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

AGENDA
October 22, 2024

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(d) (2), Conference with Legal Counsel about significant exposure to litigation involving a matter of compliance; privileged communication (1 Item).

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service and Strategic Planning (1 Item) Estimated Date of Disclosure – January 2025

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: September 1, 2026

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2025

G. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (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. Conference with Legal Counsel; Anticipated Litigation (1 Items)
Recommended Action: Approve/Reject Claim

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (I Item)
Recommended Action: Information Only: No Action Taken

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item).
Recommended Action: Approve/Disapprove Presentation as Given

F. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item).
Recommended Action: Information Only; No Action Taken

G. 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 the 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. 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. **September 24, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove September 24, 2024 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. **Single Audit Review**
Recommended Action: Approve/Disapprove Report as Given

B. **Annual Graduate Medical Education Report**
Recommended Action: Approve/Disapprove Report at Given

C. **September 2024 Financials**
Recommended Action: Approve/Disapprove *September* 2024 Financials

D. **Resolution 10.22.2024/01 Appointing CFO Craig McDonald to Treasurer of the Board**
Recommended Action: Appoint CFO, Craig McDonald as Treasurer of the Board

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – November 26, 2024 at 5:00 p.m.
B. Board Ethics Training due by November 26th Board Meeting.

XII. Adjournment

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
OCTOBER 22, 2024

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.

PUBLIC NOTICE ABOUT COPIES

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

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MEDICAL EXECUTIVE COMMITTEE	10/02/2024
BOARD OF DIRECTORS APPROVAL	
	10/22/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
October 22, 2024 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**
• Administration of Formula Via Feeding Tube, Gravity, Bolus, Pump	1-8	
• Assessment – Body	9-10	
• Blanket Warmer	11	
• Bowel Management Protocol	12-13	
• Care of Residents with Dementia on the DP/SNF Unit	14-17	
• Confidentiality of Completion of MDS Data	18	
• Criteria for Collection of Stool for Ova and Parasites	19-20	
• Death of a Resident	21-23	
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• Communication Barriers, Reduction of	25	
• DP/SNF Room Change	26	
• Emergency Blood Release	27-28	
• Equal Access to Quality of Care	29	
• Feeding, Transitional-Enteral to Oral Intake	30-31	
• Hand Care of, Contracture	32-33	
• Infection Control – Blood Bank	34-35	
• Initial Resident Assessment and Reassessment – MDS	36-41	
• Leave of Absence, Therapeutic	42-44	
• Leave of Absence, Therapeutic Outing Checklist	45-47	
• MDS, Diagnosis Coding on MDS Assessments and UB 92 Claim Forms	48-49	
• MDS Tracking Form	50-51	
• Massive Transfusion	52	
• Mechanical Lift	53-54	
• Mechanical Ventilation	55-60	
• Medication Pass Observation	61-62	
• Multiple Transfusions	63	
• Nasal Care for Nasogastric Tube Fed Residents	64-65	
• Nourishments	66-67	
• Nursing Documentation of Enteral Feeding	68-71	
• Patient Blood Samples for Blood Bank	72	
• Patient Food from Home – DPSNF	73-74	
• Physician's Services	75-78	
• Resident Self-Determination in Medical Decision Making (PSDA)	79-83	
• Residents' Fund Policy	84-86	
• Resident's Rights	87-88	

• Restraints, Chemical • Siderails • Sign-Out Protocol for Blood Components • Transfer Within Facility – Change of Room/Roommate • VAC Therapy – Negative Pressure Wound Therapy System DPSNF	89-94 95 96-97 98-100 101-112	

SUBJECT: **ADMINISTRATION OF FORMULA VIA FEEDING TUBE GRAVITY, BOLUS, PUMP**	SECTION: **Page 1 of 8**

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

PURPOSE:

The purpose of this policy is to offer guidance on the administration of enteral nutrients to residents who are unable to eat orally and to ensure optimal absorption of nutrients, without untoward side effects.

DEFINITIONS:

1. Enteral Feeding: Delivery of nutrients directly into the stomach, duodenum or jejunum. Also called enteral nutrition (EN).
2. Gastrostomy Tube (GT): A tube that goes through the skin into the stomach. It may be placed there using a technique called percutaneous endoscopic gastrostomy (PEG).
3. Jejunostomy tube (JT): A tube placed into the small intestine. It may be placed there using a technique called percutaneous endoscopic jejunostomy (PEJ).
4. Gravity Method: Allowing the enteral feeding to flow into the tube by hanging the feeding above the patient, without the use of a pump.
5. Bolus Method: Pushing the enteral feeding into the tube in measured increments; may occur several times a day.
6. Continuous Infusion Method: Delivery of the enteral feeding infusion to the feeding tube via a pump at a set flow rate.

POLICY:

Residents of Sierra View Medical Center (SVMC) Distinct Part Skilled Nursing Facility (DP/SNF) will receive enteral nutrition according to physician orders and the American Society for Parenteral and Enteral Nutrition (ASPEN) clinical recommendations.

EQUIPMENT:

- Gravity Method:

  Feeding formula

  - Graduated container (for formula)
  - 60mL syringe
  - Stethoscope
  - Feeding bag and tubing
  - IV Pole

- Water

- Enteral Feeding Pump:
  - Feeding formula (cans or closed container)
  - Feeding bag and tubing (or spike set)
  - Feeding pump
  - IV Pole
  - Stethoscope
  - 60mL syringe
  - Water
  - Graduated container (for canned formula)

- Bolus Method:
  - Feeding formula (dated when opened, if not used all at once and properly stored per manufacturer's recommendation)
  - Graduated container
  - Stethoscope
  - 60mL syringe
  - Water

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN)*

PROCEDURE:

A. Implementation of Physician Order Regarding Tube Feeding Regimen

1. Charge Nurse will provide a copy of written order to Medication Nurse responsible to named resident's care.

2. Charge Nurse will ensure Physician Order is correctly transcribed in medication administration record (M.A.R.) by comparison to original written order.

3. Charge Nurse and Medication Nurse will initiate change in feeding pump settings per MD Order.

4. Charge Nurse and Medication Nurse will each document MD Order in EMR individually.

B. Enteral Feeding:

1. Provide privacy.

2. Wash hands thoroughly and don gloves.

3. Explain procedure.

4. Check formula can, bag, or container for expiration date.
Properly label with resident's name and room number, formula/water, rate and the date opened/hung.

5. Elevate head of bed at a 35-45 degree angle during the feeding and for at least one hour after the feeding.

6. Verify placement of tube by aspiration and auscultation (refer to procedure for verification of tube placement).

7. Flush feeding tube with 30 to 50mL of water.

C. Bolus Method (follow steps 1 through 7 above, then):

1. Open formula and pour prescribed amount into a graduated container.

2. Properly label with resident's name and room number, formula/water, rate and the date opened/hung.

3. Remove plunger from the 60mL syringe.

4. Attach syringe to feeding tube with Lopez Valve in off position to prevent excess air from entering stomach.

5. Fill syringe with formula to flow through by natural gravity.

6. Open Lopez Valve to allow formula to flow in slowly.

7. When syringe is one quarter full, add formula.

8. Repeat until specified amount is given.

9. The height at which syringe is held determines flow rate.

10. Administer slowly over 15 minutes to prevent untoward effects.

11. If nausea, vomiting, distention, diarrhea or dumping occurs, discontinue feeding (notify the physician).

12. When feeding is completed, flush tube with amount of water specified by physician order, or 30 to 50mL.

13. Plug or close Lopez Valve to feeding tube.

14. Clean syringe and store according to policy.

15. Throw disposable graduated container away or wash plastic graduated container thoroughly for storage until time for next feeding.

D. Intermittent Gravity Method (feedings administered over a 30-40 minute period, then disconnected until next feeding in 3 to 6 hours – complete steps 1 through 7 above, then:

1. Clamp tubing on the gravity bag.

2. Open formula.

3. Properly label with resident's name and room number, formula/water, rate and the date opened/hung.

4. Pour prescribed amount into well-rinsed gravity bag for open system.

5. Spike the container for closed systems.

6. Hang bag or container on IV pole.

7. Prime drip chamber less than half full.

8. Prime tubing by opening roller clamp and allowing formula to fill tubing.

9. Close roller clamp and recap tubing.

10. Unplug feeding tube.

11. Connect feeding tube to gravity bag or container tubing.

12. Open roller clamp to adjust flow of formula.

13. When bag empties, or required amount has been administered, clamp tubing.

14. Disconnect tubing from feeding tube.

15. Flush feeding tube with 30 to 50mL of water or follow with water as ordered.

16. Rinse feeding bag thoroughly with tap water (or cap off spike set tubing of closed system container).

17. Tube feeding bag, syringe and tubing are to be changed every 24 hours and properly dated, labeled and initialed.

18. Record feeding on resident's record in PCS.

E. Pump of Infusion Controller Method (follow steps 1 through 7 of Procedures for Enteral Feeding and then):

1. Clamp tubing on pump bag.

2. Open formula.

3. Properly label with resident's name and room number, formula/water, rate and the date opened/hung.

4. Pour prescribed amount into thoroughly rinsed pump bag and tubing for open system. Do not add new formula to old formula.

5. Spike container for closed system.

6. Hang bag or container on IV pole.

7. Prime drip chamber less than half full.

8. Prime tubing by opening to roller clamp and allowing formula to fill tubing to empty it of air bubbles.

9. Close roller clamp and recap tubing.

10. Thread tubing from pump bag or container through the controller according to the manufacturer's directions.

11. Open roller clamp.

12. Set flow rate according to manufacturer's directions.

13. Turn pump on.

14. Monitor the resident.

15. Flush feeding tube with 30 to 50mL of water when container empties and at least every shift.

16. Turn off pump, rinse bag and tubing; add new formula as ordered for continuous feeding. DO NOT fill bag with more formula than will be administered in 8 hours for canned formula or 4 hours for reconstituted formula to decrease risk of spoilage and adverse effects to resident. (Closed system container may hang for a maximum of 24 hours.)

17. Pump bags, syringe and tubing are to be changed every 24 hours and properly labeled with date, time, and nurse's initials.

18. Record feeding in resident's record in PCS.

F. Closed System Feeding Guideline: Special Considerations to minimize risk of microbial contamination of enteral formulations:

1. Given at room temperature

2. Insert spike from administration tubing into feeding container

3. Confirm correct patient identity with full patient name and date of birth

4. Change feeding tube and feeding container every 24 hours

5. Change feeding tubing with every new bottle that is hung.

6. Label feeding bottle with resident's name, room, date, formula and rate.

7. Do not re-spike bottle already in use with the new tubing

G. Open System Feeding Guidelines (cans, bottles, powder formulas):

1. Given at room temperature.

2. Clean container top with alcohol wipe/swab before opening.

3. Fill bag with just enough feeding for maximum hang time.

4. Hang canned formula for a maximum of 8 hours.

5. Hang reconstituted formula for a maximum of 4 hours.

6. Allow bag to empty before adding additional formula.

7. Change tubing and feeding container every 24 hours.

8. Any unused portion of canned formula cannot be taken out of resident's room and must be discarded.

9. Formula selected will be from the SVMC Enteral Formulary whenever possible. Other formulas may be used if a patient's unique condition/needs warrant it. Non-formulary products may require up to 72 hours to obtain.

H. Documentation : Record in the resident's medical record in PCS:

1. Date

2. Time of feeding

3. Amount of feeding

4. Method of delivery (bolus, gravity or pump)

5. Route of delivery (NG, GT, JT)

6. Residents' in tolerance of feeding, including:

   a. diarrhea

   b. nausea, vomiting

   c. regurgitation

   d. abdominal distention

   e. residuals 250ml or more

7. If a resident has residuals of 250ml or more, hold the tube feeding and recheck in one hour. If the residuals remain above 250ml, recheck every hour. If the tube feeding is held 24 hours or more, notify the MD and get a Dietary consult.

8. Condition of GT, JT or NG site (i.e., skin at site clean and dry or any drainage or excoriation, plus interventions provided as indicated).

9. Record formula and water amount on intake and output section in Meditech, include:

   a. Water used for flushing after feeding

b. Medication flushes

10. Record measures taken to prevent aspiration such as:

a. Elevation of the head of bed

b. Checking of placement by auscultation

c. Checking of residual of gastric contents

I. Also Record:

1. Changes of administration sets

2. Flow rate checks

3. Mouth care

4. Nasal care

5. Any changes of feeding tubes

REFERENCES:

- Med Pass, Inc. (updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (k) (3) (i) (ii), 483.25 (i) United States of America, Med Pass Inc.
- Abbott Labs, Inc., Ross Products Division. (2000). Preventing microbial contamination of enteral formulas and delivery systems. pp. 1-17.
- A.S.P.E.N. Safe Practices for Enteral Nutrition Therapy, Journal of Parenteral and Enteral Nutrition, Volume 41 Number 1, January 2017, 15-103). Boullata, J.I., Gilbert, K., Sacks, G., jpen.sagepub.com
- Enteral Nutrition Therapy: Medical Necessity and Documentation Requirements, 08/05/2017, CMS.gov, U.S Centers for Medicare & Medical Services, 7500 Security Blvd, Baltimore, MD 21244.

SUBJECT: **ASSESSMENT- BODY**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide an ongoing system for monitoring resident skin conditions, to implement interventions when needed, and to prevent complications.

POLICY:

It is the policy of this facility to monitor the resident's skin condition daily and provide documented licensed nurse assessments on a weekly basis and as needed.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)*

PROCEDURE:

1. Body assessments will be completed upon admission of the resident by the Registered Nurse (RN). Observations will be documented in EMR. The RN will contact the physician for treatment orders and ensure treatment is initiated.

2. Nursing assistants will check each resident's skin every shift and shall report any skin integrity impairment to the licensed nurse for follow-up. The licensed nurse will observe the reported impairment and Report to the RN, who will then get a Wound Nurse consult if needed

3. The RN/ Wound Nurse shall perform weekly skin checks on all wounds and as needed for reported skin issues from the licensed nurses or CNAs.

4. The RN will notify physician for orders and follow up of treatment. Notify resident or family of changes in the resident's skin status.

5. Licensed nurse will update the resident's care plan as needed

6. Wound Nurse will initiate a weekly Pressure Sore Report and/or a weekly Non – Pressure Skin Problem Report, as appropriate for IDT.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.2 United States of America, Med Pass Inc.

- *Skin Assessment in Long Term Care,* Susan M. Cleveland, BSN, RN, WCC, CDP, NADONA.

- *Wound Source September 12, 2019*

- *Wound Care Essentials 5th Edition,* June 23, 2020, Wolters Kluwer, by Sharon Baranoski MSN, RN, CWOCN,APN, FAAN,

SUBJECT: **BLANKET WARMER**	SECTION: **Page 1 of 1**

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

PURPOSE:

To provide guidelines for ensuring the proper functioning of the Blanket Warmer on the DP/SNF Unit.

POLICY:

The facility will utilize the blanket warmer for the residents' comfort, to provide them with warm gowns, blankets, towels as per request of the resident and/or after their shower or bath. The DP/SNF unit will maintain safe usage of the blanket warmer at all times.

AFFECTED PERSONNEL/AREAS: *DIRECTORS, CLINICAL MANAGERS, REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA), ENVIRONMENTAL SERVICES (EVS), AND BIOMED*

PROCEDURE:

1. The blanket warmer will be stocked on a daily basis by EVS staff or nursing when needed.
2. The RN on the unit will monitor the temperature of the unit each shift and log on the *Blanket Warmer Log Sheet* the actual temperature and the set point temperature of 125 degrees Fahrenheit. MIFU will be reviewed to its updated guidelines.
3. Each shift, the RN will monitor that the actual reading of the temperature on the unit does not read above the set point temperature of 125 degrees Fahrenheit.
4. The RN will notify Bio Med if the temperature reads above the set point and tag the unit "Out of Order" until evaluated and cleared by Bio Med.

REFERENCE:

- Venture Medical (2019). Blanket Solution Warming Cabinets. Retrieved from https://www.venturemedical.com/knowledge-center/medical-warming-cabinets/.

SUBJECT: **BOWEL MANAGEMENT PROTOCOL**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a system for bowel management / treat constipation.

POLICY:

It is the policy of this facility that the residents will be assisted in maintaining regular bowel elimination without complication.

AFFECTED PERSONNEL/AREAS: *RN, LVN*

PROCEDURE:

OBJECTIVE:

For all residents who have not had a bowel movement (BM) in 3 consecutive shifts, bowel management protocol will be followed.

1. Designated shift licensed nurse on each station will check BM record of each resident.
2. Give milk of magnesia (MOM), per MD order, if resident has had no BM x 2 days/ 5th shift.
3. If no results from MOM on the 5th shift, give Dulcolax suppository on the 6th shift.
4. If Dulcolax is ineffective on 3rd day, give Fleets enema as per MD order. Notify MD if no results from enema.
5. If no BM in three (3) days, check manually for possible impaction. If impaction is noted, remove fecal impaction as able.
6. If still no results, give second round of Milk of Magnesia, Dulcolax suppository and Fleets enema.
7. If still no results after the second round of the Bowel Protocol call the MD for further orders.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72315, Section i-3, San Francisco, California, Title 22.
- Population Health Learning Network, Volume 27, Issue 8, August 2019, Management of Constipation in Long Term Care: Updates on Regulations and Treatment, Taylor Bradshaw, PharmD, BCACP, Allergan plc.

- States Operation Manual-CMS, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, (Rev 173, 11-22-17), F540, F584, F620, CMS.gov.

SUBJECT: **CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT**	SECTION: ***Provisions of Care*** **Page 1 of 4**

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

PURPOSE:

To provide guidelines used to enhance the quality of life care to residents with the diagnosis of dementia in the DP/SNF unit by individualizing the residents' care to meet physical, spiritual and psychosocial needs.

DEFINITIONS:

Dementia: A syndrome or a group of symptoms that occur together; an umbrella term describing a set of memory and cognitive decline symptoms; many different conditions lead to these symptoms.

POLICY:

It is the DP/SNF unit staff's responsibility to provide a resident with dementia, a therapeutic living environment with regards to what constitutes quality of life most affected by the disease process

AFFECTED PERSONNEL/AREAS: *ANCILLARY STAFF, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), RESPIRATORY THERAPIST (RT), AND ENVIRONMENTAL SERVICES (EVS).*

PROCEDURE:

A. Obtain an initial assessment with details of the residents' cognitive and physical function before admission, if possible. Obtain input from the resident, and their family or guardian, if applicable. Some pertinent questions:

1. What changes have been noticed with memory?
2. Can he/she remember at intervals; is it getting worse or does it remain the same?
3. Have there been changes in personality or behavior?
4. Have there been declines in personality or behaviors?
5. Have there been declines in personal care/hygiene?
6. Is he/she a fall risk?

B. Monitor resident for episodes of dementia-related behavioral problems or changes in behavior such as:

1. Repetitive vocalizations
2. Psychomotor hyperactivity
3. Physical aggression

4. Self-neglect
5. Resisting help with personal care
6. Anger and irritability
7. Manic-like behavior
8. Disturbance of sleep cycle
9. Psychosis
10. Depression
11. Inappropriate sexual behavior
12. Pacing or wandering

C. For changes in or new dementia-related behaviors, collaborate with the physician to determine the need for the following interventions:

1. Psychiatric evaluation as needed.
2. Physical restraints for resident safety, if needed, with MD order and consent.
3. The order for restraint will include the type and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. As needed (PRN) restraint orders will be neither issued nor accepted.
4. Initiation without Physicians Order: If a physician is not available, an RN may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the resident's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 12 hours of its initiation.
5. Initial In-Person Physician Assessment Within 24-hours of Initiation: The treating physician will perform an in-person assessment of the restrained resident within 24-hours of initiation to verify that restraint is needed and that less-restrictive means are not appropriate.
6. Residents on the DP/SNF unit will be taken to the Emergency Room for full evaluation before Violent Self Destructive restraints are used, especially if the resident has a diagnosis of dementia, and/or has become violent and can harm self or others. The resident will not remain on the DP/SNF unit if Violent Self Destructive restraints are used.

7. Antidepressant/antipsychotic medications per MD order

8. Monitor/discuss the use of antipsychotic/psychotropic medications weekly in the Interdisciplinary Team (IDT) meetings and reduce medications as able.

9. Monitor resident closely while on antipsychotic medications using the Abnormal Involuntary Movement Scale (AIMS) tool initially. Re-evaluate using AIMS every 6 months and as indicated.

10. Pharmacy to review issues of adverse medication effects that may cause cognitive impairments and may be mistaken as worsening dementia.

D. Activities should be directed towards managing residents with all stages of dementia. These may include:

1. Reducing long periods of isolation

2. Using distractions

3. Talking/interacting frequently with resident

4. Predictable routines, avoiding frequent or sudden changes

5. Frequent reassurance, calmness

6. Structured environment

7. Orienting stimuli

8. Adequate daylight lighting, night lights, supporting normal wake/sleep cycles

E. If resident is a fall risk/wanderer, place in a low bed if available, place bed in lowest position, assign room closest to nurses' station to be monitored at all times, and place fall mats on the floor next to the bed if indicated. Complete the Bed Assessment for side rail use.

F. Monitor resident routinely for hyperglycemia, dysphasia, weight gain/ weight loss, Parkinsonism, or excessive sedation.

G. Assess resident's decision-making capacity routinely, based on degree/stages of dementia.

REFERENCES:

- Annals of Long Term Care, Consuelo H. Wilkins, MD, 2022 HMP Global, *Diagnosis and Management of Dementia in Long Term Care*. http://www.hmpgloballearningnetwork.com
- Healthcare Brands (n.d.). Dementia.org. *The Difference Between Alzheimer's and Dementia*. Retrieved from http://www.dementia.org/types/the-difference-between-alzheimers-and-dementia.

- California Department of Public Health (October 7, 2017). All Facilities Letter (AFL-14-05). *Verifying informed consent for psychotherapeutic drugs before transferring patients to Skilled Nursing Facilities*. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-14-05.aspx.

- California Association of Health Facilities (February 2020). *Guide to Long Term Care*. https://www.cahf.org/About/Consumer-Help/Guide-to-Long-Term-Care.

- Centers for Disease Control and Prevention (Updated May 12, 2020). *Considerations for Memory Care Units in Long-term Care Facilities*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html.

- Centers for Medicare & Medicaid Services (February 27, 2020). National Partnership- Dementia Care Resources. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-Dementia-Care-Resources.

CROSS REFERENCES:

- DP/SNF Policy and Procedure – RESTRAINTS, CHEMICAL

- DP/SNF Policy and Procedure – RESTRAINT USE – NON-VIOLENT, NON SELF-DESTRUCTIVE (NVNSD) AND EMERGENCY-VIOLENT SELF DESTRUCTIVE (VSD)

SUBJECT: **CONFIDENTIALITY OF COMPLETION OF MDS DATA**	SECTION: **Page 1 of 1**

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

PURPOSE:

To provide for and ensure the resident's right to confidentiality as it relates to the completion and transmission of the Minimum Data Set (MDS) data from persons not authorized by law to obtain this information.

POLICY:

The facility will make reasonable efforts to protect and promote the resident's best interests. The resident or responsible party will be informed at the time of admission of the requirement of the electronic transmission of the Minimum Data Set information. The facility's handling of resident information will be in compliance with state law, resident advocacy and regulatory standards for long-term care.

AFFECTED PERSONNEL/AREAS: *MDS COORDINATOR AND SOCIAL WORKER*

PROCEDURE:

1. The Minimum Data Set assessment information will be entered on the Minimum Data Set form in Meditech by the Interdisciplinary Team.

2. The MDS Coordinator, Interdisciplinary Team will input the assessment data into the computer. The information will be processed and transmitted according to Federal requirements outlined in the Resident Assessment Instrument (RAI) Guidelines.

3. When assessment information is entered into the computer, the confidentiality of this information will be maintained under the provisions of the Federal Privacy Act.

REFERENCES:

- MDS 3.0 RAI Manual v1.15 (Last update MDS 3.0 RAI Manual 10/2023). Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Retrieved from https://downloads.cms.gov/files/mds-30-rai-manual-v115-october-2017.pdf.

- MDS 3.0 RAI Manual v1.16 (October 2018). Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Retrieved from https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf.

SUBJECT: **CRITERIA FOR COLLECTION OF STOOL FOR OVA AND PARASITES #1020**	SECTION: **Page 1 of 2**

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

PRINCIPLE:

One of the most important steps in the diagnosis of intestinal parasites is the proper collection of specimens. Improperly collected specimens can result in inaccurate results.

SPECIMEN CONTAINER:

Total-Fix transport system

AFFECTED AREAS/PERSONNEL: *NURSING, LABORATORY STAFF*

PROCEDURE:

- Collect all fecal specimens prior to the administration of antibiotics or antidiarrheal agents. Avoid the use of mineral oil, bismuth, and barium prior to fecal collection, since all of these substances may interfere with the detection or classification of intestinal parasites.
- A bedpan is an ideal initial collection container provided it has been thoroughly cleaned and the patient is cautioned against contaminating the specimen with urine. A clean, wide mouthed container or a plastic bag or plastic wrap placed over the toilet seat is also acceptable.
- An appropriate (i.e. bloody, slimy, watery) area of stool should be selected and sampled with the collection spoon provided in the cap of the transport container. Add sufficient specimen to bring the liquid level up to the "Add Specimen to this Line" mark. This will result in approximately 5 ml of sample. Repeat for the other transport container.
- Agitate each specimen with the spoon along the sides of the vial, tighten the cap and shake firmly to insure that the specimen is adequately mixed. The specimen should appear homogenous.
- Label each specimen, return the containers to the ziplock bag and transport specimens to the laboratory.

PROCEDURE NOTES:

- To ensure the recovery of parasitic organisms that are passed intermittently and in fluctuating numbers, the examination of a minimum of three specimens collected over a 7- to 10-day period is recommended. Infections with Entamoeba histolytica/E. dispar or Giardia lamblia may require the examination of up to six specimens before the organism is detected.
- Stools from inpatients who have been in the hospital for >3 days are of limited value. Patients may become symptomatic with diarrhea after they have been inpatients for a few days; however symptoms are usually attributed not to parasitic infections but generally to other causes.

CRITERIA FOR SPECIMEN REJECTION:

When a specimen is rejected for any of the reasons listed below, the nursing unit will be notified by phone, giving the reason for the rejection and a new specimen will be requested.

- Specimen received in improper transport container, or appears to be dry on the surface or edges. Protozoan trophozoites will not survive if the stool specimen begins to dry out.
- Specimen contaminated with urine or water from the toilet.
- Specimens contaminated with the materials listed in the table below.

Materials and/or Drugs Used	Required Interval After Use
Iron Bismuth (in some ulcer medications) Oil (castor or mineral) Particulate substances (Metamucil or others)	One Week
Barium Gallbladder dye Antibiotics Iodine preparations Antiamebic drugs Antimalarial drugs (certain)	Three Weeks

REFERENCE:

- Patricia M. Tille, PhD, MLS(ASCP), AHI(AMT), FACSc, (2022), Bailey and Scott's Diagnostic Microbiology, C.V. Mosby Co., St. Louis, Missouri, 15th edition.
- Isenberg, Henry D., Clinical Microbiology Procedures Handbook, American Society for Microbiology, 1994
- Murray, Patrick R., Manual of Clinical Microbiology, American Society for Microbiology, 1995
- Medical Chemical Corporation, Total-Fix package insert, Rev. 05/15

SUBJECT: **DEATH OF A RESIDENT**	SECTION: **Page 1 of 3**

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

PURPOSE:

The care given a body after death, post-mortem care, maintains the dignity of the resident, prepares the body for viewing by the family and properly identifies the body for transfer.

POLICY:

It is the policy of this facility that all residents who expire will be given post mortem care.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)*

PROCEDURE:

A. Administrative

1. All residents with Do Not Resuscitate (DNR) status can be pronounced dead by a physician or certified personnel. If a physician is unable to come to the facility to pronounce the resident, the certified personnel will record appropriate information to reflect that "no signs of life" are apparent. For example, "No blood pressure or respirations are obtainable. No pulses felt and no signs of life present." All others must be pronounced by a M.D.

2. Obtain physician's order to release body. If no mortuary is listed and family/responsible party is not available, call the mortuary on call.

3. Notify the family (by physician or licensed nurse) of the resident's death.

4. Notify the coroner if the death is a coroner's case. The body will be released or held for autopsy on the coroner's order. Coroner's office will advise where to send the body. (See Policy on Deaths Reportable to the coroner.)

5. Check with the physician before removing any drains or tubes from the body. They may be left in place if an autopsy is to be performed. Notify Organ Donor Network.

6. Have the mortuary or coroner's representative sign mortuary release form.

7. Notify appropriate departments (pharmacy, business office, dietary).

B. Care of the Body

1. Screen the unit for privacy.

2. Straighten the body and elevate head on one pillow to prevent hypostasis which might discolor the face.

3. Provide dentures in a labeled cup to mortuary.

4. Close eyes by gently pulling down on lashes.

5. Jewelry left with the body must be accounted for on the personal inventory sheet and signed for by mortuary representative.

6. If an autopsy is ordered, leave any tubes in place unless Coroner's office says they can be removed. If no autopsy is anticipated, remove all tubes after checking with the physician.

7. Bathe the body and comb hair.

8. Change dressings if needed.

9. Place body in supine position.

10. Place disposable pads under buttocks and over perineum.

11. Identification bracelet must be on.

12. Extend the arms at sides. Cover body to neck with a sheet.

13. Provide for family privacy.

C. Preparation

1. Assemble all the resident's belongings and check for valuables.

2. If the belongings are given to the family, note items given and to whom. Have the recipient sign for receiving clothing, valuables, and other possessions of the resident on the inventory list. If family is not available, send deceased's personal property to a designated storage area.

3. If the resident's family needs to go to the Social Service office to pick up valuables, escort them and help them obtain the items.

D. Documentation

1. Resident's condition prior to death.

2. Administration of Last Rites of church or attendance of clergy.

3. Time resident was pronounced dead and by whom or name of physician notified.

4. Presence of family and/or notification to them of resident's death and by whom.

5. Time body was transferred to mortician or County coroner representative. Include signed slip from mortician. Notification of Organ Donor Network and referral number.

6. If a coroner's case, record the date and time the coroner's office was notified, name or coroner's representative, the assigned case number, the receiving mortuary and any other instructions.

REFERENCES:

- Nursing Home Practices Following Resident Death, Adrita Barooah, MS, Kathrin Boerner, PhD, 2015, Geriatric Nursing online at www.ncbi.nlm.nih.gov.
- National League for Nursing, 2022, How to Perform Post-Mortem Care, CNA Plus Academy, Retrieved from: https://m.cna.plus

SUBJECT: **CLOSETS- ORGANIZING/CLEANING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To control infection and to enable residents and staff access to personal belongings stored in resident closets.

POLICY:

It is the policy of this facility to maintain the organization and cleanliness of the resident closets.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSING ASSISTANTS (CNA), LICENSED VOCATIONAL NURSES (LVN)*

PROCEDURE:

1. The Nurse Aides/ Shower Team will organize and clean the resident's closets on a daily basis.
2. Reorganization and cleaning shall include proper hanging of resident clothing, shoes stored appropriately, and the removal of inappropriately stored items from the closet.
3. The Nurse Aide will monitor that laundry hampers for personal clothing laundered by families are clean and have tightly sealed lids. Those requiring cleaning or lids shall be reported to the Charge Nurse for communication to Social Services for family notification.
4. The Nurse Aide will ensure that only personal laundry hampers and resident shoes/slippers are stored on the floor of the closet.
5. The Nurse Aide on duty at the time of a resident's transfer/discharge will empty the resident's belongings from the closet and follow facility policy and procedures for the care of the residents' belongings during transfer/discharge.
6. Housekeeping will provide terminal unit cleaning upon transfer/discharge of a resident, per housekeeping policies and procedures

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.70(1) (2) (iv) United States of America, Med Pass Inc.

SUBJECT: **COMMUNICATION BARRIERS, REDUCTION OF**	SECTION:

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

PURPOSE:

To assist residents in communicating their needs.

POLICY:

Residents will be provided methods of communication to ensure adequate communication between residents and staff.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, ANCILLARY STAFF*

PROCEDURE:

1. The facility will make arrangements for interpreters or alternate means of communication, such as pictures, sign language, Braille, etc., to enhance communication between residents and staff.
2. Certified bilingual employees, HCIN, TDD phone for the deaf and disabled family members, clergy, or other outside resources may be used in this capacity to reduce communication barriers.
3. Methods instituted to assist residents in communicating their needs will be identified in the residents' plan of care.
4. A list of facility interpreters will be maintained on the unit.
5. Telephone and mail service are available to all residents

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (1) United States of America, Med Pass Inc.
- Thompson, S. (2017). Overcoming Communication Barriers to Healthcare for Culturally and Linguistically Diverse Patients. Retrieved from https//www.sth.nhs.uk.

SUBJECT: DP/SNF ROOM CHANGE	SECTION:

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

PURPOSE:

To define the process of notification of change of room or roommate.

POLICY:

The resident's right to notification of any change in room assignment or roommate will be respected.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICE*

PROCEDURE:

1. A written notification form will be completed by the Social Service Designee to notify the Resident or responsible party that there will be a change in room or roommate.

2. The form must be acknowledged by the resident or responsible party signature or telephone consent prior to the change occurring.

3. The form is filed in the resident's medical record.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, Appendix PP 483.15 (e) (2) United States of America, Med Pass Inc.

SUBJECT: **EMERGENCY BLOOD RELEASE**	SECTION: **Page 1 of 2**

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

PURPOSE

To define the process for releasing blood components for transfusion in a time-sensitive emergency situation.

No blood components will be issued for transfusion before completion of processing or crossmatching. In the event of an emergency, the attending physician may request blood components from the blood bank department of the clinical laboratory and assume responsibility for the outcome of the use of those products by signing the emergency release form. This form must be returned to the blood bank department and attached to the original request for blood products. All physician requests for emergency blood products must be done so on patients who have been registered in the SVMC hospital information system, whether their identity is known or not. All requests for blood components must be accompanied with a *Request For Blood Component* form.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. ABO/Rh Requirements:

   a. If time permits, a properly-labeled sample shall be obtained and the patient's ABO and Rh shall be determined. Type-specific blood shall then be issued when possible, or type-compatible blood issued if type-specific is not available.

   b. If there is insufficient time to obtain a specimen, or to perform tests to determine the ABO/Rh, Group O (PRBCs) is the only ABO group that can be administered to patients of unknown ABO. Do not rely on past records to determine the patient's ABO/Rh.

   c. Pull segments from units if the blood is issued before testing has begun.

   d. Issue blood.

   e. Units are issued in the laboratory information system (LIS) under the Emergency Issue Protocol. This will generate the Emergency Issue Card, which needs to be signed by the attending physician. If the patient has not yet been admitted into the hospital information system, the "computer down time" emergency issue card should be used.

2. Compatibility Testing:

   a. A properly collected and labeled patient sample must be collected and the routine compatibility testing procedure must begin. If the physician requires the blood for transfusion before the crossmatch is complete, it may be released if the "UNCROSSMATCHED BLOOD Emergency Unit Issue Card" has been signed, but the crossmatch must be completed in any event.

Massive Bleed Protocol:

- An elevated emergency level of response for patients that are in immediate jeopardy beyond the usual Emergency Release.
- Requires immediate communication to the Lab, "Emergency release of uncrossmatched

blood for a massive bleed in_____(location)."

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- Lab Blood Bank will tag and issue 2-4 units of PRBC and 1 unit of FFP if requested, per specific situation, and will work closely with Nursing Services to release continued blood products as needed. Crossmatched blood will be utilized upon availability.

- The other processes of Emergency Release, such as the use of the Emergency Release forms and follow up crossmatching, will still apply.

REFERENCES:

- Association for the Advancement of Blood & Biotherapies, Standards for Blood Banks and Transfusion Services, 33rd Edition, 5.27, 2022.

- The Joint Commission (2023). Laboratory accreditation standards. QSA.05.11.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **EQUAL ACCESS TO QUALITY OF CARE**	SECTION:

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

PURPOSE:

- To ensure all residents are treated alike when the facility is making transfer and discharge decisions.
- To ensure the facility does not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.

POLICY:

The facility will maintain identical policies and procedures regarding transfer, discharge, and the provision of services under the state plan for all individuals regardless of payer source. The facility may charge any amount for services furnished to non-Medi-Cal residents consistent with the notice requirements in the Resident Rights (42 C.F.R. – 483.10(b)(5)(i) and (b)(6) describing the charges. The State is not required to offer additional services on behalf of the resident other than services provided in the State plan.

AFFECTED PERSONNEL/AREAS: *DIRECTOR OF NURSING, REGISTERED NURSES, PHYSICIANS, SOCIAL SERVICES, BUSINESS OFFICE*

PROCEDURE:

1. At the time of admission, the Social Worker or Designee will inform the resident/responsible party of their rights concerning equal access to care, statement of services provided, and the facilities' policies for handling transfer and discharge processes.
2. The Director of Nursing will oversee the IDT processes and will ensure that all Nursing Services, Specialized Rehabilitative Services, Social Services, Dietary Services, Pharmaceutical Services, or Activities that are mandated by law will be provided to residents according to their individual needs, as determined by assessments and care plans.
3. The RN and Social Worker or Designee will coordinate the reporting of changes in resident care status/needs through daily census reporting and accounts tracking systems, and will coordinate all transfers, discharges, and services according to facility policies and procedures.
4. The Director of Nursing and/or Social Worker or Designee will ensure the resident is informed by appropriate disciplines/departments of changes in care, discharge plans and services provided under the State plan or current payer source.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 United States of America, Med Pass Inc.

SUBJECT: **FEEDING, TRANSITIONAL-ENTERAL TO ORAL INTAKE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure that each resident is appropriately weaned from a tube feeding and is an appropriate candidate for oral intake only.

POLICY:

It is the policy of this facility to safely wean tube fed residents to oral intake under the direction of a physician with supervision provided by appropriate members of the interdisciplinary health team.

AFFECTED PERSONNEL/AREAS: *NURSING (RN, LVN), SPEECH THERAPY, DIETARY, NUTRITION SERVICES*

PROCEDURE:

1. An interest is expressed to discontinue a tube feeding, such as by resident request, physician order, and/or by recommendation of a speech therapist, nursing, or registered dietitian.

2. A physician order is obtained for a Speech Therapy evaluation to determine swallowing ability.

3. In order to stimulate the resident's appetite, it is recommended the transitional feeding formula be infused in the evening hours with the feeding ending no later than 6:00 a.m.

4. If the resident passes the swallow evaluation, then the resident will be offered foods and/or fluids as best tolerated. The therapist will actively work with the resident to promote safe oral intake. In order to promote continuity, the therapist will communicate with the restorative aide and/or nursing staff additional instructions for the feeding program.

    a. Accurate documentation of the percentage of oral (po) intake must be included on the "CNA Meal and Snack Intake" Section of the Electronic Health Record.

5. During this feeding program interval, a Dietitian will monitor po intake and calculate dietary adequacy.

    a. When the % amount indicates an accepted level of intake, orders will be obtained to discontinue the tube feeding. The resident will remain in the feeding program for continual close monitoring until released to staff by the Speech Therapist.

    b. If the calorie count indicates an acceptable level of intake cannot be achieved orally, a conference should be held by the physician and dietitian to determine the feasibility of additional therapy.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.75(1) United States of America, Med Pass Inc.

- Charney, Pamela. (May 31, 2016). *Nutrition Assessment*. Momentum Press.

- **ASHA American Speech Language Association,1997-2022, *Alternative Nutrition and Hydration in Dysphasia Care,*** retrieved from: **https://www.asha.org**

- **Nutrition Care Systems, Staci Betticker, MS, RD, LDN, June 2022, Tube Feeding in a Long Term Care Facility. Retrieved from: https://www.nutritioncaresystems.com**

SUBJECT: **HAND CARE OF, CONTRACTURE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To maintain cleanliness, prevent injury or skin breakdown, and to prevent progression of the contracture.

POLICY:

It is the policy of this facility to provide for cleansing of the contracted hand on a daily and as needed basis, and to provide measures to prevent injury, skin breakdown or contracture progression on all shifts.

AFFECTED PERSONNEL/AREAS:

RNA, LICENSED NURSES

EQUIPMENT:

- Basin
- Soap
- Warm water or warm soapy water
- Washcloth
- Towel
- Hand roll
- Nail clippers
- Nail file

PROCEDURE:

1. Wash hands thoroughly and don gloves. Explain procedure to the resident. Provide privacy.
2. Fill basin with warm water not to exceed 105 degrees F.
3. Soak the affected hand for 5 minutes.
4. Wash hand with washcloth.
5. Gently lift fingers to wash underneath. Do not force fingers beyond range of easy mobility. This procedure can cause pain to the resident and forced movement could result in injury to the resident.

6. Spread the fingers to wash between each finger. Do not force fingers apart. Gentle movement and washing is essential to this procedure.

7. Rinse the hand well.

8. Dry the hand well with the towel. Gently dry beneath and between the fingers.

9. Clip nails to prevent injury to the hand.

10. Clean beneath the nails as necessary and file all rough areas of the nail.

11. Apply hand roll appropriately if used. Ensure that Velcro strap holding hand roll in place is not binding the skin or impairing skin or circulation if used. Ensure that the hand roll is properly placed for maximum efficiency.

12. Empty basin, wipe dry and store appropriately.

13. Place soiled linen in laundry hamper. Clean nail care items and return to appropriate storage area.

14. Ensure resident is comfortable.

15. Each shift will check all residents with contracted hands to ensure hand rolls are in place and are appropriately applied.

16. Report pertinent observations noted during cleansing procedure and check of hand rolls each shift.

DOCUMENTATION:

Report and/or document any unusual observations in the medical record.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72315 (f), 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.

SUBJECT: **INFECTION CONTROL - BLOOD BANK #5021**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide guidelines for the safe handling of blood and blood products to lessen the risk of exposure of hospital patients and Laboratory personnel to blood borne infections.

POLICY:

STAFF RESPONSIBILITIES:

All Laboratory staff who are on duty in or rotate through the blood bank area are responsible for adhering to established Blood Bank policies and procedures and infection control guidelines (both Sierra View Medical Center and Departmental).

BLOOD SCREENING PROCEDURES:

Infectious Agent Screening:

Blood products are received from the Central California Blood Bank (CCBB) and are screened for infectious agents according to Association for the Advancement of Blood and Biotherapies (AABB) acceptable standards.

BLOOD PRESERVATIONS/SAFETY MEASURES:

All red cell products are kept refrigerated at 1 – 6 degrees C. Refrigerators are equipped with alarms to signal significant deviations from acceptable temperature levels.

Blood is to be administered to the patient within two (2) to three (3) hours and it is to hang no longer than four (4) hours.

The Blood Bank will not accept blood for return, which has been away from the Laboratory Blood Bank for a period longer than 30 minutes. (Also see Blood Bank Quality Control/General Lab Manual.)

The Blood Bank dispenses by single units. More than one unit per patient at a single time is released only in emergency cases (e.g. traumatic hemorrhaging) or to surgery, where blood can be stored in a monitored refrigerator and returned to lab at the end of the day.

All platelet (apheresis) units are cultured for the CCBB by Community Regional Medical Center Microbiology Department. Any positive findings will have gram stains phoned stat and organism identification with antibiotic sensitivities available to our clinicians for pertinent patient care.

GENERAL LABORATORY PROCEDURES:

Protective Clothing:

All personnel must wear personal protective clothing (lab coats) in the Blood Bank area.

Lab coats and other protective clothing in the Lab area must be removed before going to the cafeteria or leaving the hospital at the end of the shift.
Protective apparel must be worn in the restricted (biohazard) area of the lab.

Cleaning Procedures:

Blood spills should be flooded with Clorox bleach solution (1:10) or an approved disinfectant and allowed to stand for a period of 10 minutes before wiping or mopping up.

All flat surfaces are cleaned with a bleach solution or approved disinfectant as recommended by the general Laboratory Manual at the end of each day or more often as needed during the course of a day.

Medical Waste (Infectious Waste):

All blood is considered a possible source of infection and is treated as such by using proper protection (e.g., use gloves for handling specimens).

Blood bags from the patient care areas of the hospital are to be disposed in the biohazard trash by the transfusionist or nursing designee after completion of transfusion.

REFERENCES:

- Association for the Advancement of Blood and Biotherapies (AABB), Standards for Blood Banks and Transfusion Services, 33rd Edition, Section 10, 2022.
- Fung, Grossman, Hillyer and Westhoff, Association for the Advancement of Blood and Biotherapies (AABB), Technical Manual, 21st Edition, 2023.

SUBJECT: **INITIAL RESIDENT ASSESSMENT AND REASSESSMENT- MDS**	SECTION: **Page 1 of 6**

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

PURPOSE:

To ensure that each resident is properly assessed to best meet his/her needs.

POLICY:

It is the policy of this facility that each resident admitted to the institution shall receive a complete head to toe assessment by a qualified individual so that a plan of care can be developed to best meet the needs of the resident. The assessment of the care or treatment required to meet the needs of the resident will be ongoing throughout the resident's facility stay, with the assessment process individualized to meet the needs of the resident population.

Minimum Data Set Admission assessments (comprehensive) must be completed by the 14th day of the resident's stay.

SCOPE OF PRACTICE:

All nursing personnel in the resident care units shall be qualified by the level of licensure to perform a complete assessment and reassessment of the resident. A complete assessment shall include physical, psychological, pain management, spiritual needs, social status, as well as educational and discharge preparedness/planning needs.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RNs); LICENSED VOCATIONAL NURSES (LVNs)*

PROCEDURE:

1. At the time of admission, each resident shall have an initial physical/psychological assessment completed by a registered nurse or a licensed practical/vocational nurse under the direct supervision of a registered nurse.

2. The assessment is structured to identify facilitating factors and possible barriers to the resident reaching his or her goals, including the presenting problems and needs such as:

    a. Symptoms that might be associated with a disease, condition or treatment (such as pain, nausea or dyspnea)

    b. Social barriers, including cultural and language barriers

    c. Social and environmental factors

    d. Physical disabilities

e. Vision and hearing impairments and disabilities

f. Developmental disabilities

g. Communicative disorders

h. Cognitive disorders

i. Emotional, behavioral and mental disorders

j. Substance abuse, dependence and other addictive behaviors

3. The nursing plan of care will be implemented on admission to ensure the resident receives the following necessary and immediate care: Activities of Daily Living (ADL) medications, nutrition, etc.

4. The plan of care will be completed when the Minimum Data Set (MDS) and Care Area Assessment (CAA's) are completed by all disciplines.

5. The RN Resident Assessment Coordinator will ensure that the MDS assessment is completed within 14 days of admission. The RN Resident Assessment Coordinator will conduct or coordinate each assessment and will sign and certify the completion of the assessment.

6. Resident Assessment Instrument (RAI) shall be completed for any resident residing at the facility longer than 14 days. The Resident Assessment Instrument (RAI) is comprised of:

a. Minimum Data Set (MDS)

b. Care Area Assessment (CAA's)

c. Utilization Guidelines (state operations manual)

7. The sources of information for the MDS include:

a. Review of the resident's record

b. Communication with the resident

c. Observation of the resident

d. Communication with direct care staff

e. Communication with licensed professionals from all disciplines

f. Communication with the resident's physician

g. Communication with the resident's family members

8. MDS sections include:

a. Identification Sections:

- Identification of Information

b. Clinical Sections:

- Hearing, Speech, Vision
- Cognitive Patterns
- Mood
- Behavior
- Preference for Customary Routine and Activities
- Functional Status
- Bowel and Bladder
- Active Disease Diagnosis
- Health Conditions
- Swallowing/Nutritional Status
- Oral/Dental Status
- Skin Condition
- Medications
- Special Treatments, Procedures, and Programs
- Restraints

- Participation in Assessment and Goal Setting
- State Supplement
- Care Area Assessment (CAA) Summary
- Correction Request
- Assessment Administration

9. States may establish additional MDS requirements. Check with your state rules and regulations.

10. The MDS must be signed off with the following information:

    a. Name

    b. Initials of profession

    c. Date

11. The RN Resident Assessment Coordinator or designee must sign:

    a. CAA's Summary Form

    b. Quarterly Review

12. If an error is discovered within seven (7) days of the completion of a MDS and before submission to the state MDS database, the response may be corrected using standard editing procedures on the hardcopy (cross out, enter correct response, initial and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.

13. The plan of care must be based on the resident's comprehensive assessment and must be completed within seven (7) days after the comprehensive assessment is completed.

14. The MDS will trigger elements that need to be addressed in the resident's plan of care. These elements are known as Care Area Assessment (CAA's).

15. Each CAA area triggered is noted in the MDS Care Area Assessment summary and requires further assessment.

16. CAA areas include:

    a. 01 Delirium

b. 02 Cognitive Loss/Dementia

c. 03 Visual Function

d. 04 Communication

e. 05 ADL Function/Rehabilitation Potential

f. 06 Urinary Incontinence and Indwelling Catheter

g. 07 Psychosocial Well-Being

h. 08 Mood State

i. 09 Behavior Symptoms

j. 10 Activities

k. 11 Falls

l. 12 Nutritional Status

m. 13 Feeding Tubes

n. 14 Dehydration/Fluid Maintenance

o. 15 Dental Care

p. 16 Pressure Ulcers

q. 17 Psychotropic Drug Use

r. 18 Physical Restraints

s. 19 Pain

t. 20 Return to Community Referral

17. After appropriate documentation on the MDS CAA Summary, the RN Resident Assessment coordinator must date and sign to verify that all triggered CAA's have been applied.

18. Detailed care planning will be documented on the resident's plan of care.

19. Any changes in the resident's condition shall require an immediate reassessment with changes in the plan of care reflecting the change in condition.

20. Quarterly Assessment (state mandated subset or MPAF) must be completed every 92 days by the RN Resident Assessment Coordinator.

21. An MDS assessment is completed on all new resident admissions and those residents who have returned to the facility after being discharged.

22. A hardcopy of all MDS forms within the last 15 months, including signatures of the facility staff attesting to the accuracy and completion of the records, must be maintained in the resident's clinical record.

REFERENCE:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 United States of America, Med Pass Inc.
- The Medicare Learning Network®, MLN Connects®, and MLN Matters®. U.S. Department of Health & Human Services (HHS). ICN 909067 October 2017.
- CMS. Chapter 2: Assessments for the Resident Assessment Instrument (RAI). https://www.aanac.org/docs/mds-3.0-rai-users-manual/11114_mds_3-0_chapter_2_v1-12r2.pdf?sfvrs.
- *The MDS Assessment Process* by American Association of Nurse Assessment Coordination (AANAC). American Association of Post-Acute Care Nursing (AAPACN). November 08, 2017.

SUBJECT: **LEAVE OF ABSENCE, THERAPEUTIC**	SECTION:

PURPOSE:

Residents will be allowed short stays out of the facility to enhance their social, emotional and therapeutic well-being. Leave of absences or therapeutic outing allow the resident, interdisciplinary team and family to evaluate the resident's functional status and strengths, as well as identify problem areas for further rehabilitative or restorative programs.

POLICY:

Resident leave of absences will be authorized by the attending physician and in accordance with regulatory guidelines set forth and governing leave for residents in sub-acute and skilled nursing levels of care. All leave or outings will be allowed and conducted in accordance with standards and requirements determined by the resident's medical insurance or payer sources. All decisions regarding the appropriateness of leave of absence will be made in collaboration with the interdisciplinary health care team, the resident and family.

AFFECTED PERSONNEL/AREAS: *ALL DPSNF; SOCIAL SERVICES DESIGNEE*

PROCEDURE:

1. Therapeutic leave or outings may be initiated by the resident, family or team members as determined essential in promoting the resident's physical and emotional well-being and quality of life.

2. An assessment of the resident's medical appropriateness, supportive care needs, caregiver capability, equipment needs, transportation resources, self-sufficiency, medications and treatment administration, supplies, diet and environmental concerns will be made by the team prior to the resident's leave. This also includes review of any information regarding the resident's destination, date and time of departure and return, and identity of persons responsible for the resident's care.

3. At the time of admission, or during the rehabilitation process, the Social Service Designee will ensure resident and/or responsible representative is aware of facility and regulatory procedures for leave. A written consent for participation in leave of absence or outings from the facility and/or a release of responsibility will be obtained prior to leave.

4. The resident and/or responsible party must receive education, training and written instructions (as appropriate), regarding procedures and information likely to be encountered during resident's absence from the facility in order to assure continuity of care.

5. Social Services Designee will work with nursing and resource persons to coordinate training and to arrange equipment and supply needs prior to leave. Documentation of all training, financial agreements and support arrangements will be entered into the medical record.

6. The resident's participation in a leave of absence should be included in the individual plan of care, including special care and dietary treatment needs.

7. The resident or responsible representative must confirm arrangements for a leave from the facility with nursing staff and the Social Services Designee. The resident must be signed out at the nursing station (use leave of absence form) and signed in upon return. The address of the intended leave destination and the inclusive dates of leave must be indicated.

8. Nursing staff will assure that the resident receives appropriate medication before leave commences and that medications needed during leave are reviewed and provided to resident/responsible party before signing out.

9. The facility will hold the resident's bed vacant during an approved leave. The nursing supervisor and/or Social Services Designee must be notified when the resident/responsible representative anticipates failure to return from leave within the approved period and when medical complications arise that warrant emergency treatments or hospitalizations. A Bed-Hold Notice will be provided to the resident/responsible representative when leave is anticipated to be over a 24-hour period, in accordance with the Bed Hold policy.

10. Upon return to the facility, the licensed nurse to obtain response/feedback about the outing will interview the resident or responsible party. The resident will return all unused medications, supplies and equipment.

11. Private medical insurance programs and publicly funded programs, such as Medi-Cal and Medicare, may or may not provide hospitalization benefits for the period of time during and subsequent to the time a resident is away from the hospital. If the private or public insurance program does not provide such hospitalization benefits, the resident or the person financially responsible for the resident's hospitalization expenses will remain obligated to pay the hospital for such expenses in accordance with the hospital's regular rates and terms.

12. When out overnight, the day of departure will be counted as one day of leave and the day of return shall be counted as one day of patient care. Leave is terminated if resident necessitates admission to another inpatient facility, exceeds approved period of leave, or is determined to be absent without leave. (Shall apply unless otherwise determined by medical insurance payors). Any leave that is not recommended or approved by the physician will be considered leave against medical advice (AMA) which is grounds for discharge from the facility.

13. Leave of absence for Medi-Cal beneficiaries at sub-acute or skilled nursing facility (SNF) level of care will be authorized per Title XXII regulations: Up to 18 (eighteen) calendar days per year. Up to 12 (twelve) additional days of leave per year may be approved when the request for additional days of leave is in accordance with the individual resident care plan and appropriate to the physical and mental well-being of the resident. The attending physician must approve and document in the resident's plan of care for those leaves involving the up to 12 (twelve) additional days described.

14. Leave of absence for Medicare beneficiaries at the skilled level of care will not be routinely authorized, and must be reviewed on a case by case basis to determine whether the outing constitutes a special circumstance. In some cases, outings can be allowable as short absences

from the facility to handle emergent situations (i.e. funeral, wedding, need to secure residence or property in residence, discharge planning, needed to handle a special financial matter that cannot be resolved, etc.)

15. Leave of absence for private insurance residents must be approved by the medical insurance payors (i.e. case manager, physician reviewer, etc.) in order to assure continued coverage, and may be subject to short absences under special circumstances as with Medicare beneficiaries.

16. Due to the nature of disability and the complex support and skilled needs of the sub-acute resident, frequent or extended leave of absences may not be determined medically indicated by the physician and interdisciplinary team. It is recommended that the team consider leave for the sub-acute resident to return to the facility in order to resume the level and continuity of care provided within the sub-acute framework. Outings of longer daytime duration, allowing the resident to return to the facility in order to resume the level and continuity of discharge planning trial visits are recommended for the sub-acute resident as the rehabilitative processes become more eminent.

17. The Social Services Designee will monitor the resident's response, progress and goals, responsible party involvement and interdisciplinary planning of resident leave from the facility.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.15 United States of America, Med Pass Inc.

SUBJECT: **LEAVE OF ABSENCE, THERAPEUTIC OUTING CHECKLIST**	SECTION: **Page 1 of 3**

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

PURPOSE:

The purpose is to provide a reference checklist for use by the Interdisciplinary Team (IDT), in preparing for leave away from the facility.

POLICY:

Social Services will assist the resident, family and Interdisciplinary Team in the coordination of therapeutic leave of absence or outings, in accordance with policies and procedures established by the facility and regulatory standards.

AFFECTED PERSONNEL/AREAS:

SOCIAL SERVICES, NURSING, INTERDISCIPLINARY TEAM

PROCEDURE:

When resident/family request and/or it is determined by the Interdisciplinary Team that an outing would be beneficial for resident, the following steps should be taken:

Yes Or N/A	Date	
_____	_____	1. Details of the outgoing determined by Interdisciplinary Team: type of outing; medical, psychosocial and environmental appropriateness of the outing; length of time involved; responsible caregiver, staff needed, etc.
_____	_____	2. Review of hospital policies and procedures for therapeutic leave/outings to assure compliance.
_____	_____	3. Determine if outing is allowable by insurance coverage (i.e. private insurance and Medicare may not cover absence from Hospital); document approval and financial responsibility.
_____	_____	4. If determined medically appropriate, then physician's order is obtained (specify type of outing and time frame).
_____	_____	5. Develop a Care Plan regarding outing (steps necessary to achieve outing, and/or for ongoing maintenance).
_____	_____	6. Administrative approval for outing, (if necessary).
_____	_____	7. Determine whether location of outing is available or feasible for the resident to attend (prior reservations or special arrangements made, as necessary).

SUBJECT: **LEAVE OF ABSENCE, THERAPEUTIC OUTING CHECKLIST**	SECTION: **Page 2 of 3**

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

Yes Or N/A	Date		
_____	_____	8.	Resident and family training provided by all necessary disciplines (documentation of training in chart notes and/or skills sheet).
_____	_____	9.	Arrangements made with facility, family, insurance company, durable medical equipment to ensure resident has equipment needed for outing (i.e. portable vent, wheelchair, suctioning, etc.)
_____	_____	10.	Ensure appropriate staff available and designated to accompany resident on outing (if required).
_____	_____	11.	Coordinate/confirm transportation (hospital van, family car, community van, etc.) prior to outing.
_____	_____	12.	Counsel and education provided to resident and/or family regarding roles, expectation of behavior during outings, compliance, emergency procedures, time frame, pass medications, etc.
_____	_____	13.	Ensure consent form is signed for outings.
_____	_____	14.	Ensure medications and care instructions are completed and provided to resident and/or caregiver by nursing at time of outing.
_____	_____	15.	Ensure resident/caregiver signs out and in (before and after) outings.
_____	_____	16.	Follow-up interview with resident/family after outing to determine and document response/outcome of outing and future goals (nursing must interview resident upon return to Facility). Social Service to provide follow-up counsel and assure education as needed ongoing.
_____	_____	17.	Ensure that any twenty-four (24) hour leave of absence is noted properly on the daily census report.
_____	_____	18.	Ensure a Bedhold Notification Form is completed when leave of absence is planned for over twenty-four (24) hours.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.15 United States of America, Med Pass Inc.

SUBJECT: **MDS, DIAGNOSIS CODING ON MDS ASSESSMENTS AND UB 92 CLAIM FORMS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a process for communicating the MDS (Minimum Data Set) Assessment information to the Medical Records Department to ensure consistency of ICD-10 (Diagnosis) Coding.

POLICY:

It is the policy of this facility that the Medical Records Department provides the ICD-10 codes to the MDS Coordinator for entry onto the MDS Assessment.

AFFECTED PERSONNEL/AREAS: *MDS COORDINATOR, MEDICAL RECORDS CODER, BILLER*

PROCEDURE:

1. The MDS Coordinator will complete, lock and transmit to the State Offices the MDS Assessment for each resident in accordance with their primary funding for admission:

   a. Medicare, Medicare HMOs, and MSP (Medicare as Secondary Payors) – Completed according to Medicare's schedule for 5-day, change of condition, admission, quarterly and annually.

   b. Commercial Insurance, Non Medicare HMOs, Workers' Compensation, Medi-Cal, and Cash – Completed according to the State's Schedule for, change of condition, admission, quarterly and annually.

2. The Medical Records Coder will ensure that a valid ICD-10 code is provided to the MDS Coordinator for each diagnosis listed. The ICD-10 codes will be provided within the timeframes listed to ensure compliance with MDS completion requirements.

3. The Medical Records Coder will enter the ICD-10 codes into the computer system on the patient's account for each MDS Assessment. Additional ICD-10 codes identified on subsequent MDS Assessments will be added to the prior ICD-10 codes listed on the patient's account, to accommodate monthly interim billing.

4. The MDS Coordinator will enter the ICD-10 codes on the MDS Assessment.

5. The ICD-10 codes will print on the UB92 claim form that is used for billing Medicare, Medicare HMOs, MSP, Commercial Insurance, Non Medicare HMOs and workers' compensation claims.

6. The Biller will submit UB92 claims on an interim monthly basis, upon exhaustion of primary funding, and upon discharge.

REFERENCES:

- MDS 3.0 RAI Manual v1.16 (October 2018). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

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

SUBJECT: **MDS TRACKING FORM**	SECTION:

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

PURPOSE:

Track Minimum Data Set (MDS) dates to assure that all time frames are met timely for change of condition annual and quarterly reviews by the Interdisciplinary Team (IDT).

POLICY:

All MDS time frames will be accurate for change of condition, annual and quarterly reviews.

AFFECTED PERSONNEL/AREAS:

MDS COORDINATOR

PROCEDURE:

- MDS Coordinator will prepare the MDS monthly calendar the fourth week of the prior month
- The MDS calendar will be placed in the MDS book the 1st of each month so it is available for the IDT. This allows the IDT to plan their schedule for assessments.
- To determine timely dates, if a change of condition assessment is due, an addendum note is placed in the chart on the date the change is identified. That date is put in the "Type of MDS" column.
- The next column identifies the 7-day assessment period (assessment reference date).
- The next column identifies the documentation start date for the IDT assessment to be completed. The team members are to complete their section of the assessment in Meditech.. On the 13th day, the MDS coordinator will review the process and sign off appropriately by the 14th day.
- For annual assessments, MDS Coordinator should count back 14 days from the last quarterly assessment date and repeat the time frame in steps 5 and 6.
- For quarterly assessments, MDS Coordinator should identify the last assessment date and count back 11 days and then forward 7 days. These 7 days will constitute the observation period for the IDT and this date would be entered in the referenced date column. The next 2 days are for the team to complete the assessment and the next 2 days for the MDS Coordinator to input the assessment into the computer and the team to sign it off.
- Less time is required for the MDS quarterly assessment Reference date will be scheduled per RAI manual.

Example:

1. Last quarterly completed on *September 15.*
2. Count back to *September 4.*
3. Count forward to *September 4 to September 11.*
4. The assessment period will be *September 12 and 13.*
5. The input time and sign off will be *September 14 and 15.*

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	**2**	**3**	**4** 11 days to start for 7 days observation	**5** OBSERVATION ←----------	**6** PERIOD ----------	**7** ----------
8 FOR	**9** ASSESSMENT IDT	**10** BY	**11** Reference date to put on MDS	**12** COMPLETE ---------- --	**13** ASSESSMENT BY	**14** Input in computer by MDS Coordinator
15 Last quarterly date 9/15 Sign off by team	**16**	**17**	**18**	**19**	**20**	**21**
22	**23**	**24**	**25**	**26**	**27**	**28**

Template calendar will be used for monthly calendar.

REFERENCES:

- Centers for Medicare/Medicaid Services. MDS 3.0 RAI Manual (10/2023 last update). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.
- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 United States of America, Med Pass, Inc.

SUBJECT: **MASSIVE TRANSFUSION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish the criteria for activating the massive transfusion protocol.

PRINCIPLE:

Following massive transfusion, there is such a small volume of the patient's blood left that complete crossmatching has limited benefit. The pretransfusion sample no longer represents currently circulating transfused blood and sensitive AHG testing on the current specimen accomplishes virtually nothing. It is usually only necessary to confirm ABO compatibility of subsequently transfused blood.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. The crossmatch can be abbreviated in those instances in which the patient has received a volume of blood approximately equal to their own blood volume within a 24 hour period. For an average adult this can be assumed to be 10 units.

2. In cases of massive transfusions as defined above, an immediate spin major crossmatch is all that is required prior to transfusion provided that the patient has had a negative antibody screen performed within the last 3 days.

3. If the antibody screen is positive and:

    a. If the antibody has been identified, units known to be negative for the target antigen may be transfused after immediate spin crossmatch only.

    b. If the specificity of the antibody has not been determined, or if the antigen has not been tested for in the donor units, then a complete major crossmatch is required.

4. This procedure applies up to 24 hours after the occurrence of a massive transfusion.

REFERENCE:

- Association for the Advancement of Blood & Biotherapies (AABB) Technical Manual, 21st Edition, pg 609 - 611, 2023.
- Association for the Advancement of Blood & Biotherapies (AABB) Standards, 33rd Edition, p46, 5.19.6, 2022

SUBJECT: **MECHANICAL LIFT**	SECTION: **Page 1 of 2**

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

PURPOSE:

To move a resident safely and with as little physical effort as possible.

POLICY:

It is the policy of this facility that the mechanical lift will be utilized for resident transfers only. It will not be used to transport residents to another location. Assistance of two personnel will be used with mechanical lift.

AFFECTED PERSONNEL/AREAS: *LICENSED STAFF, CERTIFED NURSING ASSISTANTS (CNAs)*

EQUIPMENT:

- Mechanical lift with hooks for slings
- Canvas seat and back
- Slings with loops

PROCEDURE:

1. Explain the procedure to the resident and bring the mechanical lift to bedside. Screen resident for privacy.
2. Roll resident on the side away from the attendant. Maintain resident privacy.
3. Roll canvas seat in half with the wider section under the resident's thighs and lower edge of seat under knees.
4. Place narrow part just above the small of the back.
5. Roll resident toward attendant and pull slings through. (Like positioning a draw sheet.)
6. Position seat sling and elevate head of bed to facilitate placing back piece.
7. Move mechanical lift so that the open end of horseshoe base is slid under the bed.
8. Attach hooks of the lift to the holes in the canvas seat. Insert hooks away from the resident to outside of sling.

9. Attach hooks in the canvas back in the holes as required. Check to see that hooks are hooked all the way into the loops and that the seat is close to the knees for safety.

10. Close release valve by turning knob gently to the right. Use slight pressure.

11. Resident's arms should be inside and crossed over chest. They may hold on to the sides, if desired, and if at all possible.

12. Check loops and hooks to make sure they are properly positioned.

13. Push button for lift. Hand may be placed on steering wheel. After resident is lifted several inches off the bed, stop and reassure resident.

14. Position wheelchair and lock brakes. Swing resident's feet off bed; when resident has been lifted clear off bed, grasp steering handles and move resident over chair or shower bed. U-base of lifter fits around wheelchairs.

15. Turn release valve slowly to the left. Push gently on their knees as they are being lowered into the chair or shower bed so the correct position will be obtained. Lower resident slowly. Guide their descent.

16. When the resident is seated, open release knobs two turns and press down on the arm of the mechanical lift.

17. Detach hooks from seat and back. Resident may remain seated on seat. Be sure resident is sitting on canvas portion of sling only.

18. Permit resident to remain up according to physician's orders, unless resident complains of feeling tired or there are signs of ill effects.

19. Return the lifter to its designated area when not in use.

20. To return the resident to bed, use the same procedure in reverse. Center resident over bed and lower gently.

REFERENCES

- MAXI MOVE™ Instructions for Use ...with people in mind 001.25060. EN (Revised 11 January 2014). Retrieved from https://www.manualslib.com/manual/1292554/Arjohuntleigh-Maxi-Move.html.

SUBJECT: **MECHANICAL VENTILATION**	SECTION: **Page 1 of 6**

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

PURPOSE:

To ensure a consistent method of providing ventilator support.

POLICY:

Respiratory Care Practitioners are responsible for the setup, maintenance and care of mechanical ventilators. Respiratory Care is responsible for management of the resident receiving mechanical ventilation.

AFFECTED PERSONNEL/AREAS:

RESPIRATORY CARE PRACTITIONER, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN)

PROCEDURE:

1. Check to see if an operation verification of the ventilator has been performed.
2. Perform a system check prior to connecting the resident to the ventilator.
3. Connect oxygen supply tubing and compressed air supply tubing to wall outlets.
4. Connect electrical plug to properly grounded electrical emergency power outlet.
5. Push the ON/OFF switch to start the machine.
6. Set the tidal volume as prescribed by the physician.
7. Set the pressure limit to the maximum and occlude the resident connector to test the pressure alarm.
8. Set the respiratory rate as prescribed by the physician.
9. Set the FiO_2 as prescribed by the physician.
10. Set MODE as prescribed by the physician.
11. The ventilator is now ready to be used on the resident.
12. Observe the peak pressure on the manometer required to deliver the set tidal volume. Set the pressure limit < = 15 cm H_2O higher than the peak inspiratory pressure.

13. Observe the peak pressure on the manometer required to deliver the set tidal volume. Set the low inspiratory pressure alarm 10 cm lower than the peak pressure. ***See the Alarm Setting guidelines.***

14. Allow the resident to stabilize the ventilator. Comfort and reassure the resident as necessary.

15. Fill out the Ventilator Flow Chart completely.

16. Chart all appropriate data in the resident's chart.

17. Refer to resident ventilator system checks.

18. Physician may order vent settings to keep ABGs within parameters.

ASSESSMENT:

Assessment of the mechanically ventilated resident should include:

- Visual observation of adequate chest excursion
- Auscultation of sounds
- Arterial blood gases 30 minutes after starting mechanical ventilation
- Non-invasive monitoring of ventilation and oxygenation

HAZARDS:

- Accidental disconnection from the ventilator
- Accidental extubation
- Loss of airway
- Oxygen toxicity
- Barotrauma
- Nosocomial pneumonia
- Over or under hydration from improperly operating humidification devices

EQUIPMENT:

- Mechanical Ventilator (with complete circuit) and disposable filters

- Manual Resuscitation Device
- Suction Equipment
- Humidification System
- Additional Artificial Airway
- Ventilator Flow Chart
- Cuff manometer
- Stethoscope
- Pulse Oximeter

VENTILATOR CIRCUIT CHANGES:

Description: The ventilator circuit change will be done once per month and prn and will consist of placing a clean ventilator circuit on an operating mechanical ventilator. Ventilator circuits will be disposable. The circuit will consist of large bore tubing, monitoring tubing, and humidifier or heat moisture exchangers (HME), thermal monitoring probes, water traps, and medication delivery devices.

Objectives:

- To limit the occurrence of nosocomial infections
- Assure the circuit maintains its physical integrity

Contraindications/Hazards/Complications:

- Pressure of conditions in the resident's cardiopulmonary status that might make tolerance of a ventilator circuit change hazardous to the resident.
- Manipulation and disconnection of the ventilator's tubing can cause contaminated ventilator condensation to spill into the resident's airway, exposing the resident to further risk of infection.
- Failure to assure proper function prior to reinstituting mechanical ventilation may endanger the resident.

VENTILATOR SYSTEM CHECKS

A resident ventilator system check is a documented evaluation of a mechanical ventilator and of the resident's response to mechanical ventilator support. This procedure is often referred to as a ventilator check.

1. Evaluate and document the resident's response to mechanical ventilation at the time the check is performed.

2. Ensure and document the proper operation of the mechanical ventilator.

3. Verify and document that the ventilator is functioning and is properly connected to the resident.

4. Resident assessment and objectives will be documented every 6 hours.

5. All data relevant to the resident ventilator system check should be documented on the Respiratory Care Services Ventilator Flow Sheet in Meditech.

    a. Documentation that all alarms are functional/audible and properly set.

    b. Documentation of measured inspired gas temperatures

    c. Endotracheal or tracheostomy tube size

    d. Documentation of any circuit changes

    e. Date and time of resident's ventilator system check

6. Documentation of a "vent check" must include:

    a. FIO2 setting

    b. Temperature setting (if applicable)

    c. Set ventilator frequency

    d. Peak pressures

    e. Set peak inspiratory limits and pressure support level (if applicable)

    f. Set tidal volume

    g. Exhaled tidal volume (Acute Care)

h. Set high variables (if applicable)

i. Set inspiratory time (if applicable)

j. Set I:E ratio, percent inspiration, or inspiratory and expiratory times (if applicable)

k. Set sensitivity threshold (if applicable)

l. Documentation of all alarm settings and activation of appropriate alarms

m. Signature of person performing ventilator system checks

n. A daily assessment of clinical observations indicative to the residents response to mechanical ventilation

o. Documentation of the resident's oxygenation and ventilation status

7. Residents ventilator system check must be performed QID. In addition, a check should be performed:

a. Following any change in ventilator settings

b. As soon as possible following an acute deterioration of the resident's condition

c. Any time that a ventilator performance is questionable

EQUIPMENT:

- Stethoscope
- Pulse oximeter

INFECTION CONTROL:

- Standard Precautions should be observed.
- Head of bed should be elevated to 35-45 degrees or greater unless contraindicated.

DOCUMENTATION:

- Please see Respiratory Care Policy and Procedure: Documentation

SAFETY PRECAUTIONS:

- Use a properly grounded electrical (red) outlet only.
- Check all alarms every shift.
- Place nothing on top of the ventilator.
- NEVER turn alarms to off position.
- Exercise caution when handling liquids near electrical devices to avoid electrical shock or damage to the machine.
- Only properly licensed personnel are allowed to set-up, monitor or make any adjustments to a mechanical ventilator.

REFERENCES:

- Patient-Ventilator System Checks. (n.d.). Retrieved from https://www.aarc.org/wp-content/uploads/2014/08/08.92.882.pdf
- AARC (2016). Safe initiation and management of mechanical ventilation: A white paper from the American Association for Respiratory Care (AARC) and University HealthSystem Consortium's (UHC) Respiratory Care Network. Retrieved from https://www.aarc.org/wp-content/uploads/2016/05/White-Paper-SAFE-INITIATION-AND-MANAGEMENT-OF-MECHANICAL-VENTILATION.pdf

SUBJECT: **MEDICATION PASS OBSERVATION**	SECTION:

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

PURPOSE:

To ensure the review and monitoring of pharmaceutical services and staff performance regarding medication and medication administration.

POLICY:

The RN Clinical Manager, Regulatory and Quality RN or designated Charge RN will annually observe the administration of medications by the licensed nurses and to assure regulatory and professional standards are followed. A licensed nurse under direct supervision and/or that has been trained and deemed competent may assist in conducting the medication pass observations, when designated by the unit Clinical Director.

AFFECTED PERSONNEL/AREAS:

PHARMACIST, REGISTERED NURSE, CLINICAL DIRECTOR, REGULATORY AND QUALITY RN, COMPLIANCE RN, LICENSED VOCATIONAL NURSES

PROCEDURE:

1. The Regulatory and Quality RN or designated Charge RN will be involved in the medication pass observation/ Competency of all licensed staff annually each September when annual competencies are completed in order to better assess the unit's overall performance and staff's adherence to policy and procedure.

2. Medication pass observations will be documented by the Regulatory and Quality RN or Charge RN on a Medication Administration Competency Form or on an alternate format that is designated by the pharmacist/facility for reporting audits, inspections and pharmaceutical activities within the facility.

3. The Regulatory and Quality RN or Charge RN will validate medication pass observations with the physician's order and medication administration records (MAR), to determine whether medications were managed accurately, and will assess techniques to determine whether medications were distributed appropriately.

4. Results of medication pass observations will be forwarded to the unit Director for review and follow-up with involved staff when medication errors have occurred.

5. The Director / Designee will review medication errors with the appropriate nurse, coordinate necessary training and provide performance coaching as needed to improve medication administration on the unit.

6. The Director will also share the results of medication observation outcomes with pertinent staff during regular unit processes, such as staff meetings and RN Meetings.

SUBJECT: **MEDICATION PASS OBSERVATION**	SECTION: **Page 2 of 2**

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

REFERENCE:

- Med Pass, Inc.,(updated February 6, 2015) Facility Guide to OBRA Regulations, Subtask, 5E United States of America, Med Pass Inc.

SUBJECT: **MULTIPLE TRANSFUSIONS**	SECTION: **Page 1 of 1**

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

POLICY:

- When multiple transfusions are given over a period of days, a new sample of the recipient's blood must be obtained, if subsequent transfusions are required after 3 days of the previous transfusion. This new sample must be used to retest the patient's ABO/Rh, antibody screen and to crossmatch any newly ordered units for transfusion, or re-crossmatch any blood on hold for the patient.

- If a patient is discharged and readmitted and the physician requires products for transfusion, new orders, sample collection and testing are required regardless of the status of any previous blood bank orders, or availability of previous blood bank samples.

- Cross matched blood may be held for up to 72 hours. (Exception: autologous blood)

- Cross matched autologous units are available for transfusion for the expiration life of the unit.

- The nursing units will be notified when blood is available for in-patients and ED. If crossmatched blood is not used, the units will be released and returned to stock at 72 hours.

AFFECTED AREAS/PERSONNEL: *LABORATORY STAFF, NURSING*

REFERENCES:

- Association for the Advancement of Blood & Biotherapies (AABB) Standards, 33rd Edition, p 36, 5.14.4
- Joint Commission Laboratory Standards (2023) QSA.05.09.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **NASAL CARE FOR NASOGASTRIC TUBE FED RESIDENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To prevent excoriation of the nose and to assess nose for pressure from the nasogastric tube.

POLICY:

Nasal care will be provided at least once per shift and as needed to the resident with a nasogastric tube.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSE VOCATIONAL NURSE (LVN)*

EQUIPMENT:

- Gloves
- Cotton tipped applicators
- Container with warm water
- Washcloth
- Soap and water
- Paper or silk tape (if needed)

PROCEDURE:

1. Assemble equipment.
2. Wash hands thoroughly/wear gloves.
3. Provide privacy.
4. Explain the procedure.
5. Assess the taped areas to determine if re-taping is needed:
    a. Carefully remove tape.
    b. Wash skin with warm soapy water, rinse, and dry well.
    c. Re-tape area.
6. Clean outer edges of both nostrils with warm water using cotton swabs.
7. Assess the nares for pressure areas, encrusted areas, or bleeding.

8. Water soluble lubricant may be used to lubricate the nostrils if needed.

SPECIAL CONSIDERATIONS:

Take into consideration that if a resident is going to be a long term tube feeder and can tolerate placement of gastrostomy tube, this should be discussed with the resident (where applicable), and with family or guardian by the physician.

RECORDING:

Nasal care should be done and documented at least once each shift. This is recorded in Meditech on the LVN Intervention GT/NG section.

Record any pressure areas or bleeding on the resident's chart, as well as the interventions.

If nasal irritation occurs, assess and consider changing the nasogastric tube to the other nostril.

REFERENCE:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, §483.25 (g) United States of America, Med Pass Inc.
- Journal of Wound, Ostomy and Continence Nursing, September-October 2021, 48(5):389-393, Reducing Nares Acquired Pressure Injuries "Protect the Nares Because I Care" in Adult inpatients.

SUBJECT: **NOURISHMENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To meet the nutritional needs of identified residents.

POLICY:

It is the policy of this facility that residents may be given nourishments without obtaining a physician's order, following appropriate diet as recommended by the registered dietitian or licensed nurse.

AFFECTED PERSONNEL/AREAS: *RN, LVN, CNA, NUTRITION SERVICES, DIETITIAN*

SCOPE:

Provision of nourishments is the responsibility of the Nutrition Services Department. The Dietitian will initiate nourishment service whenever it has been determined that a resident requires additional nutritional support. Nourishments are not a replacement for routine meals.

PROCEDURE:

1. ORDERING AND DISCONTINUING – The Dietitian will coordinate with nursing regarding residents who require nourishments. If initiated by nursing, the Charge Nurse will order and/or discontinue via Meditech.

2. IMPLEMENTATION – The food service staff and Dietitian will maintain a current "Nourishment List- Dietary Special Needs."

3. MONITORING – The Dietitian will review the need for the nourishment with Charge Nurse monthly for continuance. The Registered Dietitian will review the list of residents routinely.

4. NOURISHMENT COST – Nourishments will be included in the food cost and will not be charged to residents.

5. NOURISHMENT TIME AND DISTRIBUTION

   a. Routine Nourishments (Snacks)

   - Routine nourishments will be offered at bedtime (H.S.) unless contraindicated by diet or condition. Items available for H.S. nourishments will be recommended by the Registered Dietitian.

     Schedule is as follows:

     a. 0800 – 1000 (coordinated with activities)
     b. 1400
     c. 1900

- Bedtime (H.S.) nourishments will be provided by Nutrition Services and will be delivered by the staff to each nursing station before closing the kitchen each night.

b. Recommended Nourishments

- Recommended nourishments will be served at the designated times and frequency. They will be labeled with the resident's name and room number and delivered by dietary to the nursing station.

- The Nursing Staff will be responsible for nourishment distribution each time and will document intake in the appropriate notes.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72335 (2), 72351, San Francisco, California, Title 22.

SUBJECT: **NURSING DOCUMENTATION OF ENTERAL FEEDING**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide complete documentation of enteral feeding.

POLICY:

Nursing documentation of enteral feeding will be compliant with all State and Federal regulations; and will reflect all aspects of enteral feeding as required and as ordered by the physician.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN)*

PROCEDURE:

1. Administration of enteral feeding and all related procedures will be recorded daily on the Intake and Output Record in the EMR according to facility documentation policies. This documentation is required for each shift.

2. Additional information is to be recorded as follows:

    a. The Licensed Nurses' Notes must include any feeding omitted and why, complications from feeding, tube changes and why, and any resident or family instructions.

    b. Care plans must address all resident nutritional needs, enteral interventions, tube care, and potential problems. (Note that feeding tubes are an automatic trigger on the MDS/RAI.)

    c. Nursing Weekly Summaries must reflect all aspects of the nutrition/enteral care plan.

RECORDING:

As indicated above.

SPECIAL CONSIDERATIONS:

REFERENCE LIST COMPLICATIONS OF TUBE FEEDINGS

1. Fluid and electrolyte disturbances can be caused by excessive protein intake accompanied by inadequate fluid intake, frequent suctioning, vomiting, diarrhea, fever, infection

    a. Dehydration

    b. Hypernatremia (increased sodium, normal 135-145 mEq/L)

    c. Azotemia (increased urea-nitrogenous waste products) Renal failure

d. Glycosuria (increase urine sugar)

2. Aspiration pneumonia – possible causes include:

a. Large bore tubes (increased risk of reflux and aspiration)

b. Decreased level of consciousness

c. Decreased GI motility

d. Pulmonary disease

e. Diminished or absent gag reflex

f. Incorrect resident position and tube placement

3. Diarrhea – the most common complication of tube feedings. Possible causes include:

a. Rapid infusion rate

b. Infusing cold formula

c. Bacterial contamination of formula

d. Hyperosmolar formula

e. Low residue formula

f. Lactose intolerance

g. Not rinsing bag and tubing between feedings and adding new formula

Note: Other causes such as illness, flu, impaction or antibiotic therapy must be ruled out.

4. Constipation – possible causes:

a. Elderly bedridden resident

b. Residents with history of constipation

c. Chronic laxative abuse

d. Long term maintenance on tube feeding

e. Dehydration

5. Bloating and retention – causes include:

   a. Large volume feedings

   b. Intolerance to feedings

   c. Decreased gastric motility

   d. Constipation

   e. Bowel obstruction

   f. Ileus

6. Erosion of esophageal, tracheal, nasal and oral mucosa. Causes include long term tube placement, use of large bore PVC tubes, dehydration, improper nasal and mouth care.

   a. Skin pressure, excoriation of nose

   b. Sinusitis

   c. Esophagitis

   d. Esophageal – tracheal fistula

   e. Gastric ulceration

   f. Pulmonary and oral infections

   g. GI bleeding

   h. Increased mucous secretions

Xerostomia (decreased salivation,)

7. Vomiting – causes might include:

   a. Clogged tube

   b. Improper infusion of feeding

   c. Initiation of enteral therapy

   d. Constipation – bowel obstruction – impaction

   Note: Other causes such as illness, flu, and medications must be ruled out.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.75 (1), 483.20 (k) (2) (iii) United States of America, Med Pass Inc.

SUBJECT: **PATIENT BLOOD SAMPLES FOR BLOOD BANK**	SECTION:

POLICY:

1. Properly labeled specimens (pink top or red top) shall be used for pretransfusion testing procedures. Properly label as follows:

   a. Blood draws on **all** patients must be from patients with **armbands.**

   b. Write the Blood Bank Number (BBK#) (as found on the armband) along the bottom of the patient label. The BBK# is the last six digits of the number found on the armband. Write the Meditech user mnemonic and time of draw on the tube.

   c. A second clinical staff person must confirm the BBK# at the bedside and add their Meditech mnemonic to the tube.

   d. An extra tube must show the original label done in the same way or it cannot be used for Blood Bank (NO over-labeling)

   e. CLS: Double check the hand printed information for correctness before crossmatching. This can be done by checking the custom BBK# report in the Meditech Blood Bank module.

2. Blood can be collected from an infusion line if the patient is receiving intravenous fluids. The tubing should be flushed with saline and the first 5 ml of blood withdrawn and discarded.

3. Hemolyzed samples should not be used unless there is no alternative to using hemolyzed specimens, as with burn or hemolytic anemia patients. It is helpful to compare the size of this test RBC button against a control button suspended in saline in order to see whether the test RBCs have been lysed by the patient's serum.

4. Compatibility tests must be performed on blood samples collected within 3 days before red cell transfusion. It is important the sample used represent the patient's current immunological status.

AFFECTED AREAS/PERSONNEL: *CLINICAL, NURSING, LAB PERSONNEL*

REFERENCES:

- Association for the Advancement of Blood and Biotherapies Technical Manual, 21st Edition, 2023
- Association for the Advancement of Blood and Biotherapies, Standards for Blood Banks and Transfusion Services, 33rd Edition, 2022, Sections 5.11 through 5.11.3.
- The Joint Commission (2023). Hospital accreditation standards. NPSG.01.01.01, Ep's 1&2. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PATIENT FOOD FROM HOME - DPSNF**	SECTION:

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

PURPOSE:

To establish a policy regarding use and storage of foods brought to Sierra View Medical Center Distinct Part Skilled Nursing Facility (DP/SNF) residents by family and other visitors to ensure safe and sanitary storage, handling and consumption.

POLICY:

It is the policy of the Food & Nutrition Services (FNS) Department to prepare and deliver food safely to our residents, families and staff. This policy will ensure proper handling, serving and storage of any food items brought in for our residents from all outside sources.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, DP/SNF DEPARTMENT*

PROCEDURE:

1. It is a resident's right to obtain foods from outside sources such as ordering takeout and to receive foods brought in by the resident's family and friends. The FNS Department and the unit's nursing staff will make every effort to advise the residents of foods that are permitted within their diet restriction. However, the resident has the right to make food choices that may not follow their diet restriction.

2. All food or beverages brought into the unit for resident consumption will be checked by a staff member before being accepted for storage. Any suspicious or obviously contaminated food or beverage will be discarded immediately.

3. Foods and beverages brought in from the outside will be labeled with the resident's name, room number and dated by the receiving staff with the current date that the item(s) are brought into the facility for storage.

4. Residents with dietary restrictions, texture modifications and adaptive equipment needs will be advised and assisted as necessary to ensure the resident's diet/devices are being followed/provided.

5. Food or beverage items may be stored in the designated patient refrigerator, freezer or pantry. Items may be stored in the resident's room or their personal room refrigerator.

    a. Food or beverage in the original container that is past the manufacturer's expiration date will be discarded by staff.

    b. All cooked or prepared food brought in from outside will be dated by the receiving staff member, when accepted for storage, and discarded after three (3) days. No home-prepared foods that are home canned or preserved will be permitted.

6. In support of our residents, families and visitors, and in understanding of safe food handling practices, a copy of the food handling safety guidelines will be included in our admission packets and reviewed annually with resident and/or family during the interdisciplinary team meeting.

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). §483.60(i)(3). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03. Joint Commission Resources. Oak Brook, IL.
- Med Pass, Inc. (Updated Feb 6, 2015) Facility guide to OBRA Regulations, 483.10.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of regulations 72343, 72335 (6), San Francisco, California. Title 22.
- Food From Home handout, Tips for Family Members 2022. https://www.cahf.org/Portals/29/Clinical-Quality/Food%20From%20Home%20Handout.pdf?ver=2022-03-29-180723-740

SUBJECT: **PHYSICIAN'S SERVICES**	SECTION: **Page 1 of 4**

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

PURPOSE:

To ensure physician services to the residents on the DP/SNF Unit in order to achieve for each resident the highest optimal health possible in his/her circumstances by obtaining prompt and adequate medical attention.

POLICY:

A. The Medical Director is a physician who is currently licensed to practice in the State of California, and has experience and knowledge in the care of DP/SNF residents.

B. The Medical Director is appointed by the Administrator and shall be designated by the Medical Staff of the Hospital with the approval of the Board of Directors.

C. The duties and responsibilities of the Medical Director include, but are not limited to, the following:

1. Directing and coordinating medical care in the unit, including providing orientation to other attending physicians on the unit. Orientation shall include Title 22 and OBRA Regulations.

2. Assisting in arranging for continuous physician coverage to handle medical emergencies.

3. Assisting in developing procedures for emergency treatment of unit residents.

4. Participating in establishing policies, procedures and guidelines designed to assure the provision of adequate comprehensive services.

5. Participating in the resident care management system (i.e., attending weekly team conference).

6. Serving as a member of the Medical Staff, attending its meetings, and helping to assure adherence to the Medical Staff bylaws and Rules and Regulations.

7. Participating with other health care professionals in establishing policies designed to assure the governing board that all health care professionals act within the scope of their practice and license and within the scope of California's laws.

8. Providing consultation in the development and maintenance of an adequate medical record system.

9. Participating in the in-service training program.

10. Monitoring the health status of employees and advising the administration on employee health policies.

11. Providing consultation to the Unit's Clinical Director and the individual responsible for Social Services concerning the evaluation of the unit's ability to meet the psychosocial, medical and physical needs of the residents.

12. Advising the Clinical Director about the adequacy and appropriateness of the unit's scope of services for the residents, its medical equipment and its professional and support staff, the use and availability of ancillary services such as lab, radiology, etc..

13. Assisting in assuring a safe and sanitary environment for residents and personnel by:

    a. Reviewing and evaluating summaries of occurrence reports

    b. Identifying hazards to health and safety

    c. Making relevant recommendations to the Administrator

    d. Being knowledgeable about the policies and programs of public health agencies that may affect the resident care programs

    e. Acting as the unit's medical representative in the hospital and the community

    f. Monitoring the quality and appropriateness of medical services as an integral part of the overall Quality Assurance Performance Improvement (QAPI) program of the unit and the hospital

14. The Medical Director will be involved in the physicians credentialing process for the DP/SNF unit (as more particularly described in the following paragraph).

    a. The Medical Director recognizes that all physicians caring for residents in the DP/SNF unit must be a member in good standing, of the hospital's medical staff. As such, following processing of a physician's application by the hospital's Medical Staff Coordinator (who will already have validated the physician's credentials and professional information), the application for a physician wishing to care for residents on the DP/SNF unit will be forwarded to the Medical Director to assess the application/credentials and other professional information. His/her recommendations will be forwarded to the hospital's Credentials Committee who will review and forward, together with its recommendations, to the hospital's Medical Executive Committee or Governing Board, as the case may be, who will make the determination as to whether or not privileges should be granted to the applying physician for the provision of DP/SNF care services.

b. The Medical Director will be knowledgeable about quality indicators for all DP/SNF services provided and will ensure that care provided to residents is adequate, comprehensive and appropriate.

c. The Medical Director will be available to and responsive to all unit residents, families and/or unit staff, either physically or by telephone, and in his/her absence will make arrangements to provide adequate coverage during those periods in which he/she may be away from the facility.

d. The Medical Director recognizes that there may be instances when expertise in the areas of neurology, pulmonology, podiatry, cardiology, dentistry, and oncology, may be required. As such, if the Medical Director does not have expertise in the specialty required, the Medical Director will seek adequate consultation.

15. The Medical Director agrees to the foregoing and to any additional requirements of the DP/SNF Care Certification Manual, and as required by Title XXII of the laws of the State of California.

D. Upon admission, the resident's physician will see the resident within48 hours to evaluate the resident's needs and complete a history and physical, as necessary, and to initiate via appropriate orders a care plan to achieve those needs.

1. The physician will be credentialed and privileged by the facility, per Medical Staff Bylaws.

2. Physician's visits for residents of the DP/SNF unit are medically required at least twice weekly during the first month, a minimum of at least once every seven days thereafter and as necessary for acute problems.

3. The physician is required to attend each resident's team conference weekly for DP/SNF residents.

4. Federal and State regulations and professional ethics mandate that the physician complete the resident's medical record in a timely manner that conforms to the regulations mentioned.

5. All orders for treatment and medication must be in writing and signed/dated/timed by the physician.

6. Admission orders must include the following: date/time of order, diagnosis, activity level/functional status, medications/treatments, and diet.

7. The admission diagnosis and orders must be placed in the EMR on admit and signed/dated/timed by the physician within 48 hours of admission for DP/SNF.

8. All telephone orders must be signed/dated/timed in the EMR by the physician within 48 hours.

9. Progress notes reflecting review of the residents overall condition and program of care must be written into the resident's EMR and signed/dated following each visit to the facility by the physician.

10. History and Physicals for all residents will be reviewed and rewritten annually.

AFFECTED PERSONNEL/AREAS: *MEDICAL DIRECTOR AND/OR ATTENDING PHYSICIAN*

REFERENCES:

- Med Pass, Inc. (updated February 6, 2015) Facility Guide to OBRA Regulations, 73303 United States of America, Med Pass Inc.

SUBJECT:	SECTION:
RESIDENT SELF-DETERMINATION IN MEDICAL DECISION MAKING (PSDA)	***Social Services*** **Page 1 of 5**

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

PURPOSE:

The purpose of this document is to ensure that each resident's ability and right to participate in medical decision making is maximized and not compromised as a result of admission for care through this organization. Additionally, the purpose of this policy and procedure is to assure compliance with the Patient Self-Determination Act (PSDA), which is required of this organization as a condition of participation in the Medicare/Medicaid program.

POLICY:

A. It is the policy of this organization to respect and encourage resident self-determination. The policy will encourage residents to be active participants in decision making regarding their care through education and inquiry. It is hoped that such education and inquiry about advance directives will, in turn, encourage residents to communicate their preferences and values in that regard in advance to their loved ones. Thereafter, such communications will guide surrogates in medical decision making for the resident when the resident is incapacitated.

B. The implementation of PSDA in the DP/SNF and transitional care programs will include:

1. Inquiry at time of admission about existing Advance Directives.

2. Provision of information regarding the resident's right to make decisions concerning medical care, including written information to all residents (21 years or older) who have the capacity to consent to his/her own health treatment, concerning the right to accept or refuse medical or surgical treatment, even if that treatment is life sustaining.

3. Provision of the facility's policy information regarding implementation of the above referenced rights, including assurance that care is not conditioned in any event on whether or not an Advance Directive had been completed.

4. Provision of a written statement that the resident may file a complaint with the Licensing & Certification district office concerning non-compliance with Advance Directives, or for resident abuse, neglect, or misappropriation of resident property in the facility.

5. Documentation in the resident's medical record as to their response and actions taken regarding Advance Directives.

6. Training facility staff and educating the community on issues concerning Advance Directives (i.e., educational information about Advance Directives and facility's policies and procedures; forums, family groups and council meetings; the distribution and posting of written materials.)

C. For purposes of this policy, the following terms shall be interpreted in accordance with their respective definitions as set forth below:

1. **Medical Decision Making- Authorization** for treatment, the withholding of treatment, or the withdrawing of treatment (including life-sustaining treatment) obtained from the resident or, in the event of the resident's incapacity, from the resident's surrogate decision maker.

2. **Life-sustaining Treatment**- Any medical intervention, including the administration of fluids and nutrition by artificial means, or the use of a ventilator, that sustains life for a particular resident.

3. **Advance Directive**- A written instruction, as a Living Will, a declaration pursuant to the Natural Death Act, a Durable Power of Attorney for Health Care, or other documentary evidence recognized by the course of this state, relating to the provision of medical care when the author is incapacitated.

4. **Surrogate Decision Maker**-An individual other than the resident to whom health care providers appropriately look for medical decision making regarding the resident's care when the resident is incapacitated. This individual may be formally appointed (e.g., by the resident in a durable Power of Attorney for Health Care or by a court in a conservatorship or guardianship proceeding) or, in the absence of a formal appointment, may be informally authorized by virtue of a relationship with the resident (e.g., the resident's next of kin or, in the absence of next of kin, close friend.)

5. **Incapacitated**- A condition of the resident, as determined and documented by the physician, where the capacity to make informed decisions regarding care is temporarily lost (e.g., due to unconsciousness, being under the influence of mind-altering substances, or otherwise suffering from treatable mental disability), is permanently lost (e.g., irreversible coma, persistent vegetative state, or untreatable brain injury rendering understanding by the resident impossible), or never existed (e.g., congenital retardation, rendering understanding by the resident impossible, or severe brain injury as a child).

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, NURSING / DPSNF*

PROCEDURE:

A. The Social Service Designee will include the facility's Policy Statement.

B. The Social Service Designee admitting the resident will inquire if there have been any Advance Directives executed and document the response in the designated area of Notes in the EMR. If one has been completed, a request will be extended to obtain a copy to place on the resident's medical record.

C. The Social Service Designee will:

1. Provide the resident/surrogate decision-maker with the aforementioned documents as part of the admission process or as soon as reasonably possible.

2. Inquire of each competent resident/surrogate decision-maker if an Advance Directive such as Durable Power of Attorney for Health Care, Directive to Physician, or Living Will exists.

3. If document exists, request that a copy be brought to the facility for placement in the medical record.

4. Refer the resident/surrogate decision maker to the policy statement and brochure, briefly explain the topic, and inform them that further information may be obtained from the physician and nursing staff.

5. If the resident is incapacitated at the time of admission and is unable to receive information or articulate whether an Advance Directive has been executed, then the Social Service Designee will document resident's current capacity and may give the Advance Directive information to the family or surrogate decision maker in the same manner that it issues other materials about policies and procedures to the family of an incapacitated resident or surrogate in accordance with State law.

6. It shall be noted that although an Advance Directive cannot be executed after the resident loses decisional capacity, it is extremely important that the surrogate decision maker address a variety of care preferences (see Intensity of Service form) on behalf of the resident. These decisions shall be made, if possible, by using the substituted judgment standard. If this standard cannot be used, then the decision shall be based on the best interest standard.

7. The Social Service Designee is obligated and will provide the Advance Directive Information to the resident directly, once he or she is no longer incapacitated or unable to receive the information.

D. The Social Service Designee will:

1. Review existing documentation on the nursing assessment and acknowledgement form as part of the admission interview, and provide further information as requested.

2. Remain as a point of reference re: Advance Directive while the resident is in the DP/SNF program, if requested. (The Ombudsman must witness an Advance Directive developed while a resident is in a facility.)

3. Follow up with resident/surrogate decision-maker to assure a copy of the Advance Directive is obtained. If the resident was admitted from another acute or LTC facility, or by a home health agency, follow up with the facility or agency to obtain a copy of the AD if available. If the resident was admitted directly from SVMC, follow up with medical records to obtain a copy. Document in progress notes all efforts made to obtain the Advance Directive.

4. In conjunction with Staff Development, develop an educational program for staff regarding Advance Directives, to be presented periodically.

E. In collaboration with facility staff, the Social Service Designee will ensure that resident's desires regarding their medical care decisions are carried out; ongoing review of Advance Directives during monthly team conference or at a change of condition; previous of ongoing counseling and education to assist in decisions toward Advance Directive; notification of physician and nursing staff when a resident/family wishes to institute an Advance Directive.

F. Upon the resident's transfer or discharge from the facility, the Advance Directive will be included with the transfer documents. Staff will also assure that a copy of the Advance Directive is maintained in the chart and is filed with the closed medical record.

G. The Physician Order for Life Sustaining Treatment shall be reviewed only on an as-needed basis to be sure it continues to accurately reflect that wishes of the resident. A new form will be completed and placed in the medical record at the time of this a review.

H. The Advance Directive needs to be reviewed on an as-needed basis, to make sure that the directives and the agent (if any) are still correct as written. If there are changes to be made, they should be made and initialed by the resident or surrogate. Family should be directed to make the same changes on any existing copies of the document.

I. The SVMC Bioethics Committee is available to residents and their families as well as facility staff should conflicts arise about decision-making.

REFERENCES:

- California Code of Regulations (2020). Title 22. §72527, 72529. Residents Rights. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Residents Rights in Nursing Homes (2022). Retrieved from: https://canhr.org>residents-rights.

- Residents Rights & Quality of Care, September 6, 2023, retrieved from:www.cms.gov>what-we-do

- National Ombudsman Resource Center, *National Consumer Voice for Quality Long Term Care (2023).* Retrieved from www.ltcombudsman.org.

SUBJECT: **RESIDENTS' FUND POLICY**	SECTION: **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 handle Distinct Part/Skilled Nursing Facility (DP/SNF) residents' funds, for the benefit of the residents, conforming to Title 22 regulations, with reasonable business practices and generally accepted accounting standards in maintaining their accounts.

Sierra View Medical Center will only handle DP/SNF residents' funds when asked to by the resident, their responsible party or other authorized agent or agency.

Sierra View Medical Center shall inform residents upon admission that this service is available.

A resident's fund bank account shall be established separate from the facility's accounts and clearly designated as a resident demand trust account. Any resident funds in excess of $50 must be deposited into the trust account, (see Social Services P & P Trust Account). This account shall be interest bearing. At no time will the balance in this account be less than zero. (However, should a credit balance occur, the patient or responsible party will be notified immediately.) This bank account will be reconciled monthly.

A record showing an individual resident's account activity shall be given to SSD quarterly by Patient Accounting for DPSNF.

A resident's funds shall be returned within thirty days, upon death of the resident, using state regulations and guidelines.

A surety bond shall be secured in an amount sufficient to comply with state regulations.

A separate list shall be maintained for all checks from residents' funds which are, or have been, outstanding for 45 days or more as reflected on the most recent bank statement. Bank statements shall be reconciled monthly with copies of the reconciliation maintained by the facility. Any checks' on such accounts written off or uncashed shall result in an addition to the appropriate resident's account.

The Business Office Manager has been assigned by the Administrator; the responsibility to handle all patient monies, under the Administrator's coordination and direction.

The DP/SNF Patient Account Specialist shall have access to the Organization's safe, located at the Cashier, where some residents' cash (as applicable) will be kept for regular use per the latter's requests for minimal purchases. The specified fund will be available Mondays through Fridays from 0800-1630.

AFFECTED PERSONNEL/AREAS:

RN, SOCIAL SERVICES, PATIENT ACCOUNTING

PROCEDURE:

1. Sierra View Medical Center does not mingle resident's monies with any other monies.

2. When resident/responsible party asks the facility to handle his/her funds, a "Resident Trust Fund Authorization" form is completed and kept with the resident's ledger.

3. The individual resident ledger will then be established for the resident.

4. Each resident ledger will reflect all transactions, including deposits and withdrawals, as well as balance in chronological order.

5. Withdrawal will be recorded on resident's ledger will be given quarterly. One copy will be kept with the resident's ledger.

6. A monthly "Cash Receipts Journal" will be kept for listing all cash received in chronological order.

7. Withdrawals will be recorded on resident's ledger with appropriate receipt and description of the expenditure kept with the ledger. Signature of authorized person is required on the ledger.

8. Trust fund bank statements will be reconciled monthly with residents' ledgers.

9. Interest will be posted monthly on each resident ledger as a deposit.

10. All records of resident monies, including banking records, deposit slips, checks, cancelled checks, statements, and check registers are maintained for three (3) years from the date of the transaction.

11. For residents who choose to keep money at their bedside, the Social Services Designee will offer to have such funds be kept at the designated safe in the cashier's office, which will be handled by the Patient Account Specialist. If the resident refuses, a care plan shall be immediately initiated to reflect this preference. A limit of $50 will be suggested if the resident chooses to keep money at the bedside. Note that once the resident decides to keep any amount of money at the bedside and refuses offered safe-keeping, that the resident claims full responsibility of whatever happens with the money. This means that the department will not be expected to replace any amount missing or be held accountable for any noted discrepancy.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72529, 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.

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (c) United States of America, Med Pass Inc.

CROSS REFERENCES:

- Social Services Policy and Procedure: TRUST ACCOUNT-SOCIAL SERVICE POLICY

SUBJECT: **RESIDENT'S RIGHTS**	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 ensure that the facility demonstrates respect for the rights of the Residents.

POLICY:

It is the policy of this facility that Social Services Designee will work to protect the following rights of each resident.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES*

PROCEDURE:

Residents shall have the right to:

1. Choose activities consistent with his or her interests.
2. Interact with members of the community both inside and outside the facility.
3. Reside in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of other Residents would be endangered.
4. Be informed or notified when there is a significant change in mental or psychosocial status or the need to alter treatment significantly.
5. Be informed or notified when there is a decision to transfer or discharge the Resident from the facility.
6. Retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights, health, or safety of other Residents.
7. Make choices about aspects of his/her life in the facility that are significant to the Resident.
8. Receive notification when there is a change in room or roommate assignment and, if known, the Resident's legal representative or interested party.
9. To be assured of confidential treatment of his/her personal and medical records and to approve/refuse their release to any individual or agency as provided by HIPAA regulations.

REFERENCES:

- The Residents Bill of Rights, Motley Rice LLC, 28 Bridgeside Blvd, Mt. Pleasant, SC 2020. Retrieved from http://www.nursinghomealert.com/residents-bill-of-rights.
- Centers for Medicare & Medicaid Services. Nursing Home Resource Center. Retrieved from https://www.cms.gov/nursing-homes.
- The National Long-Term Care Ombudsman Resource Center. *Resident's Rights*. Retrieved from https://ltcombudsman.org/issues/residents-rights.

SUBJECT: **RESTRAINTS, CHEMICAL**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 6**

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

PURPOSE:

To establish set guidelines for the proper use of chemical restraints in the DP/SNF

POLICY:

When psychoactive medications are ordered, the assessment process will be utilized to ensure:

1. Environmental causes of resident's distress or behavior have been ruled out.
2. Alternative behavioral management programs have been attempted prior to the use of psychoactive medication.
3. Early identification and reporting of drug side effects are documented.
4. Physician is provided with summaries of resident's behavioral manifestation, frequency, response to behavioral programs and medications, as well as recommendations for changes in medication.
5. Psychoactive medications are used in the lowest possible dose, and are discontinued when no longer required to treat a mood or behavior problem, unless the medication is used to maintain a resident with a psychotic diagnosis, or organic mental disorder.
6. Psychoactive medications are given only after the physician has obtained informed consent from the resident/surrogate decision maker.
7. Facility staff have verified that informed consent has been obtained.
8. Residents with dementia on antipsychotic/psychotropic medications will be reviewed by Pharmacy for any issues of adverse medication effects that may cause cognitive impairments and may be mistaken as worsening dementia.

POLICY:

1. Residents will be enabled to achieve the highest level of functioning, and will receive psychoactive medications only when they are necessary to treat medical, mood, behavioral, or psychiatric symptoms. These medications will not be used for the convenience of staff. Informed consent will be obtained by the physician from the resident, unless the resident lacks decisional capacity, in which case, consent will be obtained from the surrogate. In the absence of surrogate, the Interdisciplinary Team will make the recommendation regarding the use of the medication. Consent will also be obtained for any change of dosage.
2. Antipsychotic Medications

a. Anti-psychotic medications will not be initiated for residents who have not used them previously, unless the clinical record documents the medication is necessary to treat a "specific condition".

b. Non-pharmacological interventions will be initiated and documented prior to the use of antipsychotic medications.

c. Psychologist consults as per MD order.

d. In the event that non-pharmacological interventions are ineffective, and a pharmacological intervention has been initiated secondary to consult, licensed nursing staff will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anti-psychotic medications.

e. Continued aggravation or deterioration in status will be reported to the physician.

f. Anti-psychotics will be given in the lowest effective dose to start, and increased as needed by physician order.

g. Use of a one-time only dose of anti-psychotics more than two times in seven days will be assessed by the Interdisciplinary Team for side effects and continued use.

h. Gradual dose reductions will be attempted twice in a year unless the physician documents that it is clinically contraindicated.

i. The medication's effectiveness will be reevaluated by the physician on a weekly basis during the Interdisciplinary Team Meeting.

3. Anti-anxiety Medications

a. Nursing will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anxiolytics.

b. Antianxiety medications are to be administered for 14 days only, then reevaluation for continued use every 14 days x3 then may be extended to 30 days thereafter with a reevaluation done every 30 days.

c. Anti-anxiety medications will be administered only when the appropriate indications/diagnoses are present:

- Generalized anxiety disorder
- Organic mental syndrome associated with agitated states
- Panic disorder

- Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder (e.g., depression, adjustment disorder).

d. Long acting benzodiazepines will not be used unless the short acting benzodiazepines have failed.

4. Antidepressant Medications

a. Residents with symptoms of depression (e.g., withdrawn behavior, refusal to speak, poor appetite, and/or loss of interest) will be provided appropriate non-pharmacological interventions such as altered lighting, distractions with activities, relaxation techniques, calming music, repositioning, sit and conversing with resident, etc. These non-pharmacological interventions will be attempted prior to the initiation of any drug therapy.

b. Any use of an antidepressant medication outside the Diagnostic and Statistical Manual of Mental Disorders (DSM V) guidelines will be justified by a physician's note explaining why the medication is clinically appropriate, and this should be supported by a psychiatrist/psychologist consultation.

c. Behavioral monitoring charts via EMR will be used for residents receiving antidepressant medications.

5. Sedative/Hypnotic Medications

a. All environmental factors for insomnia will be ruled out before pharmacological interventions will be initiated to assist a resident to sleep.

b. Daily use of drugs for sleep induction will be less than ten consecutive days or as the physician deems necessary, unless an attempt at a gradual dose reduction has been unsuccessful.

c. Barbiturates will not be used except as a single dose for dental or medical procedures, and phenobarbital will be used only for seizure disorder.

d. When resident is admitted with barbiturates, or miscellaneous hypnotic, sedative, or anxiolytic drugs, there will be a gradual dose reduction at least two times in one year before dose reduction is determined to be "clinically contraindicated".

e. Neither barbiturates, nor miscellaneous sedative, hypnotic, anxiolytic drugs will be initiated in the facility as part of an initial therapeutic treatment program.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. Residents who are admitted with a psychoactive medication will have an assessment of the continued need, dosage, and indications for the medication.

   a. The physician's admitting order for psychoactive medication will state the behavior or mood problem being treated.

   b. The physician is to obtain the informed consent.

   c. The behavior or mood problem will be entered on the care plan with the side effects of the drug and non-drug interventions.

   d. The Interdisciplinary Team will complete the "Psychoactive Medication Assessment" at the first Team Conference Meeting following admission, review the treatment progress in the monthly Team Conference Meeting, and reevaluate in a quarterly assessment the appropriateness of continued treatment with psychoactive medications.

   e. Nursing and Social Service Designee will document in their progress notes the interventions provided, and resident's response to treatment.

   f. Nursing will stop the medication and notify the physician if medication side effects are suspected.

2. When psychoactive medications are initiated on the unit, the resident's medical record will contain completed assessments, documented interventions, and appropriate consents, before the drug is administered.

   a. The physician's order for psychoactive medication will identify the mood or behavior problem being treated and order behavioral monitoring when behaviors are targeted.

   b. The physician will then complete the appropriate consent form for the medication with the resident.

   c. If the resident is not capable of giving informed consent, consent will be obtained from the resident's surrogate.

   d. Nursing will have documentation in regards to the non-drug interventions that have been unsuccessfully implemented.

   e. A care plan will be completed noting the behavior or mood problem being treated, non-drug interventions, and drug side effects.

3. Informed consent, assessment, and response to psychoactive medications will be documented in the medical record.

a. Prior to the administration of any psychoactive medications initiated on the unit, the consent for the specific medication will be documented in the medical record.

b. When a resident, or the resident's surrogate refuses a psychoactive medication that has been ordered, the Refusal of Medication will be documented in the medical record. Documentation will state that the resident was informed, inclusive of details, regarding the risk and benefits of the medications ordered.

c. The Interdisciplinary Team will review the use of psychoactive medications in the Interdisciplinary Team Conference meeting, and will document in the Team Conference notes a re-evaluation of the medication's effectiveness, with recommendations for the continued usage, dose reduction, or discontinuance of the medication.

d. When resident is receiving a psychoactive medication and dosage reduction is "clinically contraindicated," the physician will document the reason as to why the medication is necessary on a Risk vs. Benefits form.

e. When medications are ordered outside the "Unnecessary Drug Guidelines," the physician will document the reason for the medication and the psychiatric condition necessitating the medication. The physician's documentation should be supported by a psychiatric/ psychologist consultation.

f. Nursing will document frequency of incidents of the behavior on each shift, when a resident is receiving any psychotropic medication for a disorder, which is manifested by inappropriate behaviors.

g. Nursing will document responses to dosage reduction attempts.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) *Barclays California Code of Regulations,* 72319 (j) 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.

- Stones, MJ (2019). *Psychotropic Medication Use and Mortality in Long Term Care Residents.* Retrieved from https://www.intechopen.com/books/aging-life-span-and-life-expectancy/psychotropic-medication-use-and-mortality-in-long-term-care-residents.

- Medicare State Operations Manual for Long Term Care Facilities, Department of Health and Human Services, September 2000 , Tag F221, F222, Appendix PP.

CROSS REFERENCES:

- DP/SNF Policy and Procedure: CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT .

SUBJECT: **SIDERAILS**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose of this policy is to provide a device to assist residents in independent bed mobility, to provide a safety device for preventing residents from falling from bed, or as a restraint to prevent injuries for those residents who have been screened for the use of restraints and for whom the use of side rails has been determined to be the appropriate, least restrictive type of restraint. An Informed Consent from the family/responsible party and a physician's order has also been obtained for their use and must be obtained before they are used.

POLICY:

It is the policy of this facility to assess all residents for the appropriate use of side rails.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)*

PROCEDURE:

1. Upon admission, all residents will be assessed for functional and cognitive levels.

2. The appropriate use of side rails will be determined by the resident DPSNF Bed/Side rail Assessment in the EMR.

3. Residents for whom side rails are determined appropriate for assistive or safety reasons will have care plan entries identifying the reason for use.

4. Residents for whom side rails are determined appropriate will have an appropriate personalized care plan completed and informed consent signed by the resident, family, significant other or guardian.

REFERENCES:

- Thomson Reuters (2019). Barclay's California Code of Regulations, 72319, 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.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25(n), (2) (3) (4) United States of America, Med Pass Inc.

SUBJECT: **SIGN-OUT PROTOCOL FOR BLOOD COMPONENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

At the time a unit is issued, Blood Bank Standards require a final check of transfusion service records, the patient's identification, and each unit of blood or component.

POLICY:

- All units of blood and blood components must be signed out by a clinical lab scientist (CLS) and another clinical care representative. The CLS and clinical care representative must be on staff at Sierra View Medical Center (SVMC).

PROCEDURE:

- The clinical care representative must present a copy of the blood bank transfusion request containing complete patient identification when coming to pick up blood or blood components.

- After successful crossmatch of the unit, the clinical lab scientist will utilize printed unit "luggage tags" and attach them to the appropriate unit. At the time of issue, the CLS will examine the unit for appearance and expiration date and indicate the acceptability by documenting on the transfusion issue card. The transfusion luggage tag with the patient's name, medical record number, the donor unit number, the patient and donor unit ABO/Rh, and the expiration date of the unit will be compared with the identical information contained on the transfusion issue card, by both the CLS and the clinical care representative. All information must agree before the unit can be signed out for transfusion. ANY DISCREPANCIES MUST BE RESOLVED BEFORE ISSUE.

- After determining that the above information is in agreement and the identity of the recipient and donor are confirmed, the clinical care representative will sign the blood bank transfusion issue card (both copies).

- The clinical care representative will now be able to take the unit along with the transfusion issue card back to the nursing unit for transfusion.

- A clinical care representative will be allowed to sign-out more than one unit at a time for transfusion on the same patient, but will not be allowed to sign-out units on different patients simultaneously.

- Units of blood issued to surgery will be placed in resealable plastic bags with the patient name, date of birth, and Blood Bank number boldly written on the resealable plastic bag.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

REFERENCES:

- Association for the Advancement of Blood & Biotherapies, "Standards for Blood Banks and Transfusion Services", 33rd Edition, 5.22 through 5.25.

- The Joint Commission (2023). Laboratory accreditation standards. QSA.05/03/01. QSA.05.10.01, QSA.05.14.01, QSA.05.17.01, QSA.05.18.01, QSA.05.22.01, QSA.05.24.03. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **TRANSFER WITHIN FACILITY- CHANGE OF ROOM/ROOMMATE**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the process of notification of change of room or roommate.

POLICY:

The resident and/or representative will be provided a written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES DESIGNEE*

PROCEDURE:

Administrative:

1. Changes in resident's room or roommate will be based on nursing/medical care needs and/or resident request. The resident's cultural, spiritual, and age related needs will be considered whenever a room or roommate change is necessary.

2. No resident will be involuntarily transferred within the facility without reasonable notice in writing (as required by law), except in an emergency, which necessitates transfer to acute level for health reasons, or safety and regulatory compliance reasons.

3. The resident's right to refuse certain transfers (per regulatory standards) and his/her wishes regarding transfer will be considered and complied with when they do not interfere with the resident's care and safety needs, and/or the rights and needs of other residents.

4. If the resident lacks the capacity to make decisions or to participate in his/her care, the responsible party will be contacted for notification of room or roommate changes. Written notice will be sent via one of the following options: certified mail, e-mail, fax. Acknowledgement of receipt of notification will be confirmed via phone call and will be documented as appropriate.

5. Documentation of verbal and written notice of changes in the resident's room or roommate will be maintained in the resident's record.

6. The Ombudsman's Office will be contacted to serve as advocate and liaison as needed to assure the resident's rights, when refusal of certain transfers occur, and to assist the resident/responsible party and facility to resolve concerns regarding room or roommate changes.

Preparation for Transfer:

1. The Social Services Designee will discuss the room change with the resident, responsible party and affected roommates, and complete charting needs related to the notification for transfer.

2. The licensed nurse will assemble current health records and all medication and treatment supplies.

3. The nursing assistant will assemble all resident's belongings, verify belongings against the personal inventory form, and date and initial upon completion; complete current charting needs; and, assemble all resident information forms located in the resident's room.

Transfer:

1. The licensed nurse and nursing assistant will transfer the resident with all belongings, records, medications and treatment supplies, after verification of the new room assignment.

2. The nursing assistant will assist resident adjustment through introductions to the new nursing assistant and review of the resident's ADL needs. The new assistant will introduce the resident to his/her new roommate(s) and orient the resident to the new room.

3. The licensed nurse will give verbal report to the receiving nurse (medication and care orders, resident care plan information, general condition and vital signs, medications administered and treatments done), will transfer all medications and treatment supplies, and will document that the transfer of the resident and all belongings has occurred and include the new room and bed number.

Post-Transfer:

1. The nursing assistant receiving the resident will complete admission to the room, safely store resident belongings and appliances for use, and will implement appropriate records maintained in the resident's room.

2. The licensed nurse receiving the resident will introduce self, document the admission in the Electronic Health Record, and notify the Dietary Department of the change in room.

3. The nursing assistant transferring the resident will check the resident's old room for any overlooked belongings (ensure that the bedside stand, closet and drawers are empty), and will remove all linen from the resident's old bed to prepare for cleaning.

4. The licensed nurse transferring the resident will document completion and assignment change in the Electronic Health Record, and will notify Housekeeping of the need to terminally disinfect the resident's old room.

5. Social Services and Nursing will monitor and assist in the adjustment of the resident and roommate(s) to the change, as well as the responsible parties.

GUIDANCE 483.10(e)(4)-(6)

Residents have the right to share a room with whomever they wish, as long as both residents are in agreement. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.

There are some limitations to these rights. Residents do not have the right to demand that a current roommate is displaced in order to accommodate the couple that wishes to room together. In addition, residents on DP/SNF are not able to share a room if one of the residents elects to pay privately for his or her care, or one of the individuals is not eligible to reside in a nursing home.

Moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of the facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move.

A resident receiving a new roommate should be given as much advance notice as possible. The resident should be supported when a roommate passes away by providing time to adjust before moving another person into the room. The length of time needed to adjust may differ depending upon the resident. Facility staff should provide necessary social services for a resident who is grieving over the death of a roommate.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10(e)(4)-(6) United States of America, Med Pass Inc., Rev 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17.

SUBJECT: **VAC THERAPY- NEGATIVE PRESSURE WOUND THERAPY SYSTEM DPSNF**	SECTION: **Page 1 of 12**

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

PURPOSE:

The purpose of this policy is to provide guidelines on how to identify residents who would benefit from Vacuum Assisted Closure (V.A.C.) Therapy. This policy provides instruction on how to initiate treatment, conduct continuous monitoring, and discontinue therapy.

Vacuum Assisted Closure Therapy is utilized to:

- Promote rapid granulation tissue formation by increasing blood supply to the wound.
- Remove excessive interstitial fluid, bacteria and wound exudates.
- Convert an open wound to a closed moist wound-healing environment.
- Identifying and evaluating risk factors and changes in the patient's condition that would warrant removal of the V.A.C. (i.e. hemorrhage).

DEFINITION:

V.A.C. therapy is non-invasive active therapy utilizing a controlled localized sub-atmospheric/negative pressure which is applied directly to the wound. The V.A.C. may be applied to one or more wounds to supply negative pressure therapy. The V.A.C. increases blood supply to the wound thereby promoting granulation tissue formation. It stretches cells, enhances epithelial migration and converts an open wound into a controlled closed moist wound healing environment. The V.A.C. removes excessive interstitial fluid, bacteria and wound exudate into a disposable V.A.C. canister.

POLICY:

The wound V.A.C. Therapy program will include:

- Identification of patients whose wound(s) qualifies for V.A.C.
- Monitoring the effectiveness of the V.A.C. each dressing change
- Discontinuance of the V.A.C. if there is no evidence of wound healing
- All licensed nursing staff (i.e. RN, LVN) will complete an initial V.A.C. competency on hire and an annual competency thereafter which includes application, maintenance and troubleshooting.

AFFECTED PERSONNEL/AREAS: *PHYSICIANS, REGISTERED NURSES (RNs), LICENSED VOCATIONAL NURSES (LVNs)*

PROCEDURE:

A. The wound will be assessed by the RN Wound Specialist or Physician. An order will be written with the following information included:

1. When to initiate V.A.C. therapy
2. Location and number of wounds to receive V.A.C. therapy
3. Negative pressure setting in mmHg (125 mmHg) or desired pressure. If no pressure setting is specified, the default setting of 125 mmHg will be delivered until clarification can be obtained.
4. Mode of therapy (Continuous or Intermittent). If no mode of therapy is written, the default setting of Continuous will be delivered until clarification can be obtained.
5. Size and type of wound dressings.

B. Contact KCI at 1-800-275-4524 to initiate the process of ordering the Wound V.A.C. along with appropriate resident supplies. **Please note that it may take some time to obtain insurance authorization for V.A.C. use.**

C. A qualified, competent staff member will apply the V.A.C.

D. KCI is to be notified immediately upon discontinuance of V.A.C. therapy so billing can be stopped and arrangements can be made for V.A.C. pickup.

E. Nursing will return the V.A.C. pump to the "dirty" side of Central Processing when V.A.C therapy is discontinued. If Central Processing is closed, the V.A.C. will be placed in the dirty utility room and the day shift unit clerk advised so that it can be returned during normal business hours.

NEGATIVE PRESSURE WOUND THERAPY CONSIDERATIONS

1. **Indications:**

- Acute surgically dehisced wounds (Orthopedics)
- Traumatic Wounds
- Dehisced Incisions
- Pre/Post Split Thickness Meshed Grafts and Flaps
- Stage III and IV Pressure Ulcers

- Enteric Fistulas
- Partial-Thickness Burns

2. **Contraindications:**

- Presence of necrotic tissue
- Greater than 30% necrotic tissue (slough) present in the wound
- Untreated Osteomyelitis (May initiate V.A.C therapy 24 hours after initiation of systemic antibiotic therapy)
- Cancer within the wound bed or its margins
- Unexplored non-enteric fistulas
- DO NOT place foam dressing directly over exposed veins or arteries

3. **Precautions:**

- Uncontrolled active bleeding
- Difficult hemostasis of wound
- When anticoagulants are being administered
- Enteric Fistula
- When placing the dressing in close proximity to blood vessels, ensure all vessels are adequately protected with overlying fascia, tissue, or other protective barrier.

4. **Documentation:**

The following will be documented in the medical record **in the EMR:**

- Measurement and documentation of the wound's length, width and depth along with undermining/tunneling must preclude V.A.C placement and must occur weekly.
- Initiation of V.A.C, including therapy mode, negative pressure setting and type of foam used (Black, Silver or White)
- Dressing changes (M-W-F or Tu-Th-Sat)

- Number of foam pieces used inside the wound
- Drainage amount, if applicable
- Resident tolerance (pain), daily
- Appearance of dressing (raisin-like) on days when dressing change is not due
- Discontinuance of V.A.C.

GUIDELINES FOR SPECIFIC WOUNDS AND MACHINE SETTINGS (To be determined by RN Wound Nurse or MD):

1. Acute Wounds and Pressure Injuries: Cycle: Continuous
   Target Negative Pressure: 125 mmHg
   - Consider Intermittent Cycle mode when drainage decreases and minimal change in wound dimension occurs.
2. Surgically Created and Wound Dehiscence: Cycle- Continuous
   Target Negative Pressure- 125 mmHg
   - Consider Intermittent Cycle mode when drainage decreases and minimal changes in wound dimensions occur.
3. Meshed Grafts: Cycle: Continuous
   Target Negative Pressure: 75-125 mmHg
   - Initial dressing change is performed 4-5 days and drainage is minimal.
   - Place a single layer of non-adherent, Adaptic dressing between the skin graft and black foam.
   - White foam may be indicated.
4. Compromised Flaps: Cycle: Continuous
   Target Negative Pressure: 125 mmHg
   - Check for flap/base adhesion and edema reduction
   - White foam may be used with pressures 125-175 mmHg
5. Chronic Ulcers: Venous Stasis, Arterial Insufficiency and Neuropathic Ulcers
   Cycle: Continuous
   Target Negative Pressure: 50-125 mmHg

- White foam may be used with Target Pressures 125-175 mmHg

6. Wound Undermining:

- Fill undermined areas with foam. DO NOT over pack such that capillaries may compress.
- Irrigation and aggressive wound cleansing with each dressing change is recommended.

7. Tunneling:

- White foam is moist and dense, therefore recommended when placing in narrow areas.
- Insert foam until it reaches approximately 1 cm from distal end of tunnel.
- Be sure to extend foam outside of tunnel to allow for easy removal.

Note: V.A.C. dressing should never be used in conjunction with wall or other suction devices.

DRESSING CARE AND MANAGEMENT (Aseptic Technique):

Supplies needed:

- V.A.C. Pump
- V.A.C. Dressing Kit of choice that includes foam dressing, transparent/occlusive drape and TRAC pad
- Wound Cleanser
- Scissors
- Towels and/or gauze to maintain a dry peri-wound area
- Skin Prep
- Gloves
- Optional- clippers to clip hair, Y-connector to connect multiple wounds

Dressing Application Using Aseptic Technique:

- Aggressively clean and irrigate wound with wound cleanser

- Achieve hemostasis
- Clip hair around border if needed
- Dry peri-wound area. Skin prep to be applied to secure occlusive drape
- Cut foam dressing to shape and size of wound, if necessary
- Gently place the foam into the wound. DO NOT PACK the wound tightly.
- Multiple pieces of foam dressing may be used when faced with a large or odd shaped wound as long as foam touches foam. This will ensure collapse of the foam when negative pressure is applied
- When cutting foam, make sure to remove excess foam fragments that may become embedded into granulation tissue
- Cover the foam and surrounding healthy tissue with the occlusive drape
- Cut a portion of the occlusive drape where the TRAC pad is to be placed. The cut should measure the size of a nickel or quarter. Take care in positioning tubing near areas of bony prominence.
- Position clamps away from patient to avoid additional source of pressure

Undermining Wounds

- DO NOT over pack the dead space created by undermining. Gently fill it. Over packing can cause capillary compression which prohibits adequate wound perfusion.
- Fill the distal portion of the undermined area first, remembering to stop about a centimeter from the wound wall to allow granulation tissue to form.

Tunneling Wounds

Tunneling can result in abscess formation when the main body of the wound heals and closes the entrance to the tunnel. To avoid this from happening, the white foam should be inserted into the tunneled area approximately a centimeter from the distal end of the tunnel. Leave a portion of the foam extending beyond the surface to allow for easy removal. Record the number of individual foam pieces to ensure the total number gets removed during the next dressing change. The white foam is soft, moist and dense which allows for easier insertion and removal from tunneled areas.

Wounds Small in Diameter

Frame outer wound edge with skin prep and V.A.C. drape. Place foam dressing inside wound and lay a large piece of foam directly on top making sure that foam touches foam. Cover foam with V.A.C. drape and apply TRAC pad after creating a nickel or quarter size opening in drape.

Multiple Wounds (Contact wound nurse for assistance):

When treating multiple wounds, a "Y" connector can be inserted into the system as along as the surface area of total wounds does not exceed the V.A.C. pump's ability to achieve an adequate negative pressure seal.

Wounds that are in close proximity to one another may be dressed using the "bridging" technique. The advantage to this technique is that multiple wounds can receive therapy with the use of only one TRAC pad.

- It is critical to protect intact skin between the wounds with skin prep and the clear V.A.C drape to prevent breakdown of healthy tissue from constant negative pressure and moisture applied through the porous dressing.
- Cover each wound with the VAC foam dressing of choice. Attach an additional piece of foam between wound(s), acting as the "Bridge." Remember to place foam on top of the V.A.C. drape and ensure that foam touches foam in order to achieve proper collapse of the foam when negative pressure is initiated.
- Apply the TRAC pad to only one of the foam dressings. When negative pressure is applied, evaluate the entire area to ensure that collapsing of all foam is achieved.

Maintaining an airtight sealed dressing:

To assure optimal outcomes in utilizing the V.A.C., an airtight dressing seal is critical. The following techniques will be helpful in achieving a tight dressing seal.

- Dry the peri-wound area thoroughly. Use skin prep to prepare the area before applying the clear occlusive drape.
- Frame the wound with the skin prep when the skin around the wound is delicate or convoluted.
- Reduce the height of the foam dressing by cutting or beveling the edges when treating shallow wounds or wounds near the perineal area.

Fecal Incontinence:

When a tight seal is difficult to achieve on a resident who has fecal incontinence and the wound is in the sacral, coccyx or perineal region, the following techniques may be helpful in achieving a tight dressing seal.

- Utilize a fecal collection bag or a rectal tube with a collection device.
- Frame the wound with skin prep and V.A.C drape. May frame the wound with Stoma adhesive as well.
- RN Wound Specialist to consult the physician about the possibility of a temporary ostomy until the wound heals or improves.

Dressing changes:

Dressing changes are performed every forty-eight to seventy two hours by competent and qualified personnel. Deviations from the 48-72 hour dressing are as follows:

- Infected Wounds-(bacterial count > 10 to the 5th power) Dressing changes are to be performed every 12 hours. When the bacterial count decreases to < 10 to the 5th power, or clinical signs of wound improvement are present, resume dressing changes every 48 hours.
- Status Post Graft- Perform dressing change every 4-5 days

Dressing Removal:

- Raise tubing above V.A.C. pump to allow the pump to pull exudate remaining in the tubing into the canister.
- Press the Therapy ON/OFF button to deactivate pump.
- Clamp both dressing and canister clamps.
- Gently remove occlusive drape. The drape may be stretched horizontally to release the adhesive which allows for gentle removal when sensitive skin is present.
- If dressing adheres to the base of the wound:
  - Consider a single layer of Adaptic or White foam between the wound base and foam dressing.
  - Turn V.A.C. pump off. Inject foam with wound cleanser or normal saline. Allow the foam to become completely saturated. Wait 5-15 minutes prior to removal of dressing.
- If pain is present during dressing changes, turn the V.A.C. pump off. Inject the foam with 1-2% Lidocaine. Wait 5-15 minutes prior to removal of dressing.

Canister Changes:

The canister is to be changed every five days or prn when full. The canister is self-contained and cannot be emptied.

- Close both dressing and canister clamps.
- Disconnect canister tubing at the male/female connector.
- Push the canister release button on the pump. This releases the canister, which can now be removed from the pump.
- Dispose of the canister in the appropriate receptacle per hospital policy.

CARE AND SAFETY RECOMMENDATIONS:

- Keep NPWT ON- V.A.C. therapy must be applied to the wound at least twenty-two hours a day. Should therapy be interrupted for more than two consecutive hours, the entire dressing must be changed to avoid bacterial colonization in the foam dressing.
- Dressing Changes- Always use sterile unopened foam disposables when performing dressing changes. Do not "save" foam after package is opened. It is acceptable to use excessive occlusive drape.
- Daily Wound Care- Inspect wound frequently. Visually observe the VAC dressing to assure that it has the collapsed appearance of a raisin. Review the pump screen to verify proper negative pressure setting and mode of therapy. Watch for signs/symptoms of infection (fever, redness, increased warmth to wound area and purulent discharge or strong odor.
- Discomfort- Consider lowering the V.A.C target pressure. A physician order is required.
- Wound Appearance- A steady decrease in wound volume should be noted. Initially the wound may appear larger due to the wound edges softening and the reduction of edema. The wound may appear paler as the amount of collagen in the wound increases.
- V.A.C. Pump Operation

Buttonology:

- Power Switch- Provides electricity to the V.A.C. pump.
- Main Screen: Shows the operator Utility button, Therapy button, battery status, whether or not AC power is in use, current negative pressure being measured at the wound site, Therapy mode, Lock Out status and (?) Help option.

- Lock out button is activated or deactivated by pressing and holding the Lock symbol on the display screen for three seconds.
- Therapy Screen: Shows the operator
  - On/Off button- Turns the negative pressure on and off
  - Target pressure display
  - Arrow buttons- Adjusts the negative pressure, changes intermittent therapy intervals and controls the intensity of the initial collapse of foam.
  - Intensity button- Sets the rate of negative pressure change at the wound bed, after initiating therapy. The lower the intensity, the more comfortable it is for the patient as the dressing draws down.
  - Continuous and Intermittent mode buttons.
- Utilities Screen:
  - Gives the operator five different options
  - About
  - Cleaning
  - Hour Log
  - Service
  - Options

ALARMS:

There are a total of five alarms. Each alarm will be displayed on the LED screen when it is activated and there will be a prompt to troubleshoot the alarm condition.

1. Leak- The screen message will display- Tubing and/or dressing has leaks

Action: Check that the canister is securely connected to the dressing. If that does not resolve the alarm condition, apply pressure with your fingers around the dressing and clear occlusive drape. When the leak is located and sealed, the dressing will collapse. It may be necessary to cut away the drape and reapply drape to area to achieve an effective seal.

- If the alarm condition is not corrected in two minutes, the audible alarm will sound.
- If the alarm condition is not corrected, the pump will shut down five minutes after the audible alarm is activated.

2. Tubing blocked- The screen will display - Tubing is blocked

Action: Ensure tubing clamps are open and check that the tubing is not kinked or pinched.

3. Canister Full- The screen will display- Canister full. The canister has reached the maximum capacity of 500ml

Action: Turn pump off. Clamp and disconnect the canister from the dressing tubing. Remove the canister and dispose of it per hospital policy. Insert a new canister and reconnect it to the dressing tubing. Open the clamps. Activate the pump. Observe the dressing for proper compression. The dressing should appear "raisin-like."

4. Therapy is not activated - The screen will display - Therapy not activated

Action: Turn therapy on.

5. Low Battery- The screen will display - Battery is low

Action: Plug the AC cord into a red electrical outlet. Be sure that the plug to the pump unit is also firmly attached.

6. Back Up Battery Operation:

The backup battery will be automatically activated when the pump is disconnected from the AC source. The plug symbol will disappear from the screen. Once the V.A.C. is plugged into the AC source, the unit will begin recharging.

- Average battery life is approximately four hours.
- Average time to recharge the battery is four hours to reach 85% charge capacity and approximately ten hours to achieve full charge.
- The battery life is represented by the battery symbol on the display screen. The lines inside the battery symbol represent the battery time remaining. Each line has a value of one hour.
- Automatic pump shutdown will occur when the battery has reached a critical level. The pump will remain off even when AC power is restored. The operator must flip the green power button to regain pump function.

7. Mute button- silences the alarm for two minutes

REFERENCE:

- Thomson Reuters (2019) Barclay's California Code of Regulations, §72315 (7), 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.

- KCI The Clinical Advantage, San Antonio, Texas, 78219. Retrieved from www.kci1.com.

- Negative Pressure Wound Therapy with Instillation: International consensus guidelines update. Kim PJ, et al. Int Wound J. 2020. PMID 31667978.

Senior Leadership Team	10/22/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	10/22/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
October 22, 2024
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 ↓
• Contingency Plan for Water Damaged Medical Records	2	
• Ergonomic Awareness	3-7	
• Medical Records Storage and Safe Keeping	8-9	
• Review and Query Process for Clinical Documentation Improvement (CDI) Program	10-19	
Plans:		
• HIM Coding Compliance Plan	20-24	
Proposal		
• Sierra View Local Health Care District 403 (b)	25-36	

SUBJECT: **CONTINGENCY PLAN FOR WATER DAMAGED MEDICAL RECORDS**	SECTION: **Page 1 of 1**

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

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide a contingency plan in the event that records are damaged due to water damage. Any type of damage is destructive. Water damage from flood or fire can be most devastating.

PROCEDURE

1. The following procedures should be implemented as soon as the water is removed and the amount of damage is assessed.

    a. Determine what documents should be rescued using the retention requirements.

    b. Prioritize which records should be removed first in order to keep the hospital functioning.

    c. Records are to be removed within 48 hours of damage to prevent mold, mildew and bacteria growth.

    d. Depending on the degree of damage, the records can be restored by:

        - Air drying the records by placing absorbent material between each document and then using fans for increased air circulation.

        - Freezing the records and keeping them in cold storage. This process stops the deterioration of handwritten data on paper records.

        - Freeze-drying is the quickest and most expensive method. It is only for optimal preservation of original records that are totally irreplaceable.

        - Remember that time is a critical factor. Move as quickly as possible to recover damaged information.

REFERENCE:

- California Code of Regulations, Title 22, § 70751

SUBJECT: **ERGONOMIC AWARENESS**	SECTION: **Page 1 of 5**

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

PURPOSE:

To establish an ergonomics policy and program that guides Sierra View Medical Center (SVMC) in prevention measures for work-related musculoskeletal disorder (WMSD) injuries. When WMSD injuries result from a repeated task, process, or operation/actions performed over time by an employee, they are referred to as a Repetitive Motion Injury (RMI).

RMI occurs in healthcare settings from repeated tasks that cause wear and tear over time on the soft tissues of the body. Use of ergonomic principles can help to identify risk factors for injury and design safer work tasks, tools, technology and environments which can eliminate or minimize RMI.

This policy is based on current evidence-based practice and requirements of the California Ergonomics Standard, California Code Regulations (CCR) Title 8, § 55110 – Repetitive Motion Injuries (RMI).

POLICY:

Sierra View Medical Center places a high value on the safety of its employees and patients. SVMC is committed to supporting employee health, safety, and wellness by providing ergonomic education and worksite and job evaluations. Likewise, employees are expected to commit to their own responsibility for health and safety of self, co-workers and patients, by adhering to the outlined policy and procedures and complying with any ergonomic recommendations given during evaluation and education.

WMSD are major cause of injury for many healthcare workers. All professions in the healthcare industry have potential to be exposed to WMSDs. Force, duration, repetition, posture, and vibration are all risk factors that can contribute to WMSDs. All work-related injuries are to be reported by employees and documented by Employee Health. In addition, injury trends and risk factors will be identified and controlled, as is reasonably practicable, and employees trained and monitored for effective prevention measures

AFFECTED PERSONNEL/AREAS: *ALL SIERRA VIEW MEDICAL CENTER (SVMC) EMPLOYEES*

DEFINITIONS:

Ergonomics - The scientific discipline concerned with the understanding of interactions among humans and other elements of a system (people, tools, technology, tasks, and environment), and the profession that applies theory, principles, data, and other methods designed to optimize human well-being and overall system performance.

Injury trends – Injuries occurring to more than one employee, by the same cause, while performing a job process, or operation of identical or similar work activity.

Repetitive Motion Injuries (RMI): Musculoskeletal injuries that occur over time and cause wear and tear on the muscles, tendons, ligaments, and nerves and are objectively identified and diagnosed by a

licensed physician or medical provider licensed to diagnose musculoskeletal disorders. Other names for RMI include repetitive strain injuries, repetitive stress injuries, cumulative trauma disorders, and overuse disorder / injury.

Work-related Musculoskeletal Disorders (WMSD): Injuries sustained while performing work that affect the muscles, tendons, ligaments, nerves, joints, blood vessels, spinal discs and other soft tissues of the body. WMSDs can be repetitive or from a single event.

Responsibilities:

1. Senior Leadership / Directors:

    i. Ensures that processes and funding are in place to 1) Perform ergonomic assessments and 2) Manage the risk factors associated with WMSDs, 3) Fund the adaptation or redesign of the worksite/work task, and 4) Provide ergonomic education to all employees.
    ii. Oversees responsibility for assigning a person(s) responsible for ergonomics program oversight.
    iii. Communicates in a format understandable by all employees about safety and health topics related to WMSDs and ergonomic interventions.

2. Ergonomics Program Administrator / Employee Health Supervisor

    i. Develops, manages and evaluates, at least annually, the ergonomics program.
    ii. Performs or arranges for performance of preventive and workers compensation ergonomic assessments of employees and gives a written report to the supervisor/ manager and employee to follow.
    iii. Ensures all new employees receive ergonomics education on risk factors specific to their job.
    iv. Provides employees continual access to ongoing education on ergonomics by several means: annual classes, intranet resources, local departmental and system resources (handouts, ergonomics champions) or in-servicing where WMSD injury trending is occurring.
    v. Establish a list of approved ergonomic equipment that can be purchased.
    vi. Collaborate as needed to provide ergonomic input into any new construction or remodeling projects.
    vii. Analyze the injury data pertaining to WMSD injuries, review and / or participate in injury investigations.
    viii. Communicate and collaborate with leadership on implementation of risk factor remediation strategies.

3. Managers / Supervisors:

    i. Ensures that all new employees receive ergonomics education and resources for understanding how to set up their worksite correctly to prevent WMSDs.
    ii. Respond promptly to schedule an ergonomic assessment upon employee request within 3 days. [].
    iii. Provide time during the ergonomic assessment of an employee that they are free from work duties and can participate.
    iv. Coordinate purchase of ergonomic equipment and arranges for installation as recommended by the assessment process in a timely manner [Preferrably within 2 weeks, supply chain accessibility may delay this timeframe].
    v. Ensure that employees comply with ergonomic recommendations made during an assessment.

4. Employees:

    i. Promptly report all known hazards / risk factors present in your job to your supervisor or managerand complete an electronic incident report.
    ii. Promptly report / document any work-related WMSDs / injuries and notify your supervisor or manager.
    iii. Attend new employee training for ergonomics.
    iv. Notify your supervisor or manager of the need for an ergonomic assessment.
    v. Comply with any ergonomic recommendations or equipment use advised during your ergonomic assessment.

2. PROCEDURE:

1. Ergonomic Assessments:

    i. **Preventive Ergonomic Assessments** will be provided for any employee requesting a worksite or job evaluation due to discomfort, pain or adaptation needed to perform their job safely. The employee must notify their supervisor or manager of the request. The supervisor / manager is responsible for promptly (3 days) arranging / requesting an ergonomic assessment, providing time free of work duties for the employee to attend the assessment and facilitate purchase and installation of the recommended equipment. A written report with recommendations should be given to both the manager and the employee and kept on file as long as the employee works for the organization.

    For computer workstations, employees should first go through a self-assessment process using provided resources (handouts, checklists, online education) to learn how to adjust their equipment or notify the supervisor / manager of equipment

needs. If further intervention is required, or employee is still experiencing discomfort, an ergonomic assessment should be ordered.

ii. **Workers Compensation Ergonomic Assessments** as needed should be performed by a competent assessor outside the organization to prevent conflict of interest. The supervisor / manager is responsible for promptly (3 days) arranging / requesting the assessment, providing time free of work duties for the employee to attend the assessment, and facilitating purchase and installation of the recommended equipment. A written report with recommendations should be given to both the manager and the employee and kept on file for as long as the employee works for the organization.

2. **Hazard / Risk Factor identification:**

i. Use of a safety hierarchy of controls should be used to remediate risk factors found during a worksite assessment or job assessment.
   1. **Eliminate** – physically remove the hazard.
   2. **Substitution** – replace the hazard with a different product or procedure.
   3. **Engineering Controls** – isolate people from the hazard.
   4. **Administrative Controls** – change the way people work; providing and enforcing breaks, job rotation, and job enlargement.
   5. **Personal Protective Equipment (PPE)** – protect the worker from the hazard by use of a PPE.

3. **Training:**

i. **New Employee Training:** All new employees will receive ergonomics education specific to their work tasks, tools, technology and environments. Education should contain at a minimum:
   a. Information about Sierra View's program on ergonomics.
   b. Information on how to find ergonomic resources including how to request an ergonomic assessment of their worksite or work tasks.
   c. How to identify WMSD / RMI risk factors, known exposures that may occur with their job and current means of prevention that are utilized.
   d. Symptoms associated with WMSDs / RMI and consequences of injuries.
   e. Importance of reporting symptoms and injuries promptly to their manager / supervisor.

f. Training can be accomplished by 1) Oral presentations, 2) Videos 3) Distribution of written material 4) Online learning modules 5) Hands-on training, or any combination of above.

ii. **Refresher training:** Resources will be made available for ongoing employee self-help and annual refresher training. Training can be accomplished by 1) Oral presentations, 2) Videos 3) Distribution of written material 4) Online learning modules 5) Hands-on training or any combination of above. It must cover, at a minimum, the initial information.

4. **Record Keeping:**

i. Documentation of new and refresher retraining should be recorded and kept for a period of two years.
ii. Ergonomic assessments should be kept on file for as long as the employee is employed by SVMC.

5. **Program Review:**

i. A written review of the Ergonomics Program will be done annually by the program administrator / manager. The annual assessment will be shared with Senior Leadership and frontline employees. Minimal assessment inclusion should be the number of ergonomic assessments performed by type, percentage of employees trained (both new and refresher), and WMSD / RSI injury and first aid analysis. Different locations within the organization should be summarized individually and system trends should be evaluated.

REFERENCES:

- California Ergonomics Standard, California Code Regulations (CCR) Title 8 (2000), §5110 – Repetitive Motion Injuries (RMI). October 2024
- CDC (2022). *2016 Survey of Occupational Injury and Illnesses Charts Package*. https://www.bls.gov/iif/osch0060.pdf. October 2024
- What is Ergonomics? (2018). Definitions *and Domains of Ergonomics.* International Ergonomics Association Website. https://iea.cc/about/what-is-ergonomics October 2024

SUBJECT: **MEDICAL RECORDS - STORAGE AND SAFEKEEPING**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the Medical Record Storage policy for Sierra View Medical Center (SVMC) and all affiliated facilities including, but not limited to, the Ambulatory Surgery Department (AHD), Cancer Treatment Center (CTC), Wound Healing Department (WHD) and Rehabilitation Services to specify what measures will be taken to ensure the safekeeping of the medical records.

POLICY:

1. It is the facility's policy to file the patient medical record in an easily accessible manner within its facilities or in an approved medical storage facility off the hospital premises.

2. All primary health records shall be housed in physically secure areas under the immediate control of the Director of Health Information Management (HIM).

3. All original health records will be scanned into the electronic health record.

4. All original medical records once incorporated into the electronic health record will be destroyed after 90 days from date of discharge.

5. It shall be the responsibility of the hospital, through its Director of HIM, to safeguard the information in the record against loss, defacement, tampering, used by unauthorized persons and damage by fire or water. The following measure will be taken to ensure this:

    a. Access to hospital areas that house health information records shall be limited to the HIM Department personnel and other authorized individuals.

    b. Medical Records shall be kept in secure areas at all times.

    c. Smoking will not be allowed in any area housing health records.

    d. Medical record storage areas will be equipped with a sprinkler system in case of fire.

    e. In the event of internal disaster, medical records will be stored until they can be safely transferred back to Sierra View Medical Center.

6. All individuals engaged in the collection, handling or dissemination of patient health information should be specifically informed of their responsibility to protect patient confidentiality.

7. Secondary records, indices or other maintained health information, which can be individually identifiable, shall be subject to the institutional policies for the maintenance or confidentiality of patient health information.

8. Access to storage facilities off Sierra View Medical Center's premises shall be limited to HIM personnel authorized in writing for such access. A copy of each authorization shall remain on file

in the HIM Department and a copy of the authorization shall be furnished to the off-site storage facility.

9. When in use within the hospital, health records shall be always kept in secure areas. Health records shall not be kept unattended in areas accessible to unauthorized individuals.

AFFECTED AREAS/PERSONNEL: *ALL HIM DEPARTMENT PERSONNEL*

REFERENCE:

- The Joint Commission (2024). Hospital accreditation standards. IM.02.01.03. Joint Commission Resources. Oak Brook, IL.

CROSS-REFERENCES:

- Rehabilitation Department P&P – "PHYSICAL AND SPEECH THERAPY MEDICAL RECORDS STORAGE AND SAFE KEEPING "
- Laboratory P&P – "LABORATORY RECORDS – STORAGE & RETENTION "

SUBJECT: **REVIEW AND QUERY PROCESS FOR CLINICAL DOCUMENTATION IMPROVEMENT (CDI) PROGRAM**	SECTION: **Page 1 of 10**

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

PURPOSE:

To establish processes to clarify documentation regarding diagnosis, conditions and/or procedures that are representative of the patient's severity of illness, risk of mortality, and resource consumption during an inpatient hospitalization.

To define when a query will be initiated and outlines the appropriate query processes to be utilized. Appropriate querying will improve the accuracy, integrity and quality of patient data; minimize variation in the query process; and improve the quality of the physician documentation within the body of the medical record.

DEFINITIONS:

1. Query: an established mechanism of communication between CDI Specialists/Coders and physicians to clarify ambiguous, incomplete or conflicting documentation in the medical record.

2. Concurrent Query: a query that is initiated during the patient's hospital admission/episode of care prior to discharge.

3. Retrospective Query: a query that is initiated after the patient has been discharged from the facility, but before the claim has been billed.

4. Post Initial Billing Query: a query that is executed within 12 months of the discharge date as a result of additional documentation (e.g., discharge summary) being added to the record or findings during a retrospective coding review (internal or external) that occurs after the claim has been billed.

POLICY:

A. Sierra View Medical Center workgroup members, consisting of Clinical Documentation Improvement Specialists (CDIS), Coders and providers of care will follow appropriate process to generate a query either concurrently or retrospectively consistently.

B. CDIS/Coders will initiate queries as appropriate when documentation within the medical record fails to meet one of the following criteria: legibility, completeness, clarity, consistency, and/or precision.

C. Ensure control processes are implemented to minimize potential compliance risks.

D. Improve the quality of the physician documentation within the body of the medical record.

E. Accurately reflect the patient's clinical picture for severity of illness and risk of mortality.

F. Promote accurate ICD-9-CM/ICD-10-CM/PCS code assignment and/or Present on Admission (POA) Indicator;

G. Ensure appropriate reimbursement based upon the acceptable medical record documentation.

AFFECTED PERSONNEL/AREAS: *HIM CDI, HIM CODERS, MEDICAL STAFF, NURSING STAFF*
PROCEDURE:

1. Review Process

   a. The CDI Specialist (CDIS) will identify patients for review using the Daily Review Worklist from 360 Encompass. CDIS will prioritize reviews based on incomplete documentation of the following:

      i. New admissions
      - Medicare
      - Medi-Cal
      - Commercial

      ii. Surgical Major Complications or Comorbidities (MCC)/ Complications Comorbidities (CC) Opportunity Cases

      iii. Medical MCC/CC Opportunity Cases

      iv. Signs & Symptoms Diagnostic Related Groupings (DRGs)

      v. Unanswered Queries

   b. Records will be reviewed within 48 hours of admission, excluding weekends and holidays. Admissions from the weekend will be reviewed on the next business day.

   c. The CDIS will document pertinent clinical findings:

      i. Concurrent Reviewer

      ii. Type of Review – Initial or Continued Stay

      iii. Review Date

      iv. Signs/symptoms, assessments, consults, vital signs

   d. The CDIS will identify the working DRG assignments using 3M Coding and reimbursement systems with 360 Encompass by assigning codes for documented conditions and procedures which will compute/group to provide:

      i. Working Principal diagnosis

ii. Working Secondary diagnosis

iii. Working Principal procedure

iv. Working Secondary procedure

e. Continued stay reviews are conducted to identify additional opportunities for accurate reflection of SOI/ROM and daily if a symptom DRG is assigned, w/out MCC or CC or if query left on previous visit. Continued stay reviews will be conducted with a frequency as determined by the existent documentation and clinical status. Generally, each case will be reviewed at least every three (3) days with variation from daily to weekly.

f. The CDIS should seek input/assistance from another CDIS or the HIM Manager for reviews that are very complex and/or need additional time due to the complexity of the review.

g. When there is a difference of opinion about post-discharge coding between the CDIS and Coding Professional, the following process will be followed:

i. The CDIS and Coder discuss and attempt to resolve

ii. If unable to resolve the difference of opinion, the conversation is referred to the HIM Manager or HIM Director for review and summary of the opinions will be provided

iii. The final decision regarding coding practice rests solely with the HIM Manager and/or HIM Director

2. Post Discharge Outstanding Query Reconciliation

a. The CDIS will run the Discharged Open Queries work list each day. The reviewer will check to see if a discharge summary has been dictated or the query answered and if so, will access 360 and update the response field.

b. If there's no discharge summary, or if there's a discharge summary but the query is still unanswered, the query will be processed by the Document Imaging Specialists and forwarded to the physician's incomplete area for completion. The physician may answer the query which will become a permanent part of the medical record.

c. Alternatively, the physician may tell the CDIS they prefer to dictate an addendum to their summary to include the query response. The CDIS will check Meditech for this dictated response and when verified that it is on the account, will

i. Email the coding group to inform them of this action, and

ii. Inform the Transcription Coordinator to pull the query and clear the Incomplete Record.

3. Coding

a. After reviewing the record, the coder may identify a new query opportunity. In these cases they may create the query and follow the query reconciliation process stated above.

b. The coders will review, code, and abstract the chart, follow up on unanswered queries if applicable, and validate the DRG assignment in 360 Encompass and populate the reason.

4. Query Documentation

a. Sierra View Medical Center has developed and requires utilization of the approved standardized query forms. The approved query forms include all of the required data elements for an appropriate query. If there is a unique payer requirement that impacts the standard query form, the facility must contact the HIM Director immediately for resolution of query format discrepancies.

5. Query Format

a. The query process can be conducted and documented on a concurrent (pre-discharge), retrospective (post-discharge) or post initial billing (after billing) basis.

b. The query may be posed verbally, in writing, or electronically utilizing one of the approved and required standardized query forms; and must be maintained as part of the medical record.

c. Verbal queries must be documented in writing using approved standardized query forms. The physician must provide the response to the query and authentication within the body of the medical record. A query must not be posed to elicit only one response for a condition, diagnosis, procedure and/or POA indicator. It should never be the intent of a query to lead the physician to a particular outcome.

d. The query must include clinical indicators, provide reasonable options, and must include the ability to respond if no additional documentation or clarification can be provided. Clinical indicators supporting the query may include elements from the entire medical record.

e. The yes/no query format may only be utilized on approved standardized query forms that have the printed yes/no query responses. These query forms are to be used in the following circumstances:

i. Substantiating or further specifying a diagnosis already present in the health record

ii. Establishing a cause and effect relationship between documented conditions

iii. Resolving conflicting documentation from multiple practitioners

f. It is appropriate to ask the physician multiple questions if there are multiple conditions, diagnoses, procedures and/or POA indicators that require clarification, however, each question must be on a separate query form unless they are related. It is inappropriate for a CDIS or coder to ask multiple questions on one physician query form that are **not interrelated** as to the reason for the query.

g. The selection of the approved query form will be determined based upon the specific type of query that is being initiated.

6. Query Response

a. The query response from the physician that will be used to support CDI, a code and/or a POA indicator assignment must be documented by the physician in the body of the traditional medical record and/or, at a minimum, on the query form kept as a permanent part of the medical record. The traditional medical record is defined as the customary forms (e.g., discharge summary, H&P, consultation), based on the patient type, which are contained in the medical record to furnish documentary evidence of the course of the patient's illness and treatment during each hospital admission. The physician must have the ability to access the patient medical record prior to responding to a query. This medical record may be in paper or an approved electronic form.

b. For concurrent, retrospective and post-billing queries:

i. The response to a query (including the physician's documentation of the sign, symptom, condition, diagnosis, procedure, or POA indicator) must be documented by the physician and be signed, timed and dated with the date/time that the information is added to the medical record.

ii. It is not acceptable for a clinician to document a verbal response from the physician as a result of a query anywhere within the medical record.

iii. When the physician's response dictates a rebill, the rebill process must be initiated promptly.

c. Post initial billing query – the physician's response to a post initial billing query must be obtained within 2 weeks (14 calendar days) of the query initiation and must also be within 12 months of the patient's discharge date. If the physician's response to the post initial billing query generated is not obtained within 2 weeks, the query is neither considered nor acceptable for supporting the code/MS-DRG assignment.

d. When no additional documentation can/will be provided by the physician in response to a concurrent query, the query should be updated by the physician and/or person performing the documentation review that no additional documentation is warranted or will be provided.

7. Incomplete/Delinquent Record Count for a Record with a Query

a. At the time of coding, Coders will assess any unanswered concurrent queries to determine if a response will continue to be pursued. A determination to continue to wait for a response will be deferred to the HIM Director or HIM Manager.

b. Any chart awaiting a response to a query must be held according to the facility's delinquency timeframe. (see Delinquent Medical Records policy)

c. In no event should the timeframe awaiting a physician response be greater than timely payer filing requirements.

d. Records that are final abstracted (final billed) without a physician's response must be documented, tracked, monitored, trended and reported to the Utilization Review Committee on a quarterly basis.

8. Query Form Approval Process

a. The facility must submit the standardized query forms for approval following the process outlined in the Forms policy for adding forms to the medical record.

b. Should a new query need to be created or a current query need to be revised or updated, notification must be sent to the HIM Informatics Coordinator for completion.

c. All new and/or revised physician query forms must be submitted for HIM Director review.

9. Query Education and Tracking

a. The HIM CDIS and HIM Manager will educate the physicians on the importance of concurrent documentation within the body of the medical record to support complete, accurate, and consistent clinical documentation and coding.

b. Education will be provided to the medical staff that Coders or CDI specialist will query physicians when there are questions regarding documentation.

c. The concurrent query form and/or worksheet will be available to the coder to ensure knowledge of interaction and outcome.

d. Query tracking and trending must be performed for Coder and CDI generated queries. The trends will be assessed on a quarterly basis, but at a minimum, the analysis must be performed annually. The tracking must include the following outcomes for Coder and CDI Queries:

i. Sufficient documentation was provided in the medical record and no query was required.

ii. The clinical picture supported a diagnosis/procedure not documented by the physician and a query was required in order to obtain the appropriate documentation.

iii. The physician responded to the query form with either of the following:

1. The physician responded with additional documentation in the medical record/query form.

2. The physician responded "no".

3. The physician responded "unable to determine"

4. The physician did not respond to the query or answer the query within documentation of the medical record.

iv. The response was appropriately documented and authenticated.

e. Queries generated from the CDI program should be tracked and trended separately from Coder generated queries.

f. Performance metrics should be established to measure the outcome of the concurrent and retrospective queries. Consideration should be given to establishing baseline metrics as well as ongoing performance metrics. The following performance metrics could be considered, as applicable:

i. Percentage of patient population concurrently reviewed

ii. Percentage of physician queries with physician concurrence

iii. Percentage of physician query responses

iv. Total number of physicians queries issues and type of response received

v. Total number of retrospective coding queries issued

vi. Case Mix (CMI for the same month the year prior to implementation of CDI compared to CMI with CDI program)

vii. Severity of illness and risk of mortality scores

g. Trending information will be shared with administration and physician(s) trend(s) be included within physician education.

h. Results of query tracking must be available to Regulatory Compliance support upon request and include, at a minimum, the total number of queries for each query form generated concurrently for CDI and retrospective for coding including the four outcomes listed in item 7D within this policy.

10. Query Guidelines

a. The personnel responsible for performing and supervising the CDI and coding practices must understand and NOT:

i. Use the word "possible" in a query to a physician to clarify ambiguous, incomplete, or conflicting documentation unless referencing the term from specific physician documentation. The words probable, questionable, suspected or likely are acceptable in queries to clarify incomplete or conflicting documentation

ii. Generate queries to physicians that are not based on patient-specific clinical indicators

iii. "Lead" the physician by directing or sounding presumptive, by asking the physician to make an assumption or providing a query that is not supported by the clinical elements in the health record and/or directs the provider to a specific diagnosis or procedure. Indicate the financial impact or reimbursement of the response to the query on the query form

iv. Be rewarded financially or otherwise based on indicators that may lead to inappropriate queries or patterns. Examples of inappropriate indicators include:

1. Case Mix

2. Base case mix;

3. Complication and comorbidity (CC) and/or major complication and comorbidity (MCC) percentage

4. DRG Pair percentages or volumes

v. Make repeated attempts to clarify the physician's response to a query with the intent only to receive a particular outcome.

vi. Utilize a yes/no query format for a new diagnosis that may have clinical indicators present but are not yet documented in the health record.

11. CDIS and Coding Meetings

a. Meetings between CDIS and Coders will be held monthly. Meetings will include:

i. DRG assignment/coding issues, concerns or discrepancies in the final DRG selection

ii. Discussion of Alternate Principal Diagnoses offered by the CDIS and not selected by the Coder

iii. Process/Worksheet issues

iv. Physician issues/strategies

v. Changes in coding guidelines or significant Coding Clinic articles

vi. Opportunities to enhance clinical education

vii. 360 Encompass reports and trends

b. The HIM Manager will be responsible for chairing the meetings and recording the minutes.

REFERENCES:

- *Coding Clinic for ICD-9-CM* is the official publication of ICD-9-CM coding guidelines and advice as designated by four cooperating parties: American Hospital Association (AHA), American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

- *Guidelines for Achieving a Compliant Query Practice,* American Health Information Management Association (AHIMA), Chicago Illinois, February 2013.

- *Practice Brief on Continuous Clinical documentation improvement,* American Health Information Management (AHIMA), Chicago Illinois, May 2010.

- *Practice Brief on Managing an Effective Query Process,* American Health Information Management (AHIMA), Chicago Illinois, October 2008.

- *Practice Brief on Developing a Query Process,* American Health Information Management Association (AHIMA), Chicago, Illinois, October, 2001.

- *Practice Brief on Data Quality,* American Health Information Management Association (AHIMA), Chicago, Illinois, February 1996.

- *AHIMA Standards of Ethical Coding,* American Health Information Management Association (AHIMA), Chicago, Illinois, Revised December 1999.

CROSS REFERENCES:

- Clinical Documentation Improvement (CDI) Program

- *DELINQUENT MEDICAL RECORDS* – SVMC Policies and Procedures

SUBJECT: **HIM CODING COMPLIANCE PLAN**	SECTION: **Page 1 of 5**

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

SCOPE:

This policy applies to all Sierra View Medical Center (SVMC) personnel responsible for performing, supervising or monitoring of inpatient and outpatient coding services. This policy applies to diagnosis and procedure code assignment by Health Information Management (HIM) Coders for all inpatient and outpatient services.

PURPOSE:

The purpose of this policy is to affirm SVMC's commitment to ethical, complete, accurate and consistent HIM coding and documentation improvement.

POLICY:

This policy outlines the requirements for validating coding accuracy (e.g., ICD-10-CM, CPT, modifiers) and various types of inpatient reimbursement methodologies (e.g., MSDRG, APRDRG, etc.) for hospital inpatient and outpatient services.

DEFINITIONS:

A. **"AHIMA"** means the American Health Information Management Association. AHIMA is the national organization for HIM professionals. AHIMA is one of four parties that are responsible for establishing national ICD-10-CM coding guidelines.

B. **"HIM coding"** means short-term, DPSNF, or other affiliated departments based on coding and abstracting services on behalf of SVMC for the purpose of claim submission. SVMC HIM coding function includes assignment of any ICD-10-CM diagnosis (including present on admission (POA) indicator) or procedure code, assignment of any CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding 36415), designated HCPCS Level II codes, designated HCPCS modifiers, and designated CPT Category III Codes.

C. **"HIM Coder" or "Coder"** means a SVMC, telework employee, contractor, subcontractor, agent or other person who performs SVMC HIM coding. It also includes those employees or contractors involved indirectly, such as in a supervising or monitoring role, with the HIM coding.

D. **"Clinical Documentation Improvement Specialist" or "CDIS"** means a SVMC, telework employee, contractor, subcontractor, agent or other person who performs clinical documentation improvement duties. It also includes those employees or contractors involved indirectly, such as in a supervising, assisting or monitoring role, with clinical documentation improvement.

E. **"Office Guidelines"** means applicable portions of the following publications:

1. International Classification of Diseases, 10th revision, Clinical Modification, including addenda, conventions and instructions, (ICD-10-CM)
2. Current Procedural Terminology, including addenda, conventions and instructions, (CPT)
3. ICD-10-CM Office Guidelines for Coding and Reporting
4. Coding Clinic for ICD-10-CM
5. Coding Clinic for HCPCS
6. Online CMS manual system.

Each of the above publications is a CMS-approved reference for hospital inpatient and outpatient coding and reporting. CPT Assistant, while not an official CMS reference, provides additional nationally recognized guidance regarding CPT codes and shall be included as an "official guideline" by HIM Coders in areas not addressed by CMS-approved references.

F. **"Outpatient Procedure"** as used in this policy means any account with a HIM assigned CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding 36415, collection of venous blood by venipuncture), designated HCPCS Level II codes, designated HCPCS Modifiers, and designated CPT Category III codes. Note: Accounts in this group are not limited to those procedures performed in the operating room.

POLICY:

A. HIM coding is to be complete, consistent, accurate and compliant. SVMC must strive to code every patient's claim correctly and take reasonable and necessary efforts to achieve this outcome.

B. Any individual involved in HIM coding, and CDI must adhere to the AHIMA Standards of Ethical Coding, Official Coding Guidelines as well as applicable SVMC policies, and Coding Compliance procedures, processes and guidelines.

C. Each patient's account is to be released, or re-released, for billing only when all of the following are met:

1. All ICD-10-CM diagnoses and outpatient procedures CPT/HCPCS codes (including select modifiers) that are submitted for billing purposes under a SVMC provider number must be assigned by a HIM coder.
2. All ICD-10-CM diagnoses and outpatient procedure (CPT/HCPCS) codes reported on the patient's claim are supported by legible, complete, clear, and consistent provider documentation.

3. A sufficient clinical documentation set exists in the patient record from which to assign a complete set of codes.

4. Diagnosis and procedure codes are assigned and sequenced appropriately according to Office Coding Guidelines.

5. Other claim elements, including the discharge disposition code, admission status (inpatient or outpatient) and admit/discharge dates as recorded in the patient accounting system, correlate with documentation in the patient's medical record.

Accounts with identified discrepancies in one or more of the above areas must not be released for billing until the discrepancy is resolved and the account can be billed with an accurate and complete code set.

D. When a discrepancy is detected with the HIM coding on a previously submitted claim, SVMC must undertake reasonable efforts to correct the deficiency and prevent the defect from reoccurring on future claims. Overpayments must be corrected and resubmitted to the payer.

Each HIM coding staff shall have and maintain coding accuracy rates of 95% or as measured by periodic coding compliance audits. Coding staff who do not achieve the accuracy rate are subject to appropriate corrective action.

E. General Coding Compliance Policies

1. SVMC adopts the AHIMA Standards of Ethical Coding as the foundation of its Coding Compliance Program. All employees directly or indirectly involved in coding, clinical documentation and/or revenue cycle processes are required to abide by the AHIMA Standards of Ethical Coding. In addition, all CDI initiatives are to be guided by the AHIMA Ethical Standards of Clinical Documentation Improvement Specialists and the ACDIS Code of Ethics.

2. Physician Queries and Clinical Documentation Improvement Program. Refer to the *REVIEW AND QUERY PROCESS FOR CLINICAL DOCUMENTATION IMPROVEMENT (CDI) PROGRAM Policy and Procedure*.

3. HIM Coder Education and Training

   a. HIM Coders (and other pertinent staff as indicated) are required to complete training activities as assigned.

   b. HIM coders are required to complete the required CEU's to maintain their coding certification. SVMC may provide some educational resources such as audio conferences, which include CEUs. Coders are responsible for the maintenance of their credentials as required by their position.

4. Coding audits for coding accuracy will be conducted periodically. At the conclusion of the audit, investigation as to the causes of any coding discrepancies, remediation of potential claims made in error, education regarding trends identified, if any, and appropriate disciplinary action are to occur under the direction of the HIM Director.

5. The HIM Lead in collaboration with the HIM Director must ensure all new HIM coders (including newly hired and new contract coders) are provided orientation and training. Additionally, pre-bill coding reviews must be conducted until acceptable coding quality can be demonstrated.

6. SVMC permits final coding of inpatient accounts without a discharge summary. When the patient's payer reimburses based on DRG methodology (including APR-DRG), an account originally coded without the discharge summary (where one is required by hospital/medical staff policy) must be returned to the coder to determine whether the summary supports a change to the final ICD-10-CM code set.

7. Contract Coding Arrangements

    a. Approval by the SVMC Chief Financial Officer (CFO) is required before engaging a new consultant/vendor in coding.

    b. HIM is ultimately responsible for the accuracy of work produced by a contract coder. It is recommended that the contract have provisions to reduce payment or terminate the contract if any contract coder's individual coding error rate is less than 5%.

8. External Coding Consultants and External Clinical Documentation Consultants

    a. Engaging an external consultant/vendor to review patient accounts with the goal of assessing the quality/completeness of coding and/or clinical documentation, requires written approval of the Chief Financial Officer (CFO).

PROCEDURE:

A. Responsible Person

1. The hospital HIM Director is responsible for assuring that all individuals adhere to the requirements of this policy and that all applicable procedures and processes are implemented and followed.

2. Auditing and monitoring

    a. All audits will adhere to this policy as part of its coding compliance audits.

3. Enforcement

   a. All employees whose responsibility is affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination.

REFERENCES:

- AHIMA. Standards of Ethical Coding, 2016. Retrieved from https://bok.ahima.org/CodingStandards

- AHIMA. Code of Ethics, 1957, 1977, 1988, 1998, 2004, 2011, and 2019. Retrieved from http://www.ahima.org/downloads/AHIMACodeofEthicsPrinciplesFINALApprovedApril292019.pdf.

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PROPOSAL

Sierra View Local Health Care District 403(b) Plan

September 5, 2024

Proposal For Sierra View Local Health Care District 403(b) Plan
This proposal valid until: 12/5/2024

This Proposal was provided at the request of the plan sponsor or the Plan's advisor on behalf of the plan. The fee information provided in this Proposal is based on the assumptions and/or investment options reflected in the Proposal. This Proposal is invalid if the assumptions and/or investment options are inaccurate or change.

Plan Assumptions — September 5, 2024

Plan Assets:	$0
Annual Contribution:	$100,000
Plan Participants with a Balance:	10
Total Eligible Employees:	1,000
Number of Plans:	1
Investment Platform:	Custom NAV
Investment Fiduciary:	None
Mapping Strategy:	N/A Start-up Plan
Default Fund:	Target Date
Empower Retirement Plan Document	Required

Fee Summary

	Fee	Paid By
Annual Plan Maintenance (Per Plan)	$0	Employer
Annual Participant Account Maintenance	$33.75	Participant
Asset Based Fee	0.00%	Participant
Investment Access Fee	$1,000	Employer
Installation Fee	Waived	Employer
Weighted Average Net Investment Expense	0.47%	Participant

Additional Plan Services

Trustee/Custodial Services:	Empower Trust Full Custodian	BEL Restoration:	N/A
Compliance Services:	N/A	Manual Payroll:	N
Auto Enroll:	N	Prospectus Fulfillment:	N
Fee Levelization:	Y	Addt'l Participant Notice Delivery:	N

For Home Office Use Only		Sierra View Local Health Care District 403(b) Plan				Version
Group Account Number:	State Situs:	Product Code:	Quote Date:	RSD Name:	Prepared by:	403(b) Version:
	CA	gvmt-403(b)	9/5/2024 4:44:49 PM	Michael Wannell	cnlk	v17.0 8/22/2024 5:32:00 AM

EMPOWER

Plan and Participant Fees

Plan Service Fees		
Fee Type	**Fee**	**Paid By**
Participant Account Maintenance	$33.75 Per Account Annually	Deducted from Participant Accounts Quarterly
Plan Maintenance	$0 Annually Per Plan	Billed to Plan Sponsor Quarterly
Investment Access Fee	$1,000 Annually	Billed to Plan Sponsor Quarterly

Participant Transaction Fees		
Transaction fee type	**Fee**	**Paid by**
Loan initiation	$75 per request	Netted From Distribution
Maintenance fee for loans (recurring)	$50 annually	Deducted from participant accounts quarterly
Withdrawals (including Separation of Service, Retirement, Plan Terminations)	$75 per request	Netted from withdrawal
Withdrawals for small balance force-outs (deminimus)	$25 per request	Netted from distribution
Distributions (including In-Service, Hardship, QDRO, Death, Disability)	$50 per request	Netted from distribution
Express delivery fee	$40 per request	Netted from distribution
Hardship approval services	$75 per request	Netted from distribution or participant account
Beneficiary distribution review services	$75 per request	Netted from distribution or participant account
QDRO review services	$400 per request	Netted from distribution or participant account
Periodic payment setup	$50 per request	Deducted from participant accounts
Periodic payment maintenance	$25 annually	Deducted from participant accounts quarterly

The above recordkeeping fees will be guaranteed for the initial five (5) year contract term from the Effective Date of the Administrative Services Agreement. Material changes (+/- 10%) from assumptions used in pricing (participants, assets, net flow, asset allocations) could void this guarantee.

The Participant Transaction services above will be provided to the Plan unless the plan sponsor elects otherwise.

Fund Information

			Revenue Sharing Included In Gross/Net Expense Ratio		
Investment Name	Ticker	Gross/Net Expense Ratio	12B-1	Admin	Assets
American Funds Europacific Growth R6	RERGX	0.47/0.47%	0.00%	0.00%	$0
Cohen & Steers Instl Realty Shares	CSRIX	0.76/0.75%	0.00%	0.10%	$0
Conestoga Small Cap Institutional	CCALX	0.98/0.90%	0.00%	0.00%	$0
DFA International Small Company I	DFISX	0.39/0.39%	0.00%	0.00%	$0
Dodge & Cox International Stock X	DOXFX	0.57/0.52%	0.00%	0.00%	$0
Harbor Capital Appreciation Retirement	HNACX	0.64/0.60%	0.00%	0.00%	$0
Northern Small Cap Value	NOSGX	1.16/1.01%	0.00%	0.30%	$0
PGIM Total Return Bond R6	PTRQX	0.40/0.39%	0.00%	0.00%	$0
T. Rowe Price Equity Income I	REIPX	0.57/0.57%	0.00%	0.00%	$0
Vanguard Target Retirement 2020 Fund	VTWNX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2025 Fund	VTTVX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2030 Fund	VTHRX	0.08/0.08%	0.00%	0.00%	$0

Fund Information Continued			Revenue Sharing Included In Gross/Net Expense Ratio		
Investment Name	Ticker	Gross/Net Expense Ratio	12B-1	Admin	Assets
Vanguard Target Retirement 2035 Fund	VTTHX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2040 Fund	VFORX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2045 Fund	VTIVX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2050 Fund	VFIFX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2055 Fund	VFFVX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2060 Fund	VTTSX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2065 Fund	VLXVX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement 2070 Fund	VSVNX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Target Retirement Income Fund	VTINX	0.08/0.08%	0.00%	0.00%	$0
Vanguard Total Bond Market Index I	VBTIX	0.04/0.04%	0.00%	0.00%	$0
Vanguard Total Intl Stock Index I	VTSNX	0.09/0.09%	0.00%	0.00%	$0
Vanguard Total Stock Market Idx I	VITSX	0.03/0.03%	0.00%	0.00%	$0

Average Net Expense Ratio	0.47%

Not all 12b-1 and Admin fees may flow through the Recordkeeper. A third party may be receiving 12b-1 and/or Admin fee(s) directly that are not reflected above.

General Account Investments	Ticker	Fee Estimate	Allocation to Recordkeeper	Assets
Empower General Account				
Empower Investments Fixed Account Series VI	GWAQ10	0.10%	0.00%	$0

For an explanation of the Fee Estimate and the Allocation to Recordkeeper, please see the "General Account Fund and General Provision" disclosure in the Disclosure Section of this document.

Payments to Others

Financial Professional Services (Included in Plan Pricing)		
Service Provider	**Service**	**Fee**
None		

Other Services (Included in Plan Pricing)		
Service Provider	**Service**	**Fee**
None		

Empower will pay Revenue Credits to the Plan on a monthly basis. Revenue Credits shall be determined by multiplying the average daily balance in each of the Plan's investment options for the month by the annual rate (prorated for the month) of fund service fees paid to Empower by the investment option or its affiliates as reflected in the Plan's Plan Fee Disclosure Report (A copy of the Plan's most recent Fee Disclosure Report is available on the Plan Sponsor Website). Plan Sponsor directs Empower to allocate any Revenue Credits to Plan Participant accounts proportionately based on the average daily balance of such accounts in the investment option during the month and to invest such amounts based on the Participant's investment elections with respect to future contributions or, if none, the applicable Plan default fund. Revenue Credits shall be determined and allocated within 45 days after the end of the month.

Trustee/Custodial Services (Included in Plan Pricing)		
Service Provider	**Service**	**Fee**
Empower Trust Company	Full Custodian	$500 Annually

Participant Advice		Opt-In	
Service Provider	**Service**	**Annual Fee**	**Basis**
Advised Assets Group, LLC.	Online Investment Guidance	No Charge	N/A
Advised Assets Group, LLC.	Online Investment Advice	$0	Per Participant
Advised Assets Group	My Total Retirement Services	0.45% <$100k 0.35% Next $150k 0.25% Next $150k 0.15% >$400k	My Total Retirement Assets

Online Investment Advice and Managed Accounts services are optional services that are offered by Advised Assets Group, LLC. Each individual participant may elect to enroll in either one of these services. These participant advice fees are only deducted from participant account balances of those that have enrolled in the service.

Plan Sponsor agrees the managed account service fee will be paid for by a Plan Participant unless the following box is selected.

☐ Plan Sponsor Pay

Disclosures

This document contains estimates of plan expenses and is intended to provide a detailed summary of fees being charged to the plan or its participants to the extent such information is in the Recordkeeper's possession. While it is intended to provide information regarding all material fees, this document may not be comprehensive, and it may not include full information on fees associated with some specially negotiated services or with certain investment options, such as Self-Directed Brokerage Accounts, Life Insurance, Employer Stock, etc. For further fee information, please refer to the relevant service agreements and/or prospectuses, including information that may be needed to comply with Participant Disclosure obligations. As your Recordkeeper, we make no representation as to the completeness or accuracy of materials, such as prospectuses, created and/or provided by a third-party investment provider.

The Plan Sponsor expressly warrants and represents that the 403(b) plan is not exempt from ERISA due to the safe harbor exemption described in Labor Regulation section 2510.3-2(f) and understands that Empower's proposal is contingent upon the Plan being exempt from ERISA because the Plan Sponsor is exempt from ERISA. In the event that it is later determined that the Plan Sponsor is subject to ERISA but the 403(b) plan is intended to be exempt from ERISA under the safe harbor exemption, the Plan Sponsor agrees that Empower has the option to immediately terminate its services.

General

Float:
If the Plan's assets pass through a bank account held by Empower Retirement LLC (Empower) or its affiliates/ subsidiaries (Empower Trust Company, LLC), it may earn credits and/or interest on Plan assets awaiting investment or pending distribution. Plan Sponsor acknowledges that it has received and reviewed the Float Disclosure. Plan Sponsor agrees that, as additional compensation for its services hereunder, ETC, Empower, and/or its affiliates shall retain float consistent with the terms of the Float Disclosure.

Recordkeeping Costs Estimate
Empower recordkeeping fees are agreed to with the plan sponsor based on the total value of the relationship with the plan. Empower may provide recordkeeping fee credits in its sole discretion based on criteria as solely determined by Empower which may include the plan's use of affiliated and non-affiliated funds or products. Such credits may reduce some or all of the recordkeeping fees that would otherwise be charged by Empower. The average cost of Empower recordkeeping services without any reduction or offset is $120.23 per participant for plans less than $50 million, $94.42 per participant for plans between $50m and $500m and $70.13 per participant for plans greater than $500m.

Prospectus Delivery:
Employer agrees to accept delivery of prospectuses for the selected investment options through the Plan Sponsor section of the Empower Web site - www.empower-retirement.com.

Acceptance and Use of Participant Emails for Electronic Delivery:
Plan Sponsor and/or the Participant have authorized the Plan to use the Participant email(s) in the Plan's records to deliver Plan-related notices and documents to the Participant electronically. The Plan Sponsor Directs Empower to accept a transfer of Participant work and/or personal emails to its recordkeeping system as provided by the Plan Sponsor or its delegate, including but not limited to the Plan Administrator, a payroll vendor, a Plan adopting employer, third-party administrator or other current or prior Plan service provider. The Plan Sponsor agrees to provide all Participant work emails in its records to Empower and to make best efforts to provide Empower with work or personal email addresses for all newly eligible Participants.

a. Plan Sponsor Directs Empower to deliver Plan notices, including the Transition Guide and Blackout Notice and other Plan documents it has agreed to provide under the services agreement between the parties ("Agreement") to the Participant's email address in the following order:

   (i) to a work or personal email address provided and agreed to by the Participant.

   (ii) to a work email address provided by the Plan Sponsor in accordance with the "wired at work" method described in Department of Labor regulation §2520.104b-1. The Plan Sponsor confirms the Participant has the effective ability at work to access notices delivered to the work email addresses provided to Empower.

   (iii) to a personal email address provided by the Plan Sponsor or Participant in accordance with the "notice and access" method described in Department of Labor regulation §2520.104b-31.

☐ Check here if the prior record keeper did not distribute "Initial notifications of default electronic delivery" according to Department of Labor regulation §2520.104b-31.

b. If the "notice and access" delivery method is used, Empower will send an initial notification of electronic delivery (§2520.104b-31(g)) via regular mail to each Participant at least 10 days prior to delivering any plan-related documents via email, unless Empower obtains confirmation that the initial notification has already been provided to the Participant from the Plan Administrator, third party administrator or other Plan service provider.

   (i) If notice of availability of a plan-related document is returned undeliverable, Empower will send the notice to another email on file for the Participant. If no other email is on file for the Participant or such other email is also returned undeliverable, plan related documents will be delivered via regular mail to the Participant until such time as Empower is provided another email address for the Participant.

   (ii) Participants may request to receive a paper copy of a plan-related document for no cost. In addition, Participants may opt out of electronic delivery and request that their plan-related documents be delivered via regular mail at any time.

   (iii) Empower will maintain access to plan-related documents on the Participant website in accordance with Department of Labor regulation §2520.104b-31(e).

c. If Empower is not provided with an email address, plan-related documents will be delivered to the Participant via regular mail.

Third-Party Fee Debits from Participant Accounts:
If the plan fiduciaries authorize payment of a third-party fee (e.g., advisor, auditor, TPA, etc.) from participant accounts, note that the participant fee disclosure prepared by Empower at the plan's transition (and delivered to participants if we have agreed to do so) will not reflect third-party fee payments. The payment process for a third-party fee is set-up following the transition. Third-party fee payments authorized by the Plan Sponsor will be updated to the participant fee disclosure and posted to the participants' accounts online. The plan fiduciaries may wish to discuss the debit of third-party fees from participant accounts with their legal and tax advisors as they deem appropriate and prepare and deliver to participants a supplement to the disclosure prepared by Empower which contains the additional third-party fee information for distribution at transition.

Fiduciary Disclosures

Advised Assets Group (AAG):
If Advised Assets Group, LLC provides services to the Plan under an agreement with Plan Sponsor, it may be a fiduciary and Registered Investment Advisor to the Plan to the extent provided in such agreement.

Empower:
Empower is not acting as a fiduciary for this plan

Investments

Mutual Fund Expense Ratio:
The Service Provider has entered into agreements with certain funds (or their service providers including advisors, administrators or transfer agents, and underwriters) whereby the Service Provider provides shareholder and/or distribution services and receives compensation from the funds (or their service providers) based on the value of the plan's investment in the funds. This compensation may include fees for administrative and other expenses and/or fees paid under a plan of distribution under SEC Rule 12b-1 ("12b-1 fees"). The fees received by the Service Provider are included in the expense ratio described in the applicable fund's prospectus or similar disclosure document, and reduce the fund's net asset value (NAV). Generally, fees and expenses included in the fund's expense ratio are deducted at regular intervals based on a percentage of the fund's average daily net assets.

Redemption Fees:
Redemption fees are charged by mutual fund companies to discourage investors from making a short-term "round trip" (i.e., a purchase, typically a transfer, followed by a sale within a short period of time). Many mutual fund companies will impose the fee upon the purchase and subsequent sale occurring within a specified time frame. Please refer to your mutual fund prospectuses for specific redemption fee details.

Additional Fund Compensation:
Empower Retirement, LLC Insurance Company receives payments from some investment fund families through the Empowering Fund Partnership Program ("EFPP"). Under the EFPP, fund families receive several services based on the EFPP tier in which they participate. These services are provided directly to fund families and include: (i) consideration for inclusion in Empower products developed for some segments of the retirement and IRA market, (ii) inclusion on the Empower Select investment platform, which is available in the small plan recordkeeping market, (iii) a waiver of the connectivity fee described below, (iv) enhanced marketing opportunities, (v) additional reporting capabilities, (vi) collaboration in thought leadership opportunities, (vii) access to meetings with Empower leadership, Empower staff, and the third party advisory and brokerage firms through whom Empower distributes its services, and (viii) access to conferences put on by Empower and Empower Financial. The yearly fees for EFPP participation are $1,000,000 for tier 1, $500,000 for tier 2, and $250,000 for tier 3. These fees do not vary based on an Empower client's use of the funds offered by the fund family.

For additional information about funds that participate in the fund partner program, please visit https://docs.empower-retirement.com/advisor/Empowering-Fund-Partnership-Disclosure.pdf.

Empower Retirement, LLC Insurance Company also receives payments from fund families through a connectivity program (the "Connectivity Program"). The Connectivity Program charges fund families for the cost of administering funds on Empower investment platforms, and for building and maintaining data connections between Empower and the fund family. In 2019, the Connectivity Program charges $1,000 per investment fund used on recordkeeping and IRA investment platforms. Beginning in May 2019, if a retirement plan begins receiving recordkeeping services through Empower's small plan recordkeeping segment, and the plan offers a fund from a fund family that does not participate in the Connectivity Program or the EFPP, then Empower will assess a supplemental, separate investment access fee to the plan. Depending on the level of investment in the non-participating fund family, the investment access fee charge may be more or less than the fees received under the Connectivity Program from the fund family.

For additional information about funds that participate in the Connectivity Program, please visit https://docs.empower-retirement.com/advisor/Empowering-Fund-Partnership-Disclosure.pdf.

Investment Access Fee:
Empower charges an investment access fee if the plan's fiduciary selects a fund for the plan's investment lineup from a fund provider that does not participate in Empower's fund connectivity program, under which the fund provider compensates Empower or its related companies for costs associated with providing and maintaining the fund on investment platforms. The investment access fee is an annual fee shown in this document, billed directly to the Plan Sponsor on a quarter basis.

General Account Fund and Guarantee Provisions:
General Account crediting rates are net of cost of capital and expenses, fund and guarantee provisions and any contract series charge, to the extent applicable.

Cost of Capital is the return Empower Retirement, LLC Insurance Company of New York (Empower) earns on Empower capital. Empower is required by regulators to hold capital for the purpose of ensuring Empower can meet all of its obligations associated with the General Account Fund. The amount of Empower's capital and required return will fluctuate over time based on regulatory requirements, capital market conditions and the competitive environment.

The Fund Provision covers the range of investment expenses that are netted from the crediting rate, such as investment and operating expenses. The Fund Provision is calculated annually in aggregate for all General Account fixed funds offered by Empower and does not reflect any product or plan specific underwriting adjustments.

The Guarantee Provision covers the range of insurance expenses that are netted from the crediting rate, such as asset defaults, cost of insurance guarantees, and other expenses. The Guarantee Provision is calculated annually in aggregate for all General Account fixed funds offered by Empower and does not reflect any product or plan specific underwriting adjustments.

A Contract Series Charge may apply to the general account option selected by the plan sponsor. This charge will be explicitly described in the Empower Investments Fixed Account group annuity contract and is meant to cover expenses related to contract administration, investment management and other services that are provided to the plan pursuant to a separate agreement with the plan. There may be an adjustment to the credited interest rate which is used to reduce the amount for plan recordkeeping/administration services that would otherwise be charged to the plan.

For more information on the General Account Fixed Funds, including termination options, please see your Group Annuity Contract.

Affiliates and Subcontractors

We are required to disclose certain fees paid between Empower and its related parties (affiliates and subcontractors). This includes compensation paid in connection with the services Empower or its affiliates have agreed to provide to the plan, if the compensation is set on a transaction/incentive basis (such as commissions, soft dollars, or finder's fees) or if the compensation is charged directly against a plan investment and reflected in the investment's net value.

The fees disclosed are not in addition to previously disclosed fees; rather, this information is intended to increase transparency about how Empower uses the fees it receives.

Affiliates:
The following entities are affiliates of the Recordkeeper, in that they directly or indirectly control, are controlled by, or are under common control with the Recordkeeper. These affiliates may receive fees from the plan, or from the Recordkeeper or another affiliate for performing certain services for the plan.

Refer to the Itemized Services and Cost section for details regarding affiliate payments.

GWFS Equities, Inc. is an affiliate that receives payments from the Investment Provider. Payments are first paid to GWFS Equities, Inc. which in turn pays the Recordkeeper.

Empower Capital Management, LLC is an affiliate that receives payments from the Investment Provider.

Empower Funds, Inc. is an affiliate that receives payments from the Investment Provider.

Affiliates: The following are affiliates of Empower, but not all Empower affiliates may pertain to your Plan.

- Advised Assets Group, LLC
- GWFS Equities, Inc.
- EMJAY Corporation
- FASCore, LLC
- Empower Capital Management, LLC
- Empower Funds, Inc.
- Putnam Investment Company
- Empower Trust Company, LLC
- Empower Retirement, LLC of New York

Subcontractors:
A subcontractor is any person or entity that is not an affiliate of the Recordkeeper and that is expected to receive $1,000 or more in compensation for performing one or more services for your Plan under a contract or arrangement with the Recordkeeper. All such subcontractors that receive the specific types of compensation described above are included. All such subcontractors, if any, are listed in the table below, along with the service they provide.

Please refer to the Itemized Services and Cost section for details regarding subcontractor payments.

Company Subcontractor	Service Provided
QDRO Consultants	Plan administration services - QDRO review services

By signing this signature page, the Plan Sponsor, Broker and any other signatories certify that they have received, read and understand this proposed Fee Schedule and Disclosure Statement. All parties understand the proposal assumptions stated above determine the plan's expenses. A change to the assumptions will cause expenses and fees to also change Plan Sponsor understands and agrees to all services and fees identified in this Fee Schedule and agrees to pay all fees according to the Service Agreement to which this Fee Schedule applies. The Plan Sponsor further understands that all payroll deduction and matching contributions will be remitted electronically using the Plan Service Center system. Contributions received using any other method will be returned unallocated for resubmission via the Plan Service Center and will not be considered plan assets until such resubmission. Plan Sponsor also understands that no payroll deduction contributions may be withheld until there is a signed Plan Document in place and no contribution or transfer of assets will be accepted earlier than 15 days from the receipt and acceptance of the Client Application in Greenwood Village, CO.

The Plan Sponsor directs Empower to reflect the Advisor and Firm below as the Plan's financial advisor on its recordkeeping system and to provide plan data upon request. The Plan Sponsor understands and agrees that Empower does not provide investment advice to the Plan, the Plan Sponsor or the Advisor regarding Plan investment options.

I agree any changes to products, plan services, fees, or investment options hereafter must be made post-conversion

Plan Sponsor Signature: _____
Print Name: _____
Date: _____

Advisor/Broker Signature: _____
Print Name: _____
Date: _____

Additional Plan Information

*****Please complete upon selecting Empower as your provider*****

Legal Name of Plan:	
Plan Headquartered State:	
EIN:	
Plan Year End (MM/DD):	
Plan Contact for Conversion:	First Name:
	Last Name:
	Phone Number:
	Email:
Is the Financial Representative properly licensed to sell in Headquartered State?	**Y N N/A**

Core securities, when offered, are offered through GWFS Equities, Inc. and/or other broker dealers.

GWFS Equities, Inc., Member FINRA/SIPC, is a wholly owned subsidiary of Great-West Life & Annuity Insurance Company.

Empower Retirement™ refers to the products and services offered in the retirement markets by Great-West Life & Annuity Insurance Company (GWL&A), Corporate Headquarters: Greenwood Village, CO; Great-West Life & Annuity Insurance Company of New York, Home Office: White Plains, NY; and their subsidiaries and affiliates. The trademarks, logos, service marks, and design elements used are owned by GWL&A. The Great-West Family of Companies refers to products and services offered through The Great-West Life Assurance Company, London Life Insurance Company, The Canada Life Assurance Company, Irish Life Assurance Company, Great-West Life & Annuity Insurance Company, Putnam Investments, LLC, and their affiliates and subsidiary companies.

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SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS RESOLUTION NO: 10-22-2024/01
APPOINTING TREASURER FOR THE BOARD OF
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

WHEREAS, The Board's Bylaws at 5.5 and 7.4 require the Board of Directors appoint a Treasurer for the Board and to do so by passing a resolution when appointing a new Treasurer to ensure there is a record of compliance with all Federal, State and Local laws and regulations.

WHEREAS, Director Hans Kashyap was appointed Board Treasurer by Resolution passed on January 23, 2024 and he now wishes to resign as Board Treasurer;

IT IS THEREFORE RESOLVED, that the Board hereby accepts the resignation of Director Hans Kashyap and appoints in his place Chief Executive Officer, Craig McDonald as Treasurer for the Board of Directors of Sierra View Local Health Care District.

IT IS RESOLVED FURTHER: that the Board delegates to the Chief Financial Officer ("CFO") for Sierra View Local Health Care District all powers and authority necessary to ensure that the Treasurer, and thereby Sierra View Local Health Care District, is in compliance with all Local, State and Federal laws and regulations that apply to a Treasurer's duty to manage public funds, including but not limited to all powers necessary to conduct those duties outlined in Cal. Health & Safety Code § 32127. It is understood that the day-to-day operations necessary to remain in compliance will be conducted solely by the CFO.

PASSED AND ADOPTED, by the Board of Directors of Sierra View Local Health Care District of Tulare County, State of California at a regular meeting of the Board on October 22, 2024.

The vote of the Board is as follows: (Official Seal)

Yes: ___

No: ___

Absent: ___

By: _____ Attest: _____

Bindusagar Reddy, M.D., Chairman Areli Martinez, Secretary

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

The monthly meeting of the Board of Directors of Sierra View Local Health Care District was held **September 24, 2024 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 5:01 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ**
Directors Absent at Start of Meeting: PANDYA, KASHYAP

Others Present: Donna Hefner, President/Chief Executive Officer, Tracy Canales, VP of Human Resources, Melissa Mitchell, VP of Quality and Regulatory Affairs, Craig McDonald, Chief Financial Officer, Ron Wheaton, VP of Professional Services/Physician Recruitment, Terry Villareal, Executive Assistant and Clerk to the Board, Malynda Parsons, Senior Marketing and Community Relations Specialist, Dan Blazar, Patient Experience Officer, Silvia Roberts, Manager of Care Integration , Barbra Riegel, Strategic Healthcare Advisor, Dr. Bhinder, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director PANDYA, seconded by, Vice Chairman LOMELI 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 5:02 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 – Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item).

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (First of 2 Items).

Closed Session Items D (Second of 2 Items), E and F were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:40 p.m., reconvening in Open Session at 5:40 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 – Quality of Care/Peer Review/Credentials

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Update – Quality Report

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve the position of Treasurer of the Board be delegated and restored to the Chief Financial Officer. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

IV. Public Comments

Ron Wheaton introduced Dr, Bhinder to the Board, she is the new Oncologist that will be overseeing patient treatment at the Cancer Treatment 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 Director MARTINEZ, seconded by Vice Chairman LOMELI, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director MARTINEZ and seconded by Vice Chairman LOMELI to approve the August 27, 2024 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. Business Items

A. August 2024 Financials

Craig McDonald, CFO presented the Financials for August 2024. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the August 2024 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

B. Capital Budget Report

Craig McDonald, CFO presented the Capital Budget Report for Quarter 4. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP and carried to approve the Capital Budget Report for Quarter 4 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Conflict of Interest Code

A copy of the Conflict of Interest Code is attached to the file copy of these minutes.

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VIII. CEO Report

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

IX. Announcements:

A. Regular Board of Directors Meeting – October 22, 2024 at 5:00 p.m.

X. Closed Session: Board adjourned Open Session at 6:20 p.m., reconvening in Closed Session at 6:30 p.m. to discuss the following items.

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (Second of 2 Items). Estimated date of Disclosure: September 1, 2026

E. Pursuant to Gov. Code Section 54956.9(d)(2): Conference with Legal Counsel; Anticipated Litigation; Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter. (2 items).

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

XI. Open Session: Chairman REDDY adjourned Closed Session at 7:09 p.m., reconvening in Open Session at 7:09 p.m.

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

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

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

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. Conference with Legal Counsel Regarding Personnel Matter
Information Only: No Action Taken

F. Conference with Legal Counsel
Information Only: No Action Taken

XII. Adjournment

The meeting was adjourned at 7:45 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv

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FINANCIAL PACKAGE
Semptember 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
September 2024

	Sept 2024				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	(Decrease) Sep-23	% Change
Utilization											
SNF Patient Days											
Total	30	56	(26)	-46.7%	92	169	(77)	-45.5%	261	(169)	-64.8%
Medi-Cal	30	56	(26)	-46.4%	92	168	(76)	-45.2%	261	(169)	-64.8%
Sub-Acute Patient Days											
Total	980	970	10	1.1%	3,046	2,909	137	4.7%	2,789	257	9.2%
Medi-Cal	510	777	(267)	-34.3%	1,593	2,404	(811)	-33.7%	2,305	(712)	-30.9%
Acute Patient Days	1,493	1,648	(155)	-9.4%	4,678	4,943	(265)	-5.4%	5,188	(510)	-9.8%
Acute Discharges	418	427	(9)	-2.1%	1,310	1,281	30	2.3%	1,337	(27)	-2.0%
Medicare	172	162	10	6.3%	516	481	35	7.3%	502	14	2.8%
Medi-Cal	198	203	(5)	-2.4%	625	630	(5)	-0.8%	658	(33)	-5.0%
Contract	44	57	(13)	-23.4%	157	160	(3)	-1.9%	167	(10)	-6.0%
Other	4	5	(1)	-16.4%	12	10	2	25.9%	10	2	20.0%
Average Length of Stay	3.57	3.86	(0.29)	-7.5%	3.57	3.86	(0.29)	-7.5%	3.88	(0.31)	-8.0%
Newborn Patient Days											
Medi-Cal	122	161	(39)	-24.3%	461	475	(14)	-2.9%	545	(84)	-15.4%
Other	36	31	5	15.7%	117	102	15	14.5%	122	(5)	-4.1%
Total	158	192	(34)	-17.8%	578	577	1	0.2%	667	(89)	-13.3%
Total Deliveries	92	99	(7)	-7.1%	296	297	(1)	-0.3%	338	(42)	-12.4%
Medi-Cal %	79.57%	83.43%	-3.86%	-4.6%	82.83%	83.43%	-0.60%	-0.7%	81.31%	1.52%	1.9%
Case Mix Index											
Medicare	1.5095	1.6368	(0.1273)	-7.8%	1.6180	1.6368	(0.0188)	-1.1%	1.5358	0.0822	5.4%
Medi-Cal	1.0794	1.1975	(0.1181)	-9.9%	1.1612	1.1975	(0.0363)	-3.0%	1.1571	0.0041	0.4%
Overall	1.2597	1.3724	(0.1127)	-8.2%	1.3486	1.3724	(0.0238)	-1.7%	1.3161	0.0325	2.5%
Ancillary Services											
Inpatient											
Surgery Minutes	8,699	8,224	475	5.8%	24,030	24,672	(642)	-2.6%	26,821	(2,791)	-10.4%
Surgery Cases	98	94	4	4.5%	280	281	(1)	-0.4%	294	(14)	-4.8%
Imaging Procedures	1,299	1,404	(105)	-7.5%	4,291	4,213	78	1.9%	4,166	125	3.0%
Outpatient											
Surgery Minutes	12,665	12,775	(110)	-0.9%	42,032	38,325	3,707	9.7%	40,265	1,767	4.4%
Surgery Cases	192	204	(12)	-5.8%	576	611	(35)	-5.8%	615	(39)	-6.3%
Endoscopy Procedures	172	192	(20)	-10.2%	557	575	(18)	-3.0%	600	(43)	-7.2%
Imaging Procedures	4,187	3,886	301	7.8%	11,859	11,657	202	1.7%	11,131	728	6.5%
MRI Procedures	324	302	22	7.4%	919	905	14	1.5%	961	(42)	-4.4%
CT Procedures	1,176	1,237	(61)	-4.9%	3,687	3,711	(24)	-0.6%	3,889	(202)	-5.2%
Ultrasound Procedures	1,325	1,244	81	6.5%	4,045	3,731	314	8.4%	3,855	190	4.9%
Lab Tests	30,146	32,140	(1,994)	-6.2%	95,103	96,421	(1,318)	-1.4%	96,727	(1,624)	-1.7%
Dialysis	2	6	(4)	-68.4%	6	19	(13)	-68.4%	8	(2)	-25.0%

Sierra View Medical Center
Financial Statistics Summary Report
September 2024

Statistic	Sept 2024 Actual	Budget	Over/ (Under)	% Var.	YTD Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	Increase/ (Decrease) Sep-23	% Change
Cancer Treatment Center											
Chemo Treatments	1,891	1,924	(33)	-1.7%	6,467	5,771	696	12.1%	4,266	2,201	51.6%
Radiation Treatments	1,519	1,836	(317)	-17.3%	5,916	5,507	409	7.4%	5,735	181	3.2%
Cardiac Cath Lab											
Cath Lab IP Procedures	10	11	(1)	-11.1%	27	34	(7)	-20.0%	37	(10)	-27.0%
Cath Lab OP Procedures	45	30	15	50.4%	98	90	8	9.2%	100	(2)	-2.0%
Total Cardiac Cath Lab	55	41	14	33.6%	125	124	2	1.2%	137	(12)	-8.8%
Outpatient Visits											
Emergency	3,443	3,415	28	0.8%	10,317	10,244	73	0.7%	10,279	38	0.4%
Total Outpatient	13,806	13,994	(188)	-1.3%	41,878	41,983	(105)	-0.2%	39,971	1,907	4.8%
Staffing											
Paid FTE's	860.84	855.00	5.84	0.7%	876.09	855.00	21.09	2.5%	853.89	22.20	2.6%
Productive FTE's	718.21	734.21	(16.00)	-2.2%	735.31	734.21	1.10	0.2%	740.65	(5.34)	-0.7%
Paid FTE's/AOB	5.11	4.82	0.29	6.0%	5.24	4.93	0.31	6.2%	4.92	0.31	6.4%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,029	10,552	476	4.5%	11,152	10,552.20	599	5.7%	10,338	813	7.9%
Cost/Adj.Patient Day	2,787	2,631	156	5.9%	2,735.48	2,639.37	96	3.6%	2,572.32	163	6.3%
Revenue/Adj. Discharge	52,455	53,065	(610)	-1.2%	52,862	53,065	(204)	-0.4%	51,345	1,516	3.0%
Cost/Adj. Discharge	13,256	13,233	22	0.2%	12,967	13,273	(306)	-2.3%	12,776	191	1.5%
Adj. Discharge	1,062	1,057	4	0.4%	3,247	3,172	75	2.4%	3,214	33	1.0%
Net Op. Gain/(Loss) %	-6.49%	-4.82%	-1.68%	34.8%	-4.25%	-4.82%	0.56%	-11.7%	-6.81%	2.56%	-37.5%
Net Op. Gain/(Loss) $	(858,070)	(643,097)	(214,973)	33.4%	(1,718,250)	(2,055,611)	337,361	-16.4%	(2,618,596)	900,346	-34.4%
Gross Days in Accts Rec.	91.96	95.03	(3.07)	-3.2%	91.96	95.03	(3.07)	-3.2%	94.13	(2.17)	-2.3%
Net Days in Accts. Rec.	51.54	57.75	(6.20)	-10.7%	51.54	57.75	(6.20)	-10.7%	63.57	(12.03)	-18.9%

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

	SEP 2024	AUG 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 13,003,907	$ 13,647,993
SHORT-TERM INVESTMENTS	1,072,560	35,633
ASSETS LIMITED AS TO USE	532,720	135,974
PATIENT ACCOUNTS RECEIVABLE	171,559,318	185,376,544
LESS UNCOLLECTIBLES	(22,899,094)	(23,305,088)
CONTRACTUAL ALLOWANCES	(126,999,294)	(139,207,024)
OTHER RECEIVABLES	23,047,401	22,094,084
INVENTORIES	4,361,557	4,353,301
PREPAID EXPENSES AND DEPOSITS	2,451,985	2,498,830
LEASE RECEIVABLE - CURRENT	314,237	314,237
TOTAL CURRENT ASSETS	66,445,296	65,944,485
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	32,798,283	32,699,209
LONG-TERM INVESTMENTS	133,891,008	133,831,650
PROPERTY, PLANT AND EQUIPMENT, NET	75,653,158	76,296,260
INTANGIBLE RIGHT OF USE ASSETS	387,341	399,337
SBITA RIGHT OF USE ASSETS	2,349,279	2,458,128
LEASE RECEIVABLE - LT	901,631	927,459
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,447,593	1,468,573
TOTAL ASSETS	$ 314,123,590	$ 314,275,101

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

	SEP 2024	AUG 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 346,763	$ 231,175
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,888,832	1,972,966
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	4,271,665	4,837,933
ACCRUED PAYROLL AND RELATED COSTS	7,147,980	6,982,667
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,524,136	3,554,136
LEASE LIABILITY - CURRENT	141,812	141,812
SBITA LIABILITY - CURRENT	1,110,658	1,154,846
TOTAL CURRENT LIABILITIES	22,666,846	23,110,535
SELF-INSURANCE RESERVES	2,191,729	2,192,259
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,546,190	2,598,147
LEASE LIABILITY - LT	267,849	279,470
SBITA LIABILITY - LT	1,435,230	1,504,580
DEFERRED INFLOW - LEASES	1,145,013	1,171,314
TOTAL LIABILITIES	63,527,856	64,131,304
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	2,210,223	1,758,287
TOTAL LIABILITIES AND FUND BALANCE	$ 314,123,590	$ 314,275,101

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

SEP 2024 ACTUAL	SEP 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
4,887,192	5,253,784	366,592	(7)%	INPATIENT - NURSING	15,425,189	15,761,352	336,163	(2)%
17,065,261	17,396,290	331,029	(2)%	INPATIENT - ANCILLARY	53,982,073	52,188,872	(1,793,201)	3%
21,952,453	22,650,074	697,621	(3)%	TOTAL INPATIENT REVENUE	69,407,262	67,950,224	(1,457,038)	2%
33,742,340	33,463,072	(279,268)	1%	OUTPATIENT - ANCILLARY	102,233,386	100,389,215	(1,844,171)	2%
55,694,793	56,113,146	418,354	(1)%	TOTAL PATIENT REVENUE	171,640,649	168,339,439	(3,301,210)	2%
				DEDUCTIONS FROM REVENUE				
(17,509,636)	(18,243,309)	(733,673)	(4)%	MEDICARE	(51,835,589)	(54,729,927)	(2,894,338)	(5)%
(13,745,986)	(18,032,202)	(4,286,216)	(24)%	MEDI-CAL	(51,665,011)	(54,096,606)	(2,431,595)	(5)%
(7,696,291)	(6,660,852)	1,035,439	16%	OTHER/CHARITY	(23,085,356)	(19,982,556)	3,102,800	16%
(3,839,284)	(9,556)	3,829,728	40,077%	DISCOUNTS & ALLOWANCES	(5,502,365)	(28,668)	5,473,697	19,093%
(328,315)	(499,610)	(171,295)	(34)%	BAD DEBTS	(890,508)	(1,498,830)	(608,322)	(41)%
(43,119,512)	(43,445,529)	(326,017)	(1)%	TOTAL DEDUCTIONS	(132,978,830)	(130,336,587)	2,642,243	2%
12,575,281	12,667,617	92,337	(1)%	NET SERVICE REVENUE	38,661,818	38,002,852	(658,966)	2%
640,952	682,482	41,531	(6)%	OTHER OPERATING REVENUE	1,723,401	2,047,446	324,045	(16)%
13,216,232	13,350,099	133,867	(1)%	TOTAL OPERATING REVENUE	40,385,219	40,050,298	(334,921)	1%
				***** OPERATING EXPENSE *****				
5,450,511	5,499,218	(48,707)	(1)%	SALARIES	17,046,598	16,608,970	437,628	3%
465,369	670,131	(204,762)	(31)%	S&W PTO	1,710,916	2,024,305	(313,389)	(16)%
1,441,231	1,463,155	(21,924)	(2)%	EMPLOYEE BENEFITS	4,330,672	4,406,816	(76,144)	(2)%
1,556,751	1,423,023	133,728	9%	PROFESSIONAL FEES	4,472,098	4,271,659	200,439	5%
912,352	854,270	58,082	7%	PURCHASED SERVICES	2,380,373	2,542,543	(162,170)	(6)%
2,123,850	2,036,596	87,254	4%	SUPPLIES & EXPENSES	6,065,895	6,103,289	(37,394)	(1)%
258,337	291,484	(33,147)	(11)%	MAINTENANCE & REPAIRS	742,679	837,077	(94,398)	(11)%
420,398	277,064	143,334	52%	UTILITIES	1,037,863	831,192	206,671	25%
30,057	19,602	10,455	53%	RENT/LEASE	96,882	58,812	38,070	65%
120,759	121,228	(469)	0%	INSURANCE	389,231	363,684	25,547	7%
967,539	1,023,851	(56,313)	(6)%	DEPRECIATION/AMORTIZATION	2,913,748	3,095,830	(182,082)	(6)%
327,149	313,574	13,575	4%	OTHER EXPENSE	916,516	961,732	(45,216)	(5)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,074,302	13,993,196	81,106	1%	TOTAL OPERATING EXPENSE	42,103,470	42,105,909	(2,439)	0%
(858,070)	(643,097)	214,973	33%	NET GAIN/(LOSS) FROM OPERATIONS	(1,718,251)	(2,055,611)	(337,360)	(16)%
138,253	138,253	0	0%	DISTRICT TAXES	414,759	414,759	0	0%
470,693	343,455	(127,238)	37%	INVESTMENTS INCOME	1,187,603	1,030,363	(157,240)	15%
49,033	54,010	4,977	(9)%	OTHER NON OPERATING INCOME	147,396	162,031	14,635	(9)%
(76,478)	(80,573)	(4,095)	(5)%	INTEREST EXPENSE	(232,804)	(241,719)	(8,915)	(4)%
(29,166)	(36,952)	(7,786)	(21)%	NON-OPERATING EXPENSE	(108,562)	(110,859)	(2,297)	(2)%
552,335	418,193	(134,142)	32%	TOTAL NON-OPERATING INCOME	1,408,393	1,254,575	(153,818)	12%
(305,735)	(224,904)	80,831	36%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(309,858)	(801,036)	(491,178)	(61)%
757,671	100,000	(657,671)	658%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	2,520,081	300,000	(2,220,081)	740%
451,936	(124,904)	(576,840)	(462)%	NET GAIN/(LOSS)	2,210,223	(501,036)	(2,711,259)	(541)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
09/30/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(858,070)	(1,718,251)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	967,539	2,913,748
Provision for bad debts	(405,994)	(647,181)
Change in assets and liabilities:		
Patient accounts receivable, net	1,609,497	2,801,245
Other receivables	(953,317)	(4,797,218)
Inventories	(8,256)	(70,905)
Prepaid expenses and deposits	46,845	(130,581)
Advance refunding of bonds payable, net	20,980	62,939
Accounts payable and accrued expenses	(566,267)	(2,051,927)
Deferred inflows - leases	(26,301)	(78,903)
Accrued payroll and related costs	165,313	(1,411,839)
Estimated third-party payor settlements	(30,000)	(132,809)
Self-insurance reserves	(530)	2,729
Total adjustments	819,509	(3,540,702)
Net cash provided by (used in) operating activities	(38,561)	(5,258,953)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	414,759
Noncapital grants and contributions, net of other expenses	8,848	2,495
Net cash provided by (used in) noncapital financing activities	147,101	417,254
Cash flows from capital and related financing activities:		
Purchase of capital assets	(312,441)	(716,380)
Proceeds from lease receivable, net	25,828	77,023
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,828)	(789,272)
Net change in notes payable and lease liability	(100,444)	(300,020)
Net changes in assets limited as to use	(495,820)	3,103,140
Net cash provided by (used in) capital and related financing activities	(884,705)	(2,680,509)
Cash flows from investing activities:		
Net (purchase) or sale of investments	698,313	(2,635,566)
Investment income	470,693	1,187,603
Net cash provided by (used in) investing activities	1,169,006	(1,447,963)
Net increase (decrease) in cash and cash equivalents:	392,841	(8,970,171)
Cash and cash equivalents at beginning of month/year	13,683,626	23,046,638
Cash and cash equivalents at end of month	14,076,467	14,076,467

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
September 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Oct-23	10,806,912	1,614,798	12,421,710
Nov-23	11,048,937	5,395,178	16,444,115
Dec-23	9,261,593	1,749,227	11,010,820
Jan-24	12,040,509	3,417,973	15,458,481
Feb-24	10,531,309	1,474,392	12,005,701
Mar-24	11,275,398	3,178,205	14,453,603
Apr-24	13,314,378	6,920,700	20,235,078
May-24	11,564,879	10,488,610	22,053,489
Jun-24	10,598,225	7,664,994	18,263,219
Jul-24	13,499,837	278,849	13,778,686
Aug-24	10,684,807	298,095	10,982,902
Sep-24	**12,800,001**	**1,611,606**	**14,411,607**

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 Supplemental Funds
- Medicare interim payments

September 2024 Summary of Other Activity:

846,043	M-Cal HQAF8 Direct Grant CY23
35,265	Tulare County First 5 04/24 - 06/24 Qtr
444,147	M-Care Temporary Allowance
286,151	Miscellaneous
1,611,606	09/24 Total Other Activity