MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
February 19 2025 @ 1:00 PM
Mayers Memorial Healthcare District
Fall River Boardroom
43563 HWY 299 E
Fall River Mills, CA 96028

Mission Statement
Leading rural healthcare for a lifetime of wellbeing.

In observance of the Americans with Disabilities Act, please notify us at 530-336-5511, ext 1264 at least 48 hours in advance of the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations. The District will make every attempt to accommodate your request.

						Approx. Time Allotted
1	**CALL MEETING TO ORDER**					
2	2.1	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS** Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board, 43563 Highway 299 East, Fall River Mills, or in the Boardroom). If you have documents to present for the members of the Board of Directors to review, please provide a minimum of nine copies. When the President announces the public comment period, requestors will be called upon one-at-a time, please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.) action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.				
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting –January 29, 2025		***Attachment A***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.1	Resolution 2025.01 – January Employee of the Month		***Attachment B***	Report	2 min.
	4.2	Hospice Quarterly	Lindsey Crum	***Attachment C***	Report	2 min.
	4.3	Mayers Foundation Quarterly	Michele King	***Attachment D***	Report	2 min.
	4.4	Quality and Risk	Jack Hathaway	***Attachment E***	Report	2 min.
	4.5	Skilled Nursing	Arnese Stern	***Attachment F***	Report	2 min.
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 January 2025 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.

	5.1.3	Quarterly Finance Review- https://teams.microsoft.com/Fianceaudit Meeting ID: 241 958 687 820 Passcode: tw2aD9eV	***Attachment G***	Report	5 min.
	5.2	**Quality Committee**			
	5.2.1	February Quality Meeting Committee Report		Report	5 min.
6		**OLD BUISNESS**			
	6.1	WanderGuard Door System for SNF- quote	**Attachment H**	Discussion	5 min.
7		**NEW BUISNESS**			
	7.1	Policies and Procedures: Identification of Potential Organ and/or Tissue Donors Medication Administration Physician Assistant Core Privileges for Outpatient Retention and Bladder Scanning Post-Catheter Removal Suicide Risk Assessment and Interventions Columbia Protocol in Non-Beha	***Attachment I***	**Action Item**	5 min.
	7.2	Real Estate Negotiation		**Action Item**	5 min.
8		**ADMINISTRATIVE REPORTS**			
	8.1	Chief's Reports – ***Written reports provided. Questions pertaining to written report and verbal report of any new items***	***Attachment J***		
	8.1.1	Director of Operations- Jessica DeCoito		Report	5 min.
	8.1.2	Chief Financial Officer – Travis Lakey		Report	5 min.
	8.1.3	Chief Human Resources Officer – Libby Mee		Report	5 min.
	8.1.4	Chief Public Relations Officer – Val Lakey		Report	5 min.
	8.1.5	Chief Clinical Officer – Keith Earnest		Report	5 min.
	8.1.6	Chief Nursing Officer – Theresa Overton		Report	5 min.
	8.1.7	Chief Executive Officer – Ryan Harris		Report	5 min.
9		**OTHER INFORMATION/ANNOUNCEMENTS**			
	9.1	Board Member Message: Points to highlight in message		Discussion	2 min.
	9.2	Board Education: Chapters 6-10		Discussion	10 min.
10		**MOVE INTO CLOSED SESSION**			

10.1	Hearing (Health and Safety Code §32155) – Medical Staff Credentials Elliott Wagner, MD Nabeel Dar, MD Walter Uyesugi, DO Ron Mark, MD Tad Tanoura, MD Rajiv Kumar, MD Philip McDonald, MD Justin Pham, MD John Pohl, MD Junsung Rho, MD Roberto Rivera-Morales, MD Amit Sanghi, DO Arjun Sharma, MD Russell Gelormini, MD Anne Glaser, MD Susan Gootnick, MD Grant Holz, MD Sayed Jafery, MD Sampath Alapati, MD Derek Armfield, MD Dennis Burton, MD Abbas Chamsuddin, MD Nilofar Firooznie, MD Michael Gabe, MD Adel Abdalla, MD	**Action Item**	10 mins.
10.2	Conference with legal counsel regarding pending litigation (§54956.9) https://teams.microsoft.com/l/closedsession Meeting ID: 293 735 099 149 Passcode: cc2RK2ex	Discussion/ **Action Item**	20 min.
10.3	Update regarding pending litigation (§54956.9)	Discussion	10 min.
10.4	Conference with Real Estate Negotiators (54956.8) Property: Masonic Lodge, Fall River Mills CA Real Estate Negotiator: APN: 018-200-006	Discussion/ Action Item	20 min.
11	**RECONVENE OPEN SESSION**		
12	**ADJOURNEMENT:** Next Meeting March 26, 2025		

Posted: 02.14.2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Minutes
January 29, 2025 @ 1:00 PM
Mayers Memorial Healthcare District
Burney Board room
20647 Commerce Way
Burney, CA 96013

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.

CALL MEETING TO ORDER: Jeanne Utterback called the regular meeting to order at 1:00 PM on the above date.

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Abe Hathaway, President	Ryan Harris, CEO
Jeanne Utterback, Vice President	Travis Lakey, CFO
Tami Humphry, Treasurer	Valerie Lakey, CPRO
Lester Cufaude, Director	Libby Mee, CHRO
ABSENT:	Theresa Overton, CNO
Jim Ferguson, Director	Jack Hathaway, Director of Quality
	Jessica DeCoito, Director of Operations
	Ashley Nelson, Board Clerk
	Dana Hauge, Director of Safety & Security
	Jeff Miles, IT Manager
	Alex Johnson, Maintenance Manager
	Kristen Stephenson,
	Keith Earnest, CCO

2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS:** NONE.		
3	**APPROVAL OF MINUTES**		
3.1	A motion made and carried; Board of Directors accepted the minutes of December 4, 2024.	***Cufaude, Hathaway***	***Approved by All***
4	**DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS**		
4.1	Resolution 2024.16- December 2024 Employee of the Month: Erica Baur, RHC	***Humphry, Hathaway***	***Approved by All***
4.2	Safety Quarterly: Dana submitted her report. She reiterated the culture of safety and security being integrated into the MMHD culture.		
4.3	IT: Jeff submitted his report. Les asked Jeff MMHD's plan regarding cyber security. Jeff is in the process of becoming certified in cyber security and how to apply it to the IT system- although many programs are already in place to protect the district's cyber security.		
4.4	Facilities and Engineering:		

		Alex submitted his report.		
	4.5	Infection Control: Kristen submitted her report. Kristen the Board that the staff will be holding a February hand hygiene event to encourage "foaming in and out" of patient rooms- including a competition between depts. The overall includes changing the culture, but the overall policy as well. She also confirmed that the UV light being requested is not enough to cover the entire district, but they are starting with 1.		
5	**BOARD COMMITTEES**			
	5.1	**Finance Committee**		
		5.1.1 Committee Report: Tami Humphry reported that the Nov and Dec 2024 financials were approved. The overall costs have increased 1.1% and Registry costs have decreased by 806k. Then IT and Nurse Call system quotes are being proposed to the full board. 296 days of cash on hand. Dec AR days are down by 1 point.		
		5.1.2 November 2024 Financial Review Motion moved, seconded and approved.	***Cufaude, Humphry***	***Approved by All***
		5.1.3 December 2024 Financial Review Motion moved, seconded and approved.	***Humphry, Hathaway***	***Approved by All***
	5.2	**Quality Committee**		
		January Quality Meeting Committee Report: Les Cufaude reported that Jack and Dr. Magno met regarding hand hygiene. MMHD will no longer be apart of the W.H.O and it was discussed which entity (CDC) MMHD will be following going forward.		
		5.2.1 Jack explained the medication error rate in SNF and the changes that Arnese- interim SNF Director- have put into place to lower this rate, including looking at the error rate daily instead of monthly. Jack explained that he is pursuing a way to gauge our achievement value of QIP. He explained the difference between meeting 2 versus 1 quality measures- PY8 will be attested in March 2025. MMHD will know if they met the measures of PY7 by June 2025.		
6	**NEW BUSINESS**			
	6.1	Cerner Ticketing Process: Travis reported that it has improved, average time is 38 days until the closing of a ticket. Travis explained the ticketing process to the board. Travis, Libby and Ryan are in the process of implementation refunds. Jessica and Holly in IT are creating a system for depts to submit their own Cerner tickets, instead of having to go through IT. Wifli agency is reviewing the Revenue Cycle.		
	6.2	WanderGuard Door System for SNF quote: Theresa reported that it is a safety system for all of the exit doors in the Burney facility. CDPH is also requiring this update. The plan of corrections includes a plan for a putting a place in system. The topic is tabled until next month to include the Westcall system quote- including exit doors- is explored.		
	6.3	IT licenses quote: A few end of life systems have expired. The Board approved the GPO pricing of $158,702.	***Humphry, Cufaude***	***Approved by All***
	6.4	Nurse Call System quotes: Jessica explained that the Fall River system was installed in the 1970's and Burney's was installed in the 1990's. This specific nurse call system has already been put in the Acute dept. She will also look into the GPO price quote. Fall River quote is $180,000 and Burney quote is $239,000.	***Cufaude, Hathaway***	***Approved by All***

		The Board approved both quotes.		
	6.5	Updated MMHD Staffing Plan: Ryan explained that the new staffing plans highlights all positions, including openings in each department. This is a living document and will be updated regarding openings. Libby explained that status' (FT,PT, Per diem) of each employee will be added to the staff, as well as contracted staff.		
	6.6	Policies and Procedures: Alternative Life Safety Measures Alternative Life Safety Measures Assessment Tool Master Staffing Plan Patient Medication Profile Multi Drug Resistant Organism	***Cufaude, Humphry***	***Approved by All***
7	**ADMINISTRATIVE REPORTS**			
	7.1	**Chief's Reports: written reports provided in packet**		
		7.1.1 **DOO:** Jessica submitted her report. Her update includes Aspen Street and Burney Fire District will be meeting on Friday morning. A site walkthrough will occur on Monday, regarding the most recent proposals for MMHD's project management firm. Solar panel pole digging will begin February 12th, regardless of the weather. There is an issue with the placement of the panels and making sure they do not obstruct the view of the Bluff. She also explained that each Chief owns their own binders for ACHC- 60 in total- for them to complete and then present to ACHC upon the survey date. She confirmed that Phase 3 in the TCCN building has been completed, and it is being confirmed before it is submitted to the county. The building code aspects were discussed between Ryan and the Board and the Board agreed that bringing all entities to the table is a proactive solution moving forward.		
		7.1.2 **CFO:** Travis explained that the USDA pre application is complete and he is awaiting their response. There are a couple items left on the Feasibility Study- projecting 5 years out. The audit will hopefully be presented in the February meeting.		
		7.1.3 **CHRO:** Libby submitted her report. She explained that "active employees" are the employees that we have interacted with in the past year, and "current" means employees that are currently employed at MMHD. She also confirmed that MMHD currently has 18 employees over 65 years of age.		
		7.1.4 **CPRO:** Val submitted her report. She explained that the Denim and Diamonds Gala was a huge success and the community member that won the car has stated they will now be a life-long donor to the Mayers Foundation. She explained that Laura, MMHD's grant writer, attended a 9-week class in grants regarding Rural Healthcare. Val has also discovered a new website that will assist with grants available to our district.		
		7.1.5 **CCO**: Keith submitted his report. Abe asked Keith about progress regarding prescription labels in the Retail Pharmacy- Kristi is working with our software vendor to access braille labels that can be readily accessible in the Retail Pharmacy. He explained the IV fluid shortage is positively progressing, however the fluids with potassium included are still lacking in availability. Mercy hospital in Redding has been replacing IV fluids that they have borrowed to MMHD- a direct result of the collaboration MMHD had with Mercy during the pandemic. The FUJI systems will integrate with Cerner and other entities in real time. He also explained with the Quantiferon system is- a state-of-the-art TB system that will benefit our staff compliance and members of the community.		
		7.1.6 **CNO**: Theresa submitted her report. No memory care bed are available in the Burney facility. The staff meet-and-greet with families have been successful in filling SNF beds in both Fall River and Burney. MMHD's Clinical		

		Educator, Brigid Doyle, is retiring- resulting in a slight change to the job description going forward as an educator for all of the district, instead of just clinical. An offer letter for a SNF DON candidate is out and Theresa is awaiting a response. She has extended the interim SNF DON to help the new perm SNF DON acclimate. She explained that the CNA program waiver has been accepted and the team will now determine the steps that needs to be taken to start up the program again- Fall 2025 is the timeline goal of the restarting program. She explained that a policy is being revised so that our staff RN's can attend EMS staff on transfers needed.
	7.1.7	**CEO:**. Ryan submitted his report. A change includes the FRJUSD Superintendent, Mr. Nugent, is collaborating with MMHD regarding reinstating high school ROP programs- he is meeting with contractors regarding residential properties for educators. He is also interested in building additional housing on the MMHD Lodge property. Ryan is also collaborating with Pit River Health regarding Mental Health services- including talk therapy with the SNF residents. Modoc currently offers this service to their residents so we will mirror their model. He highlighted and thanked various depts. MRI services are being resumed- they had previously ended in 2014. He will be approaching 2 local congressmen regarding potential monetary donations to the cause. He highlighted the most recent Strategic Planning meeting- a mid-year review was completed due to readjustment and pivoting of goals. He explained in the "Quality of Service" goal adjustment includes the need for technology to assist in meeting the 80% compliance goal, however, is it very expensive. If the Board would like to see proposals Ryan can present them but he feels reaching 60% compliance with infection prevention is more realistic with the help of the IP staff. Les proposed the idea of monetary incentives to staff, in lieu of dept lunches. Ryan explained the pros and cons of this suggestion. Ryan proposed a revision to the Smart Goal in the Strategic Plan itself. He proposed a revision to the Growth Goal from "overall 5% growth" to "dept specific" growth, due to the varying sizes in depts. He proposed a revision to the Communication Goal, including patient surveys specific to the Clinic regarding the referral process and workflow process for Clinic staff. The board approved Ryan to present the discussed revisions to the next regular board meeting.
8	**OTHER INFORMATION/ANNOUNCEMENTS**	
	8.1	Board Member Message: Ryan's highlights + EOM, thanking volunteers at the Thrift Store, thank the gala donors/volunteers/ community members, thank donors of the car, restarting CNA program, stay tuned on MRI services and collaboration with agencies
	8.2	Board Education: Tami, Ryan and Jeanne agreed to be on the Ad Hoc committee regarding Robert's Rules of Order and the conditions of the Brown Act- and putting a policy in place for the future. Ashley will get this information to the Ad Hoc committee members. The Board discussed chapters 1-5 in the Board book, "52 ways to be a better board"- including the Mission, Vision and Values of MMHD. Ashley will update the Mission on the Board documents- including the agenda and minutes. Jeanne assigned the Board chapters 6-10 of the book for next meeting.
9	**MOVE INTO CLOSED SESSION:** 3:50 pm	
	9.1	**Hearing (Health and Safety Code §32155) – Medical Staff Credentials** **MEDICAL STAFF REAPPOINTMENT** 1. David Panossian, MD (Pulmonary) 2. Jack Lin, MD (UCD) 3. Reena Nanjireddy, MD (UCD) 4. Alan Yee, DO (UCD) 5. Trinh Truong, MD (UCD) 6. Daphney Say, MD (UCD) 7. Maheen Hassan, MD (UCD) 8. Kelly Haas, MD (UCD)

9. Arthur DeLorimier, MD (UCD)
10. Daniel Kirkham, MD (TCR)

MEDICAL STAFF APPOINTMENT
1. Lindsay Frye, DO
2. Hossein Mousavi, MD (UCD)
3. Sandy Lee, DO (T2U)
4. Howard Fellows, MD (Mercy Oncology)
5. Jorge Perez-Cardona, MD (Mercy Oncology)
6. Kyle Greene, MD (Mercy Oncology)
7. Arun Kalra, MD (Mercy Oncology)
8. Keith Shonnard, MD (TCR)

AHP REAPPOINTMENT
1. Thelma Wadsworth, PA (MVHC)
2. Shannon Davidson, CRNA
3. Erica Bauer, PA

AHP APPOINTMENT
1. Kevin Metz, CRNA

	9.2	Conference with real property negotiators (§54956.8) 43514 CA 299. Fall River Mills, CA 96028
	9.3	Conference with legal counsel regarding pending litigation (§54956.9)
10	**RECONVENE OPEN SESSION:** 4:50 pm	
11	**Adjournment:** 4:50 pm. Next Meeting is February 19, 2025 in Fall River.	

I, _____, Board of Directors _____, certify that the above is a true and correct transcript from the minutes of the regular meeting of the Board of Directors of Mayers Memorial Healthcare District

_____ Board Member

_____ Board Clerk

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Board, are available for public inspection at the office of the Clerk to the Board of Directors, 43563 Highway 299 East, Fall River Mills CA 96028. This document and other Board of Director's documents are available online at www.mayersmemorial.com.

RESOLUTION NO. 2025-01

A RESOLUTION OF THE BOARD OF TRUSTEES OF MAYERS MEMORIAL HEALTHCARE DISTRICT RECOGNIZING

Cody Robertson

As January 2025 EMPLOYEE OF THE MONTH

WHEREAS, the Board of Trustees has adopted the MMHD Employee Recognition Program to identify exceptional employees who deserve to be recognized and honored for their contribution to MMHD; and

WHEREAS, such recognition is given to the employee meeting the criteria of the program, namely exceptional customer service, professionalism, high ethical standards, initiative, innovation, teamwork, productivity, and service as a role model for other employees; and

WHEREAS, the MMHD Employee Recognition Committee has considered all nominations for the MMHD Employee Recognition Program;

NOW, THEREFORE, BE IT RESOLVED that, Cody Robertson is hereby named Mayers Memorial Healthcare District Employee of the Month for January 2025; and

DULY PASSED AND ADOPTED this 19th day of February by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Jeanne Utterback, President
Board of Trustees, Mayers Memorial Healthcare District

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

Department Reporting
Manager's Meeting and Regular Board Meeting

Manager & Department:

Lindsey Crum – Hospice

Reporting Month & Year:

February 2025

Summary:

Hospice has been very busy until the last couple of weeks. We continued holding onto a high census while getting our new nurses through training. Hospice has begun to slow down, and we are playing catch-up with our chart audits. Keith and I learned many things during our regulatory boot camp in December. I am bringing some of the things I learned into play, especially during audits.

Top Projects (1-3):

1. The Leadership Academy is half over. The focus has been on various aspects of leadership, such as decision-making, communication, strategic thinking, and team management. This has greatly helped to develop the skills, knowledge, and attributes that individuals need to become effective leaders.
2. We are building tri-fold pamphlets to give out as part of the children's bereavement program. All marketing and public relations resources have been shared with Rowan. She will be helping design and build pamphlets so they are available to the community
3.

Wins (1-2):

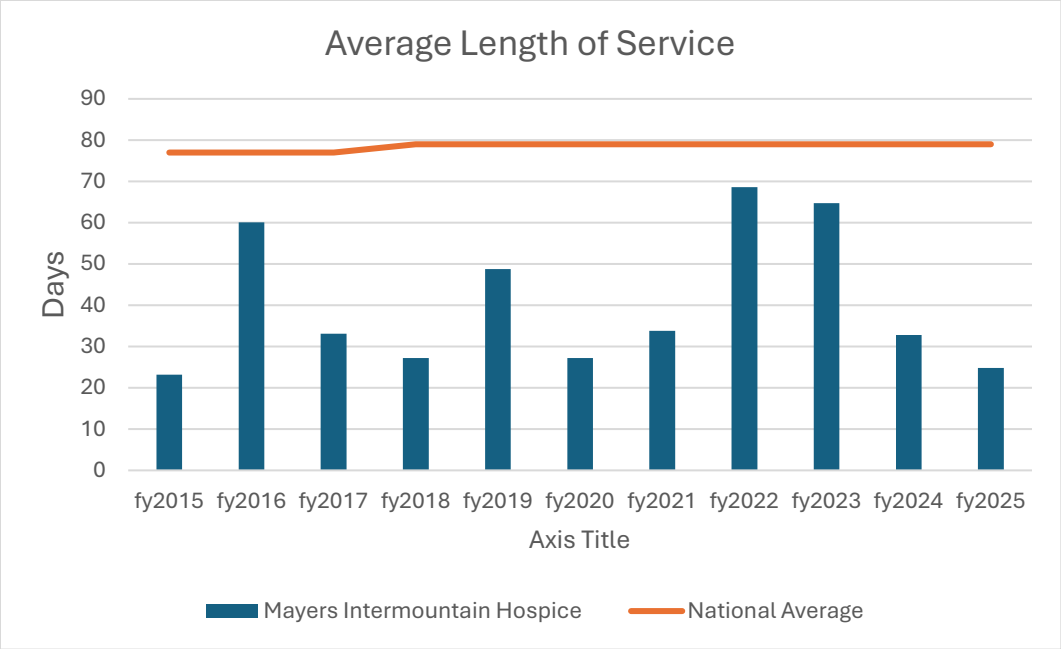
Officially fully staffed. Two full-time RNs have made it through training and can help with on-call time. We welcomed Marsha Rugen, RN, to our team, and she has been a great addition. She worked in Acute care and Mountain Valley. She has experience with outreach programs and will significantly help when starting the nurse visit program.

Challenge (1):

The start of the new nurse visit program has not begun. Due to an overload of patients and a staffing shortage, we could not start the process. We are currently waiting for leadership to purchase an EMR system. Getting the necessary training on computer programs and regulations is essential for everything to move smoothly and to begin seeing patients

Statistics:

Length of Service Remains well below the national average.



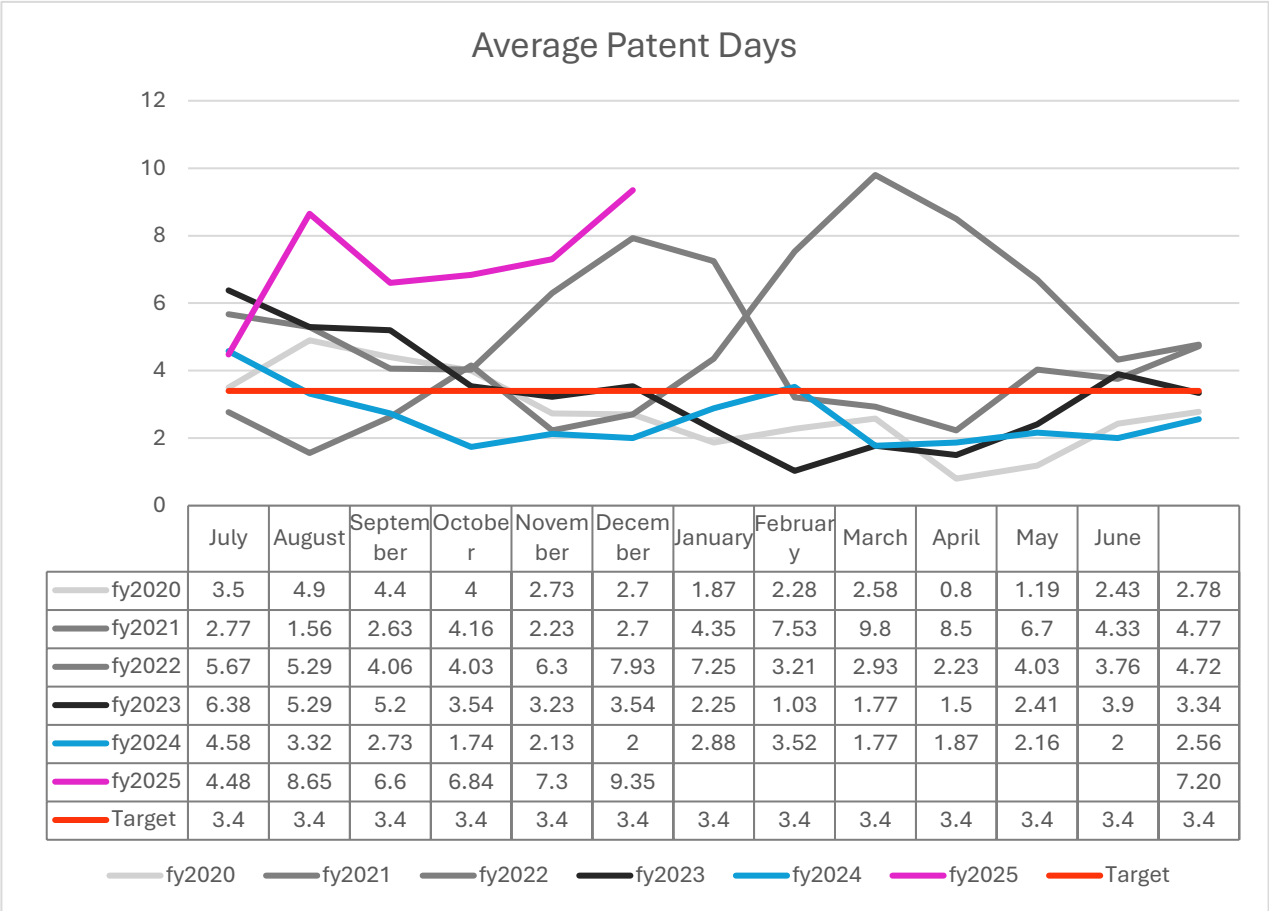
Live Discharges

Discharges by calendar year						Incomplete--matrix data only	
	2018	2019	2020	2021	2022	2023	2024
Death	28	25	28	29	13	7	36
Live-Extended Prognosis	2	2	2	3	2	1	2
Live-Revocations	1	0	0	2	2	2	0
Live-Moved Away	0	0	0	1	0	0	0
Live-Transferred	0	0	0	0	1	0	0
Live-Desired Curative Treatment	0	0	0	0	0	0	0
Percent Live Discharge	9.60%	7.40%	6.60%	17%	27%	30%	5%
Benchmark (max)	30%	30%	30%	30%	30%	30%	30%

Hospice Deaths on SNF

Hospice and Mayers SNF	2024
Death: Hospice Patients Admitted to SNF	2
Dath: SNF residents referred to Hospice	10
Total Hospice Deaths on SNF	12
All Deaths on SNF	20
Percent Deaths on Hospice	60
National Benchmark	40

Average Patient Days



	July	August	September	October	November	December	January	February	March	April	May	June	
fy2020	3.5	4.9	4.4	4	2.73	2.7	1.87	2.28	2.58	0.8	1.19	2.43	2.78
fy2021	2.77	1.56	2.63	4.16	2.23	2.7	4.35	7.53	9.8	8.5	6.7	4.33	4.77
fy2022	5.67	5.29	4.06	4.03	6.3	7.93	7.25	3.21	2.93	2.23	4.03	3.76	4.72
fy2023	6.38	5.29	5.2	3.54	3.23	3.54	2.25	1.03	1.77	1.5	2.41	3.9	3.34
fy2024	4.58	3.32	2.73	1.74	2.13	2	2.88	3.52	1.77	1.87	2.16	2	2.56
fy2025	4.48	8.65	6.6	6.84	7.3	9.35							7.20
Target	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department: Mayers Healthcare Foundation **Reporting Month & Year: Feb. 2025**

Summary: The Mayers Healthcare Foundation had a great year in 2024 and has started 2025 off with more successes.

Top Projects (1-3):

New donor software – integrating QuickBooks into the system.

Acquiring the Fall River Arts Building and moving the Thrift Store

Wins (1-2):

MHF had a very successful January gala Event. We sold out the dinner and all of the Corvette Raffle tickets. Preliminary net profit numbers are looking good.

Awarded $49,214.70 in Department Awards and a fall round of Scholarships to two employees. These scholarships were in addition to those that were presented in the spring.

Challenge (1):

Volunteer numbers are needed to help with a growing Thrift Store. If we had more volunteers to run the store, we could easily have expanded hours.

MAYERS MEMORIAL
HEALTHCARE DISTRICT

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department:
Jack Hathaway - Quality

Reporting Month & Year:
02/2017

Summary:

The Quality department has grown in numbers and capacity over the last few years, and I am incredibly grateful for that growth. We have seen incredible involvement from everyone in the district in gathering data and using that data to improve outcomes for residents and patients. We have some opportunities ahead with all of the continuing ACHC work, and we look forward to seeing how that plays out to improve outcomes for those we have the pleasure of serving in our community.

Top Projects (1-3):

1. DHCS / PHP QIP work - We have made significant strides in our QIP work, and I am very hopeful that this will translate into success in the future. The data I have now leads me to believe that we should find comfortable success in both programs and lay a foundation for the future years as the DHCS and PHP programs continue to blend.

2. UR - we have also made significant strides in the UR processes that we have built and employed in our hospital, and we look forward to analyzing our 2024 data to set a baseline for the program and build to know we are providing the most clinically current and appropriate care for the patients that we serve.

3. My personal work with the group and Wes has been enlightening. I was not sold at first. However, some valid points can be found and applied from work, and I look forward to using them to continue refining my leadership style and serving those I have the fortune to work with.

Wins (1-2):

Data! We have more data now informing the decision-making in the district then we ever have before... (and maybe we have ACHC in the building already or soon to fix that win into a frozen best practice)

Team: Pam and I love having Jenna and Yas on the team, and I love having folks to geek out with about all of the strange and fantastic things that come up in our healthcare settings.

Challenge (1):

The continually changing healthcare landscape in state and federal regulatory bodies should be an adventure for the next few years.

Department Reporting

Managers Meeting and Regular Board Meeting

Manager & Department: Arnese Stern & Britany Hammons, SNF

Reporting Month & Year: February 2025

Summary:

The Skilled Nursing Facility currently has a census of seventy-six (76) residents, with thirty-three (33) in Fall River and forty-three (43) in Burney. Bed availability includes one (1) male bed and two (2) female beds in Burney and one (1) female bed and two (2) male beds in Fall River. We have accepted one (1) female admission pending rehabilitation completion to Fall River. There are currently four (4) people on the waitlist for Memory Care in Burney: two (2) males and two (2) females. Social Services and Nursing Leadership reviews are timely, and the Admission Intakes Forms for potential resident admissions are in-person reviews and scheduled family tours (when appropriate). We also have eight (8) pending self-reports submitted between September 2024 and January 2025, awaiting review by the California Department of Public Health (CDPH). These include resident-to-resident verbal and physical abuse incidents and a case of staff-to-resident verbal abuse.

Top Projects (1-3):

The Healthcare Leadership Institute training has been a significant focus, with the Associate Director of Nursing attending all sessions to date and receiving positive feedback. The newly hired permanent D.O.N., Sharon Lyons, began February leadership training. These group sessions have facilitated valuable learning opportunities and provided a platform for exchanging ideas with other leaders. Another key project is the new hire competency program, aiming for an 80% completion rate for all full-time employees. Orientation Tools, Competency Validations, and Standard Work Guidelines have been collaboratively developed for CNAs, Staff Nurses, and Charge Nurses, approved by Executive Leadership, and implemented. In-person realignment orientation for CNA staff commenced on February 10th, with the Staff and Charge Nurses to follow. Additionally, efforts to maintain an average compliance rate of 80% for hand hygiene among nursing staff are ongoing. The SNF Leadership and the Infection Prevention team have been conducting regular rounds to monitor compliance, with resident family members participating as secret shoppers to support these efforts.

Wins (1-2):

The Skilled Nursing Facility won the 2024 Department of the Year Award. We have successfully hired four Licensed Vocational Nurses and one Registered Nurse, all slated to start in February. Additionally, we have hired a full-time Staff Director of Nursing, with the current Interim Director staying through the end of May to ensure a smooth transition. The

initiation of nursing orientation and competency validation has been another significant achievement, fostering team realignment and paving the way for a more cohesive and productive future. Implementing a family council has also been a notable success, generating ideas and positive feedback that have strengthened communication with residents' families. Furthermore, we have introduced protected time for the departmental environment of care validation checklists, allowing consistent team support and thorough follow-up on concerns and ideas. This initiative will also contribute to better preparation for the Annual Survey.

Challenge (1):

One of the primary challenges we face is the high percentage of agency utilization, which complicates the process of hardwiring new implementations. To address this, we have initiated discussions with Nurses in Professional Healthcare (NPH) and continue to engage in these discussions to align registry training and review role shift duties, ensuring consistency and effectiveness across the board.

Updates as of: 02/13/25

Attachment G

Mayers Memorial Hospital District

Financial Statements and
Supplementary Information

Years Ended June 30, 2024 and 2023

MAYERS MEMORIAL
HEALTHCARE DISTRICT

WIPFLI

Independent Auditor's Report

Board of Directors
Mayers Memorial Hospital District
Fall River Mills, California

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of Mayers Memorial Hospital District (the "District"), which comprise the statements of net position as of June 30, 2024 and 2023, and the statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of June 30, 2024 and 2023, and the changes in financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America (GAAP).

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with GAAP, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

WIPFLI

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

WIPFLI

Required Supplementary Information

GAAP requires that a management's discussion and analysis on pages 4 through 8, be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the GASB who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards and notes to the schedule of expenditures of federal awards as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the schedule of expenditures of federal awards and the notes to the schedule of expenditures of federal awards are fairly stated in all material respects in relation to the financial statements as a whole.

Wipfli LLP

Wipfli LLP

Spokane, Washington
February 12, 2025

Mayers Memorial Hospital District

Management's Discussion and Analysis

Years Ended June 30, 2024 and 2023

Introduction

Mayers Memorial Hospital District (the "District"), offers readers of our financial statements this narrative overview and analysis of the financial activities of the District for the fiscal years ended June 30, 2024 and 2023. We encourage readers to consider the information presented here in conjunction with the District's financial statements, including the notes thereto.

The District is a nonprofit, municipal corporation that operates an acute-care hospital, a long-term care unit, hospice, and an ambulance company. The District is licensed for 16 hospital beds, 99 long-term care beds including 21 beds in the Alzheimer's Dementia Care Unit (ADCU). The hospital services include 24-hour emergency care, radiology, lab, outpatient services, cardiac rehabilitation, surgery, physical therapy and a rural health clinic. The District serves a large geographic region that is roughly 35 miles in all directions; encompasses portions of Lassen, Shasta, and Modoc Counties; and has a population of approximately 10,000.

The District was established in November 1969 with a 10-bed facility in Fall River Mills, California. Additions to the facility were built in 1973, 1984, and 2020. The long-term care facility was expanded in 1994 with the addition of a site in Burney, California, which includes the ADCU. In August 2020, the District opened a Rural Health Clinic on the Burney site.

The District is designated as a critical access hospital (CAH). CAH status has had and continues to have a favorable impact on the District's finances in as much as CAH Medicare and Medi-Cal reimbursement are cost-based and therefore typically higher than what the District would otherwise receive under prospective payment system (PPS) reimbursement methodology. The District receives property tax revenue on assessed property within the District's boundaries to support operations. During the years ended June 30, 2024 and 2023, the District received property tax revenue of $1,782,537 and $1,151,416, respectively.

The District is governed by a five-member elected Board of Directors. Day-to-day operations are managed by the Chief Executive Officer. The District employed 231 employees on June 30, 2024, and had an annual payroll of $22.2 million, not including benefits.

Overview of the Financial Statements

This discussion and analysis is intended to serve as an introduction to the District's audited financial statements. The financial statements comprise the statements of net position; revenues, expenses, and changes in net position; and cash flows. The financial statements also include notes to the financial statements, which explain in more detail some of the information in the financial statements. The financial statements are designed to provide readers with a broad overview of the District's finances.

Required Financial Statements

The District's financial statements report information of the District using accounting methods similar to those used by private-sector healthcare organizations. These statements offer short-term and long-term information about its activities. The statements of net position include all of the District's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the District's creditors (liabilities). The statements of net position also provide the basis for evaluating the capital structure of the District and assessing the liquidity and financial flexibility of the District.

All of the revenue and expenses for the years ended June 30, 2024 and 2023, are accounted for in the statements of revenues, expenses, and changes in net position. These statements can be used to determine whether the District has successfully recovered all of its costs through its patient and resident service revenue and other revenue sources. Revenues and expenses are reported on an accrual basis, which means the related cash could be received or paid in a subsequent period.

The final required statements are the statements of cash flows, which report cash receipts, cash payments, and net changes in cash resulting from operations, investing, and financing activities. They also provide answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period.

Financial Highlights Executive Overview

The District's financial performance exceeded administration's expectations as fiscal 2024 ended, with an excess of revenue over expenses of $9,009,000. The gain was driven largely by an increase in net patient and resident service revenue.

- The District's total revenue from operations was $57,311,000 in 2024 and $47,364,000 in 2023.
- The District's gain from operations was $6,873,000 in 2024 and $3,331,000 in 2023.
- During 2024 and 2023, excess of revenue over expenses totaled $9,009,000 and $4,228,000 respectively.
- During 2024 and 2023, nonoperating revenue net of expenses totaled $2,136,000 and $896,000, respectively.

Financial Analysis of the District

The statements of net position and the statements of revenues, expenses, and changes in net position report the net position of the District and the changes in net position. The District's net position, the difference between assets and liabilities, is a way to measure the financial health or financial position of an organization. Over time, sustained increases or decreases in the District's net position are one indicator of whether its financial health is improving or deteriorating. However, other nonfinancial factors such as changes in economic condition, population growth, and new or changed governmental legislation should also be considered.

Condensed Statements of Net Position
(In Thousands)

June 30,	2024	2023	Change 2024-2023
Other assets	$ 45,997	$ 36,291	$ 9,706
Capital assets	32,982	33,190	(208)
Total assets	$ 78,979	$ 69,481	$ 9,498
Other liabilities	$ 4,705	$ 3,502	$ 1,203
Long-term liabilities	22,431	23,145	24,020
Total liabilities	27,136	26,647	25,223
Net position:			
Net investment in capital assets	9,225	9,370	(145)
Restricted	2,854	2,949	(95)
Unrestricted	39,764	30,515	9,249
Total net position	51,843	42,834	9,009
Total liabilities and net position	$ 78,979	$ 69,481	$ 34,232

The District's net position reflects an increase that is caused primarily by an increase in net patient and resident service revenue.

- Current assets increased by approximately $9,706,000 in 2024 and $1,290,000 in 2023.
- Noncurrent assets consist mostly of capital assets, debt service reserve, and cash set aside to meet borrowing agreements. Noncurrent assets decreased by $443,350 in 2024 due to building improvement projects.

Financial Analysis of the District (Continued)

The following table presents a summary of the statements of revenues, expenses, and changes in net position:

Condensed Statements of Revenues, Expenses, and Changes in Net Position
(In Thousands)

Years Ended June 30,	2024	2023	Change 2024-2023
Operating revenue:			
Net patient and resident service revenue	$ 52,869	$ 42,587	$ 10,282
Other operating revenue	4,442	4,776	(334)
Total operating revenue	57,311	47,363	9,948
Operating expenses:			
Salaries and wages	22,187	18,132	4,055
Employee benefits	4,638	4,250	388
Professional fees and purchased services	9,895	10,184	(289)
Supplies	7,227	6,157	1,070
Insurance	681	506	175
Other operating expenses	3,927	2,935	992
Depreciation	1,884	1,868	16
Total operating expenses	50,439	44,032	6,407
Gain from operations	6,872	3,331	3,541
Nonoperating revenue - Net	2,137	896	1,241
Increase in net position	9,009	4,227	4,782
Net position at beginning of year	42,834	38,606	4,228
Net position at end of year	$ 51,843	$ 42,834	$ 9,009

Salaries, wages, and benefits increased in 2024 by 22.4% due to across-the-board wage increases. In the prior year, salaries and benefits increased by 17.6%. The total number of full-time equivalent employees was approximately 231 in 2024 and 254 in 2023.

Total operating expenses increased by 14.5% compared with the previous year's increase of 7.3%. This was due primarily to an increase in salaries and benefits by roughly $4,443,000 as a result of competitive wage scale adjustments. In addition, supplies expense increased by roughly $1,070,000 due to the increased cost of supplies and higher volumes causing a higher supply usage.

Financial Analysis of the District (Continued)

Capital asset activity included purchases related to the building improvement projects related to the District's acute care and emergency facilities in the amount of $1,678,000 and $3,828,000, for each of the years ended June 30, 2024 and 2023, respectively.

Long-term debt activity included the USDA loan that refunded existing debt and new borrowing to finance capital construction and equipment purchases for each of the years ended June 30, 2024 and 2023.

Items Affecting Operations

The challenges facing the District this fiscal period are largely similar to those issues facing the healthcare industry in general and small rural hospitals in particular. Immediate environmental circumstances uniquely influencing the District are highlighted below:

- Reimbursement: Medicare and Medi-Cal programs continue to look for ways to reduce reimbursement.
- Possible state legislation to cap charge increases on an annual basis, a bill to introduce a single-payor system in California, as well as a bill to make healthcare minimum wage 25 dollars an hour.
- Indigent and uncompensated care: High uncompensated care continues to grow as eligibility requirements are raised for government-funded programs.
- Labor: Nursing and some technician positions continue to be difficult to recruit and retain.

In summary, the external environment continues to challenge small rural hospitals amidst continued declines in reimbursement, increases in uncompensated care, and ongoing labor and health insurance issues. Furthermore, the District and its employees are working together to improve the clinical care and service provided to its patients and community, while striving to improve its financial position and overall fiscal performance.

Contacting the District's Finance Management

This financial report provides the District's patients, citizens, taxpayers, investors, and creditors with a general overview of the District's finances and shows the District's accountability for the money it receives. For questions regarding this report or for additional financial information, please contact:

Mayers Memorial Hospital District
PO Box 459
Fall River Mills, CA 96028

Mayers Memorial Hospital District

Statements of Net Position

June 30,	2024	2023
Current assets:		
Cash and cash equivalents:		
Unrestricted	$ 32,822,699	$ 25,620,907
Restricted, available for current debt service	222,510	80,423
Cash held in trust for others	23,086	30,794
Receivables:		
Patient and resident accounts, net of contractual allowances and discounts	8,580,479	5,101,205
Other	3,595	33,240
Estimated third-party payor settlements	155,421	630,595
Inventories	614,766	671,789
Prepaid expenses	942,057	1,253,832
Total current assets	43,364,613	33,422,785
Noncurrent assets:		
Restricted cash, net of amount available for current debt reserve	2,631,985	2,868,442
Capital assets - Nondepreciable	2,732,294	1,166,417
Capital assets - Net of accumulated depreciation	30,250,574	32,023,344
Total noncurrent assets	35,614,853	36,058,203
TOTAL ASSETS	$ 78,979,466	$ 69,480,988

Mayers Memorial Hospital District

Statements of Net Position (Continued)

June 30,	2024	2023
Current liabilities:		
Accounts payable	$ 1,674,812	$ 1,234,561
Accrued expenses	2,293,208	1,562,136
Current portion of bonds payable	656,878	611,555
Current portion of subscription-based liability	38,460	35,092
Current portion of lease obligation	18,358	27,035
Balances held in trust for others	23,085	30,794
Total current liabilities	4,704,801	3,501,173
Noncurrent liabilities:		
Bonds and accreted interest, less current portion	22,413,756	23,070,625
Subscription-based liability, less current portion	17,094	55,554
Lease obligation, less current portion	-	18,460
Total noncurrent liabilities	22,430,850	23,144,639
Total liabilities	27,135,651	26,645,812
Net position:		
Net investment in capital assets	9,225,017	9,371,440
Restricted	2,854,495	2,948,865
Unrestricted	39,764,303	30,514,871
Total net position	51,843,815	42,835,176
TOTAL LIABILITIES AND NET POSITION	$ 78,979,466	$ 69,480,988

See accompanying notes to financial statements.

Mayers Memorial Hospital District

Statements of Revenues, Expenses, and Changes in Net Position

Years Ended June 30,	2024	2023
Operating revenue:		
Net patient and resident service revenue	$ 52,869,079	$ 42,587,019
Other operating income	4,441,994	4,776,526
Total operating revenue	57,311,073	47,363,545
Operating expenses:		
Salaries and wages	22,185,866	18,132,062
Employee benefits	4,636,677	4,249,851
Professional fees	1,484,227	1,605,403
Supplies	7,227,387	6,157,408
Purchased services	8,410,891	8,578,436
Repairs and maintenance	479,868	454,309
Rents and leases	115,611	119,139
Utilities	1,185,307	1,052,835
Insurance	681,183	506,002
Other	2,146,573	1,308,227
Depreciation	1,884,459	1,868,498
Total operating expenses	50,438,049	44,032,170
Gain from operations	6,873,024	3,331,375
Nonoperating revenue (expenses):		
Property taxes	1,782,537	1,151,416
Grants and contributions	126,634	419,373
Interest income	949,451	334,446
Interest expense	(723,007)	(1,008,899)
Net nonoperating revenue	2,135,615	896,336
Increase in net position	9,008,639	4,227,711
Net position - Beginning of year	42,835,176	38,607,465
Net position - End of year	$ 51,843,815	$ 42,835,176

See accompanying notes to financial statements.

Mayers Memorial Hospital District

Statements of Cash Flows

Years Ended June 30,	2024	2023
Cash flows from operating activities:		
Receipts from and on behalf of patients and residents	$ 49,872,061	$ 43,461,176
Receipts from other operating revenue	4,471,639	4,365,725
Payments to employees	(21,454,794)	(17,589,135)
Payments to suppliers, contractors, and others	(26,179,689)	(25,738,198)
Net cash provided by operating activities	6,709,217	4,499,568
Cash flows from noncapital financing activities:		
Property taxes	1,782,537	1,151,416
Cash received from grants and contributions	119,552	365,592
Net cash provided by noncapital financing activities	1,902,089	1,517,008
Cash flows from capital and related financing activities:		
Acquisition of capital assets	(1,064,261)	(3,928,971)
Proceeds from debt issuance	-	110,187
Principal payments on debt	(673,775)	(500,960)
Interest paid on debt	(723,007)	(800,323)
Proceeds from sale of assets	-	362,314
Net cash used in capital and related financing activities	(2,461,043)	(4,757,753)
Cash flows from investing activities - Interest received	949,451	334,446
Net increase in cash and cash equivalents	7,099,714	1,593,269
Cash and cash equivalents - Beginning of year	28,600,566	27,007,297
Cash and cash equivalents - End of year	$ 35,700,280	$ 28,600,566

Mayers Memorial Hospital District

Statements of Cash Flows (Continued)

Years Ended June 30,	2024	2023
Reconciliation of gain from operations to net cash provided by operating activities:		
Gain from operations	$ 6,873,024	$ 3,331,375
Adjustments to reconcile gain from operations to net cash provided by operating activities:		
Depreciation and amortization	1,884,459	1,868,498
Provision for bad debts	1,746,982	725,855
Changes in assets and liabilities:		
Patient and resident accounts receivable	(5,226,256)	(609,851)
Other accounts receivable	29,644	16,151
Estimated third-party payor settlements	482,256	758,153
Inventories	57,023	(52,386)
Prepaid expenses	311,775	(534,969)
Accounts payable	(173,054)	(1,369,931)
Accrued expenses	731,072	360,269
Balances held in trust for others	(7,708)	6,404
Total adjustments	(163,807)	1,168,193
Net cash provided by operating activities	$ 6,709,217	$ 4,499,568
Supplemental disclosure of noncash noncapital financing activities:		
Capital purchase in account payable	$ 613,305	$ -

See accompanying notes to financial statements.

Mayers Memorial Hospital District

Notes to Financial Statements

Note 1: Summary of Significant Accounting Policies

The Entity

Mayers Memorial Hospital District (the "District") is a political subdivision of the State of California, organized under Local Healthcare District Law, as set forth in the Health and Safety Code of the state of California. The District operates a community hospital, long-term care unit, hospice, and ambulance service located in Fall River Mills, California, that provide healthcare services to residents of the surrounding communities and visitors to the area. The District derives a significant portion of revenue from third-party payors, including Medicare, Medi-Cal, and commercial insurance organizations.

The District maintains its financial records in conformity with guidelines set forth by Local Healthcare District Law and the Office of Statewide Health Planning and Development of the State of California.

Method of Accounting

The District's financial statements are presented using the economic resources measurement focus and the accrual basis of accounting.

Basis of Accounting

The financial statements have been prepared in accordance with generally accepted accounting principles in the United States of America (GAAP) as prescribed by the Governmental Accounting Standards Board (GASB).

Use of Estimates in Preparation of Financial Statements

The preparation of the accompanying financial statements in conformity with GAAP requires management to make estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from these estimates.

The District considers significant accounting estimates to be those which require significant judgments and include the valuation of accounts receivable, including contractual allowances, allowance for doubtful accounts, the estimated third-party payor settlements, and the valuation of lost revenues calculated to recognize revenue from grant programs.

Cash and Cash Equivalents

The District considers all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents.

Note 1: Summary of Significant Accounting Policies (Continued)

Cash and Cash Equivalents (Continued)

The District is authorized under California Government Code (CGC) to make direct investments in local agency bonds, notes, or warrants within the state; U.S. Treasury instruments; registered state warrants or treasury notes; securities of the U.S. government or its agencies; bankers' acceptances; commercial paper; certificates of deposit (CD) placed with commercial banks and/or savings and loan companies; repurchase or reverse repurchase agreements; medium-term corporate notes; shares of beneficial interest issued by diversified management companies, certificates of participation, or obligations with first-priority security; and collateralized mortgage obligations.

The District maintains a portion of its cash in the Shasta County Treasury as part of the common investment pool. The County is restricted by CGC, Section 53635, pursuant to Section 53601, to invest in time deposits, U.S. government securities, state-registered warrants, notes, bonds, state treasurer's investment pool, bankers' acceptances, commercial paper, negotiable CDs, and repurchase or reverse repurchase agreements. Investments in the county pool are valued using the amortized cost method (which approximates fair value) and include accrued interest. The pool has deposits and investments with a weighted-average maturity of more than one year. As of June 30, 2024, the fair value of the county pool is 99% of the carrying value and is deemed not to represent a material difference. Information regarding the amount of dollars invested in derivatives with the county was not available. The county investment pool is subject to regulatory oversight by the Treasury Oversight Committee, as required by CGC, Section 27130, and is not a registered investment company with the U.S. Securities and Exchange Commission. The District is considered to be an involuntary participant in the external investment pool.

Patient and Resident Receivables and Credit Policy

Patient and resident receivables are uncollateralized patient and resident obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The District bills third-party payors on the patients' or residents' behalf, or if a patient or resident is uninsured, the patient or resident is billed directly. Once claims are settled with the primary payor, any secondary payor is billed, and patients and residents are billed for copay and deductible amounts that are the patients' or residents' responsibility. Payments on patient and resident accounts receivable are applied to the specific claim identified on the remittance advice or statement. The District does not have a policy to charge interest on past due accounts.

Patient and resident receivables are recorded in the accompanying statements of net position, net of contractual adjustments and an allowance for doubtful accounts, which reflects management's estimate of the amounts that will not be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of gross revenue and a credit to patient and resident receivables. In addition, management provides for probable uncollectible amounts, primarily for uninsured patients or residents and amounts patients or residents are personally responsible for, through a reduction of gross revenue and a credit to a valuation allowance.

Note 1: Summary of Significant Accounting Policies (Continued)

Patient and Resident Receivables and Credit Policy (Continued)

In evaluating the collectibility of patient and resident receivables, the District analyzes past results and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. Specifically, for receivables associated with services provided to patients or residents who have third-party coverage, the District analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts for expected uncollectible deductibles and copayments on accounts that the third-party payor has not yet paid or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely.

For receivables associated with self-pay patients or residents (which includes both patients or residents without insurance and patients or residents with deductible and copayment balances due for which third-party coverage exists for part of the bill), the District records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients or residents are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged to allowance for doubtful accounts.

Inventories

Inventories are valued at the lower of cost, determined on the first-in, first-out (FIFO) method, or net realizable value.

Capital Assets and Depreciation

Capital assets are recorded at cost if purchased or estimated acquisition value at the date received if contributed. The District maintains a threshold level of a unit or group cost of $5,000 or more for capitalizing capital assets. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Estimated useful lives range from 5 to 25 years for land improvements and buildings and fixed equipment, 2 to 20 years for major moveable equipment, and 3 to 5 years for computer software.

Accrued Compensated Absences

District employees earn vacation, sick, and holiday leave (PTO) in varying amounts based on length of service. Accumulated PTO benefits are paid to an employee, if the employee leaves, either upon termination or retirement. Liabilities for PTO and salary-related payments, including Social Security taxes, are recorded when incurred. Accrued PTO benefits, which are recorded in accrued expenses on the statements of net position, totaled $1,179,112 and $956,340 as of June 30, 2024 and 2023, respectively.

Note 1: Summary of Significant Accounting Policies (Continued)

Net Position

Net position is reported in three categories:

Net investment in capital assets: This category consists of capital assets, net of accumulated depreciation, reduced by the outstanding balance of any long-term debt used to build, acquire, or improve those assets. Deferred outflows of resources and deferred inflows of resources that are attributable to the construction, acquisition, or improvement of those assets or the related debt are also included in this category.

Restricted: This category consists of noncapital assets whose use is restricted, reduced by liabilities, and deferred inflows of resources related to those assets. Net position is reported as restricted when there are limitations imposed on its use through external restrictions imposed by creditors, grantors, or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation.

Unrestricted: This category consists of the remaining net position that does not meet the definition of the two preceding categories.

When both restricted and unrestricted resources are available for use, it is the District's policy to use externally restricted resources first.

Net Patient and Resident Service Revenue

The District recognizes patient and resident service revenue associated with services provided to patients and residents who have third-party payor coverage on the basis of contractual rates for the services rendered. Certain third-party payor reimbursement agreements are subject to audit and retrospective adjustments. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Tax Revenue

The District has the authority to impose taxes on property within the boundaries of the healthcare district. Taxes are received from the county, which bills and collects the taxes for the District. Secured property taxes attach as an enforceable lien on property as of January 1. Taxes are payable in two installments, due on November 1 and February 1. Unsecured property taxes are payable in one installment on or before August 31.

Shasta County is responsible for assessing, collecting, and apportioning property taxes on behalf of the District. Taxes are levied for each fiscal year on taxable real and personal property in the county. Secured property taxes attach as an enforceable lien on property as of January 1. Property taxes on the secured roll are due on November 1 and February 1 and become delinquent after December 10 and April 10.

Note 1: Summary of Significant Accounting Policies (Continued)

Tax Revenue (Continued)

Secured property taxes are recorded as revenue, when apportioned, in the fiscal year of the levy. The County apportions secured property tax revenue in accordance with the alternate method of distribution prescribed by Section 4705 of the California Revenue and Taxation Code. This alternate method provides for crediting each applicable fund with its total secured taxes upon completion of the secured tax roll, approximately October 1 of each year.

The amount of property tax received is dependent on the assessed real property valuations as determined by the Shasta County assessor. The District received approximately 2.6% and 1.9% of its financial support in 2024 and 2023, respectively, from property taxes.

Operating Revenue and Expenses

The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenue and expenses. Operating revenue results from exchange transactions associated with providing healthcare services, the District's principal activity. Nonexchange revenue, including taxes and donations received for purposes other than capital asset acquisition, is reported as nonoperating revenue. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs.

Charity Care

The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The District maintains records to identify the amount of charges forgone for services and supplies furnished under the charity care policy. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient and resident service revenue.

Grants and Contributions

The District receives grants and contributions from individuals and private organizations. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or capital purposes. Amounts that are unrestricted or are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue (expenses).

Unemployment Compensation

The 1971 session of California's legislature extended unemployment insurance protection to public employers. Each entity has the right to elect to pay the regular quarterly employer tax on covered wages or to reimburse the Unemployment Compensation Fund for actual claims paid to its former employees for unemployment.

The District has elected to pay quarterly employer tax on covered wages for the years ended June 30, 2024 and 2023.

Note 2: Reimbursement Arrangements With Third-Party Payors

The District has agreements with third-party payors that provide for reimbursement to the District at amounts that vary from its established rates. A summary of the basis of reimbursement with major third-party payors follows:

Hospital

Medicare - The District is designated as a CAH. Under this designation, inpatient, outpatient, and swing bed services rendered to Medicare program beneficiaries are paid based on a cost-reimbursement methodology, with the exception of certain lab and mammography services, which are reimbursed based on fee schedules.

Medi-Cal - Under CAH designation, inpatient and swing bed services rendered to Medi-Cal program beneficiaries are paid based on a cost-reimbursement methodology. The reimbursement for outpatient services is based on a fee schedule. The District also applies for and receives supplemental reimbursement for its inpatient and outpatient services. The supplemental reimbursement is based on a cost-reimbursement methodology.

Nursing Facility

Medicare - Medicare pays the skilled nursing facility for Part A services based on a predetermined rate per resident day, which varies depending on a resident's level of care and the types of services provided.

Medi-Cal - Long-term care services are reimbursed at a daily rate, which is adjusted annually. The District also applies for and receives supplemental reimbursement for its Distinct Part Nursing Facility (DPNF). The supplemental reimbursement is based on a cost-reimbursement methodology.

Others

The District has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes discounts from established charges and prospectively determined daily rates.

Accounting for Contractual Arrangements

The District is reimbursed for certain cost-reimbursable items at an interim rate, and final settlements are determined after an audit or desk review of the District's related annual cost reports by the Medicare Administrative Contractor (MAC) and Medi-Cal. Estimated provisions to approximate the final expected settlements are included in the accompanying financial statements. The District's cost reports have been final settled by the MAC and Medi-Cal through June 30, 2021.

Note 2: Reimbursement Arrangements With Third-Party Payors (Continued)

Compliance

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include but are not necessarily limited to matters, such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and billing regulations. Violations of these laws and regulations could result in expulsion from government healthcare programs, together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. While no significant regulatory inquiries have been made of the District, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

The Centers for Medicare & Medi-Cal Services (CMS) uses recovery audit contractors (RAC) as part of CMS's efforts to ensure accurate payments. RACs search for potentially inaccurate Medicare payments that might have been made to healthcare providers and not detected through existing CMS program integrity efforts. Once a RAC identifies a claim it believes is inaccurate, it makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. As of June 30, 2024, the District had not been notified by the RAC of any potential significant reimbursement adjustments.

Note 3: Cash and Cash Equivalents

Custodial Credit Risk - The risk that, in the event of a bank failure, the District's deposits might not be recovered. The District has a collateralization agreement with the bank that mitigates custodial credit risk. Deposits are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000. At June 30, 2024, the District had a bank balance of $35,056,998. Of this balance, $8,346,734 is insured by the FDIC and $1,346,320 is held in the investment portfolio of the Local Agency Investment Fund (LAIF) and is fully collateralized by the California Government Code (CGC). The remaining amount not covered is subject to risk of bank failure.

The CGC requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. California law also allows financial institutions to secure public deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits and letters of credit issued by the Federal Home Loan Bank of San Francisco having a value of 105% of the secured deposits.

Interest Rate Risk - As a means of limiting its exposure to fair value losses arising from rising interest rates, the District's investment policy limits its investment portfolio to the LAIF guidelines promulgated by the California Debt and Investment Advisory Commission, with the following exceptions:

- Equity mutual fund investments may not exceed 20% of the total portfolio.
- At least 75% of equity investments must be U.S. equities; the remaining 25% may be international.
- At least 75% of equity investments must be large cap growth or value; the remaining 25% may be invested in small cap or mid cap.
- All equity investments are not to exceed 25% in any one mutual fund.

Note 3: Cash and Cash Equivalents (Continued)

Credit Risk - The risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by assignment of a rating by a nationally recognized statistical rating organization. The District has an investment policy that limits its investment choices by credit rating. LAIF is not rated.

Concentration of Credit Risk - CGC limits the purchase of certain investments to defined percentages of the investment portfolio.

The District adopted and uses California Health and Safety Code, Section 32127 (the "Code") as its policy for limitation on instruments of investment. The Code authorizes investments in obligations of the U.S. Treasury, commercial paper, bankers' acceptances, repurchase agreements, and LAIF, which is a pooled investment fund held at the California treasurer's office, among other investments.

Cash and cash equivalents consisted of the following:

June 30,	2024	2023
Demand deposits	$ 34,351,880	$ 20,501,751
Cash on hand	2,080	2,080
LAIF	1,346,320	8,096,735
Totals	$ 35,700,280	$ 28,600,566

The composition of cash and cash equivalents consisted of the following:

June 30,	2024	2023
Current:		
Unrestricted cash and cash equivalents	$ 32,822,699	$ 25,620,907
Cash held in trust for others	23,086	30,794
Noncurrent:		
Restricted for debt service, net of current amount	2,854,495	2,948,865
Totals	$ 35,700,280	$ 28,600,566

Restricted for Debt Service

The restricted debt service reserve fund is required by the United States Department of Agriculture (USDA) debt agreements, as discussed at Note 8.

Cash Held in Trust for Others

Current cash and cash equivalents include assets held in trust for others, which consisted of cash held for patients and the employee relief fund.

Note 4: Patient and Resident Accounts Receivable

Patient and resident accounts receivable, net of contractual allowances and discounts consisted of the following:

June 30,	2023	2023
Patient and resident accounts receivable:		
Medicare	$ 6,347,680	$ 2,572,734
Medi-Cal	5,741,749	2,867,046
Commercial and other	2,978,946	2,006,165
Self-pay	795,430	871,259
Total patient and resident accounts receivable	15,863,805	8,317,204
Less:		
Contractual adjustments	6,710,856	2,564,109
Allowance for doubtful accounts	572,470	651,890
Patient and resident accounts receivable - Net	$ 8,580,479	$ 5,101,205

Note 5: Charity Care

The District provides healthcare services and other financial support through various programs that are designed to, among other matters, enhance the health of the community, including the health of low-income patients. Consistent with the mission of the District, care is provided to patients regardless of their ability to pay, including providing services to those persons who cannot afford health insurance because of inadequate resources.

Patients who meet certain criteria for charity care, generally based on federal poverty guidelines, are provided care based on criteria defined in the District's charity care policy and from applications completed by patients and their families.

The District maintains records to identify and monitor the level of charity care it provides. The amount of charges forgone for services and supplies furnished under the District's charity care policy was $211,024 and $68,275 for the years ended June 30, 2024 and 2023, respectively.

Note 6: Net Patient and Resident Service Revenue

Net patient and resident service revenue consisted of the following:

Years Ended June 30,	2024	2023
Gross patient and resident service revenue:		
Inpatient services	$ 30,576,212	$ 25,179,551
Outpatient services	32,257,738	29,150,403
Total gross patient and resident service revenue	62,833,950	54,329,954
Revenue deductions:		
Contractual allowances	8,217,889	11,017,080
Provision for bad debt	1,746,982	725,855
Total deductions	9,964,871	11,742,935
Net patient and resident service revenue	$ 52,869,079	$ 42,587,019

The following table reflects the percentage of gross patient and resident service revenue by payor source:

Years Ended June 30,	2024	2023
Medicare	41 %	40 %
Medi-Cal	43 %	42 %
Other third-party payors	14 %	16 %
Patients	2 %	2 %
Totals	100 %	100 %

Note 7: Capital Assets

Capital assets consisted of the following:

	Balance June 30, 2023	Additions	Retirements	Transfers	Balance June 30, 2024
Nondepreciable capital assets:					
Land	$ 461,135	$ -	$ -	$ -	$ 461,135
Construction in progress	705,282	1,565,877	-	-	2,271,159
Total nondepreciable capital assets	1,166,417	1,565,877	-	-	2,732,294
Depreciable capital assets:					
Land improvements	3,508,717	-	-	-	3,508,717
Buildings and fixed equipment	39,457,489	-	-	-	39,457,488
Major moveable equipment	14,849,922	111,689	-	-	14,961,611
Computer software	1,246,750	-	-	-	1,246,750
Total depreciable capital assets	59,062,878	111,689	-	-	59,174,566
Total capital assets before depreciation	60,229,295	1,677,566	-	-	61,906,860
Total accumulated depreciation	(27,131,357)	(1,847,730)	-	-	(28,979,087)
Subscription-based assets	110,188	-	-	-	110,188
Accumulated amortization: SBA	(18,365)	(36,729)	-	-	(55,094)
Total subscription-based assets	91,823	(36,729)	-	-	55,094
Capital assets - Net	$ 33,189,761	$ (206,893)	$ -	$ -	$ 32,982,868

At June 30, 2024, construction in progress consisted primarily of building and building improvement projects, such as facility master planning, Clearwater Lodge improvements, fire alarm remodel, and a seismic wall project. Estimated costs of completion are approximately $1.675 million for the outstanding projects. The estimated completion date for all projects is unknown at this time and the District intends to fund the projects with USDA loan proceeds.

Note 7: Capital Assets (Continued)

Capital assets consisted of the following:

	Balance June 30, 2022	Additions	Retirements	Transfers	Balance June 30, 2023
Nondepreciable capital assets:					
Land	$ 461,135	$ -	$ -	$ -	$ 461,135
Construction in progress	4,161,318	2,650,427	-	(6,106,463)	705,282
Total nondepreciable capital assets	4,622,453	2,650,427	-	(6,106,463)	1,166,417
Depreciable capital assets:					
Land improvements	3,508,717	-	-	-	3,508,717
Buildings and fixed equipment	34,135,302	428,805	(376,900)	5,270,283	39,457,489
Major moveable equipment	13,295,572	748,870	(30,700)	836,180	14,849,922
Computer software	1,246,750	-	-	-	1,246,750
Total depreciable capital assets	52,186,341	1,177,675	(407,600)	6,106,463	59,062,878
Total capital assets before depreciation	56,808,794	3,828,102	(407,600)	-	60,229,295
Total accumulated depreciation	(25,358,827)	(1,871,597)	99,067	-	(27,131,357)
Subscription-based assets	-	110,188	-	-	110,188
Accumulated amortization: SBA	-	(18,365)	-	-	(18,365)
Total subscription-based assets	-	91,823	-	-	91,823
Capital assets - Net	$ 31,449,967	$ 2,048,328	$ (308,533)	$ -	$ 33,189,761

Note 8: Long-Term Debt Obligations

Long-term debt obligations consisted of the following:

	June 30, 2023	Additions	Reductions	June 30, 2024	Amounts Due Within One Year
Long-term debt:					
Direct placements:					
General Obligation Bonds, 2011 Series A - Capital appreciation	$ 465,886	$ -	$ (150,000)	$ 315,886	$ 180,000
General Obligation Bonds, 2011 Series A - Accreted interest of CAP bonds	1,430,168	-	-	1,430,168	-
Total direct placements	1,896,054	-	(150,000)	1,746,054	180,000
Direct borrowings:					
USDA bonds	20,457,000	-	(396,000)	20,061,000	410,000
Notes payable	1,329,126	-	(65,546)	1,263,580	66,878
Total direct borrowings	21,786,126	-	(461,546)	21,324,580	476,878
Total long-term debt obligations	$ 23,682,180	$ -	$ (611,546)	$ 23,070,634	$ 656,878

Note 8: Long-Term Debt Obligations (Continued)

Long-term debt obligations consisted of the following:

	June 30, 2022	Additions	Reductions	June 30, 2023	Amounts Due Within One Year
Long-term debt:					
Direct placements:					
General Obligation Bonds, 2011 Series A - Capital appreciation	$ 465,886	$ -	$ -	$ 465,886	$ 150,000
General Obligation Bonds, 2011 Series A - Accreted interest of CAP bonds	1,221,592	208,576	-	1,430,168	-
Total direct placements	1,687,478	208,576	-	1,896,054	150,000
Direct borrowings:					
USDA bonds	20,842,000	-	(385,000)	20,457,000	396,000
Notes payable	1,393,384	-	(64,258)	1,329,126	65,555
Total direct borrowings	22,235,384	-	(449,258)	21,786,126	461,555
Total long-term debt obligations	$ 23,922,862	$ 208,576	$ (449,258)	$ 23,682,180	$ 611,555

Note 8: Long-Term Debt Obligations (Continued)

Scheduled principal and interest payments on bonds and notes payable are as follows:

	Direct Placements		Direct Borrowings	
Years Ending June 30,	Principal	Interest	Principal	Interest
2025	$ 180,000	$ -	$ 476,878	$ 669,981
2026	205,000	-	491,228	655,095
2027	230,000	-	505,605	639,759
2028	260,000	-	522,010	623,940
2029	290,000	-	537,444	544,530
2030-2034	502,563	1,047,437	2,948,761	3,080,264
2035-2039	78,491	1,386,509	3,432,180	2,040,164
2040-2044	-	-	3,637,474	1,721,061
2045-2049	-	-	3,738,000	1,104,057
2050-2054	-	-	2,616,000	611,098
Totals	$ 1,746,054	$ 2,433,946	$ 21,324,580	$ 11,850,385

Direct placements:

General Obligation Bonds, 2011 Series A Bonds

On June 16, 2011, the District issued $5,000,886 in General Obligation Bonds, 2010 Election, 2011 Series A (the "2011 Series A bonds") to finance the acquisition, improvement, construction, or alteration of real property of the District; seismic upgrades of the acute care and emergency facilities; certain other capital projects; and the costs of issuance of the bonds. The 2011 Series A bonds consisted of two types of bonds: Current Interest Bonds and Capital Appreciation Bonds, issued in the amounts of $4,530,000 and $547,991, respectively.

Interest on the Current Interest Bonds was payable semiannually on February 1 and August 1 at a rate of 5%. The Current Interest Bonds were eligible for redemption on or after August 1, 2017. The District refinanced these bonds on September 28, 2017, using USDA financing.

The Capital Appreciation Bonds mature annually commencing on August 1, 2023, through August 1, 2038, in amounts ranging from $150,000 to $320,000, inclusive of interest accreted through such maturity dates. Interest on the Capital Appreciation Bonds is accreted every year beginning at a 7.75% rate commencing in 2023 and increased annually to a max rate of 8.14%. Interest is paid at maturity. The Capital Appreciation Bonds are not subject to optional redemption prior to their scheduled maturities.

Note 8: Long-Term Debt Obligations (Continued)

Direct borrowings:

USDA Bonds Payable

On September 28, 2017, the USDA Rural Development program issued a series of four secured bonds to the District, amounting to a total of $21,805,000 at a rate of 3.25% and were collaterized with the District's tax revenue.

The first bond was issued for $9,900,000 to fund building improvement projects. Interest on the bond is payable semiannually on September 1 and March 1 and is based on amounts drawn until the full amount has been drawn. Principal payments on the bond are due annually commencing September 2020 through 2057 in amounts ranging from $125,000 to $462,000.

The second bond was issued for $4,300,000 to fund building improvement projects and to refinance the 2011 Certificate of Participation Bonds. Interest on the bond is payable semiannually on September 1 and March 1. Interest is based on amounts drawn until the full amount has been drawn and the amount of the debt refinanced. Principal payments on the bond are due annually commencing September 2018 through 2057 in amounts ranging from $21,000 to $193,000.

The first and second USDA-issued bonds require the District to set aside one-tenth of the average annual installments in a reserve account. The debt service reserve amount for the following fiscal year is represented as current restricted cash and cash equivalents on the statements of net position and contains a balance of $2,854,495 as of June 30, 2024.

The third bond was issued for $4,574,000 to refinance and pay off the General Obligation Bonds, 2011 Series A. Interest on the bond is payable semiannually on September 1 and March 1. Principal payments on the bond are due annually commencing September 2018 through 2057 in amounts ranging from $92,000 to $236,000.

The fourth bond was issued for $3,031,000 to finance the acquisition, improvement, construction, or alteration of real property of the District; seismic upgrade of the acute care and emergency facilities; and certain other capital projects. Interest on the bond is payable semiannually on September 1 and March 1 and is based on amounts drawn until the full amount has been drawn. Principal payments on the bond are due annually commencing September 2020 through 2057 in amounts ranging from $68,000 to $161,000.

Notes Payable

The District entered into a debt agreement with the California Health Facilities Financing Authority (CHFFA) dated June 1, 2020, and financed on July 30, 2020, in the amount of $1,500,000, with an interest rate of 2.0% and due in monthly installments of $7,628 until maturity on August 1, 2040, and is secured by property tax revenue. The District will use the funds to finance renovations of the new clinic.

Note 9: Lease Obligations

Changes in leases payable consisted of the following for the years ended June 30:

	Balance June 30, 2023	Additions	Reductions	Balance June 30, 2024	Due Within One Year
Xerox copy machines	$ 45,495	$ -	$ (27,137)	$ 18,358	$ 18,358

	Balance June 30, 2022	Additions	Reductions	Balance June 30, 2023	Due Within One Year
Xerox copy machines	$ 97,197	$ -	$ (51,702)	$ 45,495	$ 27,035

Equipment financed with leases consisted of the following:

June 30,	2024	2023
Cost of equipment	$ 126,950	$ 126,950
Accumulated amortization	(114,255)	(63,474)
Right of use assets - Net	$ 12,695	$ 63,476

Future minimum lease payments as of June 30, 2024, are:

	Principal	Interest	Total
2025	$ 18,358	$ 428	$ 18,786
Totals	$ 18,358	$ 428	$ 18,786

Lease Agreements

As of June 30, 2024, the District had one lease agreement in place. The lease agreement is with Xerox Financial Services LLC beginning January 1, 2021, is payable in monthly installments of $2,716, including interest at 9.2% through December 2025, and is collateralized by equipment.

Note 10: Subscription-Based Information Technology Arrangements

Changes in subscription-based technology arrangements consisted of the following:

	Balance June 30, 2023	Additions	Reductions	Balance June 30, 2024	Amounts due Within One Year
Kaseya	$ 90,646	$ -	$ (35,092)	$ 55,554	$ 38,460

	Balance June 30, 2022	Additions	Reductions	Balance June 30, 2023	Amounts due Within One Year
Kaseya	$ -	$ 110,187	$ (19,541)	$ 90,646	$ 35,092

The terms of the District's subscription-based technology arrangements are as follows:

- Kaseya - Subscription-based technology arrangement in the original principal amount of $110,187 (from implementation date), due in monthly installments of $3,498, including interest imputed at 9.2%, through November 2025, collateralized by the subscription-based technology.

Future minimum subscription-based technology arrangement payments consist of the following:

Years Ending June 30	Principal	Interest
2025	$ 38,459	$ 3,516
2026	17,095	395
Totals	$ 55,554	$ 3,911

Note 11: Retirement Plan

The District sponsors and administers the Mayers Memorial Hospital District Governmental 401(k) plan. The defined contribution plan covers substantially all of its employees who are age 21 or older and have completed one year of service. Employees enter the plan on the first day of the quarter following the date the eligibility requirements are met.

Note 11: Retirement Plan (Continued)

The 401(k) plan is funded entirely by employee elective deferrals, which are immediately 100% vested. The plan provides for employer discretionary contributions that are allocated pro rata on the basis of eligible compensation. Benefit terms, including discretionary employer contributions, are established by management and the Board of Directors. No employer contributions are required. The District contributed 3% of eligible compensation annually to participants' accounts during each fiscal year ended June 30, 2024, and 2023. Participants employed on or before December 31, 2010, are 100% vested in their employer discretionary contributions. Participants employed after December 31, 2010, are subject to a five-year graded vesting schedule at the rate of 25% starting the second year and 25% each year thereafter annually until the fifth year, for a total of 100%. Forfeitures are used to reduce future employer contributions. For the plan years ended December 31, 2024 and 2023, forfeitures reduced the District's employee contributions by less than $1,000 each year. Employee contributions for the years ended June 30, 2024 and 2023, were approximately $314,000 and $224,000, respectively.

Note 12: Risk Management

The District is exposed to various risks of loss related to medical malpractice; torts; theft of, damage to, and destruction of assets; errors and omissions; injuries of employees; and natural disasters.

The District's comprehensive general liability insurance covers losses of up to $5 million per claim with $5 million annual aggregate for claims incurred during a policy year regardless of when the claim was filed ("occurrence based coverage"). The District's professional liability insurance covers losses up to $5 million per claim with $15 million annual aggregate for claims reported during a policy year ("claims made coverage"). The deductible per claim is $10,000. Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the District. Although the possibility exists of claims arising from services provided to patients through June 30, 2024, that have not yet been asserted, the District is unable to determine the ultimate cost, if any, of such possible claims, and accordingly no provision has been made for them. Settled claims have not exceeded commercial coverage in any of the three preceding years.

Workers' Compensation

The District is exposed to the risk of loss resulting from workers' compensation claims. To address this risk, the District participates in a joint venture under a joint powers agreement with the Association of California Healthcare Districts, Inc. BETA FUND (the "Fund"). The Fund arranges for and provides member entities with pooled workers' compensation self-insurance. Member entities include governmental entities, nonprofit hospital corporations, and nonprofit corporations that provide healthcare services similar to services provided by a healthcare district. The District pays an annual premium to the Fund for its workers' compensation insurance coverage, which covers losses of up $2,000,000 per incident with no deductible. If participation in the Fund were terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the Fund.

Note 13: Concentration of Credit Risk

Financial instruments that potentially subject the District to credit risk consist principally of patient accounts receivable. Patient and resident accounts receivable consist of amounts due from patients and residents, their insurers, or governmental agencies (primarily Medicare and Medi-Cal) for healthcare provided to the patients and residents. The majority of the District's patients are from Shasta County, California, and the surrounding area.

The mix of receivables from patients and third-party payors consisted of the following:

June 30,	2024	2023
Medicare	40 %	30 %
Medi-Cal	36 %	34 %
Other third-party payors	19 %	26 %
Patients	5 %	10 %
Totals	100 %	100 %

Supplementary Information

Mayers Memorial Hospital District

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2024

Federal Grantor/Pass-Through Grantor/Program Title	Federal Listing Number	Contract or Award Number	Period of Award	Total Federal Expenditures
U.S. Department of Agriculture:				
Direct Program:				
Community Facilities Loans and Grants Cluster				
Community Facilities Loans and Grants	10.766	04-045-4940	09/28/2017 to 09/01/2057	$ 20,457,000
Total expenditures of federal awards				$ 20,457,000

See Independent Auditor's Report.
See accompanying notes to schedule of expenditures of federal awards.

Mayers Memorial Hospital District

Notes to Schedule of Expenditures of Federal Awards

Note 1: General

The accompanying schedule of expenditures of federal awards (the "Schedule") includes the federal award activity of the District. The information in the Schedule is presented in accordance with requirements of the Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (the "Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of the District, it is not intended to and does not present the financial position, changes in net position, or cash flows of the District.

Note 2: Basis of Accounting

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance wherein certain types of expenditures are not allowable or are limited as to reimbursement. Pass-through entity identifying numbers are presented where available.

Note 3: Loan Balance

The District had outstanding loans with USDA as of June 30, 2024, with a balance of $20,061,000. The loan balance at the beginning of the year was included in the federal expenditures presented on the Schedule. There were no new loans received during the year ended June 30, 2024.

Note 4: Indirect Cost Rate

The District has elected not to use the 10-percent de minimis indirect cost rate allowed under the Uniform Guidance.

Note 5: Subrecipients

The District does not have any subrecipients of federal awards.

WIPFLI

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Board of Directors
Mayers Memorial Hospital District
Fall River Mills, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Mayers Memorial Hospital District (the "District"), as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise the District's basic financial statements, and have issued our report thereon dated February 12, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting ("internal control") as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit the attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies, and therefore material weaknesses or significant deficiencies may exist that have not been identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We identified a deficiency in internal control, described in the accompanying schedule of findings and questioned costs as item 2024-001 that we consider to be a significant deficiency.

WIPFLI

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

The District's Response to Findings

Government Auditing Standards require the auditor to perform limited procedures on the District's response to the findings identified in our audit and described in the accompanying schedule of findings and questioned costs. The District's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance, and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Wipfli LLP

Wipfli LLP

Spokane, Washington
February 12, 2025

Mayers Memorial Hospital District

Schedule of Findings and Questioned Costs

Year Ended June 30, 2024

Section I - Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified	
Internal control over financial reporting:		
Material weakness(es) identified?	___ yes	_x_ no
Significant deficiency(ies) identified?	_x_ yes	___ no
Noncompliance material to financial statements noted?	___ yes	_x_ no

Federal Awards

Internal control over major programs:		
Material weakness(es) identified?	___ yes	_x_ no
Significant deficiency(ies) identified?	___ yes	_x_ no
Type of auditor's report issued on compliance for major programs	Unmodified	
Any audit findings disclosed that are required to be reported in accordance with the Uniform Guidance [2 CFR 200.516(a)]?	___ yes	_x_ no

Identification of major federal programs:

CFDA Number	Name of Federal Program or Cluster
10.766	Community Facilities Loans and Grants

Dollar threshold used to distinguish between Type A and Type B programs:	$750,000	
Auditee qualified as low-risk auditee?	_x_ yes	___ no

Mayers Memorial Hospital District

Schedule of Findings and Questioned Costs (Continued)

Year Ended June 30, 2024

SECTION II - Findings Related to Financial Statements Reported in Accordance With Government Auditing Standards

Finding Number: 2024-001
Repeat Finding: Yes
Type of Finding: Significant deficiency
Description: Financial statement preparation and accompanying note disclosures

Criteria:	Government Auditing Standards considers the inability to report the financial data reliably in accordance with GAAP to be an internal control deficiency.
Condition:	The District relies on the auditor to compile the financial statements and notes. As part of our professional services for the year ended June 30, 2024, Wipfli LLP assisted in drafting the basic financial statements and related notes. This condition is not unusual in an organization of its size.
Cause:	The District prepares a set of full disclosure financial statements only on an annual basis and does not maintain the expertise to prepare full disclosure financial statements due to cost and other considerations.
Effect:	The completeness of the financial statement disclosures and the accuracy of the overall financial presentation may be negatively impacted, since outside auditors do not have the same comprehensive understanding as its internal finance staff.
Recommendation:	We recommend management and those charged with governance continue to evaluate the degree of risk associated with this condition because of cost or other considerations. It is the responsibility of management and those charged with governance to make the decision whether to accept the degree of risk associated with this condition because of cost or other considerations.
View of responsible officials:	The CEO and CFO will continue to evaluate the cost versus benefits of having financial reporting personnel obtain expertise on financial statement preparation and disclosure requirements. Like many small organizations, the District may continue to rely on its external auditors to draft the financial statements, footnotes, and schedule of expenditures of federal awards. The CFO and controller review interim financials on a monthly basis and present results to the Finance Committee and Board of Directors.

SECTION III - Findings and Questioned Costs Related to Federal Awards

None reported.

Mayers Memorial Hospital District

Schedule of Prior-Year Findings and Questioned Costs

Year Ended June 30, 2024

Finding Number: 2023-001
Type of Finding: Significant deficiency
Description: Financial statement preparation and accompanying note disclosures

Condition:	The District relies on the auditor to compile the financial statements and notes. As part of our professional services for the year ended June 30, 2023, Wipfli LLP assisted in drafting the basic financial statements and related notes. This condition is not unusual in an organization of its size.
Current Status:	Not corrected; see current-year finding 2024-001.

MEDICAL EQUIPMENT PURCHASE REQUISITION

PO: Attachment H

MAYERS MEMORIAL HEALTHCARE DISTRICT

MAYERS MEMORIAL HEALTHCARE DISTRICT

Department & Cost Center #		Date Submitted
LTC - SNF - 6580		

Suggested Vendor : Securitas Healthcare

Name of Contact

Address:

City:

State

Zip

Phone

Fax

NOTES

****THIS REQUISITION IS FOR MEDICAL EQUIPMENT ONLY****

ATTACH APPROVED QUOTE WITH REQUISITION

APPROVAL LIMITS

DEPT MGR $500
DIRECTOR $2,500
CHIEF UP TO $7,500
CEO OVER $7,500

SPECIALTY ORDERS
SURG $1,500
PLANT OP $1,500
IT $1,500
QUALITY $1,500

Line #	Quantity	Unit of Measure	Vendor Cat #	Product/Service Description	Unit Price	Extended Price
1				New WanderGuard system in Burney Annex		$58,974.38
2						$0.00
3						$0.00
4						$0.00

NOTE: Any orders placed without the authority of the Purchasing Department may not be approved for payment, and may become the sole responsibility of the individual placing the order.

Subtotal		$58,974.38
State Tax		
Shipping		
TOTAL		$58,974.38

Requested by:

MAINTENANCE MANAGER APPROVAL: [signature]

IT MANAGER APPROVAL: Jessica DiCarlo on Behalf of IT

SAFETY OFFICER APPROVAL: Dave Heuse

DEPARTMENT HEAD APRROVAL:

Buyer:

REV: 09/24

CEO APPROVAL IF NEEDED:

Securitas Healthcare

Customer: Mayers Memorial Hospital District
Account Number: 1424500

Date: 11/21/2024
Quote Valid Until: 12/21/2024
Quote Number: Q-49385

Shipping Address	Billing Address
Mayers Memorial Hospital District 43563 Hwy 299 E Fall River Mills California 96028 United States	Mayers Memorial Hospital District Po Box 459 Fall River Mills California 96028 United States

Line #	QTY	SKU	Product Name and Description	List Price	Customer Price	Customer Total
1	11	INST-DOOR REMOVAL	Labor - Door Removal	$0.00	$0.00	$0.00
2	11	WGB-DOOR-1000-NA	WanderGuard Blue Door Bundle - North American	$2,375.00	$2,375.00	$26,125.00
3	11	ANT-4210	ANT4210 External LF Antenna	$115.00	$115.00	$1,265.00
4	11	AGESM01-016	SELECT SOUND MODULE	$200.00	$200.00	$2,200.00
5	3	14321	ARIAL REPEATER ES (BROADCAST MODE ONLY)	$716.81	$716.81	$2,150.43
6	2	14325	WIRELESS REMOTE ANNUNCIATOR (ECHOSTREAM)	$1,517.74	$1,517.74	$3,035.48
7	20	WGB-TAG-1000-90D	WanderGuard Blue Bracelet - 90 days	$45.00	$45.00	$900.00
8	11	54350	ARIAL UNIVERSAL TRANSMITTER ES	$108.18	$108.18	$1,189.98
9	1	WGB-STARTER-1000-NA	WanderGuard Blue Starter Kit - NA	$970.00	$970.00	$970.00

Securitas Healthcare

Line #	QTY	SKU	Product Name and Description	List Price	Customer Price	Customer Total
10	1	INST-WG	INSTALLATION OF WANDER SYSTEM	$17,733.26	$17,733.26	$17,733.26
					Sub-Total:	$55,569.15

Equipment Subtotal	$37,835.89
Installation Cost	$17,733.26
Shipping Cost	$662.13
Sales Tax	$2,743.10
Total	$58,974.38

Quote currency is USD

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Identification of Potential Organ and/or Tissue Donors	POLICY #MS026
DEPARTMENT/SCOPE:	Med-Surg	Page 1 of 7
REVISION DATE:		EFFECTIVE DATE: 11/5/2024
AUDIENCE: All Acute Clinical Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

DEFINITIONS:

Timely Notification: The referral by the hospital to Donor Network West (DNW) of any time prior to, or within 60 minutes of meeting referral cues, and prior to any measures taken to decelerate care, for the evaluation of potential organ donation eligibility.

Imminent Death: Defined in the context of this policy as a ventilated patients with a non-recoverable illness/injury with any one of the following:

1. All first indication patient has suffered a non-recoverable illness or injury,
2. Prior to plans for family discussions regarding comfort care or withdrawal of life-sustaining measures.
3. Prior to plans for formal brain death determination.

Donation After Circulatory Death (DCD): Organ donation from a patient who is pronounced dead on the basis of irreversible cessation of circulatory and respiratory functions.

Organ Procurement Organization (OPO): The organization responsible for donor evaluation and care, and organ removal and preservation, which is Donor Network West (DNW) for MMHD. DNW employs coordinators who work with donor families and provide educational programs to hospitals. DNW is an independent organization not affiliated with any particular hospital but serves many hospitals.

POLICY:

In compliance with the Conditions of Participation, the Omnibus Budget Reconciliation Act of 1986, and applicable provisions of the Uniform Anatomical Gift Act, it is the policy of Mayers Memorial Healthcare District (MMHD) to identify potential organ and tissue donors and to cooperate in the procurement of anatomical gifts. This policy may be addressed as the "required request" policy and consists of the required reporting of patient deaths to Donor Network West (DNW).

PROCEDURE:

The hospital wishes to facilitate organ donation in the interest of the individual recipient and society, without infringing on others deeply held values, rights, religious beliefs, and cultural convictions. We recognize the importance of allowing those who wish to give the opportunity to do so by providing the family an opportunity to give life and happiness to others at the time of unexpected tragedy. The principles of voluntary giving are always to be upheld while allowing autonomy to families of potential donors.

SUBJECT/TITLE:	Identification of Potential Organ and/or Tissue Donors	POLICY #MS026
DEPARTMENT/SCOPE:	Med-Surg	Page 2 of 7
REVISION DATE:		EFFECTIVE DATE: 11/5/2024
AUDIENCE: All Acute Clinical Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

The "*Donor Network West Resource Manual for Organ, Eye, Tissue Donation*" will be utilized in conjunction with this procedure to serve as a guide for identifying and referring potential organ, eye, and tissue donors.

Responsibility of the DNW:

1. Donor Network West, the federally designated Organ Procurement and Tissue Recovery provider for the region, will be available to provide something twenty-four hours a day, seven days a week and work closely with MMHD.
2. Maintain sufficient and appropriate facilities and staff to recover and distribute organs, eye, and tissue deemed appropriate for transplantation.
3. Contact legal next of kin or surrogate decision maker to present the option of donation. Hospital personnel/physicians do not have to discuss the donation option with next of kin or surrogate decision maker. The DNW recommends that this be accomplished in conjunction with a DNW coordinator prior to the donation discussion.

   NOTE: Organ/tissue donations may be accepted from coroner's cases and/or court cases. When a physician has prior knowledge of a potential organ/tissue donor and the patient will become a reportable coroner's case, the physician should notify the coroner's office and DNW as soon as possible. The coroner's office will supply the appropriate release forms, as required.

4. Make the final decision regarding donor suitability for transplant or research. If DNW determines that the potential for donation exists, the team will discuss this with the next of kin or surrogate decision maker (on site of organ donations, by telephone for eye and tissue donations).
5. Maintain computerized file documentation on DNW screening evaluation for organ donation on every death reported by the hospital for a minimum of ten years.

Responsibilities of Mayers Memorial Healthcare District

1. The hospital will notify the DNW of ALL imminent deaths and cardiac deaths within <u>one</u> hour of meeting referral cues by calling (800) 55-DONOR (800-553-6667).
2. The hospital assists in reviewing/obtaining medical records as needed to insure suitability of donated organs, eye, and tissues.
3. The hospital allows access to hospital departments by photo-ID badge of DNW staff for organ, eye, and tissue cases.
4. The hospital names the Director of Nursing as the Hospital Staff Liaison with DNW.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Identification of Potential Organ and/or Tissue Donors	POLICY #MS026
DEPARTMENT/SCOPE:	Med-Surg	Page 3 of 7
REVISION DATE:		EFFECTIVE DATE: 11/5/2024
AUDIENCE: All Acute Clinical Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

Notification:

1. Notify Donor Network West via the 24-hour hotline at (800) 55-DONOR or (800) 553-6667.
    a. It is the responsibility of the patient's nurse to verify DNW has been notified as soon as it is determined that death is imminent, or that cardiac death has occurred.
    b. The nurse then documents the notification, date and time, records the reference number and signs on the Authority for Release of Remains form.
    c. Notify the patient's attending that DNW has been called per legislative requirements.
    d. Patients who donate organs such as the heart, liver, lungs, pancreas, kidneys, or small bowel must be maintained on a ventilator until the organs can be procured.

2. The DNW policies and procedures are applicable and are contained in the *Donor Network West Resource Manual for Organ, Eye, Tissue Donation*," located in the Emergency Department, and Medical-Surgical Unit (Note: Manuals provided by the DNW).
3. Follow the instructions from DNW in the event that organ/eye/tissue donation is deemed appropriate.
    - Disclosure Forms – DNW provides authorization forms for organ, eye, and tissue donation. The next of kin or surrogate decision maker must sign the *Authorization for Organ, Eye, and Tissue Donation*, even if the donor card has been signed.
4. Attach a copy of the *Authorization for Organ, Eye, and Tissue Donation* to the medical record and give the original to DNW.
5. If the body is to be transferred, the discharge summary must be included with the medical record. Complete the Record of Death / Permit to Release Body MMH#332. The individual who picks up the body must sign the form. The form remains with the medical record.

AUTHORIZATION FOR DONATION:

1. The following authorizations are legal in the state of California.
    a. Signed donor card (concurrence from the family is always sought). A copy of the donor card should be sent with the registration sheets to the patient care unit.
    b. Signed authorization from the next-of-kin for Anatomical Donation (legal next-of-kin is defined by the Uniform Anatomical Gift Act, 1987. California Health and Safety Code 7150.40 (a) Subject to subdivisions (b) and (c), and unless barred by Section 7150.30 or 7150.35, an anatomical gift of a decedent's body or part for the purpose of transplantation, therapy, research, or education may be made by

SUBJECT/TITLE:	Identification of Potential Organ and/or Tissue Donors	POLICY #MS026
DEPARTMENT/SCOPE:	Med-Surg	Page 4 of 7
REVISION DATE:		EFFECTIVE DATE: 11/5/2024
AUDIENCE: All Acute Clinical Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

any member of the following classes of persons who is reasonably available, in the following order of priority:

i. An agent of the decedent at the time of death who could have made an anatomical gift under subdivision (b) of Section 7150.15 immediately before the decedent's death.
ii. The spouse or domestic partner of the decedent
iii. Adult children of the decedent
iv. Parents of the decedent
v. Adult siblings of the decedent.
vi. Adult grandchildren of the decedent.
vii. Grandparents of the decedent.
viii. An adult who exhibited special care and concern for the decedent during the decedent's lifetime.
ix. The persons who were acting as the guardians or conservators of the person of the decedent at the time of death
x.

1. Any other person having the authority to dispose of the decedents body, including, but not limited to, a coroner, medical examiner, or hospital administrator, provided that reasonable effort has been made to locate and inform persons listed in paragraphs (i) to (x), inclusive of their option to make, or object to making, an anatomical gift.
2. Except in the case where the useful life of the part does not permit, a reasonable effort shall be deemed to have been made when a search for the persons has been underway for at least 12 hours. The search shall include a check of local police missing persons records, examination of personal effects, and the questioning of any persons visiting the decedent before his or her death or in the hospital, accompanying the decedent's body, or reporting the death, in order to obtain information that might lead to the location of any persons listed.
3. If there is more than one member of a class listed in paragraph (1), (3), (4), (5), (6), (7), or (9) of subdivision (b) entitled to make an anatomical gift, an anatomical gift ma be made b a member of the class unless that member or a person to which the gift may pass under Section 7150.50 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.
4. A person shall not make an anatomical gift if, at the time of the decedent t's death, a person in a prior class under subdivision (a) is reasonably available to make, or to object to the making of, an anatomical gift.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Identification of Potential Organ and/or Tissue Donors	POLICY #MS026
DEPARTMENT/SCOPE:	Med-Surg	Page 5 of 7
REVISION DATE:		EFFECTIVE DATE: 11/5/2024
AUDIENCE: All Acute Clinical Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

DONOR CRITERIA:

1. Organ Donation: Organ donation can take place when **neurologic death** has been established and the potential donor is maintained on organ support systems.
    a. **Neurological Death:** Two qualified physicians must independently determine and document in the medical record that the patient has suffered a total and irreversible cessation of brain function, including brain stem and their basis for the diagnosis of brain death. This decision shall be made by the physicians not involved in the transplant of organs or tissue from the deceased.
    b. **Donor Maintenance**: The donor must be maintained on organ support systems until the transplant team can arrive to remove the organs in surgery. Once the DNW coordinator arrives he/she will assist with medical management.

2. Organ Donation After Circulatory Death (DCD): Appropriate candidates for organ donation after circulatory death shall be limited to those patients who meet the following criteria:
    a. The patient has a non-recoverable illness or injury that has caused neurologic devastation though the patient does not fulfill the criteria for brain death, and/or the patient has other system failure resulting in ventilator dependency and meets the criteria for imminent death.
    b. The patient shall meet the suitability criteria listed below:
        i. No known medical condition that would exclude organ donation
        ii. Known cause of injury/insult
        iii. Approval by Medical Examiner/Coroner if case falls under their jurisdiction
        iv. Inadequate respiratory effort to maintain life when disconnected from the ventilator.
    c. The patient and/or family in conjunction with the medical staff have decided to withdraw life support. This decision is documented in the patient's medical record
    d. It is the opinion of the health care team that cardiorespiratory death will likely occur within two hours of withdrawal of life support. DNW will assist in this determination.
3. Tissue Donation: Tissue donation should be considered on all deaths including those who suffer neurological death. Tissue donation can be done up to 24 hours following biological death.

CORONER NOTIFICATION:

If the deceased falls under the jurisdiction of the coroner, the coroner must be notified by hospital staff. DNW will follow up with the coroner to discuss organ, eye, and tissue donation suitability and release. Appropriate documentation will be prepared for the coroner, which

SUBJECT/TITLE:	Identification of Potential Organ and/or Tissue Donors	POLICY #MS026
DEPARTMENT/SCOPE:	Med-Surg	Page 6 of 7
REVISION DATE:		EFFECTIVE DATE: 11/5/2024
AUDIENCE: All Acute Clinical Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

includes a copy of the chart and copy of the donation authorization form. Coroner authorization must be obtained before proceeding with donation. Normally, The DNW staff will obtain this information.

REQUIRED DOCUMENTATION:

1. Physician: The physician shall document "determination of death" on medical record including date, time, and a statement regarding criteria used to determine neurological or clinical death.
2. DNW Coordinator: Completes and obtains signatures on the "Organ and Tissue Donation" authorization form.
3. Licensed Staff: Document all nursing care, notification of DNW, any donation of organs/eye/tissues that occurred, interaction with family/significant others, authorizations obtained, disposition of remains and acceptance or declination to donate.

ORGAN/TISSUE/EYE RECOVERY:

1. Organ Donors: Mayers lacks an on-call surgeon or on-call surgery crew. Mayers operating room is not sufficient for organ recovery. Mayers will work closely with DNW to make arrangements for the patient to be transferred to another location for organ recovery.
2. Current practice at MMHD is to transport the tissue remains to a local mortuary where the remains are held for the tissue or eye recovery.
3. Costs: All costs incurred by MMHD in connection with the donation of anatomical gifts from the time brain death is declared and authorization has been obtained from the designated next-of-kin will be assumed by DNW. Bill shall be sent to the Donor Network West, 12667 Alcosta Blvd. Suite 500, San Ramon, CA 94583.
4. The DNW Coordinator will assume responsibility for notifying all appropriate agencies regarding the donation such as the mortician and the coroner, if appropriate.

HOSPITAL GUIDELINES FOR POTENTIAL ORGAN DONOR MANAGEMENT/CATASTROPHIC BRIAN INJURY:

The DNW Coordinator will fax to the hospital the recommendations for catastrophic brain injury medical management at the time of the brain injury decision.

REFERENCES:

Department of Health and Human Services 42 CFR Part 482-Conditions of Participation for Hospitals, the California Assembly Bill 631, Section 7184, and Public Law 99509, Section 9318

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Identification of Potential Organ and/or Tissue Donors	POLICY #MS026
DEPARTMENT/SCOPE:	Med-Surg	Page 7 of 7
REVISION DATE:		EFFECTIVE DATE: 11/5/2024
AUDIENCE: All Acute Clinical Staff		APPROVAL DATE:
OWNER: K. Earnest		APPROVER: K. Earnest

The Joint Commission, Centers for Medicare/Medicaid (CMS) COP 485.643 (a-f), DNW, web site www.donornetworkwest.org, Donate Life California, web site www.donatelifecalifornia.org, California Health and Safety Code 7150-7151.4

COMMITTEE APPROVALS:

P&P: 12/11/2024
MEC: 1/27/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Medication Administration	POLICY #MS003
DEPARTMENT/SCOPE: Med/Surg	Page 1 of 5
REVISION DATE: n/a	EFFECTIVE DATE: 1/11/2024
AUDIENCE: All Acute Staff	APPROVAL DATE:
OWNER: M. Padilla	APPROVER: T. Overton

Also see policies and procedures:

Patient Own Medications
Medication Errors
Adverse Drug Reaction Reporting
Injection, Intramuscular
Multidose Vials

QUALIFIED PERSONNEL 06.01.12

- Medications shall be administered only upon the order of physicians, who are members of the medical staff. Administration shall be by a physician, registered nurse, licensed practical/vocational nurse, respiratory therapist, pharmacists within their scope, and/or their respective supervised students.
- Registered nurses may administer all intravenous, parenteral, oral, rectal and topical medication, including blood and blood products.
- Licensed practical/vocational nurses may administer IV electrolytes, nutrients, blood and blood products, if IV certified, and all IM, subcutaneous, intradermal, rectal, topical, sublingual and oral medications.
- Up-to-date medication information shall be available to the individual administering the medication. This information is available through the Lexicomp® app in the Citrix platform or computer desktop. Additional medication information is available through the Cerner EHR platform. Available information shall include, but not be limited to:
    - Information on drug therapy, side effects, toxicology, dosage, indications for use, route of administration
    - Potential drug-to-drug interactions
    - Potential allergies or cross sensitivities
    - Proper dose ranges
    - Proper instructions for administration
- The individual administering a medication shall be aware of the following information concerning each medication before administration.
    - Therapeutic action
    - Untoward actions or side effects
    - Antidote (if applicable) and its location
    - Route and frequency of administration
    - Appropriate timing of medication administration
    - Normal dosage and maximum safe dosage
    - Signs of medication deterioration
    - Precautions
    - Any contraindications that would preclude the administration of the medication
    - That the expiration date has not been exceeded

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Medication Administration	POLICY #MS003
DEPARTMENT/SCOPE: Med/Surg	Page 2 of 5
REVISION DATE: n/a	EFFECTIVE DATE: 1/11/2024
AUDIENCE: All Acute Staff	APPROVAL DATE:
OWNER: M. Padilla	APPROVER: T. Overton

BASIC SAFE PRACTICEES FOR MEDICATION ADMINISTRATION 06.01.16

- Right Patient: the patient's identity – acceptable patient identifiers include but are not limited to: patient's full name; identification number assigned by the CAH; or date of birth. Identifiers must be confirmed by patient wrist band, patient identification card, patient statement (when possible). The patient's identification must be confirmed to be in agreement with the medication administration record and medication labeling prior to medication administration.
- Right Medication: The medication being given to the patient matches that prescribed for the patient and the patient does not have a documented allergy to it.
- Right Dose: The dosage of the medication matches the prescribed dose, and the prescription itself does not reflect an unsafe dosage level
- Right Route: The method of administration – oral, intramuscular, intravenous, etc., is the appropriate one for the particular medication and patient.
- Right Time: Administration time adheres to the prescribed frequency and time of administration.

MEDICATION ADMINISTRATION TIMEFRAMES: 06.01.17

- Scheduled medications are to be administered within one hour before or after their scheduled dosing time. For a total window of two hours.

ASSESSMENT AND MONITORING OF PATIENTS RECEIVING MEDICATIONS 06.01.18:

- Observing the effects medication has on the patient is part of the mediation administration process. Patients must be carefully monitored to determine whether the medication results in the therapeutically intended benefit, and to allow for early identification of adverse effects and timely initiation of appropriate corrective action. See P&P Adverse Drug Reaction Reporting.
- Depending on medication and route/delivery mode, monitoring may include assessment:
    - Clinical and laboratory data to evaluate the efficacy of medication therapy, to anticipate or evaluate toxicity and adverse effects.
    - Physical signs and clinical symptoms relevant to the patient's medication therapy, including but not limited to, change in vital signs, somnolence, confusion, agitation, unsteady gait, pruritus, etc.
- Patient risk factors and the risks inherent in a medication must be considered when determining the type and frequency of monitoring.
- Communicate all relevant information regarding patients' medication risk factors and monitoring requirements during hands-off report of the patients to other clinical staff, including when patients are moved for tests, at change of shift, etc.

MEDICATION ADMINISRATION PREPARATION:

- Medications and solutions for IV administration shall be observed to assure that the medication is stable and that there are no signs of precipitation, discoloration, or particulate matter prior to patient administration.
- All math calculations shall be independently double-checked.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Medication Administration	POLICY #MS003
DEPARTMENT/SCOPE: Med/Surg	Page 3 of 5
REVISION DATE: n/a	EFFECTIVE DATE: 1/11/2024
AUDIENCE: All Acute Staff	APPROVAL DATE:
OWNER: M. Padilla	APPROVER: T. Overton

- The patient's most recent weight (in kilograms) shall be documented and maintained in the patient's medical record for accurate weight-related medication administration.
- The expiration date of all medications shall be checked before administration.
- Incompatible injectable (IM, subcutaneous) medications shall be administered at different injection sites.
- Medications shall be prepared immediately prior to administration, particularly medications prepared for parenteral administration. To the maximum extent possible, drugs are to be administered by the person preparing the dose (except intravenous admixtures prepared by the Pharmacy).
- Also see P&P Multidose Vials.

MEDICATION ADMINSITRATION PROCEDURE:

A. Patient Identification
    1. A barcoded name band is applied to all patients within one hour
    2. There will be only one active wristband per patient.
    3. Nursing staff will replace worn, missing, or inaccurate wristbands immediately
    4. Mayers Memorial Hospital District staff permitted by State law and hospital policy to administer medications will use the barcode system.

B. Barcode Administration of Medications
    1. Verify the label on the medication with the patient's MAR before scanning
    2. Identify the patient using two (2) patient identifiers
    3. Scan the following using the handheld barcode reader:
        i. The barcode on the patient's identification wristband before medication administration
        ii. The barcode on the medication immediately before administration to verify:
            - The right patient
            - Right medication
            - Right time
            - Right dose
            - Right route
    4. Verify the allergy information displayed in barcode system before medication administration with information from another source, i.e., allergy bracelet, asking patients to recite allergies before medication administration.
    5. The barcode system shall give the nurse a visual warning if the medication cannot be matched with the order.
    6. If a warning is issued, the nurse shall not administer the medication until the discrepancy is resolved.
    7. Ensure medication administration including the time of administration is documented in the patient's MAR.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Medication Administration	POLICY #MS003
DEPARTMENT/SCOPE: Med/Surg	Page 4 of 5
REVISION DATE: n/a	EFFECTIVE DATE: 1/11/2024
AUDIENCE: All Acute Staff	APPROVAL DATE:
OWNER: M. Padilla	APPROVER: T. Overton

C. Prior to the administration of high-alert medications, such as heparin, insulin, or IV digoxin, the amount ordered and amount prepared must be checked by two licensed nurses.
D. No medication shall be left at the patient's bedside except for the following:
Nitroglycerin Tabs
- The nurse must document that the patient has been taught to use the medication and is competent to place under the tongue unsupervised.

Metered Dose Inhalers
- Nurse or Respiratory Therapist must document that the patient has been taught to use the medication and is competent to use the inhaler unsupervised.
- Nurse or Respiratory Therapist must provide patient with Patient Package Insert that is sent with prescription from pharmacy with each refill.

Topical Medications (Creams, Ointments, Solutions, Powders)
- The Nurse must document that the patient has been taught to use the topical medication and is competent to self-apply the medication unsupervised.

Anesthetic Lozenges and Throat Sprays
- The Nurse must document that the patient has been taught to use the agent and is competent to self-apply the medication unsupervised.
- The Nurse must document that the patient is not at increased risk for choking on a lozenge if used unobserved.

Over-the-Counter Nasal Spray or Eye Drops
- The Nurse must document that the patient has been taught to use the topical medication and is competent to self-apply the medication unsupervised.

E. The nurse administering the medication shall stay with the patient until the medication is taken. If a medication has been opened and is refused by a patient, it is to be destroyed. This also applies to medications held because of nurse discretion. (If a medication is held or refused, a notation shall be made on the patient's medication record.) Wasted control drugs shall be witnessed and cosigned.

PATIENT EDUCATION:

- The individual administering a medication shall advise the patient and/or family about the possibility of any clinically significant adverse reaction to the medication(s) or any other concerns regarding the administration of a new medication. The discussion shall be documented in the patient's medical record.
- The individual administering a medication shall discuss any unanswered, significant concerns about the medication with the patient's physician or prescriber of the medication and/or healthcare staff providing care, treatment and services to the patient. The discussion shall be documented in the patient's medical record.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Medication Administration	POLICY #MS003
DEPARTMENT/SCOPE: Med/Surg	Page 5 of 5
REVISION DATE: n/a	EFFECTIVE DATE: 1/11/2024
AUDIENCE: All Acute Staff	APPROVAL DATE:
OWNER: M. Padilla	APPROVER: T. Overton

DOCUMENTATION EXPECTATIONS 06.01.21:

- Documentation is expected to occur after actual administration of the drugs or biologicals to the patient and at patient bedside utilizing a medication barcode scanner.
- Proper documentation of medication administration actions and their outcomes is essential for planning and delivering future care of the patients.
- The time and dose of the drug or treatment administered to the patient shall be recorded in the patient's individual medication record by the person who administers the drug or treatment.

REFERENCES:

Centers for Medicare & Medicaid Services (CMS).*State Operations Manual (SOM) for Survey Expectations Related to 485.635(d)(3) and 482.23(c)(2).* Accessed Day Month Year.

Accreditation Commission for Health Care (ACHC).*Manual 06.01.06, 06.01.07, 06.01.16, 06.01.18, 06.01.21.* Accessed Day Month Year.

"Oxygen Therapy: Nursing Interventions."*Lippincott Procedures*, Wolters Kluwer Health, 2024. Accessed 26 Sept. 2024. procedures.lww.com.

Schub, Tanja, Carita Caple, and Diane Pravikoff, editors. "Administration of Medication in Adults: Intramuscular." *CINAHL Nursing Guide*, EBSCO Publishing, 9 Oct. 2015. Accessed Day Month Year, www.cinahl.com.

Caple, Carita, Sara Richards, and Diane Pravikoff, editors. "Administration of Medication in Adults: Subcutaneous Injection." *CINAHL Nursing Guide*, EBSCO Publishing, 11 Sept. 2015. Accessed Day Month Year, www.cinahl.com.

Institute for Safe Medication Practices (ISMP). "Guidelines for Timely Medication Administration Response to the CMS '30-Minute Rule.'" *Acute Care ISMP Medication SafetyAlert!*, 31 Jan. 2011, www.ismp.org/newsletters/acutecare/articles/20110113.asp. Accessed Day Month Year.

COMMITTEE APPROVALS:

M/P&T: 10/10/2024
P&P: 11/13/2024
MEC: 1/27/2025

MAYERS MEMORIAL HEALTHCARE
DELINEATION OF CLINICAL PRIVILEGES

- Physician Assistant –

The exercise of all privileges may occur only in the context of prevailing bylaws, rules and regulations, and hospital policies. It is required that all services performed be documented in the patient medical record and countersigned as appropriate and required by law. All services will be overseen and countersigned by the supervising physician(s). Please note that write-in privileges are <u>not</u> permitted. Please contact the Medical Staff Office if you wish a privilege not listed below.

The MMHD Medical Staff Bylaws recognizes that in the case of an emergency, any member of the medical staff, to the degree permitted by his or her license and regardless of service, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm.

EDUCATION, LICENSE AND CERTIFICATION REQUIREMENTS

- A certificate of completion from a college or university-based Physician Assistant program, and
- A current license to practice as a Physician Assistant in the State of California
- Current certification by the National Commission on Certification of Physician Assistants

SCOPE OF PRACTICE

Medical Privileges:

☒ **Requested** ☐ **Approved** ☐ **Not Approved**

- General core privileges include initial and ongoing assessment of the patient's medical, physical, and psychiatric status including the following: perform and document complete medical history, perform and document complete physical examination, record diagnostic impressions, write orders for diagnostic tests; activities, therapies, diet and vital signs; drugs; IV fluids; blood and blood products; oxygen; and consultation with medical staff members, instruct, educate and counsel patients on health status, results of tests, disease process, discharge summaries, and planning. Evaluate interim patient status and document in the progress notes, initiates consultation by other physicians at the direction of the supervising physician.
- Order or transmit orders for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, medication, laboratory and nursing services.

I fully understand and agree to follow the standards as set out above in the performance of all duties and actions.

_____ _____

Signature of Physician Assistant Date

NAME: _____

Physician Assistant Supervision

A physician assistant's scope of practice will be limited to the supervising physician's specialty.
Examination of the patient by the supervising physician within fourteen (14) days from time care is given by the physician assistant.
Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant.
Each time a physician assistant provides care for a patient and enters his or her name, signature or initials on a patients record, chart or written order, the physician assistant shall also enter the name of his or her approved supervising physician who is responsible for the patient. When a physician assistant transmits a verbal order, he or she shall also state the name of the supervising physician responsible for the patient.
The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision.

Supervising Physician(s):

I understand and accept full legal and ethical responsibility for the performance of all duties or acts performed by my physician assistant. I understand and agree to provide supervision as set out above. I further agree to notify the Medical Staff Office of Mayers Memorial Hospital District when I am no longer the supervising physician for the physician assistant listed above.

_____ _____
Print Physician Name Signature of Supervising Physician

_____ _____
Print Physician Name Signature of Supervising Physician

_____ _____
Print Physician Name Signature of Supervising Physician

NAME: _____

The privileges requested above have been approved subject to the following exceptions or additional requirements:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Approval of the IDP/AHP Committee Date

_____ _____

Approval of Medical Executive Committee Date
Chief of Staff or Vice Chief of Staff

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Urine Retention and Bladder Scanning Post-Catheter Removal		POLICY # MS023
DEPARTMENT/SCOPE: Med/Surg and Swingbed		Page 1 of 2
REVISION DATE:		EFFECTIVE DATE: 11/17/2024
AUDIENCE: Acute and Swing Bed Clinical Staff		APPROVAL DATE:
OWNER: Moriah Padilla		APPROVER: T. Overton

With attachment:

Bladder Scan: Using the PBS Bladder Scanner

DEFINITIONS:

- **Urinary Retention:** The inability to empty the bladder completely or at all, leading to discomfort or health risks.
- **Bladder Scan:** A non-invasive ultrasound used to measure the amount of urine in the bladder.

POLICY:

This policy is established to ensure the proper assessment and management of urinary retention following catheter removal in patients. It is designed to reduce the risks of urinary retention, including bladder damage, urinary tract infections, and other complications associated with prolonged urinary stasis.

PROCEDURE:

1. **Post-Catheter Removal Assessment:**
    - After the removal of an indwelling urinary catheter, monitor the patient for signs of urinary retention, such as inability to void, lower abdominal discomfort, or a distended bladder.
2. **Bladder Scanning:**
    - If the patient has not voided within 6 hours post-catheter removal, perform a bladder scan to assess urine volume.
    - Bladder scanning should be performed by a trained and certified healthcare professional.
    - Record the bladder volume as measured by the bladder scanner in the patient's chart.
3. **Action Based on Scan Results:**
    - If the bladder volume is > 400 mL, notify the healthcare provider for further intervention (e.g., in-and-out catheterization or reinsertion of the catheter as needed).
    - If the bladder volume is < 400 mL, continue to monitor the patient and reassess within the next 2 hours.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE: Urine Retention and Bladder Scanning Post-Catheter Removal		POLICY # MS023
DEPARTMENT/SCOPE: Med/Surg and Swingbed		Page 2 of 2
REVISION DATE:		EFFECTIVE DATE: 11/17/2024
AUDIENCE: Acute and Swing Bed Clinical Staff		APPROVAL DATE:
OWNER: Moriah Padilla		APPROVER: T. Overton

4. **Documentation:**
    - All assessments, bladder scan results, and actions taken must be thoroughly documented in the patient's medical record, including any provider notifications and interventions.

5. **Patient Education:**
    - Educate the patient on the importance of reporting any discomfort or inability to void after catheter removal.
    - Provide guidance on normal bladder function following catheter removal.

SPECIAL CONSIDERATIONS:

- Associated Policies: Catheter Care Policy, Documentation Policy
- Use discretion for patients with pre-existing urinary conditions.

REFERENCES:

UroToday. “Indwelling Urinary Catheter Post-Removal.” *UroToday*, UroToday, 2021, www.urotoday.com/cauti-home/69854-cauti-challenge-home.html.

COMMITTEE APPROVALS:

P&P: 11/13/2024
MEC: 1/27/2025

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 1 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

DEFINITIONS:

- Ligature Risk**:** A ligature risk (point) is defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes, and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges, and closures. Mayer's Memorial is not a behavioral health hospital and is not required to be ligature "free."
- Ligature-Resistant: Is defined as without points where a cord, rope, bedsheet, or other fabric or material can be looped or tied to create sustainable point of attachment that may result in self-harm or loss of life.
- One to One (1:1) Observation: Intervention for high risk for suicide. Continuous observation and staff are able to see the patient in clear view and staff can respond quickly to intervene and assure safety at all times, including while the patient sleeps, uses the toilet, bathes, etc.
- One to One (1:1) Observation within Arm's Length: Intervention for high-risk for suicide. Continuous observation and staff are within arm's length of the patient to immediately intervene to prevent patient self-harm.
- Frequent Observation (every 15 min checks): Intervention for moderate risk for suicide. Observation of patient in clear view every 15 minutes and respond immediately to intervene and assure safety.
- Post-Partum Depression: intense feelings of sadness, anxiety or despair after childbirth that interfere with a new mother's ability to function and that do not go away after 2 weeks.
- Suicidal Ideation; Thoughts of harming or killing oneself. Intensity is determined by assessing the frequency, duration, and intensity of these thoughts, in addition to the presence of a plan.
- Non-Suicidal Injurious Behavior: Engaging in behavior purely (100%) for reasons other than ending one's life; either to affect internal state (e.g., feel better, relieve pain, self-mutilation) or external circumstances (e.g., get attention, sympathy, make angry, etc.).
- Suicide Attempt: A self-injurious act committed with at least some intent to die as a result of the act. There does not need to be any injury or harm, just the potential for harm (e.g., gun failing to fire). Any non-zero attempt to die does not need to be 100%. Intent and behavior must be linked. A suicide attempt begins with the first pill swallowed or scratch of the knife. Intent can be inferred clinically from the behavior or circumstances (e.g., if someone denies intent to die but they thought that what they did could be lethal, then intent can be inferred). Clinically impressive circumstances where no other intent but can be inferred includes a highly lethal act (e.g., gunshot to head, taking 200 pills, setting self on fire, jumping from high floor/story).
- Interrupted or Aborted Suicide Attempt: The person starts to end their life but interrupted by someone or something (e.g., someone grabs the knife or pills or police pulls off ledge) or the person starts to end their live but changes their own mind (e.g., gun to her head, then puts the gun down).

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 2 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

- Suicide Preparatory Acts or Behavior: Any other behavior (beyond saying something) with suicidal intent (e.g., purchasing a gun, collecting, or buying pills, writing a will or suicide note).
- Suicide Risk Factors: Iindividual, relationship, community, and societal characteristics which contribute to the risk of suicide, such as:

Actual suicide attempt	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)	Hopelessness	Agitation or severe anxiety
Interrupted attempt	Pending incarceration or homelessness	Major depressive episode	Perceived burden on family or others
Aborted or self-interrupted attempt	Current or pending isolation or feeling alone	Mixed affective episode (e.g., Bipolar)	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, Cancer, etc.)
Preparatory acts to kill self	Previous psychiatric diagnosis and treatments	Command hallucinations to hurt self	Homicidal ideation
Non-suicidal injurious behavior	Hopeless or dissatisfied with treatment	Highly impulsive behavior	Aggressive behavior towards others
	Not receiving treatment	Substance abuse or dependence	Method for suicide available (gun, pills, etc.)
	Family history of suicide (lifetime)	Refuses or feels unable to agree to safety plan	Sexual abuse (lifetime)

- Protective Factors [6,7]: Characteristics buffer individuals from suicidal thoughts and behavior, such as:

Identifies reasons for living	Fear of death or dying due to pain and suffering
Responsibility to family or others; living with family	Belief that suicide is immoral; high spirituality
Supportive social network or family	Engaged in Work or School

POLICY:

All adolescent and adult patients (ages ≥ 11 y.o.) who present for care and services will be screened for suicide ideation and behavior using the Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS). Screening very young children (ages ≥6 y.o. - 10y.o.) or if cognitively impaired, only if the chief complaint / primary diagnosis is of an emotional / behavioral disorder including substance abuse or if suicidal ideation, intent, or behavior is observed.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 3 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

Based on the severity and immediacy of suicide risk assessed using the Columbia Protocol, patient safety measures and interventions will be implemented as a means to keep patients from inflicting harm to self. This policy is applicable to patients presenting to the Emergency Department, admitted to observation or inpatient status, and ambulatory surgery outpatients. The suicide risk assessment is completed during the nursing admission assessment, triage, or initial intake. This policy does not apply in outpatient healthcare services such as rehabilitation (e.g., physical, and occupational therapies), wound care, laboratory, sleep lab and imaging.

PURPOSE:

Worldwide, nearly 1 million people die by suicide each year — equal to one life lost every 40 seconds. Reports from the Centers for Disease Control and Prevention show that in the U.S. alone, more than 9 million adults seriously considered suicide in 2013 and more than 41,000 people took their own lives; that is more than the number of people who die each year in car accidents.

The Columbia Protocol supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether a patient is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of interventions needed to keep patient safe. Users of the tool will ask patients:

- Whether and when they have thought about suicide (ideation)
- What actions they have taken — and when — to prepare for suicide
- Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 4 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

PROCEDURE:

Required Action Steps	Guidance (see Table 1)
RN* (*LPN if allowed per state practice act) Screen all adolescent and adult patients (ages ≥ 11 y.o.) for suicide ideation and behavior during the initial intake/admission process: *In the past month*: 1) *Have you wished you were dead or wished you could go to sleep and not wake up?* 2) *Have you actually had any thoughts of killing yourself?*	If patient is impaired and non-verbal due to intoxication of drugs and/or ETOH, or refuses to answer, screening for suicide ideation and behavior should be completed when patient is verbal, agrees to answer and/or intoxication level is resolved or minimal. Determining suicide risk level can include additional information and sources other than the patient such as EMS, significant others and/or other observers who report suicide ideation, intent, and/or behavior.
	Document any additional information and sources used to determine suicide risk in notes or comments sections (e.g., 'EMS reports suicide attempt observed by wife' or 'patient says no thoughts of suicide, but mother reports patient has been verbalizing suicidal thoughts over past week') and notify physician if moderate or high risk for suicide is determined.
Required Action Steps	**Guidance (see Table 1)**
If patient answers "NO" to screening questions 1 & 2, then proceed to question #6: 6) *a. Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but did not swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. b. If YES to 6a, ask: *How long ago did you do anything, start to do anything, or prepare to do*	Question #6 has two parts: Lifetime or within the past 3 months. If patient answers "YES" to question #1 but "NO" to Question #2, proceed to Question #6. Regardless of if patient answers "YES" or "NO" to question #1, if patient answers "YES" to question #2, proceed to further assess by asking questions #3, #4, #5, and #6. If answered YES to question 6a, asking how long ago will determine risk level. If greater than one year ago determined to be LOW risk. If within the past year but

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 5 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

anything to end your life? (greater than one year ago, within the past year but greater than 3 months ago or less than 3 months ago)	greater than 3 months ago determined to be MODERATE risk. If within the past 3 months determined to be HIGH risk.
If patient answers "YES" to questions #2, ask questions #3, #4, #5 and #6: 3) *Have you been thinking about how you might kill yourself?* *4) Have you had thoughts and had some intention of acting on them?* *5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?* *6a) Have you ever done anything, started to do anything, or prepared to do anything to end your life? In your lifetime? In the past 3 months?* *<u>b. How long ago</u> did you do anything, start to do anything, or prepare to do anything to end your life? (greater than one year ago, within the past year but greater than 3 months ago or less than 3 months ago)*	If answered YES to question 6a, asking how long ago will determine risk level. If greater than one year ago determined to be LOW risk. If within the past year but greater than 3 months ago determined to be MODERATE risk. If within the past 3 months determined to be HIGH risk.
If patient answered "NO" to all screening questions (#1, #2 and #6), there is no suicide ideation or behavior and considered LOW RISK.	No suicide ideation or behavior identified, no patient safety measures or interventions necessary.
Note: Suicide Risk level (LOW, MODERATE, HIGH) is determined according to the number of the <u>last</u> question (#1 - #6) in which the patient answered "YES".	Regardless of answering "NO" to any other question #1 - #6, the suicide risk is determined by the last "YES" answer. The RN* can raise the level of risk and interventions, in the absence of a physician, with documented reasons based upon observed or reported changes in suicide ideation and/or behavior.
Required Action Steps	**Guidance (see Table 1)**
If patient answered "YES" to questions #1 <u>or</u> #2 <u>only</u>, (answered "NO" to #6) considered **LOW RISK**.	RN* will notify provider of ideation and provider will determine appropriate discharge plan. If discharging to schedule appointment for outpatient Mental Health services schedule within 3 days. Notify physician if > days.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 6 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

If patient answered "YES" to question #3 but answered "NO" to questions #4, #5 and #6 patient is considered **MODERATE RISK**.	RN* will notify provider and implement suicide precautions: Complete environmental risk assessment of the patient's room and remove all risks that can be removed. Keep patient under continual observation. Update the plan of care. Complete the Q Shift Room Checklist every shift.
If patient answered "NO" to questions #1 and #2 but answered "YES" to question #6 and #6a for >3months to 1 year ago, considered MODERATE RISK	Patients in line of sight or frequent monitoring only, complete the Q 15 Minute Observation Form.
If patient answered "YES" to questions #4, #5 or #6 for past 3 months patient is considered **HIGH RISK**.	RN* will notify provider. Implement immediate continual observation. Continuous observation 1:1, staff (nursing, sitter) are able to see the patient in clear view and staff can respond immediately to intervene and assure safety at all times. Remove all suicide risk items from the patient's room that can be removed immediately. Utilize the Q Shift Room Checklist prior to placing patient in the room and repeat every shift. Document patient observations on the Q 15-Minute Observation form.

MAYERS MEMORIAL HEALTHCARE DISTRICT

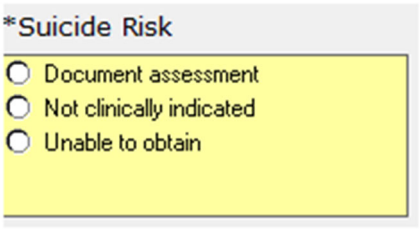
SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 7 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

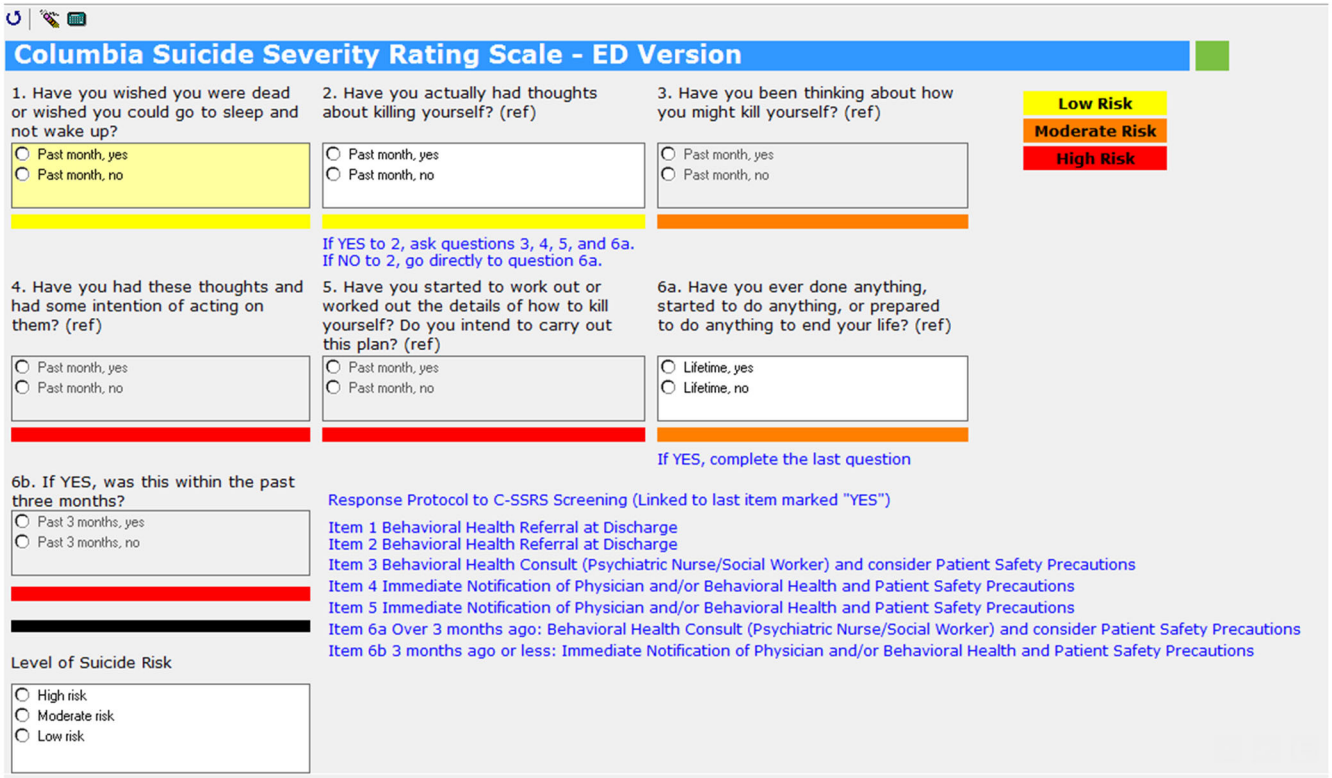
Required Action Steps	Guidance (see Table 1)
**Optional for RN* to screen very young children *In the past month:* *1) Have you thought about being dead or what it would be like to be dead? Have you wished you were dead or wished you could go to sleep and never wake up? Do you wish you were not alive anymore?* *2) Have you thought about doing something to make yourself not alive anymore? Have you had any thoughts about killing yourself?* *3) Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about it?* *4) When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from (as opposed to) having thoughts but knowing you would not do anything about it.* *5) Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it? What was your plan? When you made this plan (or worked out these details), was any part of you thinking about actually doing it?* *6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: *Collected pills, obtained a gun, wrote a suicide note, took out pills but did not swallow any, held a gun but changed your mind, took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*	Applicable to very young children in the emergency department, ambulatory surgery, observation, and inpatient: (ages ≥6 y.o. - 10y.o.) or if cognitively impaired, for suicide ideation and behavior with age-appropriate questions only if the chief complaint/primary diagnosis is an emotional/ behavioral disorder including substance abuse or if suicidal ideation, intent, or behavior is observed or reported. For very young children and cognitive impaired patients, the screening questions are essentially the same as with adolescents and adults but includes additional age-appropriate suggested language.
Implement the appropriate level of precautions based on Low risk, Moderate Risk, or High Risk, as described above.	

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 8 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

Completion of Suicide Risk Assessment – Emergency Department





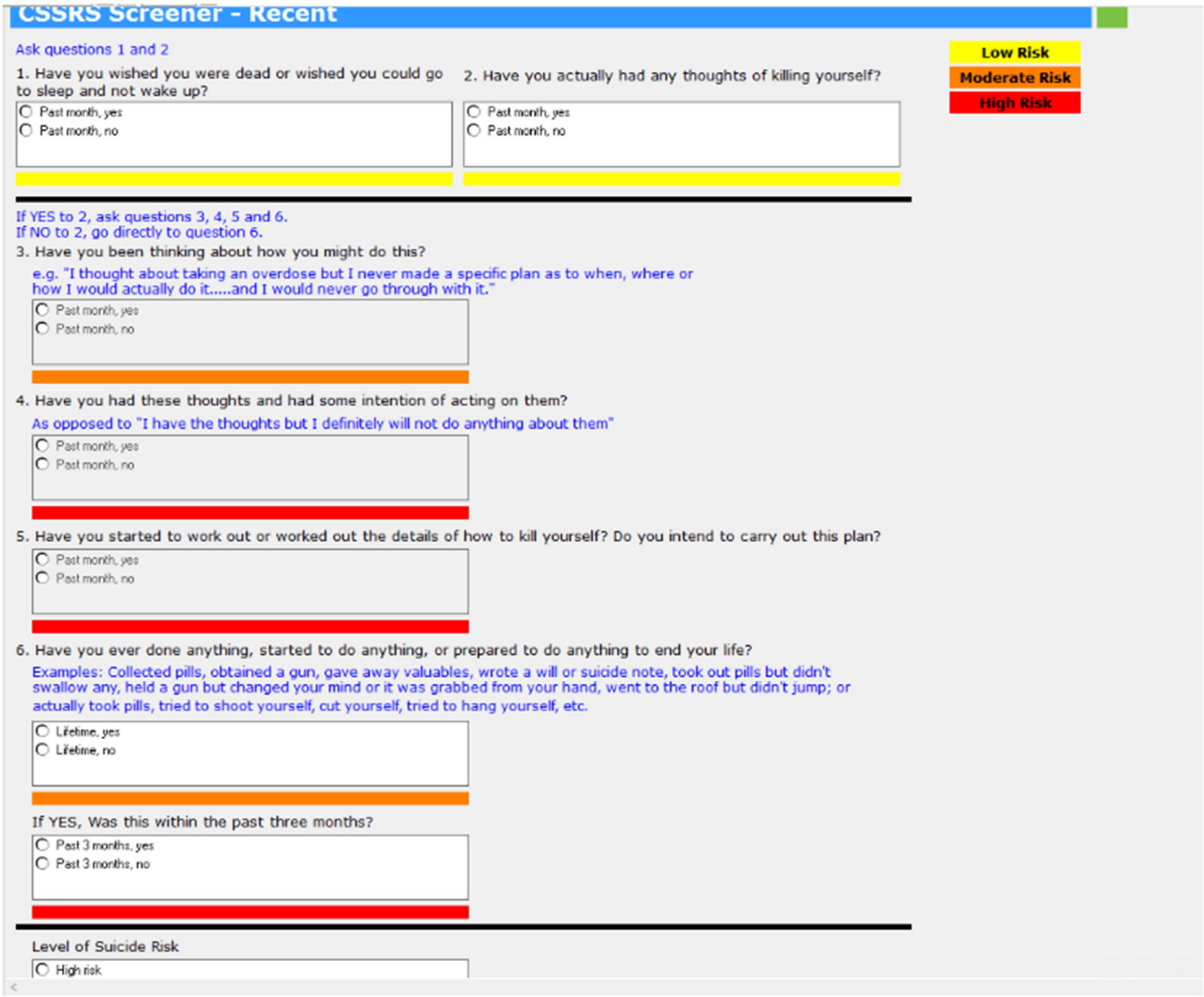
Completed at triage and reassessed every shift if risk identified OR with new onset suicidal ideations or behavior indicative of plans for self-harm.

Completion of Suicide Risk Assessment – Inpatient and Ambulatory Surgery

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 9 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

Acute Care: The below CSSRS Screen shows up on the adult admission assessment, but it is not a hard stop - so it's not being completed...



Completed at time of admission assessment and repeated every shift for patients identified at risk OR with new onset suicidal ideations or behavior indicative of plans for self-harm.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 10 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

Required Action Steps	Guidance (see Table 1)
If family/significant other with patient, RN* to provide suicide prevention education.	Ensure family does not have contraband patient could use for self-harm and instruct family not to bring in items to the patient that have not been inspected by nursing staff.
RN * to Re-assess suicide risk and need for suicide precautions at least every shift if MODERATE OR HIGH risk and/or if there is an observed or stated change in behavior	Document and initiate interventions according to risk level. If at any time in the patient's episode of care screened as MODERATE or HIGH risk, reassess every shift.
RN* to Notify the physician if the assessment changes. Discontinuing or reducing safety precautions or interventions are only by physician order.	The RN can raise the level of interventions, in the absence of a physician, with documented reasons based upon changes in suicide ideation and/or behavior.
For MODERATE and HIGH RISK: All staff to utilize communication/de-escalation techniques: ✓ Orient the patient; introduce yourself. ✓ Emphasize you want to keep them safe; you will not let any harm come to them, and you will help them gain control. ✓ Use positive reinforcements and listen. ✓ Communicate in an empathetic and concerned way. ✓ Be non-provocative, do not argue. ✓ Offer choices and alternatives but set limits and consequences. ✓ Demonstrate a calm demeanor, voice, and facial expression. ✓ Relaxed stance, hands open, normal eye contact, positions self at arm's length from patient ✓ Meet their needs by offering them food, drink, blanket or quiet. ✓ Refer to Seclusion/Restraints Policy if violent/self-destructive behavior	Consider the safety of staff and patient when determining appropriate distance and adjust accordingly to individual situation.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 11 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

DISCHARGE PLANNING	
Required Action Steps	**Guidance**
Refer to Social Worker. Post-discharge Mental Health Professional referral appointment for outpatient services to be scheduled within 1-3 days post-discharge.	Refer and schedule appointments for outpatient behavioral health services at the earliest possible appointment. Discuss with physician if earliest possible appointment is > 3days.
Social Worker to discuss the discharge plan verbally and in writing with the patient and family/significant others (in person when possible) and confirm understanding.	Use 'Repeat Back or Teach Back' to confirm understanding.
Social Worker to discuss and document creating a safe environment by removing lethal means with family/significant others and patient.	Lethal Means may include firearms, potentially lethal medications, weapons, poisonous substances
Document all communications with the patient, his or her family members and significant others, and other caregivers.	Document why the patient is at risk for suicide and the care provided to patients with suicide risk in detail, include the content of the discharge plan and the patient's reaction to and use of it; and any follow-up appointments.
Share the discharge plan with other providers involved in patient's care	
Social Worker to provide written suicide prevention patient resources at discharge including what to do if condition worsens and when to return to the ED: National Suicide Prevention Lifeline: 1-800-273-TALK (8255) and for veterans or active military press- 1, in Spanish press- 2. State Suicide Hotlines [specific state hotline contact information can be found at: http://www.suicide.org/suicide-hotlines.html	

1. Other Patient Populations or Care Specific Suicide Risk Screening and Interventions:
    a) For patients presenting for obstetrical services, screening for suicidal risk factors on admission and after delivery, assess for post-partum depression by an RN in the OB unit using the Edinburgh Post-Natal Depression Scale (EPDS) prior to discharge, which includes assessing for suicide ideation:

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 12 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

- The American Academy of Family Physicians recommends screening for depression in the general adult population, including pregnant and postpartum women.
- The American College of Obstetricians and Gynecologists recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms. Screening must be coupled with appropriate follow-up and treatment when indicated (practices should be prepared to initiate medical therapy, refer patients to appropriate care, or both), and systems should be in place to ensure follow-up for diagnosis and treatment.

2. Educate staff about how to identify and respond to patients with suicide ideation or behavior:
    a) Required education:
        - For clinical and other staff who provide 1:1 observation – completion of suicide risk assessment and prevention policy.
        - For clinical and other staff who complete Q Shift Patient Room Suicide Risk Checklists – completion of education on how to conduct the room assessment and risk mitigation.
        - For environmental safety and other staff who complete annual ligature risk assessment – how to complete the assessment and mitigation strategies.
        - For non-clinical, ancillary support staff: Provide the education the steps staff should take if someone verbalizes suicide ideation, thoughts, or plans or is concerned about someone's risk for suicide. Do not leave patient unattended and discuss with primary care physician need to refer/escort patient immediately to the Emergency Department.
    b) Educate and document competency of staff who provide continuous visual surveillance (e.g., security, observers/patient care sitters) and nursing staff who complete Q Shift Patient Room Checklists.

3. If a patient presents to an outpatient patient care setting (non-ED) such as pre-operative testing where an admission/intake assessment is performed and the suicide ideation and behavior screening results in a positive screen for risk of suicide, notify the ordering/attending/primary care physician as soon as possible. Do not leave patient unattended and discuss with primary care physician need to refer/escort patient immediately to the Emergency Department.

4. If a patient, while receiving outpatient healthcare services such as rehabilitation (e.g., physical, and occupational therapies), wound care, laboratory, sleep lab and imaging and verbalizes suicide ideation or plan, or requests treatment for suicide ideation, do not leave patient unattended and

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 13 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

immediately notify referring physician and refer/escort patient immediately to the Emergency Department.

5. If a visitor (non-patient) requests treatment relating to suicidal ideation or plan, refer/escort patient immediately to the Emergency Department. Refer to policy, EMTALA Medical Screening Stabilization Policy section “The Location in Which the Medical Screening Examination Should Be performed”.

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 14 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE: All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.		APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

Table 1: Patient Safety Measures and Interventions Based on Screening Responses

C-SSRS Screening Questions			***Patient Safety Measures & Interventions with Last "Yes" Answer***
Question	**"Yes" Indicates**	**Level of Risk**	**ED at Triage and Inpatient Care (non-BH Unit)**
1. *Have you wished you were dead or wished you could go to sleep and not wake up?*	Wish to be dead	**LOW**	• If "No" to questions #1, #2 & #6, no ideation or behavior identified, no safety precautions or interventions. • Consider referral to Mental Health Professional at discharge from ED/Inpatient. at discretion of provider • Provide written suicide prevention resources at discharge including what to do if condition worsens and when to return to the ED
2. *Have you actually had any thoughts of killing yourself?*	Nonspecific thoughts		
3. *Have you been thinking about how you might kill yourself?*	Thoughts with method (without specific plan or intent to act)	**MODERATE**	• RN* to assess and complete Q Shift Room Checklist • RN* to notify provider and provider to order Mental Health Professional referral. • More frequent observation (every 15 min. checks) • RN* to Re-assess suicide risk and need for suicide precautions at least every shift and/or if there is an observed or stated change in behavior
4. *Have you had thoughts and had some intention of acting on them?*	Intent without plan	**HIGH**	• Initiate continuous observation (1:1 or in dedicated, secured, ligature-resistant area or room) • RN* to assess and complete Q Shift Room Checklist • RN* to notify provider and provider to order Mental Health Professional face-to-face consult before leaves the area/unit. • All staff use communication/de-escalation techniques. • RN* to Re-assess suicide risk and need for suicide precautions at least every shift and/or if there is an observed or stated change in behavior
5. *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	Intent with plan		
6. *Have you ever done anything,*	Behavior	>1 year ago: **LOW**	• No safety precautions or interventions

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 15 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

started to do anything, or prepared to do anything to end your life? If YES to above, ask: *How long ago did you do anything, start to do anything, or prepare to do anything to end your life? (greater than one year ago, within the past year but greater than 3 months ago or less than 3 months ago)*			• Ø Consider referral to Mental Health Professional at discharge from ED/Inpt. at discretion of provider • Provide written suicide prevention resources at discharge including what to do if condition worsens and when to return to the ED
		Within past year but >3 months ago: **MODERATE**	• RN* to assess and complete Q Shift Room Checklist • RN* to notify provider and provider to order Mental Health Professional referral. • More frequent observation (every 15 min checks) • RN* to Re-assess suicide risk and need for suicide precautions at least every shift and/or if there is an observed or stated change in behavior
		Within past 3 months: **HIGH**	• Initiate continuous observation (1:1 or in dedicated, secured, ligature-resistant area or room) • RN* to assess and complete Q Shift Room Checklist • RN* to notify provider and provider to order Mental Health Professional referral (recommended before leaves the area/unit) • Use communication/de-escalation techniques. • If family/significant other with patient: Nurse to provide "Support Person Education." • RN*to re-assess suicide risk and need for suicide precautions at least every shift and/or if there is an observed or stated change in behavior

REFERENCES:

1. American Foundation for Suicide Prevention. (PowerPoint educational presentation) http://www.afsp.org/files/Misc_//standardizedpresentation.ppt#55
2. American College of Obstetricians and Gynecologists (2015, May). *Screening for Perinatal Depression*. Retrieved from internet: http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression
3. Baker, D. (Nov. 2017). *Special Report Suicide Prevention in Healthcare Settings*. Joint Commission *Perspectives*.
4. Centers for Disease Control. (Sept. 6, 2018). *Suicide: Risk and Protective Factors*. Retrieved from website: https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Suicide Risk Assessment and Interventions Protocol in Non-Behavioral Health Setting	POLICY # MS033
DEPARTMENT/SCOPE:	Acute, ED	Page 16 of 16
REVISION DATE: n/a		EFFECTIVE DATE: 7/31/2024
AUDIENCE:	All Nursing personnel in the emergency department, ambulatory surgery, and inpatient areas. All clinical employees of outpatient departments. Administrative personnel.	APPROVAL DATE:
OWNER: M. Padilla		APPROVER: T. Overton

5. Clarification of Ligature Risk Policy (Dec. 8, 2017). Center for Clinical Standards and Quality/Survey & Certification Group. S&C Memo: 18-06-Hospitals. Retrieved from website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-06.pdf
6. Columbia Lighthouse Project (2007). *About the Protocol*. Retrieved from website: http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/evidence/
7. Columbia Protocol (C-SSRS) – For Healthcare. Retrieved from website: http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/.
8. Joint Commission on Accreditation of Healthcare Organizations, Sentinel Events. FAQs for the Joint Commission's 2007 National Patient Safety Goals. Web site: http://www.jointcommission.org/SentinelEvents/Statistics/
9. Joint Commission, February 24, 2016. *Sentinel Event Alert: Detecting and Treating Suicide Ideations in all settings*. Retrieved from website: http://www.jointcommission.org/sentinel_event.aspx
10. National Center for Injury Prevention and Control. Fact book for the year 2000: suicide and suicidal behavior. Available at: http://www.cdc.gov/ncipc/factsheets/suicide-prevention.htm. Retrieved August 10, 2006.
11. Posner, Kelly. Screener Training. *On the Road to Prevention: Identification and triage using the Columbia-Suicide Severity Rating Scale (C-SSRS)*. Retrieved from website: https://www.youtube.com/watch?v=01P6id9wvig
12. Suicide Safe: The Suicide Safe Application for Healthcare Providers. SAMSHA. Retrieved from website: http://store.samhsa.gov/apps/suicidesafe/
13. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington DC: HHS; 2012.
14. Suicide Prevention Resources to support Joint Commission Accredited Organizations Implementation of NPSG 15.01.01 (2019). Joint Commission on Accreditation of Healthcare Organizations. Retrieved from website: https://www.jointcommission.org/ep_3__4_validated_evidence_based_suicide_risk_assessment_tools/

COMMITTEE APPROVALS:

P&P: 11/13/2024
MEC: 1/27/2025

Director of Operations Report
Prepared by: Jessica DeCoito, DOO

Facilities, Engineering, Other Construction Projects

- We continue to hold weekly calls with Aspen Street Architects to discuss all the projects we have going on with their team.
    - TCCN: The Maintenance team met the changes for the TCCN phase 1 and 2 plans. A final inspection and approval with the fire district is scheduled for late this week.
    - FR Rural Health Clinic: The drawings are with the engineering team and should be resubmitted by the 31st. Legal was engaged in helping to begin the bid package.
    - PIN 74: still in design with the engineering team. We aim for a submittal date to the county by the end of the month.
    - Fire Smoke Dampers: the engineering team is still working on the design, but we should have a design to review in the next few weeks.
    - RACS: The engineering team is still working on reports to show us what the project would look like if we repurposed the space for more SNF beds. We should have an update by the end of the month.
    - Master Planning Project: We will have questions on the RFP/RFQ submitted by the 17th, and our team will turn answers around by the 21st. Then, the RFP/RFQ packages are due to MMHD by March 7th. A committee will be formed to review, score, and recommend a construction project management firm to the Board for approval by the March 26th Board Meeting.
- The Solar Project has hit another roadblock: a delay in construction start due to weather and safety concerns. We anticipate beginning construction the week of the 17th with the spider excavator on site.

Dietary

- The Dietary team, including the Registered Dietician and Infection Prevention RN, meets every two weeks to review their findings in the kitchen regarding cleanliness and necessary repairs. With the help of their dedicated dietary team members and maintenance, the group has made significant progress in their environment, allowing for a smooth ACHC survey.

ACHC

- I want to extend my heartfelt thanks to the Operations Departments for their exceptional hard work and dedication during the ACHC Survey. Their commitment to excellence and attention to detail was evident throughout the entire process, and it was clear that their teamwork and collaboration played a key role in ensuring the survey's success. Their efforts reflected the high standards MMHD strives for and contributed to maintaining our operations' integrity and quality. I truly appreciate the time and energy they all invested in the survey preparedness, and I am proud to work alongside such a talented and dedicated team.

Human Resources

February 2025

Submitted by: Libby Mee, Chief Human Resource Officer

Employee Support and Recruitment

The Human Resources, Payroll, and Benefits department currently serves 303 active employees. We are actively working on several recruitment and retention initiatives, with 18 specific requisitions posted and 33 vacant positions to be filled. To strengthen our hiring efforts, we have partnered with specialized recruitment firms to assist with sourcing candidates for some of our most critical roles. These roles include:

- **Chief Medical Officer (CMO)**
- **Director of Clinical Services**
- **Respiratory Therapist/Manager**
- **Rural Health Clinic Provider**
- **Pharmacist**
- **Skilled Nursing Positions**

Employee Health and Wellness

The Director of Safety and Security and CHRO will meet with our Loss Prevention Specialist from our Workers' Compensation carrier to review last year's safety statistics and trends. Based on the discussion, we will identify potential areas for improvement and explore BETA programs that could enhance our employee safety initiatives.

HR Cohorts

The CHRO recently participated in my first Rural Healthcare HR Roundtable with recent graduates from the NRHA program from across the country. During this session, participants shared valuable resources on peer mentorship programs and discussed the HRIS systems used across various organizations.

Additionally, MMHD continues to engage regularly with local HR counterparts, fostering a collaborative environment by exchanging best practices and policies.

ACHC Accreditation

As part of the recent ACHC accreditation survey process, survey team members met with our HR Generalist to review compliance with employee file standards. We are pleased to report that we were in full compliance with all relevant chapters, with no deficiencies noted in Staffing.

Leadership Development

On February 11, MMHD welcomed back Jen Miley from Elite Edge Coaching for our quarterly leadership development session. Jen worked with the leadership team on Transitional Quotient, a forward-thinking approach to help individuals effectively manage and thrive through transitions. She also provided resources to enhance team environments and strategies for breaking down organizational silos.

Jen also conducted one-on-one coaching sessions with individual leaders, providing tailored guidance to develop leadership skills further.

Additionally, Jen spent an entire day with our clinic team, reviewing prior work on referrals and assessing current positions and processes to ensure continuous improvement.

Chief Public Relations Officer – Valerie Lakey
February 2025 Board Report

Legislation/Advocacy

The California Legislature approved a $50 million legal fund along party lines to support potential lawsuits against President Donald Trump's administration. This effectively closes out the 2025-26 legislative session's first special session.

FEDERAL UPDATE

Congressional GOP leadership continues to work toward a budget resolution that will serve as the foundation for legislation that could target significant healthcare spending cuts.

STATE UPDATE

Legislature: Budget committees will begin meeting over the next few weeks, and the deadline to introduce bills is February 21.

The OCHA board will meet on February 25 to propose hospital sector targets for hospitals deemed "high-cost" outliers. Formal board action to establish sector target values could occur by June 1.

Legislative budget subcommittees will begin hearings in the coming weeks. Senate Budget Subcommittee 3 on Health and Human Services will start on February 27 with an overview of the Medi-Cal budget, including a discussion of Proposition 35 funding.

If certain conditions are met, AB 447 will allow physicians or authorized prescribers to dispense unused portions of non-controlled medications to emergency department patients upon discharge.

AB 356 is a placeholder bill to address the author's concerns about health facility fees billed to patients when they receive a service at a hospital — but may not be charged when the same service is provided at a medical office building.

SB 246, sponsored by the District Hospital Leadership Forum, would establish a Medi-Cal graduate medical education program for district hospitals.

Grants

We are currently working on a federal HRSA substance use grant with TCCN for a community recovery center program.

Upcoming are two USDA grants regarding telemedicine and community development.
Spring grants season for the local community will begin soon.
Federal grants are in an interesting space right now. Several reviews are underway, and many are being re-aligned with new administration priorities, but many are still available to move forward. We are keeping an eye on the landscape.

We will be working on creating a “database” of grant documents to create a bank of knowledge that is easily accessible for future grants. This will be an ongoing project.

We are awaiting the outcome of the SHIP grant award; we will know soon.

Public Relations/Marketing

Handwashing Campaign: We are developing an internal awareness campaign to reinforce proper hygiene practices among staff. We have purchased stickers for the sanitizer stations and buttons with the message "Foam In, Foam Out" as reminders. The campaign includes signage, posters, and educational materials tailored to different departments.

Marketing for New Physician: We have met with the team and new physicians to develop a comprehensive marketing strategy to introduce and promote our new physician to the organization. This includes social media announcements, press releases, and promotional events.

Hospital-Wide Brochure: An updated hospital brochure is currently being developed. This brochure will provide a comprehensive overview of our services, facilities, and care options and serve as a key resource for patients and partners.

Quarterly Digital Newsletter: Our quarterly digital newsletter was successfully released during the first week of February. It features updates on hospital initiatives, patient success stories, staff highlights, and upcoming events.

Mayers Healthcare Foundation

Gala Recap & Financial Update: Preliminary numbers from the gala indicate a net profit of nearly $60,000. This successful outcome reflects the generosity of our supporters and the hard work of our team and volunteers. Final figures will be confirmed once all expenses and donations are fully accounted for.

Fall River Arts Building Purchase: We are in the early stages of planning to purchase the Fall River Arts Building. A timeline and action plan are being developed to ensure a smooth acquisition process. More details will be provided as plans progress.

Upcoming 2025 Events: Planning is underway for our 2025 events. Key dates to note:

- Health Fair – June 21, 2025
- 25th Annual Golf Tournament – August 2, 2025
- North State Giving Tuesday – December 2, 2025

These events are integral to our fundraising efforts, and we look forward to engaging with our community to ensure their success.

Donations & Annual Appeal: We have received several generous donations in memory of Pam Giacomini, including a significant $20,000 contribution. We continue to receive donations from our annual appeal, demonstrating ongoing community support for our mission.

Operational Update: Reset & Moving Forward With the conclusion of the gala, we are in a "reset" mode. Our focus is now on:

- Preparing for upcoming events
- Writing thank-you notes to donors and sponsors
- Finalizing financial records in preparation for tax filings

We appreciate the continued dedication of our board members, staff, and volunteers as we move forward with our mission to support healthcare initiatives in our community.

Tri-County Community Network

Children's Programs

Bright Futures

- In January and February, Bright Futures continued strengthening community ties with agencies and schools in the Inter-Mountain Community.
- Events like Tiny Tunes and Story Time maintain strong attendance. Participation in Burney Tiny Tunes increased significantly, with 14 parents and children attending on January 6.
- TK classes in Big Valley, Fall River, Burney, and Round Mountain regularly host Story Time and Tiny Tunes. The program serves over 100 children and caregivers each month.
- On January 17, Bright Futures hosted a Family Film Night, drawing 80 attendees for a free screening of The Incredibles—special thanks to Les Schwab and Manager Tyler Bushnell for providing fresh popcorn.

BOTVIN Life Skills Training (LST)

- LST has been implemented in both elementary schools. Fifth-grade students are completing their 8-week program, learning self-esteem, decision-making, and the dangers of smoking. Sixth-grade students will begin their program on February 25.

- Two hundred 4th to 6th graders will participate in the program, funded by the Shasta County Asset Forfeiture grant.

Grants/Grant Programs

- Lunch with Community Helpers
- TCCN received a $700 grant from First 5 Shasta to host this event during the Week of the Young Child.
- The event will provide a safe, educational space where children (ages 0-5) can engage with local law enforcement and emergency personnel. Parents and caregivers will also learn about community programs and services.

Backpacks to Home Food Pantry

- In collaboration with FRJUSD, TCCN applied for a $2,588 grant to launch a food pantry for students.
- If awarded, the program will deliver $862 worth of food three times between August 2025 and May 2026.
- FRJUSD will oversee sustainability efforts, with Burney Elementary and Burney High School hosting food drives.

Kid Fit

- If funded, six Kid Fit events will occur from June to August 2025, promoting family health and educating on Adverse Childhood Experiences (ACEs). Events include a Color Run, Take Me Fishing, a Community Concert, Water Wars, Art in the Park, and Family Swim Night.
- PGE donations will support a Jr. Intern position within the program, providing leadership and data collection experience.

Shasta Substance Use Coalition

- TCCN has joined the newly formed coalition, developing strategies to address youth substance use in Shasta County.

- Funding will come from the county's Opioid Settlement funds, though TCCN's specific funding allocation is currently unknown.

Enhanced Care Management (ECM) Partnership

- TCCN and MMHD collaborate with HANC and Partnership HealthPlan of California to implement ECM services.
- A one-year, $102,000 contract will support operational costs, including training and billing processes.
- A case manager has been hired and will undergo 60 days of training. By April, they will begin seeing clients in collaboration with the Rural Clinic.

Mindful Connections Program

- TCCN is pursuing federal funding for the Mindful Connections Program. The application process began on February 10 and will conclude on March 10.
- Funds will be used to establish a peer counseling program, create a community space for recovery support, and expand SUD prevention efforts.

Mayers Health Foundation CPR Training

TCCN received nearly $9,000 to provide CPR training to all 9th and 12th graders in FRJUSD.

With support from Zita Biehle, 200 students will be trained, increasing lifesaving skills and interest in medical careers and strengthening community ties with MMHD.

Training will occur at Burney and Fall River high schools, concluding in April 2025.

Partnerships

SMART Employment Services

- TCCN continues its partnership with SMART to bring employment services to the area.
- “Pop-up" employment centers will resume in the spring, while referral services will be available during winter.

IMAGE (Intermountain Action Growth and Education) Revitalization

- The last IMAGE meeting on January 14 saw increased attendance and productivity.

- A community needs survey is in development. The final questions will be decided on March 11. The survey launch is planned for May 2025.

Website Updates

- The TCCN website continues to expand, with weekly updates to the community calendar and event promotions on social media.
- Over the next two months, the learning library will grow, job listings will be posted, and monthly health observances will be highlighted.

Community Events

- Bright Futures Weekly Events – Ongoing for children aged 0-5.
- BOTVIN Life Skills Training – Every Tuesday at Fall River Elementary and every Wednesday at Burney Elementary through May.
- Senior Sip and Social – Every Thursday through May 2025.
- Lunch with Community Helpers – Scheduled for April 7.

Intermountain Community Center Building Update

- The building's offices and event spaces will be open within the next few weeks.
- Plans for the children's program portion of the building have been submitted to the county.

January Board Report
Clinical Division
2/10/2025

The ACHC accreditation survey took place on February 4 and 5. Managers in the clinical division worked hard to prepare, and the survey went well. Although the process was stressful, the surveyors were easy to work with and helpful. At the time of the survey, not all the updated policies had made it through the approval process. We are working to get them all approved. I am proud of our team and our organization. Department-specific issues are summarized by department below.

Retail Pharmacy

- Our 340B Third-Party Administrator (TPA), Hudson Headwaters, has merged with RXStrategies and RPH Innovations, becoming Pillr Health. This will expand available resources and expertise to ensure the highest quality of care.
- Liberty Pharmacy Software system announced the requirement that all workstations be updated to Windows 11 by October 14, 2025.
- The DEA has updated its electronic ordering process. We are navigating the new system and ordering on paper until our application is processed.
- En-vision America is the only company we have found with a compliant product to meet the new regulations regarding labeling for blind people. The system is a device that audibly reads the label on the prescription vial. The regulation started on January 1, 2025. We have not found any retail pharmacies that currently comply. We are scheduling an onsite demonstration.

Hospital Pharmacy

ACHC Survey

- Not all policies had full approval, but no content issues were identified.
- The process for crash-cart cleaning needs to be implemented.
- We appreciate the work the maintenance staff did in the pharmacy in anticipation of the ACHC survey.

Cerner

- I am processing open tickets for high-risk medications and continuous infusions. I am currently working on propofol and heparin. Insulin is also in the work queue.

Infection Prevention

ACHC Survey

- Policies and data were reviewed with no issues.
- The ACHC surveyor identified areas for improvement, including dust in the ER, no crash cart cleaning process, and cardboard in the food storage areas.

- Surveyors were pleased with the Infection Control Risk Assessment process, the number of ICRAs, and the teamwork between Infection Prevention and Maintenance.

Hand Washing

- February Handwashing Campaign—Valentine's Day-themed stickers reminding staff to foam-in and foam-out.

- Executive team training on hand washing observations and direct interaction with staff when handwashing is missed.
- The Med/Surg Unit reached 60% in January!

Laboratory

The ACHC survey did not show lab-specific deficiencies.
Procalcitonin

- The medical staff has requested the addition of the Procalcitonin test (a sepsis marker) to the labs performed onsite. We are working with Siemens on how to perform this test on our Dimension EXL machine.

Quantiferon Analyzer

- Validation is on track.
- Working on charges in Cerner
- Interface testing between the Quantiferon machine interface and Cerner will be scheduled once validation is complete.

Respiratory Therapy

Respiratory Therapy Department Manager Position

- The candidate is scheduled for an onsite visit/interview on February 12
- The second candidate was interviewed; discussions ongoing

Staffing

- Traveler accepted maternity leave contract, onsite February 24.

ACHC Accreditation Survey

- We are replacing the free-standing sign with door signage indicating that testing is in progress.
- Some policies had not completed the approval process

Nova Biomedical Support (arterial blood gas (ABG) testing machine)

- Staff continue to work with the Nova service representative to streamline our processes.

Cerner Optimization

- Working with Cerner to make ABG ordering easier for providers by hiding inactive orders.

Cardiac Rehab

- Cardiac Rehab staff are enjoying the new chairs purchased through an award by the Mayers Healthcare Foundation.
- Zita Biehle, cardiac rehab coordinator, has set up an area in the department for patient health education.
- Cardiac Rehab week is February 9-15

- Zita and Daryl Schneider will represent the Cardiac Rehab department at the Heart Healthy events on February 26 and 27.
- The Arm Ergo machine in Cardiac Rehab was replaced under warranty as a faulty part made noise.

Imaging

ACHC Accreditation Survey

- Imaging had one deficiency from the accreditation survey regarding the competencies of our ultrasound department.
- Kevin Davie and Harold Swartz will work with Moriah Padilla on utilizing Relias to track competencies.

Echo update

- Kim Elliot completed a cardiac echo refresher course
- Cardiac echo orders have been added to Cerner. The next step is adding charges to orders and studies to the appointment book.
- Mindray ultrasound machine is now connected to the Wi-Fi network
- Mindray unit set-up to communicate with Fuji PACS

MRI Update

- Cerner ticket submitted to add MRI scheduling book
- An onsite visit with Heritage is scheduled for February 20 to review the pad and power supply.

Fuji PACS Update

- Imaging Techs have been trained
- Nursing staff orientation starts the week of February 10.
- The contract for an interface between Fuji and Cerner has been approved. We are waiting for Cerner's project plan and timeline.
- Harold has started transferring 75K+ studies from Ambra (the old PACS) to Fuji. As of February 7, 51K had been moved to Fuji.

Vesta Radiology

- Vesta Radiology is Mayers new teleradiology group. Conversion is planned to take place on March 1.
- Harold Swartz is working with Vesta's IT team so we can transmit images to Vesta radiologists for reading.
- Credentials are awaiting approval by the Medical Executive Committee and Mayers Board of Directors.

Patient Experience

- The imaging techs have started handing out Thank-You cards to our patients after their exams. The thank-you card also has a QR code on the back for a patient engagement survey. So far, we have received feedback from 5 patients.

Physical Therapy

- MRI patients will register in the PT department, as that is the closest waiting room to the location of the MRI trailer. Preliminary discussions of the process have started.
- ACHC—all electrical exercise equipment in Physical Therapy and Cardiac Rehab will need a bio-med inspection sticker. The inspections are scheduled for March.

NURSING SERVICES BOARD REPORT

February 2025-Reporting for January

CNO Board Report

SNF
(Reporting for this Quarter)

Acute
January 2025 Dashboard

- Acute ADC: 1.74
- Acute ALOS: 4.11
  - Medicare ALOS 2.11
  - 4 non-Medicare accounts exceeded 4.0
- Swingbed ADC: 2.06
- Swingbed ALOS: 7.44
- OBS Census Days: 4

January Staffing

- **Staffing Requirements:** Our staffing needs for optimal department operations include 8 FTE RNs, 2 PTE RNs, 4 FTE CNAs, and 2 FTE Ward Clerks. We ended this month with the transfer of one RN to the ED, one RN on an LOA, and one RN's resignation. We conducted several interviews and successfully hired one FTE RN New Graduate while awaiting a response from another candidate.

- **Utilization of NPH Staff:** For the second part of the month, we utilized 1 FTE NPH RN and 1 FTE Contracted RN.

Updates

- **ACHC Accreditation Preparation:** This month, we completed all binder work in preparation for the survey, a significant milestone in our accreditation efforts. This achievement included drafting several new policies and refining many others to ensure full compliance with ACHC standards.
- **ACHC Accreditation Education:** This month, we successfully conducted our final make-up class, achieving an impressive 94% compliance rate across all employees. This further solidified our commitment to meeting ACHC accreditation standards.
- **Zoll Defibrillator Implementation:** The defibrillators were ordered in early January and have arrived, marking a key step forward in the project. We are now moving into the implementation phase, collaborating with MMHD team members and the Zoll group to finalize our connectivity plan and Biomed inspection process. Additionally, we held our initial education planning meeting and expect to complete training in early April. After completing education, we are on track to launch the project for patient use in April fully.

Emergency Services

January 2025

- Total treated patients: 400
- In-patient Admits: 19
- Transferred to higher level of care: 16
- Pediatric patients: 58
- AMA: 5
- LWBS: 0
- Present to ED vis EMS: 43

- **Staffing:**
  - Required: 8 FTE RNs, 2 PTE RNs, 2 FTE Techs, 1 PTE Tech
  - Utilizing 3 FTE contracted travelers
    - Two Day shift to cover two LOAs for the next 6 weeks
    - One Noc shift to cover until NOC FTE is off orientation
  - ED Manager also serves as:
    - Clinical Project Manager for Cerner
    - Learning Coordinator
    - Ongoing resources for clinical areas in the facility
    - Collaborating with internal teams on referral processes
    - Weekly meetings with Hollie to address open SRs
    - Assigning learning journeys to new contract and hired staff
  - **Open Positions:**
    - FTE NOC: Hired, will be on orientation for a minimum of 6 months
    - 1 FTE Tech position open
- **Updates:**
    - Centering staff education around ACHC guidelines:
    - Policy signoffs each month
    - Monthly updates on current ACHC PI indicators
- Focus on improving chart check processes to increase captured revenue, avoid late charging, and enhance charting standards.
- New Zoll defibrillators have arrived, and education to start soon—possible go-live April 1st.

Ambulance Services

- 42 ambulance calls/requests.
- 6 interfacility transfers.
    - We received our advanced airway training equipment purchased with grant funds from the foundation.
    - We are working on scheduling some training days with our ambulance crews and look forward to sharing pictures of that shortly.

Outpatient Surgery:

January Referrals:

34 - Referrals received
21 – Scheduled (3 cancelled/ or No show to procedure)
2 – Rejected (BMI > 45, Medically complex, Procedure not performed or requesting consultation)
0 – Pending insurance clearance
9 - Called patient and unable to reach or patient does not want to schedule.
2 – Needs Nurse review
17 – Outstanding/ Pending referrals received before January

Outstanding/Pending Reason breakdown:

9 - Previously scheduled and cancelled (unable to reach, needs medical clearance, or patient does not want to reschedule).

8 – Unable to reach patient or patient does not want to schedule currently.

Procedures Performed	**January 2025**	
Colonoscopy	9	
EGD	4	
Colonoscopy/ EGD Combo	4	
Total cases Performed	**Monthly Total: 17**	

- **The Surgeon's Contract** with Modoc Medical Center was renewed for two years, and they will meet with Mayers Memorial's CEO to discuss the contract terms.
- **Part-time Endoscopy Technician Position:** The department is no longer receiving assistance on procedures days from the Endoscopy/ scrub techs from Modoc Medical Center. This has significantly impacted the workload of our surgical tech and the circulating RN, resulting in longer turnover times between cases and increased salary expenses due to longer days. A proposal to hire and train a Part-time endoscopy tech was submitted and approved to provide support to the Surgeon and tech during procedure days.
- **Referrals**: Referrals from local clinics continue to be received. In January, we received 34 referrals, which matches the highest monthly volume we had in 2024 (November).
- **Training and Certification**: The Surgery Manager is preparing for the CNOR certification exam. All required Relias training modules have been assigned, and 12 new

competencies have been created. We are actively working on staff competency assessments and audits.

- **Department Development**: We are continuously working to meet ACHC, AORN, and AIMI standards of practice. This includes policy updates, log creation, tracking systems, survey readiness training, and performance indicators.
- **Steam Sterilizer/ Autoclave Down:** We have two large sterilizers in our Central Sterilization department that reprocess surgical instruments. A preventative maintenance was performed on 1/24. During this inspection, the technician tested the water hardness and found the levels to be softer than required for proper functioning. This is a result of the new Reverse Osmosis Water filtration system installed in November. The sterilizers were placed out of commission, and a work order was placed to add filter components to the unit.
- **Equipment Upgrade requests:** A proposal was submitted for the approval to purchase 2 new Gastrointestinal Scopes and video equipment (Flexible cameras during an Upper Endoscopy/ EGD to visualize and take biopsies in the esophagus and stomach). Our current Gastrointestinal Scopes are more than 20 years old and have reached End-of-life in terms of servicing/ repairs. We must consider upgrading this equipment to continue performing these procedures safely.

Outpatient Medical

January 2025

- Census OPM:
  - January 143 patients
- ACHC visit only fire safety came into the OPM department for inspections
- Currently, high acuity patients need multiple procedures during visits
- Working with LTC with their new orientation process to have nursing staff have a day in the wound clinic for experience and wound care training
- Working on upcoming conferences and CE's for OPM this Spring

Social Services

January 2025

We had 2 Long-Term care admits.
1- at the Burney Campus
1-at the Fall River Campus

Updates:

- We have hosted two resident family support groups that have been going very well.
- I have completed 41 risk assessments on the Acute floor for SWING bed patients. This tool has helped identify any needs before discharge.

Clinical Education

January 2025

Certifications/Licenses

- BLS training participants on 1/14 with 7 participants recertified. 100% of staff requiring BLS are current.
- PALS & NRP - March 25, 2025
- ACLS - April 28, 2025
- ACLS - Aug 18th, 2025
- NRP - Oct 15, 2025

ACHC Trainings

- ACHC Training for Acute/ED training on 1/23/25… compliance rate >93%. (We are working on getting the exact rate now.) The five core areas are EMTALA, Suicide Risk Assessment and Prevention, Patient Rights, Physical and Chemical Restraints, and a Fall Risk Assessment and Prevention Program.
- These trainings will be ongoing for newly hired staff and registry staff onboarding

CNA INSERVICE TRAINING

- 2025 Inservice/CEU training for the CNA schedule is complete and has been posted on monitors, distributed to all staff by email, and posted in break rooms
- CNA in-service training scheduled for Abuse, Dementia, Infection Prevention, Patient/Resident center care, Professionalism, Resident Safety, and Skills validation (Fair)
- Safe Patient Handling & Mobility Program scheduled
- "Just In Time" training will be added in response to real-time quality and regulatory issues and events by leadership and educators.

RN/LVN Training

Providing Regina Blowers LVN, DSD, and instructor orientation for the DSD role. Reviewing CDPH guidelines for CNA orientation, in-service, and renewal process for recertification of Orientation and In-service programs due 1/31/2026.

Ongoing Projects

ACHC Suicide Risk & Prevention Awareness for Ancillary Staff initiated with Clinical Educator rounding on Departments during monthly meetings and invites to work areas.

I want to express my gratitude for the opportunity and privilege to be able to work at Mayers Memorial Hospital since 2018. It has been an enriching experience.

Respectfully Submitted by Theresa Overton, CNO

Chief Executive Officer Report
Prepared by: Ryan Harris, CEO

ACHC Accreditation
We are pleased to announce the successful completion of our Accreditation Commission for Health Care (ACHC) Survey this week. While we received several tags identifying areas for improvement, none should jeopardize our accreditation status, marking a significant improvement from our previous mock survey. Our immediate focus is to address these findings and integrate necessary changes into our operations. The following steps include reviewing survey findings, receiving a deficiency report, and submitting our plan of correction within designated timelines. I want to thank the MMHD team for their exceptional effort and teamwork throughout this process.

Provider Search Update
The search for a new Chief Medical Officer and primary care physician for our clinic is ongoing. Factors such as our location, the composition of the physician group, and wages have made recruitment for these positions challenging. I will meet with our recruitment team to formulate aggressive strategies to fill these essential roles.

Collaboration
The CEO group representing Modoc, Seneca, Mayers, Plumas, and Eastern Plumas is currently discussing the MRI owned by the group. We are evaluating the advantages and disadvantages of establishing a Joint Powers Authority (JPA) versus entering into a contractual agreement. Heritage, our vendor during the transition to our owned unit, will visit on February 20th.

Quality Improvement Program
While not yet official, we have received validation indicating we will likely succeed in our well-child visit measure. However, additional work and validation will be necessary to determine our success in cervical cancer screenings and other measures.

Clinical AI Agent
Last week, we began discussions with Cerner regarding their clinical AI agent, which aims to enhance charting and documentation in our clinical environments. We will provide more updates on this initiative as details become available.

Strategic Priorities Update
See attached report.

Telemedicine
See attached report.

Strategic Priority Update

Quality

Current:

Specific:
Implement and refine the infection prevention program by June 30, 2025, to achieve a minimum hand hygiene adherence rate of 80% among healthcare workers.

Measurable:
The goal's success will be measured by tracking and monitoring hand hygiene adherence rates, with a target of at least 80% compliance rate among healthcare workers.
Lower target rate to 60%:

Achievable:
This goal is achievable by implementing and integrating technology-based solutions, such as automated hand sanitizer dispensers, electronic monitoring systems, and staff education and training programs.
Increase Observers: Minimum # of observers per month. Breakout groups: ELT, Managers, secret observers
Increase baseline: We established the current baseline of 48.65% average at 6 months and set the increase to a minimum of 60% average for the facility.

Relevant:
The goal is relevant to the Quality Service pillar by fostering a culture of quality and safety through ongoing education, training, and accountability.

Time-bound:
The goal must be achieved by June 30, 2025, to ensure that the enhanced infection prevention program is fully implemented and effectively improves hand hygiene adherence rates.

Proposed New:

Specific:
Implement and refine the infection prevention program by June 30, 2025, to achieve a minimum hand hygiene adherence rate of 60% among healthcare workers.

Measurable:
The goal's success will be measured by tracking and monitoring hand hygiene adherence rates, with a target of at least a 60% compliance rate among healthcare workers.

Achievable:

This goal is achievable through the implementation of staff education and training programs, the promotion of a culture of hand hygiene, and regular feedback on adherence rates to encourage improvement.

Relevant:
The goal is relevant to the Quality Service pillar by fostering a culture of quality and safety through ongoing education, training, and accountability in infection prevention practices.

Time-bound:
The goal must be achieved by June 30, 2025, to ensure that the enhanced infection prevention program is fully implemented and effectively improves hand hygiene adherence rates.

Growth

Current:

Specific:
By June 30, 2025, increase outpatient visits across all departments (Rural Health Clinic, Laboratory, Radiology, Outpatient Medical, Physical Therapy, Cardiac Rehab, Outpatient Surgery, and Respiratory Therapy) by 5% year-over-year.

Measurable:
The success of the goal will be measured by tracking and monitoring outpatient visit numbers for each department. The target increase is 5% combined compared to the previous year's data.

Achievable:
This goal is achievable by implementing targeted marketing campaigns, community outreach initiatives, patient engagement programs, care coordination, and staff training to improve patient flow and wait times.

Relevant:
The goal is relevant to the Growth pillar by driving consistent departmental growth to achieve a sustainable future.

Time-bound:
The goal must be achieved by June 30, 2025, to ensure that the strategies are fully implemented and effective in driving growth and increasing outpatient visits."

Proposed New:

Specific:

By June 30, 2025, each department within outpatient services (Rural Health Clinic, Laboratory, Radiology, Outpatient Medical, Physical Therapy, Cardiac Rehab, Outpatient Surgery, and Respiratory Therapy) will individually achieve a 5% increase in outpatient visits, charges, or procedures year-over-year, contributing equally (12.5%) to the overall target of 100%.

Measurable:
Success will be determined by tracking and monitoring outpatient visits, charges, or procedure numbers for each department monthly. Each department's ability to achieve a 5% increase compared to the previous year's figures will be assessed individually.

Achievable:
This goal is achievable by implementing targeted marketing campaigns, community outreach initiatives, patient engagement programs, care coordination, and staff training to improve patient flow and wait times.

Relevant:
The goal is relevant to the Growth pillar by driving consistent departmental growth to achieve a sustainable future.

Time-bound:
The goal must be achieved by June 30, 2025, to ensure that the strategies are fully implemented and effective in driving growth and increasing outpatient visits.

Communication

Current:

Specific:
By December 31, 2024, Mayers Memorial Healthcare District (MMHD) will develop and implement a comprehensive patient satisfaction program to improve communication, referrals, medical records, and scheduling efficiency.

Measurable:
The program will be evaluated through ongoing patient satisfaction surveys, with a minimum 5% improvement in patient satisfaction scores within the first 3 months of implementation or a minimum 10% improvement overall from the time of implementation by the end of FYE 2025.

Achievable:
A dedicated care coordination team will lead the initiative, consisting of at least two full-time equivalent staff members with expertise in patient engagement, care coordination, and quality improvement.

Relevant:

The comprehensive patient satisfaction program will align with the Communication pillar and provide timely communication to patients about their care.

Time-bound:
The program will be implemented, data from surveys obtained, and improvements measured by June 30, 2025, with ongoing evaluation and refinement throughout the year. Regular progress updates will be provided to leadership and stakeholders to ensure timely and effective implementation."

Proposed New:

Specific:
By June 30, 2025, Mayers Memorial Healthcare District (MMHD) plans to launch an extensive patient satisfaction program with the following objectives:
1. Conduct surveys by June 30, 2024, to establish a baseline for patient experience scores in clinics and the emergency room.
2. Choose a patient satisfaction program and partner by June 30, 2025.
3. Develop and implement new clinic workflows, covering scheduling through to referrals, by June 30, 2025.
4. Establish a dedicated care coordination department by June 30, 2025.
5. Select and implement a new communication platform.

Measurable:
We will evaluate progress by collecting patient experience surveys, monitoring the rollout of new workflows, selecting a patient experience vendor, choosing a communication platform, and establishing the care coordination department.

Achievable:
These objectives are realistic, given thorough strategic planning, effective resource allocation, and stakeholder collaboration.

Relevant:
This initiative supports MMHD's commitment to enhancing patient care, communication, and satisfaction, ultimately improving community health outcomes.

Time-bound:
To ensure improved patient satisfaction during this fiscal year, the goal must be achieved by June 30, 2025.

Telemedicine Program Update as of February 3rd, 2025
Respectfully submitted by Samantha Weidner for Ryan Harris, CEO and Kimberly Westlund, Clinic Manager

<u>We have completed a total of 3,531 live video consults since August 2017 (start of program).</u>

Endocrinology:

- Dr. Bhaduri saw 30 patients in January. She continues to be our most productive, consistent provider.
- We've had 1,280 consults since the start of this specialty in August 2017.

Nutrition:

- Jessica saw no nutrition patients in January due to illness. She will be providing us with a makeup day for this cancelled block.
- We've had 241 consults so far since we started this specialty in November 2017.

Psychiatry:

- Dr. Granese saw 13 patients in January.
- We've had 793 consults since the beginning of the program in August 2017.

Infectious Disease:

- Dr. Siddiqui saw two patients in January.
- We've had 138 consults since the start of this specialty in September 2017.

Neurology:

- Dr. Nalla saw two patients in January. At this time, she is only able to see patients with Partnership and Blue Shield/Blue Cross insurances. Due to this, we are working on credentialing an additional Neurologist who can provide care for patients with other insurances.
- We've had 474 consults since the start of the program in November 2018.

Rheumatology:

- Dr. Tang saw 11 patients in January.
- We've had 222 consults since the start of the program in May 2020.

Nephrology:

- Dr. Bassila saw four patients in January.
- We've had 80 consults since the start of the program in April 2023.

Talk Therapy:

- We began talk therapy services with Ryan McNeel, LCSW in mid-April 2023. It has been a struggle to keep a consistent schedule with this provider. I have been pushing for updates often on this issue. Telemed2U has **two** new providers wanting to onboard with

Mayers. We are excited to have more than one option for our patients and looking to get credentialing completed as quickly as possible.

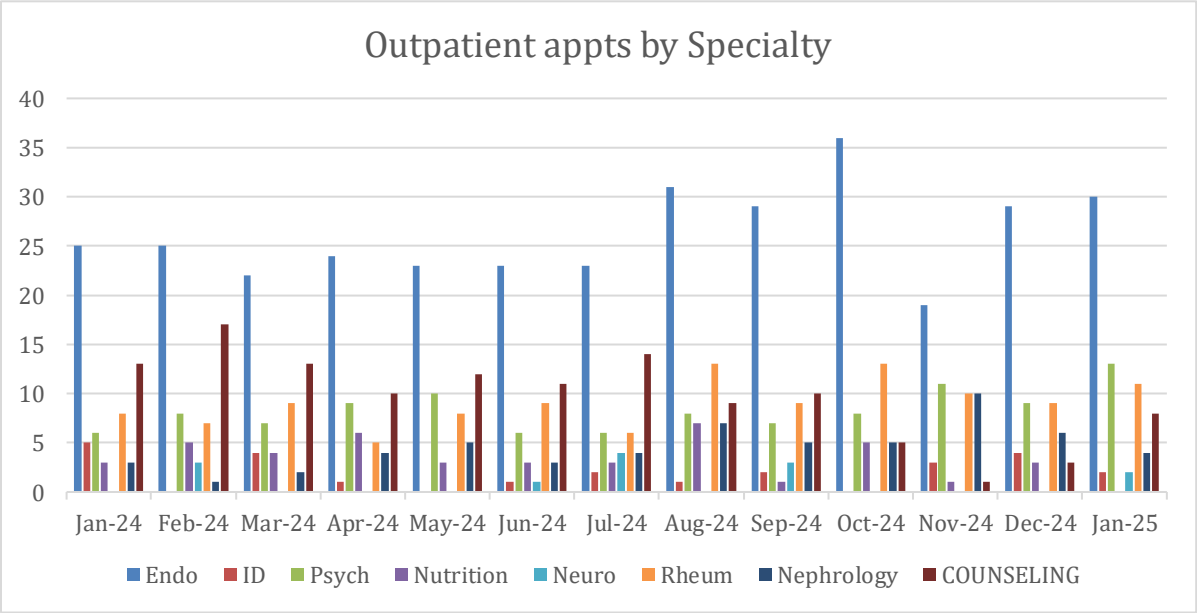
Referral Update:

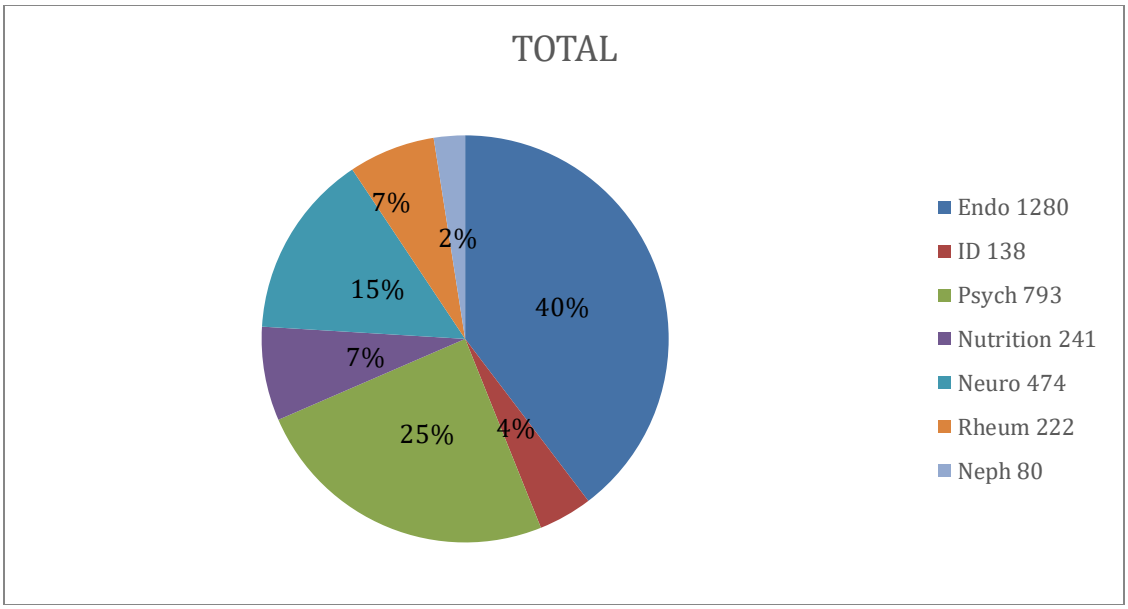
We received 36 New Patient referrals in January. Below is a breakdown of where we received them from:

- Mountain Valleys Health Center – 1
- Hill Country Clinic – 9
- Pit River Health Center – 1
- Canby Family Practice – 0
- Mayers RHC – 22
- Mayers SNF – 3

ConferMED –

We had three ConferMED consultations sent in the month of January. It has been a struggle to get some providers on board with sending referrals through ConferMED.




TOTAL
40%
4%
25%
7%
15%
7%
2%
Endo 1280
ID 138
Psych 793
Nutrition 241
Neuro 474
Rheum 222
Neph 80