AGENDA

LAST FRONTIER HEALTHCARE DISTRICT

BOARD OF DIRECTORS

Thursday, July 30, 2026, 3:30 pm
City Council Chambers; Alturas, California

Parties with a disability, as provided by the American Disabilities Act, who require special accommodations or aids in order to participate in this public meeting should make requests for accommodation to the Modoc Medical Center Administration at least 48 hours prior to the meeting. Board Agenda packets are available to the public online at www.modocmedicalcenter.org or at the MMC Administration offices.

3:30 pm - CALL TO ORDER – R. Boulade, Chair

1. PLEDGE OF ALLEGIANCE TO THE FLAG OF THE UNITED STATES OF AMERICA – R. Boulade, Chair

2. AGENDA APPROVAL - Additions/Deletions to the Agenda – R. Boulade, Chair

3. PUBLIC COMMENT - *This is the time set aside for citizens to address the Board on matters not on the Agenda or Consent Agenda. Comments should be limited to matters within the jurisdiction of the Board. If your comment concerns an item shown on the Agenda, please address the Board after that item is open for public comment.* ***By law, the Board cannot act on matters that are not on the Agenda.*** *The Chairperson reserves the right to limit the duration of each speaker to* ***three minutes.*** *Speakers may not cede their time. Agenda items with times noted, will be considered at that time. All other items will be considered as listed on the Agenda, or as deemed necessary by the Chairperson.*

4. VERBAL REPORTS

A.) K. Kramer – CEO Report to the Board
B.) E. Johnson – CNO Report to the Board
C.) J. Lin – Finance Director Report to the Board
D.) A. Vucina – CHRO Report to the Board
E.) A. Willoughby – COO Report to the Board
F.) Board Member Reports

5. DISCUSSION

A.) D. King – Lodging Expenses **Attachment A**

REGULAR SESSION

6. CONSENT AGENDA - *Items under the Consent Agenda heading do not require discussion before a vote. If discussion is needed, that item needs to be moved to the Consideration/Action part of the Agenda where discussion is allowed.*

A.) D. King - Adoption of LFHD Board of Directors Regular Meeting Minutes – June 25, 2026, **Attachment B**
B.) T. Ryan - Medical Staff Committee Meeting Minutes – June 24, 2026 **Attachment C**
- **Pathology Report – 3/28/2026**
  3/29/2026
  4/30/2026
  5/1/2026

C.) E. Johnson – Policy and Procedures **Attachment D**

SURGERY/OPERATING ROOM
7420.26 EGD and Colonoscopy Policy
7420.26 OR Personnel Policy Procedure Before the Patient Enters the OR

SKILLED NURSING FACILITIES
6580.26 Skin Care Policy
6580.26 Admission Nursing Assessment
6580.26 Change in Resident Status
6580.26 Advanced Health Care Directive
6580.26 Body assessment Protocol

DIETARY ACUTE
8345.26 Cleaning Instructions for Cloths, Pads, Mops and Buckets
8345.26 Available Diets

AMBULANCE
7041.26 Ambulance Dispatching Page System
7041.26 Ambulance Operations

EMERGENCY DEPARTMENT
7010.26 Infusion Pumps Inspection, Care and Maintenance Policy
7010.26 Emergency Department Diversion Policy and Procedure
7010.26 Hand Off Communication Policy and Procedure
7010.26 Do Not Resuscitate Policy and Procedure
7010.26 Education of Patient and Family Policy and Procedure
7010.26 Epistaxis Standard of Care Policy and Procedure
7010.26 Care of Latex Sensitive Patient Policy and Procedure
7010.26 Coroner Notification Policy and Procedure
7010.26 Emergency Department Automated Dispensing Cabinet Omnicell
7010.26 Mandated Reporting of Decubitus Ulcers Policy and Procedure
7010.26 Lumbar Puncture Assisting with Procedure Policy and Procedure Documentation
7010.26 Endotracheal Tube Placement Confirmation Policy and Procedure Documentation
7010.26 Eye Emergency Standard of Care
7010.26 Emergency Department Log Maintenance Policy and Procedure
7010.26 Hypothermia Standard of Care Policy and Procedure
7010.26 Medication Labeling Policy and Procedure
7010.26 Burn Patient Standard of Care Policy and Procedure
7010.26 Hemoccult Testing Policy and Procedure
7010.26 Head Injury Standard of Care Policy and Procedure
7010.26 Cervical Spine Immobilization
7010.26 Intravenous Access for Radiological Procedure Policy and Procedure
7010.26 Diarrhea Standard of Care
7010.26 Infection Control Standard in the Emergency Department
7010.26 Intraosseous Access Policy and Procedure
7010.26 Discharge Instructions Policy and Procedure
7010.26 Medication Errors Policy and Procedure
7010.26 Dying Patient-Standard of Care Policy and Procedure
7010.26 Chest Pain-Standard of Care Policy and Procedure
7010.26 Visitors in the Emergency Department Policy

NURSING MED/SURG
6170.26 Bedside Commode Use Policy and Procedure
6170.26 Bed Making Procedure for Inpatient Care

7.CONSIDERATION/ACTION

A.) E. Johnson – Departmental Manuals	**Attachment E**
B.) J. Lin – June 2026 LFHD Financial Statement *(unaudited)*	**Attachment F**
C.) K. Kramer – Updated FYE 26.27 Budget and Capital Budget	**Attachment G**

D.) K. Kramer – Certification of Assessment 26-27 Attachment H
E.) K. Kramer – #26-02 Resolution for Tax Collection 2026-2027 Attachment I

EXECUTIVE SESSION

8. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items –June 24, 2026, (Per Evidence Code 1157) Attachment J

- Medical Executive Committee Minutes & Credentialing Items OPPE 2019B –May 27, 2026

REGULAR SESSION

9. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items –June 24, 2026 (Per Evidence Code 1157)

- Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – May 27, 2026

10. MOTION TO ADJOURN – R. Boulade – Chair

POSTED AT: MODOC COUNTY COURTHOUSE / ALTURAS CITY HALL / MMC WEBSITE / MMC FRONT ENTRANCE - (www.modocmedicalcenter.org) ON Jule 24, 2026.

ATTACHMENT A

Lodging Expenses

MEMORANDUM

Lodging Expense Spreadsheet Summary

Spreadsheet	Entries	Total
FY 2025–26 lodging expenses	8	$25,283.00
FY 2026–27 lodging expenses—spent so far	4	$11,878.60
Combined total shown on both spreadsheets	**12**	**$37,161.60**

The totals include the lodging charges along with any cleaning fees, pet fees, occupancy taxes, and discounts shown on the invoices.

Kacy Geaney invoice INV0002 totaled $6,400 for 64 nights at $100 per night. Because the stay crossed fiscal years, it was divided as follows:

- FY 2025–26: 4 nights from June 27–30, 2026 = $400
- FY 2026–27: 60 nights from July 1–August 29, 2026 = $6,000

FY 25.26 Lodging Expenses

Invoice Count	8
Grand Total	$25,283.00

Invoice Date	Vendor / Payee	Invoice #	Bill To	Stay Start	Stay End	Description	Nights / Qty	Lodging	Cleaning Fee	Pet Fee	Taxes	Discount	Total
01/05/2025	Kacy Geaney	INV0005	Modoc Medical Center	01/05/2025	03/20/2025	Lodging for Locums	74	$8,880.00	$660.00	$0.00	$0.00	$0.00	$9,540.00
05/21/2025	Kacy Geaney	INV0003	Modoc Medical Center	06/08/2025	06/13/2025	Lodging for Revenue Cycle Director	5	$575.00	$60.00	$0.00	$0.00	$0.00	$635.00
09/08/2025	Juan Ledezma		Modoc Medical Center	10/05/2025	10/11/2025	Site Visit Lodging	6	$654.00	$80.00	$0.00	$0.00	$0.00	$734.00
11/18/2025	Juan Ledezma		Modoc Medical Center	11/20/2025	11/22/2025	Site Visit Lodging	2	$218.00	$80.00	$0.00	$0.00	$0.00	$298.00
01/20/2026	The First Motel		Modoc Medical Center	01/25/2026	05/02/2026	Lodging for Locums	97	$3,600.00	$0.00	$0.00	$0.00	$0.00	$3,600.00
02/26/2026	Kacy Geaney	INV0001	Modoc Medical Center	03/30/2026	06/26/2026	Lodging for Locums	90	$10,350.00	$585.00	$900.00	$0.00	-$1,935.00	$9,900.00
06/11/2026	Kacy Geaney	INV0002	Modoc Medical Center	06/27/2026	08/29/2026	Lodging for Locums	64	$400.00	$0.00	$0.00	$0.00	$0.00	$400.00
06/12/2026	Kathy Ramirez		Modoc Medical Center	06/14/2026	06/15/2026	Site Visit Lodging	1	$95.00	$65.00	$0.00	$16.00	$0.00	$176.00

TOTAL	$25,283.00

FY 2026–27 Lodging Expenses

Expenses recorded so far for July 1, 2026 through June 30, 2027

Invoice Count	**4**
Spent So Far	**$11,878.60**

Invoice Date	Vendor / Payee	Invoice #	Bill To	Stay Start	Stay End	Description	Nights / Qty	Lodging	Cleaning Fee	Pet Fee	Taxes	Discount	Total
06/11/2026	Kacy Geaney	INV0002	Modoc Medical Center	07/01/2026	08/29/2026	Lodging for Locums – Split from FY 25.26	60	$6,000.00	$0.00	$0.00	$0.00	$0.00	$6,000.00
06/12/2026	Kathy Ramirez		Modoc Medical Center	07/08/2026	07/10/2026	Site Visit Lodging	2	$300.00	$125.00	$0.00	$0.00	$0.00	$425.00
07/19/2026	Juan Ledezma		Modoc Medical Center	07/19/2026	08/22/2026	Site Visit/ Dr. Syverson Lodging – 3 Stays	14	$1,536.00	$240.00	$0.00	$177.60	$0.00	$1,953.60
07/24/2026	Kacy Geaney	INV0003	Modoc Medical Center			Lodging for Locums	35	$3,500.00	$0.00	$0.00	$0.00	$0.00	$3,500.00

TOTAL SPENT	**$11,878.60**

ATTACHMENT B

Adoption of LFHD Board of Directors Regular Meeting Minutes

June 25, 2026

REGULAR MEETING MINUTES
LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
Thursday, June 25, 2026, at 3:30 pm
City Council Chambers; Alturas City Hall; Alturas, California

Directors present: **Rose Boulade, Carol Madison, Paul Dolby, Keith Weber, Mike Mason**
Directors absent:
Staff in attendance: **Kevin Kramer, CEO; Edward Johnson, CNO; Adam Willoughby, COO; Amber Vucina, CHRO;Jin Lin, Finance Director; Denise King, LFHD Clerk**
Staff absent:

CALL TO ORDER

Rose Boulade, Chair, called the meeting of the Last Frontier Healthcare District (LFHD) Board of Directors (Board) to order at 3:30 p.m. The meeting was held at the City Council Chambers, located at 200 W. North St., in Alturas, California.

1. PLEDGE OF ALLEGIANCE TO THE FLAG OF THE UNITED STATES OF AMERICA

2. AGENDA – Additions/Deletions to the Agenda

Paul Dolby moved that the agenda be approved with the addition of a Subsequent Need Item for the 2026 Election Resolution be added as Item 7I. **Keith Weber seconded**, and the motion carried with all present voting "aye."

3. PUBLIC COMMENT

There was no public comment.

4. VERBAL REPORTS

A.) K. Kramer – CEO Report to the Board

Provider Recruitment

- A Physician Assistant has accepted an offer to provide services in the Skilled Nursing Facility in collaboration with the Medical Director. The candidate has begun the credentialing process, and the employment agreement is being finalized.
- Recruitment efforts continue for two Family Nurse Practitioner/Physician Assistant positions and two physician positions to support the Alturas and Canby Clinics.

Security Incident

- The third-party review remains in progress. A final data analysis and summary are anticipated by the end of July 2026.

Cost-Based Ambulance Services

- Discussions continue regarding the cost-based ambulance services initiative. Legal coordination is underway between the respective parties.

ERHC Grant (USDA)

- Approximately $850,000 in grant funding has been awarded through the USDA. Project implementation continues.

Geothermal Grant

- The project remains ongoing, with continued coordination on the site host agreement.
- Staff are evaluating the use of grant funds for eligible legal services necessary to ensure compliance with applicable school construction requirements.
- Draft design documents and technical specifications have been completed, and bid documents are currently being prepared.

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Other Items

- The organizational wage analysis remains in progress.
- The DHCS Quality Incentive Program (QIP) submission has been completed. Preliminary results indicate the organization met two performance metrics, including exceeding expectations for tobacco screening and intervention. Funding is anticipated to be received in December 2026.

B.) E. Johnson – CNO Report to the Board

Skilled Nursing Facility (SNF)

- Maintained a 5-Star CMS Quality Rating.
- Fall prevention efforts continue to show positive results.
    - A multidisciplinary review process has been implemented to evaluate all resident falls and identify opportunities for improvement.
    - These quality improvement measures have contributed to a significant reduction in falls over the past two months.

Warnerview

- Current census: 18 residents.

Mountain View

- Current census: 48 residents.
- Admissions: 6
- Discharges: 3
- Continued efforts are underway to increase census, with a goal of reaching approximately 70 residents by the end of July.
- Residents participated in Independence Day activities, including community parade events.
- A Warnerview Field Day is planned for July 31, featuring outdoor activities, a barbecue, and opportunities for resident and staff engagement.

Acute Care

- Average Daily Census: 1.29
- Average Length of Stay: 2.67 days
- Swing Bed Average Daily Census: 0.65
- Swing Bed Average Length of Stay: 4.00 days
- Admissions:
    - 15 Acute Care
    - 5 Swing Bed
- Surgeries Performed: 24

Emergency Department

- Total patient visits: 532
- Average daily census: 17.2 patients
- Efforts continue to evaluate opportunities to expand specialized emergency care services and enhance patient access.

Ambulance Services

- Total ambulance responses: 71
- Call volume increased compared to the previous two months.

Pharmacy

- Welcomed a new Retail Pharmacy Manager to the team.
- Recruitment efforts continue for an additional pharmacist.
- A new refrigerator and freezer temperature monitoring system has been implemented in the pharmacy, with plans to expand the system throughout additional hospital departments.
- Prescriptions filled: 4,320

Physical Therapy

- Department is fully staffed.
- Patient treatment sessions: 709, representing a significant increase from the previous month.

Laboratory

- Laboratory tests performed: 5,477.

Wound Care & Infusion Services

- Continued evaluation of wound care service delivery and operational processes.
- Planning continues to further integrate wound care services within the hospital setting to enhance patient care.
- Infusion services continue to experience growth.

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- Therapeutic Phlebotomy services have been added to expand treatment options for patients requiring management of specific blood disorders.

Patient Safety & Quality

- Three staff members were nominated for the Good Catch Award, recognizing proactive efforts to improve patient safety.
- Award recipients will be announced following committee review.

C.) J. Lin – Finance Director Report to the Board

Accounting

- Continued implementation and transition to the ADP payroll and human resources system.
- Prepared fiscal year-end adjusting journal entries for FY 2026.
- Evaluated vendor payment solutions, including the use of virtual payment cards, to improve payment processes and explore potential rebate opportunities.
- Coordinated preparations for the annual physical inventory count conducted on June 30.

Purchasing

- Purchasing is preparing for physical inventory counts on 6/30.

D.) A. Vucina – CHRO Report to the Board

Permanent/Travel Staff

- We currently have 319 total staff
- We have a total of 24 travelers, both Acute and SNF.
- New hires 11 started in June.

Compliance

- Performance Evaluations 82% compliant
- TB 96% compliant
- Physicals 96% compliant

Healthcare Minimum Wage

- June 1st all staff will see a 3.5% increase in their wage.

Other Items

- Attending ADP Transition meetings

E.) A. Willoughby – COO Report to the Board

Revenue Cycle

- Financial performance remained strong in May.
    - Payments received: $3.12 million
    - Gross revenue: Approximately $5.4 million
    - Average Daily Revenue (ADR): $174,300
    - Accounts Receivable (AR) Days: 58.31
- June financial performance continues to trend positively.
    - Payments received to date: $2.6 million
    - Average Daily Revenue (ADR): $178,000
    - Accounts Receivable (AR) Days: 57.41
- Reimbursement coordination with the Sheriff's Office is ongoing as payment processes and applicable billing activities continue to be finalized.

Clinics

- Clinic Expansion Project
    - Architectural revisions are underway following the most recent planning committee meeting.
    - Updated plans will include evaluation of future MRI and Mammography space to support long-term growth and improve connectivity with Imaging Services.
- Canby Clinic Remodel
    - Exterior improvements have been completed on Buildings 2 and 3.
    - Interior work on Building 2 is nearing completion.
    - Building 1 renovations remain in progress.
    - Project completion is anticipated by the end of July.
- Telehealth Services
    - Procurement is underway for equipment to establish a dedicated telehealth room at the Canby Clinic.

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Maintenance

- Planning continues for the Highway 299/Nagle Street lighting project. Additional updates will be provided as the project progresses.

Information Technology & Marketing

- Information Technology and Marketing operations continue to support organizational priorities and ongoing projects.

F.) Board Member Reports

- **Carol Madison** – Nothing to report.
- **Paul Dolby –** Nothing to report.
- **Mike Mason –** Attended the Quality Council Meeting – provided the idea of improving the good at the facility. Also mentioned that he and Ed Johnson will be making surprise visits to taste test the food being served.
- **Rose Boulade –** Attended the Finance Meeting. Also attended the Health Fair this year with Plumas Bank and had a booth – had a great time.
- **Keith Weber –**Nothing to report.

5. DISSCUSSION

A.) K. Kramer – Sierra Health Collaborative

Kevin Kramer, CEO, advised the Board of a potential opportunity for Modoc Medical Center to join the Sierra Health Collaborative. He explained that the collaborative is a formally established organization comprised of independent healthcare systems that work together to improve quality of care, increase operational efficiency, and reduce costs through regional collaboration. Current member organizations include several rural hospitals and some larger hospitals throughout Northern California and Nevada.

Kevin also shared that the collaborative focuses on initiatives such as group purchasing, joint contract negotiations, shared consulting resources, collaborative management services, and professional peer networks for clinical and administrative leadership. These efforts are intended to strengthen member organizations while allowing each facility to maintain its independence. He noted that Modoc Medical Center has been invited to participate and that leadership will continue evaluating the potential benefits, costs, and opportunities associated with membership before bringing any future recommendations to the Board.

B.) D. King – Tax Appeals Finalized

Denise King, District Clerk, provided an update on the finalized tax appeal process. A total of seven property owners submitted appeals involving 22 Assessor's Parcel Numbers (APNs). Following review, taxes remained applied to six APNs, were removed from 15 APNs, and one appeal was denied because the property remained subject to the tax. A total of $2,925 was approved for reimbursement.

REGULAR SESSION

6. CONSENT AGENDA - *Items under the Consent Agenda heading do not require discussion before a vote. If discussion is needed, that item needs to be moved to the Consideration/Action part of the Agenda where discussion is allowed.*

A.) D. King - Adoption of LFHD Board of Directors Regular Meeting Minutes – May 28, 2026,

B.) T. Ryan - Medical Staff Committee Meeting Minutes – May 27, 2026

- **Medical Staff Committee Meeting Minutes – April 29, 2026**
- **Infection Control Meeting Minutes – 4/23/2026**
- **Patient Safety/Lifting Committee Meeting Minutes – 5/20/26**
- **Pathology Report – 2/5/26 and 3/1/26**

C.) E. Johnson – Policy and Procedures

Carol Madison moved that the Consent Agenda be approved, **Mike Mason** seconded, and the motion carried with all present voting "aye."

7. CONSIDERATION/ACTION

A.) E. Johnson – Departmental Manuals

Ed Johnson, CNO, presented the Departmental Manuals to the Board, providing an overview of the manuals and the associated review processes while addressing questions from Board members.

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Keith Weber moved to approve the **Departmental Manuals**, **Paul Dolby** seconded, and the motion carried with all voting "aye."

B.) J. Lin – May 2026 LFHD Financial Statement *(unaudited)*

Jin Lin, Finance Director, presented the May 2026 LFHD Financial Statement provided in the Board meeting packet and answered the questions the Board had.

Paul Dolby moved to accept the April 2026 LFHD Financial Statement as presented, **Mike Mason** seconded, and the motion carried with all present voting "aye."

C.) C. Channel – Capstone Advantage Employee Benefit Program

Cameron Channel, gave a brief presentation on the Capstone Advantage employee wellness program, a Section 125 pre-tax benefit designed to enhance existing employee benefits through preventative healthcare, telehealth services, and wellness resources. The program is intended to improve employee recruitment, retention, and overall wellness while potentially reducing payroll tax liability at no net cost to the employer or employees.

Carol Madison moved to accept the **Capstone Advantage Employee Benefit Program** as presented, **Mike Mason seconded**, and the motion carried with all present voting "aye."

D.) K. Kramer – Laparoscopic Surgeon Contract

Kevin Kramer, CEO, presented the **Laparoscopic Surgeon Contract** to the Board while addressing questions from Board members.

Keith Weber moved to approve the **Laparoscopic Surgeon Contract**, **Paul Dolby** seconded, and the motion carried with all voting "aye."

E.) K. Kramer – Laparoscopic Surgeon Contract

Kevin Kramer, CEO, presented the **Laparoscopic Surgeon Contract** to the Board while addressing questions from Board members.

Mike Mason moved to approve the **Laparoscopic Surgeon Contract**, **Paul Dolby** seconded, and the motion carried with all voting "aye."

F.) K. Kramer – Strategic Plan

Kevin Kramer, CEO, presented the **Strategic Plan** to the Board while addressing questions from Board members.

Carol Madison moved to approve the **Strategic Plan** with the suggested change of Customer Service to Customer Experience, **Paul Dolby** seconded, and the motion carried with all voting "aye."

G.) J. Lin – FYE 2027 Budget

Jin Lin, Finance Director and Kevin Kramer, CEO, discussed the **FYE 2027 Budget** with the Board and requested that the budget be tabled due to some questions that the finance committee had regarding the budget that need to be answered prior to their recommendation to approve the budget to the Board. **Kevin and Jin** would like to refine the budget and answer all Finance Committee questions prior to asking the Board to review and approve the budget. .

Carol Madison moved to table the **FYE 2027 Budget until it has been reviewed and recommended by the Finance Committee, with final Board consideration to occur prior to September 1, 2026**, **Keith Weber,** seconded, and the motion carried with all voting "aye."

H.) A. Willoughby – Large Account Write Off

Adam Willoughby, COO, presented the **Large Account Write Off** to the Board while addressing questions from Board members.

Keith Weber moved to approve the **Large Account Write Off**, **Carol Madison** seconded, and the motion carried with all voting "aye."

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I.) K. Kramer – Resolution #26-01

Kevin Kramer, CEO explained to the Board, Resolution #26-01 which orders the November 3, 2026 election for three Board of Director seats, requests that the Modoc County Elections Department conduct the election, and requests consolidation of the District's election with the statewide general election in accordance with the California Elections Code. The resolution authorizes the County to administer the election and identifies the Board Member seats currently held by Rose Boulade, Mike Mason, and Paul Dolby as the positions to be placed on the ballot.

Carol Madison moved to approve Resolution #25-05, and **Paul Dolby** seconded.

Rose Boulade, Chair, called for a roll call vote:

- **Carol Madison** **Aye**
- **Paul Dolby** **Aye**
- **Mike Mason** **Aye**
- **Rose Boulade** **Aye**
- **Keith Weber** **Aye**

The motion to approve Resolution #26-01 as presented carried with all present voting "aye" as shown in the roll call vote above.

Mike Mason moved to close the Regular Session of the Board of Directors, **Keith Weber** seconded, and the motion carried with all voting "aye."

The Regular Session of the Last Frontier Healthcare District Board of Directors was adjourned at 4:57 pm.

EXECUTIVE SESSION

Executive Session was called to order by **Rose Boulade, Chair**, at 4:57 pm.

7. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items – May 27, 2026 – (*Per Evidence Code 1157*).

- **Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – April 29, 2026.**

Based upon character, competence, training, experience and judgment, favorable recommendation by peers and credentialing criteria fulfillments, the Medical Executive Committee recommended the following appointments for Last Frontier Healthcare District Board of Directors' acceptance:

- **Patricia Horvath, FNP** – Recommends appointment of Allied Health status/privileges in the Family Practice category.
- **Robert James III, MD** – Recommends reappointment of Consulting privileges in the Pathology category.
- **Edward Richert, MD** – Recommends reappointment of Allied Health status/privileges in the Family Medicine, Emergency Medicine, and Minor Surgery category.

The Executive Session of the Board of Directors was adjourned at 4:58 pm.

RESUME REGULAR SESSION

The Regular Session of the Board of Directors was called back to session by **Rose Boulade, Chair**, at 4:59 pm.

8. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items –May 27, 2026 – (Per Evidence Code 1157).

- **Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – April 29, 2026.**

Keith Weber moved to approve and accept Minutes, Credentialing, and Privileging items as outlined above, **Paul Dolby** seconded, and the motion carried with all members voting "aye."

11.) MOTION TO ADJOURN

Carol Madison moved to adjourn the meeting of the Last Frontier Healthcare District Board of Directors at 4:59

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pm**, Mike Mason** seconded, and the motion carried with all present voting "aye."

The next meeting of the Last Frontier Healthcare District's Board of Directors will be held on July 30, 2026, at 3:30 pm in the Alturas City Council Chambers, City Hall in Alturas, California.

Respectfully Submitted:

_____ _____

Denise R. King **Date**
Last Frontier Healthcare District Clerk

DRAFT

ATTACHMENT C

Medical Staff Committee Meeting Minutes
June 24, 2026

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

DATE: JULY 30, 2026

TO: GOVERNING BOARD

FROM: T. RYAN – CREDENTIALING AIDE

SUBJECT: MEDICAL STAFF COMMITTEE MINUTES

*The following Medical Staff Committee Minutes were reviewed and accepted at the June 24, 2026, meeting and are presented for Governing Board review:

A. REVIEW OF MINUTES

1. Medical Staff Committee Meeting Minutes – May 27, 2026

B. COMMITTEE REPORTS – No Committee Reports

C. PATHOLOGY REPORT – 03/28/2026 - 03/29/2026 & 04/30/2026 - 05/01/2026

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

MEDICAL STAFF COMMITTEE MEETING
May 27, 2026 – Education Building
MINUTES

In Attendance

Edward Richert, MD Vice Chief Medical Officer
James Appel, MD
Landin Hagge, DO
Kevin Kramer- CEO
Ed Johnson- CNO
Walter Dimarucut- Laboratory Manager
Vahe Hovasapyan- Pharmacist
Alicia Doss- Risk Management
Brandy Morris-Wright- MSC/H.I.M
Taylor Ryan- Credentialing Aide

SUBJECT	DISCUSSION	ACTION
I. CALL TO ORDER	After noting that the required members were present to constitute a quorum, the regularly scheduled Medical Staff Committee Meeting was called to order at 1206 by Dr. Richert, MD Vice Chief Medical Officer.	
II. CONSENT AGENDA ITEMS	1. The following Minutes were reviewed: A. Medical Staff Committee Meeting of April 29, 2026.	Minutes approved by motion, second, and vote. Forward to Governing Board.
	1. The following Committee Reports were reviewed with no corrections or additions noted: A. Infection Control Committee Meeting Minutes, 04/23/2026. B. Patient Safety/Safe Lifting Committee Meeting Minutes, 05/20/2026.	Minutes approved by motion, second, and vote. Forward to Governing Board.
III. PATHOLOGY REPORT	Review of Report, 02/05/2026 & 03/01/2026	Report at next meeting
IV. VICE CHIEF MEDICAL OFFICER REPORT	Currently, in the Alturas Clinic, we are losing Wendy Richardson for the same-day Clinic, but we will have a replacement for her soon. At our last Providers Meeting, we discussed different possibilities for hiring more Providers. Overall, more to come.	Report at next meeting
V. EMERGENCY ROOM	Currently, there are still a lot of things that automatically come up when we're ordering	Report at next meeting

SUBJECT	DISCUSSION	ACTION
REPORT (DR. APPEL, MD)	medications that come up as 'Daily' or 'BID', so if you are not careful, then some of our Nurses have orders that they're having to sit there and manually change everything and we are wondering if there is anyway with common medications there could be more options to have. For the most part, it just comes up once, but with common medications like Ibuprofen or Prednisone or other common ones we use, it seems like it just keeps coming up as multiple day things. Another thing is before Chantel's passing; she mentioned the idea of turning the first 4 beds closest to the ER to like an observation unit for the ER, so we are putting out the idea to proceed with this and function as such.	
VI. CEO REPORT	Currently, the Cardiology contracts are going to go to the board for approval this week so Dr. Rowan will be seeing patients soon, in the next couple of months, I hope. Too, we are working on getting some equipment and software that will make their lives easier so now we are just looking for space to put it. Will likely be looking for another Echo Sonographer to hire as well with the new equipment since Heather is backed out about a month so more to come on all that. Also, we have got 2 Laparoscopic Surgeons that are in the process of coming on board. One has reviewed his contract and is good with it and the other is currently reviewing so hopefully by June the contracts will be good to go to the board and be approved so we can get a couple more on board to start doing procedures here as well. The Clinic Building Expansion is still being worked on. I did throw a curve ball as I want to add an Outpatient Geriatric Behavioral Health service out of the Clinic so they are going to try to find space for 3 offices and a group counseling area in addition to what we previously talked out so that will probably be the next mockup that we review. Additionally, we are not going to build everything with loans anymore. Everything else that we add onto this building will be cash basis. So, after the final full scale construction drawings are done, we will evaluate if we can afford it and if so, we will start the construction and if not, we will pause and wait till we can. We want the Clinic expansion to happen first and then down the road, the construction of the MRI Building. Provider Recruitment, we may have	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	found a Skilled Nursing Facility FNP, so Denise is trying to get a site visit scheduled. Other than that, we are still looking for Providers everywhere else. Security Incident Update, MOXFIVE is still sifting through the data, so there is no update on that. Loan Update, the ERAC Grant with the USDA, the USDA is going to pay us around $150,000 - $1,000,000 grant to reimburse us for HVAC Equipment and stuff so that should be coming in the next week or two. Geothermal Brand is up 4:2, just had another monthly meeting with those guys. Just as a refresher, that is a $1.5 million dollar grant that we were given to help transition one of the production wells that the school owns to an injection well so that we can gain capacity this winter. When the Skilled Nursing Facility came online, that system, we could not inject enough water to keep that system functioning so, our pumps, the school's pumps, and the pool's pumps, they were all sucking too much air as a result. The only other things I have on my plate is I have wage analysis that I just received from Amber so we are in the process of revealing our pay compared to other regional Providers and make sure that we are competitive enough so I think this will take us around 3 to 4 weeks to complete that. Overall, more to come.	
VII. CNO/SNF REPORT	Currently, I am working with the Lab to figure out some issues Dr. Richert is facing. Apparently, he does not see labs when they're in the Skilled Nursing side. I found out that when we put in an order for a future order like Radiology, someone must send it to their portal, it doesn't automatically go. So, we must grab it and push it to them so they can see it. Also, we did look at the ER Doctors wanting a Telemonitor. They wanted one in the hallway and one in the office so we figured we would put one in the office, a 42-inch screen in the office. It costs about $1,000 if maintenance does it. Our falls have improved this month. We went from 15 to 9. I still think the bigness of the facilities is starting to weigh on everybody. Our WanderGuard got fixed as of today so hopefully it works like it did. We are currently testing it, so more to come.	Report at next meeting
VIII. PHARMACY REPORT	Currently, the Pharmacies are moving along. I will be short staffed for a little bit. We are looking at a	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	NewMed Power System for the SNF with board approval. It is a different way of preparing medications for the whole month so we'd put them on a cycle, but instead of bubble packs we would use Med. Pouches that have their medications for say morning and evening, dated and the time for when you are supposed to take it. It would really simplify the Skilled Nursing Facility, Nurse's job and honestly for patients in the community that are more elderly that are dealing with the pill bottles. Also, you can program the Med. Pouches to however you want them to be set up for the patient as well. Overall, it does provide great service, but the bad thing is there are not a lot of financial incentives that come with it. We also have 9 temperature sensing monitors that we've installed in all the refrigerators in the Pharmacy. Basically, listing in real time, it senses the temperature of the air in the refrigerator, and it has this AI system where it kind of knows when to alert somebody at all times. It is very user friendly and now, the Pharmacy is being the tester for how it functions. Too, we are looking into the data for it. Lastly, we have sent some offers for 2 different Pharmacists for 2 positions to fill so hoping we get those filled soon. For the time being, you will see me at both places till we figure things out. Overall, more to come.	
IX. RISK MANAGEMENT REPORT (ALICIA DOSS)	Nothing to Report.	
NEW BUSINESS X. POLICY REVIEW & APPROVAL	The following New Business was presented for review/approval: 1. Updated Policies, May 2026 (13)	After review and discussion, a recommendation was made to implement the Updated Policies (13) presented May 2026. The recommendations were ratified by motion, second, and vote. Recommendations will be forwarded to the Governing Board for final approval.
XI. ADJOURNMENT	The meeting was adjourned at 1317.	

Lisanne Burkholder, MD Chief Medical Officer

05/27/2026
Date

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

PATHOLOGIST ON-SITE VISIT REPORT
DATE OF VISIT: 3.28.2026 – 3.29.2026

During the pathology on-site visit, I spent approximately 9-9½ hours in the Laboratory, Medical Records, and at Canby Clinic.

While in medical records, I reviewed 13 surgical path reports and compared them with their clinical histories, 3 blood transfusions, and 3 mortality reports. There were no issues identified with any of the reports.

While in the laboratory, I spoke with Walter concerning the laboratory and staffing. The staff is continuing to perform well, and everyone seems to be getting along forming a coherent family unit. The vitros machine was being overhauled while I was here, as there have been some minor issues with testing modules. In addition, I signed the verification for the statistics for bringing in the new molecular instrument for detecting several of the very common infectious agents. The new molecular testing is for agents such as the Flu etc. Because of the computer issues in January and February, I reviewed laboratory test and QC results from these months. I reviewed the siemens hemostasis QAP program, the monthly quality control review summary. The QC for Glucose monitors Sysmex insight data for the XN-550 analyzer (11.19.2025 – 2.24.2026). The Sysmex insight data on the XN-550 lot number 5319 for 11.19.2025 - 2.24.2026 and the vitros statical data from January 1.26.2026 – 1.31.2026. For the month of February, I examined the chemistry data for all critical results. The Alcor group coordinator report. The siemens hemostasis QAP program. The UA Quantrell levels 1 and 2 for the multistix test system. The quality control for the XN-L instrument. The QC report for glucose monitoring. The monthly quality control review summary. The statical data for the vitros machine.

I Spoke with Dr. Kappen in the emergency room and he indicated there were no issues with the laboratory and thought that the staff performed very well.

I spoke with Kevin Kramer about the laboratory. We discussed the new Gene Xpert (cepheid) analyzer that will be coming online shortly to identify infectious agents. We also discussed the vitros and how it's being overhauled and hopefully that will take care of some of the problems in the recent past. We spoke briefly about the staffing and the moral in the laboratory and how the staff is happy with their working conditions and their associates they work with.

ROBERT JAMES, MD, PhD
CONSULTING PATHOLOGIST

6/5/26
Date

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

PATHOLOGIST ON-SITE VISIT REPORT
DATE OF VISIT: 4/30/2026 – 5/1/2026

During the pathology on-site visit, I spent approximately 8 hours in the Laboratory, Medical Records, and at Canby Clinic.

While in medical records, I reviewed the remaining surgical path reports, mortality reports and transfusion for the month of January and February. For January I reviewed 8 surgical path reports and compared with the clinical history's, 1 transfusion report and 2 mortality reports. There were no issues identified in these reports. For February there were 8 pathology reports correlated with clinical history. There was one mortality report. There were no issues with any of these reports.

While in the laboratory, I spoke with Walter concerning the laboratory and staffing. The vitros analyzer was overhauled today and the maintenance was completed during my visit. I signed off on the documents that included the gene expert testing for chlamydia trigonous gonorrhea Covid / flu / RSV Streptococcus A and MRSA MVP (multi plex vaginal panel for women's health) MTB (is Mycobacterium tuberculosis) w / risampicin resistant. The 2026 hemostasis / coagulation verification first event. The API (American proficiency institute) 2026 immunology / hematology first event. The API (American proficiency institute) 2026 chemistry core verification first event. The API (American proficiency institute) 2026 chemistry / miscellaneous - first event. The API (American proficiency institute) 2025 hematology / coagulation – third event. The API (American proficiency institute) 2026 microbiology – first event. The API (American proficiency institute) 2026 hematology / coagulation first event. The 6th month linier and range verification studies for the vitros. The creatinine verification summary on the nova biomedical instrument for August 2025. The quality control data for the XN – LX instrument. The QC for March XN – 550 instruments. The QC results for March glucose testing. The monthly cordially control review summary for March 2026. The UA Quantrell level 1 and level 2 documentation. the March Istat monthly CG4 plus calibration verification. March 2026 Istat 6th month KM 8 plus calibration verification. The memo concerning the MQUAL QC for one day on the vitros. New QC log verification worksheet for vitros. Modoc Medical Center Laboratory Coagulation PT verification. Summary of all exception reports concerning chemistry values. The Alcor group coordinator reports on the Minni SED-291 instrument. The siemens hemostasis QAP program data. And the QC statistics report for March for the vitros.

I spoke with Dr Kappen in the emergency room concerning the satisfaction of the laboratory. He indicated there were no issues and he was happy with the level of support the laboratory provides to the Emergency Room.

I spoke with Kevin Kramer about the students' coming to the hospital and visiting the laboratory, and what they should be exposed to in regards to the way the laboratory performs.

Robert James 6/5/26
ROBERT JAMES, MD, PhD Date
CONSULTING PATHOLOGIST

ATTACHMENT D

Policy and Procedures

MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

MEMORANDUM

DATE: 7/30/2026
TO: Last Frontier Healthcare District Board of Directors
FROM: Policy Committee
SUBJECT: **Review of Departmental Policies and Yearly Memo/Signature Page**

The following information regarding Departmental Policies is submitted for your review:

Review of Departmental Policies (see attached):

SURGERY/OPERATING ROOM

7420.26 EGD and Colonoscopy Policy
7420.26 OR Personnel Policy Procedure Before the Patient Enters the OR

SKILLED NURSING FACILITIES

6580.26 Skin Care Policy
6580.26 Admission Nursing Assessment
6580.26 Change in Resident Status
6580.26 Advanced Health Care Directive
6580.26 Body assessment Protocol

DIETARY ACUTE

8345.26 Cleaning Instructions for Cloths, Pads, Mops and Buckets
8345.26 Available Diets

AMBULANCE

7041.26 Ambulance Dispatching Page System
7041.26 Ambulance Operations

EMERGENCY DEPARTMENT

7010.26 Infusion Pumps Inspection, Care and Maintenance Policy
7010.26 Emergency Department Diversion Policy and Procedure
7010.26 Hand Off Communication Policy and Procedure

Review of Departmental Policies (continued):

7010.26 Do Not Resuscitate Policy and Procedure
7010.26 Education of Patient and Family Policy and Procedure
7010.26 Epistaxis Standard of Care Policy and Procedure
7010.26 Care of Latex Sensitive Patient Policy and Procedure
7010.26 Coroner Notification Policy and Procedure
7010.26 Emergency Department Automated Dispensing Cabinet Omnicell
7010.26 Mandated Reporting of Decubitus Ulcers Policy and Procedure
7010.26 Lumbar Puncture Assisting with Procedure Policy and Procedure Documentation
7010.26 Endotracheal Tube Placement Confirmation Policy and Procedure Documentation
7010.26 Eye Emergency Standard of Care
7010.26 Emergency Department Log Maintenance Policy and Procedure
7010.26 Hypothermia Standard of Care Policy and Procedure
7010.26 Medication Labeling Policy and Procedure
7010.26 Burn Patient Standard of Care Policy and Procedure
7010.26 Hemoccult Testing Policy and Procedure
7010.26 Head Injury Standard of Care Policy and Procedure
7010.26 Cervical Spine Immobilization
7010.26 Intravenous Access for Radiological Procedure Policy and Procedure
7010.26 Diarrhea Standard of Care
7010.26 Infection Control Standard in the Emergency Department
7010.26 Intraosseous Access Policy and Procedure
7010.26 Discharge Instructions Policy and Procedure
7010.26 Medication Errors Policy and Procedure
7010.26 Dying Patient-Standard of Care Policy and Procedure
7010.26 Chest Pain-Standard of Care Policy and Procedure
7010.26 Visitors in the Emergency Department Policy

NURSING MED/SURG

6170.26 Bedside Commode Use Policy and Procedure
6170.26 Bed Making Procedure for Inpatient Care

Review of Department Yearly Manual Memo and Yearly Signature Page (see attached)

HUMAN RESOURCES/ORIENTATION

Memorandum
Annual Review Signature Page

INFUSON DEPARTMENT

Memorandum
Annual Review Signature Page

Yearly Manual Memo and Yearly Signature Page (continued)

EMTALA
Memorandum
Annual Review Signature Page

OPRATING ROOM/SURGERY
Memorandum
Annual Review Signature Page

CENTRAL SUPPLY
Memorandum
Annual Review Signature Page

INFECTION CONTROL/ACUTE
Memorandum
Annual Review Signature Page

RETAIL PHARMACY
Memorandum
Annual Review Signature Page

HOSPITAL PHARMACY
Memorandum
Annual Review Signature Page

SNF PHARMACY
Memorandum
Annual Review Signature Page

To complete approval of the above-listed Policies, please sign and date where indicated on the attached Excell Spreadsheet.

Thank you for your time and attention to the above.

Respectfully submitted:

Sandra A. Brown
Administrative Assistant to CNO
1111 N. Nagle Street
Alturas, CA 96101
(530) 708-8808
Enc.

OPRATING ROOM/SURGERY

REFERENCE #	7420.26	EFFECTIVE: 04/2009
SUBJECT:	7420.26 ESOPHAGOGASTRODUODENOSCOPY (EGD) AND COLONOSCOPY POLICY	REVISED: 05/2026
DEPARTMENT:	OPERATING ROOM	

PURPOSE:
The purpose of this policy is to establish guidelines for the treatment of patients that are admitted to the Out-patient Surgery Department for the purposes of Endoscopy procedures.

AUDIENCE:
Department Wide

TERMS/DEFINITION:

None

POLICY:
It is the policy of Modoc Medical Center (MMC) to provide instructions for admitting patients to the Surgery Department for the purpose of Endoscopy procedures.

PROCEDURE:
Peri-operative nurse:

- Ensure that the patient is admitted as an Out-patient, unless otherwise ordered.
- Complete the designated assessments on the Electronic Medical Record (EMR).
- Activate the surgery endoscopy order set.
- Complete the appropriate consents.
- Document all IV fluids, treatments, medications and pre-operative procedures (i.e., Electrocardiogram, EKG, labs, vitals).

Surgical Scrub Technicians (ST):

- Set up the Endoscopy supplies.
- Turn on the Endoscopy Tower.
- Turn on the Carbon Dioxide (C02) and make sure there is a sufficient amount for the day's procedures.
- Choose the correct endoscope to be used.
- Run the diagnostic cycle on the reprocessor.

Anesthesia Provider:

- Complete the Anesthesia Pre-operative Assessment.
- Review any labs and-EKG's performed.
- Document all medications administered during the procedure in the-EMR and on the anesthesia record.
- Follow all guidelines for safe sedation.
- If no anesthesia provider is present during the procedure, the medications for sedation must be administered by a Registered Nurse that has experience and is competent to do so.

During and After the Procedure:

- Any biopsies taken will be documented in the EMR by the RN. An order for pathology will also be initiated in the EMR by the RN.
- Biopsies must be labeled with the patient's name, date of birth, surgeon name, patient medical record number, and the time the biopsy was received.
- Biopsies will be taken to the laboratory with a pathology form, face sheet, and surgeon's operative note after the procedure is done.
- At the end of the procedure, the scrub technicians are responsible for cleaning the area and setting it up for the next case.
- The ST also cleans the scope at the point of care and then takes it to the reprocessing area for further cleaning.
- The patient is taken to the PACU after the procedure for further monitoring.
- The patient can be discharged per the anesthesia provider and surgeon when the patient is stable.
- All patients that had sedation must have a designated driver and be instructed not to drive or operate motorized vehicles for 24 hours.

REFERENCES:

None

ATTACHMENTS:

None

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	~~OR PERSONNEL POLICY-PROCEDURE BEFORE THE PATIENT ENTERS THE OPERATING ROOM OR PROCEDURE ROOM~~7420.26 OR PERSONNEL POLICY-PROCEDURE BEFORE THE PATIENT ENTERS THE OPERATING ROOM OR PROCEDURE ROOM	REVISED 05/2026
DEPARTMENT:	OPERATING ROOM ~~OPERATATING ROOM~~	

PURPOSE:
The purpose of this policy is to provide a checklist of tasks that must be completed before the patient enters the ~~O~~operating ~~R~~room (OR) or the ~~P~~procedure ~~R~~room.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
~~Operating Room—OR~~
~~Registered Nurse—RN~~
None

POLICY:
It is the policy of Modoc Medical Center (MMC) that each patient entering the ~~O~~operating ~~R~~rooms will have the following tasks completed with appropriate documentation.

PROCEDURE:

~~•~~ Check with the Pre-operative Registered Nurse (RN) to see that the patient pre-op care is completed and all documentation is done.

- Check the chart for the following:
  - The Conditions of Admission form is signed.
  - The Informed Surgical Consent and the Informed Consent for Anesthesia are signed.
  - Any additional consents such as Elective Sterilization, Hysterectomy, etc.
- Always check identification with 2 identifiers, verifying name and date of birth.
- Patients are not to come to the ~~O~~operating ~~R~~room or ~~P~~procedure ~~R~~room with dentures (unless approved by anesthesia), hair pins, hearing aids, contact lens, wigs, sanitary belts, or jewelry.
- Pajama bottoms must be removed unless otherwise noted and a hospital gown worn.
- No wool or synthetic materials are allowed in the OR.
- Remove the patient's underwear.
- When transporting the patient via a gurney, the gurney rails must be in the up position.
- Two people must accompany the patient to the OR or ~~P~~procedure room.
- If other non-staff persons are in the OR or the ~~P~~procedure ~~R~~room, a consent for an observer must be on the chart and signed by the appropriate parties.

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	~~OR PERSONNEL POLICY-PROCEDURE BEFORE THE PATIENT ENTERS THE OPERATING ROOM OR PROCEDURE ROOM7420.26 OR PERSONNEL POLICY-PROCEDURE~~ BEFORE THE PATIENT ENTERS THE OPERATING ROOM OR PROCEDURE ROOM	REVISED 05/2026
DEPARTMENT:	~~OPERATING ROOM OPERATATING ROOM~~	

REFERENCES:

None

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ATTACHMENTS:

None

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SNF

REFERENCE #	6580.26	EFFECTIVE 1991
SUBJECT:	6580.26 SKIN CARE ASSESSMENT	REVISED05/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

PURPOSE:

The purpose of this policy is to indicate that all residents are to be assessed for the risk of skin breakdown.

AUDIENCE:

Department Wide

TERMS AND DEFINITIONS:

None

POLICY:

It is the policy of Warnerview and Mountain View Skilled Nursing Facilitiesy that all staff will be aware of residents at risk for skin breakdown by completing an assessment form. The facilities will ensure that a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable.

PROCEDURE:

The Nurse Manager/Nurse Supervisor or designee will:

Assess the resident's skin on day one of admission and immediately implement care planning for any resident at risk for pressure ulcers.

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Complete a comprehensive head to toe assessment of the resident's skin with each scheduled assessment and with any significant change of condition, that includes evaluating Risk Factors such as:

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- Bad positioning in a chair
- Bad positioning of braces, casts, or other devices
- Contractures
- Dementia
- Diseases such as dDiabetes or rRenal failure
- Drugs like steroids that impair wound healing
- Excessive moisture on skin
- Friction and shearing
- History of skin breakdown
- Ill-fitting shoes
- Impaired blood flow
- Impaired mobility
- Incontinence
- Nutrition or hydration deficit
- Peripheral vascular disease

REFERENCE #	6580.26	EFFECTIVE 1991
SUBJECT:	6580.26 SKIN CARE ASSESSMENT	
DEPARTMENT:	SKILLED NURSING FACILITIES	REVISED05/2026

- Remaining too long in one position
- Restraint
- Skin desensitized to pain or pressure

The Unit Nurse will:

Provide measures to decrease pressure/irritation to skin: fleece pad, egg crate mattress, heel protectors.

Administer treatments and dressing as ordered.

Complete head to toe skin inspection as scheduled.Purpl

Supervise Certified Nursing Assistants (CNA) to ensure that each resident's monthly summary, with every skin inspection, treatment or dressing change:

- Status of the resident's skin
- Condition of each area of skin breakdown, including:
  - Measurement
  - Width
  - Length
  - Depth
  - Type of tissue
  - Exudate

Staff members will identify and report Sign of Skin Breakdown, such as:

- Purple or dark area
- Edema
- Hardening of skin (induration)
- Redness (erythema)
- Bogginess

Nursing Assistants will:

- Keep skin clean and dry.
- Change incontinent pad ASAP after voiding or bowel movement.
- Apply protective or barrier lotion after incontinence.
- Avoid hot water and irritating soaps.
- Keep bed linen clean, dry, and free of wrinkles.
- Assist resident to turn and reposition every two hours.
- Position with pads and cushions to prevent pressure.
- Use a draw sheet or lifting device to move resident.
- Inspect skin daily with ~~and~~ care and bathing, and report any changes to charge nurse

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REFERENCE #	6580.26	EFFECTIVE 1991
SUBJECT:	6580.26 SKIN CARE ASSESSMENT	REVISED05/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

~~1. The skin assessment form is a tool to identify any resident at risk to develop pressure areas by assessing for seven clinical condition parameters and assigning a score.~~

~~2. On admission and yearly thereafter, the form will be completed and placed in the medical record.~~

~~3. A resident with a score greater than eight (8) will be considered at risk for developing pressure areas and an appropriate plan will be developed.~~

~~4. A resident with a score greater than twenty (20), will be considered at high risk for pressure areas and aggressive measures will be taken to prevent any skin breakdown.~~

~~See skin/decubitus section for further policies and procedures.~~

REFERENCES:

None

ATTACHMENTS:

None

~~5.~~

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REFERENCE #	6580.26	EFFECTIVE 1998
SUBJECT:	6580.26 ADMISSION NURSING ASSESSMENT	REVISED 5/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

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PURPOSE

The purpose of this policy is to ensure that all nurses are familiar with the process of assessing a new resident upon admission to the facility.

AUDIENCE

Department Wide

TERMS AND DEFINITIONS

None

POLICY

It is the policy of Modoc Medical Center (MMC) to document an in-depth assessment of each resident upon admission to the facility.

PROCEDURE

All licensed nursing staff shall be knowledgeable about the admission assessment and shall abide by the procedure in order to promote quality care planning. Admission assessments are completed within eight (8) hours of admission. The resident, the family, caregiver or conservator and the resident's old medical records may be used in the ~~assessment~~assessment of data collection.

1. Review the resident's previous records, transfer information, and/or current chart, if the resident is ~~a~~ transferred from the acute section of the facility, prior to interviewing and assessing the resident and/or family.
2. Complete portions of the assessment form, from the transfer records, as able.
3. Explain to the resident/family the purpose of the assessment, (i.e., to gather information to better plan their care), the length of time it may take and the need for their participation.
4. Conduct a head-to-toe physical examination of the new resident, including a skin exam of high risk areas like heals and sacrum, under the breast and pannus and document findings in the appropriate sections of the form. Use the body graph to mark problem areas and describe in depth.
5. Assess the resident's mental status and psychological/social status. Ask questions regarding knowledge of their health problems, discharge plan, family involvement, etc., ~~-~~and complete appropriate sections.
6. Obtain a history of the resident's current physical healthcare problems and concerns from the resident/family or previous caregivers and complete the physical assessment portion of the form.
7. Obtain and record vital signs, height, and weight.

REFERENCE #	6580.26	EFFECTIVE 1998
SUBJECT:	6580.26 ADMISSION NURSING ASSESSMENT	REVISED 5/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

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8. Obtain a history of the resident's Activities of Daily Living (ADL) status by asking questions regarding sleep, diet, mobility, hygiene, and bathing. Summarize problem areas and sign form.

9. The bowel and bladder functions on the form should be started on admission and completed as much as possible within the first eight (8) hours.

10. The record of the completed evaluation is required to be completed within 24 hours. ~~two (2) weeks after admission.~~

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REFERENCES

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None

ATTACHMENTS

None

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~~10.~~

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REFERENCE #	6580.26	EFFECTIVE 1993	
SUBJECT:	6580.26 CHANGE IN RESIDENT STATUS	REVISED 05/2026	
DEPARTMENT:	SKILLED NURSING FACILITIES		

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PURPOSE

The purpose of this policy is to provide guidelines to staff regarding change of status ~~of~~for a Skilled Nursing Facility (SNF) resident.

AUDIENCE

Department Wide

TERMS AND DEFINITIONS

None

POLICY

It is the policy of Warnerview and Mountain View SNF that all designated persons will be notified of changes in the resident's status either medically or financially as soon as possible after nursing service or administration is aware of the change.

PROCEDURE

- Medical Changes
    - Any sudden or serious change in a resident's condition or established pattern of physical or mental behavior or any accident shall be reported to the attending physician by the charge nurse. The charge nurse should communicate all signs and symptoms to the physician and may request a physician visit if needed.
    - The responsible party of the resident will be notified that there has been a change in the resident's condition and that the physician has been notified. Any accidents or falls shall also be reported to the resident's responsible party.
    - Other than in the case of a medical emergency, treatment will not be altered in a radical manner, nor will a resident be transferred or discharged without consultation with the resident's next of kin or responsible party.
    - For ~~R~~residents needing IV therapy for a new acute process, the ~~ignition~~initiation of IV medications, blood transfusion, or cardiac monitoring, the resident should generally be evaluated in acute care (ER, Observation or Acute in-patient). If the patient needs to be transferred to another acute care facility or any location other than Modoc Medical Center, ~~then~~ this should generally be done through the Emergency Room. If a patient becomes acutely ill and the family/resident requests acute interventions, the resident should be transferred to an acute status for further evaluation and treatment.

REFERENCE #	6580.26	EFFECTIVE 1993
SUBJECT:	6580.26 CHANGE IN RESIDENT STATUS	REVISED 05/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

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- Any accident or unusual occurrence resulting in a significant injury to the resident (such as burns, fractures, extensive lacerations, etc.) must be reported to nursing administration for investigation and appropriate follow-up of the incident.

- Financial Change
  - Notification of changes in charges or billing procedures will be given to the resident and/or responsible party. The resident or responsible party will be notified of Medicarte denials at least one day prior to denial.
  - The Administrator or designee is responsible for all notifications pertaining to financial or administrative procedures.

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REFERENCES

None

ATTACHMENTS

None

REFERENCE #	6580.26	EFFECTIVE: 09/2006
SUBJECT:	6580.26 ADVANCED HEALTH CARE DIRECTIVE	REVISED: 05/2026
DEPARTMENT:	SKILLED NURSING FACILITY	

PURPOSE:

It is the purpose of this policy to ~~To~~ ensure residents of the Skilled Nursing Facility (SNF) are informed of, supported in, and able to exercise their rights regarding advanced health care decisions in accordance with California ~~l~~law, federal regulations, resident rights requirements, and facility standards of care.

AUDIENCE:
Department Wide

TERMS/DEFINITION:

Advance Health Care Directive (AHCD) – A written instruction regarding medical treatment or designation of health care agent to make decisions if the individual becomes incapable of making decisions. This may include:

- Durable Power of Attorney for Health Care (DPOA)
- Individual Health Care Instruction
- Physician Order for Life Sustaining Treatment (POLST)
- Do Not Resuscitate (DNR) order
- Request to Forego Resuscitative Measures

Health Care Agent – An individual designated by the resident to make health care decisions on the resident's behalf if the resident lacks capacity.

Capacity – The ability to understand the nature and consequences of proposed health care decisions and to make and communicate informed decisions.

POLST – Physician Orders for Life-Sustaining Treatment signed by a physician or authorized provider and the resident or legally recognized decision-maker.

POLICY:

It is the policy of Modoc Medical Center that ~~T~~the facility shall recognize and honor a resident's right to make health care decisions, including the right to accept or refuse medical treatment and the right to formulate an advance health care directive. The facility shall not condition admission, treatment, or continued stay on whether a resident has executed an advance directive. The facility shall maintain written policies and procedures regarding advanced directives and shall provide information to residents upon admission and when requested.

PROCEDURE:

1. **Admission Requirements**

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Upon admission, the facility shall:

- Inform the resident orally and in writing of:
  - The right to make health care decisions
  - The right to accept or refuse treatment
  - The right to formulate an advanced directive
  - Facility policies regarding advance directives
- Determine whether the resident has:
  - An Advance Health Care Directive
  - POLST
  - DNR order
  - Conservatorship documents
  - ~~Durable Power of Attorney~~ DPOA for Health Care
- Request copies of all applicable documents
- Document in the medical record
  - Whether an advanced directive exists
  - Type of directive
  - Location of original document
  - Contact information for the health care agent
  - Ensure documents are readily accessible in the medical record
  - Provide assistance in obtaining information regarding advance directives if requested.

2. Resident Rights

Residents have the right to:

- Participate in care planning
- Refuse medical treatment
- Modify or revoke advanced directives
- Designate a decision-maker
- Receive information in a language they understand
- Be free from discrimination related to advance directive decisions

3. POLST and DNR Orders

- POLST forms shall:
  - Be signed by an authorized provider and resident or representative
  - Be reviewed upon admission, significant condition change, transfer, and quarterly review
- DNR orders must:
  - Be signed by an authorized physician
  - Be clearly documented in the medical record
  - Be communicated to nursing and emergency personnel
- Staff shall honor valid POLST and DNR orders consistent with state law and facility procedures.

4. Changes or Revocation

Residents with decision-making capacity may revoke or modify advance directives at any time. The facility shall:

- Immediately update the medical record
- Notify appropriate staff and providers
- Replace outdated forms
- Document the date and nature of the change

5. Incapacitated Residents

When a resident lacks capacity:

- The designated health care agent or legally authorized representative shall participate in decision-making consistent with the resident's known wishes and best interests.
- Staff shall verify authority prior to implementing decisions.

6. Medical Record Documentation

Documentation shall include:

- Presence or absence of advance directives
- Copies of applicable forms
- Discussions with resident/family
- Changes or revocations
- Physician notification when applicable

7. Transfers and Emergencies

Copies of applicable POLST, DNR, or advance directive documents shall accompany the resident during transfer to another health care setting whenever possible.

REFERENCES:

- ~~California Probate Code §§4600–4806~~
- ~~California Probate Code §4675~~
- ~~42 CFR §483.10~~
- ~~42 CFR §489.102~~
- ~~California Code of Regulations, Title 22 §72527~~

ATTACHMENTS:

None

REFERENCE #	6580.26	EFFECTIVE 1997
SUBJECT:	6580.26 BODY ASSESSMENT PROTOCOL	REVISED 5/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

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PURPOSE

The purpose of this policy is to ensure monitoring of the resident's skin status on an ongoing basis and to initiate skin care management to improve outcomes.

AUDIENCE

Department Wide

TERMS AND DEFINITIONS

None

POLICY

It is the policy of Warnerview and Mountain View Skilled Nursing Facilitiesy to monitor the resident's skin status on an ongoing basis. The primary purpose of the monitoring is to develop a system for expected resident outcomes as it relates to skin care management.

PROCEDURE

1. The certified nursing assistant will check and document the skin status of non-ambulatory residents every shift and twice weekly for ambulatory residents.
2. Any sign of skin abnormalities will be reported to the licensed nurse for follow up.
3. The licensed nurse will perform a weekly skin check on all non-ambulatory residents and document the findings on the weekly summary.
4. The licensed nurse will notify the physician, and the resident (or legal representative) of any abnormal findings.
5. Treatment and the care plan will be initiated in the event the status of the skin ~~has changed~~changes.
6. The weekly body checklist will be routed to the Director of Nursing.

REFERENCES

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None

ATTACHMENTS

None

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REFERENCE #	6580.26	EFFECTIVE 1997
SUBJECT:	6580.26 BODY ASSESSMENT PROTOCOL	
DEPARTMENT:	SKILLED NURSING FACILITIES	REVISED 5/2026

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DIETARY ACUTE

REFERENCE #	8345.26	EFFECTIVE 9/2020
SUBJECT:	8345.26 CLEANING INSTRUCTIONS FOR CLOTHS, PADS, MOPS AND BUCKETS	REVISED 5/12/2026
DEPARTMENT:	DIETARY - ACUTE	

PURPOSE

The purpose of this policy is to provide clean and sanitary cloths, pads, ~~mops~~mops, and buckets.

AUDIENCE

Department Wide

TERMS AND DEFINITIONS

None

POLICY

It is the policy of Modoc Medical Center's (MMC's) Acute Dietary Department that cleaning tools (cloths, pads, mops, and buckets) be maintained in clean, fresh and odor-free ~~condition~~conditions.

PROCEDURE

- Cleaning cloths and pads will be washed by the Laundry Department.
  - Cleaning cloths will be kept in container of clean sanitizing solution between uses.
  - The sanitizing solution will be tested daily to ensure that it maintains the correct concentration.
- Mops will be rinsed thoroughly after each use in fresh, hot water to which a sanitizer has been added. Mops will be washed by the Laundry Department. Fresh mop heads will be used each day.
- Mop buckets and wringers will be washed out after each ~~use, and~~use and stored inverted to allow for proper drainage. Mops, ~~wringers~~wringers, and buckets will be stored in an appropriate area away from food and food preparation.
- Mops should be hung inverted between ~~uses, and~~uses and stored separately from food areas.

REFERENCES

1. Dorner, Becky, Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide, Becky Dorner &Associates, Inc., Dunedin, FL 2019.

ATTACHMENTS

~~1.~~ None

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REFERENCE #	8345.26	EFFECTIVE 8/2020
SUBJECT:	8345.26 AVAILABLE DIETS	REVISED 5/2026
DEPARTMENT:	DIETARY - ACUTE	

PURPOSE

The purpose of this policy is to inform the physicians and nursing staff of available diets the facility is able to provide and accommodate.

AUDIENCE

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Department Wide

TERMS/DEFINITIONS

Diet - Is a type and amount of food prescribed for a person to either meet their nutritional needs and/or treat a medical condition.

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~~Is a type and amount of food prescribed for a person to either meet their nutritional needs and/or treat a medical condition.~~

POLICY

It is the policy of Modoc Medical Center's (MMC) that the Acute Dietary Department ~~to provide~~provides a diet/nutrition care manual that outlines diets available for use in our facility.

PROCEDURE

- Diets will be offered as ordered by the physician. The following diets are offered at our facility and may be found in the Diet/Nutrition Care Manual. Any diets ordered that are not available on the menu will be written/clarified and approved by the facility's Registered Dietitian.
  - Regular diet
  - Vegetarian diets and variations
  - High calorie/high protein
  - Fortified
  - Finger foods
  - Low lactose/lactose free
  - Gluten free
  - Fluid restrictions
  - Protein restrictions

- Clear/full liquid
- Diabetic/45g CCHO, 60g CCHO
- Sodium restricted diets i.e., no added salt & 2 gm Na
- Low fat
- Heart healthy (cardiac)
- Bland
- Renal 60g
- In addition to these diets, the facility will accommodate texture modifications ordered by the physician/IDDSI.

- ~~In an effort to~~To individualize therapeutic diet orders, secondary diet orders may be offered and can be combined with the main diet order to achieve desired results. The following secondary diets are offered:

~~IDDSI~~

REFERENCES

None

ATTACHMENTS

None

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REFERENCE #	8345.26	EFFECTIVE 8/2020
SUBJECT:	8345.26 AVAILABLE DIETS	REVISED 5/2026
DEPARTMENT:	DIETARY - ACUTE	

AMBULANCE

REFERENCE #	7041.26	EFFECTIVE 1998
SUBJECT:	7041.26 AMBULANCE DISPATCHING PAGING USE	REVISED 6/2026
DEPARTMENT:	AMBULANCE	

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PURPOSE

The purpose of this policy is to facilitate rapid notification by 911 to on-call personnel, ambulance, and hospital staff on a 24-hour basis.

AUDIENCE

Department Wide

TERMS AND DEFINITIONS

None

PROCEDURE

It is the policy of Modoc Medical Center (MMC) to have guidelines in place for the proper use of the ambulance dispatching/pager system ~~use~~. Those guidelines are outlined below.

Equipment

The system consists of:

- A microphone radio that the emergency room can talk with the ambulance crew on.
- A direct phone call to nurses' station (530) 708-8800, or the recorded line (530) 233-6763
- A pocket pager unit that is used by all on-call personnel of the ambulance department.

911 Calls Requesting an Ambulance

1. All ambulance calls will be dispatched by the Sheriff's Office.
2. The 911 ambulance dispatch calls from the MCSO can be heard at MMC Nurse's station and on the pagers that the on-call personnel wear. All pertinent information will be given when paged for an ambulance run, i.e. Location, medical emergency, and time dispatched.

Private calls received by MMC requesting an ambulance

1. Emergency

    ~~2.~~a. If an MMC employee receives a call requesting an ambulance, the person receiving the call will gather information and stay on the line with the caller while a second employee will call the Modoc County Sheriff's office dispatch and relay the caller information.

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~~3.~~2. Non-emergency

REFERENCE #	7041.26	EFFECTIVE 1998
SUBJECT:	7041.26 AMBULANCE DISPATCHING PAGING USE	
DEPARTMENT:	AMBULANCE	REVISED 6/2026

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a. The on-duty personnel will be contacted if there is an interfacility transfer or airport transfer.

Paging the Ambulance crew

a. All page outs will be done through the Sheriff's Office, recorded in the Computer Aided Dispatch system which includes all radio communications with the hospital and Sheriff's Office.

On-Call Personnel

1. On-call staff members shall check that pager batteries are charged and in good working condition before use.
2. The pager must be on and in the possession of on-call personnel during their shift.
3. It will be the ambulance personanel's responsibility to notify the Sheriff Office:
   a. When the ambulance leaves to respond to the call
   b. When arriving on scene
   c. When leaving the scene
   d. When arriving at the hospital
   e. When back in service and available.
   ~~e.~~

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REFERENCES

None

ATTACHMENTS

None

REFERENCE #	7041.26	EFFECTIVE 4/1995
SUBJECT:	7041.26 AMBULANCE OPERATIONS	REVISED 6/1/2026
DEPARTMENT:	AMBULANCE	

PURPOSE:

The purpose of this policy is to ensure that ambulance personnel are properly trained in the safe and efficient operation of the ambulance allowing for optimal patient care and expedient transport to an appropriate facility, in accordance with the laws set forth by the State of California.

AUDIENCE:

Department Wide

TERMS/DEFINITIONS:

Code 3- driving with lights and sirens

EMT B- Emergency Medical Technician Basic

EMT A- Emergency Medical Technician Advanced

EMT P- Emergency Medical Technician Paramedic

CCP- Critical Care Paramedic

MICN- Mobil Intensive Care Nurse

POLICY:

It is the policy of Modoc Medical Center (MMC) to adhere to the following ambulance operations:

Ambulance Operations

- Ignition keys will be kept in the vehicle while they are on stand-by or in a garage.
- Ambulances will not serve as escorts at any time.
- Only one family member may accompany the patient in the ambulance, except in the most unusual circumstances, and may only sit in the cab of the ambulance. Exceptions may be made at the discretion of the most senior Emergency Medical Technician (EMT) on the unit.
- No persons, except authorized hospital employees, patients, a family member, and first responders shall ride in the ambulance without written expressed consent of the ambulance supervisor. This policy may be waived in disaster situations only.
- Whenever a patient is in the ambulance, ambulance personnel will ~~be at the patient's side at all times~~always be at the patient's side to provide care as appropriate. Ambulance personnel are defined as currently certified EMT-B, EMT-A, EMT-P, CCP and MICN, who are employed with MMC.

- Each ambulance will respond with a minimum of one certified EMT and one Ambulance Driver employed by MMC whenever answering a call. They will be responsible for the safe and appropriate care of the patient, as well as the safe and efficient operation of the ambulance.
- There will be no smoking in or around the ambulance at any time.
- Seatbelts will be worn by the driver and all passengers at all times, including compartment crew members whenever possible. Patients will be strapped to the gurney as their condition permits.
- The Ambulance Supervisor will be notified immediately of any condition which disables or limits the operation of any vehicle, at which time a backup unit will be placed in service. The ambulance Supervisor will make arrangements for the repair of the disabled vehicle in accordance with usual maintenance procedures.
- Ambulance operation and maintenance ~~is to~~will be in accordance with the California Highway Patrol Ambulance Driver's Handbook, as well as Title 13, California Code of Regulations (Ambulances).
- Code 3 response to a call is indicated whenever any dispatch is made from Modoc County Sheriff office, except when responding to an inter facility transfer or otherwise specified.
- The decision to employ lights and sirens on all runs will be made by highest certified ambulance personnel on board the ambulance. Ambulance personnel will advise both the hospital and dispatch of a code 3 transport.

REFERENCES:

CALIFORNIA CODE OF REGULATIONS: § 1105. Ambulance Driver's Responsibilities.

Title 13. Motor Vehicles

Division 2. Department of the California Highway Patrol

Chapter 5. Special Vehicles

Article 1. Ambulances 1105.

ATTACHMENTS:

None

EMERGENCY

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~INFUSION PUMPS: INSPECTION, CARE AND MAINTENANCE~~7010.26 PUMPS: INSPECTION, CARE AND MAINTENANCE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure all Sigma Spectrum Infusion Pump devices are safe, accurate, clean, and maintained in accordance with manufacturer's recommendations and healthcare facilities standards.

AUDIENCE:
Facility Wide

TERMS/DEFINITION:
None.

POLICY:
It is the policy of Modoc Medical Center (MMC) that a~~A~~ll Sigma Spectrum Infusion Pumps will be inspected before each use, cleaned after each patient use, and undergo preventive maintenance at least annually. Only trained and authorized personnel will operate, inspect, or service the pump. Pumps showing signs of malfunction, physical damage, inaccurate flow rates, or alarm failure will be removed from service immediately and referred to Biomedical Engineering. Preventive maintenance will be completed annually, after any repairs, after being dropped or exposed to fluid intrusion, and whenever performance concerns are reported. Documentation of inspections, cleaning, repairs~~,~~ and preventive maintenance will be maintained.

PROCEDURE:
- Pre-Use Inspection (b~~B~~efore each patient use)
  - Verify pump cleanliness.
  - Inspect power cord, housing/case, keypad and display, intravenous (IV) tubing channel, pole clamp~~,~~ and battery compartment.
  - Ensure labels and calibration stickers are legible.
  - Confirm no cracks, loose parts, or fluid contamination.
  - Power "ON" the pump and verify the self-test completes successfully, audible alarms function~~,~~ and display operates correctly.
  - Check battery charge status.
  - Verify correct drug library/profile if applicable.
  - If any defect is identified: remove the device from service, tag as "Do Not Use," and notify Biomedical Engineering (maintenance).
- Cleaning and Disinfection
  - After each patient use.
  - When visibly soiled.
  - Before preventive maintenance.
  - Turn the pump "Off" prior to cleaning.
  - Disconnect from AC power.
  - Remove the IV tubing.
  - Wipe exterior surfaces using approved disinfectant.
  - Clean tubing channel with lint-free swab.
  - Clean flow sensor carefully using isopropyl alcohol only.
  - Allow surfaces to dry completely before reusing.

- Do Not: immerse pump in liquid, autoclave, spray cleaning fluids directly onto pump, or use abrasive cleaners.

- Preventative Maintenance Procedure
  - Minimum annually or according to manufacturer recommendations.
  - Biomedical checklist includes the following:
    - Visual inspection of the housing integrity, keypad function, connectors and ports, battery contacts~~,~~ and labels and markings.
    - Functional testing includes the power-on self-test, keypad/display test, alarm verification, air-in-line detector test, occlusion pressure test, flow accuracy test, battery runtime/capacity test, and electrical safety test.
    - Calibration: perform flow rate accuracy verification using approved test equipment and manufacturer-compatible tubing.
    - Battery maintenance: recharge fully if low battery indication occurs; replace weak or failed batteries; and check charging operation.
- Storage
  - Store in a clean, dry area.
  - Avoid excessive heat, moisture, and direct sunlight.
  - Do not store below 35 degrees Fahrenheit or above 110 degrees Fahrenheit.
  - Recharge stored pumps every 3 months if unused for extended periods.
- Documentation
  - Maintenance department keeps preventive maintenance records for the Sigma IV pumps.
  - Preventive maintenance records should include the following: inspection date, preventive maintenance completion date, test results, any repairs performed, battery replacement dates and the technician's signature.

REFERENCE:

Baxter Healthcare Corporation. (n.d.). SIGMA Spectrum infusion pump service manual. Retrieved May 7, 2026, from https://manualzz.com/doc/6331870/sigman-spectrum-infusion-pump-service-manual

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~EMERGENCY DEPARTMENT DIVERSION~~7010.26 EMERGENCY DEPARTMENT DIVERSION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish a standardized process for initiating, managing, and terminating Emergency Department (ED) diversion in compliance with federal Emergency Medical Treatment and Labor Act (EMTALA), Centers for Medicare & Medicaid Service requirements and applicable California Emergency Medical Services (EMS) regulations, ensuring patient safety and continuity of emergency care.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Emergency Department Diversion: a temporary status in which the hospital requests that EMS transport patients to alternative facilities due to limited capacity or capability.

Medical Screening Examination (MSE): ~~an~~An examination performed by qualified medical personnel to determine the presence of an emergency medical condition.

Stabilization: provision of medical treatment necessary to ~~assure~~ensure, within reasonable medical probability, that no deterioration occurs.

POLICY:
It is the policy of Modoc Medical Center (MMC) that they may request temporary diversion of ambulance traffic when patient care capacity is exceeded, or resources are insufficient to safely manage additional patients. At no time will the diversion status delay or deny a medical screening exam, stabilizing treatment, or appropriate transfer. Any individual presenting to hospital property will receive care consistent with EMTALA guidelines.

PROCEDURE:
Diversion may be initiated only when all the following conditions exist:

1. The ED or hospital has reached unsafe capacity, including:
    - No treatment spaces available.
    - Critical staffing shortages.
    - Lack of specialty coverage or essential resources.
2. Internal surge capacity measures have been implemented and exhausted.
3. The hospital is temporarily unable to safely provide care for additional patients.
4. Approval is obtained from the ED Medical Director (or designee), and/or the Administrator on~~of~~ Duty.

Initiation of Diversion:

1. Perform real-time assessment of the following:
    - Patient volume and acuity.
    - Staffing levels.
    - Bed availability.
2. Implement internal surge protocols consistent with administrative responsibility for operations.
3. Obtain authorization from appropriate leadership.

4. Document rationale for diversion.

Notification Process (Upon initiation):

1. Notify local EMS –Modoc Ambulance Service.
2. Notify EMS dispatch/base hospital.
3. Update regional communications system.
4. Notify internal departments.

Operations During Diversion:

1. Maintain EMTALA Compliance
   - Provide MSE to all individuals presenting to hospital property.
   - Provide stabilizing treatment as indicated.
   - Accept ambulance patients who arrive despite diversion.
2. Maintain Title 22 Requirements.
   - Maintain emergency services capability.
   - Provide necessary care within hospital capacity.
   - Ensure appropriate transfers when necessary.
3. Accept Patients When:
   - The ambulance arrives at hospital grounds.
   - The patient has an emergency medical condition and requires available services.
   - The hospital has specialized capabilities not available elsewhere.
4. Prohibited Actions:
   - Redirecting or refusing walk-in patients.
   - Delaying care due to diversion status.
   - Using diversion for non-clinical reasons.

Monitoring and Reassessment:

1. Reassess diversion status at minimum every 2 hours or per NorCal requirements.
2. Maintain operational compliance with ongoing administrative oversight.
3. Maintain communication with EMS and regional hospitals.
4. Track operational status and patient safety indicators.

Termination of Diversion:

1. Diversion will be discontinued when:
   - Adequate capacity and staffing are stored.
   - The hospital can safely resume normal operations.
2. Steps for notifications:
   - Notify NorCal and EMS dispatch (Sheriff Department).
   - Regional systems update.
   - Communicate internally.
   - Document termination time and rationale.

Documentation Requirements:

1. Date and time of diversion initiation and termination.
2. Specific reason(s) for diversion initiation.
3. Names/titles of approving personnel.

4. Notifications made (NorCal, EMS, Sheriff Department).
5. Any incidents involving EMS arrivals during diversion.

REFERENCE:

Centers for Medicare & Medicaid Services. (n.d.). Emergency Medical Treatment and Labor Act (EMTALA). U.S. Department of Health & Human Services. https://www.cms.gov/emtala

Centers for Medicare & Medicaid Services. (2023). State Operations Manual: Appendix V-Interpretive Guidelines-Responsibilities of Medicare participating hospitals in emergency cases (EMTALA). U.S. Department of Health & Human Services. https://www.cms.gov

California Department of Public Health. (n.d.). California Code of Regulations, Title 22: Division 5-Licensing and certification of health facilities. https://www.cdph.ca.gov

California Office of Administrative Law. (2024). California Code of Regulations, Title 22, 70213, 70215, 70217, 70703, 70707, 70751. https://www.oal.ca.gov

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE:7/2008
SUBJECT:	7010.26 HAND OFF COMMUNICATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish a standardized process for patient handoff communication in the Emergency Department (ED) to ensure continuity of care, reduce medical errors, and promote patient safety.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
None

POLICY:
It is the policy of Modoc Medical Center that a~~A~~ll transitions of patient care in the Emergency Department will utilize a standardized, structured communication process. Handoffs must be clear, concise, interactive, and include an opportunity for questions and verification. Failure to adhere to this policy may compromise patient safety.

PROCEDURE:
1. Preparation
    - Review electronic medical record (EMR).
    - Update documentation, including clinical status, test results, orders, and interventions.
    - Identify critical patients, pending diagnostics, and anticipated disposition.
2. Handoff Process should include the following:
    - Name, age, gender, medical record number.
    - Presenting symptoms and working diagnosis.
    - Vital signs, stability, severity classification.
    - Treatments provided and patient response.
    - Laboratory results, imaging studies, consultations.
    - Required follow up tasks.
    - Disposition plan if known: Admission, discharge, observation, or transfer.
3. Documentation
    - Time of handoff.
    - Name of providers involved.
    - Identification of critical issues (if applicable).
4. Special Circumstances
    - Prioritize unstable or high-risk patients.
    - Utilize team based or bedside handoff when feasible.
    - For the critical or unstable patients, bedside handoff strongly recommended.
    - Include airway status, intravenous (IV) infusions/drips, and monitoring equipment.

REFERENCE:
None.

ATTACHMENTS:
None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 DO NOT RESUSCITATE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized procedures in the Emergency Department (ED) for recognizing, validating, and honoring Do Not Resuscitate (DNR) orders in accordance with California law, including the California Health & Safety Code, Physician Orders for Life-Sustaining Treatment (POLST) regulations, and applicable advance directive statutes.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Do Not Resuscitate Order: a medical order signed by a licensed California physician (or authorized practitioner under California law) indicating cardiopulmonary resuscitation is not to be performed.

Physician Orders for Life-Sustaining Treatment: portable medical order recognized in California that specifies scope of treatment, including resuscitation preferences.

Advance Health Care Directive: legal document under California Probate Code allowing a patient to appoint an agent and state treatment preferences.

POLICY:
It is the policy of Modoc Medical Center (MMC) to honor valid DNR orders, Advance Health Care Directives (AHCD), and POLST forms consistent with California law. In the event of cardiac or respiratory arrest, cardiopulmonary resuscitation (CPR) will not be initiated for patients with a valid DNR order. Patients with DNR orders will continue to receive all other medically appropriate care unless otherwise specified in the directive or POLST. When DNR status is uncertain or cannot be immediately verified, resuscitation will be initiated until clarification is obtained.

PROCEDURE:
1. Identification of DNR Status
    - Locate the documentation of POLST form (bright colored California-approved form), signed physician DNR order or AHCD.
2. Validation Requirements (California Compliance)
    - A DNR/POLST is valid if completed on an approved California POLST form, or a valid physician order is signed by both the patient (or surrogate if applicable), and a licensed California physician/nurse practitioner/physician assistant (within scope of law).
    - Not visibly altered or revoked.
    - Consistent with current clinical context.
    - EMS personnel may honor out-of-hospital DNR/POLST per California EMS Authority guidance.
3. Uncertainty or Conflicting Documentation
    - If documentation is missing, unclear, or conflicting, or family disagreement exists, then initiate full resuscitation (Full Code status), and notify the attending physician immediately.

4. Clinical Management of DNR Patients.
    - For confirmed DNR patients, permitted interventions include the following (unless otherwise restricted by POLST):
        - Oxygen therapy
        - Intravenous (IV) fluids.
        - Pain and symptom management.
        - Antibiotics.
        - Non-invasive support (case dependent and consistent with POLST selections).
    - Withheld Interventions
        - Chest compressions
        - Defibrillation
        - Advanced cardiac life support (ACLS) during arrest.
        - Intubation if explicitly refused in POLST.
5. Cardiac or Respiratory Arrest Protocol. If patient is confirmed DNR:
    - Do not initiate CPR.
    - Notify ER physician immediately.
    - Provide comfort-focused and palliative care.
    - Support family at bedside when appropriate.
6. Pediatric Considerations
    - DNR decisions for minors require the following:
        - Parental/legal guardian consent
        - Physician orders consistent with California law and institutional policy.
    - Ethics consultation is recommended in complex cases.
7. Documentation Requirements
    - Type of DNR documentation reviewed.
    - Verification process and source.
    - Time and circumstances of arrest (if applicable).
    - Treatments provided or withheld.
    - Family discussions and decisions.
    - Physician notifications.

REFERENCE:

U.S. Department of Health and Human Services. (n.d.). Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd. https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 DO NOT RESUSCITATE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

EFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~EDUCATION TO PATIENT AND FAMILY~~7010.26EDUCATION TO PATIENT AND FAMILY	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure that patients and their families/significant others receive timely, accurate, and understandable education regarding the patient's condition, treatment, medications, and follow-up care while receiving services in the Emergency Department (ED).

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Patient Education: is a planned process of providing information and instruction to patients and families to improve health outcomes and ensure safe care after discharge.

Family: individuals identified by the patient as significant to their care, including caregivers or legal representatives.

POLICY:
It is the policy of Modoc Medical Center (MMC) Emergency Department to provide patient-and-family-centered education that is appropriate to the patient's age, cognitive ability, literacy level, language, and cultural background. Education will be documented in the electronic medical record and reinforced prior to discharge or transfer of care.

PROCEDURE:
1. Assessment of Learning Needs:
    - Patient's cognitive status and emotional readiness.
    - Preferred language and need for interpreter services.
    - Health literacy level.
    - Cultural and religious considerations.
    - Presence and involvement of family or caregiver.
    - Barriers to learning (e.g., pain, anxiety, sensory impairment) will be identified and addressed when possible.
2. Planning of Education:
    - Education will be individualized based on assessment findings.
    - Family or caregivers will be included with patient consent.
    - Interpreter services will be arranged when indicated.
3. Implementation of Education:
    - Education will be provided throughout the patient's ED stay and will include, but not limited to following:
        - Diagnosis or presenting condition.
        - Diagnostic tests and procedures.
        - Medications (name, purpose, dosage, side effects).
        - Pain management strategies.
        - Treatment plan and expected outcomes.
        - Self-care instructions (e.g., wound care, equipment use).

    - Activity and dietary restrictions.
    - Signs and symptoms requiring immediate medical attention.
    - Follow up care instructions.
  - Education methods may include:
    - Verbal instruction.
    - Written materials.
    - Demonstration and return demonstrations.
  - Staff will use plain language and avoid medical jargon.
4. Discharge Education:
  - The nurse/provider will review all discharge instructions with the patient and/or family.
  - Provide written instructions.
  - Reconcile and explain medications.
  - Confirm follow-up appointments or referrals.
  - Identify any gaps in understanding and address prior to discharge.
5. Documentation:
  - Information covered by nurse/provider.
  - Educational materials are provided.
  - Patient/family response and level of understanding.
  - Interpreter service if utilized.
  - Identified barriers to learning.
  - Refusal of education (if applicable).

REFERENCES:

None

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~EPISTAXIS STANDARD OF CARE~~7010.26 EPISTAXIS STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish a standardized, evidence-based approach for the evaluation and management of patients presenting to the Emergency Department (ED) with epistaxis (nasal hemorrhage), ensuring prompt control of bleeding, identification of life-threatening causes, and appropriate disposition.

AUDIENCE:
Department Wide

TERMS/DEFINITION:

POLICY:
It is the policy of Modoc Medical Ceanter (MMC) that ~~A~~all patients presenting with epistaxis will be managed according to a protocol prioritizing airway, breathing, and circulation, followed by local hemostatic measures, escalation to nasal packing or cautery, and specialty consultation when indicated.

PROCEDURE:
1. Initial Assessment and Triage
    - Assess airway, breathing, and circulation (ABCs).
    - Evaluate hemodynamic stability (vital signs, orthostasis, mental status).
    - Identify high-risk conditions:
        - Anticoagulant or antiplatelet use.
        - Known bleeding disorders.
        - Recent nasal trauma or surgery.
        - Suspected posterior bleeding.
    - Initiate emergent intervention for any of the following:
        - Hemodynamic instability.
        - Airway compromise.
        - Active massive hemorrhage.
2. Initial Management
    - Position patient upright with head slightly forward.
    - Apply continuous direct pressure to anterior nares for 10-15 minutes.
    - Suction blood and clots as needed.
    - Administer supplemental oxygen if indicated.
3. Adjunctive Medical Therapy (If bleeding persists)
    - Apply a topical vasoconstrictor.
    - Consider topical anesthetic (e.g., lidocaine with vasoconstrictor) for patient comfort and improved examination conditions.
4. Identification of Bleeding Source
    - Provider to perform anterior rhinoscopy using nasal speculum and adequate lighting.
    - Classify as anterior source (most common), or suspected posterior source (poor visualization, bilateral bleeding, or persistent posterior drainage).

5. Definitive Hemostasis
   Anterior Epistaxis
   - Chemical or electrical cautery.
     - Silver nitrate is preferred if bleeding source visualized.
     - Avoid bilateral septal cautery.
   - Topical hemostatic agents
     - Absorbable materials (gel foam, oxidized cellulose, thrombin-based agents).
   - Anterior nasal packing
     - Absorbable packing is preferred when available.
     - Non-absorbable packing (nasal tampons or gauze) if required.

   Posterior Epistaxis
   - Insert posterior nasal balloon tamponade device (provider will insert).
   - Consult Otolaryngology (ENT) specialist.
   - May consider admission or transfer for monitoring and definitive management.
6. Laboratory Evaluation (obtained based on clinical judgement)
   - Complete blood count (CBC) for significant bleeding or suspected anemia.
   - Coagulation studies for anticoagulated patients.
   - Type and screen for severe hemorrhage.
   - Basic metabolic panel if indicated.
7. Anticoagulation Management
   - Assess risk-benefit prior to reversal.
   - Consider reversal in life-threatening or uncontrolled bleeding.
   - Do not discontinue anticoagulation without provider evaluation.
8. Documentation Requirements
   - Suspected source of bleeding.
   - Interventions performed in chronological order.
   - Response to each intervention.
   - Presence of anticoagulation or bleeding disorders.
   - Consultation requests and outcomes.
   - Discharge instructions provided.

REFERENCE:

UpToDate. (2025). Evaluation and management of epistaxis. Wolters Kluwer. Retrieved (May 6, 2026), from https://www.uptodate.com

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 CARE OF THE LATEX SENSITIVE PATIENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized procedures for the identification and management of patients with latex allergies, ensuring a safe, latex-reduced, or latex-free healthcare environment and minimizing the risk of allergic reactions.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Latex allergy~~:~~ is an immune-mediated reaction to proteins found in natural rubber latex.

~~Latex~~A latex-safe environment~~:~~ is a clinical setting in which latex-containing products have been removed or substituted with latex-free alternatives.

High-risk individuals~~:~~ are patients with conditions such as spina bifida, multiple surgical exposures, or occupational exposure to latex.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~A~~all patients with known or suspected latex sensitivity will be promptly identified, and appropriate precautions will be implemented to prevent or minimize exposure to natural rubber latex products throughout the continuum of care.

PROCEDURE:
- Patient i~~I~~dentification and s~~S~~creening
  - Screen all patients upon admission for latex ~~allergy~~allergies.
  - Document allergy status in the electronic medical record (EMR).
  - Place ~~allergy~~an allergy sticker on ~~outside~~the outside of ~~chart~~the chart for latex.
- Environment of c~~C~~are
  - Remove all latex-containing items prior to patient placement in ~~room~~the room.
  - Ensure environmental cleaning to reduce airborne latex particles.
  - Maintain a supply of latex-free equipment in designated areas.
- Equipment and s~~S~~upplies
  - Use only latex-free products, including gloves, catheters and tubing~~,~~, and adhesives and dressings.
  - Avoid ~~use~~the use of latex gloves, balloons, and items containing natural rubber latex components.
- Communication
  - Notify all departments involved in patient care of the latex allergy.
  - Clearly indicate latex allergy status during handoffs and transfers.
  - Ensure allergy alerts are visible in all patient records.
- Personal p~~P~~rotective e~~E~~quipment (PPE)
  - Use non-latex gloves exclusively.
  - Avoid powdered gloves due to ~~risk~~the risk of airborne allergen exposure.

- Monitoring and eEmergency mManagement
  - Monitor for signs of allergic reactions such as urticaria, rash, pruritus, respiratory ~~distress~~distress, and hypotension.
  - Be prepared to respond to anaphylaxis:
    Administer emergency medications per protocol.
    Activate emergency response system if indicated.
- Documentation and rReporting
  - Document all interventions and patient responses in the EMR.
  - Report any exposure incidents according to hospital policy.
  - Complete incident report for allergic reaction (Safety First Report).

REFERENCES:

Centers for Disease Control and Prevention. (n.d.). Latex allergy: A prevention guide. U.S. Department of Health and Human Services. https://www.cdc.gov/niosh/topics/latex/

Occupational Safety and Health Administration. (n.d.). Occupational exposure to latex. U.S. Department of Labor. https://www.osha.gov/latex-allergy

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26CORONER NOTIFICATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure compliance with California law regarding mandatory reporting of deaths to the coroner and to establish a standardized process for Emergency Department (ED) staff to notify the coroner/medical examiner in a timely and appropriate manner.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
California Government Code 27491: defines the official duties of the coroner in the State of California. It governs when and how coroners must investigate deaths to determine their cause, manner, and circumstances. This statute forms the legal foundation for death investigations and public inquests in California's counties.

POLICY:
It is the policy of Modoc Medical Center (MMC) that aAll deaths and specified clinical circumstances presenting to the Emergency Department will be reported to the coroner when required under California Government Code 27491. No body will be released, and no death certificate completed, until the coroner has been notified and has provided disposition instructions when a case meets reporting criteria.

PROCEDURE:
1. Determination of Reportability.
    - The emergency room provider will evaluate the circumstance of death.
    - If uncertainty exists, the physician will err on the side of reporting to the coroner.
    - Per California law, the coroner will be notified immediately in the following circumstances:
        - Violent, Unusual, or External Cause Deaths: homicide, suicide, accidental death, death due to trauma (including falls, motor vehicle collisions, burns), and deaths related to overdose, poisoning, or toxic exposure.
        - Sudden and Unexplained Deaths: deaths without a known medical cause, deaths within 24 hours of hospital admission without clear diagnosis, and sudden death in individuals not under physician care.
        - Deaths in Custody or State Responsibility: deaths in law enforcement custody, and deaths in correctional facilities or during detention.
        - Suspicious or Neglect-Related Deaths: suspected abuse or neglect (child, dependent adult, elder), and deaths under suspicious or unusual circumstances.
        - Unknown or Unidentified Persons.
        - Procedure Related or Occupational Deaths: deaths related to medical or surgical procedures where cause is unclear and deaths due to occupational illness or injury.
2. Notification Process.
    - The emergency room nurse will contact the county coroner/medical examiner immediately upon pronouncement. Modoc County Sheriff Department 530-233-4416. (All ED deaths are reported to the coroner).
    - Provide the following information:
        - Patient name, age, and identifiers.

    - Date, time, and location of death.
    - Clinical history and events leading to death.
    - Any known medical conditions.
3. Documentation. The following must be documented in the electronic medical record.
    - Date and time of coroner notification. (Complete the record of death form).
    - Name and title of coroner personnel contacted.
    - Case/report number if assigned.
    - Any instructions provided by the coroner.
    - Final disposition (accepted or declined case).
4. Post-Notification Actions

    _If Accepted as Coroner Case
    - Do not remove any of the following items:
        - Tubes, lines, or medical devices
        - Clothing or personal effects (unless directed).
    - Do not clean or alter the body.
    - Secure belongings per chain-of-custody ~~procedures~~procedure.
    - Do not release the body to family or funeral home.

    _If Declined by Coroner
    - Proceed with standard hospital post-mortem care.
5. Evidence Preservation
    - Treat all potential coroner cases as medico-legal cases.
    - Preserve forensic evidence (e.g., clothing, foreign objects).
    - Minimize handling of the body.
6. Family Communication
    - Notify the next of kin in a timely and compassionate manner. (ER provider should complete the notification).
    - Inform family when the case has been referred to the coroner.
    - Do not speculate on cause of death if under investigation.
7. Documentation Requirements
    - Complete the ED ~~record~~record, including clinical events.
    - Time of death pronouncement.
    - Coroner notification details.
    - Disposition and instructions.
    - Record of Death Form.

REFERENCES:

California Government Code 27491. (West, current through 2026).

California Department of Public Health. (n.d.). Death registration handbook. State of California

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26CORONER NOTIFICATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

ATTACHMENTS:

None

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REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 EMERGENCY DEPARTMENT AUTOMATED DISPENSING CABINET (OMNICELL) USE POLICY	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized procedures for the safe, secure, and compliant use of the Omnicell automated dispensing cabinet (ADC) within the Emergency Department (ED), including medication access, dispensing, documentation, controlled substance management, override use, inventory control, and diversion prevention.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Automated Dispensing Cabinet (ADC): a computerized medication storage and dispensing device designed to improve medication security and accountability.

Override: removal of medication prior to pharmacist verification in urgent or emergent situations where delay in therapy may compromise patient safety.

Witnessed Waste: disposal of unused medication in the presence of another authorized healthcare professional.

Controlled Substance: a medication regulated under federal or state-controlled substance laws.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~T~~the Emergency Department will utilize the Omnicell automated dispensing system to support safe medication distribution and inventory control. Access to the system is restricted to authorized personnel who have completed required training and competency validation.
All medications removed from the Omnicell system will be associated with a valid medication order except in approved emergency override situations. Users are responsible for accurate medication selection, timely administration documentation, proper wasting procedures, and immediate reporting of discrepancies.
This organization maintains a zero-tolerance approach to medication diversion, unauthorized access, and falsification of records.

PROCEDURE:
- User Access
  - Access to Omnicell is limited to authorized personnel.
  - Users must complete initial education, competency validation, and annual review requirements.
  - Each user will maintain a unique login credential.
  - Password sharing is prohibited.
  - Users must log off the system when leaving the workstation unattended.
- Routine Medication Removal
  - Verify active medication ~~order~~orders in the electronic medical record (EMR).
  - Confirm patient identity using two approved identifiers.
  - Access Omnicell using authorized credentials.

  - Select the correct patient profile.
  - Select the ordered medication.
  - Remove only the required quantity.
  - Compare the medication to the right patient, right medication, right dose, right route, and right time.
  - Administer medication promptly.
  - Document administration in the EMR immediately after administration. This is documented in real time by scanning the patient's armband for identification and then scanning the medication for administration.
- Override Medication Removal
  - Overrides may be used when immediate medication access is necessary to prevent patient harm including, but not limited to cardiac arrest, respiratory arrest, rapid sequence intubation, status epilepticus, severe allergic reaction/anaphylaxis, emergency sedation and stroke emergencies.
  - Select ~~override~~the override function.
  - Choose the appropriate override reason.
  - Remove only the required medication dose.
  - Administer medication immediately.
  - Ensure provider order entry as soon as possible.
  - Document administration in the EMR.
  - Pharmacists will review override activity daily.
- Controlled Substance Management
  - Users are responsible for count accuracy.
  - Unused controlled substances will be wasted immediately after administration.
  - Waste must occur in the presence of an authorized witness.
  - Both individuals will electronically document the waste in Omnicell.
  - Unused medications eligible for returns will be returned promptly.
  - Controlled substance returns will follow Pharmacy procedures.
  - At no time will a narcotic be left out on the counter unwitnessed.
- Discrepancy Management
  - Users will immediately investigate discrepancies identified during medication removal, return, or waste.
  - Unresolved discrepancies will be reported to the charge nurse, pharmacist, and nursing leadership.
  - Pharmacists will review discrepancy reports daily.
  - Suspected diversion will be escalated according to organizational diversion prevention policy.
- System Downtime
  - In the event of Omnicell downtime, notify pharmacy and Information Technology (IT) immediately.
  - Follow approved downtime medication access procedures.
  - Utilize paper documentation if electronic systems are unavailable.
  - Reconcile all medication transactions once systems are restored.

REFERENCE:

Omnicell. (n.d.). Omnicell healthcare automation solutions. Retrieved May 11, 2026, from https://www.omnicell.com

U.S. Drug Enforcement Administration. (n.d.). Diversion control division. U.S. Department of Justice. Retrieved May 11, 2026, from https://www.deadiversion.usdoj.gov

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 05/2026
SUBJECT:	7010.26 MANDATED REPORTING OF DECUBITUS ULCERS	REVISED: ~~5/2026~~
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure compliance with California elder/dependent adult abuse reporting laws, California adverse event reporting requirements, Centers for Medicare and Medicaid Services (CMS) nursing facility regulations, and facility patient safety obligations regarding pressure injuries that may indicate neglect, abuse, or reportable adverse events.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Pressure Injury/Decubitus Ulcer: localized injury to skin and/or underlying tissue caused primarily by pressure or pressure in combination with shear.

Reportable Pressure Ulcer Event Under California law for hospitals: include any Stage 3 or Stage 4 pressure ulcer acquired after admission, excluding progression from Stage 2 to Stage 3 when Stage 2 was documented upon admission.

Neglect: failure to provide medical care, pressure relief, nutrition, hydration, hygiene, repositioning, or other services necessary to avoid harm.

POLICY:
It is the policy of Modoc Medical Center (MMC) to prevent avoidable pressure injuries through evidence-based care, promptly assess and treat all pressure injuries, ensure compliance with California mandated reporting laws for suspected elder or dependent adult abuse and neglect, report qualifying hospital-acquired Stage 3 or Stage 4 pressure injuries to the California Department of Public Health (CDPH) as required, and maintain confidentiality of all reports and investigations.

PROCEDURE:
Identification and Immediate Response

- Perform immediate skin and wound assessment.
- Document location, measurements, staging, drainage, odor, surrounding tissue condition, and pain level.
- Photograph wound per hospital policy.
- Notify the attending physician, the charge nurse, and supervisor.
- Initiate pressure-relief and wound treatment interventions.
- Assess for indicators of neglect or deficient care.

Indicators Requiring Further Review (The following may indicate neglect or reportable events)

- Unrelieved pressure.
- Lack of repositioning.
- Untreated incontinence.
- Poor hygiene.
- Delayed treatment.
- Nutritional deficiencies.

- Worsening wounds without intervention.
- Absent documentation.
- Inadequate staffing patterns.
- Repeated occurrence of facility-acquired injuries.

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In California, decubitus ulcers (pressure ulcers/bedsores) become a mandatory reportable adverse event for hospitals when they meet specific severity criteria.

- Stage 3 or Stage 4 pressure ulcers acquired after hospital admission must be reported to CDPH under the adverse event rules.
- Ongoing urgent/emergent threats must be reported within 24 hours.
- Other adverse events must be reported within 5 calendar days after detection.
- If the ulcer is present on arrival from a skilled nursing facility, home, or another facility, document thoroughly, and photograph the area. If a severe decubitus ulcer appears suspicious for neglect, may also need to be reported to Adult Protective Services, Ombudsman and/or Law Enforcement Agency.

REFERENCE:
California Health and Safety Code 1279.1

Title 22 CCR 70971-70973 (general acute care hospitals)

CDPH AFL-15-03: Reporting of Healthcare Acquired Pressure Ulcers

ATTACHMENTS:
None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~LUMBAR PUNCTURE ASSISTING WITH PROCEDURE~~7010.26 LUMBAR PUNCTURE ASSISTING WITH PROCEDURE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized guidelines for the safe, effective, and evidence-based performance of lumbar puncture (LP) in the Emergency Department for diagnostic and therapeutic purposes.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Lumbar Puncture (LP): a sterile invasive procedure involving insertion of a spinal needle into the subarachnoid space of the lumbar spine to obtain cerebrospinal fluid (CSF) or measure CSF pressure.

POLICY:

It is the policy of Modoc Medical Center (MMC) that the aforementioned procedures are to be followed and adhered to when a LP is performed.

PROCEDURE:
Indications for an LP to be performed:

- Suspected central nervous system infection (e.g., meningitis, encephalitis).
- Evaluation of subarachnoid hemorrhage when imaging is non-diagnostic.
- Suspected inflammatory, autoimmune, or demyelinating central nervous system disease.
- Measurement of opening pressure (e.g., idiopathic intracranial hypertension).
- Therapeutic CSF drainage when clinically indicated.
- Administration of intrathecal medications when approved by hospital protocol.

Contraindications

- Increased intracranial pressure caused by spinal mass, intracranial mass, or central nervous system lesion.
- Noncommunicating (obstructive) hydrocephalus.
- Infection at lumbar puncture site.
- Anticoagulation therapy, such as heparin or warfarin.
- Coagulopathies, such as hemophilia
- Vertebral trauma
- Platelets are less than 50,000 and/or International Normalized Ratio (INR) greater than 1.5.

Pre-Procedure Evaluation

- A focused neurologic examination will be performed prior to LP. Establish baseline vital signs and neurologic assessment, including level of consciousness (LOC), motor and sensory function, and pupil size and reactivity, before procedure starts. Monitor for changes, which can indicate brain herniation, spinal nerve injury, or acute hematoma formation at needle insertion site.
- Neuroimaging (cat scan head) will be obtained prior to LP when clinically indicated, including but not limited to altered mental status, focal neurologic deficits, seizure within prior 7 days, papilledema, or immunocompromised status.
- Empiric antimicrobial therapy will not be delayed when bacterial meningitis is suspected.

Informed Consent

- Informed consent must be obtained and documented unless emergent circumstances exist.
- Discussion must include indication, benefits, risks (including post-LP headache, bleeding, infection, neurologic injury, failure, herniation risk)~~,~~ and alternatives.

Equipment

- Sterile LP tray.
- Antiseptic solution (chlorhexidine preferred unless contraindicated).
- Sterile drapes and gloves.
- Local anesthetic (1% lidocaine).
- Spinal needle with stylet.
- Manometer with tubing.
- CSF collection tubes (minimum 4).
- Sterile dressing supplies.
- Labels and specimen requisitions.

Procedure Time-Out

- A standardized procedural time-out will be performed confirming patient identity, procedure, site, indication, allergies~~,~~ and anticoagulation status.

Procedure Steps

- Perform hand hygiene and apply proper attire per facility practice, which may include surgical hat, mask~~,~~ and personal protective equipment if exposure to bodily fluids is anticipated.
- Establish baseline vital signs and neurologic assessment, including LOC, motor and sensory function~~,~~ and pupil size and reactivity.
- Position patient per treating provider orders.
- Assist patient into side-lying position with back near side of bed/table, knees in chest, and back and head/neck flexed. Place a small pillow or rolled towels to support head and between legs to support spine. Keep legs aligned and prevent top leg from sliding off bottom leg, as needed.
- If patient is unable to tolerate side-lying position, assist into seated position on edge of surface with upper body learning over bedside table or stand.
- Assist treating provider as he/she identifies lumbar puncture site. Note most common site for lumbar puncture is intervertebral spaces of L4-L5 but L3-L4 or L5-S1 may be used.
- Ask patient to arch his/her back "like a cat."
- Provide treating provider with marking pen to mark needle insertion site.
- Prepare patient for procedure.
- Inform the patient of sensations he/she may feel, such as mild discomfort, and emphasize importance of staying still.
- Provide the patient with strategies to cope with anxiety/distress, as needed.
- Administer analgesic and/or anxiolytic medications, per provider order after verifying rights of safe medication administration.
- Perform hand hygiene, apply sterile gown and gloves~~,~~ and assist treating provider with preparing sterile field and supplies.
- Support the patient during needle insertion.

- Maintain the patient's position. If position is side lying, stand in front of patient and reach across to support behind neck and knees. If position is sitting, support patient behind neck and shoulders.
- Encourage the patient to stay still during procedure, especially during needle insertion. Maintain conversation with the patient to provide distraction.
- Provide patient care during lumbar puncture. If requested, assist the provider with performing lumbar puncture.
- Monitor vital signs, respirations, and neurologic status per facility practice.
- Administer additional analgesic/anxiolytic medications, if ordered, to maintain patient comfort.
- Monitor for and immediately report adverse effects.
- If the patient is seated, have them lie on their side when treating provider is ready to measure the CSF pressure.
- Return the patient to supine or prone position immediately after procedure.
- Instruct the patient to lie flat for duration of time specified by the provider.
- Allow the patient to change body position, while ensuring he/she remains in either a supine or prone position.
- If permitted by the provider, allow slight head elevation.

Post Procedure Care

- Monitor patient for neurologic changes, headache, bleeding or CSF leak, and vital sign instability.
- Reassess post procedure vital signs, respirations~~,~~ and neurologic status at regular intervals per facility practice.
- Label test tubes, noting order of collection on label such as #1 of 4, and prepare for transport to lab.
- Prepare to obtain serum or whole blood glucose level per provider order. Note this allows for comparison of CSF serum glucose values.
- Discard supplies.
- Remove gloves and other personal protective equipment and perform hand hygiene.
- Monitor vital signs, assess lumbar puncture site for drainage, and perform neurologic assessments.
- Ensure the patient maintains supine or prone position per provider order and assist with position changes every 2 hours.
- Administer fluids per provider order to reduce occurrence of spinal headaches. If the patient can have fluids by mouth, a straw can facilitate this while the patient is lying flat.
- Promptly notify the provider of any signs of adverse effects or significant assessment findings.

Documentation Requirements

- Date/time of lumbar puncture.
- Patient assessment, including vital signs and neurologic assessments before, during, and after procedure.
- Description of nursing care provided, including name and dose of medications administered, location and size of IV access, and patient's response to medications and insertion of IV if applicable.
- Patient position during lumbar puncture.
- Patient's tolerance of lumbar puncture.
- Specimens obtained during lumbar puncture.
- Lumbar puncture site assessment.

- Any unexpected patient events or outcomes, interventions performed~~,~~ and whether the provider was notified.
- Patient/family education, such as topics presented, response to education, plan for follow-up education, any communication barriers, and techniques that promoted successful communication.

REFERENCE:

The Joint Commission. National Performance Goals effective January 2026 for the hospital program. September 26, 2025. https://www.jointcommission.org

Dynamic Health. 2026 EBSCO Information Services.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 4/2015
SUBJECT:	7010.26 ENDOTRACHEAL TUBE PLACEMENT CONFIRMATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure accurate and timely confirmation of endotracheal tube (ETT) placement in all patients undergoing intubation, minimizing the risk of unrecognized esophageal intubation and associated complications.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Waveform capnography: measures the concentration of carbon dioxide (CO_2) in respiratory gas.

End-tidal carbon dioxide ($EtCO_2$): is the measurement of the concentration or partial pressure of carbon dioxide at the end of exhalation. It reflects the amount of CO_2 present in alveolar gas and provides insight into how effectively a patient is ventilating.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~A~~all patients undergoing endotracheal intubation must have ETT placement confirmed using continuous waveform capnography as the primary method. Clinical assessment and adjunct methods will be used in conjunction with, but not as a substitute for continuous waveform capnography.

Failure to confirm placement with sustained end-tidal CO_2 ($EtCO_2$) waveform requires immediate reassessment and possible reintubation.

PROCEDURE:
1. Immediate Confirmation (Required):
    - Attach waveform capnography immediately following intubation.
    - Confirm ~~presence~~the presence of sustained $EtCO_2$ waveform over multiple breaths.
    - Acceptable findings include persistent waveform tracing, and $EtCO_2$ consistent with clinical condition.
    - Absence of sustained waveform: presumed esophageal intubation until proven otherwise.
2. Concurrent Clinical Assessment (Adjunct Only)- Perform immediately but do not rely on these alone:
    - Direct visualization of tube passing through the vocal cords with intubation.
    - Bilateral chest rise.
    - Bilateral breath sounds on auscultation.
    - Absence of epigastric sounds on auscultation.
    - Observation of tube depth at teeth/lips.
3. Secondary Confirmation:
    - Obtain chest radiograph as soon as clinically feasible.
    - Verify tube tip location (3-5 centimeters above carina).
    - Verify absence of right mainstem intubation.
    - Radiographic confirmation does not replace capnography.

4. Continuous Monitoring:
    - Always maintain continuous waveform capnography.
    - Reconfirm ETT placement with any of the following:
        - After patient movement or transport.
        - After procedures.
        - With any change in clinical status.
5. Alternative Methods (If Capnography Unavailable):
    - Use colorimetric CO2 detector as a temporary adjunct.
    - Transition to waveform capnography as soon as available.
6. Special Considerations:
    - Cardiac Arrest: lower EtCO2 values expected. Persistent waveform is still required for confirmation.
    - High-Risk Situations include obesity, difficult airways, and pediatric patients.
    - Increased vigilance and reassessment are required.
7. Documentation Requirements:
    - Method of confirmation (waveform capnography).
    - Presence of sustained EtCO2 waveform.
    - Tube size and depth (centimeters at teeth/lips).
    - Bilateral breath sounds on auscultation.
    - Chest X-ray confirmation and findings.
    - Any complications or need for repositioning.

REFERENCE:

American Heart Association. (2020). 2020 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. Circulation, 142(16_suppl_2), S337-S357. https://doi.org/10.1161/CIR.0000000000000916

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 EYE EMERGENCY STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized procedures for the timely assessment, stabilization, treatment, and disposition of patients presenting with ophthalmologic emergencies ~~in order to~~to preserve vision and prevent complications.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
None.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~A~~all patients presenting to the Emergency Department with eye-related complaints will receive prompt triage, assessment, and management based on clinical severity. Emergent conditions will be prioritized for immediate intervention and specialty consultation.

PROCEDURE:
1. Initial Assessment
    - Perform primary survey (Airway, Breathing, Circulation).
    - Obtain focused ocular history to include onset, duration, mechanism of injury, contact lens use, and chemical exposure.
    - Assess and document a visual acuity (prior to intervention when possible), pupillary response, extraocular movements, and external eye structures.
2. Management Protocols

    Chemical Eye Injury
    - Initiate immediate copious irrigation (normal saline or lactated ringer).
    - Do not delay for visual acuity testing.
    - Check ocular pH and continue irrigation until neutral.
    - Urgent ophthalmology consultation required.

    Corneal Abrasion
    - Confirm with fluorescein staining (provider to complete).
    - Administer topical antibiotic therapy by provider order.
    - Provide oral analgesia by provider order.
    - Do not dispense topical anesthetics for outpatient use.

    Ocular Foreign Body
    - Evert eyelids to inspect for retained material.
    - Remove superficial foreign bodies (provider to complete).
    - For any embedded objects: do not remove; place rigid eye shield over eye; and consult ophthalmology.

    Suspected Globe Rupture
    - Signs: irregular pupil, decreased vision, extrusion of contents
    - Place rigid eye shield immediately.
    - Keep patient NPO (nothing by mouth).

- Administer intravenous (IV) antibiotics by provider order.
- Avoid intraocular pressure measurement.
- Immediate ophthalmology consultation required.

Acute Angle-Closure Glaucoma

- Symptoms: severe pain, blurred vision, halos, nausea/vomiting.
- Initiate treatment with topical ocular hypotensive agents, and systemic carbonic anhydrase inhibitor as ordered by provider.
- Urgent ophthalmology consultation.

Retinal Detachment

- Symptoms: flashes, floater, curtain-like vision loss.
- Minimize delays.
- Immediate ophthalmology referral.

Infectious Eye Conditions

- Examples include Conjunctivitis and Keratitis.
- Initiate appropriate antimicrobial therapy based on suspected etiology by provider order.
- Contact lens wearers require careful evaluation for corneal ulceration.

3. Pain Management
   - Provide systemic analgesics as first-line therapy as ordered by provider.
   - Topical anesthetics will not be prescribed for home use.
4. Documentation
   - Visual acuity (pre-and post-treatment).
   - History and mechanism of injury.
   - Physical examination findings.
   - Diagnostic tests performed.
   - Treatments administered.
   - Consultation details.
   - Discharge instructions and follow-up plan.

REFERENCE:

American College of Emergency Physicians. (2023). Clinical policy: Critical issues in the evaluation and management of emergency department patients with ocular complaints.

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 5/2026
SUBJECT:	~~EMERGENCY DEPARTMENT LOG MAINTENANCE~~7010.26 EMERGENCY DEPARTMENT LOG MAINTENANCE	REVISED: ~~5/2026~~
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure accurate, complete, and timely documentation of all individuals who present to the Emergency Department (ED), in compliance with Emergency Medical Treatment and Labor Act (EMTALA) and Centers for Medicare & Medicaid Services (CMS) Conditions of Participation.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Emergency Department Log: a record of all individuals who present to the ED seeking examination or treatment, regardless of disposition.

Medical Screening Examination (MSE): ~~an~~An examination performed by a qualified medical provider to determine whether an emergency medical condition exists.

Disposition: the outcome of the patient's ED visit (e.g., admitted, discharged, transferred).

POLICY:
It is the policy of Modoc Medical Center (MMC) to maintain a centralized Emergency Department log documenting every individual who comes to the ED seeking examination or treatment. The log must be complete, accurate~~,~~ and retained by regulatory requirements.

PROCEDURE:
1. Log Inclusion Criteria. The ED log must include every individual who:
   - Presents to the ED requesting care.
   - Appears on hospital property requesting emergency services.
   - Patients brought in by emergency medical services (EMS) for evaluation.
   - Leaves prior to triage, medical screening exam (MSE), or treatment.
2. Required Data Elements. Each log entry must include, at a minimum:
   - Patient name or unique identifier.
   - Date and time of arrival.
   - Mode of arrival (walk-in, EMS, transfer, etc.).
   - Chief complaint or presenting issue.
   - Age and sex of the patient.
   - Triage category (if applicable).
   - Disposition, including treated and released; admitted; transferred; left without being seen (LWBS); left against medical advice (AMA); expired.
   - Time of disposition.
   - Receiving facility (if transferred).
3. Timeliness Requirements.
   - Entries must be made in real time or as close to real time as possible.
   - Disposition updates must be completed promptly after patient outcome is determined.

4. Log Format
    - Electronic based in Cerner Reports.
    - It must be readily retrievable for review by CMS or surveyors.
    - Must allow tracking of patient flow and outcomes.
5. Retention Requirements.
    - Maintain ED logs for at least 5 years (or longer per state law or hospital policy).
    - Logs must be accessible for regulatory review upon request.

REFERENCES:

Centers for Medicare & Medicaid Services. (2024). State operations manual: Appendix V-Interpretive Guidelines-Responsibilities of Medicare participating hospitals in emergency cases (EMTALA). U.S. Department of Health and Human Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_v_emerg.pdf

Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd. (1986). https://www.govinfo.gov/content/pkg/USCODE-2023-title42/html/USCODE-2023-title42-chap7-subchapXVIII-partE-sec1395dd.htm

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 HYPOTHERMIA STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish a standardized approach for the assessment, stabilization, and treatment of patients presenting with hypothermia in the Emergency Department (ED).

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Hypothermia: is a condition that occurs when core body temperature drops below 95 degrees Fahrenheit (35 degrees Celsius). It is a medical emergency. In hypothermia the body loses heat faster than it can produce heart, causing a dangerously low body temperature.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~A~~any patient presenting with suspected or confirmed hypothermia will receive prompt evaluation, continuous monitoring, and appropriate rewarming interventions based on severity classification. Care will prioritize prevention of further heat loss, safe rewarming, and management of complications.

PROCEDURE:
- Triage and Initial Assessment
  - Perform primary survey (Airway, Breathing, Circulation, Disability, Exposure).
  - Obtain core temperature.
  - Place patient on continuous cardiac monitoring.
  - Manage patients gently to reduce risk of arrhythmia.
  - Remove wet clothing and dry patient.
- Diagnostic Evaluation
  - Complete blood count (CBC), electrolytes, glucose, arterial or venous blood gas, coagulation profile, and lactate level.
  - Additional tests as indicated such as blood cultures (if infection suspected) and toxicology screening.
  - Imaging: Chest radiograph or cat scan (CT) imaging if trauma suspected.
  - Electrocardiogram (ECG) monitoring for arrhythmias.
- Rewarming Protocol

  Mild Hypothermia (32-35 degrees Celsius)
  - Warm blankets.
  - Warm environment.
  - Oral warm fluids if patient is alert.

  Moderate Hypothermia (28-32 degrees Celsius)
  - Forced-air warming systems (e.g., Bair Hugger)
  - Warm intravenous (IV) fluids (38-42 degrees Celsius).
  - Monitor for cardiac instability.

  Severe Hypothermia (less than 28 degrees Celsius)
  - Warm IV fluids
  - Heated humidified oxygen (Neptune device).

  - Patients will require intensive care unit (ICU) level of care. Anticipate transfer order.
- Cardiac Management
  - Continuous ECG monitoring.
  - Limit patient movement.
  - If ventricular fibrillation or pulseless ventricular tachycardia, initiate advanced cardiac life support (ACLS) protocol.
- Medication Considerations
  - Administer medications cautiously due to decreased metabolism.
  - Treat hypoglycemia if present.
  - Avoid unnecessary sedatives.
- Special Considerations
  - Continue resuscitation efforts until patient is rewarmed to >32-35 degrees Celsius, and no signs of life are present.
  - Evaluate for associated conditions such as frostbite, trauma, intoxication, and infection/sepsis.
- Disposition
  - Mild hypothermia: consider discharge after observation if stable.
  - Moderate to severe hypothermia: admit to hospital or transfer.
  - Severe or unstable patients: ICU admission. Initiate transfer to higher level of care (provider).
- Documentation
  - Initial and serial core temperatures.
  - Method of temperature measurement.
  - Rewarming techniques utilized.
  - Cardiac rhythm and monitoring findings.
  - Neurological status.
  - Response to interventions.

REFERENCE:

UpToDate. (2025). Accidental hypothermia in adults: Clinical manifestations and diagnosis. Retrieved from https://www.uptodate.com

UpToDate. (2025). Accidental hypothermia in adults: Treatment and prognosis. Retrieved from https://www.uptodate.com

ATTACHMENTS:

None.

REFERENCE # 7010.26	EFFECTIVE: 7/2008
SUBJECT: 7010.26 MEDICATION LABELING	REVISED: 5/2026
DEPARTMENT: EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure all medications, medication containers, syringes, basins, and solutions used within the Emergency Department are accurately labeled to reduce medication errors and enhance patient safety.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
None.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~A~~all medications and medication containers prepared but not immediately administered must be labeled according to hospital standards and regulatory requirements. Medication labeling must occur whenever a medication leaves the original manufacturer packaging or pharmacy-prepared container.

PROCEDURE:

General Labeling Requirements Formatted: Font: Bold

- All medication labels must include:
  - Medication name
  - Strength/concentration
  - Diluent (if applicable)
  - Total amount/volume
  - Expiration date and time when applicable
  - Initials of preparer
  - Date and time prepared when not used immediately.
- High-alert medications require independent double verification when indicated.

Medication Preparation Formatted: Font: Bold

- Before preparation, the clinician must:
  - Verify provider order.
  - Perform hand hygiene.
  - Confirm patient using two identifiers.
  - Compare medication to MAR/order three times:
    1. When removing medication
    2. During preparation
    3. Before administration

Labeling Process Formatted: Font: Bold

- Prepare one medication at a time.
- Label syringe/container immediately after preparation.
- Do not pre-label empty syringes.
- Use standardized hospital-approved labels when available.
- Ensure labels remain legible and securely attached.

REFERENCE #	7010.26	EFFECTIVE: 7/2008
SUBJECT:	7010.26 MEDICATION LABELING	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

Syringe Labeling

- All syringes not immediately administered must be labeled.
- Required elements:
  - Drug name
  - Concentration
  - Date/time prepared.
  - Initials

Intravenous (IV) Solutions and Infusions

- IV bags and tubing must include:
  - Medication additive
  - Dose/concentration
  - Infusion rate
  - Date/time initiated.
  - Expiration date/time
  - Initials/signature
  - Continuous infusions must be verified during handoff.

Procedural Areas and Sterile Fields

- Any medication or solution transferred from the original container during:
  - Trauma resuscitation
  - Sedation
  - Intubation
  - Central line insertion
  - Bedside procedures
- Must be labeled immediately on the sterile field unless administered immediately.
- Unlabeled containers on the sterile field will be discarded.

Verbal and Emergency Orders

- During emergencies:
  - Verbal orders must be read back.
  - Medications prepared during codes/resuscitations will be labeled as soon as clinically feasible.
  - Team communication must clearly identify:
    - Drug
    - Dose
    - Route
- Crash cart medications removed from original packaging and not used must be discarded according to pharmacy policy.

Storage and Disposal

- Unlabeled medications must be discarded immediately.
- Expired medications will not be used.
- Multi-dose vials must be dated upon opening.
- Controlled substances must follow Drug Enforcement Administration (DEA) and institutional security procedures.

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Documentation

- Medication administration documentation must include:
  - Drug name
  - Dosage
  - Route
  - Time
  - Patient response when applicable
  - Waste documentation for controlled substances.

REFERENCE:

Institute for Safe Medication Practices. (2023). ISMP guidelines for safe medication use and labeling practices. Institute for Safe Medication Practices

California Department of Public Health. (2025). California Code of Regulations, Title 22, 70263 Pharmaceutical service general requirements. California Department of Public Health Title 22 Regulations

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/9/2007	
SUBJECT:	7010.26 BURN PATIENT STANDARD OF CARE	REVISED: 5/2026	
DEPARTMENT:	EMERGENCY DEPARTMENT		

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PURPOSE:
The purpose of this policy is to establish standardized guidelines for the assessment, stabilization, treatment, and ongoing management of patients presenting with burn injuries, ensuring safe, evidence-based and high-quality care.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Burn Injury: tissue damage caused by thermal, chemical, electrical, or radiation sources.
TBSA (Total Body Surface Area): percentage of body affected by burns.
Full-Thickness Burn: burn involving all layers of skin.
Burn Center: specialized facility for comprehensive burn care.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~A~~all patients with burn injuries will receive prompt and systematic care in accordance with current clinical guidelines, including those recommended by the American Burn Association and World Health Organization. Care will prioritize airway management, fluid resuscitation, pain control, infection ~~prevention, and~~prevention and timely referral when indicated to a burn center.

PROCEDURE:
- Initial Assessment (Primary Survey)
  1. Assess airway, breathing, and circulation (ABCs).
  2. Administer 100% oxygen if an inhalation injury is suspected.
  3. Establish at least two large-bore intravenous (IV) lines.
  4. Fully expose the patient while preventing hypothermia.
- Burn Assessment
  1. Determine burn depth (superficial, partial, full thickness).
  2. Estimate TBSA using Rule of Nines or Lund-Browder chart.
  3. Identify high-risk areas (face, hands, feet, genitalia, airway).
- Immediate Interventions
  1. Stop the burning process.
  2. Cool burn with tepid running water (avoid ice).
  3. Remove restrictive clothing and jewelry.
  4. Cover with sterile, dry dressing.
- Fluid Resuscitation
  1. Initiate fluid therapy for burns > 10-15% TBSA using the Parkland Formula:
     - 4 mL x body weight (kg) x %TBSA burned.
  2. Administer fluids as below:
     - 50% in the first 8 hours.
     - 50% over the next 16 hours.
  3. Monitor urine output and adjust fluids accordingly.

- Pain Management
  1. Administer IV opioids (e.g., Morphine).
  2. Reassess pain regularly using standardized pain scales.
- Wound Care
  1. Cleanse wounds with sterile saline.
  2. Perform debridement as indicated. Gentle cleansing and debridement of nonviable tissue.
  3. Apply topical antimicrobial agents (e.g., Silver sulfadiazine).
  4. Apply appropriate sterile dressings. Use ~~of~~ modern occlusive or biosynthetic dressings to promote healing.
  5. For deep burns, early surgical excision and skin grafting ~~is~~are now standard of care.
- Infection Prevention
  1. Maintain strict sterile techniques.
  2. Monitor for signs of infection or sepsis.
  3. Implement isolation precautions as required.
- Nutritional Support
  1. Initiate early enteral nutrition for moderate to severe burns.
  2. Provide a high-calorie, high-protein diet.
  3. Monitor metabolic and electrolyte status.
- Monitoring and Ongoing Care
  1. Continuous vital sign monitoring.
  2. Track fluid intake/output. Urine output goal: 0.5 milliliter/kilogram/hour for adults.
  3. Monitor laboratory values (electrolytes, renal function).
  4. Assess for complications (shock, sepsis, compartment syndrome).
- Burn Center Referral Criteria
  Patients meeting criteria established by the American Burn Association will be transferred promptly. Criteria include the following:
  - Burns > 10% TBSA
  - Burns involving the face, hands, feet, or genitalia.
  - Full-thickness burns.
  - Electrical or chemical burns.
  - Inhalation injuries.
- Documentation
  - All assessments, interventions, patient responses, and communications must be documented in the electronic medical record in a timely and accurate manner.

RREFERENCES

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American Burn Association. (n.d.). Practice guidelines for burn care. American Burn Association. https://ameriburn.org

World Health Organization. (n.d.). Burns. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/burns

ATTACHMENTS

None

REFERENCE #	7010.26	EFFECTIVE: 12/2022
SUBJECT:	~~HEMOCCULT TESTING~~7010.26 HEMOCCULT TESTING	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized procedures for the safe, accurate, and consistent use of the Sure-Vue Signature Immunochemical Fecal Occult Blood Test (iFOBT) for qualitative detection of occult blood in stool specimens within the Emergency Department.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Occult Blood: blood present in stool that is not visibly apparent.

iFOBT- immunochemical fecal occult blood test used to detect human hemoglobin in stool specimens.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~T~~the Sure-Vue Signature iFOBT will be performed only by personnel who have completed required education, competency validation, and annual reassessment. Testing will be conducted in accordance with the manufacturer instructions for use, clinical laboratory improvement amendments (CLIA) requirements and infection prevention and safety standards. The test is intended as a qualitative aid in the detection of occult blood in stool specimens and will not replace definitive diagnostic procedures.

PROCEDURE:
Indications for testing
- Suspected gastrointestinal bleeding.
- Unexplained anemia.
- Dark stools without visible blood.
- Provider-directed evaluation for occult gastrointestinal blood loss.

Contraindications/Limitations
- As a substitute for colonoscopy, endoscopy, or definitive gastrointestinal evaluation.
- On specimens contaminated with urine, toilet water, or cleaning agents.
- During active menstrual bleeding.
- When gross blood is visibly present in stool.
- Beyond manufacturer-established storage or testing timeframes.
- False positive or false negative results may occur and must be interpreted within the complete clinical context.

Specimen Collection
- Verify patient identity using two approved identifiers.
- Perform hand hygiene and don gloves.
- Obtain stool specimen in a clean, dry container.
- Unscrew collection tube applicator cap.
- Insert applicator into stool specimen at multiple sites according to manufacturer instructions.
- Return applicator to collection tube and secure it tightly.
- Shake collection tube thoroughly to mix specimen with extraction buffer.

REFERENCE #	7010.26	EFFECTIVE: 12/2022
SUBJECT:	~~HEMOCCULT TESTING~~7010.26 HEMOCCULT TESTING	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Specimen Rejection Criteria

- Unlabeled or mislabeled.
- Leaking or contaminated.
- Improperly collected.
- Expired or stored outside manufacturer recommendations.

Test Procedure

- Allow test materials to reach room temperature prior to testing.
- Remove test cassette from foil pouch immediately before use.
- Label cassette with patient identifiers. Be sure to positively identify the patient with scanning the patient's armband and specimen label at the bedside.
- Shake specimen collection tube thoroughly.
- Remove dispensing cap.
- Apply three (3) drops of processed specimen into the sample well of the cassette.
- Start timer immediately.
- Read test results between 5 and 10 minutes of applying drops of processed specimen into the sample well of the cassette.
- Do not interpret results after 10 minutes.

Interpretation of Results

- Control line and test line visible: Positive result.
- Control line only visible: Negative result.
- No control line visible: Invalid result.

Documentation

- Date and time of testing.
- Patient identification.
- Test result.
- Operator initials/signature.
- Lot number and expiration date if required.
- Any invalid or repeated testing.
- \

Forward specimen and results to the Lab

- After you have performed the test in the ER specimen is forwarded to the Lab for official results.

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REFERENCE:

Fisher HealthCare. (n.d.). Sure-Vue Signature immunochemical fecal occult blood test (iFOBT) instructions for use. Thermo Fisher Scientific.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 12/2022
SUBJECT:	~~HEMOCCULT TESTING~~7010.26 HEMOCCULT TESTING	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 HEAD INJURY STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure the timely identification, assessment, management, and escalation of patients presenting with head injury in order to reduce morbidity and mortality associated with traumatic brain injury, including concussion and intracranial hemorrhage.

AUDIENCE:
Department wWide

TERMS/DEFINITION:
Glasgow Coma Scale (GCS) is: a standardized neurologic assessment tool used to assess consciousness.

Head iInjury means: any trauma to the head resulting in potential or actual injury to the scalp, skull, or brain.

Traumatic Brain Injury (TBI) is : any injury to the brain caused by external mechanical force.

POLICY:
It is the policy of Modoc Medical Center (MMC) that aAll patients presenting with head injury will receive prompt triage, neurological assessment, and appropriate imaging and/or referral in accordance with clinical severity and established guidelines.

PROCEDURE:
- Initial aAssessment (tTriage)
  - Assess airway, breathing, and circulation (ABC).
  - Record vital signs.
  - Perform Glasgow Coma Scale (GCS) scoring.
  - Identify mechanism of injury (fall, assault, sports injury).
  - Immobilize ~~cervical~~the cervical spine if indicated.
- Clinical aAssessment
  Neurological eExamination:
  - GCS.
  - Pupillary size and reaction.
  - Limb strength and sensation.
  - Speech and cognitive status.

  Symptom aAssessment:
  - Loss of consciousness.
  - Vomiting.
  - Headache severity.
  - Amnesia.
  - Seizure aActivity.
  - Behavioral changes.
- Red Flag Criteria (Immediate Escalation)
  - GCS < 15 or declining

  - Repeated vomiting
  - Seizure following injury.
  - Suspected skull fracture.
  - Focal neurological deficit.
  - Persistent confusion or agitation.
  - Signs of basilar skull fracture such as raccoon eyes, battle's sign, hearing loss, facial nerve injury, altered consciousness or cerebrospinal fluid leakage.
  - Use of anticoagulant therapy.
- Imaging Guidelines
  - CT brain scan per provider order.
  - Urgent CT for moderate/severe head injury or red flag symptoms.
- Management

  Mild Head Injury
  - Observation for minimum of 4-6 hours in ED or as clinically indicated.
  - Discharge only if stable with responsible caregiver and clear instructions.

  Moderate Injury
  - Admit for observation.
  - Repeat neurological observations.
  - Neurosurgical consultation if indicated (by ~~provider).~~provider.

  Severe Injury
  - Immediate airway protection and resuscitation.
  - Intensive Care Unit (ICU) admission. Initiate ~~transfer~~the transfer process (provider).
  - Neurosurgical referral urgently.
- Observation Protocol
  - Neurological observations every 15-30 minutes initially, then hourly if stable.
  - Monitor GCS, pupils, and vital signs.
  - Document all changes immediately and notify the provider.
- Documentation
  - Mechanism of injury
  - GCS scores.
  - Neurological findings.
  - Imaging results.
  - Treatment provided.
  - Discharge instructions, admission, or transfer details.

REFERENCE:

American College of Surgeons Committee on Trauma. (2018). Advanced trauma life support (ATLS) student course manual (10th ed.). American College of Surgeons.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 HEAD INJURY STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 CERVICAL SPINE IMMOBILIZATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to provide standardized guidelines for the identification, immobilization, and spinal motion restriction of patients with suspected cervical spine injury to minimize the risk of secondary spinal cord injury.

AUDIENCE:
Department wide

TERMS/DEFINITION:
Spinal Motion Restriction (SMR) is a technique to minimize movement of the spine without mandatory use of rigid backboards

Manual In-Line Stabilization (MILS) is a hands-on stabilization of the head and neck to prevent movement
A cervical collar is a rigid device used to limit cervical spine motion

POLICY:

It is the policy of Modoc Medical Center (MMC) that cervical spine protection will be initiated in patients with suspected injury based on mechanism, clinical findings, or inability to clinically clear the cervical spine. Spinal immobilization will be performed using spinal motion restriction techniques consistent with current evidence-based practice.

PROCEDURE:

CERVICAL SPINE CONSIDERATIONS

Cervical spine immobilization will be considered in patients with the following:

- Trauma with one or more of the following:
  - Neck pain or midline cervical tenderness
  - Neurologic deficits (e.g., numbness, weakness, paralysis)
  - Altered level of consciousness
  - Evidence of intoxication (alcohol or drugs)
  - Distracting injury (significant pain or injury elsewhere)
- High-Risk Mechanism of Injury:
  - High-speed motor vehicle collision
  - Rollover or ejection from vehicle
  - Pedestrian struck by vehicle
  - Falls from heigh (generally > 3-5 feet or 5 stairs)
  - Axial load injury (e.g., diving injury)
- Other Indications:
  - Inability to reliably assess patient
  - Communication barriers prevent adequate examination
  - Clinical judgment of provider

Cervical spine immobilization may be withheld if the patient meets validated low-risk criteria, including:

- Normal mental status (alert and oriented)
- No midline cervical tenderness
- No neurologic deficits
- No intoxication
- No distracting injuries

Special considerations:

- Penetrating trauma
  - Immobilization is generally not required unless neurologic deficits are present.
- Agitated patients:
  - Immobilization should not compromise safety; consider alternative management per protocol.
- Respiratory compromise:
  - Modify or remove immobilization as clinically indicated.

Complications and Risks:

- Pressure injuries
- Airway compromise
- Reduced respiratory capacity
- Increased intracranial pressure in susceptible patients
- Patient discomfort and agitation

CERVICAL SPINE IMMOBILIZATION PROCESS

1. Initial Management
   a. Immediately provide manual in-line stabilization (MILS) upon suspicion of cervical spine injury
   b. Avoid movement of the head and neck
   c. Assess airway, breathing, and circulation while maintaining spinal precautions
2. Airway management
   a. Use jaw-thrust maneuver for airway opening if needed
   b. Avoid head-tilt-chin-lift unless cervical injury is excluded
   c. Maintain MILS during all airway interventions
3. Application of Cervical Collar
   a. Select appropriate collar size based on patient anatomy
   b. Maintain MILS during application
   c. Position the collar to ensure chin support is secure, airway is not obstructed, and the device is snug but not restrictive to ventilation and circulation
4. Spinal Motion Restriction (SMR)
   a. Transfer the patient to appropriate transport surface (e.g. stretcher)
   b. Secure the patient using straps at the chest, pelvis, and lower extremities
   c. Apply head stabilization devices (e.g. blocks or equivalent)
   d. Maintain neutral alignment unless contraindicated by pain or neurologic change
5. Movement and Positioning

   a. If a patient is found in a position of comfort and movement causes pain or neurologic symptoms, immobilize in that position
   b. If vomiting or airway compromise occurs, perform log roll with spinal alignment maintained
6. Reassessment to include the following:
   a. Neurologic status (motor and sensory function)
   b. Circulation, movement, and sensation (CMS) in all extremities
   c. Fit and effectiveness of immobilization device
   d. Reassess after any patient movement or clinical change
7. Documentation Requirements
   a. Mechanism of injury
   b. Neurologic assessment findings
   c. Presence or absence of indications for immobilization
   d. Method of immobilization used
   e. Patient tolerance and response
   f. Reassessment of findings.

REFERENCES:

American College of Surgeons Committee on Trauma. (2018). Advanced Trauma Life Support (ATLS): Student course manual (10th ed.). American College of Surgeons.

American College of Surgeons Committee on Trauma. (2023). Resources for optimal care of the injured patient. American College of Surgeons.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 6/2008
SUBJECT:	~~INTRAVENOUS ACCESS FOR RADIOLOGIC PROCEDURE~~7010.26 ACCESS FOR RADIOLOGIC PROCEDURE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish a standardized process for obtaining, assessing, and maintaining intravenous (IV) access for patients undergoing radiologic procedures requiring intravenous contrast administration to ensure patient safety, minimize delays in diagnostic imaging, and reduce complications associated with contrast injections.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Contrast Media: any intravenous iodinated or gadolinium-based agent administered for diagnostic imaging purposes.

Power Injection: administration of contrast media using an automated injector at prescribed flow rates.

Extravasation: unintentional leakage of contrast media into surrounding tissue outside the vascular system.

POLICY:
All patients undergoing radiologic procedures requiring intravenous contrast administration will have appropriate vascular access established and verified prior to transport or performance of the procedure. IV access will be obtained by qualified personnel operating within their scope of practice and in accordance with hospital policy.

PROCEDURE:
- Patient Identification and Verification
  - Verify patient identity using two (2) approved identifiers.
  - Confirm imaging order and contrast requirement.
  - Review patient history for previous contrast reactions, renal impairment, dialysis status, and vascular access limitations.
- Peripheral IV Access Placement
  - Preferred IV sites include the antecubital veins and forearm veins.
  - Avoid lower extremities unless clinically necessary.
  - Avoid areas of infection, edema, or compromised circulation.
  - Avoid existing infiltrated or damaged sites.
- Recommended catheter sizes
  - Routine cat scan (CT) with contrast: 20-22 gauge IV access
  - CT Angiography: 18-20 gauge IV access
  - Magnetic Resonance Imaging (MRI) with contrast: 20-22 gauge IV access
  - Hand injection only: 22-24 gauge IV access
  - Ultrasound-guided IV placement may be utilized for difficult vascular access patients by trained personnel.
- IV Patency Verification (Prior to contrast administration)
  - Flush IV with normal saline

  - Assess the site for any resistance, pain, swelling, or leakage.
  - Confirm blood return when appropriate.
  - Discontinue or replace any IV demonstrating signs of infiltration or malfunction.
- Central Venous Access Devices
  - Power-injectable central venous catheters may be used only if the device is clearly identified as power injectable, flow rate limitations are verified, and the use complies with manufacturer recommendations.
  - The following require Radiologist approval prior to use:
    - Non-power injectable peripherally inserted central catheter (PICC) lines.
    - Implanted ports
    - Tunneled central venous catheters
    - Dialysis catheters will not be used for contrast administration except in emergent situations with provider approval.
- Difficult IV Access
  - After two unsuccessful IV attempts notify the Emergency Department provider.
  - Alternative access options may include an ultrasound-guided peripheral IV, external jugular IV, central venous access, or intraosseous access in emergency situations.
- Monitoring During Contrast Administration
  - The patient will be monitored throughout contrast administration for extravasation, allergic reaction, respiratory distress, and hemodynamic instability.
  - If extravasation occurs, stop the infusion immediately, assess affected extremity, notify the Radiologist, and ordering provider, and document findings and interventions in the electronic medical record.
- Documentation
  - IV insertion site
  - Catheter gauge
  - Number of insertion attempts
  - Patency assessment
  - Date and time of insertion
  - Staff member performing insertion
  - Patient tolerance
  - Complications and interventions, if applicable

REFERENCE:

American College of Radiology. (2024). ACR manual on contrast media (Version 2024). American College of Radiology. ACR Manual on Contrast Media

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 DIARRHEA STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to provide standardized guidelines for the assessment, management, and infection control of patients presenting with diarrhea, ensuring patient safety, prevention of complications, and reduction of healthcare associated infections.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Diarrhea: three or more loose or watery stools within a 24-hour period or a significant deviation from baseline bowel habits.
Acute diarrhea: duration < 14 days
Persistent diarrhea: duration 14-30 days
Chronic diarrhea: duration > 30 days

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~A~~all patients presenting with diarrhea will be assessed promptly and managed according to evidence-based clinical guidelines. Appropriate infection prevention measures will be implemented to reduce transmission risk, including suspected or confirmed Clostridioides difficile (C. difficile) infection.

PROCEDURE:
1. Obtain patient history:
    - Onset, duration, stool frequency/characteristics.
    - Associated symptoms (fever, abdominal pain, vomiting).
    - Recent antibiotic use, travel, and/or hospitalization.
2. Assess hydration status:
    - Vital signs.
    - Skin turgor, mucous membranes.
    - Intake and output.
3. Identify red flags:
    - Bloody stools.
    - Severe dehydration.
    - Fever > 38.5 Celsius (101.3 Fahrenheit).
    - Immunocompromised status.
4. Infection Control Measures:
    - Initiate contact precautions for suspected infectious diarrhea.
    - Place the patient in a private room.
    - Use gloves and gowns for all patient contact.
    - Perform hand hygiene with soap and water (preferred for suspected Clostridioides difficile infection).
    - Use appropriate disinfectants for environmental cleaning.
5. Diagnostic Evaluation:

- Stool testing as indicated for culture, ova and parasites, and C. difficile toxin/PCR.
- Laboratory tests for complete blood count, electrolytes, and renal function.
- Additional diagnostics as clinically indicated.

6. Treatment and Management
   - Initiate oral rehydration therapy for mild to moderate dehydration.
   - Administer intravenous (IV) fluids for severe dehydration or inability to tolerate oral intake.
   - Administer antidiarrheal agents (e.g., loperamide) only if no contraindications.
   - Avoid giving antidiarrheal agents in suspected infectious or bloody diarrhea unless ordered by provider.
   - Administer antibiotics only when clinically indicated.
   - Treat confirmed Clostridioides difficile infection per hospital policy.
   - Encourage continued oral intake as tolerated.
   - Avoid foods that may exacerbate symptoms.
7. Monitoring
   - Record stool frequency and characteristics.
   - Monitor vital signs and hydration status.
   - Track intake and output.
   - Review laboratory results.
   - Assess response to treatment.
   - Notify the provider immediately about the following:
     - Hemodynamic instability.
     - Persistent diarrhea.
     - Worsening clinical condition.
     - Significant laboratory abnormalities.
     - Suspected complications (e.g., sepsis).
8. Documentation
   - All assessments, interventions, patient responses, and education must be documented in the electronic medical record.

REFERENCE:

Center for Disease Control and Prevention. (2022). Infection control in healthcare personnel: Infrastructure and routine practices for occupational infection prevention and control services, U.S. Department of Health and Human Services. https://www.cdc.gov/infectioncontrol

World Health Organization. (2017). Guidelines for the management of diarrhea and dehydration. http://www.who.int/publications

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~INFECTION CONTROL STANDARD OF CARE IN THE EMERGENCY DEPARTMENT~~7010.26 INFECTION CONTROL STANDARD OF CARE IN THE EMERGENCY DEPARTMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized infection prevention and control practices within the Emergency Department to reduce the risk of transmission of infectious agents among patients, healthcare personnel, and visitors.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Standard Precautions~~: a~~: A set of infection prevention practices used for all patient care based on the assumption that all blood, body fluids, secretions, excretions, non-intact skin, and mucous membranes may contain transmissible infectious agents.

Transmission-Based Precautions~~: is a~~: A set of additional infection control measures used for patients known or suspected of being infected with highly transmissible pathogens.

Personal Protective Equipment (PPE): ~~is s~~Specialized clothing or equipment worn for protection against exposure to infectious materials.

POLICY:
It is the policy of Modoc Medical Center (MMC) that ~~T~~the Emergency Department will implement evidence-based infection prevention and control measures in accordance with guidance from the Centers for Disease Control and Prevention, the World Health Organization, and applicable regulatory requirements including those of the Occupational Safety and Health Administration. All personnel will adhere to sStandard p~~P~~recautions for all patient encounters.

PROCEDURE:
- Standard Precautions (Apply to all patients)
  - Perform hand hygiene before and after patient contact, before aseptic procedures, after exposure to blood/body fluids, after removing gloves, and after touching patient surroundings.
  - Alcohol-based hand rub (preferred when hands are not visibly soiled).
  - Soap and water should be used when hands are visibly soiled and exposure to spore-forming organisms.
  - Use personal protective equipment (PPE) based on anticipated exposure risk.
  - Follow safe injection practices.
  - Utilize approved sharps disposal containers immediately after use.
  - Maintain respiratory hygiene/cough etiquette practices.
- Transmission-Based Precautions
  Contact Precautions
  - Gloves and gowns are required.
  - Dedicated or disposable patient equipment when possible.

Droplet Precautions

- ~~o~~ Surgical mask required within designated ~~proximity~~ proximity.
- Patient must wear a mask during transport out of room.

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Airborne Precautions

- Place the patient in a negative pressure isolation room when available (room 107 if admitted to the floor).
- N95 ~~respirator~~respirators or higher -level respiratory protection is required.
- ~~Door is~~Doors are to be kept closed except for entry/exit.

- Triage and Patient Flow
  - All patients will undergo infection risk screening at triage.
  - Patients with suspected infectious conditions will be promptly separated from ~~general~~the general patient population.
  - Appropriate signage for the type of isolation.
  - Use of required PPE.
  - Notifications to receiving departments of the type of isolation.
  - Cohorting of patients with similar symptoms/diagnosis may be implemented during surge conditions.
- Personal Protective Equipment (PPE)
  - PPE will be readily accessible at point of care.
  - Staff must receive training on proper donning and doffing procedures. Employees complete yearly HealthStream modules for hospital compliance.
  - PPE selection will be based on risk assessment and transmission category.
- Sharps Safety
  - Use aseptic ~~technique~~techniques for all injections.
  - Never reuse needles or syringes.
  - Use single-dose medication vials whenever possible.
  - Activate safety devices immediately after use.
  - Avoid recapping needles unless medically necessary.
  - Dispose of sharps at the point of use.
  - Report all needlestick injuries immediately to supervisor.
  - Wash affected ~~area~~areas immediately.
  - Complete incident documentation per facility policy.
- Environmental Cleaning and Disinfection
  - High-touch surfaces will be cleaned at regular intervals and between patient encounters.
  - Reusable equipment must be cleaned after each use, properly disinfected or sterilized, and stored in clean designated areas.
  - Isolation rooms require terminal cleaning after patient discharge.
  - Only approved hospital-grade disinfectants will be used.
- Linen and Waste Management
  - Soiled linen should be handled minimally.

  - Soiled linen should not be shaken.
  - Soiled linen should be placed in designated laundry bags.
  - Wast material should be disposed of according to classification: regular waste, biohazardous waste, and sharps waste.
- Occupational Exposure Management
  - All exposure incidents (e.g., sharps injuries, mucosal exposure) must be reported immediately.
  - Post-exposure protocols will be initiated per institutional guidelines.

REFERENCE:

Centers for Disease Control and Prevention. (2024). Isolation precautions guidelines. U.S. Department of Health and Human Services. https://www.cdc.gov/infection-control/hcp/isolation

Centers for Disease Control and Prevention. (2024). Standard precautions for all patient care. U.S. Department of Health and Human Services. https://www.cdc.gov/infection-control/hcp/basics/standard-precautions.html

Occupational Safety and Health Administration. (2024). Bloodborne pathogens standard (29 CFR 1910.1030). U.S. Department of Labor. https://www.osha.gov/bloodborne-pathogens

World Health Organization. (2009). WHO guidelines on hand hygiene in health care. World Health Organization. https://www.who.int/publication/i/item/9789241597906

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE05/2026
SUBJECT:	~~INTRAOSSEOUS ACCESS~~7010.26 INTRAOSSEOUS ACCESS	REVISED: ~~5/2026~~
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized guidelines for the insertion, maintenance, monitoring, and removal of intraosseous access in patients requiring emergent vascular access in the Emergency Department.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Intraosseous (IO) Access: a method of obtaining vascular access by inserting a needle into the medullary cavity of a bone for infusion of fluids and medications.

POLICY:
It is the policy of Modoc Medical Center (MMC) that intraosseous access may be established for emergent vascular access when peripheral intravenous (IV) access is not readily obtainable or would result in unacceptable delay in treatment. IO access may be used for the administration of fluids, blood products, and medications in accordance with current clinical guidelines and manufacturer recommendations.

PROCEDURE:
IO access may be utilized in emergent or urgent clinical situations including, but not limited to the following:

- Cardiac arrest
- Shock
- Severe dehydration
- Trauma
- Sepsis
- Respiratory failure.
- Status Epilepticus.
- Failed peripheral IV access after appropriate attempts.
- Need for immediate medication or fluid administration.

IO access is contraindicated in the following:

- Fracture of the target bone.
- Infection or cellulitis at insertion site.
- Previous IO attempt in the same bone within 24-48 hours.
- Inability to identify anatomical landmarks.
- Bone disorders compromising bone integrity.

IO access relative contraindications include the following:

- Orthopedic hardware near insertion site.
- Prosthetic limb or joint.
- Severe obesity obscuring landmarks.

REFERENCE #	7010.26	EFFECTIVE05/2026
SUBJECT:	~~INTRAOSSEOUS ACCESS~~7010.26 INTRAOSSEOUS ACCESS	REVISED: ~~5/2026~~
DEPARTMENT:	EMERGENCY DEPARTMENT	

IO approved insertion sites include the following:

- For adults: proximal tibia, proximal humerus, and distal tibia.
- For pediatrics: proximal tibia, and distal femur.

Preparation for procedure

- Verify patient identification.
- Assess indication and contraindications.
- Explain procedure to patient/family if circumstances permit.
- Perform hand hygiene.
- Don appropriate personal protective equipment (PPE).
- Select insertion site and prepare skin using approved antiseptic technique.

Insertion

- Position extremity appropriately.
- Insert IO needle according to manufacturer instructions.
- Advance needle until loss of resistance is felt.
- Remove stylet and secure sharps safely.
- Confirm placement by needle stability, aspiration of marrow or blood when obtainable~~,~~ and ability to flush without resistance or evidence of infiltration.

Post-insertion care

- Flush IO line per manufacturer recommendation.
- Secure IO device using a stabilization dressing.
- Initiate prescribed fluids and/or medications.
- Use pressure infusion device as needed for adequate flow rates.
- Administer lidocaine prior to infusion in conscious patients when ordered.

Monitoring

- Patency of IO
- Swelling
- Extravasation
- Bleeding
- Pain
- Signs of infection
- Compartment syndrome

Removal

- IO access should be discontinued as soon as alternative vascular access is established and no later than 24 hours after insertion unless otherwise clinically justified.
- Stop infusion.
- Remove stabilization dressing.
- Stabilize extremity.
- Remove catheter using gentle twisting motion.
- Apply sterile dressing.
- Document removal and site condition.

Documentation

- Date and time of insertion.
- Indication for IO access.
- Insertion site.
- Needle size/device used to insert.
- Number of attempts.
- Confirmation of placement.
- Medications and fluids administered.
- Patient tolerance and response.
- Complications encountered.
- Date and time of removal.
- Name and credentials of clinician performing procedure.

REFERENCE:

Emergency Nurses Association. (2023). Emergency nursing procedures (6th ed.). Elsevier.

Emergency Nurses Association. (2022). Clinical practice guideline: Intraosseous vascular access. Journal of Emergency Nursing, 48(4), 456-462.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~DISCHARGE INSTRUCTIONS~~7010.26 DISCHARGE INSTRUCTIONS	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to ensure that all patients discharged from the Emergency Department (ED) receive clear, complete, and standardized instructions to support safe care transitions, reduce complications~~,~~ and improve patient outcomes.

AUDIENCE:
Department Wide

POLICY:
It is the policy of Modoc Medical Center (MMC) that all patients discharged from the ED will be clinically stable at the time of discharge, receive both verbal and written discharge instructions, be provided education appropriate to their language and level of understanding, receive clear follow-up and return precautions, and have all discharge education documented in the electronic medical record.

PROCEDURE:
All discharge instructions must include the following:

1. Diagnosis/Chief Complaint
   - Clear, patient-friendly explanation.
2. Treatment Provided
   - Summary of care provided in the ED.
3. Medications
   - Name, dose, frequency, and route.
   - Duration of use.
   - Potential side effects.
4. Activity and Diet
   - Restrictions or recommendations.
5. Follow-Up Care
   - Provider/clinic name if known.
   - Recommended time frame.
6. Return Precautions
   - Explicit instructions to return to the ED for worsening symptoms, new or concerning symptoms, and specific condition-related warnings.
7. Communication Standards
   - Use plain, non-medical language.
   - Provide interpreter services (Propio) when needed.
   - Include family/caregiver when appropriate.
8. Documentation Requirements
   - Patient condition at discharge.
   - Instructions provided (verbal and written).
   - Patient understanding.
   - Prescriptions issued.
   - Inform the patient of pending results. Document communication plan for results.
   - Any refusal of care or instructions.

9. Special Circumstances
    - High-Risk Patients (e.g., elderly, cognitive impairment, language barriers)
        - Involve caregiver.
        - Consider social services consultation.
        - Provide enhanced education.
    - Against Medical Advice (AMA)
        - Document discussion of risks.
        - Provide discharge instructions. Document if patient refuses or leaves prior to discharge.
        - Attempt follow-up arrangements.

REFERENCES:

None

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~MEDICATION ERRORS~~7010.26 MEDICATION ERRORS	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish a standardized process for the identification, reporting, management, documentation, investigation, and prevention of medication errors occurring within the Emergency Department (ED) to promote patient safety and regulatory compliance.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Medication Error: any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of a healthcare professional, patient, or consumer.

Near Miss: an event or situation that could have resulted in a medication error but did not reach the patient.

Adverse Drug Event (ADE): harm experienced by a patient as a result of exposure to a medication.

High-Alert Medication: a medication that bears a heightened risk of causing significant patient harm when used in error.

POLICY:
It is the policy of Modoc Medical Center (MMC) that all medication errors, adverse drug events, and near misses occurring in the Emergency Department will be immediately addressed, documented, reported, and reviewed through the hospital Quality Assurance and Performance Improvement (QAPI) program. The hospital maintains a non-punitive culture of safety that encourages timely reporting of medication-related events to improve systems and reduce risk of patient harm.

PROCEDURE:
- Identification of Medication Error
  Medication errors may include any of the following:
  - Wrong patient.
  - Wrong medication.
  - Wrong dose.
  - Wrong route.
  - Wrong time.
  - Omitted medication.
  - Allergy contraindication.
  - Duplicate medication.
  - Incorrect documentation.
  - Infusion or pump programming error.

Any staff member identifying a medication error will take immediate action to ensure patient safety.

- Immediate Patient Care
  Upon discovery of a medication error, the staff member will do the following:
  - Stop the medication or infusion immediately, if applicable.

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  - Assess the patient's condition.
  - Obtain vital signs and additional assessments as indicated.
  - Notify the provider immediately.
  - Notify pharmacy as soon as possible.
  - Initiate emergency interventions as ordered or clinically indicated.
  - Continue to monitor the patient until stable.
- Provider Notification
  - The provider will be notified immediately for any medication error resulting in patient harm, any potentially harmful medication error, any significant omissions or delays, and any high-alert medication error.
  - Notification documentation will include the date and time of notification, provider name, orders received and any interventions initiated.
- Pharmacy Notification
  - The pharmacist will be notified as soon as possible for clinical review, antidote recommendations, monitoring guidance, event investigation and/or medication reconciliation review.
- Patient Monitoring
  - Monitoring requirements will be based on medication involvement, severity of the event, provider orders and the patient's condition.
  - Monitoring may include any of the following: cardiac monitoring, neurological assessment, blood glucose monitoring, laboratory testing and extended observation.
- Documentation
  - The electronic medical record will include any objective description of the event, patient assessment findings, notifications completed, interventions performed, and patient response.
  - The medical record will not include any reference to incident reports, blame statements or speculation or assumptions.
  - All medication errors will be reported in Safety First.

REFERENCE:

Centers for Medicare & Medicaid Services. (2024). Critical access hospital conditions of participation. U.S. Department of Health and Human Services. CMS Critical Access Hospital Regulations.

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 DYING PATIENT STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized procedures for the identification and management of patients who are actively dying in the Emergency Department (ED), to ensure care that prioritizes comfort, ~~dignity~~dignity, and respect for patient autonomy.

AUDIENCE:
Department wide

TERMS/DEFINITION:
Actively dying patient is a patient with clinical signs indicating death is imminent and irreversible.

Comfort care is treatment focused on symptom relief rather than curative intent.

Advance Directive is a legal document outlining patient preferences for medical care.

POLICY:
It is the policy of Modoc Medical Center (MMC) to provide compassionate, patient-centered end-of-life care. When curative or life-prolonging treatment is no longer appropriate or desired, care will transition to comfort-focused measures consistent with the patient's wishes, advance directives~~,~~ and the patient's clinical condition.

PROCEDURE:
1. Identification of the dying patient
    - Assess for signs of imminent death (e.g., multi-organ failure, decreased consciousness, irregular respirations)
    - Review documentation for advanced directives, Physician Orders for Life-Sustaining Treatment (POLST), or Do Not Resuscitate/Do Not Intubate Status (DNR/DNI)
    - If goals of care are unclear, the attending provider will initiate a goal-of-care discussion with the patient and/or surrogate decision-maker.
2. Transition to Comfort-Focused Care
    - The attending provider will determine when further curative treatment is non-beneficial or inconsistent with the patient's wishes.
    - Discontinue non-essential monitoring, diagnostics, and interventions
    - Document the decision to transition to comfort care in the medical record
3. Symptom management
    - The primary goal is relief of distressing symptoms
    - Interventions may include, but are not limited to the following:
        - Pain: administer opioids as ordered by the provider
        - Dyspnea: provide oxygen therapy, opioids, and positioning
        - Anxiety/agitation: administer anxiolytics or sedatives
        - Respiratory secretions: administer anticholinergic agents
        - Nausea/Vomiting: administer antiemetics
    - Titrate medications to patient comfort rather than physiologic targets

4. Communication
    - The provider will communicate clearly and compassionately with the patient and family regarding prognosis, expected course of dying, and plan of care and goals.
    - Allow time for questions and emotional support
    - Document all discussions in the electronic medical record
5. Environment and dignity
    - Provide a private or quiet space if available
    - Minimize noise, alarms, and unnecessary interruptions
    - Facilitate family presence at the bedside
    - Respect cultural, spiritual, and religious preferences
    - Offer chaplaincy or spiritual care services
6. Care during the dying process
    - Continue comfort measures and reassess symptoms frequently
    - Avoid invasive or non-beneficial procedures
    - Provide ongoing emotional support to family members
7. After death care
    - The provider will pronounce death
    - Notify appropriate parties (family, coroner/medical examiner)
    - Allow family time with the deceased
    - Ensure proper handling of the body post-mortem
    - Complete all required documentation, including time of death and circumstances
    - Complete the Record of Death Form

REFERENCES:

None

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE 05/2026
SUBJECT:	7010.26 CHEST PAIN STANDARD OF CARE	REVISED ~~5/2026~~
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to provide timely, evidence-based evaluation and management of patients presenting with chest pain or suspected acute coronary syndrome (ACS), in alignment with guidelines from the American Heart Association. All patients will receive rapid assessment, stabilization~~,~~ and appropriate disposition, including transfer to a higher level of care when indicated.

AUDIENCE:
Department wide

TERMS/DEFINITION:
Cardiac biomarkers are proteins that the heart releases when there is damage or stress

Door-in-Door-Out (DIDO) is time from arrival to transfer departure (goal is <45-60 minutes)

POLICY:
It is the policy of Modoc Medical Center (MMC) to ensure all patients presenting with chest pain will undergo rapid triage, risk stratification~~,~~ and initiation of evidence-based diagnostic and therapeutic interventions within defined timeframes.

PROCEDURE:
1. Triage and initial assessment
    - Perform a triage immediately upon patient arrival
    - Assign high-acuity level to patients with concerning symptoms
    - Obtain and document patient vital signs, focused history, and focused physical examination
    - Place the patient on cardiac monitor
    - Establish intravenous (IV) access
2. Electrocardiogram (ECG)
    - Obtain 12-lead ECG within 10 minutes of patient arrival
    - Repeat ECGs for ongoing or recurrent symptoms
    - Immediately notify the provider of abnormal findings
3. Laboratory Evaluation
    - Obtain cardiac biomarkers initial and at serial intervals
    - Complete blood count (CBC)
    - Basic metabolic panel (BMP)
    - Additional labs as clinically indicated
4. Imaging
    - Chest x-ray for most patients
    - Consider advanced imaging based on clinical suspicion
        - Computed Tomography Scan (CT)
        - angiography for suspected pulmonary embolism or aortic dissection.
5. Initial Medical Management
   If cardiac ischemia is suspected
    - Administer aspirin unless contraindicated

- Nitroglycerin for pain unless contraindicated
- Oxygen if SpO2 < 90%.
- Initiate anticoagulation and/or additional antiplatelet therapy as indicated
- Consider beta-blockers when appropriate
- High intensity statin
- Morphine for refractory pain

6. ST-Elevation Myocardial Infarction (STEMI)
   - Initiate transfer to a higher level of care
   - Goal of door-to-balloon time < 90 minutes
   - If transfer delay > 120 minutes evaluate for fibrinolytic therapy and administer within 30 minutes if indicated
   - Continue with stabilization and monitoring
7. Disposition
   - Early contact with receiving facility for STEMI, high-risk acute coronary syndrome, suspected pulmonary embolism or aortic dissection.
     - Transfer is preferred for most high/intermediate risk patients
   - High risk patients will be in a continually monitored setting. If the patient requires an intensive care unit (ICU), the transfer process will be initiated
   - Intermediate risk patients will be observed in the emergency department with serial cardiac testing. Determination will be made if transfer will be initiated.
   - Low risk patients will be discharged with outpatient follow-up and clear return precautions.
8. Documentation Requirements
   - Time of ECG completion
   - Time of transfer decision if applicable
   - Communication with receiving facility staff
   - Treatments administered prior to transfer
   - Medication administration times
   - Clinical decision-making and risk stratification
   - Patient assessment, reassessment, and response to treatment

REFERENCE:

American Heart Association. (2021). 2021 AHA/ACC guideline for the evaluation and diagnosis of chest pain. Circulation, 144(22), e368-e454. https://doi.org/10.1161/CIR.0000000000001029

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~7010.26 IN THE EMERGENCY DEPARTMENT~~7010.26 VISITORS IN THE EMERGENCY DEPARTMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:
The purpose of this policy is to establish standardized guidelines for visitor access in the Emergency Department (ED) to ensure patient rights, safety, privacy, infection prevention~~,~~ and efficient delivery of emergency medical care in compliance with applicable California Title 22 requirements and hospital licensing standards.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Clinical Restriction: limitation of visitation due to patient condition, treatment needs, or safety concerns.

POLICY:
It is the policy of Modoc Medical Center (MMC) to recognize~~s~~ the importance of patient support persons in the Emergency Department. Patients may have visitors consistent with this policy. Visitor access may be limited, modified, or restricted at any time based on clinical necessity, safety, infection prevention requirements, or operational conditions.

PROCEDURE:
General Visitation

- Patients may have up to one to two visitors at a time, subject to clinical condition and space availability.
- Visitors must check in at the front desk during business hours and at the ED entrance after hours.
- Visitors must remain in designated patient care areas unless otherwise directed.
- Visitors may be required to leave the room or ED at any time for procedures or resuscitations, patient care activities, privacy, or confidentiality considerations.

Patient Rights

- Patients have the right to designated visitors of their choosing, including non-family members, consistent with California patient rights regulations under Title 22.
- Patients may revoke or change visitor designation at any time.
- Visitor access may be restricted when clinically or operationally necessary, including but not limited to safety, infection control, or disruptive behavior concerns.

Clinical and Operational Restrictions

- Visitor access may be limited or suspended under the following conditions:
  - Trauma activations.
  - Cardiac arrest or resuscitation.
  - Patients under isolation precautions (contact, droplet, airborne).
  - Public health directives requiring restricted access.
  - Aggressive, threatening, or disruptive behavior.
  - Psychiatric emergencies requiring stabilization.
  - Law enforcement custody situations.
  - ED overcrowding or surge conditions.
  - Disaster activation or emergency operations plan implementation.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	~~7010.26 IN THE EMERGENCY DEPARTMENT~~7010.26 VISITORS IN THE EMERGENCY DEPARTMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Infection Prevention Requirements

- All visitors must comply with hospital infection control policies.
- Visitors may be required to perform hand hygiene upon entry and exit, wear personal protective equipment (PPE) as indicated, or undergo symptom screening prior to entry.

Visitor Conduct

- Follow all staff instructions without delay.
- Maintain respectful and non-disruptive behavior.
- Not interfere with patient care or medical equipment.
- Remain in assigned areas unless escorted.
- Comply with hospital safety and security screening requirements.
- Violation of conduct requirements may result in immediate removal from the facility.

Documentation

- Visitor restrictions beyond standard application of this policy will be documented in the patient's medical record when clinically relevant and/or in appropriate incident reporting systems when security related.

REFERENCE:

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 6, § 70453. (2025). *Comprehensive emergency medical services—general requirements*. https://regulations.justia.com/states/california/title-22/division-5/chapter-1/article-6/section-70453/

ATTACHMENTS:

None.

NURSING MED/SURG

REFERENCE #	6170.26	EFFECTIVE: 9/2026
SUBJECT:	6170.26 BEDSIDE COMMODE USE POLICY	REVISED: 6/2026
DEPARTMENT:	NURSING -MED SURG	

PURPOSE:
The purpose of this policy is to ensure the safe, appropriate, and consistent use of bedside commodes for hospitalized patients while minimizing the risk of falls, injury, healthcare-associated infections, and compromise of patient dignity and privacy.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
None.

POLICY:
It is the policy of Modoc Medical Center (MMC) that a bedside commode may be used for hospitalized patients when clinically indicated and when its use is determined to be safer or more appropriate than ambulation to a bathroom. The bedside commode will be used in accordance with patient-specific mobility status, fall-risk precautions, infection prevention standards, and safe patient handling practices.

PROCEDURE:
Assessment
- Prior to use, the nursing staff will assess and document the patient's mobility and transfer status, level of assistance required, cognitive status and ability to follow directions, fall-risk status and the need for assistive devices or safe patient handling equipment.

Preparation
- Position the commode as close to the bed as practical.
- Ensure the commode is stable and functioning properly.
- Lock wheels when equipped with wheel-locking mechanisms.
- Verify adequate lighting and a clutter-free environment.
- Provide appropriate footwear and mobility aids as indicated.

Patient Transfer
- Staff will follow established safe patient handling procedures.
- Required assistance levels will be provided based on patient assessment.
- Transfer devices, gait belts, or mechanical lifts will be utilized when indicated.
- Patients identified as high fall risk will not transfer independently unless specifically assessed and authorized to do so.

Supervision During Use
- Staff will remain available according to the patient's assessed level of risk and assistance needs.
- Patients requiring continuous supervision will not be left unattended on the bedside commode.
- Call light will remain within the patient's reach.

Completion of Use
- Assist the patient safely back to bed, chair, or other approved location.
- Ensure patient comfort and safety following transfer.
- Confirm bed or chair safety measures are in place as ordered.

Infection Prevention and Equipment Cleaning

- Standard precautions will be followed during all toileting activities.
- Appropriate personal protective equipment will be worn when exposure to bodily fluids is anticipated.
- Commode receptacles will be emptied and cleaned promptly after use.
- The bedside commode will be disinfected according to hospital infection prevention procedures.
- Shared equipment will be cleaned and disinfected between patients.

Documentation

- Use of bedside commode.
- Patient tolerance of transfer and toileting activity.
- Assistance level required.
- Elimination output when clinically indicated.
- Safety concerns, falls, near-falls, or adverse events.
- Patient education provided.

REFERENCE:

Centers for Medicare & Medicaid Services. Code of Federal Regulations. 42 CFR Part 485, Subpart F—Conditions of Participation: Critical Access Hospitals.

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 BED MAKING PROCEDURE FOR INPATIENT CARE AREA	REVISED: 6/2026
DEPARTMENT:	NURSING -MED SURG	

PURPOSE:
The purpose of this policy is to ensure that all patients are provided with a clean, safe, comfortable, and hygienic bed environment that promotes rest, recovery, infection prevention, patient dignity and skin integrity.

AUDIENCE:
Department Wide

TERMS/DEFINITION:
Occupied Bed: a bed prepared or remade while the patient remains in bed.

Unoccupied Bed: a bed prepared when the patient is not occupying the bed.

POLICY:
It is the policy of Modoc Medical Center (MMC) that all patient beds will be maintained in a clean, dry, wrinkle-free and safe condition always. Bed linen will be changed when soiled, wet, contaminated, damaged, after patient discharge and as required by unit standards. Staff will adhere to infection control practices, patient safety principles, and proper body mechanics during bed-making procedures.

PROCEDURE:
- Perform hand hygiene before and after bed making.
- Use appropriate personal protective equipment (PPE) when handling soiled or contaminated linen.
- Explain the procedure to the patient and obtain cooperation when applicable.
- Maintain patient privacy and dignity throughout the procedure.
- Raise the bed to an appropriate working height and lock bed wheels before commencing.
- Do not shake soiled linens.
- Always keep clean ~~linen~~linens separate from soiled ~~linen~~linens.
- Place soiled linen directly into designated laundry bags or containers.
- Inspect the mattress and bed frame for cleanliness and integrity.
- Ensure linens are smooth and free of wrinkles to minimize the risk of skin breakdown.

Unoccupied Bed-Making Procedure
- Gather all required supplies and equipment.
- Remove soiled linen and dispose of it according to hospital procedures.
- Clean and disinfect the mattress if indicated.
- Apply the bottom sheet securely.
- Place the draw sheet and protective pad as required.
- Apply the top sheet and blanket according to unit standards.
- Miter corners where applicable.
- Place clean pillowcases on pillows.
- Arrange linens neatly and ensure patient readiness.
- Return the bed to the appropriate position.

Occupied Bed-Making Procedure

- Explain the procedure to the patient.
- Ensure privacy measures are in place.
- Lower the side rail on the working side while maintaining patient safety.
- Assist the patient to turn to one side.
- Loosen and roll soiled linen toward the patient's back.
- Place clean linen on the exposed mattress surface and roll it toward the patient.
- Assist the patient to turn onto the clean side.
- Remove remaining soiled linen and discard appropriately.
- Pull through and secure clean linen.
- Replace top linens while maintaining patient dignity.
- Position the patient comfortably and safely.
- Ensure the call light and personal items are within reach of the patient.

Infection Prevention and Control

- Standard precautions will be observed at all times.
- Additional transmission-based precautions will be followed when indicated.
- Contaminated linen will be handled minimally and transported in designated bags.
- Clean linen will be stored in a clean, dry, and designated area.
- Linens contaminated with blood or body fluids will be managed according to infection prevention guidelines.

Safety Considerations

- Use proper body mechanics and safe patient handling techniques.
- Maintain bed brakes in the locked position during bed making.
- ~~Ensure~~Ensure that side rails are positioned according to the patient's care plan.
- Lower the bed to the safest position upon completion.
- Ensure the patient has access to the call light.

REFERENCE:

American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Centers for Disease Control and Prevention. (2024). *Guidelines for environmental infection control in health-care facilities*. https://www.cdc.gov

ATTACHMENTS:

None.

ATTACHMENT E

Departmental Manuals

YEARLY MEMO/SIGNATURE PAGES

MODOC MEDICAL CENTER
EST. 1951
Healing Hands Close To Home

LAST FRONTIER HEALTHCARE DISTRICT
A Public Entity

Date: June 17, 2026

To: Policy & Procedure Committee

Board of Directors

From: Amber M. Vucina, CHRO

Subject: Submittal of Human Resources Manual

The Human Resources manual is submitted for review and approval.

What has been accomplished for the year;

- None

To be completed/edited in the coming year;

- Onboarding policy
- Pre-employment reference check policy
- Anti nepotism policy
- Employment classification policy
- Employee performance evaluation policy
- Job description policy
- License and certification verification policy
- Background screening policy
- Pre employment physical examination policy
- Relocation assistance policy
- Performance improvement plan policy

Respectfully submitted:

Amber M. Vucina
Chief Human Resources Officer

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HUMAN RESOURCES/ORIENTATION POLICY MANUAL
2026

The Human Resources/Orientation Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

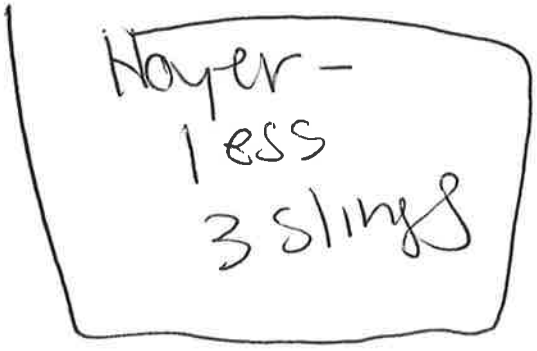
Amber M. Vucinich — 12-17-26

Human Resources/Orientation — Date

Chief Executive Officer — Date

Chair, Board of Directors — Date

Beta



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MEMORANDUM

DATE: 6/23/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: SUSAN SAUEHEBER INFUSION SERVICES
SUBJECT: ANNUAL INFUSION SERVICES MANUAL REVIEW

I have completed the review for the Infusion Services Manual.

Please note the only revision for 2026 is as follows:

6170-1.26 Treatment of Adverse Reactions

Thank you for your attention to the above.

Respectfully Submitted,

SUSAN SAUEHEBER
INFUSION SERVICES
SS/sab

INFUSION SERVICES POLICY MANUAL
2026

INFUSION SERVICES Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

Infusion Services

6/23/2026
Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

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MEMORANDUM

DATE: 6/23/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: SUSAN SAUEHEBER- ACUTE-ER NURSING MANAGER
SUBJECT: ANNUAL EMTALA MANUAL REVIEW

I have completed the review for the EMTALA Manual.

Please note that there are no revisions for 2026.

Thank you for your attention to the above.

Respectfully Submitted,

SUSAN SAUEHEBER
ACUTE-ER NURSING MANAGER
SS/sab

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EMTALA POLICY MANUAL
2026

EMTALA Manual has been reviewed and is approved for use at Modoc Medical Center.

EMTALA Services	Date 6/23/2026
Chief Executive Officer	Date
Chair, Board of Directors	Date

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MEMORANDUM

DATE: 6/23/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: DELINDA GOVER-OPERATING ROOM/SURGERY MANAGER
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the review for the OPERATING ROOM/SURGERY Manual Review.

Attached is the list of revising/archived policies. I am beginning the process of editing all required updates/changes. Those updates/changes will be submitted to Policy Committee, and the Board for approval within the next 90 days.

Based on the foregoing, it is my recommendation that the Board approve the Operating Room/Surgery manual as is.

Respectfully Submitted,

DELINDA GOVER
OPERATING ROOM/SURGERY MANAGER
DG/sab

OPERATING/SURGERY DEPARTMENT

REVISING LIST

BLOOD TRANSFUSION-coming from Susan

PRE-OP REGISTRATION FOR IN-PATIENT

POST OPERATIVE ROUTINE-in tech reader right now

ANTI-MICROBIAL SOUP SHOWER-in tech reader now

OUT-PATIENT SURGERY-in tech reader right now

DIRECTOR OF ANESTHESIA SERVICES

PRE-ANESTHESIA REQUIREMENTS

EPIDURAL CATHETER FLOW SHEET

EPIDURAL CHART ORDER

CONSIOUS SEDATION

POST ANESTHESIA CARE

MEDICATIONS FOR THE PACU

PACU GUIDE FOR NURSES NOTES

DOCUMENTATION OF THE PACU RECORD

PHYSICAL ASSESSMENT OF THE PACU

THROAT AND NECK SURGERIES

ABDOMINAL SURGERY

GYNECOLOGY SURGERY

DVT PROPHYLAXIS

SSI PATHOGENS

OPERATING/SURGERY DEPARTMENT

REVISING LIST CONTINUED

POST ANESTHESIA CARE UNIT PROTOCOLS

CLEANING AND PROCESSING ANESTHESIA EQUIPEMENT

TRAFFIC PATTERNS IN THE SURGICAL SUITE

DRYING CLEANSED HANDS AND ARMS

STERILE ITEMS OUT-DATE IN OR

OR CONTAMINATION CASES

ANESTHESIA SERVICES-in tech reader

PHOTOGRAPHY AND VIDEO-at the Board

GROSS SPECIMENS-at review right now

SURGERY CHARGE FORM-in tech reader

EDG and COLONOSCOPY

IN-ATIENT AND OUT PATIENT O.R. SURGERY

CATGORIES OF SURGICAL OUTPATIENTS

ARCHIVED/REMOVED

Anesthesia

183

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OPERATING ROOM/SURGRY POLICY MANUAL
2026

OPERATING ROOM/SURGRY Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

OPERATING ROOM/SURGERY MANAGER	Date 6/30/26
Chief Executive Officer	Date
Chair, Board of Directors	Date

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MEMORANDUM

DATE: 6/23/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: DELINDA GOVER-CENTRAL SUPPLY
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the review for the CENTRAL SUPPLY Manual Review.

At this time, the Manual has been reviewed and there are no updates/archives. In accordance with same, it is my recommendation that the Board approve the Central Supply Manual.

Respectfully Submitted,

DELINDA GOVER
OPERATING ROOM/SURGERY MANAGER
DG/sab

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CENTRAL SUPPLY POLICY MANUAL
2026

Central Supply Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

OPERATING ROOM/SURGERY MANAGER	Date 6/30/26
Chief Executive Officer	Date
Chair, Board of Directors	Date

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MEMORANDUM

DATE: 7/8/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: JUDY JACOBY INFECTION CONTROL-ACUTE
SUBJECT: ANNUAL

TO WHOM IT MAY CONCERN:

I, Judy Jacoby have completed the above Policy Review Procedure and am confident that my policy manual should be approved at this time.

I have attached a list of policies that I will be amending over the next 120 days as well as any archived policies.

Thank you for your attention to the above.

Respectfully Submitted,
Judy Jacoby MSN, PHN RN
JUDY JACOBY
INFECTION CONTROL-ACUTE
JJ/sab
Enc. Revised/archived policy list

INFECTION CONTROL ACUTE DEPARTMENT

REVISING LIST

MULTI DRUG RESISTANT ORGANISMS

SEVERE ACUTE RESPIRATOR SYNDROME (SARS)

COVID-19 EMPLOYEE HEALTH AND SAFETY PROTOCOLS

N95 FIT-TESTING

COHORTING ISOLUATION PATIENTS IN ACUTE CARE SETTING

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INFECTION CONTROL-ACUTE REVIEW MANUAL
2026

The Infection Control-Acute Manual has been reviewed and is approved for use at Modoc Medical Center.

Stacy Jones — 7/8/2026

Infection Control-Acute — Date

Chief Executive Officer — Date

Chair, Board of Directors — Date

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MEMORANDUM

DATE: 7/9/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: VAHE HOVASAPYAN RETAIL-PHARMACY
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the yearly review for the RETAIL-Pharmacy Manual.

The Retail Pharmacy Manual needs updating. I am currently revising/archiving policies as noted on the attached document. Additionally, I will be adding new policies to the Retail Pharmacy Manual.

These revisions and additional policies will be completed within 120 days of the date of this memorandum.

Thank you for your attention to the above.

Respectfully Submitted,

VAHE HOVASAPYAN
Retail Pharmacy
VH/sab

PHARMACY- REVISING/ARCHIVED LIST

REVISING LIST

Controlled Substance Inventory

Controlled Substance Prescription Monitoring Program

Patient Counseling Policy

Quality Assurance

ARCHIVED LIST

Filter Needles

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RETAIL PHARMACY POLICY MANUAL
2026

Retail/Pharmacy Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

Retail/Pharmacy Manager — Date: 7/9/26

Chief Executive Officer — Date

Chair, Board of Directors — Date

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MEMORANDUM

DATE: 7/9/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: VAHE HOVASAPYAN HOSPITAL-PHARMACY
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the yearly review for the Hospital-Pharmacy Manual.

The Manual is in good shape and it is my recommendation that the Board approve the manual as is at this time. Any revisions are listed on the attached revised/archived list. These revisions will be completed within 120 days of the date of this memorandum.

Thank you for your attention to the above.

Respectfully Submitted,

VAHE HOVASAPYAN
Hospital Pharmacy
VH/sab

PHARMACY-HOSPITAL 2026

REVISING LIST

Automatic Stop Orders CPOE

Crash Cart Contents

Medication Errors Reduction Program (MERP)

Repacking Records

ARCHIVED/REMOVED

HOSPITAL PHARMACY POLICY MANUAL
2026

Hospital Pharmacy Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

Hospital/Pharmacy Manager	Date 7/9/26
Chief Executive Officer	Date
Chair, Board of Directors	Date

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MEMORANDUM

DATE: 7/9/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: VAHE HOVASAPYAN SNF-PHARMACY
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the yearly review for the SNF-Pharmacy Manual.

The Manual is in good shape and it is my recommendation that the Board approve the manual as is at this time. Any revisions are listed on the attached revised/archived list. These revisions will be completed within 120 days of the date of this memorandum.

Thank you for your attention to the above.

Respectfully Submitted,

VAHE HOVASAPYAN
SNF Pharmacy
VH/sab

PHARMACY- REVISING/ARCHIVED LIST SNF

REVISING LIST

Crash Cart Contents

Medication Errors

ARCHIVED LIST

IV Medication Administration

MODOC MEDICAL CENTER
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Last Frontier Healthcare District

SNF PHARMACY POLICY MANUAL
2026

SNF/Pharmacy Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

SNF/Pharmacy Manager	Date 7/9/26
Chief Executive Officer	Date
Chair, Board of Directors	Date

SPREADSHEET

Contact	Name	Effective Da	Revised Date
Delinda Gover	7420.26 EGD and Colonoscopy Policy.docx	4/1/2009	5/1/2026
Edward Johnson	6580.26 Skin Care Policy.docx	1/1/1991	5/1/2026
Edward Johnson	6580.26 Admission Nursing Assessment (33).docx	1/1/1998	5/1/2026
Edward Johnson	6580.26 CHANGE IN RESIDENT STATUS.docx	1/1/1993	5/1/2026
Edward Johnson	6580.26 ADVANCED HEALTH CARE DIRECTIVE.docx	9/1/2026	5/1/2026
Edward Johnson	6580.26 BODY ASSESSMENT PROTOCOL.docx	1/1/1997	5/1/2026
Jeremy Murray	8345.20 CLEANING INSTRUCTIONS FOR CLOTHS PADS MOPS AND BUCKET	9/1/2020	5/12/2026
Jeremy Murray	8345.20 AVAILABLE DIETS (7172).docx	8/1/2020	5/1/2026
Megan Wright	7041.26 AMBULANCE DISPATCHING PAGER SYSTEM USE.docx	1/1/1998	6/1/1902
Megan Wright	7041.26 Ambulance Operations.docx	4/1/1995	6/1/2026
Susan Sauerheber	7010.26 Infusion Pumps Inspection, Care and Maintenance Policy and Proce	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Emergency Department Diversion Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Hand Off Communication Policy and Procedure.docx	7/1/2008	5/1/2026
Susan Sauerheber	7010.26 Do Not Resuscitate Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Education of Patient and Family Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Epistaxis Standard of Care Policy and Procedure.docx	10/1/2007	5/1/2006
Susan Sauerheber	7010.26 Care of the Latex Sensitive Patient Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Coroner Notification Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Emergency Department Automated Dispensing Cabinet Omnicell U	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Mandated Reporting of Decubitus Ulcers Policy and Procedure.doc	5/1/2026	
Susan Sauerheber	7010.26 Lumbar Puncture Assisting with Procedure Policy and Procedure.dc	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Endotracheal Tube Placement Confirmation Policy and Procedure.c	4/1/2015	5/1/2026
Susan Sauerheber	7010.26 Eye Emergency Standard of Care.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Emergency Department Log Maintenance Policy and Procedure.doc	5/1/2026	
Susan Sauerheber	7010.26 Hypothermia Standard of Care Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Medication Labeling Policy and Procedure.docx	7/1/2008	5/1/2026
Susan Sauerheber	7010.26 Burn Patient Standard of Care Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Hemoccult Testing Policy and Procedure.docx	12/1/2022	6/1/2026
Susan Sauerheber	7010.26 Head Injury Standard of Care Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 CERVICAL SPINE IMMOBILIZATION.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Intravenous Access for Radiologic Procedure Policy and Procedure	6/1/2026	5/1/2026
Susan Sauerheber	7010.26 Diarrhea Standard of Care Policy and Procedure.docx	10/1/2007	5/1/2026

Susan Sauerheber	7010.26 Infection Control Standards for the Emergency Department Policy a	5/1/2026	
Susan Sauerheber	7010.26 Intraosseous Access Policy and Procedure.docx	5/1/2026	
Susan Sauerheber	7010.26 Discharge Instructions Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Medication Errors Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Dying Patient- Standard of Care Policy and Procedure.docx	10/1/2007	5/1/2026
Susan Sauerheber	7010.26 Chest Pain Standard of Care Policy and Procedure.docx	5/1/2026	
Susan Sauerheber	7010.26 Visitors in the Emergency Department Policy.docx	10/1/2007	5/1/2026
Susan Sauerheber	6170.26 Bedside Commode Use Policy.docx	9/1/2006	6/1/2026
Susan Sauerheber	6170.26 BED MAKING PROCEDURE FOR INPATIENT CARE.docx	9/1/2006	6/1/2026
Susan Sauerheber	7420.26 OR PERSONNEL POLICY PROCEDURE BEFORE THE PATIENT ENTER	4/1/2009	5/1/2026

Dated: _____

_____

BoD approver signature

ATTACHMENT F

LFHD Financial Statement

June 2026

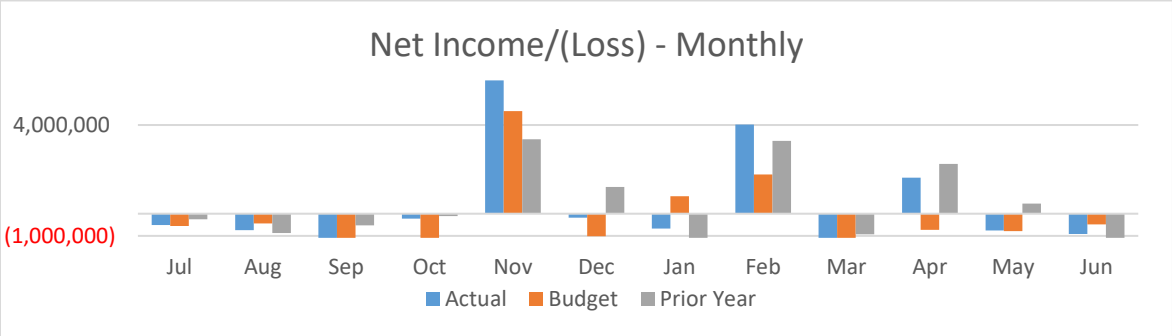
(unaudited)

Modoc Medical Center
Financial Narrative
For the Month of June 2026

Prepared by Jin Lin, Finance Director

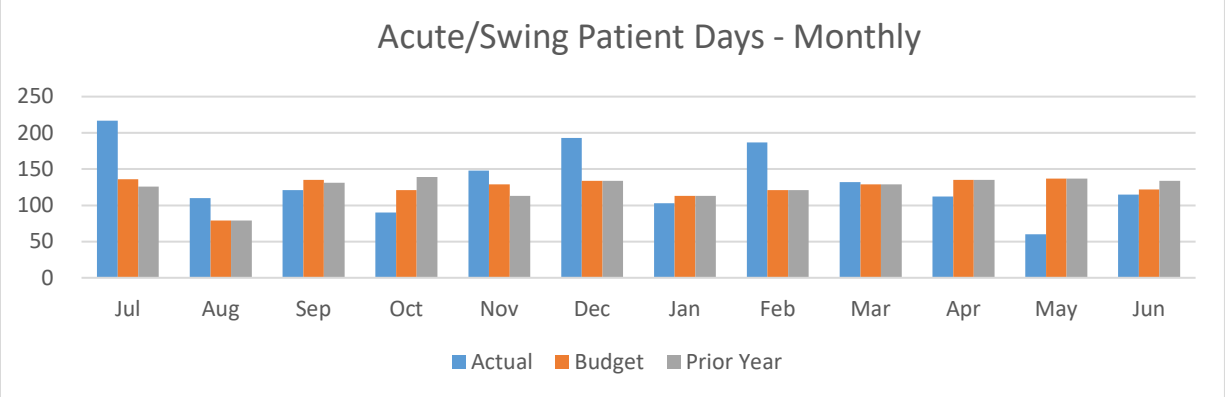
Summary

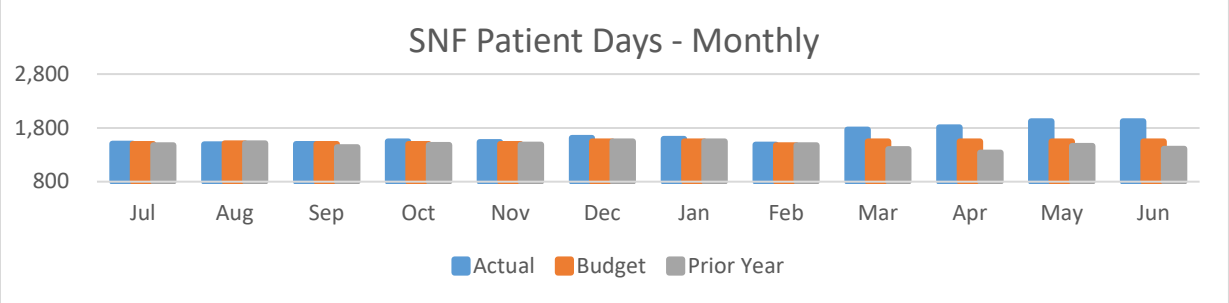
During the month of June, Modoc Medical Center reported a loss from operations of $451K, outperforming the budget that anticipated an operating loss in June of $544K. Inpatient revenue was above the budget by $346K. Outpatient revenue was above budget by $429K for the month. Total patient revenue was $5.5 million, above budget of $775K. Modoc Medical Center shows a net loss of $912K for the month that was $431K unfavorable to budget.



Patient Volumes

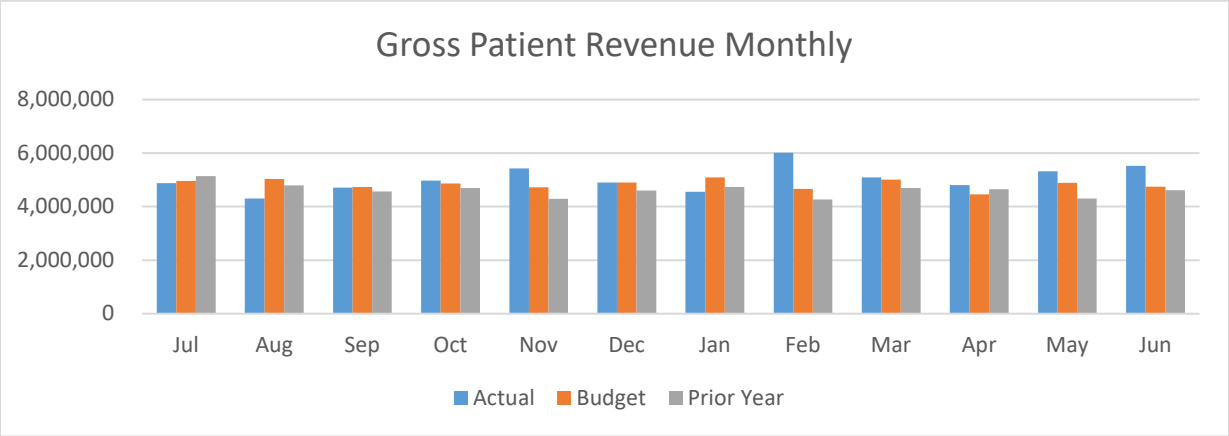
Combined Acute Days were below budget for the month by 7 days. SNF Patient Days were 1,922 for the month. Overall Inpatient and SNF Days were above budget by 365 days (2,037 actual vs. 1,672 budget). Most outpatient visits were above budget; however, Amb and Surgery were below budget.

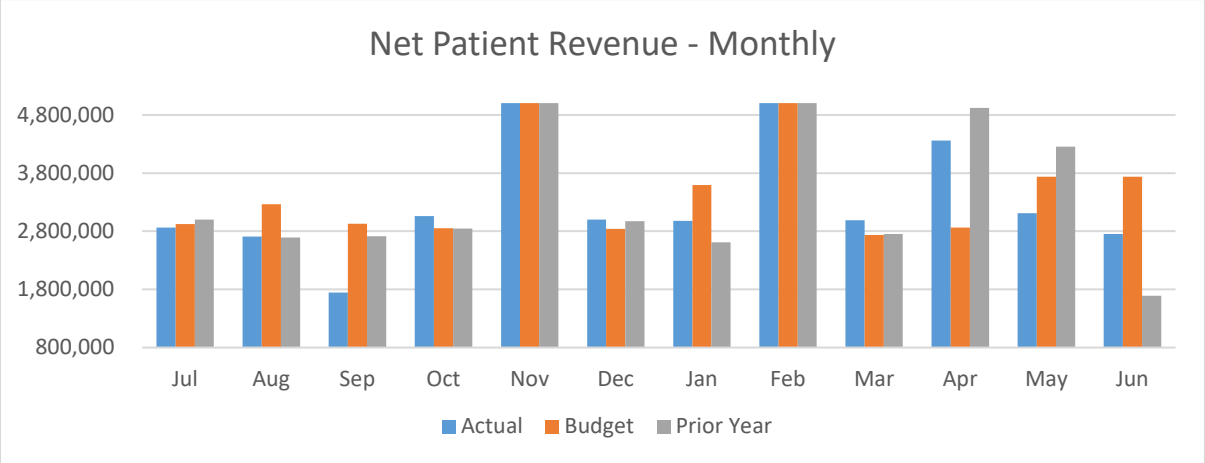




Revenues

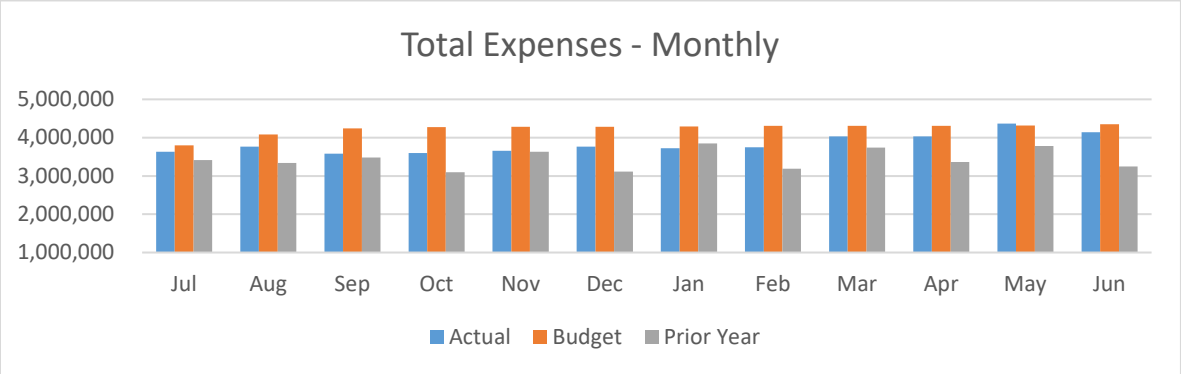
During the month of June, gross revenue (total patient revenue plus other revenue) exceeded budget by $1.7 million. Other revenue included ERCH grant of $870K from USDA. Net revenue was below budget by $110K. Gross Patient Revenue was $5.5 million vs $4.7 million budgeted. Inpatient Revenue was $1.7 million vs $1.4 million budgeted; and Outpatient Revenue was $3.8 million vs $3.4 million budgeted. Total deductions from revenue were $2.8 million vs $1.0 million budgeted. Net patient Revenue was $3.7 million vs $3.8 million budgeted.





Expenses

Total operating expenses were $4.1 million for the month and finished $202K favorable to the expense budget.

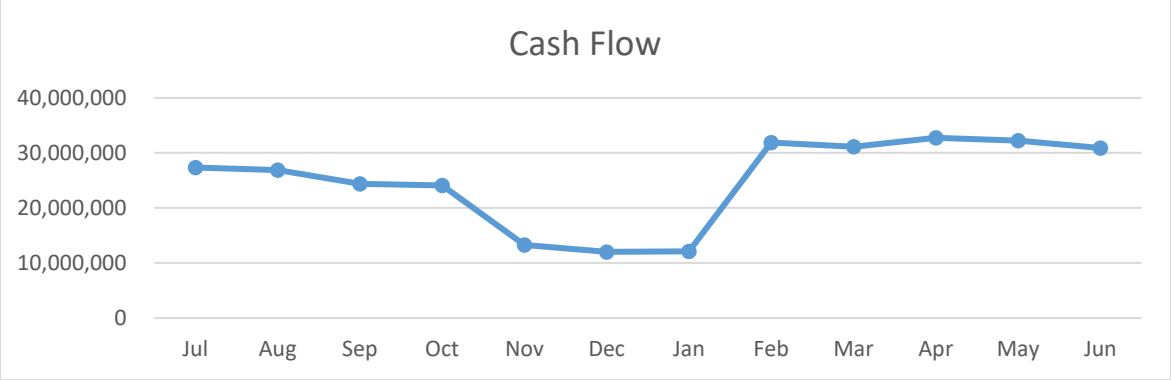


Non-Operating Activity

Non-Operating activities for the month were as follows: Accrued the last payment of FY 2026's Property Tax revenue from the County was $250K. Accrued Interest expense from USDA Loan was $167K. Interest income of $25K was earned from CDs. The retail pharmacy showed a profit of $15K. District vouchers were $4K. $578K was recorded in June as an unrealized loss from the investment account for FY2026. Total non-operating net loss for the month was $461K vs net income of $62K budgeted.

Balance Sheet

Cash for the month decreased by $1.3 million. The total current liabilities were $4.6 million. Days in Cash totaled 250. Days in AP totaled 12. Days in AR totaled 68. The current ratio was 8.25. Net AR as a percentage of gross AR was 44.25%.



Modoc Medical Center
Income Statement
For the month of June 2026

	Month	Jun-26 Budget	Variance	Prior Year Month	2026 YTD	2026 YTD Budget	Variance	Prior Year YTD
Revenues								
Room & Board - Acute	560,907	584,228	(23,320)	582,502	6,871,559	7,215,890.03	(344,331)	6,946,872
Room & Board - SNF	1,150,930	781,234	369,696	805,530	11,720,067	9,697,298.43	2,022,769	9,504,192
Total Inpatient Revenue	1,711,838	1,365,462	346,376	1,388,032	18,591,626	16,913,188	1,678,438	16,451,064
Outpatient Revenue	3,808,778	3,380,202	428,576	3,230,927	42,818,833	41,146,381	1,672,452	38,908,265
Total Patient Revenue	5,520,616	4,745,664	774,952	4,618,959	61,410,459	58,059,570	3,350,889	55,359,329
Bad Debts (580000,580011,58010	294,587	7,727	286,859	20,038	1,365,716	213,805	1,151,911	(947,440)
Contractuals Adjs	2,453,448	981,542	1,471,905	2,896,775	11,126,023	11,650,290	(524,267)	8,628,880
Admin Adjs (5930002-593001,598	20,040	16,897	3,143	10,831	1,216,189	202,764	1,013,425	4,034,450
Total Revenue Deductions	2,768,074	1,006,167	1,761,907	2,927,644	13,707,927	12,066,858	1,641,069	11,715,890
Net Patient Revenue	2,752,542	3,739,497	(986,955)	1,691,314	47,702,532	45,992,712	1,709,821	43,643,439
% of Charges	*49.9%*	*78.8%*	*-28.9%*	*36.6%*	*77.7%*	*79.2%*	*-1.5%*	*78.8%*
Other Revenue	940,797	64,115	876,682	116,853	2,700,767	979,123	1,721,645	758,704
Total Net Revenue	3,693,339	3,803,612	(110,273)	1,808,168	50,403,299	46,971,834	3,431,465	44,402,143
Expenses								
Salaries	1,853,616	1,802,496	51,120	1,566,575	21,120,700	21,412,165	(291,464)	18,318,651
Benefits and Taxes	431,540	547,095	(115,555)	353,742	4,622,121	6,386,510	(1,764,389)	4,040,217
Registry	340,001	284,982	55,019	190,043	3,283,005	3,419,780	(136,775)	3,349,908
Professional Fees	565,225	437,291	127,934	208,549	5,611,542	4,926,880	684,661	4,559,998
Purchased Services	15,051	237,618	(222,568)	125,784	1,528,891	2,819,382	(1,290,490)	1,951,518
Supplies	376,613	413,071	(36,458)	351,633	4,559,970	4,960,266	(400,296)	4,075,105
Repairs and Maint	47,194	63,391	(16,197)	31,626	490,475	474,237	16,238	391,263
Lease and Rental	2,171	4,541	(2,370)	1,647	51,180	54,507	(3,327)	54,598
Utilities	67,686	79,256	(11,570)	106,611	855,937	951,073	(95,137)	883,546
Insurance	90,105	45,821	44,284	44,772	548,269	549,856	(1,587)	547,088
Depreciation	263,543	343,633	(80,089)	178,007	2,857,117	3,833,688	(976,571)	2,125,071
Other	92,068	87,927	4,141	91,601	958,015	1,067,141	(109,126)	952,805
Total Operating Expenses	4,144,813	4,347,122	(202,309)	3,250,591	46,487,222	50,855,486	(4,368,263)	41,249,767
Income from Operations	(451,475)	(543,511)	92,036	(1,442,423)	3,916,077	(3,883,651)	7,799,728	3,152,376
Property Tax Revenue	247,075	0	247,075	257,294	2,108,344	2,144,044	(35,700)	2,143,660
Interest Income	25,379	107,670	(82,292)	93,335	908,236	1,292,045	(383,808)	1,233,759
Interest Expense	(166,860)	(155,543)	(11,317)	(799,923)	(2,259,102)	(1,716,822)	(542,280)	(1,958,479)
Gain/Loss on Asset Disposal/Forte	(577,812)	0	(577,812)		(577,812)	0	(577,812)	(202,113)
Retail Pharmacy Net Activity	15,162	119,944	(104,783)	45,656	774,838	1,417,511	(642,673)	515,756
DISTRICT VOUCHERS AND OTHER	(3,729)	(9,668)	5,939	(7,086)	(61,825)	(116,019)	54,194	(111,894)
Total Non-Operating Revenue	(460,785)	62,404	(523,189)	(410,724)	892,681	3,020,759	(2,128,079)	1,620,689
Net Income/(Loss)	(912,260)	(481,107)	(431,153)	(1,853,148)	4,808,758	(862,892)	5,671,650	4,773,065
EBIDA	(481,857)	18,068	(499,925)	(875,218)	9,924,977	4,687,618	5,237,359	8,856,614
Operating Margin %	-12.2%	-14.3%	2.1%	-79.8%	7.8%	-8.3%	16.0%	7.1%
Net Margin %	-24.7%	-12.6%	-12.1%	-102.5%	9.5%	-1.8%	11.4%	10.7%
EBIDA Margin %	-13.0%	0.5%	-13.5%	-48.4%	19.7%	10.0%	9.7%	19.9%

Modoc Medical Center
Income Statement Trend

	Jun-25	FYE 2025 YTD July-June	FYE 2026 YTD July-June	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Revenues															
Room & Board - Acute	582,502	6,946,872	6,871,559	685,444	529,453	467,429	452,283	571,794	726,928	532,410	829,139	628,680	553,481	333,612	560,907
Room & Board - SNF	805,530	9,504,192	11,720,067	841,152	893,655	878,216	946,063	942,003	992,223	940,242	871,877	1,062,592	1,022,875	1,178,239	1,150,930
	-		0	-											
Total Inpatient Revenue	1,388,032	16,451,064	18,591,626	1,526,595	1,423,108	1,345,645	1,398,346	1,513,797	1,719,151	1,472,651	1,701,016	1,691,271	1,576,357	1,511,851	1,711,838
Outpatient Revenue	3,230,927	38,908,265	42,818,833	3,351,869	2,878,680	3,369,321	3,571,943	3,919,351	3,429,157	3,578,275	4,315,586	3,562,122	3,231,645	3,802,105	3,808,778
Total Patient Revenue	4,618,959	55,359,329	61,410,460	4,878,465	4,301,788	4,714,967	4,970,289	5,433,148	5,148,309	5,050,926	6,016,602	5,253,393	4,808,001	5,313,957	5,520,616
Bad Debts	20,038	(947,440)	1,365,716	84,182	101,595	192,942	68,244	223,030	(104,018)	125,304	132,101	344,149	(256,573)	160,172	294,587
Contractual Adjs	2,896,775	8,628,880	11,126,023	1,918,848	1,481,549	1,894,197	1,731,019	(4,281,656)	1,908,514	1,634,160	(2,093,338)	1,814,765	656,971	2,007,549	2,453,448
Admin Ajds	10,831	4,034,450	1,216,189	12,361	24,241	884,264	109,742	(331,083)	344,426	17,150	24,770	28,077	49,618	32,583	20,040
Total Revenue Deductions	2,927,644	11,715,890	13,707,927	2,015,392	1,607,384	2,971,403	1,909,004	(4,389,709)	2,148,922	1,776,614	(1,936,467)	2,186,991	450,016	2,200,304	2,768,074
Net Patient Revenue	1,691,314	43,643,439	47,702,533	2,863,073	2,694,403	1,743,564	3,061,284	9,822,857	2,999,387	3,274,312	7,953,069	3,066,402	4,357,985	3,113,653	2,752,542
% of Charges	*36.6%*	*78.8%*	*77.7%*	*58.7%*	*62.6%*	*37.0%*	*61.6%*	*180.8%*	*58.3%*	*64.8%*	*132.2%*	*58.4%*	*90.6%*	*58.6%*	*49.9%*
Other Revenue	116,853	758,704	2,700,767	37,741	14,505	34,509	66,379	33,683	41,958	79,759	31,929	19,699	1,368,094	31,715	940,797
Total Net Revenue	1,808,168	44,402,143	50,403,300	2,900,814	2,708,908	1,778,073	3,127,663	9,856,540	3,041,345	3,354,071	7,984,998	3,086,102	5,726,079	3,145,368	3,693,339
Expenses															
Salaries	1,566,575	18,318,651	21,120,700	1,785,419	1,690,354	1,684,758	1,729,366	1,843,644	1,778,637	1,631,191	1,613,719	1,851,096	1,832,395	1,826,506	1,853,616
Benefits and Taxes	353,742	4,040,217	4,622,121	377,349	382,644	340,699	374,615	375,762	379,134	490,351	209,638	373,288	440,250	446,851	431,540
Registry	190,043	3,349,908	3,283,005	262,589	207,040	199,454	240,036	196,051	176,352	282,474	433,811	333,250	283,630	328,318	340,001
Professional Fees	208,549	4,559,998	5,611,542	379,442	488,717	373,455	441,028	281,514	468,475	422,087	539,964	504,303	489,117	658,214	565,225
Purchased Services	125,784	1,951,518	1,528,891	58,880	209,739	118,558	152,633	139,926	132,753	145,105	145,068	110,890	135,862	164,428	15,051
Supplies	351,633	4,075,105	4,559,970	397,284	344,376	403,531	351,006	432,662	334,753	331,062	398,634	402,573	342,094	445,381	376,613
Repairs and Maint	31,626	391,263	490,475	32,193	80,938	55,206	30,158	25,319	34,313	24,202	42,206	45,868	43,652	29,226	47,194
Lease and Rental	1,647	54,598	51,180	2,393	1,683	2,205	3,241	3,151	1,749	7,171	3,822	6,966	13,308	3,321	2,171
Utilities	106,611	883,546	855,937	59,208	60,628	56,867	54,083	65,332	111,339	64,551	101,653	78,692	63,422	72,477	67,686
Insurance	44,772	547,088	548,269	43,282	44,241	43,413	20,745	20,745	43,103	65,808	44,026	44,267	44,267	44,267	90,105
Depreciation	178,007	2,125,071	2,857,117	183,888	183,829	177,432	182,003	228,214	314,861	270,835	245,372	271,662	263,464	272,014	263,543
Other	91,601	952,805	958,015	70,025	77,764	135,953	16,174	67,798	86,043	80,616	65,455	63,712	83,555	118,852	92,068
Total Operating Expenses	3,250,591	41,249,767	46,487,222	3,651,953	3,771,953	3,591,532	3,595,087	3,680,117	3,861,512	3,815,453	3,843,368	4,086,567	4,035,014	4,409,854	4,144,813
Income from Operations	(1,442,423)	3,152,376	3,916,078	(751,139)	(1,063,045)	(1,813,459)	(467,424)	6,176,423	(820,166)	(461,382)	4,141,630	(1,000,465)	1,691,066	(1,264,487)	(451,475)
Property Tax Revenue	257,294	2,143,660	2,108,344	0	61,179	0	0	0	1,284,113	0	0	0	0	515,977	247,075
Interest Income	93,335	1,233,759	908,236	214,111	104,327	43,952	84,301	31,985	29,043	54,192	69,472	78,621	88,399	84,455	25,379
Interest Expense	(799,923)	(1,958,479)	(2,259,102)	(83,144)	(82,545)	(81,291)	(81,800)	(82,675)	(885,057)	(82,881)	(233,855)	(157,505)	(158,539)	(162,950)	(166,860)
Gain/Loss on Asset Disposal/Fortera		(202,113)	(577,812)	0	0	0	0	0	0	0	0	0	0		(577,812)
Retail Pharmacy Net Activity	45,656	515,756	774,838	93,595	235,880	40,127	246,605	(4,584)	107,370	37,725	(47,875)	3,452	9,182	38,201	15,162
DISTRICT VOUCHERS AND OTHER	(7,086)	(111,894)	(61,825)	(7,186)	(8,218)	(7,451)	(2,202)	(4,834)	9,897	(9,573)	(3,916)	(10,620)	(5,809)	(8,185)	(3,729)
Total Non-Operating Revenue	(410,724)	1,620,689	892,681	217,376	310,623	(4,663)	246,904	(60,108)	545,366	(537)	(216,174)	(86,052)	(66,766)	467,496	(460,785)
Net Income	(1,853,148)	4,773,065	4,808,758	(533,763)	(752,421)	(1,818,122)	(220,520)	6,116,315	(274,800)	(461,918)	3,925,456	(1,086,517)	1,624,299	(796,990)	(912,260)
EBIDA	(875,218)	8,856,614	9,924,977	(266,732)	(486,048)	(1,559,399)	43,283	6,427,204	925,118	(108,203)	4,404,684	(657,350)	2,046,302	(362,026)	(481,857)
Operating Margin %	-79.8%	7.1%	7.8%	-25.9%	-39.2%	-102.0%	-14.9%	62.7%	-27.0%	-13.8%	51.9%	-32.4%	29.5%	-40.2%	-12.2%
Net Margin %	-102.5%	10.7%	9.5%	-18.4%	-27.8%	-102.3%	-7.1%	62.1%	-9.0%	-13.8%	49.2%	-35.2%	28.4%	-25.3%	-24.7%
EBIDA Margin %	-48.4%	19.9%	19.7%	-9.2%	-17.9%	-87.7%	1.4%	65.2%	30.4%	-3.2%	55.2%	-21.3%	35.7%	-11.5%	-13.0%

Modoc Medical Center
Balance Sheet
For the month of June 2026

	Unaudited 6/31/2026	Unaudited 5/31/2026	Unaudited 4/30/2026	Unaudited 3/31/2026	Unaudited 2/28/2026	Unaudited 1/31/2026	Unaudited 12/31/2025	Unaudited 11/30/2025	Unaudited 10/30/2025	Unaudited 9/30/2025	Unaudited 8/31/2025	Unaudited 7/31/2025
Cash	1,879,867	1,137,090	120,812	862,818	1,502,729	419,248	932,650	537,100	1,377,232	537,347	364,654	133,445
Investments	26,985,025	29,073,663	30,595,755	29,011,915	29,130,345	10,469,699	8,412,132	6,112,326	16,085,319	17,212,464	18,491,661	19,210,474
Designated Funds	2,044,269	2,037,867	2,031,240	1,226,646	1,229,736	1,227,911	2,686,203	6,657,936	6,640,065	6,621,947	8,039,751	8,016,285
Total Cash	30,909,161	32,248,619	32,747,807	31,101,379	31,862,810	12,116,859	12,030,984	13,307,362	24,102,615	24,371,758	26,896,066	27,360,203
Gross Patient AR (Patient AR-	10,708,214	10,427,999	10,316,538	10,906,972	11,590,925	9,971,748	9,031,770	9,100,176	8,191,503	8,552,822	9,637,386	10,084,488
Allowances	(5,969,738)	(5,838,751)	(5,611,151)	(5,938,125)	(6,111,852)	(5,702,060)	(5,353,141)	(5,408,452)	(4,812,248)	(5,100,262)	(5,197,898)	(5,333,160)
Net Patient AR	4,738,476	4,589,248	4,705,387	4,968,847	5,479,073	4,269,688	3,678,629	3,691,724	3,379,255	3,452,561	4,439,488	4,751,329
% of Gross	*44.3%*	*44.0%*	*45.6%*	*45.6%*	*47.3%*	*42.8%*	*40.7%*	*40.6%*	*41.3%*	*40.4%*	*46.1%*	*47.1%*
Third Party Receivable	119,517	174,715	174,715	146,596	146,596	15,407,444	16,752,736	14,961,623	1,930,757	2,423,387	2,423,387	1,955,578
Other AR	905,739	649,116	697,254	742,070	753,769	1,329,133	1,521,565	1,455,046	920,000	784,190	842,542	674,415
Inventory	600,312	703,533	641,987	835,520	797,593	720,700	692,837	683,165	753,237	760,880	737,889	688,927
Prepaids	808,023	567,589	522,869	547,209	590,573	347,674	420,697	457,912	441,445	489,130	433,931	495,492
Total Current Assets	38,081,227	38,932,819	39,490,019	38,341,620	39,630,414	34,191,498	35,097,448	34,556,832	31,527,309	32,281,906	35,773,303	35,925,944
Land (120000-120900)	713,540	713,540	713,540	713,540	713,540	713,540	713,540	713,540	713,540	713,540	713,540	713,540
Bldg & Improvements (12110	104,953,797	104,953,797	104,953,797	104,953,797	104,953,797	104,953,797	104,953,797	104,953,797	47,945,861	47,927,861	47,927,861	47,927,861
Equipment (124100-124204)	16,670,814	16,642,370	16,642,370	16,622,409	16,622,411	16,546,582	16,546,581	16,369,150	14,495,515	14,495,515	14,495,515	14,495,515
Construction In Progress (125	2,335,463	2,261,508	2,126,123	1,998,653	1,926,750	1,851,590	1,727,082	3,897,901	59,316,095	59,132,300	57,511,960	57,155,087
Fixed Assets	124,673,614	124,571,215	124,435,830	124,288,399	124,216,498	124,065,508	123,940,999	125,934,388	122,471,011	122,269,216	120,648,876	120,292,003
Accum Depreciation	(23,311,763)	(23,048,029)	(22,775,817)	(22,512,387)	(22,240,527)	(21,994,976)	(21,723,943)	(21,408,884)	(21,180,479)	(20,998,278)	(20,820,655)	(20,636,628)
Net Fixed Assets	101,361,851	101,523,187	101,660,013	101,776,012	101,975,971	102,070,533	102,217,056	104,525,503	101,290,532	101,270,938	99,828,222	99,655,375
Other Assets	0	0	0	0	0	0	0	0	0	0	0	0
Total Assets	139,443,078	140,456,006	141,150,032	140,117,632	141,606,385	136,262,031	137,314,504	139,082,335	132,817,841	133,552,844	135,601,525	135,581,319
Accounts Payable	1,439,273	1,757,330	1,841,817	1,666,921	2,346,039	1,312,400	1,498,228	3,344,913	3,542,040	3,561,738	3,714,391	3,222,888
Accrued Payroll	1,865,633	1,702,125	1,527,471	2,215,524	1,974,628	1,885,373	1,792,561	1,579,475	1,332,074	1,904,474	1,716,038	1,513,818
Patient Trust Accounts	11,890	11,820	11,715	11,375	11,475	11,195	11,195	11,118	11,016	10,906	10,906	10,556
Third Party Payables	554,000	554,000	554,000	554,000	554,000	554,000	554,000	554,000	554,000	554,000	554,000	554,000
Accrued Interest												
Current Portion Liabilities	263,132	263,132	263,132	263,132	263,132	163,368	163,368	24,163,368	24,163,368	24,163,368	24,163,368	24,163,368
Other Current Liabilities/Accr	481,903	401,155	322,602	246,868	171,399	18,753	479,328	437,402	361,244	283,740	400,082	321,529
Total Current Liabilities	4,615,831	4,689,561	4,520,736	4,957,819	5,320,673	3,945,088	4,498,679	30,090,276	29,963,741	30,478,226	30,558,785	29,786,158
Long Term Liabilities	55,312,597	55,339,534	55,366,422	55,393,191	55,419,877	55,446,481	55,473,000	31,473,000	31,473,000	31,473,000	31,623,000	31,623,000
Total Liabilities	59,928,428	60,029,095	59,887,158	60,351,010	60,740,550	59,391,569	59,971,679	61,563,276	61,436,741	61,951,226	62,181,785	61,409,158
Fund Balance	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892	74,705,892
Current Year Income/(Loss)	4,808,758	5,721,019	6,556,982	5,060,729	6,159,943	2,164,569	2,636,933	2,813,167	(3,324,793)	(3,104,275)	(1,286,153)	(533,731)
Total Equity	79,514,650	80,426,911	81,262,874	79,766,621	80,865,836	76,870,462	77,342,826	77,519,060	71,381,099	71,601,617	73,419,739	74,172,161
Total Liabilities and Equity	139,443,078	140,456,006	141,150,032	140,117,632	141,606,385	136,262,031	137,314,504	139,082,336	132,817,840	133,552,844	135,601,524	135,581,319
Days in Cash	250	261	266	258	265	94	81	58	151	151	176	180
Days in AR (Gross)	68	66	65	69	73	63	57	50	53	55	61	64
Days in AP	12	14	15	14	19	11	12	27	29	29	34	29
Current Ratio	8.25	8.30	8.74	7.73	7.45	8.67	7.80	1.15	1.05	1.06	1.17	1.21
Net AR as a percentage of grc	44.25%	44.01%	45.61%	45.56%	47.27%	42.82%	40.73%	40.57%	41.25%	40.37%	46.07%	47.12%
Check	0	(0)	0	0	(0)	0	0	(0)	0	(0)	0	0

STATEMENT OF CASH FLOWS

June-26

	CURRENT MONTH	FISCAL YEAR YTD
CASH FLOWS FROM OPERATING ACTIVITIES		
NET INCOME	-912,260	4,808,758
ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
DEPRECIATION EXPENSE	263,736	2,859,222
CHANGE IN PATIENT ACCOUNTS RECEIVABLE	-149,229	-239,359
CHANGE IN OTHER RECEIVABLES	-201,425	1,567,147
CHANGE IN INVENTORIES	103,221	84,778
CHANGE IN PREPAID EXPENSES	-240,434	-320,789
CHANGE IN ACCOUNTS PAYABLE	-318,056	-7,306,147
CHANGE IN ACCRUED SALARIES AND RELATED TAXES	163,508	624,244
CHANGE IN OTHER PAYABLES	80,748	-37,207
NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	-297,932	-2,768,111
CASH FLOWS FROM INVESTMENT ACTIVITIES		
PURCHASE OF EQUIPMENT/CIP	-102,400	-4,988,935
CUSTODIAL HOLDINGS	70	1,309
NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES	-102,330	-4,987,625
CASH FROM FINANCING ACTIVITIES		
Current Libility	0	-23,900,236
Long Term Liability	-26,937	23,285,597
NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES	-26,937	-614,639
CASH AT BEGINNING OF PERIOD	32,248,619	34,470,779
NET INCREASE (DECREASE) IN CASH	-1,339,458	-3,561,618
CASH AT END OF PERIOD	30,909,161	30,909,161
	0	0

MODOC MEDICAL CENTER

"KEY STATISTICS"

Twelve Months Ending June 30th, 2026

	Jun-26		May-26		Apr-26		Mar-26		Feb-26		Jan-26		Dec-25		Nov-25		Oct-25		Sep-25		Aug-25		Jul-25		FY 26 YTD	FY 25 YTD	12 Mos.
	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.	Act.	Bud.			
Patient-Days																											
Adults/Peds	61	*64*	40	*81*	53	*76*	45	*64*	89	*48*	49	*56*	69	*64*	56	*83*	52	*75*	47	*86*	49	*48*	53	*90*	663	741	710
Swing	54	*58*	20	*56*	59	*59*	87	*65*	98	*73*	54	*57*	124	*70*	92	*46*	38	*76*	74	*49*	61	*31*	164	*36*	925	629	1,012
SNF	1,922	*1,550*	1,923	*1,550*	1,811	*1,550*	1,768	*1,550*	1,487	*1,477*	1,598	*1,550*	1,615	*1,535*	1,536	*1,500*	1,546	*1,500*	1,500	*1,599*	1,493	*1,511*	1,509	*1,478*	19,708	17,458	21,120
Total "Patient Days"	*2,037*	*1,672*	*1,983*	*1,687*	*1,923*	*1,685*	*1,900*	*1,679*	*1,674*	*1,598*	*1,701*	*1,663*	*1,808*	*1,669*	*1,684*	*1,629*	*1,636*	*1,651*	*1,621*	*1,734*	*1,603*	*1,590*	*1,726*	*1,604*	21,296	18,828	22,842
ADC																											
Adults/Peds	2.03	2.06	1.29	2.61	1.77	2.45	1.45	2.06	3.18	1.55	1.58	1.81	2.23	2.06	1.87	2.68	1.68	2.42	1.57	2.77	1.58	1.55	1.71	2.90	1.82	2.03	1.80
Swing	1.80	1.87	0.65	1.81	1.97	1.90	2.81	2.10	3.50	2.35	1.74	1.84	4.00	2.26	3.07	1.48	1.23	2.45	2.47	1.58	1.97	1.00	5.29	1.16	2.53	1.72	2.56
SNF	64.07	50.00	62.03	50.00	60.37	50.00	57.03	50.00	53.11	47.65	51.55	50.00	52.10	49.52	51.20	48.39	49.87	48.39	50.00	51.58	48.16	48.74	48.68	47.68	53.99	47.83	53.47
Total "Average Daily Census"	*67.90*	*53.94*	*63.97*	*54.42*	*64.10*	*54.35*	*61.29*	*54.16*	*59.79*	*51.55*	*54.87*	*53.65*	*58.32*	*53.84*	*56.13*	*52.55*	*52.77*	*53.26*	*54.03*	*55.94*	*51.71*	*51.29*	*55.68*	*51.74*	58.35	51.58	57.83
ALOS																											
Adults/Peds	2.77		2.67		2.94		3.46		3.30		2.72		3.63		3.50		3.06		2.94		3.50		3.12		3.13	3.13	3.14
Swing	4.50		4.00		6.56		8.70		7.00		10.80		10.33		9.20		7.60		14.80		8.71		13.67		8.73	7.31	8.88
Admissions																											
Adults/Peds	22	14	15	17	18	20	13	20	27	17	18	17	19	19	16	8	17	20	16	28	14	14	17	27	212	237	226
Swing	12	8	5	10	9	4	10	11	14	6	5	6	12	9	10	10	5	5	5	8	7	5	12	6	106	86	114
SNF	4	3	6	4	7	1	10	2	3	-	2	2	-	2	5	2	-	2	-	2	1	1	5	4	43	24	46
Total "Admissions"	*38*	*25*	*26*	*31*	*34*	*25*	*33*	*33*	*44*	*23*	*25*	*25*	*31*	*30*	*31*	*20*	*22*	*27*	*21*	*38*	*22*	*20*	*34*	*37*	361	347	386
Discharges																											
SNF	4		3		7		3		1		1		2		1		1		-		1		2		26	24	30
																									-	-	-
Days in Period	30		31		30		31		28		31		31		30		31		30		31		31		365	365	395
																									-	-	-
Amulatory Service Statistics																									-	-	-
Emergency Visits	514	468	532	439	440	518	485	510	444	482	485	440	486	510	474	421	550	474	471	476	494	525	487	464	5,862	5,829	6,322
Ambulance Runs Visits	77	87	71	86	56	92	65	99	78	95	73	87	107	93	90	93	78	91	94	83	82	87	106	81	977	1,044	1,052
Clinic Visits	946	903	901	932	972	905	1,112	872	968	790	805	970	772	684	808	813	837	923	791	809	827	857	959	772	10,698	9,540	11,272
Canby Clinic Visits	321	208	293	227	276	257	216	872	220	243	222	290	290	251	202	264	233	268	210	225	248	325	312	301	3,043	3,311	3,275
Canby Dental	204	174	168	173	347	163	170	171	158	133	178	185	145	147	129	171	183	200	195	180	169	210	169	171	2,215	1,842	2,407
Observation Admits	6	5	6	5	6		1	3	4	2	7		1	5	5	4	2	2	-	5	1	6	2	2	41	45	46
Observation Care Hours	199.8	119	191.8	120	214.2	110	37.3	109	229.7	94	293.2	96	23.6	158	121.2	106	115.0	159	-	128	26.2	193	145.3	50	1,597	1,422	1,767
																									-	-	-
Ancillary Services Statistics																									-	-	-
Surgeries	-	2	2	11	5	2	8	3	4	4	4	10	3	11	4	2	3	3	10	4	3	2	2	4	48	66	53
Endoscopies	21	25	22	19	26	21	17	21	16	20	21	28	23	20	23	21	35	20	21	25	24	17	17	24	266	229	291
Surgery & Recovery Minutes	428	802	643	869	835	767	541	623	732	666	632	682	658	731	577	462	1,016	566	716	498	638	501	414	642	7,830	7,664	8,632
Anesthesia Minutes	654	1,404	998	1,392	1,333	864	786	960	1,013	1,020	904	1,058	912	1,326	933	745	1,427	898	1,089	793	1,014	565	667	946	11,730	11,875	13,134
Laboratory Tests	5,594	4,619	5,477	4,554	5,497	4,773	5,117	4,498	4,991	4,648	4,247	4,591	4,721	4,427	4,454	4,269	4,680	5,079	4379	4,805	4772	4,534	5241	4,112	59,170	56,052	63,986
EKG Tests-Acute Proc																									-	-	-
EKG Tests-Clinic Proc																									-	-	-
Radiology-Diagnostic Proc	333	272	292	289	304	227	345	258	348	301	299	282	287	256	236	261	307	285	244	267	267	283	330	300	3,592	3,321	3,858
Ultrasounds Proc	143	89	98	86	135	92	127	75	96	105	101	92	126	86	73	53	138	106	112	99	114	99	156	102	1,419	1,022	1,501
CT Scans Proc	187	146	184	140	166	167	142	149	181	153	132	127	182	145	160	152	149	152	168	128	181	167	196	139	2,028	1,863	2,178
MRI Proc	47		49		38		38		39				45		21	15		-				28		26	277	46	277
Physical Therapy Sessions	840	613	709	627	497	763	873	745	409	517	469	569	545	429	450	542	582	552	851	573	967	677	1,232	775	8,424	7,791	9,241
Retail Pharmacy-Scripts	5,661	2,559	4,320	2,560	4,630	2,784	4,446	2,531	3,942	2,354	4,449	2,687	4,331	2,586	3,841	2,377	5,035	2,663	4,016	2,394	3,555	2,594	3,441	2,351	51,667	32,604	54,915

MODOC MEDICAL CENTER

"FULL TIME EQUIVALENT REPORT"

Twelve Months Ending: June 30th, 2026

Department	Jun-26	May-26	Apr-26	Mar-26	Feb-26	Jan-26	Dec-25	Nov-25	Oct-25	Sep-25	Aug-25	Jul-25	12 Mo Ave		
Med / Surg	16.65	16.55	16.98	18.32	19.24	18.35	16.90	17.36	15.63	15.21	16.15	15.37	16.89	0.10	0.01
Comm Disease Care													#DIV/0!	0.00	#DIV/0!
Swing Beds													#DIV/0!	0.00	#DIV/0!
Long Term - SNF	75.87	74.52	69.35	69.30	61.27	59.65	37.41	64.09	59.56	56.28	57.55	55.38	61.69	1.35	0.02
Mountainview - SNF	2.52	3.25	3.31	2.91	9.79	10.26	31.66						9.10	-0.73	(0.29)
Emergency Dept	13.46	13.80	12.79	11.46	13.66	12.26	11.60	12.19	12.93	12.49	14.13	10.59	12.61	-0.34	(0.03)
Ambulance - Alturas	11.67	11.82	12.65	10.99	11.90	10.55	11.55	10.79	10.86	11.31	12.65	12.06	11.57	-0.15	(0.01)
Clinic	22.33	19.97	21.74	21.85	20.74	17.92	17.28	19.78	19.45	20.43	19.71	20.32	20.13	2.36	0.11
Canby Clinic	11.49	11.37	11.31	9.29	9.48	9.04	10.54	11.49	12.06	11.47	10.55	10.89	10.75	0.12	0.01
Canby Dental	3.77	3.89	3.94	4.59	4.60	4.43	4.66	5.11	4.75	4.86	4.33	3.85	4.40	-0.12	(0.03)
Surgery	3.64	3.90	3.97	4.10	4.45	3.67	4.33	5.05	4.12	3.97	3.93	4.11	4.10	-0.26	(0.07)
IRR													#DIV/0!	0.00	#DIV/0!
Lab	8.68	8.20	8.94	8.29	8.32	8.65	8.51	8.90	8.94	9.08	9.07	8.21	8.65	0.48	0.06
Radiology	5.73	5.49	5.77	5.56	6.49	6.05	6.86	7.13	5.37	5.05	5.67	5.85	5.92	0.24	0.04
MRI													#DIV/0!	0.00	#DIV/0!
Ultrasound	1.46	1.24	1.33	1.36	1.42	1.70	1.39	1.33	1.37	1.31	1.28	1.33	1.38	0.22	0.15
CT	1.54	1.18	1.24	1.31	1.58	1.34	1.51	1.81	1.29	1.62	1.72	1.67	1.48	0.36	0.23
Pharmacy	2.10	2.09	2.13	2.24	2.12	2.01	2.05	2.00	1.96	2.16	1.83	1.33	2.00	0.01	0.00
Physical Therapy	7.08	6.49	6.65	6.25	7.35	6.30	6.61	7.38	6.40	4.84	6.75	6.88	6.58	0.59	0.08
Other PT													#DIV/0!	0.00	#DIV/0!
Dietary	18.17	18.38	19.02	17.10	18.14	19.07	13.72	16.43	12.85	12.25	13.15	14.01	16.02	-0.21	(0.01)
Dietary - MV SNF	4.65	4.20	3.73	2.98	3.10	2.33	5.89						3.84	0.45	0.10
Dietary Acute	8.08	9.68	9.62	8.29	7.52	7.35	7.48	7.08	8.43	8.17	7.77	6.76	8.02	-1.60	(0.20)
Laundry	1.01	1.06	1.05	1.01	1.02	1.01	1.00	1.10	1.00	1.01	1.03	1.01	1.03	-0.05	(0.05)
Activities	5.58	5.14	5.59	5.75	5.87	5.21	5.11	5.72	5.67	4.74	4.64	4.43	5.29	0.44	0.08
Social Services	3.97	4.00	3.07	2.77	1.96	2.16	1.79	1.97	2.02	1.82	1.95	1.43	2.41	-0.03	(0.01)
Purchasing	3.03	2.98	3.01	2.99	2.98	3.01	3.01	3.01	2.92	3.00	3.01	3.01	3.00	0.05	0.02
Housekeeping	18.95	19.87	20.37	20.55	18.65	16.81	17.10	15.12	13.97	13.67	14.00	13.78	16.90	-0.92	(0.05)
Maintenance	5.99	5.77	5.94	5.91	5.99	6.03	6.06	5.93	6.05	5.80	5.16	5.82	5.87	0.22	0.04
Data Processing	4.68	4.72	4.41	4.11	4.21	4.16	4.07	4.87	4.68	4.69	4.73	4.58	4.49	-0.04	(0.01)
General Accounting	3.29	3.54	2.88	3.84	3.86	4.21	4.14	3.92	3.94	3.71	3.99	3.92	3.77	-0.25	(0.08)
Patient Accounting	8.73	8.97	9.08	9.34	8.45	9.48	9.13	9.30	8.46	7.67	7.17	8.25	8.67	-0.24	(0.03)
Administration	3.47	3.65	3.27	3.51	3.44	3.21	3.38	3.37	3.49	3.43	3.53	3.40	3.43	-0.18	(0.05)
Human Resources	2.98	2.93	2.85	2.88	2.12	2.89	2.99	3.01	2.97	2.85	2.92	1.98	2.78	0.05	0.02
Medical Records	8.70	8.65	8.75	8.74	8.81	8.52	8.58	8.70	7.76	7.96	8.30	8.51	8.50	0.05	0.01
Nurse Administration	3.02	3.16	3.02	3.11	2.77	2.93	2.91	2.78	3.07	3.02	3.02	2.88	2.97	-0.14	(0.05)
In-Service	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.00	-
Utilization Review	1.45	1.47	1.49	1.43	1.50	1.44	1.48	1.49	1.49	1.44	1.48	1.41	1.46	-0.02	(0.01)
Quality Assurance	0.50	0.51	0.50	0.50	0.50	0.50	0.50	0.50	0.51	0.50	0.50	0.50	0.50	-0.01	(0.02)
Infection Control	0.58	0.59	0.60	0.59	0.60	0.59	0.59	0.61	0.69	0.64	0.64	0.39	0.59	-0.01	(0.02)
Retail Pharmacy	5.63	6.60	6.43	6.16	6.41	7.15	6.41	6.39	6.67	6.17	5.94	4.96	6.24	-0.97	(0.17)
TOTAL	**301.45**	**300.63**	**297.78**	**290.38**	**291.31**	**281.24**	**279.20**	**276.71**	**262.33**	**253.62**	**259.25**	**249.87**	**278.65**	0.82	0.00

June thru April 3,343.77

ATTACHMENT G

Updated FYE 26.27 Budget and Capital Budget

Modoc Medical Center - Budget FY 27 Income Statement Compared to Annualized FY 26 Performance					
	YTD May 2026	Annualized	FYE 2027 BudgetTotal	Variance FY 2027 Budget to Annualized	Notes-Variances Over 5%
IP Acute Rev	6,310,652	6,884,303	7,274,373	6%	Projected IP Census Increase
IP SNF Rev	10,569,137	11,529,968	15,218,775	32%	Increased SNF revenue, based on AVG Census of 65 in SNF for first 3 months and then 70 last 9 months of FY 27.
IP Ancillary Rev	0	0			
Total IP Rev	16,879,789	18,414,270	22,493,148	22%	
OP Rev	39,010,055	42,556,424	44,571,920	5%	
Total Pt Rev	55,889,844	60,970,694	67,065,068	10%	
BD	1,071,129	1,168,504	1,285,303	10%	BD as percentage of total revenue is consistent. Revenue growth will cause this to go up.
Contractual Allowance	8,672,575	9,460,991	8,394,119	-11%	IGT payments are projected to improve by $4 million this fiscal year.
Admin	1,196,149	1,304,890	1,447,683	11%	Admin adjustments as a percentage of total revenue are consistent. This is anticipated to grow with our revenue growth.
Total Deducs	10,939,853	11,934,385	11,127,104	-7%	
Net Pt Rev	44,949,990	49,036,308	55,937,964	14%	
% of Gross	80.43%	80.43%	83.41%	4%	
Other Rev	1,759,970	1,939,167	485,018	-75%	No ERC Payment Expected in FY 27
Total Net Rev	**46,709,961**	**50,975,476**	**56,422,982**	11%	
Salaries	19,267,084	21,018,637	23,348,287	11%	4% Annual Increase plus full year with additional SNF in operation. Positions added include Maintenance Lead Promotion, 1/2 Controller, Referrals person for Alturas Clinic, Ultrasound Tech. Anticipate recruiting physicians for Canby and Alturas by January 2027.
Benefits	4,190,580	4,571,542	4,869,820	7%	
Registry	2,943,005	3,210,550	3,956,808	23%	Both SNFs Avg Feb-May Used to Estimate Registry Fee Increases related to operating both SNFs.
Pro Fees	5,019,861	5,476,212	6,089,495	11%	Added Cardiology and Surgery Providers. Added some locums expense in anticipation of locums coverage needed in clinics throughout the entire year.
Purch Svcs	1,510,663	1,647,996	1,730,342	5%	Added anticipated expenses related to additional implementation of AI agents/tools. Added interface expenses related to vital signs machines.
Supplies	4,183,357	4,563,662	4,981,732	9%	Drug Expense was increased by 5% this year. Minor equipment is also included in this for lab and other departments in anticipation of replacing some point of care analyzers, vital sign machines, etc. Full year of Mountainview anticipated supplies expense included.
Repairs	443,281	483,579	468,827	-3%	
Lease	49,009	53,464	55,167	3%	
Utils	776,505	847,096	1,113,817	31%	8% Mark up on Utilities and Full Year of MountainView.
Ins	458,163	499,815	492,242	-2%	Property Insurance Decrease
Depr	2,593,574	2,829,354	3,734,315	32%	Full year of depreciation for New SNF. Capital budget depreciation incorporated based on estimated useful lives and service dates for assets.
Other	865,948	944,670	969,013	3%	
Total Op Exp	**42,301,030**	**46,146,578**	**51,809,866**	12%	
Income from Operations	**4,408,931**	**4,828,898**	**4,613,116**	-4%	
Prop Tax	1,861,269	2,030,475	2,336,521	15%	Last property tax payment is accrued at FYE in period 14.

Int Income	882,858	963,118	363,153	-62%	Adjusted to reflect unrealized loss on mortgage securities and cd investment
Int Exp	(2,092,242)	(2,282,446)	(1,796,717)	-21%	No Zion's Bank Interim Loan Interest Rate
Gain/Loss	0	0	0		
Retail Rx	759,795	828,867	608,100	-27%	Purchase of Packaging machine. Anticipated Script volume decrease due to major employer health plans pushing prescriptions to mail order pharmacy service.
District Vouchers	(58,096)	(63,377)	(70,840)	12%	
Total Non-Op	**1,353,584**	**1,476,637**	**1,440,217**	-2%	
Total Net Income	**5,762,515**	**6,305,535**	**6,053,333**	-4%	

Modoc Medical Center
3 year Capital Budget starting FYE 2027

Description	Budget Amount	Department	Funding Source	Fiscal Year
Tray Cart	$ 10,000	Acute Dietary	District	FYE 2027
Drawings Support Svcs Office Building	$ 350,000	Administration	District	FYE 2027
Remainder of NMR drawings for Clinic Expansion	$ 380,000	Alturas Clinic	District	FYE 2027
Remainder of Canby Clinic Remodel	$ 50,000	Canby Clinic	District	FYE 2027
Canby Clinic - New Outdoor Signs	$ 30,000	Canby Clinic	District	FYE 2027
Canby Well House - Remodel	$ 5,000	Canby Clinic	District	FYE 2027
Computers (50)	$ 85,000	Data Processing	District	FYE 2027
Server Upgrades	$ 25,000	Data Processing	District	FYE 2027
Tiny Home/Sleep Room ER Physicians	$ 200,000	Emergency Room	District	FYE 2027
New EKG Machines	$ 10,000	Emergency Room	District	FYE 2027
Pharmacy Remodel/ER Sleep Room Conversion	$ 100,000	Hospital Pharmacy	District	FYE 2027
Coag Machine	$ 25,000	Laboratory	District	FYE 2027
Wash & Dry Machines	$ 5,000	Laundry	District	FYE 2027
Side Walk - Support Service	$ 25,000	Maintenance	District	FYE 2027
Car	$ 45,000	Maintenance	District	FYE 2027
UTV Electric with Plow	$ 20,000	Maintenance	District	FYE 2027
Water Filter System	$ 20,000	Maintenance	District	FYE 2027
Heat Exchange Geothermal	$ 120,000	Maintenance	District	FYE 2027
Snow Plow for Pickup	$ 15,000	Maintenance	District	FYE 2027
New Generator-Hospital	$ 300,000	Maintenance	District	FYE 2027
New Generator-Warnerview	$ 100,000	Maintenance	District	FYE 2027
Stress Test Treadmill	$ 15,000	Maintenance	District	FYE 2027
Hospital Intersection Lighting Project and New Signage	$ 40,000	Maintenance	District	FYE 2027
Solar Proposal/Design/Bidding	$ 300,000	Maintenance	District	FYE 2027
Pictures for New SNF	$ 60,000	Mountainview	District	FYE 2027
Landscaping Improvements	$ 40,000	Multiple	District	FYE 2027
Acquire More Staff Housing	$ 500,000	Multiple	District	FYE 2027
Omni Cell Replace	$ 750,000	Pharmacy	District	FYE 2027
Metal Storage Building	$ 500,000	Purchasing	District	FYE 2027
Mobile MRI Machine (Shared with Collaborative)	$ 350,000	Radiology	District	FYE 2027
Laparoscopic Camera and Tower	$ 97,349	Surgery	District	FYE 2027
Pediatric Colonoscope	$ 30,037	Surgery	District	FYE 2027
PHILIPS US W/Cardiovascular MACHINE	$ 275,472	US	District	FYE 2027
Warnerview Remodel	$ 100,000	Warnerview	District	FYE 2027
Subtotal FYE 2027	**$ 4,977,857**			

Server Upgrades	$ 25,000	Data Processing	District	FYE 2028
Computers (50)	$ 85,000	Data Processing	District	FYE 2028
Solar Array Project	$ 3,000,000	Maintenance	District	FYE 2028
Clinic Expansion/Landing Zone/Parking Lot/Radiology Add Alternate	$ 7,500,000	Alturas Clinic	District	FYE 2028
Subtotal FYE 2028	**$ 10,610,000**			

Support Svcs Office Building Construction	$ 4,000,000	Administration	District	FYE 2029
Server Upgrades	$ 25,000	Data Processing	District	FYE 2029
Anesthesia Machine	$ 21,500	Surgery	District	FYE 2029
Computers (50)	$ 90,000	Data Processing	District	FYE 2029
Clinic Expansion/Landing Zone/Parking Lot/Radiology Add Alternate	$ 7,500,000	Alturas Clinic	District Budget	FYE 2029
Subtotal FYE 2029	**$ 11,636,500**			

ATTACHMENT H

Certification of Assessment 26-27

CERTIFICATION OF ASSESSMENT
FY 2026-2027

The **LAST FRONTIER HEALTHCARE DISTRICT** hereby certifies that the special assessments to be placed on the **2026-2027 Secured Property Tax Bill** by the Auditor for the County of Modoc, California, complies with all requirements of State Law, including but not limited to the requirements of Proposition 218 that added Articles XIIC and 111D to the State Constitution.

The **LAST FRONTIER HEALTHCARE DISTRICT** agrees to defend, indemnify, and hold harmless the County of Modoc, the Board of Supervisors, the Auditor, its officers and employees, from litigation over whether the requirements of Proposition 218 and other State laws were met with respect to such assessments.

If any judgment is entered against any indemnified party as a result of not meeting the requirements of Proposition 218 for such assessments, the **LAST FRONTIER HEALTHCARE DISTRICT** agrees that Modoc County may offset the amount of any judgment paid by an indemnified party from any monies collected by Modoc County on the **LAST FRONTIER HEALTHCARE DISTRICT'S** behalf, including property taxes, special taxes, fees or assessments.

By: _____

Rose Boulade, Chair
Last Frontier Healthcare District

Date: July 30, 2026

ATTACHMENT I

#26-02 Resolution for Tax Collection 2026-2027

Resolution #26-02 **July 30, 2026**

BOARD OF DIRECTORS
CONSIDERATION / ACTION

RESOLUTION REQUESTING COLLECTION OF CHARGES ON TAX ROLL
LAST FRONTIER HEALTHCARE DISTRICT
FOR THE FISCAL YEAR 2026-2027

WHEREAS, the **LAST FRONTIER HEALTHCARE DISTRICT (DISTRICT)** requests that the County of Modoc (County) collect on the County tax rolls certain charges that have been imposed pursuant to THE FORMATION OF THE LAST FRONTIER HEALTHCARE DISTRICT BY THE VOTE OF THE PEOPLE, adopted on AUGUST 31, 2010, attached hereto, and;

WHEREAS, the County has required as a condition of the collection of said charges that the **DISTRICT** warrant the legality of said charges and defend and indemnify the County from any challenge to the legality thereof.

NOW, THEREFORE BE IT HEREBY RESOLVED by the **LAST FRONTIER HEALTHCARE DISTRICT** that:

1. The Auditor of Modoc County is requested to attach for collection on the County tax rolls those taxes, assessments, fees and/or charges in the tax roll provided by the **DISTRICT** no later than August 14, 2026.

2. The **DISTRICT** agrees that its officers, agents and employees will cooperate with the County in answering questions referred to the **DISTRICT** by the County from any person concerning the **DISTRICT's** taxes, assessments, fees and/or charges, and that the **DISTRICT** will not refer such persons to County officers and employees for a response.

PASSED AND ADOPTED at the regular meeting of the **LAST FRONTIER HEALTHCARE DISTRICT** Board of Directors held on this 30th day of July 2026, by the following vote:

LFHD Board Members	Aye	Nay	Absent	Abstain
Carol Madison				
Rose Boulade				
Mike Mason				
Paul Dolby				
Keith Weber				

THE MOTION CARRIES / FAILS.

_____

Rose Boulade, Chair
LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS

The LAST FRONTIER HEALTHCARE DISTRICT Clerk's Attestation is on the next page and is considered a part of this Resolution #25-04.

LAST FRONTIER HEALTHCARE DISTRICT

I, **Denise R. King**, Clerk of the Board of Directors in and for the **LAST FRONTIER HEALTHCARE DISTRICT**, do hereby certify and attest that the above and foregoing is a full, true, and correct copy of an **ORDER** as it appears in the Minutes of said Board of Directors regular meeting this 30th day of July 2026 on file in my office.

WITNESS my hand and the seal of the Board of Directors this 30th day of July 2026.

_____

Denise R. King, Clerk of the Board
LAST FRONTIER HEALTHCARE DISTRICT