation policy
- Attendance & Punctuality policy
- Leave of Absence – FMLA/CFRA policy

SUBJECT:	SECTION:
STAFF CALL-IN	***Response and Assignment of Personnel*** **Page 1 of 2**

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

POLICY:

Upon initiation of Disaster Response, available in-house personnel resources will be evaluated. Additional personnel will be called in to work as needed to meet the needs of the disaster response and patient care needs. In the disaster response, staff members may be assigned to areas outside of their usual department responsibilities to meet resource requirements.

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

PROCEDURE:

1. At the time of plan initiation, a determination will be made by the Command Center regarding personnel needs to manage the disaster response. An on-going assessment of manpower needs must continue for the duration of the disaster response.

2. The Command Center and subsequently assigned Planning Chief will determine the number and skill level of personnel on duty and numbers and skill level of additional personnel. (Refer to: "*Staff Deployment Guidelines*".)

3. Individual departments will be provided with information in the briefing session that will allow them to assess and institute their individual department staff call-in immediate needs.

4. Each department should maintain a roster of its assigned personnel which is current and readily available to facilitate call-ins and to determine potential staff availability. The roster should include employee name, phone numbers, and their response when called. This roster indicates who is on duty and status of staff who may already have been contacted. It is helpful to shade the names of the staff members who live less than 10 minutes from the facility as they will be most likely to respond quickly. Each department will complete and forward a copy of the department *Staff Call In Roster* to the Planning Section after the initial call in attempts. Further staffing needs and calls will be handled by the Planning Section as the disaster response progresses.

5. Off duty personnel who may hear of a disaster involving the hospital will:

    a. If a major disaster – attempt to report to the hospital as soon as possible upon securing family and home.

    b. If a lesser disaster – contact home department for need, keep phone lines open for possible call-in.

6. Staff arriving in response to a disaster will report to the Labor Pool. Labor Pool responsibilities include:

    a. Collect all Staff Call-In Rosters from all departments

    b. Supervise staff call in activities

c. Verify identification of all incoming personnel

d. Log time of arrival of staff, skill level, assignments, and time released from duty using the *Labor Pool Tracking* form

e. Log all requests for help (see *Personnel Resource Request* form)

f. Use *HICS Section Personnel Time Sheet* form for compiling summary of all staff hours spent on the disaster and forward to Finance Section.

7. Persons who report in to the Labor Pool wishing to volunteer services in a disaster will be logged onto the "*Volunteer Staff Registration/Credentialing* Form". The Labor Pool Unit Leader will determine assignments based on Security clearance and skill level.

8. Priority will be given to providing adequate staff for the Triage and Immediate Treatment Area.

9. In carrying out a staff call-in, consideration should be given to:

a. What are the real needs at this present time? When are casualties expected to arrive? How many?

b. What are the skill levels needed to manage this specific disaster event?

c. How long will a sustained disaster response be necessary?

d. Possible distribution of help into shifts to cover prolonged needs over several hours, days, etc.

e. Release from duty as soon as extra staff are not needed.

REFERENCES:

- The Joint Commission (2023). EM.12.02.03 EP1 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- California Code of Regulations (2020). Title 22. §70741, 70743, 70745, 70746. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **SURGE CAPACITY PLAN**	SECTION: ***Emergency Management Program*** ***Patient Management*** **Page 1 of 4**

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

PURPOSE:

The Surge Capacity Plan is an enhancement to the existing Emergency Operations Plan found in the Emergency Operations Procedures Manual.

POLICY:

The Sierra View Medical Center (SVMC) will provide a Surge Capacity Plan that will be utilized during major mass-casualty incidents or other times of anticipated hospital surge.

Sierra View Medical Center surge capacity is defined as the hospital's ability to handle an influx of casualties during major mass-casualty incidents (MCI) or disease outbreaks.

Categories for Surge Capacity

1. Short term (12-24 hours): Circumstances include accidents, earthquakes and similar disasters

2. Long term (24 hours to 24 months): Circumstances include outbreaks and epidemics

Anticipated Surge

The Local Emergency Medical Services Agency has defined for the County the anticipated surge capacity:

1. 500 cases per million population for patients with symptoms of acute infectious disease-especially smallpox, anthrax, plague, tularemia, and influenza;

2. 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that result from nerve agent exposure;

3. 50 cases per million population for patients suffering burn or trauma; and

4. 50 cases per million population for patients manifesting the symptoms of radiation induced injury – especially bone marrow suppression.

SVMC Facilities Bed Capacity

SVMC is licensed for 132 General Acute Beds of which 10 are ICU, 10 are Perinatal, 4 Intensive Care Newborn Nursery, and 108 Unspecified General Acute. There are 2 negative pressure patient rooms throughout the campus. SVMC is licensed for 35 Skilled Nursing beds.

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

PROCEDURE:

Notification / Activation

Once the Sierra View Medical Center's Emergency Operations Plan is activated (partial or full activation) according to SVMC's activation policies, the following will occur to provide the surge capacity capabilities:

Incident Commander – upon identifying need for call back of all essential staff, will activate the Staff Call In policy and instruct the Labor Pool accordingly. The essential staff will include, but is not limited to:

- Medical Providers
- Infection Control
- Nursing
- Laboratory Personnel
- Respiratory Personnel
- Radiology Personnel
- Pharmacy Personnel
- Dietary
- Admitting
- Social Workers
- EVS Personnel
- Security Personnel
- Engineering Personnel
- Central Supply
- Risk Management

Mobilization

A staff pool may need to be activated to support the Emergency Operation Center's efforts to manage the disaster event either short term or long term. The Labor Pool is activated according to the Emergency Operations Plan and managed via the Hospital Incident Command System (HICS). Personnel will be assigned to perform functions to prepare logistically for the influx and the discharge of the patients and to support the operations.

Discharge Team Implementation

The Chief of Staff (COS) will assign all Medical Department Chairs to oversee the administrative process of discharging patients on the various inpatient units as well as organizing the discharge teams who will immediately conduct the discharge assessment.

The Chief of Staff and Vice President of Patient Care Services will consult and determine the discharge process for patients. Patients will be identified in two groups: **Rapid Discharge** and **Intervention Discharge.**

Rapid Discharge: Requires prescription and discharge instructions.

Intervention Discharge: Requires additional medical intervention before discharge.

One physician and one nurse will be assigned to form a Triage Discharge Team. Each inpatient unit will be assigned a Triage Discharge Team in the hospital setting. If the inpatient floors are logistically identified by East or West, North or South, a Triage Discharge Team will be formed and assigned to each unit East as well as West, North as well as South. All other units are generally set-up by service. Where services exist, a Triage Discharge Team will be assigned to that service.

The Triage Discharge Teams will assess and determine whether the patients can be discharged from the hospital.

The team will document and communicate this information to an assigned Department Medical Chair who will be responsible for identifying systems problems and creating an action plan to immediately address the patient's discharge.

The discharge plans will be communicated through the Hospital Incident Command System.

Discharge Communication Process

Department Medical Chairs must communicate their assigned inpatient unit's status to Chief of Staff (COS) in the Incident Command Center on a continuous basis.

The Incident Command Center will develop a short term plan and/or long term plan as necessary. Either plan must be communicated to the County's Emergency Operations Center.

The Medical Officer will communicate with Tulare County's Health Officer or designee, to report the hospital's patient acuity, bed status and to seek advice on safety precautions.

Equipment Inventory

The Logistics Chief will immediately call for an inventory of essential equipment (linen, PPE, Ventilators, etc.) and any additional Surge Capacity equipment must be identified (MCI Tent, Cots, Decontamination Equipment). The Logistics Chief will manage this process.

Infection Control Consultation

The Infection Control staff will communicate all pertinent communication received from the CDC, DHS and local health department to the Incident Command Center and various departments of SVMC. Infection Control staff will serve as the Public Health Liaison.

Staff Safety

When appropriate, SVMC will dispense approved prophylaxis to its staff. This process will be initiated by the Chief of Staff in consultation with Tulare County's Health Officer, or designee. The proper PPE to be worn will be recommended by the Infection Control staff.

Integration of Outside Agencies

This plan will be made known to local authorities and health care facilities for additional planning and improvement opportunities.

REFERENCES:

- The Joint Commission (2023). EM.12.01.01 Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Title 22: Section 70741, 70743, 70745, 70746

CROSS REFERENCES:

- Staff Call-In

SUBJECT:	SECTION:
THEFT OF PROPERTY	*Security Management*

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

PURPOSE:

To provide guidance for the actions to be taken when thefts of District and personal property occurs on District property.

POLICY:

Through the Security Management Program, specific areas of risk, access control, protective measures, situational response and reporting are identified and communicated to all areas of the hospital. The security policies and procedures shall be in compliance with The Joint Commission Standards, CAL OSHA Guidelines, and California Department of Public Health (CDPH) guidelines.

Consistent with the Safety Management Program philosophy and policy and with the support of the Board of Directors, the Security Management Program encompasses all areas of patient, visitor, staff and physician property protection, whether the need for protection is from an internal or external source

Sierra View Medical Center maintains a zero tolerance for thefts and illegal activity. Any employee found to have committed theft of District or personal property will be subject to disciplinary action up to and including termination.

Thefts of property shall be reported to the Porterville Police Department for investigation and possible prosecution.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

All security incidents involving the theft of District, patient, visitor, employee, volunteer, or contract staff property are reported and investigated as follows:

1. A Security Incident Report will be completed by the security officer on-duty at the time of the incident. The officer responding shall investigate each incident, and the facts as they are known shall be documented on the Security Incident Report. The Security Incident Report will be reviewed and evaluated by the Safety Officer to determine the cause of the incident. The Safety Officer will make recommendations to the Safety Committee to avoid reoccurrence of related incidents when possible.

2. The Safety Committee shall review all summaries of security incidents. Summary reports of security incidents shall include evaluation of the incident, conclusions, recommendations and actions taken.

3. When thefts of property have been discovered, the Safety Officer shall provide all documentation and evidence including, but not limited to, Closed Circuit Television (CCTV) images to Human

Resources for review. This enables appropriate actions based on the progressive disciplinary policy and procedure.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC.02.01.01 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- Performance Accountability and Commitment Policy

SUBJECT:	SECTION:
USE OF TEMPORARY TENTS, CANOPIES AND MEMBRANE STRUCTURES	***Life Safety Management*** **Page 1 of 1**

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

PURPOSE:

To comply with the 2016 State of California Fire Code Chapter 31, Section 3101, Tents, and other Membrane Structures.

POLICY:

Sierra View Medical Center (SVMC) shall comply with all regulations for the use of Tents, and other Membrane Structures as described in Chapter 31 of the California Fire Code and use the City of Porterville Fire Department as the authority agency.

Tents and other Membrane Structures having an area in excess of 200 square feet and canopies in excess of 400 square feet shall be in accordance with the 2016 version of the California Fire Code Chapter 31.

The use of all Tents, and other Membrane Structures on exterior grounds and parking areas shall be permitted by the City of Porterville Fire Department prior to their installation. All code requirements for flame retardant materials, fire extinguishers, vehicle use, no smoking signs, seating arrangements, and means of egress, occupancy load and minimum structure/parking distances shall be followed.

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

All requests for Tents, and other Membrane Structures will be submitted to the Department of General Services for review and submission to the City of Porterville Fire Department for applicable permitting prior to their assembly or installation. Failure to follow the policy guidelines and permitting requirements as determined by the City of Porterville Fire Department shall result in the immediate removal of the Tents, and other Membrane Structures.

REFERENCES:

- 2016 California Fire Code Chapter 31, Section 3101

SUBJECT: VACATION/HOLIDAY LEAVE	SECTION: Page 1 of 7

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

PURPOSE:

To define/delineate the accrual, management, and utilization of Vacation/Holiday Leave at Sierra View Medical Center (SVMC).

POLICY:

The use of Vacation/Holiday Leave shall be at the request of the employee and the discretion of the department director acting within established policies and procedures. Vacation/Holiday leave accruals are combined and may be requested for the following reasons:

- Vacation
- Holiday
- Emergency
- Personal Business

Vacation/Holiday Leave can also be used for an employee's illness when the employee's Sick Leave accruals have been exhausted and upon approval of the department director, or his/her designee.

AFFECTED AREAS/PERSONNEL: *ALL ELIGIBLE EMPLOYEES*
GME RESIDENTS, REFER TO YOUR SPECIFIC GME RESIDENCY POLICY

PROCEDURE:

ACCRUAL RATES Example below represents an 8hr employee accrual rate

	Length of Current Full Time Employment	Accrual Per Hour*	Total # of Weeks/Hours
A.	0 – 5 years hired prior to 9/1/2023	0.099209 per hour	4. 6/184
	0 – 5 years hired on or after 9/1/2023	0.076017 per hour	3.6/144
.	5+ years – 10 years	0.123286 per hour	5.6/224
C.	10 +	0.148610 per hour	6.6/264

Transfers: Employees who change status to full time on or after 9/1/2023 will receive the lesser accrual amount.
Employees may accrue Vacation/Holiday hours on the following hours up to 80 hours per pay period.

*Hours worked include: Regular hours, Overtime hours, Call Back hours, Education hours, Orientation hours, Make Up Day Regular hours, In-service hours, Jury Duty hours, Witness Duty hours, Bereavement

hours, Vacation/Holiday Leave utilized when asked to flex off, and hours missed when asked to flex off where Vacation/Holiday Leave is not utilized.

Maximum Accruals:

The maximum Vacation/Holiday Leave employees are permitted to accrue is equal 1.5 times the annual accrual. Maximum accruals of Vacation/Holiday Leave are based on length of service (refer to accrual chart). Once the maximum accrual is reached, Vacation/Holiday Leave ceases to accumulate until the employee utilizes Vacation/Holiday Leave and their accrual amount falls below the maximum allowable.

0 – 5 years prior to 9/1/2023	276 hours
0 – 5 years as of 9/1/2023	216 hours
5+ years – 10 years	336 hours
10 + years	396 hours

NOTE: Vacation/Holiday Leave payments are based on the employee's current actual base rate of pay at the time Vacation/Holiday Leave is taken.

New Employee Accrual (Exempt and Non-exempt Full-time employees):

Vacation/Holiday Leave during the ninety-day (90) introductory period is accrued at a rate prescribed by the incumbent's position. However, newly hired employees may not utilize any Vacation/Holiday Leave the first ninety (90) days of employment. The 91st day of employment, Vacation/Holiday Leave accrued becomes accessible, and with each successive payday subsequent accruals are credited to the employee's account. Accruals and adjustments to accruals will appear on paycheck stubs the first pay period following the initial ninety (90) days of employment.

HOLIDAYS (Coordination of **Vacation/Holiday Leave**)

1. Employees scheduled to work on a recognized calendar holiday shall receive actual base rate of pay, applicable overtime, holiday differential if on one of the eight premium-paid holidays, and other appropriate differentials. Employees scheduled off due to a holiday must elect one of two choices:

   a. Employees who have completed their initial ninety (90) day introductory period must elect Vacation/Holiday Leave be paid for the holiday. Employees who have not yet completed their initial (90) day introductory period will not be paid on the holiday.

   --OR--

   b. Employees who do not intend to utilize Vacation/Holiday Leave for a holiday may work on the holiday if pre-approved by their Department Director.

2. Employees scheduled to be on call during the Holiday must use their Vacation/Holiday Leave to complete their scheduled hours. If an employee is called in to work while on call, the employee may count their called back hours in conjunction with their Vacation/Holiday Leave hours to

complete their scheduled hours. Example: Employee is regularly scheduled to work 8 hour shifts, employee is on call during the Holiday and gets called in to work for 2 hours, the employee may use 6 hours of Vacation/Holiday Leave to complete the 8 hour shift.

3. Exempt employees who are within the first ninety (90) days of employment must report to work on the holiday unless otherwise approved by their Department Director. For additional details, please see policy, Holiday Pay.

EXEMPT EMPLOYEES

1. When an exempt employee has exhausted all accrued Vacation/Holiday Leave, or is within his/her ninety (90) day introductory period (when Vacation/Holiday Leave is accrued but is not available for use), a deduction in pay will be made for absences of one or more full days due to personal reasons, sickness or disability. For greater detail, please refer to the policy, Exempt Compensation.

NON-EXEMPT EMPLOYEES REQUESTING Vacation/Holiday Leave

1. To request Vacation/Holiday Leave, employees must submit a written request to their Department Director. If approved, the Vacation/Holiday Leave hours must be recorded by the employee on their Kronos time sheet during the week the Vacation/Holiday Leave is utilized unless it is already entered into the Kronos schedule. Vacation/Holiday Leave not recorded and approved accurately by the employee on their Kronos time sheet will be paid on the next scheduled paycheck. Vacation/Holiday Leave is to be requested in one hour increments. Each 24-hour day stands alone for the purpose of computing Vacation/Holiday Leave.

2. Employees may utilize regular Vacation/Holiday Leave for requested time off even if it results in being paid more than the employees' full-time scheduled hours. If the employee chooses to use Vacation/Holiday Leave, it must be recorded in the pay period it occurs.

    - Example: Employee normally works Monday through Friday and takes a vacation day during the week and is requested to work 8 hours on Saturday. If employee chooses, he/she will be paid 40 hours of regular time and 8 hours of Vacation/Holiday Leave

    - Example: Employee normally works Tuesday, Wednesday, and Friday and takes a vacation day for Friday and is requested to work 12 hours on Saturday. If employee chooses, he/she will be paid 36 hours of regular time and 12 hours of Vacation/Holiday Leave.

3. Regular Vacation/Holiday Leave must be utilized by full-time employees to complete their normal full-time hours in the event they request to take any time off unless the time is for a protected leave of absence and they are collecting either Disability or Paid Family Leave. (Please see LEAVES OF ABSENCE below.)

4. Vacation/Holiday Leave Flex, paid or unpaid, may be requested by full-time employees to complete their normal full-time hours only in the event they have been called off or sent home by their Director due to any reason other than disciplinary issues.

5. When an employee is unable to provide advance notice, every effort will be made to accommodate the request. The Hospital reserves the right to approve, disapprove, or reschedule Vacation/Holiday leave at any time based on operational needs.

EMPLOYMENT STATUS CHANGES

1. **Full-time to Part-time employment** - Accrual of Vacation/Holiday Leave will cease with the effective date of the status change and will be paid out with receipt of the following pay check.

2. **Part-time Status to Full-time employment** - Accrual of Vacation/Holiday Leave will begin with the effective date of the status change. Employee with unbroken continuous part-time service (i.e. FT-PT-FT) will accrue Vacation/Holiday Leave at previous full-time accrual. If service is broken, the employee is treated as a new employee for accrual purposes.

3. **Full-time to Per-diem Status employment -** Accrual of Vacation/Holiday Leave will cease with the effective date of the status change and be paid out with receipt of the following paycheck. When returning to Full-time employment, the previous status is treated as a break in service and Vacation/Holiday Leave accrual begins at the starting rate.

4. **Per-diem Status to Full-time employment** – Accrual of Vacation/Holiday Leave will begin with the effective date of the status change. Previous per-diem employment is not credited for Vacation/Holiday Leave accrual purposes.
    - New full time employees may not utilize any Vacation/Holiday hours the first ninety days (90) of Full Time status. On the 91st day of Full Time status, Vacation/Holiday hours accrued becomes accessible.

RESUMPTION OF BENEFIT ELIGIBILITY

Employees resuming their Vacation/Holiday Leave status after a separation of employment with an accompanying new service date will be treated as a new employee (i.e., the employee will accrue Vacation/Holiday Leave but will be unable to use any earned Vacation/Holiday Leave for the initial ninety (90) days of employment and the accrual rate will be based on that of a new hire.).

TERMINATION OF EMPLOYMENT

Payment of accrued Vacation/Holiday Leave will occur for employees terminating their employment status through retirement and/or voluntary/involuntary separation of employment. Payment of accrued Vacation/Holiday Leave will be made to any employee who is terminated within the first (90) days of employment even though she or he is unable to utilize accrued Vacation/Holiday Leave during that time. Accrual of Vacation/Holiday Leave will cease with the effective date of the status change and be paid with receipt of the final paycheck. Payments are based on the employee's current actual base hourly pay rate at the time of the termination, and will be treated as supplemental wages.

PROMOTIONS

Management positions begin with a Vacation/Holiday Leave accrual rate of 0.13210 per hour. The effective date is either the date of hire into a management position or the promotion date. If years of service are greater than five (5) years, the rate will be adjusted to 0.15762 per hour.

LEAVES OF ABSENCE

1. **Workers' Compensation**

   Accrual of Vacation/Holiday Leave ceases upon the last date worked. Employees may elect to supplement either their workers' compensation benefits or contributions toward dependent health care premiums and elected benefits through the use of Vacation/Holiday Leave.

2. **FMLA/CFRA Leaves of Absences**

   Accrual of Vacation/Holiday Leave will cease with the last date worked. Since employees are expected to return from a leave status, Vacation/Holiday Leave will not be cashed out. The use of Vacation/Holiday Leave is required for exempt and non-exempt employees who are on a Family Medical Leave Act (FMLA) and/or California Family Rights Act (CFRA) leave of absence unless they are receiving either disability payments, (i.e. state disability, insurance, workers' compensation) or Paid Family Leave (PFL) payments while on FMLA/CFRA leave. If the employee is receiving disability or PFL payments, the employee may elect to supplement his/her disability or PFL benefit payments with Vacation/Holiday Leave.

   The use of Vacation/Holiday Leave is also required for exempt and non-exempt employees when on an intermittent FMLA/CFRA leave of absence, unless disability or PFL payments are being received.

3. **Pregnancy Disability Leaves of Absence**

   Accrual of Vacation/Holiday Leave will cease with the last day worked. Vacation/Holiday Leave will not be cashed out when an employee commences a leave of absence due to pregnancy. Exempt and non-exempt employees have the option of utilizing Vacation/Holiday Leave while out on a PDL leave to the extent that the employee's Sick Leave accruals have been exhausted. If available Vacation/Holiday Leave is not requested, such pregnancy leave will be unpaid.

4. **Medical Leaves of Absence**

   Accrual of Vacation/Holiday Leave will cease with the last date worked. Vacation/Holiday Leave will not be cashed out when an employee commences a medical leave of absence. The use of Vacation/Holiday Leave is required for exempt and non-exempt employees unless they are receiving disability payments, (i.e. state disability, insurance, workers' compensation) while on Medical Leaves of Absence. If the employee is receiving disability payments, the employee may elect to integrate his/her disability payments with Vacation/Holiday Leave.

5. **Personal Leaves of Absence**

Accrual of Vacation/Holiday Leave will cease with the last date worked. Since employees are expected to return from a leave status, Vacation/Holiday Leave will not be cashed out when the employee commences a personal leave of absence. Exempt and non-exempt employees are required to exhaust all accrued Vacation/Holiday Leave while on a Personal Leave of Absence (PLOA) before going on an unpaid PLOA.

6. **Military Leaves of Absence**

Accrual of Vacation/Holiday Leave ceases with the last date worked to the extent permitted by law. Vacation/Holiday Leave will not be cashed out when an employee commences a military leave of absence. Non-exempt employees may elect to integrate payments received from the government with the use of Vacation/Holiday Leave. Exempt employees will be paid for temporary military leaves of absence; however, fees received by the employee will be applied to offset the pay otherwise due to the employee for the week. Please refer to the hospital's Exempt Compensation Policy.

7. **Jury Duty/Bereavement**

Time off for jury duty or bereavement will not be deducted from Vacation/Holiday Leave during the first five (5) days for jury duty or the first (3) days for bereavement (for full-time employees only). Vacation/Holiday Leave may be used by non-exempt employees when the need for time off for either event surpasses the authorized days paid by SVMC. Exempt employees' pay will not be deducted for absences for jury duty unless no work is performed during the workweek. However, an exempt employee may utilize Vacation/Holiday Leave for jury duty, witness leave and/or bereavement if he or she wishes to avoid a deduction in pay for weeks where no work is performed Please refer to the hospital policies on jury duty/witness leave and bereavement.

Coordination with SDI Benefits

Vacation/Holiday Leave hours may be designated by the employee to integrate SDI benefits up to the maximum of the employee's normal scheduled hours and actual base rate of pay.

VACATION/HOLIDAY LEAVE PAY OUT ELECTION

Employees may elect the option of receiving their actual base hourly rate for a maximum of forty (40) hours. The employee's election request must be received during the last pay period of December for receipt with the last paycheck in March of the following year. Employees must maintain a base of eighty (80) hours following withdrawal.

EMPLOYEE HARDSHIP WITHDRAWALS

Employees experiencing an unforeseeable emergency may access their Vacation/Holiday Leave account prior to their eligible Vacation/Holiday Leave pay out election. An unforeseeable emergency is defined by law as a severe financial hardship resulting from an illness or accident of the employee, the employee's spouse or the employee's dependent as defined by IRS regulations, loss of property due to casualty other than a natural disaster, imminent foreclosure or eviction from the employee's primary

residence, medical expenses, including non-refundable deductibles, as well as for the cost of prescription drug medication, and funeral expenses of a spouse or a dependent as defined by IRS regulations.

The withdrawal of Vacation/Holiday Leave due to an unforeseeable emergency replaces the employee's December election, as only one withdrawal is permitted annually. The request cannot exceed an amount reasonably necessary to satisfy the emergency need, which may include amounts necessary to pay any federal, state, local or foreign income taxes or penalties reasonably anticipated to result from the payout. Hours will be reimbursed at the employee's actual base hourly rate of pay. Employees must maintain a base of eighty (80) hours following withdrawal.

CROSS REFERENCES:

- HOLIDAY PAY
- LEAVE OF ABSENCE – FMLA/CFRA
- LEAVE OF ABSENCE – PERSONAL
- LEAVE OF ABSENCE – MILITARY
- JURY DUTY & WITNESS DUTY
- BEREAVEMENT LEAVE
- SICK LEAVE
- ATTENDANCE AND PUNCTUALITY

SIERRA VIEW MEDICAL CENTER **PHYSICIAN UROLOGY OFFICE NOTE**

Reason for visit:

Exam:

Findings/Diagnosis:

New Medication prescribed:	Dosage (Specifiy MG or MCG)	Route	Frequency

Provider Signature: _____ Date: _____ Time: _____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

PHYSICIAN UROLOGY OFFICE NOTE

Form # 025475 REV 11/23

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

SIERRA VIEW MEDICAL CENTER

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date: _____

Patient name: _____

Date of birth: _____ Medical Record#: _____

Please tell us what protected health information you want changed:

_____

_____

_____

_____

Please tell us why you want this change. You must give a reason:

_____

_____

_____

_____

NOTE: We cannot delete or destroy any information already included in your medical record. We can only add clarifying or correcting statements.

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide.

Tell us where to send you a letter:

_____

_____

Give a phone number so we can call you: _____

If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Tell us if there are any such persons who need the changed information:

❑ No Initials: _____ ❑ Yes Initials: _____

Please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Form # 021285 REV 9/17

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

We will also send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

❑ No Initials: _____ ❑ Yes Initials: _____

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   _____

   _____

2. The information is accurate and complete.

4. You do not have the legal right to access the protected health information you want changed.

   The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

Date: _____ Time: _____ AM/PM

Signature: _____
(Patient/Legal Representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Legal Representative)

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.sierra-view.com or by sending a written request to:

The Director of Health Information Management
Sierra View Medical Center
465 W. Putnam Ave
Porterville CA 93257

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact the Compliance/Privacy Officer at (559) 791-3838. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

When you have finished filling out this form, please send it to Sierra View Medical Center. Health Information Management (HIM) Department, 465 W. Putnam Ave., Porterville, CA 93257.

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257
REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

MEDICAL EXECUTIVE COMMITTEE	11/01/2023
BOARD OF DIRECTORS APPROVAL	
	11/28/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
November 28, 2023 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

		Pages	Action
I.	**Policies**:		**APPROVE**
	• Bland Aerosol Administration	1-3	↓
	• Call System	4-5	
	• Cardiac Cath Lab Discharge Criteria	6-8	
	• Care Planning, Social Service	9-10	
	• Closed Trach System	11-13	
	• Discharge to Home	14-15	
	• Methotrexate for Ectopic Pregnancy – Standard Operating Procedure	16-18	
	• Modalities: Electrical Stimulation	19-21	
	• Performance Improvement Plan	22-27	
	• Skin Care, Preventative	28-30	

SUBJECT: **BLAND AEROSOL ADMINISTRATION**	SECTION:

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

PURPOSE:

To define a consistent and safe method for administering aerosols (without measurements) for the purpose of humidification.

POLICY:

Residents of the DPSNF that no longer require ventilator support yet still have a tracheostomy tube will receive Blow-By humidification in a safe and consistent manner following the below guidelines

AFFECTED PERSONNEL/AREAS:

RESPIRATORY CARE PRACTITIONER, RN, LVN

PROCEDURE:

1. Verify physician's order.
2. Assemble equipment.
3. Wash hands and wear gloves.
4. ID the resident.
5. Explain procedure to resident.
6. Connect aerosol devices to water and gas sources; turn on flow.
7. Connect to resident with wide bore aerosol tubing.
8. Insert drain cup mid distance
9. Attach resident with aerosol, trach mask on T-tube.
10. Adjust flow to obtain correct FiO_2 if on supplemental O_2.

INDICATIONS:

- Prevent drying of secretions which may cause plugs.
- To assist in obtaining sputum specimens

CONTRAINDICATIONS:

- Bronchoconstriction

EQUIPMENT:

Depending upon the specific application of Blow-by, components may include but are not limited to:

- Barrel Nebulizer
- Patient application device
- T-Piece
- Tracheostomy Mask
- Corrugated aerosol tubing and water trap
- Tissues and emesis basin or container for collecting or disposing of expectorated sputum
- Gloves, goggles, gown, and mask
- Closed system suction catheter

MONITORING AND DOCUMENTATION:

The extent of resident monitoring should be determined on the basis of the stability and severity of the resident's condition. Residents receiving Bland Aerosol Therapy should be monitored at least every 6-8 hours for:

- Heart rate
- Respiratory Rate
- SpO2
- Breath Sounds
- Sputum Production

The resident's response to treatment will be documented in the Medical Record once a shift.

SUBJECT: **BLAND AEROSOL ADMINISTRATION**	SECTION: **Page 3 of 3**

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

INFECTION CONTROL:

Management of the Bland Aerosol delivery system is performed in order to limit the occurrence of nosocomial infections and to assure that the circuit maintains its physical integrity.

Aerosol set up, including tubing, drain cup and suction will be changed weekly and documented at the time of the change, on the patient treatment sheet by the Respiratory Care Practitioner. In addition, the new circuit will be dated at the time of change, usually on the drain cup itself.

REFERENCES:

Executive Summary: Long Term Care of Residents with a Tracheostomy, September 2015, Fisher & Paykel Healthcare Retrieved from: www.maverickoxygen .com

tracheducation, May31,2019, Humidification and Hydration for Tracheostomy and/or Mechanical Ventilation, retrieved from: info@tracheostomyeducation.com

SUBJECT: **CALL SYSTEM**	SECTION:

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

PURPOSE:

To provide a mechanism for residents to communicate to staff a need for assistance.

POLICY:

It is the policy of this facility to provide each resident with a call system to enable them to request assistance.

AFFECTED PERSONNEL/AREAS: *ALL STAFF*

EQUIPMENT:

- Functioning call bell / over door light system
- Adaptive device as needed

PROCEDURE:

1. Instruct each resident in the use of the call bell system upon their admission to the facility.
2. Make sure call cords are placed within the resident's reach at all times. When the resident is out of bed, the call cord will be clipped to the bedspread in such a way as to be available to a wheelchair bound resident.
3. Answer call bells promptly, (within 3 minutes for room lights, immediately for bathroom lights).
4. Always be courteous when responding to a request for assistance.
5. Do not answer the residents call light via the intercom system
6. Turn off the call bell.
7. Listen to resident's request. Do not make him/her feel that you are too busy to help.
8. Respond to request. If requested item is not available or request is questionable, get assistance from Charge Nurse.
9. Return to resident with item or reply promptly.
10. Offer further assistance before leaving.
11. If call bell is defective, report immediately to maintenance. Replace, if possible, with functional equipment until repaired.

12. *Routine calls:* Routine calls will be accompanied by an audible signal and the light above the resident's room door will go on. Routine calls should be answered within five minutes.

13. *Emergency Calls*: Call bells located within resident bathrooms are considered "emergency calls" due to the potential for falls and injury. These lights have a more frequent audio sound and the call light above the room door is red or will flash on and off. Emergency calls must be answered immediately.

REFERENCES:

- Med Pass, Inc.,(updated February 6, 2015) Facility Guide to OBRA Regulations, 483.70 (f) United States of America, Med Pass Inc.

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72315, 79839, 73631. San Francisco, California, Title 22.

SUBJECT: **CARDIAC CATH LAB DISCHARGE CRITERIA**	**1 of 3**

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

PURPOSE:

To establish safe parameters for the discharge of patients undergoing Cardiac Cath procedures

POLICY:

To provide safe guidelines for the discharge /transfer of the patient undergoing procedures in the Cardiac Cath Lab.

All patients having a procedure in the Cardiac Cath Lab shall meet the following discharge criteria prior to leaving the facility/Department.

AFFECTED PERSONNEL/AREAS:

CARDIAC CATH LAB, ICU, TELEMETRY

EQUIPMENT:

Patient monitoring equipment. Electronic medical record.

PROCEDURE:

A. Patients will be continuously monitored until all criteria are achieved or the variance is reported to the physician and orders are received.

1. Three systolic blood pressures are within 20mm of each other and/or the blood pressure is within normal limits for the patient unless being treated with medication for hypertension.
2. ECG rhythm is within normal limits for the patient.
3. Aldrete score of 8 or within 2 points of their pre-procedure baseline.
4. Hemostasis is achieved at puncture site with no active bleeding or swelling.
5. Post procedure pulses are equal to pre-procedure pulses.
6. Patient is able to verbalize understanding of unit discharge instructions.
7. Be able to take oral fluids with minimal nausea and no vomiting.
8. Ambulate without dizziness, consistent with developmental age and procedure.
9. Pain is manageable. Adequate response to analgesia with no adverse reaction noted.
10. Dressing is dry and intact.

11. Have a responsible adult escort.

B. Patients and their families or significant others should receive printed discharge instructions and verbalize an understanding of the instructions. Verbal repetition is necessary of specific care aspects such as:

1. Signs of infection.

2. Potential or anticipated post sedation effects and limitations on activities.

3. Emergency contact arrangements and follow-up appointment.

C. If patient fails to meet discharge criteria at the termination of the procedure, the Cardiologist will be notified of the variance.

1. The Admit/ Recovery RN will contact the Cardiologist and obtain orders for the care and possible transfer of the patient to the appropriate unit.

2. Receiving area will be given hand off communication prior to patient transfer to include but not limited to:

(a) Identity of patient

(b) Procedure performed with interventions if any

(c) Type of sedation/patient specific information regarding care

(d) Procedure or sedation complications

(e) Amount of I.V. fluids given

(f) Urinary output in Cath Lab and recovery area

(g) Status of dressing; amount and type of drainage if any

(h) Vital signs – Temp, Pulse, Respirations, Blood Pressure, SpO2.

(i) Level of comfort, any medications given in recovery and patient response

D. A cath lab/IR staff member will transport the patient to the room and assist with transfer onto bed and ensure that staff is available to assume care of the patientPatients transported to

ICU/CCU are transported with 1 ACLS-certified nurse and staff member in attendance with a monitor and portable oxygen if continuously required.

REFERENCES:

- American College of Cardiology/ American Heart Association Guidelines; Abstract 2023.
- Nettina, S. M. (2019). *Lippincott Manual of Nursing Practice 11th Edition.* Philadelphia: Wolters Kluwer Health.

SUBJECT: **CARE PLANNING, SOCIAL SERVICE**	SECTION: *Social Services* **Page 1 of 2**

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

PURPOSE:

To define the role of Social Service in planning care for facility residents.

POLICY:

The interdisciplinary team shall develop a comprehensive Care Plan for each Resident. The Social Service Designee is responsible for specific areas, as assigned.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICE, NURSING*

PROCEDURE:

1. A comprehensive Care Plan is developed within seven (*=7) days of completion of the Resident Minimum Data Set (MDS).

2. The Care Plan is developed by the interdisciplinary team which includes, but is not limited to the following professionals:

   a. The attending physician

   b. The registered nurse responsible for the Resident

   c. Dietary Supervisor/Dietitian

   d. Social Services staff member responsible for the Resident

   e. Activity staff member responsible for the Resident

   f. Rehabilitation specialist, and physical, occupational, and/or speech therapists as indicated

   g. Consultants (as appropriate)

   h. Director of Nursing (as applicable)

   i. Nursing assistants responsible for Resident care

   j. Respiratory staff member as indicated

   k. Others as necessary or indicated

3. To the extent possible, the Resident, the Resident's family and/or responsible party, should participate in the development of the Care Plan.

4. Every effort will be made to schedule Care Plan meetings to accommodate the availability of the Resident and family or responsible party.

5. When the Resident has no family or responsible party, and is unable to make his/her own health care decisions, the Interdisciplinary Team (IDT) will act as surrogate decision makers.

6. Scheduling and preparation of the Care Plan meeting calendar is completed by the MDS Coordinator or Social Service Designee

7. The MDS Coordinator, assisted by Social Services, will notify the Resident, family, and/or responsible party, and other interested parties designated by the Resident, of the date and time of the Care Plan Conference at least a week prior to the meeting.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.20 (k), 483.20(1), 483.10(d)(3), 483.20(k)(2). United States of America, Med Pass Inc.

CROSS REFERENCE:

- INTERDISCIPLINARY ASSESSMENT AND REASSESSMENT DPSNF

SUBJECT: **CLOSED TRACH SYSTEM**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide tracheal suction without interrupting mechanical ventilation and reduce the risk of respiratory infection.

PATIENT POPULATION:

21 years and older

AFFECTED PERSONNEL/AREAS:

REGISTERED NURSE, RESPIRATORY CARE PRACTITIONER

PROCEDURE:

FORMAT	RATIONALE/PRECAUTIONS:
1. Select equipment • Trach care suction catheter • Suction regulator, tubing • Oxygen adjuncts • Oximeter • Normal saline for instillation	Ventilator, trach mist, etc. Provide 100% oxygen, if indicated. Monitor saturation during procedure.
2. Prepare equipment • Wash hands and wear gloves.	Prevention of transmission of infection.
3. Turn on suction. • Adjust suction regulator.	120-150mm Hg for adults. Pressures greater than 150mm Hg greatly increase the risk of trauma.
4. Prepare resident. • Introduce yourself to resident; explain procedure and purpose.	Professional courtesy reassures resident.
5. Begin procedure. • Attach Trach Care T-piece to ventilator circuit, using flex tube, if desired.	Prevents inadvertent interruption of suctioning. Suctioning cannot be accomplished when valve is locked. Blue line on catheter indicates direction catheter tip

• Attach system to resident. • Make sure all connectors are secure; i.e., T-piece to trach tube, suction tubing to control valve, wall connector to container. • Lift and turn control valve to unlocked position. • With resident's head in the 12 o'clock position, advance catheter to black square indicator mark on the catheter. • Reassure resident. • Depress suction control valve, gently withdrawing the catheter to its fully extended length.	will follow. One o'clock position will assist with access to left lung; eleven o'clock position will assist with access to right lung. Suctioning is a very traumatic procedure for some residents; provide reassurances and explanations throughout the procedure. Monitor saturation during procedure. Catheter is fully withdrawn when black mark is visible at back of T-piece. Do not allow suction procedure to last longer than 15 seconds.
6. Lavage • Advance catheter to the black square indicator mark on the catheter into the tracheostomy tube. • Instill 3-5cc lavage solution into irrigation port. • Suction as above.	Do not apply suction during lavage procedure. Close irrigation port. Use lavage practice sparingly • Contraindications to lavage 1. Decreased O2 saturations 2. Excessive coughing 3. Bronchospasms 4. Tachycardia 5. Dyspnea
7. Cleansing catheter. • After suctioning, flush catheter by depressing control valve and slowly introducing 3-5cc flush solution into irrigation port.	Catheter must be in fully withdrawn position. Make sure irrigation port is closed when not in use.
8. Lift and turn control valve 180° to locked position.	Prevents inadvertent suction.

9. Chart procedure in resident progress notes and department records.	

REFERENCES:

- American Association of Respiratory Care. AARC Clinical Practice Guidelines>2014/08>06.10.0758.PDF (2010). Retrieved from https://www.ncbi.nlm.nih.gov>pub.
- American Association of Respiratory Care. AARC Clinical Practice Guidelines: Artificial Airway Suctioning (2022). Retrieved from https://doi.org/10.4187/RESPCARE.09548

SUBJECT: **DISCHARGE TO HOME**	SECTION: **Page 1 of 2**

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

PURPOSE:

To adequately prepare the resident and family for discharge and to ensure appropriate home care arrangements have been made.

POLICY:

It is the policy of this facility that residents will be discharged from the facility as per physician order. Pursuant to the physician's orders and discharge planning, a review of the resident's home care needs and medications are completed with the resident/family. If necessary, help will be provided to the resident in making arrangements for transportation when he/she is discharged.

AFFECTED PERSONNEL/AREAS: *NURSING (RN, LVN, CNA), SOCIAL SERVICES*

PROCEDURE:

1. Social Worker or designee and nursing will collaborate with the Interdisciplinary Team, including the resident and/or responsible party, in formulating discharge plans and completing the Discharge Evaluation and Plan of Care, Review and Summary.

2. Obtain physician order for discharge, preferably 24 hours before discharge. The physician order will specify any medications that will not be sent home with the resident.

3. Obtain the name of the attending physician who will take over care once the resident leaves and make a follow-up appointment with this physician. Fax all information needed to the attending physician, (i.e., progress notes, discharge summary form, medication reconciliation sheet, history and physical, physical therapy notes, speech therapy notes, dietary notes, etc.)

4. Nursing will order any discharge medications needed. The social worker or designee will arrange for take-home equipment as ordered by the physician or as needed.

5. Once the discharge order has been obtained, nursing will notify the business office of pending discharge.

6. Nursing will complete the Discharge Plan of Care form and review with the resident and family.

7. Active Discharge

    a. Nursing will check the residents' Personal Inventory List to ensure all belongings are accounted for. Once reconciled, the resident or responsible party will sign the Inventory List to verify receipt of belongings, valuables, and monies. Assist resident with packing belongings. Check closet, drawers, bedside stand and windowsills for any belongings.

    b. Nursing will provide resident and/or family with the final review of the Post Discharge Plan of Care form including any follow-up appointments and discharge medications. Ensure resident/family understand instructions clearly. Obtain signatures. Send original

Post Discharge Plan of Care form with resident/responsible party. Maintain copy of Post Discharge Plan of Care and original Discharge Planning Assessment form in chart.

c. Nursing will escort the resident from the facility, assist into transportation vehicle and assist with transferring belongings to the vehicle.

d. Nursing will ensure that the linen and personal care utensils are removed from the resident's unit.

e. Nursing will notify Housekeeping that the room is ready to be cleaned.

f. Nursing will notify the Dietary Department of discharge.

DOCUMENTATION REQUIREMENTS:

1. See Documentation Requirements – Discharge Planning.

2. Nursing Notes: Record date, time of discharge, manner in which resident left the facility, condition of the resident, who accompanied, and mode of transport. Include any instructions or appointments given in the Electronic Medical Record.

3. Nursing will gather all medical record documents for the resident and send complete chart to Medical Records.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (1) (3), AHCA 483.12 United States of America, Med Pass Inc.

SIERRA VIEW MEDICAL CENTER

Pharmacy

STANDARDARIZED OPERATING PROCEDURE

SUBJECT:

Methotrexate for Ectopic Pregnancy

SOP Owner Manager of Pharmacy & Clinical Coordinator

Standard Operating Procedure

1. Purpose

Define the process and protocol for use of methotrexate for treatment in ectopic pregnancy. (See Addendum A for reference for provider in determination of method of treatment).

2. Procedure

A. Pre-Procedure
   a. Obtain written/ computerized provider order entry (CPOE) for the administration of methotrexate.
   b. Document patient's height, weight, and allergies. The dose of methotrexate is determined based on the patient's height, weight, and body surface area (BSA).
      i. BSA = squareroot ((Height (cm) * Weight (kg))/3600) m^2
         1. Example: Height = 165 cm; Weight = 71 kg
            a. BSA = squareroot ((165*71)/3600) m^2 = 1.8 m^2
   c. Ensure the following labs have been drawn prior to administration and reported to the Physician:
      i. Quantitative HCG, CBC, CMP
      ii. Blood Type and Rh (To check for Rh negative mother)
   d. Please note that methotrexate is contraindicated when SCr or AST are greater than twice the upper limit of normal.
   e. Methotrexate will be available in the form of oral tablets.

B. Procedure
   a. After the nurse confirms that the patient has been informed of the risk and benefits of the medication, the consent will be obtained using consent form #15004: Consent for Methotrexate Treatment for Ectopic Pregnancy.
   b. Oral Methotrexate
      i. Methotrexate is to be administered by a Registered Nurse.
      ii. Methotrexate is obtained from Pharmacy during normal business hours.

1. After Pharmacy hours, nursing is to contact the on-call Pharmacist to obtain the calculated dose. Pharmacy will request the BSA or manually calculate based on the patient's height and weight.
2. To prevent a medication dosing error, one pharmacist must verify the dose prior to administration.

iii. Dosing using standard Methotrexate 2.5 mg tablets
1. Methotrexate 60 mg/m^2 orally divided into two (2) doses two (2) hours apart.
a. Round dose to the nearest whole tablet. See example below:
i. 60 mg/m^2 * 1.8 m^2 = 108 mg
ii. 108 mg/ 2 doses = 54 mg per dose
iii. 54 mg/ 2.5 mg tablet = 21.6 tablets per dose
iv. Round up to 22 tablets (55 mg) per dose.

iv. Doses will be double-checked and co-signed by two nurses prior to administration and documented into the medical record.

v. Administration instructions
1. Wash hands before donning gloves.
2. Don one pair of gloves. Gloves should be chemo-certified gloves ASTM D6978 compliant.
3. If vomit or potential to spit up, wear eye/face protection.
4. Obtain Methotrexate dose. Remove tablets from their packaging prior to administration. Any form of physical manipulation, such as cutting or crushing, is strictly prohibited.
5. Administer orally.

c. Give Misoprostol (800 mcg) PO if a physician order exists.
d. Give Rhogam (300 mcg) IM, if Rh negative, per physician order.
e. Observe the patient for increased abdominal pain, nausea and vomiting, and other possible side effects and document accordingly.

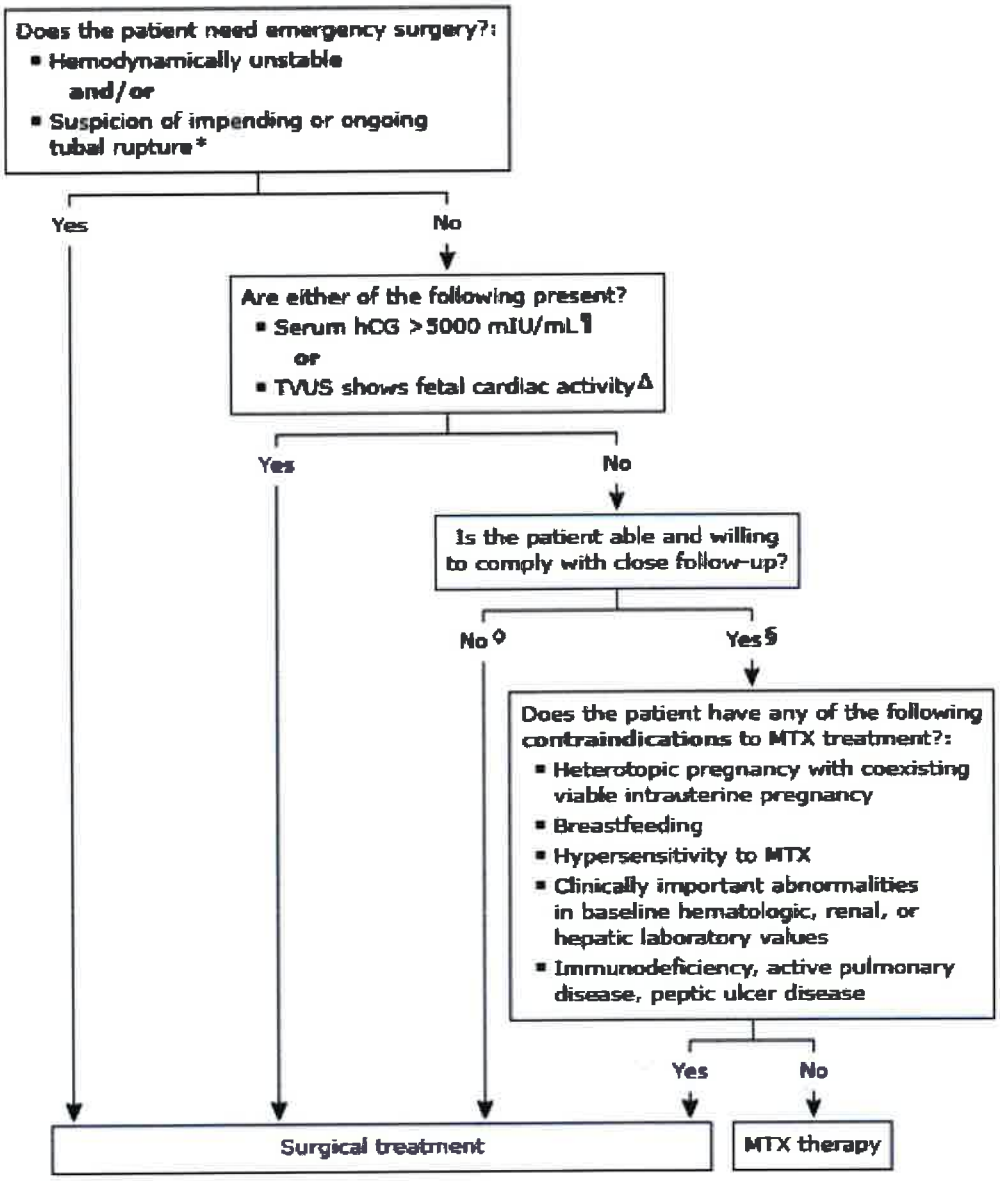
C. Post-Procedure
a. Prior to discharge, provide the patient with Form #15005: Patient Instructions After Methotrexate Administration.
b. Document patient education, including the possible drug side effects, precautions, and physician follow-up plan.

3. *References*

Lipscomb, G. H., Meyer, N. L., Flynn, D. E., Peterson, M., & Ling, F. W. (2002). Oral methotrexate for treatment of ectopic pregnancy. *American Journal of Obstetrics and Gynecology, 186*(6), 1192–1195. https://doi.org/10.1067/mob.2002.123825

Addendum A

Choosing a treatment for ectopic pregnancy



https://www.uptodate.com/contents/image/print?imageKey=OBGYN%2F114571&source=graphics_gallery&topicKey=5407&search=ectopic

SUBJECT: **MODALITIES: ELECTRICAL STIMULATION**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish guidelines for the safe and effective use of electrical stimulation.

AFFECTED AREAS/PERSONNEL: *ALL PHYSICAL THERAPY AND SPEECH THERAPY STAFF*

PROCEDURE:

1. Determine the type of current to be used.
   a. Check the unit to be used.
   b. Operations of the electrical stimulation machine:
      - Electrodes may be reusable adhesive, or made from aluminum foil.
      - Do not use frayed conducting or line cords, corroded or loose fitting electrode tips.
      - Have all materials ready to use, such as the proper electrodes or aluminum, gauze and normal saline.
      - If the reusable electrodes are used, the patient's name is written on the outside of the packet.
      - If foil is used:
        - It is folded into the desired shape for the area to be treated.
        - Normal saline is used to moisten the gauze squares that are also folded to conform to the area.
        - The gauze, then the foil is taped to the area with paper tape.
        - Alligator clips or adhesive electrodes are used to maintain contact with the leads and foil. The adhesive electrodes will be disposed of after each treatment.
2. Starting the treatment:
   a. Explain the procedure to the patient, including an explanation of what they might experience and any instructions or directions regarding patient participation with the procedure.
   b. Describe the sensation to the patient.
   c. Reassure patient that the treatment is completely safe.

d. The Therapist will be responsible for examining the area to be treated.

- The skin should be clean and free from oils, lotions, creams, etc.
- Check the skin sensation. If skin sensation is lacking or diminished, use caution.

e. Do not use electrical stimulation on:

- Patients with a cardiac pacemaker, unless this has been approved by the patient's physician.
- Directly over or through the heart.
- Over abrasions.
- Avoid placing electrodes over areas of broken skin, scars, moles, or unusual areas of skin discoloration.
- Avoid skin folds/creases.

f. Attach a lead wire to each electrode and the unit.

g. Protect the sheet and patient's clothing from moisture.

h. Inform the patient you are about to place electrodes onto his/her skin.

3. Turn on the unit.

a. When everything is ready, tell the patient you are about to turn on the current.

b. Depending on the type of stimulation used, the effect and sensation will be different.

- For actual muscle stimulation, the intensity must be high enough that a muscle contraction can be palpated.
- Most other uses of electrical stimulation, the intensity is high enough to be felt but not to cause a contraction.

c. Treatment time will depend on the condition being treated, and is normally between 15 and 30 minutes in a single location. Electrodes will be moved if treatment will be longer than 30 minutes.

- Do not over stimulate, or have the intensity up too high, as this can either fatigue the muscle or cause an increase in symptoms.

4. Terminating the treatment:

   a. Remove the electrodes and dry the patient thoroughly.
   b. Inspect the patient's skin for any signs of adverse reaction to the treatment.
   c. Document the treatment, including all treatment parameters and the patient's response to the treatment.

REFERENCES:

- Cameron, M. (2023) *Physical Agents in Rehabilitation (*6th ed,. pp 225-300). St. Louis, Missouri: Elsevier.

SUBJECT: **PERFORMANCE IMPROVEMENT PLAN**	SECTION: ***Performance Improvement*** **Page 1 of 6**

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing quality health care services to all of our patients. As an organization, we realize that in order to provide this level of care, we must continually measure and assess systems and outcomes related to those services provided. This plan describes the organizational procedures to be utilized in performance measurement, performance assessment and performance improvement activities. It is the intent of the organization's leaders to develop a performance improvement program that allows all departments and services to collaboratively perform improvement activities utilizing the Plan, Do, Study, Act (PDSA) methodology. This plan describes the communication and coordination for all organizational activities directed toward improving patient care services.

POLICY:

A. Authority and Responsibility

1. The Board of Directors has the ultimate authority and responsibility to require and support a Performance Improvement program at Sierra View Medical Center. The Board of Directors has delegated the responsibility of implementing an organization-wide performance improvement program to Administration, the Medical Staff and the Performance Improvement/Patient Safety (PIPS) Committee.

B. Specific Performance Improvement Components

1. **Hospital Support Service**

Senior Leadership shall oversee the development and implementation of performance improvement activities for Nursing and other hospital support services, assuring the integration and coordination of service-specific activities into the organization-wide performance improvement program. The substantive results of support service performance improvement activities will be reported to the Performance Improvement/Patient Safety Committee. A summarized report will be presented to the Board of Directors at least quarterly. Relevant information from the support service performance improvement activities will be shared organizationally as needed.

2. **Medical Staff Peer Review Program**

The Medical Staff has empowered the Medical Executive Committee to develop and oversee the Medical Staff Peer Review Program. The Medical Executive Committee shall assure the integration and coordination of all Medical Staff peer review activities into the organization-wide Performance Improvement Program when indicated.

3. **Medical Staff Committees**

The Medical Staff Committees review quality data and determine necessary actions to make or sustain improvements. The Medical Staff coordinates their improvement activities with other Medical Staff and administrative committees as necessary to achieve

the desired outcome. Medical staff committee reports are submitted to the Medical Executive Committee by the designated chairperson.

4. **Patient Safety Program**

The organization has developed an integrated Patient Safety Program to collect data and investigate occurrences related to patient safety and risk reduction. Hospital occurrences which may be related to patient safety or medical errors are reported to Risk/Patient Safety Management. The Risk/Patient Safety Department assures timely integration of this Risk Management information into the Organizational Performance Improvement Program. Information related to sentinel events and error reduction is reviewed by the Performance Improvement/Patient Safety Committee (PIPS). The PIPS Committee has adopted the failure mode, effects, and analysis (FMEA) model for proactive process redesign.

5. **Performance Improvement/Patient Safety Committee (PIPS)**

The Performance Improvement/Patient Safety (PIPS) Committee has been empowered to develop and oversee the organization-wide performance improvement program with focus on the safe delivery of care. This program supports the integration and coordination of medical staff, nursing and support services in order to be successful in their improvement efforts. The PIPS Committee supports and follows the fundamental principles of performance improvement, collecting and analyzing data, and taking actions to make improvements and/or to sustain achievements. Emphasis is placed on patient outcomes and meeting regulatory requirements that support safe delivery of care.

6. **Process Improvement Teams**

The organization supports the development of process improvement teams to improve patient care and services. Prioritization of team activities are determined based on organization assessment and evaluation of organizational goals. Process Improvement teams are chartered through PIPS to avoid duplication of activities throughout the organization and to standardize the process. Teams will be further prioritized based on organization need with focus on improved patient outcomes, considering high volume and problem prone, high risk and low volume areas. Team activities will be tracked and reported through the Performance Improvement/Patient Safety Committee. Process improvement teams shall follow the PDSA model. Other Performance Improvement teams may be formed within the organization as needed and shall follow the performance improvement model most appropriate for the process which is being reviewed.

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL STAFF*

PROCEDURE:

A. Reporting and Coordination

1. *Hospital Support Services*: The following hospital support services shall analyze their scope of service and goals and recommend to the appropriate Executive and/or the Performance Improvement /Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital support services include:

   a. Care Management
   b. Population Health
   c. Risk/Patient Safety
   d. Donor Network West
   e. Food and Nutrition
   f. Infection Prevention
   g. Laboratory
   h. Pharmacy
   i. Rescue/Resuscitation
   j. Regulatory
   k. Radiology
   l. Physical Therapy
   m. Graduate Medical Education

2. *Hospital Service Departments* – These departments shall analyze their scope of services and goals and recommend to the appropriate Executive and/or the Performance Improvement/Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital Service Departments include:

   a. *Critical Care*
   b. *Emergency Services*
   c. *Operative/Invasive Services*
   d. *Renal Services*
   e. *Cancer Treatment Center (CTC)*
   f. *Distinct Part Skilled Nursing Facility (DP/SNF)*
   g. *Wound Care*
   h. *Cardiac Cath Lab*
   i. *Urology Clinic*
   j. *Community Health Clinic*
   k. *Pediatrics*
   l. *Maternal Child Health*
   m. *Academic Health Center*
   n. *Sierra View Multi Specialty Center*

3. *Nursing Care Units/Departments* –Nursing shall analyze their scope of service and goals and recommend to the Performance Improvement/Patient Safety Committee specific

quality measures for inclusion in the organization-wide performance improvement program. Nursing participates in the National Database of Nursing Quality Indicators (NDNQI) program for submitting data for: Restraints, Pressure Ulcers, Falls, Patient Days, Nursing Care Hours, and Unplanned Post-Operative Transfers. Data is analyzed and actions taken to achieve desired goals.

4. *Contract Services* –Contracted services shall be monitored and evaluated yearly by the clinical leaders and medical staff. Improvement efforts will be implemented when contracted services do not meet their determined expectations as defined in their contract. This may include increased monitoring of services, training, and re-negotiation of terms. Applying penalties and termination would be considered as a last resort. Results of the yearly evaluation will be reported to the Governing Board. Oversight of Contract Services is shared with the Compliance Office.

5. *Medical Staff Department/Peer Review Committees* –The Medical Staff departments shall analyze their scope of service and goals and recommend to the Medical Executive Committee specific quality monitoring and other measures for inclusion in the organization-wide performance improvement program. Medical staff peer review committees include:

   a. *Emergency Medicine*
   b. *Family Medicine*
   c. *Pediatrics*
   d. *Radiology/Pathology*
   e. *Internal Medicine*
   f. *OB/GYN*
   g. *Surgery*
   h. *Anesthesia*

6. *Medical Staff Committees* – The following Medical Staff committees shall analyze their scope of monitoring and committee goals and recommend to the Medical Executive Committee specific quality measures for inclusion in the organization-wide performance improvement program by way of a designated Chairperson. Medical Staff Committees include:

   a. *Pharmacy and Therapeutics/Nutrition Care Committee/Infection Prevention*
   b. *Bioethics Committee*
   c. *Utilization Review Committee*
   d. *Performance Improvement/Patient Safety Committee*

B. Individual Practitioner Competence Issues

1. Issues related to the competence of individual physicians, other independent practitioners, or allied health practitioners will be referred to the appropriate Medical Staff peer review committee for review and will be reported on to the Medical Executive Committee and Board of Directors as indicated by defined Medical Staff processes. Advanced practice nurses also fall under the auspice of the Chief Nurse Executive. This includes Certified

Registered Nurse Anesthetists (CRNAs), nurse practitioners, and nurse midwives who are privileged through the medical staff.

2. Issues related to the performance of practitioners who are hospital employees or work under a hospital job description will be referred to the appropriate service director for evaluation and referred to hospital administration and the Board of Directors as indicated.

3. Written complaints or allegations regarding a provider's sexual misconduct or sexual abuse of a patient will be reported within 15 days to the provider's professional licensing board. Provider is defined to include any person with a license to practice in the healing arts.

C. Communication and Coordination of Results

1. The relevant results of Performance Improvement activities are used primarily to study and improve processes that affect patient outcomes and are related to patient safety. When relevant to the performance of an individual, performance improvement information will be utilized in the evaluation of individual capabilities as part of the human resources assessment or Medical Staff credentialing processes. The information will be communicated as may be necessary to achieve this goal.

2. The conclusions, recommendations, actions and results of the actions taken shall be documented and reported through established channels as noted in this plan.

3. Relevant information shall be communicated among departments, services and professional disciplines when opportunities to improve care involve more than one department or service in the organization. The purpose of reporting and communicating is to share information with those in the organization to whom the information is pertinent.

D. Annual Appraisal

1. The Performance Improvement / Patient Safety Committee shall report, on an on-going and periodic basis, anappraisal of the organizational Performance Improvement program. The appraisal should contain information regarding significant opportunities to improve care identified through the performance improvement process and the effectiveness of actions taken. The on-going and periodic appraisal should discuss both the strengths and weaknesses of the existing program, discuss the degree of overall integration and coordination of improvement activities, and contain recommendations for program improvement. The Performance Improvement/Patient Safety Committee shall submit on-going reports to the Medical Executive Committee and Board of Directors.

REFERENCES:

- Centers for Medicaid Services. (2021). The CMS Compliance Crosswalk. § 482.21 Quality Assessment and Performance Improvement Program. Brentwood, TN.

- The Joint Commission. (2023). Hospital Comprehensive Accreditation Manual. Standards: (PI 01.01.01, LD 03.07.01, MS05.01.01, PI 02.01.01 Oakbrook Terrace, IL.

- The Joint Commission (2023) Laboratory and Point-of-Care Testing Standards Manual. Standards – PI 01.01.01, PI 02.01.01, LD 03.07.01, LD 03.05.01, LD 04.03.09 Oakbrook Terrace, IL.

SUBJECT: **SKIN CARE, PREVENTATIVE**	SECTION:

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

PURPOSE:

The purpose is to maintain skin integrity and to prevent skin and tissue breakdown and the development of pressure injuries.

POLICY:

It is the policy of this facility to utilize preventive measures and treatments to prevent skin and tissue breakdown and the development of pressure injuries. These preventive measures and treatments will be utilized in the care of all residents.

AFFECTED PERSONNEL/AREAS:

REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSES ASSISTANTS (CNA), RESTORATIVE NURSE ASSISTANT (RNA), DIETITIAN, RESPIRATORY THERAPIST, REHABILITATION THERAPSITS, AND ALL CAREGIVERS

PROCEDURE:

1. Keep the skin clean.
    a. Cleanse the skin at the time of soiling and during scheduled baths or showers.
    b. Avoid hot water and use a mild cleansing agent that minimizes irritation and skin dryness.
    c. During the cleansing process, use care to minimize force and friction applied to the skin.
2. Minimize environmental factors leading to skin drying.
    a. Prevent excessive heat or cold related to room temperature.
    b. Use skin lubricants such as creams, moisturizers, and lotions.
3. Minimize skin exposure to moisture due to incontinence, perspiration, or wound drainage.
    a. Use under pads, briefs, or diapers that are made of materials that absorb moisture and present a quick-drying surface to the skin.
    b. Use skin protectants such as barrier protectant, or diaper type ointment.
4. Avoid massage over bony prominences.
5. Prevent skin injury due to friction and shearing.
    a. Use proper positioning, transferring, and turning techniques.

b. Use lubricants as ordered.

c. Use protective films such as transparent dressings and skin sealants as needed.

d. Use protective dressing such as multi-layer silicone as needed.

e. Use protective padding as needed.

6. Provide adequate nutrition and hydration.

a. Dietitian to assess resident nutritional status, develop nutrition plan, and provide for dietary requirements upon admission, monthly, and ongoing as needed.

b. Dietician and nursing to assess, plan, and assure resident hydration upon admission, monthly, and ongoing as needed.

7. Provide and/or improve resident mobility and activity.

a. Provide rehabilitation therapy as appropriate.

b. Provide restorative nursing program as appropriate.

c. Provide ROM bid for residents who are non-ambulatory.

8. Prevent or reduce pressure.

a. Turn and reposition the dependent resident at least every two hours, and as needed.

b. Utilize positioning devices such as pillows or foam wedges to keep bony prominences such as knees or ankles from direct contact with one another.

c. Use devices that relieve pressure on such areas as heels and elbows.

d. When resident is in side lying position, avoid positioning directly on the trochanter.

e. Consistently use pressure-reducing devices such as pressure relief mattresses, static air, alternating air, gel, or overlays.

f. Use lifting devices such as draw sheets, slide sheet, or Vertical Lifts to move or transfer residents who cannot assist.

g. Allow residents to stay up in chairs for a maximum of 2 hours each time. (Adjust high-risk residents' position at least every 1 hour).

h. Use pressure-reducing device in the chair as recommended by the wound consultant and nursing discretion. (Gel pad, foam, air pad, or combination.)

DOCUMENTATION:

1. The licensed nurse will document the overall condition of the resident's skin every shift in the resident record, utilizing the shift physical assessment or narrative notes in electronic medical record (EMR).

2. The individualized preventive skin care program will be documented on the residents' integumentary section in EMR by the LVN each shift.

3. The CNA will document the skin care provided for each resident in the EMR.

4. The Dietitian will document nutritional assessments and treatment plans in the resident's record on PCS and on the interdisciplinary care plan.

5. Any other discipline providing preventive skin care will document this care in the resident record in PCS specific to the discipline. (Example: Trach site care by Respiratory Therapy.).

SPECIAL CONSIDERATIONS:

Refer to the following policies and procedures and guidelines for additional information and requirements related to preventive skin care:

1. Skin Care Tips for Nursing Assistants

2. Pressure Ulcer Reference Information

REFERENCE:

- Thomson Reuters (2021) Barclay's California Code of Regulations, , 72315 (f) (1) (5) San Francisco, California, Title 22, Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

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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 **October 24, 2023 at 5:00 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 5:02 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ, PANDYA, KASHYAP**

Others Present: Blazar, Dan, Patient Experience Officer, Conner, Brian, Partner , Moss Adams, Dickson, Doug, Chief Financial Officer, Fenesis, John, Moss Adams, Gomes, Justen, Moss Adams, Gomez, Cindy, Director of Compliance, Hefner, Donna, President/Chief Executive Officer, Hudson, Jeffery, VPPCS/CNO/DIO, Mitchell, Melissa, VP Quality and Regulatory Affairs, Parsons, Malynda, Public Relations, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Themm, Eric, Zephyr Healthcare Associates, Wallace, Marcella, Director of Communications, 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:

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:03 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

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets. Estimated Date of Disclosure – March 2025

Item D to be continued to after the Open Session concludes.

Closed Session Items C, E, F were deferred to the conclusion of Open Session as there was not time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:46 p.m., reconvening in Open Session at 5:46 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 Sandhu. 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 Chair LOMELI, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Discussion Regarding Trade Secret

Item D to be continued to after the Open Session concludes.

IV. Public Comments

Sierra View Medical Center is delighted to introduce Dr. Timothy Tan, who will be heading the Sierra View Hip & Knee Center, a division of Sierra View Multi-Specialty Center.

Dr. Tan is a board certified and fellowship-trained orthopaedic surgeon who specializes in adult reconstruction of the hip and knee including both primary and revision surgery. He cares for patients with all types of degenerative hip and knee conditions, as well as those with complications from prior joint replacement surgery.

We're thrilled to have Dr. Tan as part of our team! Stay tuned for more information about the Sierra View Hip & Knee Center.

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 Vice Chair LOMELI, seconded by, Director KASHYAP and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Vice Chair LOMELI and seconded by Director MARTINEZ to approve the September 26, 2023 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. CEO Report

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

VIII. Business Items

A. FY2023 Audited Financials Report

The FY2023 Audited Financials Report was tabled to conclusion of Closed Session.

B. September 2023 Financials

Doug Dickson, CFO presented the Financials for September 2023. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,675,800. Supplemental Funds were $1,574,984. Total Operating Expenses were $13,654,795. Loss from operations of $978,995.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chair LOMELI and carried to approve the September 2023 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

IX. Closed Session: Board adjourned Open Session at 6:05 p.m. and went into Closed Session at 6:12 p.m. to discuss the following items:

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 3206(b): Cal. Civ. Code§ 3426.1 (d): Discussion Regarding Trade Secrets (1 Item) Estimated Dated of Disclosure – March 2025

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 3206(b): Cal. Civ. Code§ 3426.1 (d): Discussion Regarding Trade Secrets (1 Item) Estimated Dated of Disclosure – January 2024

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service and Strategic Planning

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)

X. Open Session: Board adjourned Closed Session at 7:40 p.m. and went into Open Session at 7:40 p.m. to discuss the following items:

D. Discussion Regarding Trade Secret. Information only; no action taken.

C. Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chair LOMELI and carried to approve the FY2023 Audited Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. Discussion Regarding Trade Secret and Strategic Planning. Information only; no action taken.

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

XII. Business Items

A. FY2023 Audited Financials

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve the FY2023 Audited Financials Report in Closed Session to be released to public record as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

XIII. Announcements:

A. Regular Board of Directors Meeting – November 28, 2023 at 5:00 p.m.

The meeting was adjourned 7:31 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: ww

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FINANCIAL PACKAGE
October 2023

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
October 2023

Statistic	Oct-23 Actual	Oct-23 Budget	Oct-23 Over/ (Under)	Oct-23 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) 10/2022	% Change
Utilization											
SNF Patient Days											
Total	62	108	(46)	-42.6%	323	432	(109)	-25.2%	468	(145)	-31.0%
Medi-Cal	62	81	(19)	-23.5%	323	282	41	14.7%	307	16	5.2%
Sub-Acute Patient Days											
Total	983	871	112	12.9%	3,772	3,484	288	8.3%	3,436	336	9.8%
Medi-Cal	776	610	166	27.3%	3,081	2,441	640	26.2%	2,407	674	28.0%
Acute Patient Days	1,542	1,848	(306)	-16.6%	6,730	7,393	(663)	-9.0%	7,039	(309)	-4.4%
Acute Discharges	425	480	(55)	-11.5%	1,762	1,920	(158)	-8.2%	1,876	(114)	-6.1%
Medicare	167	187	(20)	-10.8%	669	712	(43)	-6.0%	696	(27)	-3.9%
Medi-Cal	208	214	(6)	-2.7%	866	935	(69)	-7.4%	920	(54)	-5.9%
Contract	43	72	(29)	-40.1%	210	256	(46)	-18.1%	250	(40)	-16.0%
Other	7	2	5	221.6%	17	10	7	64.3%	10	7	70.0%
Average Length of Stay	3.63	3.85	(0.22)	-5.8%	3.82	3.85	(0.03)	-0.8%	3.75	0.07	1.8%
Newborn Patient Days											
Medi-Cal	198	172	26	15.2%	743	678	65	9.6%	740	3	0.4%
Other	21	33	(12)	-36.7%	143	142	1	0.6%	150	(7)	-4.7%
Total	219	205	14	6.8%	886	820	66	8.0%	890	(4)	-0.4%
Total Deliveries	100	116	(16)	-13.8%	438	464	(26)	-5.6%	496	(58)	-11.7%
Medi-Cal %	89.00%	82.81%	6.19%	7.5%	83.07%	82.81%	0.26%	0.3%	81.91%	1.16%	1.4%
Case Mix Index											
Medicare	1.6021	1.6395	(0.0374)	-2.3%	1.5509	1.6395	(0.0886)	-5.4%	1.5570	(0.0061)	-0.4%
Medi-Cal	1.1044	1.1881	0.1380	11.6%	1.1579	1.1881	(0.0302)	-2.5%	1.1771	(0.0192)	-1.6%
Overall	1.3261	1.3732	(0.2688)	-19.6%	1.3216	1.3732	(0.0516)	-3.8%	1.3206	0.0010	0.1%
Ancillary Services											
Inpatient											
Surgery Minutes	6,844	9,041	(2,197)	-24.3%	33,665	36,164	(2,499)	-6.9%	35,268	(1,603)	-4.5%
Surgery Cases	86	104	(18)	-17.3%	380	416	(36)	-8.7%	428	(48)	-11.2%
Imaging Procedures	1,346	1,479	(133)	-9.0%	5,512	5,917	(405)	-6.8%	5,689	(177)	-3.1%
Outpatient											
Surgery Minutes	13,017	12,448	569	4.6%	53,282	49,792	3,490	7.0%	49,033	4,249	8.7%
Surgery Cases	202	190	12	6.3%	817	760	57	7.5%	747	70	9.4%
Endoscopy Procedures	229	142	87	61.3%	829	568	261	46.0%	697	132	18.9%
Imaging Procedures	4,164	3,716	448	12.1%	15,295	14,861	434	2.9%	15,368	(73)	-0.5%
MRI Procedures	274	295	(21)	-7.1%	1,235	1,180	55	4.7%	1,256	(21)	-1.7%
CT Procedures	1,282	1,178	104	8.8%	5,171	4,712	459	9.7%	4,867	304	6.2%
Ultrasound Procedures	1,245	1,102	143	13.0%	5,100	4,408	692	15.7%	4,046	1,054	26.1%
Lab Tests	31,882	33,247	(1,365)	-4.1%	128,609	132,988	(4,379)	-3.3%	138,439	(9,830)	-7.1%
Dialysis	-	3	(3)	-100.0%	8	12	(4)	-33.3%	2	6	300.0%

Sierra View Medical Center
Financial Statistics Summary Report
October 2023

Statistic	Oct-23 Actual	Oct-23 Budget	Oct-23 Over/ (Under)	Oct-23 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) 10/2022	% Change
Cancer Treatment Center											
Chemo Treatments	1,714	1,713	1	0.1%	5,980	6,852	(872)	-12.7%	6,891	(911)	-13.2%
Radiation Treatments	1,998	1,653	345	20.9%	7,733	6,612	1,121	17.0%	6,252	1,481	23.7%
Cardiac Cath Lab											
Cath Lab IP Procedures	13	10	3	30.0%	50	40	10	25.0%	37	13	35.14%
Cath Lab OP Procedures	33	28	5	17.9%	133	112	21	18.8%	119	14	11.76%
Total Cardiac Cath Lab	46	38	8	21.1%	183	152	31	20.4%	156	27	17.31%
Outpatient Visits											
Emergency	3,415	3,411	4	0.1%	13,694	13,644	50	0.4%	13,717	(23)	-0.2%
Total Outpatient	13,920	12,811	1,109	8.7%	53,891	51,244	2,647	5.2%	52,629	1,262	2.4%
Staffing											
Paid FTE's	846.22	841.56	4.66	0.6%	851.97	841.56	10.41	1.2%	904.29	(52.32)	-5.8%
Productive FTE's	732.18	735.98	(3.80)	-0.5%	738.53	735.98	2.55	0.3%	765.43	(26.90)	-3.5%
Paid FTE's/AOB	5.21	5.06	0.15	3.0%	4.99	5.02	(0.03)	-0.7%	5.30	(0.31)	-5.8%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,109	11,031.70	78	0.7%	10,520	11,032	(512)	-4.6%	10,502	17	0.2%
Cost/Adj.Patient Day	2,673	2,656	17	0.6%	2,596	2,645	(49)	-1.9%	2,669.32	(74)	-2.8%
Revenue/Adj. Discharge	53,372	53,107	265	0.5%	51,835	53,108	(1,273)	-2.4%	49,580	2,255	4.5%
Cost/Adj. Discharge	12,842	12,788	54	0.4%	12,790	12,734	56	0.4%	12,601	188	1.5%
Adj. Discharge	1,047	1,070	(23)	-2.1%	4,262	4,280	(18)	-0.4%	4,445	(183)	-4.1%
Net Op. Gain/(Loss) %	-5.18%	-3.67%	-1.51%	41.0%	-6.40%	-3.67%	-2.73%	74.4%	-17.19%	10.79%	-62.7%
Net Op. Gain/(Loss) $	(662,284)	(484,840)	(177,444)	36.6%	(3,280,880)	(1,750,676)	(1,530,204)	87.4%	(8,217,660)	4,936,780	-60.1%
Gross Days in Accts Rec.	94.07	88.87	5.20	5.8%	94.07	88.87	5.20	5.8%	84.59	9.48	11.2%
Net Days in Accts. Rec.	61.13	72.82	(11.69)	-16.0%	61.13	72.82	(11.69)	-16.0%	73.44	(12.31)	-16.8%

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

	OCT 2023	SEP 2023
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 4,901,605	$ 6,084,924
SHORT-TERM INVESTMENTS	1,137,904	8,423
ASSETS LIMITED AS TO USE	64,153	65,632
PATIENT ACCOUNTS RECEIVABLE	171,723,030	168,833,145
LESS UNCOLLECTIBLES	(28,451,866)	(28,181,120)
CONTRACTUAL ALLOWANCES	(118,426,621)	(115,158,223)
OTHER RECEIVABLES	23,639,025	20,622,290
INVENTORIES	4,046,428	4,022,855
PREPAID EXPENSES AND DEPOSITS	3,366,181	2,316,390
LEASE RECEIVABLE - CURRENT	341,565	341,565
TOTAL CURRENT ASSETS	62,341,403	58,955,881
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	32,460,475	31,879,044
LONG-TERM INVESTMENTS	129,407,553	134,127,614
PROPERTY, PLANT AND EQUIPMENT, NET	82,639,470	83,012,269
INTANGIBLE RIGHT OF USE ASSETS	522,888	536,750
SBITA RIGHT OF USE ASSETS	3,280,191	3,695,160
LEASE RECEIVABLE - LT	1,296,459	1,324,669
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,678,369	1,699,349
TOTAL ASSETS	$ 313,876,806	$ 315,480,734

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

	OCT 2023	SEP 2023
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 522,467	$ 391,850
CURRENT MATURITIES OF BONDS PAYABLE	4,055,000	4,055,000
CURRENT MATURITIES OF LONG TERM DEBT	1,201,171	1,201,171
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	3,428,265	3,933,415
ACCRUED PAYROLL AND RELATED COSTS	6,902,083	7,187,026
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,856,707	3,945,565
LEASE LIABILITY - CURRENT	137,822	139,740
SBITA LIABILITY - CURRENT	1,272,203	1,272,203
TOTAL CURRENT LIABILITIES	21,375,718	22,125,970
SELF-INSURANCE RESERVES	1,518,737	1,665,956
CAPITAL LEASE LIAB LT	1,608,590	1,691,782
BONDS PAYABLE, LESS CURR REQT	37,510,000	37,510,000
BOND PREMIUM LIABILITY - LT	3,170,621	3,229,191
LEASE LIABILITY - LT	400,544	411,576
SBITA LIABILITY - LT	2,207,644	2,616,968
OTHER NON CURRENT LIABILITIES	187,927	187,927
DEFERRED INFLOW - LEASES	1,572,263	1,602,193
TOTAL LIABILITIES	69,552,042	71,041,561
UNRESTRICTED FUND	245,134,891	245,134,891
PROFIT OR (LOSS)	(810,127)	(695,717)
TOTAL LIABILITIES AND FUND BALANCE	$ 313,876,806	$ 315,480,734

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

OCT 2023 ACTUAL	OCT 2023 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,182,887	5,730,675	547,788	(10)%	INPATIENT - NURSING	21,495,376	22,922,700	1,427,324	(6)%
17,580,190	19,760,695	2,180,505	(11)%	INPATIENT - ANCILLARY	69,993,183	79,043,769	9,050,586	(12)%
22,763,077	25,491,370	2,728,293	(11)%	TOTAL INPATIENT REVENUE	91,488,559	101,966,469	10,477,910	(10)%
33,140,452	31,354,146	(1,786,306)	6%	OUTPATIENT - ANCILLARY	129,428,634	125,357,136	(4,071,498)	3%
55,903,530	56,845,516	941,986	(2)%	TOTAL PATIENT REVENUE	220,917,193	227,323,605	6,406,412	(3)%
				DEDUCTIONS FROM REVENUE				
(18,941,965)	(17,105,659)	1,836,306	11%	MEDICARE	(69,711,203)	(68,422,636)	1,288,567	2%
(16,139,478)	(20,103,940)	(3,964,462)	(20)%	MEDI-CAL	(69,926,871)	(80,415,760)	(10,488,889)	(13)%
(7,537,525)	(6,634,411)	903,114	14%	OTHER/CHARITY	(28,905,852)	(26,537,644)	2,368,208	9%
(63,061)	(13,158)	49,903	379%	DISCOUNTS & ALLOWANCES	(207,641)	(52,632)	155,009	295%
(945,086)	(439,236)	505,850	115%	BAD DEBTS	(2,994,567)	(1,756,944)	1,237,623	70%
(43,627,114)	(44,296,404)	(669,290)	(2)%	TOTAL DEDUCTIONS	(171,746,135)	(177,185,616)	(5,439,481)	(3)%
12,276,415	12,549,112	272,697	(2)%	NET SERVICE REVENUE	49,171,058	50,137,989	966,931	(2)%
512,747	654,369	141,622	(22)%	OTHER OPERATING REVENUE	2,057,964	2,617,476	559,512	(21)%
12,789,162	13,203,481	414,319	(3)%	TOTAL OPERATING REVENUE	51,229,022	52,755,465	1,526,443	(3)%
				***** OPERATING EXPENSE *****				
5,639,073	5,289,201	349,872	7%	SALARIES	22,363,962	21,210,141	1,153,821	5%
576,265	564,527	11,738	2%	S&W PTO	2,613,684	2,265,686	347,998	15%
1,123,812	1,530,723	(406,911)	(27)%	EMPLOYEE BENEFITS	5,438,327	6,192,294	(753,967)	(12)%
1,307,079	1,393,848	(86,769)	(6)%	PROFESSIONAL FEES	4,990,951	5,575,392	(584,441)	(11)%
879,990	936,959	(56,969)	(6)%	PURCHASED SERVICES	3,505,227	3,502,898	2,329	0%
2,030,268	1,977,046	53,222	3%	SUPPLIES & EXPENSES	7,934,780	7,920,828	13,952	0%
245,511	287,952	(42,442)	(15)%	MAINTENANCE & REPAIRS	908,837	1,010,370	(101,534)	(10)%
297,648	263,897	33,751	13%	UTILITIES	1,193,097	1,055,588	137,509	13%
27,010	17,049	9,961	58%	RENT/LEASE	107,325	68,196	39,129	57%
84,084	118,267	(34,183)	(29)%	INSURANCE	511,048	473,068	37,980	8%
1,285,626	879,274	406,352	46%	DEPRECIATION/AMORTIZATION	3,908,648	3,530,480	378,168	11%
(44,919)	429,578	(474,497)	(111)%	OTHER EXPENSE	1,034,017	1,701,200	(667,183)	(39)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
13,451,446	13,688,321	(236,875)	(2)%	TOTAL OPERATING EXPENSE	54,509,902	54,506,141	3,761	0%
(662,284)	(484,840)	177,444	37%	NET GAIN/(LOSS) FROM OPERATIONS	(3,280,880)	(1,750,676)	1,530,204	87%
116,558	116,558	0	0%	DISTRICT TAXES	466,232	466,232	0	0%
298,310	277,386	(20,924)	8%	INVESTMENTS INCOME	1,202,081	1,109,544	(92,537)	8%
58,527	43,282	(15,245)	35%	OTHER NON OPERATING INCOME	214,843	173,128	(41,715)	24%
(132,632)	(77,020)	55,612	72%	INTEREST EXPENSE	(366,915)	(308,080)	58,835	19%
(93,259)	(36,775)	56,484	154%	NON-OPERATING EXPENSE	(195,532)	(147,100)	48,432	33%
247,504	323,431	75,927	(24)%	TOTAL NON-OPERATING INCOME	1,320,709	1,293,724	(26,985)	2%
(414,780)	(161,409)	253,371	157%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(1,960,171)	(456,952)	1,503,219	329%
300,371	0	(300,371)		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	1,150,044	0	(1,150,044)	
(114,409)	(161,409)	(47,000)	(29)%	NET GAIN/(LOSS)	(810,127)	(456,952)	353,175	77%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
10/31/23

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(662,284)	(3,280,880)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	1,285,626	3,908,648
Provision for bad debts	270,746	710,064
Change in assets and liabilities:		
Patient accounts receivable, net	378,514	433,130
Other receivables	(3,016,735)	(7,962,351)
Inventories	(23,573)	(28,469)
Prepaid expenses and deposits	(1,049,791)	(983,202)
Advance refunding of bonds payable, net	20,980	83,919
Accounts payable and accrued expenses	(505,149)	(2,342,665)
Deferred inflows - leases	(29,930)	(119,720)
Accrued payroll and related costs	(284,943)	(454,878)
Estimated third-party payor settlements	(88,858)	701,437
Self-insurance reserves	(147,219)	(147,219)
Total adjustments	(3,190,332)	(6,201,306)
Net cash provided by (used in) operating activities	(3,852,616)	(9,482,186)
Cash flows from noncapital financing activities:		
District tax revenues	116,558	466,232
Noncapital grants and contributions, net of other expenses	(92,546)	(47,655)
Net cash provided by (used in) noncapital financing activities	24,012	418,577
Cash flows from capital and related financing activities:		
Purchase of capital assets	(898,965)	(1,354,036)
Proceeds from lease receivable, net	28,210	112,132
Principal payments on debt borrowings	-	(3,880,000)
Interest payments	(2,772)	(881,712)
Net change in notes payable and lease liability	(90,497)	(376,305)
Net changes in assets limited as to use	(579,952)	2,420,698
Net cash provided by (used in) capital and related financing activities	(1,543,976)	(3,959,223)
Cash flows from investing activities:		
Net (purchase) or sale of investments	5,020,432	3,501,777
Investment income	298,310	1,202,081
Net cash provided by (used in) investing activities	5,318,742	4,703,858
Net increase (decrease) in cash and cash equivalents:	(53,838)	(8,318,974)
Cash and cash equivalents at beginning of month/year	6,093,347	14,358,483
Cash and cash equivalents at end of month	6,039,509	6,039,509

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
October 2023

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Nov-22	10,716,042	298,921	11,014,963
Dec-22	9,551,250	2,895,404	12,446,654
Jan-23	11,383,815	396,451	11,780,266
Feb-23	10,444,477	1,486,294	11,930,771
Mar-23	11,036,309	4,353,856	15,390,165
Apr-23	9,611,508	8,659,999	18,271,507
May-23	13,011,917	3,474,340	16,486,257
Jun-23	10,589,289	5,045,026	15,634,315
Jul-23	9,542,222	1,209,276	10,751,498
Aug-23	11,411,456	2,278,509	13,689,964
Sep-23	11,153,141	297,374	11,450,515
Oct-23	**10,806,912**	**1,614,798**	**12,421,710**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

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

- Medi-Cal OP Supplemental and DSH funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP
- Medicare interim payments

October 2023 Summary of Other Activity:

70,016	Beta Healthcare Group Dividend 1st Installment
1,342,979	M-Cal IP DSH 1st Qtr 07/23 - 09/23
201,803	Miscellaneous
1,614,798	10/23 Total Other Activity