Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

July 8, 2020 12:00 pm
Boardroom: Fully Remote
Join Zoom Meeting: Click Here to Enter the meeting
Meeting ID: 914 4308 9783
Call in Number: 1-669-900-9128

Attendees

Laura Beyer, Board Secretary
Jeanne Utterback, Director
Louis Ward, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**		Chair Laura Beyer			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – June 10, 2020		Attachment A	**Action Item**	2 min.
4	**Environmental Sampling of Barrier Isolator Update:** Keith Earnest			Attachment B	Information	2 min.
5	**REPORTS: QUALITY FACILITIES: NO REPORTS**					
6	**REPORTS: QUALITY STAFF**					
	6.1	Director of Human Resources	Libby Mee	Attachment C	Report	2 min.
	6.2	Worker's Comp Quarterly	Libby Mee	Attachment D	Report	2 min.
	6.3	Lab	Chris Hall	Attachment E	Report	2 min.
7	**REPORTS: QUALITY PATIENT SERVICES**					
	7.1	HIM	Lori Stephenson	Attachment F	Report	2 min.
	7.2	Activities	Sondra Camacho	Attachment G	Report	2 min.
	7.3	Chief Nursing Officer Report	Candy Vculek	Attachment H	Report	5 min.
	7.4	SNF Events/Survey	Candy Vculek		Report	10 min.
	7.5	Infection Control	Dawn Jacobson		Report	5 min.
8	**REPORTS: QUALITY FINANCES**					
	8.1	Patient Access	Amy Parker	Attachment I	Report	2 min.
	8.2	Business Office	Danielle Olson	Attachment J	Report	2 min.
	8.3	Chief Financial Officer – Finance Report	Travis Lakey	Attachment K	Report	5 min.

9	**REPORTS: QUALITY EDUCATION**				
	9.1	REPORT	Jack Hathaway	Report	5 min.
10	**QUALITY PROGRAM REPORTING AND INITIATIVES**				
	10.1	Quality/Performance Improvement:	Jack Hathaway	Report	5 min.
	10.2	Prime	Jack Hathaway	Report	5 min.
11	**NEW BUSINESS**				
	11.1	POLICIES: Attachment L 1. Board Meetings -- Location, Time, Date and Quorum 2. Discipline Corrective Action 3. Corrective Action Notice 4. HHS POVERTY GUIDELINES - 75% MMH388		**Action**	5 min.
	11.2	Quality Agenda Template		Discussion	5 min.
12	**ADMINISTRATIVE REPORT**		Louis Ward	Report	10 min.
13	**OTHER INFORMATION/ANNOUNCEMENTS**			Information	5 min.
16	**ADJOURNMENT:** Next Regular Meeting – WHEN (Fall River Mills)				

Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes
Full Remote Teleconference
June 10, 2020 @ 12:00 PM
Fully Remote Zoom Meeting

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

1	**CALL MEETING TO ORDER:** Board Chair Laura Beyer called the meeting to order at 12:00 pm on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Laura Beyer, Secretary Jeanne Utterback, Director		Louis Ward, CEO Jack Hathaway, DOQ JD Phipps, Director of Ancillary Services Theresa Overton, DNO Acute Diana Groendyke, DNO Skilled Chris Hall, Manager of Laboratory Jessica DeCoito, Board Clerk	
	ABSENT: Dawn Jacobson, Infection Control Preventionist Candy Vculek, CNO			
2	**CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
	None			
3	**APPROVAL OF MINUTES**			
	3.1	A motion/second carried; committee members accepted the minutes of May 13, 2020	***Utterback, Hathaway***	**Beyer – Y** **Utterback – Y**
4	**Quality Facilities Reports: No reports submitted**			
5	**Quality Staff Reports: No reports submitted**			
6	**Quality Patient Reports: Written reports submitted**			
	6.1	**Emergency Department:** no additional questions.		
	6.2	**Radiology:** challenges around some start up issues but have been resolved with primary facilities – UC Davis, Shasta Regional, etc. Portals have been created to send images to without the use of email addresses. Report should include all boxes and areas to be addressed - JD to follow up.		
	6.3	**SNF:** SNF has the most incredible staff and during the COVID-19 situation, they have been able to keep up the great attitudes and keep residents happy and taken care of. Admission process is going smoothly even with the COVID-19 measures that were put into place. Star Rating – focus has been a huge priority and we hope to get a 3 Star. Change will occur in shift times on June 21st and we should see an improvement with our resident's schedule, as well as staff hours. Streamlined the dashboard in Point Click Care database for all SNF staff to help with communication issues. Residents are having a tough time with the social distancing measures but new ideas have been started to keep residents engaged with activities, seeing family members, and socializing.		
	6.4	**Acute:** Shift change for nurses will happen in all departments. And constant communication with SNF and Acute is happening with regards to all staff members. Adapting to the Daily Management System (DMS). This will allow staff members to enter their shift with the most up to date information and status on the patient. Nurses will be giving two significant notes/updates/information on their patients twice a day – beginning of shift and end of shift. In addition to all significant updates throughout the shifts.		

	6.5	**Infection Control:** no report provided		
	6.6	**SNF Events/Survey:** no report provided		
7	**Quality Finances Reports: No Department Reports**			
8	**Quality Education:** Relias is working for all of our education. COVID-19 has been through Relias as well. CNA education has continued through videos.			
9	**Quality Program Reporting and Initiatives**			
	9.1	**Quality/Performance Improvement**: Mitigation Plan was a huge piece to work on and thank you to everyone that participated in that plan and getting it together. And thank you to the Acute Nursing team that will take part in the intake of SNF Residents through the new plan. The Mitigation Plan has been approved with 98% completion and we will now be tested on the plan – which could happen soon.		
	9.2	**PRIME**: some changes could happen to Prime – those are really unknown at this point. We are continuing to follow our guidelines and submit what is required. And hope to hear of what those changes could be. We are hoping that we can continue to follow current Prime rules for another year.		
10	**NEW BUSINESS**: none			
11	**ADMINISTRATIVE REPORT**: COVID-19: 47 cases in Shasta Co. – 1 county resident being housed in a neighboring county hospital. Focus has been on hospitalized cases rather than all positive tests because more tests are being done right now. Research continues on asymptomatic cases. In house (MMHD) testing is being formulated and we have obtained tests. Testing will begin with MMHD employees starting on June 15th. SNF residents have been tested and results are pending. So far tests have not come back positive. Focus on moving to NHW - Equipment, workflows (what works today might not work in the NHW), etc. Dietary department has a full staff and less turnover for staff has been seen - a big part of the change has been closing the kitchen during lunch hours and allowing for staff to rework their workflows. We have been able to open up for online orders to MMHD Staff – starting slow with the new Point of Sale system but increasing menu options for a full menu soon.			
12	**OTHER INFORMATION/ANNOUNCEMENTS**: Lab to report next month. Departments need to complete their reports in full – please do not leave boxes unfilled.			
13	**CLOSED Session Announcement at 1:10 pm: Approval of Credentials:** moved to approve by Utterback, Beyer seconded and approved – with credentials to be review on June 11th for signature.			
14	**CLOSED Session Adjournment at 1:13 pm: Reconvene Open session**			
14	**ADJOURNMENT: 1:14 pm** - Next Regular Meeting – July 8, 2020			

2880 Bergey Road, Ste. K
Hatfield, PA 19440
www.envservices.com
800 - 345 - 6094

Presents:

Biological Sampling Report

Control ID #: 6004-227418-25945V

Prepared for:

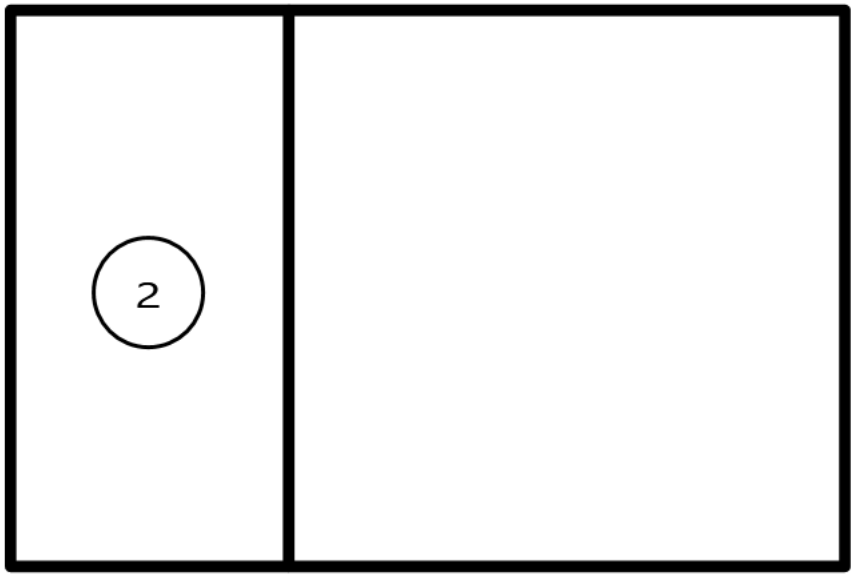
MAYERS MEMORIAL HOSPITAL
43563 HWY 299 EAST
FALL RIVER MILLS, CA 96028

Location Tested:
PHARMACY

Date(s) Tested:
JUNE 25, 2020
Field Service Technician(s):
TARENCE GLASKER

BIOLOGICAL SAMPLING LOCATIONS

OPERATIONAL / DYNAMIC



Simple Location Key

#	Air and Surface, Bacteria and Fungal
#	Surface Only, Bacteria and Fungal
#	Air Only, Bacteria and Fungal

Test Result
For Reference Only

ENV SERVICES, Inc.
PROVIDING NATIONWIDE SOLUTIONS, CERTIFICATION, CALIBRATION, VALIDATION, CLEANROOMS

Project: **MAYERS MEMORIAL HOSPITAL**
43563 HWY 299 EAST
FALL RIVER MILLS, CA 96028

Test Date: June 25, 2020

Control ID #: 6004-227418-25945V

TEST EQUIPMENT

MAYERS MEMORIAL HOSPITAL
FALL RIVER MILLS, CA 96028
PHARMACY

Equipment Name	Manufacturer	Model	Serial	Calibration Due Date
AIR SAMPLER	PBI	SAS DUO 360	16-D-11431	13 DEC 20

All testing is performed by qualified personnel using instrumentation, procedures and methods which ensure measurements observed are reliable. When specified, testing is performed in accordance with current ISO-17025, ISO-14644, USP-<797> and ENV's Quality Manual. Specifications comply with One or More of the following; applicable IEST recommended practices, CETA CAG-009-2011v3, Manufacturer Recommendations, and/or customer determined specifications. Measurement instruments used are traceable to The National Institute of Standards and Technology (NIST). Results obtained apply to the specific room or equipment and are reflective of conditions at the time of this test.

Test equipment calibration certificates available upon request.
Company ID: CA0434-001 Unique ID: 587201

RP20062936

M-BioLabs

ISO/IEC 17025:2005 Accredited
PJLA Accreditation # 94315
Testing

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USP <797>Viable Sample Report

Client Project ID:

6004-227418 CA0434-001 MAYERS MEMORIAL HOSPITAL

Reported To:

Client Name: ENV Services, Inc
Client Address: 2880 Bergey Road, Suite K
City, State, Zip: Hatfield, PA 19940
Attn: Reports Dept
Sample(s) Condition: Acceptable

Sampling Date: 06/25/2020
Date Received: 06/26/2020
Bacterial Read: 06/29/2020
Fungal Read:
Report Generation: 06/29/2020
Job ID: 20062611

Overall Comments: Growth Found.

Above Action Level Sample Summary

COC No.	Room	Description	Test Method	ISO Class	Result (Total CFUs)	Comments

* Samples with microorganisms above the recommended action levels per USP <797> or deemed highly pathogenic. Refer to sample page below for detailed results.

USP <797> Recommended Action Levels for Microbial Contamination

ISO Class	Particulate Size ($0.5m/m^3$)	Air (400-1000L) (CFU/m^3/plate)	Surface (CFU/plate)	Post Media-Fill Gloved Fingertip (CFU/plate, combined hands, all risk levels)	Gloved Fingertip (CFU/plate, combined hands, all risk levels)	Media-Fill Test
5	3,520	>1	>3	>3	0	+ or -
7	352,000	>10	>5	N/A	N/A	N/A
8 or worse	3,520,000	>100	>100	N/A	N/A	N/A

Authorized By:

Jerritt Nunneley, M.S., CNBT
Laboratory Director

RP20062936

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Client Name: ENV Services, Inc

Client Project ID: 6004-227418 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20062611
Bacterial Read: 06/29/2020
Fungal Read:
Report Generation: 06/29/2020

Pass (<1 CFU): No visible growth present, less than the limit of detection.

Under Action Levels (UAL): Microorganisms under the recommended action levels per USP <797>.

Above Action Levels (AAL): Microorganisms above the recommended action levels per USP <797> or deemed highly Pathogenic.

Unclassified (N/A): non-HEPA filtered area.

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
2	UAL	1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	BACTERIA - AIR USP	1000 (L)	20062611.01	1

	Raw CFU	CFU/m³	Organism Id Date
Bacillus (bact)	1	1	06/29/2020

Comments :

N/A	N/A	Growth	N/A	N/A	(+) Controls	(+) BACTERIA CONTROL USP	0 (L)	20062611.02	1

Comments :

N/A	N/A	<1	N/A	N/A	(-) Controls	(-) BACTERIA CONTROL USP	0 (L)	20062611.03	1

Comments :

Media Information

Test Parameter	Media	Manufacturer	Lot#	Exp. Date
BACTERIA - MEDIA	TSA	Remel	957675	07/13/2020

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Client Name: ENV Services, Inc

Client Project ID: 6004-227418 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20062611
Bacterial Read: 06/29/2020
Fungal Read:
Report Generation: 06/29/2020

USP <797>Supplemental Information

1. **Growth Media**
   - **1.1.** A general microbiological growth medium such as Soybean-Casein Digest Medium (also known as Trypticase Soy Broth (TSB) or agar (TSA) **shall** be used to support the growth of bacteria.
   - **1.2.** Malt Extract Agar (MEA) or suitable substitute **shall** be used to support the growth of fungi.
   - **1.3.** Media used for surface sampling **shall** be supplemented with additives to neutralize the effects of disinfecting agents (e.g., TSA with Lethicin and Polysorbate 80).
   - **1.4.** Bacterial media is incubated inverted for 2-3 days at 30-35°C and fungal media is incubated inverted for 5-7 days at 26-30°C.

2. **Viable Sampling**
   - **2.1. Air:**
     - **2.1.1.** **Shall** be performed dynamically at least semiannually (i.e. every 6 months) in **ALL** ISO Class environments.
     - **2.1.2.** Impact **shall** be the preferred method volumetric sampling, settling plates are not sufficient.
     - **2.1.3.** 400-1000 liters of air **shall** be tested at each location and reported as CFU/m^3 of air.
   - **2.2. Surface:**
     - **2.2.1.** **Shall** be performed dynamically in **ALL** ISO classified areas on a periodic basis (contact plates and/or swabs) and **shall** be done at the conclusion of compounding.
     - **2.2.2.** Results are reported as CFU per sampled unit area.

3. **Gloved Fingertip Testing**
   - **3.1.** **Shall** be performed for all CSP risk level compounding.
   - **3.2.** Immediately after gowning, the evaluator **shall** collect a gloved fingertip and thumb sample from both hands on a general microbiological media (TSA).
   - **3.3.** Initial gloved fingertip/thumb sampling procedure requires (0 CFU) no less than 3 times before initially being allowed to compound CSPs for human use.
   - **3.4.** Re-evaluation of all compounding personnel **shall** occur at least annually for low- and medium-risk level CSPs and semiannually for high-risk.
   - **3.5.** CFU action level **shall** be based on the total number of CFU on both gloves and not per hand.
   - **3.6.** **Should** be reported separately as number of CFU per employee per hand (left hand, right hand).

4. **Media-Fill Testing**
   - **4.1.** **Shall** be performed initially before beginning to prepare CSPs and at least annually thereafter for low- and medium-risk level; and semiannually for high-risk.
   - **4.2.** **Shall** be evaluated using sterile fluid bacterial (TSB) culture media-fill verification.
   - **4.3.** Media-filled vial or IV bag is incubated for 7 days at 20°-25° followed by 7 days at 30°-35°.

5. **Reporting Information**
   - **5.1.** Highly pathogenic microorganisms (e.g., Gram-negative rods, coagulase positive staphylococcus, molds, and yeasts) **must** be immediately remedied, regardless of CFU count. Any CFU count that exceeds its respective action level **shall** have an investigation into the source of contamination, **shall** be eliminated, the affected area cleaned, and resampling performed.
   - **5.2.** Positive controls are unopened samples submitted for growth promotion testing (inoculation) which eliminates false negatives. Negative controls are unopened samples submitted for incubation solely which eliminates false positives.
     - **5.2.1.** There should be a positive and negative control for each lot number of every media type used.
   - **5.3.** MRL is the minimum reporting limit for a sample.
   - **5.4.** Results found in this report are solely tied to the project above and the samples therein.
   - **5.5.** A positive-hole correction factor has been applied to all applicable air samples. The positive-hole correction factor accounts for the statistical possibility that multiple viable particles can pass through the same hole of an air sampler head. The positive hole correction factor is applied to the total plate colony count, therefore the sum of individual organism calculated counts may be reported as less that the total plate corrected count.

6. **References**

- *Jorgensen H., James, et al. Manual of Clinical Microbiology: 11th Edition. ASM Press, 2015.*
- *Holt G., John, et al. Bergey's Manual of Determinative Bacteriology: 9th Edition. Williams & Wilkins, 1994.*
- *St-Germain, Guy, and Richard Summerbell. Identifying Fungi: A Clinical Laboratory Handbook 2nd Edition. Star Publishing Company, 2011.*
- *Sciortino, Jr. V., Carmen. Atlas of Clinically Important Fungi. Wiley Blackwell, 2017.*
- *de Hoog S., G., et al. Atlas of Clinical Fungi: The ultimate benchtool for diagnostics, USB Version 4.1. Centraalbureau voor Schimmelcultures, Utrecht, The Netherlands.*

Note: All incubation times and temperatures listed above are not applicable to samples that have been "client incubated" prior to delivery to M-BioLabs.

2880 Bergey Road, Ste. K
Hatfield, PA 19440
www.envservices.com
800 - 345 - 6094

Presents:

Biological Sampling Report

Control ID #: 6010-219068-20811V

Prepared for:

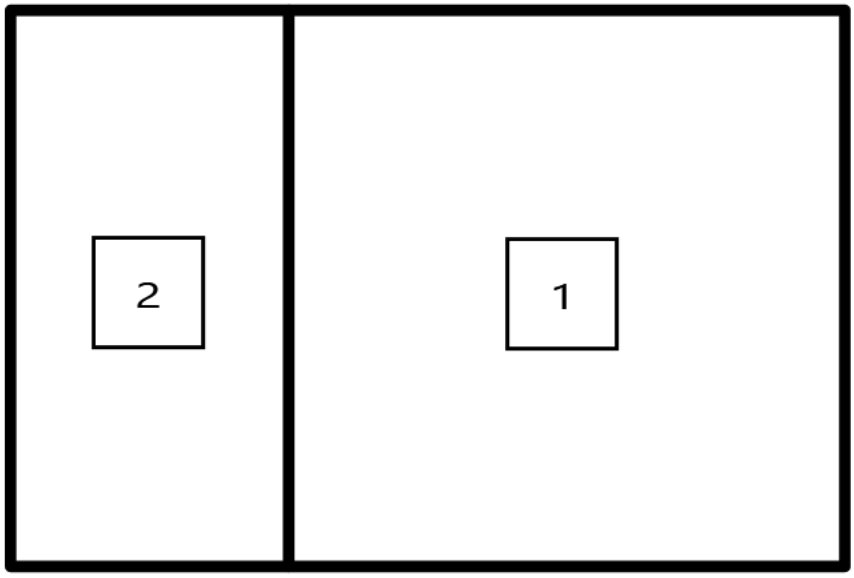
MAYERS MEMORIAL HOSPITAL
43563 HWY 299 EAST
FALL RIVER MILLS, CA 96028

Location Tested:
PHARMACY

Date(s) Tested:
JUN 10, 2020
Field Service Technician(s):
ENRICO ORLINO

BIOLOGICAL SAMPLING LOCATIONS

OPERATIONAL / DYNAMIC



= CENTER OF PHARMACY ROOM

= TOP OF TABLE

Simple Location Key

Air and Surface, Bacteria and Fungal

Surface Only, Bacteria and Fungal

Air Only, Bacteria and Fungal

Test Result
For Reference Only

ENV SERVICES, Inc.
PROVIDING NATIONWIDE SOLUTIONS, CERTIFICATION, CALIBRATION, VALIDATION, CLEANROOMS

Project: **MAYERS MEMORIAL HOSPITAL**
43563 HWY 299 EAST
FALL RIVER MILLS, CA 96028

Test Date: June 10, 2020

Control ID #: 6010-219068-20811V

TEST EQUIPMENT

MAYERS MEMORIAL HOSPITAL
FALL RIVER MILLS, CA 96028
PHARMACY

Equipment Name	Manufacturer	Model	Serial	Calibration Due Date
DUAL HEADED AIR SAMPLER	PBI	SAS DUO 360	17-D-12293	20 FEB 21

All testing is performed by qualified personnel using instrumentation, procedures and methods which ensure measurements observed are reliable. When specified, testing is performed in accordance with current ISO-17025, ISO-14644, USP-<797> and ENV's Quality Manual. Specifications comply with One or More of the following; applicable IEST recommended practices, CETA CAG-009-2011v3, Manufacturer Recommendations, and/or customer determined specifications. Measurement instruments used are traceable to The National Institute of Standards and Technology (NIST). Results obtained apply to the specific room or equipment and are reflective of conditions at the time of this test.

Test equipment calibration certificates available upon request.
Company ID: CA0434-001 Unique ID: 587201

RP20061702

M-BioLabs

ISO/IEC 17025:2005 Accredited
PJLA Accreditation # 94315
Testing

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USP <797>Viable Sample Report

Client Project ID:

6010-219068 CA0434-001 MAYERS MEMORIAL HOSPITAL

Reported To:

Client Name: ENV Services, Inc
Client Address: 2880 Bergey Road, Suite K
City, State, Zip: Hatfield, PA 19940
Attn: Reports Dept
Sample(s) Condition: Acceptable.

Sampling Date: 06/10/2020
Date Received: 06/12/2020
Bacterial Read: 06/15/2020
Fungal Read: 06/17/2020
Report Generation: 06/17/2020
Job ID: 20061202

Overall Comments: Growth Found.

Above Action Level Sample Summary

COC No.	Room	Description	Test Method	ISO Class	Result (Total CFUs)	Comments
2	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	BACTERIA - AIR USP	5	8 CFU/m³	OVER CFU LIMIT

* Samples with microorganisms above the recommended action levels per USP <797> or deemed highly pathogenic. Refer to sample page below for detailed results.

USP <797> Recommended Action Levels for Microbial Contamination

ISO Class	Particulate Size (0.5m/m³)	Air (400-1000L) (CFU/m³/plate)	Surface (CFU/plate)	Post Media-Fill Gloved Fingertip (CFU/plate, combined hands, all risk levels)	Gloved Fingertip (CFU/plate, combined hands, all risk levels)	Media-Fill Test
5	3,520	>1	>3	>3	0	+ or -
7	352,000	>10	>5	N/A	N/A	N/A
8 or worse	3,520,000	>100	>100	N/A	N/A	N/A

Authorized By:

Jerritt Nunneley, M.S., CNBT
Laboratory Director

RP20061702

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Client Name: ENV Services, Inc

Client Project ID: 6010-219068 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20061202
Bacterial Read: 06/15/2020
Fungal Read: 06/17/2020
Report Generation: 06/17/2020

Pass (<1 CFU): No visible growth present, less than the limit of detection.

Under Action Levels (UAL): Microorganisms under the recommended action levels per USP <797>.

Above Action Levels (AAL): Microorganisms above the recommended action levels per USP <797> or deemed highly Pathogenic.

Unclassified (N/A): non-HEPA filtered area.

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
1	Pass	<1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	BACTERIA - AIR USP	1000 (L)	20061202.01	1

Comments :

1	Pass	<1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	FUNGAL - AIR USP	1000 (L)	20061202.02	1

Comments :

1	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	BACTERIA - SURFACE USP	25cm²	20061202.03	1

Comments :

1	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	FUNGAL - SURFACE USP	25cm²	20061202.04	1

Comments :

RP20061702

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Client Name: ENV Services, Inc

Client Project ID: 6010-219068 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20061202
Bacterial Read: 06/15/2020
Fungal Read: 06/17/2020
Report Generation: 06/17/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
2	AAL	8 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	BACTERIA - AIR USP	1000 (L)	20061202.05	1

	Raw CFU	CFU/m³	Organism Id Date
Micrococcus luteus (bact)	8	8	06/15/2020

Comments : OVER CFU LIMIT

2	Pass	<1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	FUNGAL - AIR USP	1000 (L)	20061202.06	1

Comments :

2	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	BACTERIA - SURFACE USP	25cm²	20061202.07	1

Comments :

2	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	FUNGAL - SURFACE USP	25cm²	20061202.08	1

Comments :

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Client Name: ENV Services, Inc

Client Project ID: 6010-219068 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20061202
Bacterial Read: 06/15/2020
Fungal Read: 06/17/2020
Report Generation: 06/17/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
3	N/A	256 (CFU/m³)	N/A	PHARMACY	CENTER OF PHARMACY ROOM	BACTERIA - AIR USP	1000 (L)	20061202.09	1

	Raw CFU	CFU/m³	Organism Id Date
Micrococcus luteus (bact)	150	250	06/15/2020
Staphylococcus haemolyticus (bact)	6	6	06/15/2020

Comments : CFU EXCEEDS THE MANUFACTURE COUNTABLE LIMIT

3	N/A	11 (CFU/m³)	N/A	PHARMACY	CENTER OF PHARMACY ROOM	FUNGAL - AIR USP	1000 (L)	20061202.10	1

	Raw CFU	CFU/m³	Organism Id Date
Aspergillus fumigatus (mold)	1	1	06/17/2020
Cladosporium (mold)	9	9	06/17/2020
Paecilomyces (mold)	1	1	06/17/2020

Comments :

4	N/A	9 (CFU/25cm²)	N/A	PHARMACY	TOP OF TABLE	BACTERIA - SURFACE USP	25cm²	20061202.11	1

	Raw CFU	CFU/25cm²	Organism Id Date
Micrococcus luteus (bact)	6	6	06/15/2020
Staphylococcus epidermidis (bact)	3	3	06/15/2020

Comments :

M-BioLabs
12815 Wetmore Rd., San Antonio, TX 78247 | Toll: (877) 659-4353 | Fax: (844) 849-5313 | www.mbiolabs.com

Client Name: ENV Services, Inc

Client Project ID: 6010-219068 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20061202
Bacterial Read: 06/15/2020
Fungal Read: 06/17/2020
Report Generation: 06/17/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
4	N/A	1 (CFU/25cm²)	N/A	PHARMACY	TOP OF TABLE	FUNGAL - SURFACE USP	25cm²	20061202.12	1

	Raw CFU	CFU/25cm²	Organism Id Date
Non-Sporulating Colony (mold)	1	1	06/17/2020

Comments :

N/A	N/A	<1	N/A	N/A	(-) Controls	(-) BACTERIA CONTROL USP	0 (L)	20061202.13	1

Comments :

N/A	N/A	<1	N/A	N/A	(-) Controls	(-) FUNGAL CONTROL USP	0 (L)	20061202.14	1

Comments :

N/A	N/A	Growth	N/A	N/A	(+) Controls	(+) BACTERIA CONTROL USP	0 (L)	20061202.15	1

Comments :

RP20061702

12815 Wetmore Rd., San Antonio, TX 78247 | Toll: (877) 659-4353 | Fax: (844) 849-5313 | www.mbiolabs.com

Client Name: ENV Services, Inc

Client Project ID: 6010-219068 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20061202
Bacterial Read: 06/15/2020
Fungal Read: 06/17/2020
Report Generation: 06/17/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
N/A	N/A	Growth	N/A	N/A	(+) Controls	(+) FUNGAL CONTROL USP	0 (L)	20061202.16	1

Comments :

Media Information

Test Parameter	Media	Manufacturer	Lot#	Exp. Date
BACTERIA - MEDIA	TSA	Remel	957675	07/13/2020
FUNGAL - MEDIA	SabDex	Remel	966828	07/02/2020

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Bacterial Read: 06/15/2020
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USP <797>Supplemental Information

1. **Growth Media**
   - **1.1.** A general microbiological growth medium such as Soybean-Casein Digest Medium (also known as Trypticase Soy Broth (TSB) or agar (TSA) **shall** be used to support the growth of bacteria.
   - **1.2.** Malt Extract Agar (MEA) or suitable substitute **shall** be used to support the growth of fungi.
   - **1.3.** Media used for surface sampling **shall** be supplemented with additives to neutralize the effects of disinfecting agents (e.g., TSA with Lethicin and Polysorbate 80).
   - **1.4.** Bacterial media is incubated inverted for 2-3 days at 30-35°C and fungal media is incubated inverted for 5-7 days at 26-30°C.

2. **Viable Sampling**
   - **2.1. Air:**
     - **2.1.1.** **Shall** be performed dynamically at least semiannually (i.e. every 6 months) in **ALL** ISO Class environments.
     - **2.1.2.** Impact **shall** be the preferred method volumetric sampling, settling plates are not sufficient.
     - **2.1.3.** 400-1000 liters of air **shall** be tested at each location and reported as CFU/m^3 of air.
   - **2.2. Surface:**
     - **2.2.1.** **Shall** be performed dynamically in **ALL** ISO classified areas on a periodic basis (contact plates and/or swabs) and **shall** be done at the conclusion of compounding.
     - **2.2.2.** Results are reported as CFU per sampled unit area.

3. **Gloved Fingertip Testing**
   - **3.1.** **Shall** be performed for all CSP risk level compounding.
   - **3.2.** Immediately after gowning, the evaluator **shall** collect a gloved fingertip and thumb sample from both hands on a general microbiological media (TSA).
   - **3.3.** Initial gloved fingertip/thumb sampling procedure requires (0 CFU) no less than 3 times before initially being allowed to compound CSPs for human use.
   - **3.4.** Re-evaluation of all compounding personnel **shall** occur at least annually for low- and medium-risk level CSPs and semiannually for high-risk.
   - **3.5.** CFU action level **shall** be based on the total number of CFU on both gloves and not per hand.
   - **3.6.** **Should** be reported separately as number of CFU per employee per hand (left hand, right hand).

4. **Media-Fill Testing**
   - **4.1.** **Shall** be performed initially before beginning to prepare CSPs and at least annually thereafter for low- and medium-risk level; and semiannually for high-risk.
   - **4.2.** **Shall** be evaluated using sterile fluid bacterial (TSB) culture media-fill verification.
   - **4.3.** Media-filled vial or IV bag is incubated for 7 days at 20°-25° followed by 7 days at 30°-35°.

5. **Reporting Information**
   - **5.1.** Highly pathogenic microorganisms (e.g., Gram-negative rods, coagulase positive staphylococcus, molds, and yeasts) **must** be immediately remedied, regardless of CFU count. Any CFU count that exceeds its respective action level **shall** have an investigation into the source of contamination, **shall** be eliminated, the affected area cleaned, and resampling performed.
   - **5.2.** Positive controls are unopened samples submitted for growth promotion testing (inoculation) which eliminates false negatives. Negative controls are unopened samples submitted for incubation solely which eliminates false positives.
     - **5.2.1.** There should be a positive and negative control for each lot number of every media type used.
   - **5.3.** MRL is the minimum reporting limit for a sample.
   - **5.4.** Results found in this report are solely tied to the project above and the samples therein.
   - **5.5.** A positive-hole correction factor has been applied to all applicable air samples. The positive-hole correction factor accounts for the statistical possibility that multiple viable particles can pass through the same hole of an air sampler head. The positive hole correction factor is applied to the total plate colony count, therefore the sum of individual organism calculated counts may be reported as less that the total plate corrected count.

6. **References**

- *Jorgensen H., James, et al. Manual of Clinical Microbiology: 11th Edition. ASM Press, 2015.*
- *Holt G., John, et al. Bergey's Manual of Determinative Bacteriology: 9th Edition. Williams & Wilkins, 1994.*
- *St-Germain, Guy, and Richard Summerbell. Identifying Fungi: A Clinical Laboratory Handbook 2nd Edition. Star Publishing Company, 2011.*
- *Sciortino, Jr. V., Carmen. Atlas of Clinically Important Fungi. Wiley Blackwell, 2017.*
- *de Hoog S., G., et al. Atlas of Clinical Fungi: The ultimate benchtool for diagnostics, USB Version 4.1. Centraalbureau voor Schimmelcultures, Utrecht, The Netherlands.*

Note: All incubation times and temperatures listed above are not applicable to samples that have been "client incubated" prior to delivery to M-BioLabs.

Board Quality Report Template

Name: Libby Mee - Director of Human Resources **Department:** Human Resources **Last Quality project reported:** Ensuring compliance with new 2020 regulations and laws, most specifically AB 5. **Update on last Quality project reported:** HR communicated with previously contracted staff, clarifying how their employment agreement would look going forward based on new regulations.	**Current report date to Board Quality:** 07/08/20 **Last report date to Board Quality:** 01/08/20

What successes have you seen based on the outcome of previous Quality projects?

We were able to maintain employment relationships with all previously classified contractors.

What issues have come up in your department relating to Quality?

The need to provide a more formal Manager Training and Re-Orientation program.
Due to COVID-19, we have put a hold on the implementation of the Just Culture program.

PLAN: What plan was implemented to address those issues?

We have built a program to be presented to all MMHD managers. Attached, pleas find the agenda for all topics that will be presented with the program. The program outlines all the topics necessary to be an effective leader. Manager will be assigned appropriate trainings in Relias, will be directed to review policies in the MCN system, and will be scheduled to meet with other department managers to better understand processes.

DO: How did the implementation of that plan go? The recently completed program was previewed by a new MMHD manager and a current MMHD manager for content and feedback. All feedback was positive, and both employees thought the presented information covered everything needed and would be very helpful to have.
STUDY: What kind of results did the implementation of the plan yield? Unknown at this time. Will plan to use the program for newly hired/promoted MMHD managers, and will assign the program to current MMHD managers as a Re-Orientation to the materials that were in formerly presented previously.
ACT: What changes were made based on the results of the plan implementation? None at this time, but the program is built to be added and edited as compliance and needs change.
Is this a LEAN project? Yes ☐ **No** ■ **If YES, please attach the A3.**

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Implementation of Just Culture	To provide support to all members of Team Mayers, while adhering to P&P, State and Federal regulations.

What Strategic Plan Objective does your project BEST align with? Choose only one.

☐ **Outstanding Facilities:** By 2025, we will open two rural health clinics, update the skilled nursing facility living space at the Fall River campus and have a resolution for aging facilities.

■ **Outstanding Staff:** By 2025, we will be seen as an employer of choice in the area by providing and maintaining staff growth opportunities, flexible and safe working arrangements, and reducing the use of registry staff.

☐ **Outstanding Patient Services:** By 2025, we will be a four-star long term care facility and meet all Hospital Consumer Assessment of Healthcare Providers (HCAHP) requirements. By 2025, we will be operating two rural health clinics.

☐ **Outstanding Finances:** By 2025, we will have in place and utilize financial tools to actively develop and forecast long term expenditures.

Data/Graphics supporting project outcomes:

WELCOME TO THE MAYERS MANAGEMENT TEAM

- ❑ Agenda
- ❑ Being an Effective Leader RELIAS
- ❑ Communication Essentials RELIAS

GENERAL INFORMATION *Libby Mee, Director of Human Resource*

- ❑ Equal Employment Opportunity P&P
- ❑ Employee Handbook P&P
- ❑ Harassment Discrimination and Retaliation Prevention P&P
- ❑ Smoke and Tobacco Free Campus P&P
- ❑ Dress Code Personal Appearance P&P
- ❑ Job Description
- ❑ Employee Records
  - ○ Personnel
  - ○ Payroll
  - ○ Health
  - ○ Work Comp
- ❑ Personnel Action FORM
- ❑ Wage Scale

POLICY & PROCEDUE *Pam Sweet – Executive Assistant*

- ❑ Policy Software
  - ○ MCN
- ❑ Creation and Approval Process

ADMINISTRATION *Lisa Zaech – Executive Assistant to Louis Ward, CEO*

- ❑ Organizational Chart
- ❑ Internal/External Phone List
- ❑ Administrator on Call (AOC) schedule
- ❑ Affiliations and Designations
- ❑ Meetings
  - ○ Monthly Managers
  - ○ Monthly Department Meeting
- ❑ Reservation of Meeting Rooms
- ❑ Staff Travel P&P
- ❑ Workshop Request – Travel, Lodging & Registration FORM

SENIOR MANAGEMENT/SUPERVISION *Name:* _____

- ❑ Dress Code
- ❑ Badge
- ❑ Office
- ❑ Mail/Interoffice
- ❑ Parking P&P

APPLICATION-INTERVIEW–HIRE PROCESS *Libby Mee, Director of Human Resources*

- Hiring Process P&P
- Job Postings, Transfers & Promotions P&P
- Internal Transfer Request FORM
- Application Processing
- Interview
- Offer of Employment
- Pre-Employment Compliance
- Probationary Period

STAFFING *Libby Mee, Director of Human Resources*

- Hours of Work and Overtime P&P
- Scheduling P&P
- On Call Practices P&P
- Attendance P&P
- Paid Time Off Request P&P
- Paid Sick Time P&P
- Registry/Traveler
  - Request
  - Compliance
- Telecommuting P&P
- Hours Reduction P&P

COMPLIANCE *Libby Mee, Director of Human Resources*

- Pre-Employment
  - Background Check
  - Reference Checks P&P
  - Drug Free Workplace P&P
  - Health
    - Immunizations
    - TB Skin Test P&P
    - FIT Test
    - Physical
  - General Orientation RELIAS

- Annual
  - Performance Evaluation P&P
    - Trakstar
  - Re-Orientation RELIAS
  - TB Skin Test
  - Physical
  - Flu Vaccination
- Competencies
- In-service Education Program P&P
- Renewals, Licensed or Certified Employees P&P
  - EverCheck
- Employee Records

ONBOARDING NEW EMPLOYEES *Libby Mee, Director of Human Resources*

- Ensuring Onboarding Success RELIAS
- Onboarding Checklist
- Departmental Orientation for New Employees P&P
- Probation Period Evaluation
    - TrackStar

PAYROLL/BENEFIT *Kelly Babajan – Payroll Clerk/Benefit Administrator*

- Time and Attendance System
    - JBDevevlopers
- Time Recording P&P
- Payroll Direct Deposit P&P FORM
- Employee Benefit Program
    - Ease Central

EMPLOYEE HEALTH *Libby Mee, Director of Human Resources*

- Workman's Compensation Insurance P&P
    - Employee Injury Packet FORM
- Modification of Duties P&P
- Essential Functions Testing P&P
- Leave of Absence P&P
- Bereavement Leave P&P
- Lactation Accommodation P&P
- Return to Work P&P
- Drug Free Workplace P&P
    - Reasonable Suspicion Testing

EMPLOYEE RESOURCES *Libby Mee, Director of Human Resources*

- TEAM Mayers
- TEAM Fund
- Employee Assistance Program
- Code Lavender
- Employee Relief Fund P&P
- Education/Tuition Assistance
- Employee Referral Bonus Program P&P
- PTO Cash Out P&P

TRAININGS *Libby Mee, Director of Human Resources*

- Sexual Harassment Prevention RELIAS
- ICS 100 & 200 WEB
- Additional trainings, webinars and seminars as requested

COACHING/CORRECTIVE ACTION *Libby Mee, Director of Human Resources*

- Facing the Management Challenges of Difficult Behavior and Diverse Teams RELIAS
- Discipline Corrective Action P&P
- Corrective Action Notice FORM
- Incident Documentation
- Internal Complaint P&P

SEPERATION OF EMPLOYMENT *Libby Mee, Director of Human Resources*

- Resignation/Termination P&P
- Notification/Documentation
- Last Day
- Exit Interview P&P
- Final Check

STAFF TRAVEL *Libby Mee, Director of Human Resources*

- MMHD Fleet
- Personal Use of Vehicle for Hospital Business P&P
- Mileage and Expense Voucher FORM

PURCHASING *Steve Sweet – Purchasing Management*

- How to go shopping in the Mayers Purchasing Department
- Purchase Requisitions process
  - Approved Vendors
  - Order and Deliveries Time Frames
- How to return items

FINANCE *Travis Lakey – Chief Financial Officer*

- Annual Budget
- Quarterly Variance
- Annual Audits

ACCOUNTS PAYABLE *Lisa Simons – Accounts Payable Clerk*

- Check Request FORM
- Vendor Compensation

MAYERS HEALTHCARE FOUNDATION *Marlene McArthur - Executive Director*

- 501(c)3 Structure
- Annual Awards Cycle
- Grant Opportunity
- Capital Expenditure Plan
- Employee Scholarship Opportunity
- Volunteer Program
- Events

EXPECTATION OF THE BOARD *Jessica DeCoito – Executive Assistant*

- Brown Act Compliance
- Annual Board Report
- Additional Reports
  - Quality
  - Finance
  - Strategic Planning
- Organizational Analysis

INFECTION CONTROL *Dawn Jacobson RN, Infection Control*

- Monthly Employee Illness Report FORM

COMPLIANCE/RISK MANAGEMENT/QUALITY
Jack Hathaway, Director of Quality

- Incident Reporting
  - RL:6
- Inspection/Survey Readiness
- HIPAA Compliance
- Conflict of Interest P&P

EMERGENCY/DISASTER PREPARENESS
Val Lakey – Executive Director of Emergency Preparedness

- Disaster and Safety Committee
- General Safety Guidelines P&P

MARKETING/PUBLIC RELATIONS
Val Lakey – Executive Director of Community Relations & Business Development

- Department Marketing
- Communication
  - MMHD Webpage
  - Intranet
  - Email/Voicemail/Fax

INFORMATION TECHNOLOGY *Ryan Nicholls – IT Manager*

- IT Support How-to
- Email
- Voicemail
- Software Access
- Computer Set up

FACILITY/MAINTENANCE *Alex Johnson – Manager*

- Site Maps
- Maintenance Work Orders

CLOSING *Libby Mee, Director of Human Resources*

- Questions/Clarifications
  -
  -
  -
  -
  -

The topics in this agenda have been discussed and reviewed. I have watched all Relias trainings and read all required policies.

Manager Signature: _____ Date: _____

Print Name: _____ Title: _____

Board Quality Report Template

Name: Libby Mee - Director of Human Resources

Department: Worker's Comp

Current report date to Board Quality:

07/08/2020

Last report date to Board Quality:

05/13/2020

Last Quality project reported:

Report of1st Quarter 2020 Claims
Identified the need to evaluate and update current comp process.

Update on last Quality project reported:

2nd Quarter 2020
(5) First Aide injury - (1) day away from work
(1) Reportable injury - Employee off work, (1) Re-opened Claim from 2019 - Employee off work

Still have (1) employee from last year off work. Working closely with BETA, provider and alternate MMHD departments for a return to work program.

What successes have you seen based on the outcome of previous Quality projects?

Have been unable to start process mapping of the work comp process.

What issues have come up in your department relating to Quality?

Evaluating and updating the comp process and procedure still remains an area that needs to improve to ensure appropriate compliance and tracking.

PLAN: What plan was implemented to address those issues?

Individually working on updating internal policies and procedures.

DO: How did the implementation of that plan go? In progress
STUDY: What kind of results did the implementation of the plan yield? Not Applicable
ACT: What changes were made based on the results of the plan implementation? Not Applicable
Is this a LEAN project? Yes ☐ **No** ■ **If YES, please attach the A3.**

Upcoming Quality Items: Will present policy renewal data at full board meeting.	**Quality Related Goals for the Department:** Continue manager and employee education and support to ensure a safe and healthy work environment.

What Strategic Plan Objective does your project BEST align with? Choose only one.

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Data/Graphics supporting project outcomes:

Board Quality Report Template

Name: Chris Hall

Department: Laboratory

Current report date to Board Quality:

7/8/2020

Last report date to Board Quality:

2/12/2019

Last Quality project reported:

Hemolyzed blood samples from ED requiring redraws

Update on last Quality project reported:

Identified IV start draws as factor in significant number of hemolyzed specimens. New IV needle with one way valve had increased the number of hemolyzed specimens. Using a Y connection with a transfer device has improved the quality of most IV start draws. Number of redraws is fairly small at this time.

What successes have you seen based on the outcome of previous Quality projects?

Working with ED staff to troubleshoot a problem and identify the cause has been successful.

What issues have come up in your department relating to Quality?

1) SNF lab orders from Burney have frequently been submitted to lab with duplicate orders for the same patient and many with no ICD-10 codes for the tests ordered.
2) Corrected Final reports for lab testing have been identified as an issue that needs improvement.

PLAN: What plan was implemented to address those issues?

1) Laboratory phlebotomy staff is working with Charge Nurse to resolve.
2) Identified reasons given for Corrected Final: Repeat test to verify or recalibrate 26.3%, Adding comment after final 26.3%, Corrected after supervisor review 17.7%, Manual entry error 13.4%, No reason given 10.8%, Paragon failed to result 5.5%.
Individuals with the most frequent corrections for specific correction type were identified. ED providers, new and returning, who place orders that result in Corrected Final reports were given help with submitting lab orders.

DO: How did the implementation of that plan go?

1) The implementation is still in progress. Communication is improving and staff training is still needed.
2) A few individuals who were identified with specific corrections are no longer working in the lab. Extended training for incoming CLSs with Paragon will be implemented. Lab orders from ED that are placed creating multiple accession numbers requiring manual entries have decreased.

STUDY: What kind of results did the implementation of the plan yield?

1) Improved awareness by Burney staff concerning redundancies and omissions with lab requests have been noted.
2) There has been a 16.6% decrease since Jan 2020 of Corrected Final reports.

ACT: What changes were made based on the results of the plan implementation?

1) Pending
2) Microbiology Corrected Finals were 39% of the total count. The new micro analyzers and software will result directly into Paragon eliminating most manual entries in microbiology. Standardized order sets for ED will create more consistency with lab ordering among the ED providers. Creating standardized comments in Paragon will help eliminate many notes added after a result has been final.

Is this a LEAN project? Yes ☐ **No** ■ **If YES, please attach the A3.**

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Pending	

What Strategic Plan Objective does your project BEST align with? Choose only one.

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Data/Graphics supporting project outcomes:

Board Quality Report Template

Name: Lori Stephenson **Department:** HIM **Last Quality project reported:** Updates on One Content. Some nursing documentation issues. Chart completion by physicians improving. **Update on last Quality project reported:** One Content (EHR) is a success. It has made a huge difference in daily workflow. ROI's process has been much quicker to physician offices. It is done by 9 am every weekday morning then throughout the day as they requests come in. Documentation flow is more automated now so less hands on and scanning in the HIM department.	**Current report date to Board Quality:** 7/8/2020 **Last report date to Board Quality:** 1/08/2020

What successes have you seen based on the outcome of previous Quality projects?

Productivity has increased and in my opinion more efficient.

What issues have come up in your department relating to Quality?

We still have a few documentation issues with nursing but we have a system in place now and are getting results and seeing less errors.

PLAN: What plan was implemented to address those issues?

Copies were made of charting that was lacking documentation for proper coding/billing. It is given to the ER lead Alexis and she tracks down the nurse on their next scheduled day and has them complete the missing documentation. She then councils them as to what they are lacking and about double checking times, meds and route given for start and stop times.

DO: How did the implementation of that plan go? It is working very well now.
STUDY: What kind of results did the implementation of the plan yield? We are getting better charting by nurses as they are double checking their own work more often and we are seeing fewer errors because of this.
ACT: What changes were made based on the results of the plan implementation? Better education and training on proper documentation as we have a lot of traveler nurses and the process is different at other facilities.
Is this a LEAN project? Yes ☐ **No** ■ **If YES, please attach the A3.**

Upcoming Quality Items:	**Quality Related Goals for the Department:**

What Strategic Plan Objective does your project BEST align with? Choose only one.

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Data/Graphics supporting project outcomes:

Board Quality Report Template

Name: Sondra Camacho **Department:** Activities **Last Quality project reported:** N/A **Update on last Quality project reported:** N/A	**Current report date to Board Quality:** July 2 2020 **Last report date to Board Quality:** N/A

What successes have you seen based on the outcome of previous Quality projects?

I'm not sure what was on the last Quality project. This is my first year as Director/Management.

What issues have come up in your department relating to Quality?

The Residents were not getting quality care due to Activities being in the dining room for four hours hours a day and were performing tasks that were out of their scope of practice .At times we were driving the van for multiple hours a day and not having enough time to preform activities duties.

PLAN: What plan was implemented to address those issues?

The CNA's are now in the dining room and assisting with meals and coffee. The activity aides are no longer charting for meals on the POC/PCC and more activity aides have been hired to accommodate the activity department's work flow providing better patient centered care and enhancing the quality of life.

DO: How did the implementation of that plan go? All staff were affected by the change in some way or another and we are continuing to adjust. With time we will see results.
STUDY: What kind of results did the implementation of the plan yield? currently in progress.... More time for activities and for the residents.
ACT: What changes were made based on the results of the plan implementation? Activities no longer in the dining-room assisting with meals/ fluids and no longer charting in the POC. Activity aides no longer preforming tasks that were not in their scope of practice.
Is this a LEAN project? Yes ■ **No** ☐ **If YES, please attach the A3.**

Upcoming Quality Items:	**Quality Related Goals for the Department:** Patient centered care Less staff burnout

What Strategic Plan Objective does your project BEST align with? Choose only one.

☐ **Outstanding Facilities:** By 2025, we will open two rural health clinics, update the skilled nursing facility living space at the Fall River campus and have a resolution for aging facilities.

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■ **Outstanding Patient Services:** By 2025, we will be a four-star long term care facility and meet all Hospital Consumer Assessment of Healthcare Providers (HCAHP) requirements. By 2025, we will be operating two rural health clinics.

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Data/Graphics supporting project outcomes:

MANAGEMENT SCORECARD - OMT

Department Specific Goals		
1	Implement LEAN value stream management (VSM) for the SNF. Goal is to complete a value stream assessment (VSA) and facilitate at least 3 LEAN events that lead to successful revision of workflows and processes that supports the reduction in harm tags, and the improvement in the SNF star rating. Specific goals and metrics will be developed in the VSA A3 and each subsequent LEAN event during the VSA. Report to Board Quality by end of fiscal year 2020. Goal Met: 4 Lean events were completed and successfully implemented for the SNF. The initial event was the Value Stream Mapping where the largest gaps in performance were identified. 1. Kaizen 1. Revision of admission processes with the goal to shorten the length of time it takes to approve an admission and to increase the daily census of the department. Both goals have been met. Admission approvals have been reduced from a 5-day turn around to less than one day. Census has been hovering at or above 80 where in the past it was in the mid-70 range 2. Kaizen 2 Review and revision of the Activities workflows to increase the amount of activities provided to the residents. Workflows were adjusted, activity aides stopped spending 4 ½ hours daily helping in the dining room and have filled those hours were more activities for the residents. Other planned changes have just been implemented with the change of hours on the SNF and are now in place. 3. Kaizen 3 Review and revision of the C.N.A. workflows. The activities Kaizen identified multiple gaps in the C.N.A. workflows. Many were related to the start time of the nursing staff's shifts as well as the way the work was organized. New workflows were implemented that revised the "loads" each C.N.A. carries and the specific times work is done. The start hours of the shifts were changed to better accommodate the needs of the residents.	Goal Met
2	Train 3 to 4 LEAN facilitators to competence in managing LEAN KAIZEN events. Each facilitator will be responsible for facilitating one lean event from inception to completion of the goals. Report to Board Quality by end of fiscal year 2020. Goal partially met: 9 Staff members attended 75% of the LEAN facilitator class and worked through some simple lean methodologies such as 5S. Three of the facilitators participated in and "ran" lean events in the SNF with	Goal partially met

	oversight and assistance from the CNO. The LEAN class was not completed due to the onset of COVID. All the preparation required by the pandemic eradicated the teams capacity to complete the classes	
3	Oversee and assure compliance and certification of Lab/Rad/ED in new wing to include resolution of any discrepancies associated with inspections with anticipated Q2/Q3 opening. Report to Board Quality by end of fiscal year 2020. Goal: Work is current and on target but not complete as the new wing project has had multiple construction delays. The project is on task and on target for where MMHD is in the process. The radiology department has their certification evaluation within the next several weeks and the department is prepared. The laboratory has a functional project plan in place and is working from this document to assure CLIA compliance and certification. The ED has worked with purchasing in a LEAN event and has developed a standard stocking process that includes PAR levels and standard work for maintaining supplies. CDPH compliance needs have been reviewed and potential gaps have been considered.	Project is on task and on target at its current stage but construction delays have slowed completion

Attachment I

Board Quality Report Template

Name: Amy Parker **Department:** Patient Access **Last Quality project reported:** For over a year we were unable to receive responses for insurance eligibilities from 'One Source'. **Update on last Quality project reported:** 'One Source' was able to repair our communication on 01/09/20	**Current report date to Board Quality:** 07/08/20 **Last report date to Board Quality:** 01/08/20

What successes have you seen based on the outcome of previous Quality projects?

We have been able to check patient's insurance eligibilities and educate them on their benefits.

What issues have come up in your department relating to Quality?

There is a rule going into effect that states that healthcare providers are to give estimates for services as well as disclose negotiated pricing by specific payer/plan. One Source is able to do this for us, but the training we were getting for our Patient Estimates Tool went to the wayside when we were unable to utilize the program.

PLAN: What plan was implemented to address those issues?

Complete implementation is pending but the Financial Counselor and I have been in contact with a representative from 'One Source' to resume training and learn about the new functionalities the system has to offer for these upcoming changes.

DO: How did the implementation of that plan go? We have our first phone conference scheduled and have planned on bi-weekly calls. We hope that we can get started on this new procedure in correlation with moving into the new building and I have requested demo videos of our Patient Estimates Tool to study in the meantime.
STUDY: What kind of results did the implementation of the plan yield? I have been looking up more information on this topic so that when training begins I will be prepared with specific questions pertaining to our facility. I am also noting how other facilities direct their patient flow. My goal is to be as thorough as possible without the patients noticing any extended wait times and without Patient Access representatives feeling any pressure to rush through their part of a patients visit.
ACT: What changes were made based on the results of the plan implementation? Since we haven't gotten to practice an admit and physically see patient flow in the new building yet our department has been planning and sharing ideas on what we would all like to see in our department that would work best for any shift.
Is this a LEAN project? Yes ☐ No ■ If YES, please attach the A3.

Upcoming Quality Items:	**Quality Related Goals for the Department:**
New wing transition.	Patients will have accurate estimates specific to their coverage for any non-emergent service offered.

What Strategic Plan Objective does your project BEST align with? Choose only one.

☐ **Outstanding Facilities:** By 2025, we will open two rural health clinics, update the skilled nursing facility living space at the Fall River campus and have a resolution for aging facilities.

☐ **Outstanding Staff:** By 2025, we will be seen as an employer of choice in the area by providing and maintaining staff growth opportunities, flexible and safe working arrangements, and reducing the use of registry staff.

☐ **Outstanding Patient Services:** By 2025, we will be a four-star long term care facility and meet all Hospital Consumer Assessment of Healthcare Providers (HCAHP) requirements. By 2025, we will be operating two rural health clinics.

■ **Outstanding Finances:** By 2025, we will have in place and utilize financial tools to actively develop and forecast long term expenditures.

Data/Graphics supporting project outcomes:

Board Quality Report Template

Name: Danielle Olson **Department:** Business Office **Last Quality project reported:** We didn't report on any Quality projects last meeting. **Update on last Quality project reported:**	**Current report date to Board Quality:** 07/08/2020 **Last report date to Board Quality:** 01/02/20

What successes have you seen based on the outcome of previous Quality projects?

What issues have come up in your department relating to Quality?

COVID-19 has caused us to accelerate changes to our work flow to enable working from home.

PLAN: What plan was implemented to address those issues?

We had been slowly experimenting with working from home by working with IT as they installed Citrix. In March this plan was fast tracked and through active feedback with IT on what worked and what didn't we came up with processes to enable some of us to work from home.

DO: How did the implementation of that plan go?

Moving to Citrix and coming up with a way to call insurances from home went pretty smooth IT has been great with accommodating our needs.

STUDY: What kind of results did the implementation of the plan yield?

AR Days have recently went up since COVID-19 but I don't see that as a work flow issue, as it is taking longer for insurances to process claims. I have been monitoring the outgoing bills and follow up and we are still billing like normal.

ACT: What changes were made based on the results of the plan implementation?

Amber and I are still working at the hospital, since printing is still done here we are helping each other by mailing out everything that is print to the hospital so those working remotely do not have to come mail them themselves. Amber being the Financial Counselor she works onsite do to working closely with patients and their family members, and I took on everything that could not be done from home so that could be done by only one person.

Is this a LEAN project? Yes ☐ No ■ **If YES, please attach the A3.**

Upcoming Quality Items:	**Quality Related Goals for the Department:**
	Getting AR Days down to meet our goal.

What Strategic Plan Objective does your project BEST align with? Choose only one.

☐ **Outstanding Facilities:** By 2025, we will open two rural health clinics, update the skilled nursing facility living space at the Fall River campus and have a resolution for aging facilities.

☐ **Outstanding Staff:** By 2025, we will be seen as an employer of choice in the area by providing and maintaining staff growth opportunities, flexible and safe working arrangements, and reducing the use of registry staff.

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Data/Graphics supporting project outcomes:

Board Quality Report Template

Name: Travis Lakey **Department:** Finance **Last Quality project reported:** Installing One Content **Update on last Quality project reported:** One Content was installed and tested over the last few months in Accounts Payable, Payroll and Purchasing.	**Current report date to Board Quality:** July 8 2020 **Last report date to Board Quality:** January 8 2020

What successes have you seen based on the outcome of previous Quality projects?

Installation was just recently completed and we are still working to change work flows to utilize and optimize the new system. It's certainly a challenge to modify existing(comfortable) practices even if they are more work intensive.

What issues have come up in your department relating to Quality?

No real quality issues have come up. It's more of a change in having a Controller with lots of experience and a decade of work history together to a new controller where that relationship and work experience is being built ground up currently.

PLAN: What plan was implemented to address those issues?

My new Controller trained with Linda for a year and a half. I have to be more hands on oversight wise and adjust my time tables to accommodate for a while as I can't expect my new employee to be as quick as someone who had decades of experience in that role.

DO: How did the implementation of that plan go?

It's only been a few months but it seems to be going well.

STUDY: What kind of results did the implementation of the plan yield?

Results have been positive so far. It's taking longer to get things done but I do expect things to get to the old timetable as we move forward.

ACT: What changes were made based on the results of the plan implementation?

I retained an Accountant position that we had while my current Controller trained with my prior controller. We had someone out an extended amount of time and that position filled in for Payroll so we didn't miss a beat. This position will back up the Controller, AP and Payroll.

Is this a LEAN project? Yes ☐ No ■ **If YES, please attach the A3.**

Upcoming Quality Items:	**Quality Related Goals for the Department:**
2020 Audits, District, Medicare, and Medi-Cal. 2020 Cost Reports Medicare, Medi-Cal and Hospice 2020 OSHPD Reporting Audits on HHS Stimulus Payments	Successful 2020 Audits, District, Medicare, and Medi-Cal. 2020 Cost Reports Medicare, Medi-Cal and Hospice 2020 OSHPD Reporting Audits on HHS Stimulus Payments

What Strategic Plan Objective does your project BEST align with? Choose only one.

☐ **Outstanding Facilities:** By 2025, we will open two rural health clinics, update the skilled nursing facility living space at the Fall River campus and have a resolution for aging facilities.

☐ **Outstanding Staff:** By 2025, we will be seen as an employer of choice in the area by providing and maintaining staff growth opportunities, flexible and safe working arrangements, and reducing the use of registry staff.

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■ **Outstanding Finances:** By 2025, we will have in place and utilize financial tools to actively develop and forecast long term expenditures.

Data/Graphics supporting project outcomes:

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY

BOARD MEETINGS - LOCATION, TIME, DATE, AND QUORUM

POLICY:

Regular Meetings: Meetings of the Board of Directors, Whether regular, special or adjourned, shall be open to the public, except as otherwise permitted by law. All District Board meetings will be held in accordance with the Brown Act (Government Code Section 54950 *et seq.*), Health and Safety Code Section 32106, and Health and Safety Code Section 32155.

The regular meetings of the district Board shall be held on the fourth Wednesday of each calendar month at 1:00 p.m. at the District's offices, located at 43563 State Hwy 299 E Fall River Mills, California or 20647 Commerce Way Burney, California. The Board of Directors may, from time to time, change the time or day of the month of such regular meetings as required by holiday schedules or changing circumstances.

Special Meetings: Special meetings of the Board of Directors may be called as provided by law by the President of the Board, or by three members of the District Board, as the occasion demands. Notice of the holding of any special meeting shall be delivered to each member of the Board of Directors not less than twenty-four hours before the meeting.

The call and notice of a special meeting shall specify the time and place of the special meeting, and the business to be transacted. No other business shall be considered at such meetings by the District Board. Written notice may be dispensed to any member who at or prior to the time the meeting convenes files a written waiver of notice, with the Secretary of the Board.

Quorum: A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business.

Adjournment: The Board may adjourn any regular, adjourned regular, special, or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If all members are absent from any regular or adjourned regular meeting, the Executive Director may declare the meeting adjourned to a stated time and place and he or she shall cause a written notice of the adjournment to be given in the same manner as provided in these policies for special meetings, unless such notice, is waived as provided for special meetings. A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the regular, adjourned regular, special or adjourned special meeting was held within twenty-four hours after the time of adjournment.

When a regular or adjourned regular meeting is adjourned as provided in this section, the resulting adjourned meeting is a regular meeting for all purposes. When an order of adjournment of any meeting fails to state the hour at which the adjourned meeting is to be held, it shall be held at the hour specified by these policies for regular meetings.

REFERENCES:

Brown Act (Government Code Section 54950 *et seq.*)
Health and Safety Code Section 32106
Health and Safety Code Section 32155.

COMMITTEE APPROVALS:

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY & PROCEDURE

DISCIPLINE/CORRECTIVE ACTION

(*Step-by-Step Employee Warning Report*, and Corrective Action Notice)

POLICY:

Mayers Memorial Hospital District (MMHD) supports the concept of progressive discipline, and encourages employees and their supervisors to resolve problems before they become the foundation for disciplinary action. Mayers Memorial Hospital District is an **at will** employer and, as such, either the employee or the employer may terminate the employment relationship without cause by providing notice to the other. Mayers Memorial Hospital District does support progressive corrective action as outlined in the procedure portion of this policy. However, depending on the specifics of the given situation, steps may be skipped. Employees have the right to grieve a corrective action on the basis of the facts, the severity of action or the overall reasonableness of the action.

PROCEDURE:

Prior to entering the progressive disciplinary process it is recommended that department managers have open discussions (Coaching/Counseling) with an employee regarding standards of performance or behaviors at the point in time when the issue first surfaces. If casual coaching and counseling appear to not be effective, department managers need to engage the Human Resource Department for support in moving to the next steps of the disciplinary process.

STEPS THAT MAY BE USED IN THE PROGRESSIVE PROCESS:

I. First Disciplinary Report:

This is the formal notice that a behavior or skill deficiency is evident and reiterates the standards of performance expected.

II. Second Disciplinary Report:

This action is taken when it is believed that time off will assist in resolving the identified problem. A standard suspension covers three scheduled workdays and PTO time may not be used to cover this time off. In serious cases a suspension may also be done as necessary while an investigation is conducted. If an employee is found not in violation of standards of performance, any suspension may be reversed and become paid time.

III. Third Disciplinary Report:

This final action is the result of failing to meet standards of performance or behavior.

Multiple disciplinary actions (related or unrelated) are sufficient to warrant further progression in the discipline process.

All steps of corrective action must be documented on a Corrective Action Notice form. This is done to assure employee awareness of a problem and to make sure appropriate documentation is maintained in the personnel file.

All corrective action notices will be maintained in the personnel file in Human Resources.

IV. General Rules of Conduct

A signed and completed copy of the *General Rules of Conduct* form (see attached) must accompany **EACH** disciplinary report (First, Second and/or Third Disciplinary Reports) when it is forwarded to Human Resources, for a maximum total of three (3) forms.

COMMITTEE APPROVALS:

Chiefs: 6/25/2020

CORRECTIVE ACTION NOTICE

Employee Name: _____ Date: _____

Department: _____ Position: _____

Type of Action: Verbal Warning Written Warning

Suspension Discharge

Prior Coaching/Counseling/Disciplinary Action

Action: _____ Date: _____
Action: _____ Date: _____
Action: _____ Date: _____
Action: _____ Date: _____

Description of Incident or Performance Problem:

_____
_____
_____
_____
_____

Standards of Performance or Behavior Expectations:

_____
_____
_____
_____
_____

Employee Comments:

_____
_____
_____
_____
_____

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____

GENERAL RULES OF CONDUCT

Mayers Memorial Hospital District (MMHD) supports the concept of progressive discipline, and encourages employees and their supervisors to resolve problems before they become the foundation for disciplinary action. Mayers Memorial Hospital District is an at will employer and, as such, either the employee or the employer may terminate the employment relationship without cause by providing notice to the other. Mayers Memorial Hospital District does support progressive corrective action as outlined in the procedure portion of this policy. However, depending on the specifics of the given situation, steps may be skipped. Employees have the right to grieve a corrective action on the basis of the facts, the severity of action or the overall reasonableness of the action.

Violation Key

A	Attendance
L	Lateness/Early Quit
UA	Unauthorized Absence From Work Area
WQ	Substandard Work Quality
DD	Drinking/Drugs While at Work
C	Carelessness
PV	Violation of Company Policies or Procedures
WD	Willful Damage to Materials/Equipment
V	Threatening or Engaging in Violence
UD	Unfit for Duty
I	Insubordination
SV	Violation of Safety Rules
PM	Working on Personal Matters
UB	Unsatisfactory Behavior Towards Others
O	Other

MAYERS MEMORIAL HOSPITAL DISTRICT

2020 HHS POVERTY GUIDELINES

Persons in Family or Household	75% US Poverty Level
1	$ 9,570
2	$ 12,930
3	$ 16,290
4	$ 19,650
5	$ 23,010
6	$ 26,370
7	$ 29,730
8	$ 33,090
For each add'l person, add	$ 3,360

To determine charity eligibility according to income level:

1. Count the number of persons in your family/household
    a. For persons 18 years of age and older, include spouse, domestic partner and dependent children under 21 years of age, whether living at home or not
    b. For persons under 18 years of age, include parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative
2. Calculate the household income
3. On the row corresponding to the number of persons in your family/household above, compare your household income to the amount in the column labeled "75% US Poverty Level"
4. If your household income is less than 75% US Poverty Level amount, your income supports your eligibility for Charity Care.

Note: Pursuant to AB 774 Sect. 127405(2), Mayers Memorial Hospital has established eligibility levels for financial assistance and charity care at less than 350 percent of the federal poverty level as appropriate to maintain its financial and operational integrity. Mayers Memorial Hospital is a rural hospital as defined in Section 124840.

To determine charity eligibility according to total monetary assets:

1. Calculate your total monetary assets (referred to as "ASSETS" in the equation below)
    a. Assets included in retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans **shall not** be included
2. Insert total assets into the following equation:
    a. (ASSETS – 10,000)/2
3. If the remaining amount is less than $5,000, your total asset level supports your eligibility for Charity Care.