



AGENDA

LAST FRONTIER HEALTHCARE DISTRICT

BOARD OF DIRECTORS

Thursday, September 24, 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.) L. Burkholder – CMO Report to the Board
- B.) K. Kramer – CEO Report to the Board
- C.) E. Johnson – CNO Report to the Board
- D.) J. Lin – Finance Director Report to the Board
- E.) A. Vucina – CHRO Report to the Board
- F.) A. Willoughby – COO Report to the Board
- G.) Board Member Reports

5. DISCUSSION

- A.) A. Doss – Quality and Risk Report to the Board
- B.) K. Kramer – Board Vacancy Applicants

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 – July 30, 2026,
- B.) T. Ryan - Medical Staff Committee Meeting Minutes – August 26, 2026
 - Pathology Report –No Report
 - Committee Minutes:
 - ER Committee Minutes – 8/4/2026
 - Patient Safety/Safe Lifting Committee Minutes – 7/15/2026

Attachment B
Attachment C

- OP Infusion Committee Meeting Minutes – 7/27/2026
- Surgery Committee Meeting Minutes – 7/27/2026
- OP Infusion Committee Meeting Minutes – 8/4/2026
- Surgery Committee Meeting Minutes – 8/4/2026

C.) E. Johnson – Policy and Procedures

Attachment D

SURGERY/OPERATING ROOM

7420.26 Anesthesia Services
 7420.26 Categories of Surgical Outpatients
 7420.26 Out Patient Surgery Patient Information
 7420.26 Out Patient Surgery
 7420.26 Post Operative Routine
 7420.26 Pre-Operative Anti-Microbial Shower
 7420.26 Surgery Charges

SKILLED NURSING FACILITIES

6580.26 End of Life Comfort Care
 6580.26 Weekly Summary-Licensed Nurses
 6580.26 Completion of Resident Carr Plan
 6580.26 Resident Transport and Overnight Assignment

FACILITIES/EOC

8460.26 Inventory and Inspection of New Equipment

AMBULANCE

7041.26 Ambulance Personnel Condition of Employment

EMERGENCY DEPARTMENT

7010.26 Safe Surrender of Newborn Policy
 7010.26 Orthopedic Emergencies Policy
 7010.26 Seizure Standard of Care Policy
 7010.26 Outpatient Observation Policy and Procedure
 7010.26 Patient and Visitor Safety in the Emergency Department
 7010.26 Sentinel Event Policy
 7010.26 Stab Wounds Standard of Care
 7010.26 Patient Belongings and Property Policy
 7010.26 Alteplase Protocol for Acute Ischemic Stroke
 7010.26 Patient Discharge Medications
 7010.26 Stroke Standard of Care Policy and Procedure
 7010.26 Clinical Alarm Management
 7010.26 Patient Identification Policy
 7010.26 Suicide Risk Screening and Precautions in the Emergency Department
 7010.26 Patients Requiring Psychiatric Evaluation Policy
 7010.26 Interfacility Transfer of Patients to Higher Level of Care Policy
 7010.26 Synchronized Cardioversion Policy
 7010.26 Management of Patients Under the Influence Policy
 7010.26 Pediatric Asthma Standard of Care Policy
 7010.26 Transcutaneous Pacing Policy
 7010.26 Pediatric Dosing Guidelines Policy
 7010.26 Medication Reconciliation Policy
 7010.26 Vaginal Bleeding Standard of Care Policy
 7010.26 Pediatric Fever Standard of Care Policy
 7010.26 Neurological Assessment Policy and Procedure
 7010.26 Vital Signs Monitoring for Pediatric Patients Policy
 7010.26 Pediatric Rights and Responsibilities of Parents-Guardians Policy
 7010.26 Op site Wound Dressing Application and Management Policy
 7010.26 Central Venous Catheter Troubleshooting
 7010.26 Vomiting Standard of Care

7010.26 Release of Patient Information
7010.26 Organ Tissue Eye Donation Nursing Responsibilities
7010.26 Wound Care Standard of Care

NURSING MED/SURG

6170.26 AM Care Policy
6170.26 Anticoagulation Therapy Policy
6170.26 Application of Ward and Cold Compresses
6170.26 Assisting Patient Out of Bed
6170.26 Assisting with Examination of Patients
6170.26 Care of Patients Who are Blind or Visually Impaired
6170.26 Central Venous Catheter Removal
6170.26 Chest Tube Drainage Care
6170.26 Laboratory Specimen Collection Policy
6170.26 Ostomy Care Policy
6170.26 Radiology Procedures
6170.26 Withholding or Withdrawal of Life-sustaining Measures Policy

7. CONSIDERATION / ACTION

A.) E. Johnson – Departmental Manuals	Attachment E
B.) J. Lin – July 2026 LFHD Financial Statement (<i>unaudited</i>)	Attachment F
C.) K. Kramer – Budget Amendment	Attachment G
D.) K. Kramer – Dr. Julie Torman Contract	Attachment H
E.) K. Kramer – Dr. Gustavo Galeano Employment Agreement	Attachment I

EXECUTIVE SESSION

8. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items –July 29, 2026, (Per Evidence Code 1157)	Attachment J
• Medical Executive Committee Minutes & Credentialing Items OPPE 2019B –June 24, 2026	
B.) A. Vucina – Litigation (Per Gov. Code 54956.9(d)(3).)	Attachment K

REGULAR SESSION

9. CONSIDERATION / ACTION

A.) T. Ryan – Medical Executive Committee Minutes & Credentialing Items –August 26, 2026
(Per Evidence Code 1157)

- Medical Executive Committee Minutes & Credentialing Items OPPE 2019B – July 29, 2026

B.) A. Vucina – Litigation
(Per Gov. Code 54956.9(d)(3).)

10. MOTION TO ADJOURN – R. Boulade – Chair

POSTED AT: MODOC COUNTY COURTHOUSE / ALTURAS CITY HALL / MMC WEBSITE / MMC FRONT ENTRANCE
(www.modocmedicalcenter.org) ON September 18, 2026.

ATTACHMENT A
Board Vacancy Applicants



Board Vacancy Applicant Summary

Application Submitted: September 3, 2026

Applicant: Francis “Fritz” Barclay

Summary: The applicant reports a legal career beginning in 1981, including litigation practice, operation of a private law office, and service as a Superior Court judge from 2003 until retirement in 2023. He describes longstanding ties to the local community and continued community service.

Education and Training: Modoc High School (1972); University of California, Davis, B.A. (1976); University of California, San Francisco, Hastings College of Law, J.D. (1981).

Work and Volunteer Experience: The applicant reports earlier employment in firefighting, banking, and food service. Beginning in 1981, he worked at law firms in San Francisco and Sacramento, primarily on homeowners insurance coverage litigation. He returned to the area in 1986 and worked with John Baker, opened his own law office in 1990, and became a Superior Court judge in 2003. He retired in 2023. Community involvement includes Alturas Rotary, the ACT Niles Theater Board, and Federated Community Church.

Stated Qualifications: The applicant cites his legal and judicial experience, community service, and having lived in the community for most of his life.

Interest in Serving: The applicant states that serving on the Board would be another opportunity to give back to the community. He notes that planned extended winter travel may make in-person attendance difficult for one or two meetings.

Personal Information Omitted: Email address, phone number, residential address, and mailing address have been excluded from this board summary.



Board Vacancy Applicant Summary

Application Submitted: September 3, 2026

Applicant: Michael Conrad

Summary: The applicant has a broad employment background spanning retail, industrial, laboratory, transportation, convenience store, and facility-related roles, including prior work at Modoc Medical Center and experience described as facility management, warehouse management, inventory accountability, and business turn-around management.

Education and Training: The applicant reports completing two semesters at Lassen College in 1993–1994, coursework or training in science/electricity generation, training related to magnetic fields and computer circuitry, and Bluetooth compliance standards for the United States, Japan, and Europe.

Work and Volunteer Experience: Reported experience includes positions with retail businesses, roofing supply, gas/service businesses, pipeline work, medical center employment, laboratory/compliance-related work, transportation, convenience retail, and local Chevron-related employment. Volunteer experience includes service with the Modoc County Senior Center Board and VFW Auxiliary bingo activities.

Stated Qualifications: The applicant describes experience with insurance reimbursement rates, budgeting, personnel requirements, labor laws, environmental services, safety, team building, union representation, and contract negotiation participation.

Interest in Serving: The applicant states an interest in helping maintain forward momentum for the district and supporting efforts to bring additional medical services to the community.

Personal Information Omitted: Email address, phone number, residential address, and mailing address have been excluded from this board summary.



Board Vacancy Applicant Summary

Application Submitted: Not provided in the résumé.

Applicant: D. Don Brandon

Summary: The applicant reports healthcare executive and clinic management experience, including service as CEO of Surprise Valley Health Care District, Tribal Health Director for the Confederated Tribes of Siletz Indians, and Clinic Manager at Modoc Medical Center. His background also includes hospital construction and project management.

Education and Training: MBA from Humboldt State University and BSBA from the University of Phoenix. Reported training includes project management, project time and cost management, contract administration, program management, risk management, and human resource development.

Work and Volunteer Experience: Healthcare roles include CEO of Surprise Valley Health Care District (2019–2020), Tribal Health Director (2016–2017), and Modoc Medical Center Clinic Manager (2012–2016). Earlier work includes co-owning a chimney sweep and handyman business and managing hospital and school construction projects. Volunteer experience is not listed in the résumé.

Stated Qualifications: The résumé describes oversight of hospital, rural health clinic, skilled nursing, and federally qualified health center operations; management of a \$15 million clinic budget and more than 80 staff; compliance, payroll, and electronic medical record implementation; and project management for major healthcare construction. It also lists proficiency with office, scheduling, project management, and business software.

Interest in Serving: Not stated in the résumé.

Personal Information Omitted: Personal phone number and email address have been excluded from this board summary.

ATTACHMENT B

**Adoption of LFHD Board of
Directors Regular Meeting
Minutes – July 30, 2026**



REGULAR MEETING MINUTES

LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS

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

Directors present: **Rose Boulade, Carol Madison, Keith Weber, Mike Mason**
Directors absent: **Paul Dolby**
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

Carol Madison moved that the agenda be approved as presented. **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**

- Tanya Villers, FNP, signed an offer letter to join the Alturas Clinic.
- Recruitment efforts are continuing for two physicians to serve the Canby and Alturas clinics.
- An orthopedic surgeon completed a site visit last Friday and expressed interest in working at our facility.
 - The surgeon would divide his time among Seneca Healthcare District, an Indian health clinic in Susanville, Plumas District Hospital, and Modoc Medical Center.
 - This collaborative arrangement was coordinated by Brady Haynes of Seneca Healthcare District.
- Surgeons are scheduled to begin performing procedures in mid-September.
- The cardiologists are completing the credentialing application process and are expected to begin providing services in September.

Security Incident

- MoxFive has completed its review of our data files and compiled a list of potentially impacted community members.
- The list is currently being reviewed by legal counsel.
- Following legal review, we will meet with counsel to:
 - Begin the required notification process for affected community members.
 - Provide updated notices to the appropriate regulatory agencies.

Cost-Based Ambulance Services

- A telephone conference was held with NorCal EMS's attorney regarding the development of a policy containing the language needed to support the cost-based ambulance services exemption.

- NorCal EMS appears agreeable to drafting the proposed policy.
- NorCal EMS will consult with the California Emergency Medical Services Authority to ensure the policy is acceptable and address any potential concerns.
- We may also request that the County adopt a resolution providing NorCal EMS with this direction.
 - Keeping the County's recommendation on file may help demonstrate compliance with Medicare's exemption criteria.

Geothermal Grant

- The School District continues to review the proposed site host agreement.
- The School District's attorneys participated in this week's Technical Advisory Committee meeting.
 - They will assist in reviewing the well-work bid documents to ensure they do not create issues with the Division of the State Architect, which oversees construction projects on California school grounds.
- Well testing and inspection have been separated into an individual task within the project schedule.
 - This will allow us to attempt to complete the work before winter.
 - The results will help determine whether AL-1 can be established as a reinjection well.

Other Items

- A draft methodology has been developed for the wage analysis.
 - The goal is to have a proposal ready to present to the union in August.
 - Following an agreement with the union, a board item will be prepared summarizing the proposed wage changes and their anticipated financial impact.
- The organization received notice from the IRS that it will be auditing the Certificates of Participation issued to the USDA to finance the new hospital project.
 - We are working with bond counsel and gathering the documentation requested by the IRS to begin the audit process.
- Stacy Spahr, Tom Sandage, and I have scheduled a meeting to discuss changes to Medi-Cal eligibility requirements.
 - The discussion will focus on how we can help eligible patients retain their benefits while navigating enhanced work requirements and redeterminations every six months.
 - Many healthcare facilities may need to hire staff to assist patients with gathering documentation and completing the redetermination and work-requirement processes.
 - These efforts would support local social services agencies while helping community members maintain their healthcare benefits.
- Seneca Healthcare District is taking the lead on applying for Rural Health Transformation funding for the shared MRI unit.
 - Due to the limited application timeframe, this will likely be the only project submitted for funding this year.

B.) E. Johnson – CNO Report to the Board Skilled Nursing Facility (SNF)

- The Skilled Nursing Facility continues to maintain a five-star CMS rating, reflecting strong performance in the areas evaluated by the Centers for Medicare & Medicaid Services.
- Four resident falls were reported during June.
- An ad hoc committee has been formed to conduct a detailed review of each fall, identify contributing factors, and determine whether additional interventions are needed.
 - Preliminary reviews suggest that some falls may be related to an increase in resident behaviors.
 - The committee will continue monitoring fall trends and evaluating opportunities to strengthen resident safety and fall-prevention practices.

Warnerview

- Warnerview's current census is 18 residents.
- Mountain View's current census is 47 residents.
- During the reporting period:
 - Four residents were admitted.
 - Four residents were discharged.
 - Admissions and discharges resulted in no net change to the census.
- The combined Warnerview and Mountain View census is currently 65 residents.

- The goal is to reach a combined census of 70 residents by the end of August, requiring a net increase of five residents.

Acute Care and Swing-Bed Services

- Acute inpatient services reported:
 - Average daily census: 2.03 patients
 - Average length of stay: 2.77 days
 - Total admissions: 22 patients
- Swing-bed services reported:
 - Average daily census: 1.80 patients
 - Average length of stay: 4.50 days
 - Total admissions: 12 patients
- Combined acute and swing-bed admissions totaled 34 patients during June.
- A total of 21 surgeries were performed during the month.

Emergency Department

- The Emergency Department treated 514 patients during June.
- The average daily patient volume was 17.1 patients, consistent with the total monthly volume.
- Emergency Department activity continues to represent a significant portion of the facility's monthly patient services.

Ambulance Services

- Ambulance services completed 77 runs during June.
- This represents an average of approximately 2.6 ambulance runs per day.

Pharmacy

- Adil, the Retail Pharmacy Manager, continues to adjust well to his new role.
- A second retail pharmacist is expected to arrive toward the end of August, providing additional support for retail pharmacy operations.
- The pharmacy filled 5,661 prescriptions during June.
 - This represents an average of approximately 189 prescriptions filled per day.

Physical Therapy

- Physical Therapy completed 840 patient sessions during June.
 - This represents an average of 28 sessions per day.
- Recruitment remains ongoing for permanent Physical Therapist and Physical Therapist Assistant positions.
- Filling these positions remains important for maintaining consistent therapy coverage and supporting patient access to rehabilitation services.

Laboratory

- The laboratory completed 5,594 tests during June.
 - This represents an average of approximately 186 tests per day.
- Laboratory testing continues to support inpatient, outpatient, and emergency services throughout the facility.

Wound Care and Infusion Services

- Wound care services have been relocated to the infusion area.
- Combining wound care and infusion services within the same area is intended to support operational coordination and provide a more centralized location for patients receiving these services.

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

Accounting

- The Accounting team continues to focus on the transition to ADP while also preparing the necessary documentation and supporting materials for the upcoming audit.

Purchasing

- Purchasing is changing shredding service providers to reduce ongoing operating expenses.
 - Current monthly cost: \$2,400
 - New monthly cost: \$1,700
 - Monthly savings: \$700
 - Projected annual savings: \$8,400
- This change will reduce shredding expenses by approximately 29% annually.

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

Permanent/Travel Staff

- We currently have total staff

- We have a total of travelers, both Acute and SNF.
- New hires started in July.

Compliance

- Performance Evaluations % compliant
- TB % compliant
- Physicals % compliant

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

Revenue Cycle

- June was another strong financial month, closing with more than \$3 million in collections at \$3.03 million.
- Gross revenue totaled \$5.6 million, representing the highest monthly revenue in the organization's history.
- Average Daily Revenue (ADR) reached \$179,400, which was also an organizational record.
- July is projected to be another month exceeding \$3 million in collections.
 - Collections totaled approximately \$2.9 million as of the close of business yesterday.
 - Month-end collections are projected to exceed \$3 million.
 - July revenue has already reached approximately \$5.4 million.
 - ADR currently stands at \$182,000, exceeding \$180,000 for the first time and setting another organizational record.
- As a follow-up to the previous meeting's discussion regarding the large account write-off, the R1 contract was reviewed.
 - The contract includes language that limits R1's responsibility for indemnifying the organization for lost payments.
 - Discussions with R1 leadership are continuing to determine whether any additional resolution or recovery may be available.

Clinics

Clinic Expansion Project

- NM&R provided two revised floor plan options for the Clinic Expansion Project. Both options are currently under review.
- The first option would locate the MRI within and directly connected to the hospital.
 - This option would fall under OSHPD I jurisdiction.
 - It may provide a more efficient connection to hospital operations and the existing Radiology Department.
 - However, it would likely involve greater construction costs and more extensive administrative and regulatory requirements.
- The second option would place the MRI within the clinic expansion, with a connection to the hospital's Radiology Department.
 - This option would fall under OSHPD III jurisdiction.
 - It is expected to be less expensive and involve fewer administrative requirements.
 - However, it may not provide the same level of operational efficiency as locating the MRI within the hospital.
- Leadership is reviewing the two options and weighing construction costs, regulatory requirements, workflow, and long-term operational efficiency.

Canby Clinic

- Work continues on the Canby Clinic remodeling project.
- The contractor's anticipated completion date was the end of July; however, the project may not be fully completed within that timeframe.
- Haley Kielbas, the locum provider serving the Canby Clinic, has extended her assignment.
 - Her extension provides additional continuity of care for the clinic.
 - She has received positive feedback from staff and the community.
- Dr. Carlo's current assignment runs through October. It has not yet been determined whether he will extend his assignment beyond that date.

Maintenance

- The Maintenance team continues to address issues with the Canby Clinic's air-conditioning system.
 - Due to the current high temperatures, restoring and maintaining reliable cooling remains a high operational priority.

- The team is also assisting with the installation of the new Omnicell medication-dispensing systems.
 - The installations require a significant amount of staff coordination and technical support.

Information Technology

- The IT team is nearing completion of the Beazley Managed Extended Detection and Response (MXDR) implementation.
 - This service was approved by the Board several meetings ago.
 - It provides continuous cybersecurity monitoring 24 hours a day, seven days a week, 365 days a year.
 - The service is designed to detect potential network threats and security incidents in real time, allowing for a faster response to future cybersecurity concerns.
- Frontier has discontinued its traditional copper telephone lines.
 - The IT team is completing the necessary conversion to replacement services.
 - The transition is expected to require a relatively limited amount of work.

Marketing

- Marketing is managing several ongoing initiatives, including the conversion of the organization's website to an ADA-compliant platform.
 - The project is expected to take several months to complete.
 - The updated platform will improve website accessibility for users with disabilities and strengthen compliance with accessibility standards.
- Marketing will also update the website to make the organization's Mission and Vision Statements more visible.
 - A dedicated website section will be created to better communicate the organization's purpose, priorities, and long-term direction to patients, employees, and community members.

F.) Board Member Reports

- **Carol Madison** – Reported that her mother recently received care in the Emergency Department and shared positive feedback, noting that the staff provided exceptional care and service.
- **Paul Dolby** – Absent.
- **Mike Mason** – Nothing to report.
- **Rose Boulade** – Attended the Finance Committee Meeting and the Joint Conference Meeting.
- **Keith Weber** – Nothing to report.

5. DISCUSSION

A.) D. King – FY 25.26 Lodging Expenses

Denise King, District Clerk, provided an update regarding the District's lodging expenses. She reported that eight lodging entries totaling \$25,283 were recorded for FY 2025–26, while four entries totaling \$11,878.60 have been recorded to date for FY 2026–27. The combined expenses across both fiscal years total \$37,161.60. These costs primarily supported temporary housing for locum providers, provider recruitment and candidate site visits, and other hospital-related lodging needs. She also explained that one \$6,400 lodging invoice covered 64 nights spanning both fiscal years and was divided accordingly, with \$400 allocated to FY 2025–26 and \$6,000 allocated to FY 2026–27. The reported totals include applicable lodging charges, cleaning fees, pet fees, occupancy taxes, and discounts. The FY 2026–27 lodging register will continue to be updated as additional expenses are received.

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,

B.) T. Ryan - Medical Staff Committee Meeting Minutes – June 24, 2026

- **Pathology Report – 3/28/2026**
 3/29/2026
 4/30/2026
 5/1/2026

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.

Keith Weber moved to approve the **Departmental Manuals**, _____ seconded, and the motion carried with all voting “aye.”

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

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

Mike Mason moved to accept the June 2026 LFHD Financial Statement as presented, **Keith Weber** seconded, and the motion carried with all present voting “aye.”

C.) K. Kramer – Updated FYE 26.27 Budget and Capital Budget

Kevin Kramer, CEO presented the Updated 26.27 Budget and Capital Budget to the Board and answered any questions they may have had. The Board reviewed the updated FY 2026–27 Operating and Capital Budgets. The revisions and current financial projections were discussed.

Carol Madison moved to approve the **Updated FYE 26.27 Budget and Capital Budget** as presented, **Mike Mason** seconded, and the motion carried with all voting “aye.”

D.) K. Kramer – Certification of Assessment 26-27

Kevin Kramer, CEO, presented the **Certification of Assessment** and answered any questions the Board had. Kevin explained this one of the two items that the County needs Board approval for to collect funds for our LFHD Tax Roll.

Keith Weber moved to accept the Certification of Assessment as presented, _____ seconded, and the motion carried with all present voting “aye.”

E.) K. Kramer – #26-02 Resolution for Tax Collection 2026-2027

Kevin Kramer, CEO, presented #26-02 Resolution for Tax Collection 2026-2027 to the Board and answered any questions they had on the resolution.

Mike Mason moved to approve #26-02 Resolution for Tax Collection 2026-2027 and **Keith Weber** seconded.

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

Carol Madison	X
Mike Mason	X
Paul Dolby	Absent
Keith Weber	X
Rose Boulade	X

The motion to approve #26-02 Resolution for Tax Collection 2026-2027 as presented carried with all present voting “aye” as shown in the roll call vote above.

Carol Madison 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 4:24 pm.

EXECUTIVE SESSION

Executive Session was called to order by **Rose Boulade, Chair**, at 4:24 pm.

7. 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.**
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:
- **Clinton McBride, MD** – Recommends reappointment of Limited Active privileges in the Emergency Medicine category.

The Executive Session of the Board of Directors was adjourned at 4:28 pm.

RESUME REGULAR SESSION

The Regular Session of the Board of Directors was called back to session by **Rose Boulade, Chair**, at 4:28 pm.

8. 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.**

Mike Mason moved to approve and accept Minutes, Credentialing, and Privileging items as outlined above, **Keith Weber** 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 **4:29 pm**, **Keith Weber** 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 August 27, 2026, at 3:30 pm in the Alturas City Council Chambers, City Hall in Alturas, California.

Respectfully Submitted:

Denise R. King
Last Frontier Healthcare District Clerk

Date

ATTACHMENT C

Medical Staff Committee

Meeting Minutes – August

26, 2026



DATE: SEPTEMBER 24, 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 August 26, 2026, meeting and are presented for Governing Board review:

A. REVIEW OF MINUTES

1. Medical Staff Committee Meeting Minutes – July 29, 2026

B. COMMITTEE REPORTS

1. ER Committee Meeting Minutes – 08/04/2026
2. Patient Safety/Safe Lifting Committee Meeting Minutes – 07/15/2026
3. OP Infusion Committee Meeting Minutes – 07/27/2026
4. Surgery Committee Meeting Minutes – 07/27/2026
5. OP Infusion Committee Meeting Minutes – 08/04/2026
6. Surgery Committee Meeting Minutes – 08/04/2026

C. PATHOLOGY REPORT – No Report



MEDICAL STAFF COMMITTEE MEETING July 29, 2026 – Education Building MINUTES

In Attendance

Lisanne Burkholder, MD Chief Medical Officer
Eric Monaco, MD
Landin Hagge, DO
Ruth Moeller, FNP
Barbara Howe, RDN
Kevin Kramer- CEO

Ed Johnson- CNO
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 1220 by Dr. Burkholder, MD Chief Medical Officer.	
II. CONSENT AGENDA ITEMS	1. The following Minutes were reviewed: A. Medical Staff Committee Meeting of June 24, 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. ER Committee Meeting Minutes, 06/19/2026. 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, 06/04/2026	Report at next meeting
IV. CHIEF MEDICAL OFFICER REPORT	Currently, nothing too big is happening. As Kevin mentioned, we are interviewing a lot. A lot of the permanent candidates are currently residents who will graduate in June 2027. We have an excellent couple from back east who want to work side by side, he wants to do outpatient care, and she wants to do a mix of both. They are going to be doing some site visits soon. Terri Whiting just signed her	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	contract. We recently had a setback. We interviewed Dr. Onochie and she left us with this beautiful letter she wrote respectfully declining the position with some insights to think about. I also have been doing a lot of individual Provider coaching, some through safety first and some through just sitting down and giving some feedback about their notes, documentation, coding, use of AI, Clinic transitions, etc. Chronic Disease Program Update, we tried CHF Product Disease Management with some Provider individual coaching and Provider feedback data and many Providers have improved. The goal was to get to 60%, 50% of mentioning it in their notes like getting people on the right drug or even mentioning why they are not on them, and we are on our way there. However, it is hard to nudge really busy Primary Care Providers to do better with Chronic Disease through emails and individual visits and with all the data we gather. So, the next step for this year is to create a Chronic Disease Clinic. Social events, we said goodbye to Wendy and to our 3 locums. I am happy to do that again and keep it going. Our Infusion Center, we are working on protocols. We need good documentation throughout our specialists and authorizations from our specialists to be able to co-sign their orders here and sometimes that does delay things. We often try to sign authorizations that get denied because we are primary care folks. So, it is a work in progress. Recently, we reviewed something called GLY-TECH which would have been for inpatient. It would have order set for using insulins and we have so few patients, less than 20 a year and our Providers are so well versed in doing it on their own so far that we decided not to spend the 50 grand a year for 3 years on GLY-TECH. That said, it did upscale the Med Surg ward for using better insulin protocols for our patients, so we realized following standard of care that we have some nursing education to do to help our nurses count carbs with patients. Overall, more to come.	
V. EMERGENCY ROOM REPORT	Currently, the front triage is going really well. There was a recommendation to cover some longer shifts, like 7-day shifts starting 2027. I think that is doable, especially with the Mid-Level Provider coverage. A few years ago, that would not have	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	been doable, but overall, I think we are in a good spot.	
VI. CEO REPORT	Currently, with Clinic Expansion Project Update and Primary Care and Telemedicine Expansion Plans Discussion, last time we met we had rough floor plans projected to view, but since then our architectural firm has suggested that we may need to look at some MRI space for the future. So right now, we are redirecting to see if everything can fit what we have in floor plans right now and we will see what they say. Adam is working alongside getting together a Clinic Expansion Committee, so I think all this is coming together just fine. The Clinic Expansion is going to include a corner built for an Outpatient Geriatric Behavioral Health Program which will include 3 counseling offices, and a receptionist desk so can have a formal space for the operation. Provider Recruitment Update, another candidate, Dr. Ozuna, is coming August 10th for a site visit as a potential to fill a primary care position and a Dr. Mou and is still in the queue and possibly coming for a site visit in September. Last Friday, we talked with Seneca that has been talking with an Orthopedic Surgeon and now the Orthopedic Surgeon that used to work at Banner Lassen is interested in doing regional orthopedic surgery. His name is Dr. Rice, and we think he is going to come so I think we will have that specialty of Orthopedic Surgery at least a couple days a month as well. Also, we are in the middle of an IRS audit on the USDA Loan for the new Hospital, so I have been spending a lot of time on that. I am still adding up the Geothermal Grant with the School District. For those of you who do not know or remember, that is a \$1.5 Million Dollar Grant that we were awarded to help the School District's infrastructure. So, we will be sharing with them, and all that funding is going to go to an existing non-used production well that is down at the High School. We are going to try to repurpose it to being an injection well for the used Geothermal water. The budget is going to the Board tomorrow and hopefully if it is approved, there are some cool things in there being funded. There is a lot of AI stuff in the strategic plan, expansion, implementation of this Geriatric Behavioral Health Program which initially, those that are coordinating	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	the group therapy sessions will work from home on a scheduled basis, and the only other big project in there is a solar array in hopes to get our whole campus on solar. Lastly, we have H.R.1 budget cuts from the federal government, and we will start dealing with that next year. Enrollment is a massive concern within the healthcare industry and with redetermining eligibility every 6 months instead of every year, it is going to double the work of our current Social Services department at a county level. That being, I am going to meet with some people and discuss some strategies and roles we can play to help alleviate some of the workload and burden to and try and ensure our patient stay and stay eligible. On MediCal, determining eligibility, we may hire a couple of community health workers that would physically be in our building to help facilitate and help patients gather what they need, documents, whatever to supplement what Social Services is doing. Overall, more to come.	
VII. CNO/SNF REPORT	Currently, from the SNF side, we remain at 5 stars. We are at 66 patients right now. We are looking to get our first ALS patient. We had 4 patients that have been through Pit River Behavioral Health and seen the Psychiatrists and are working on scheduling more. We have received suggestions and are just seeing how it is going right now, but so far, no issues there. We have been looking at different CNA training programs and came across this one that embraces the abilities carried out and kind of give like recognition and other things to shoot for, for the CNA. The program is called CUSP. They start off as a CNA 1 which is basic CNA that we do the training for and then they can go to CNA 2, CNA 3, and CNA 4. The program also has what they call earn and learn which is if we pay our CNAs to go through their training, they will award us \$2,000 for every CNA and every CNA that goes through the training will get \$600 every micro. certification that they receive. Additionally, they are letting us back date to 2023 for every CNA that graduated with us and awarding us \$2,000 for each one. I am still looking into whether they get a pay raise following each certification. It is based on your facility, meaning the first module is 10 hours online they must complete and then you can say what time frame you want it done in. However,	Report at next meeting

SUBJECT	DISCUSSION	ACTION
	with each certification awarded, you must wait 3 months before going to the next one. Overall, we are excited for this program and more to come.	
VIII. PHARMACY REPORT	Currently, for the Inpatient side, the Omnicells landed. The last one came today. I am working on getting those configured and ready to go. I should be done by the end of the week. As soon as the second staff Pharmacist for Retail comes in, I am going to have the manager work on our policy book first and then Medicare part B. Hopefully we can get all that done before the end of fall, get that approved and then we can ship to other projects. Pharmacy has a lot of potential things we can really help a lot of concerns you guys brought up today like Med. Rec., Chronic Disease Management Program, etc., we just need to get the staff here. Also, pill packs are something I presented to you guys before, the ones where all the medications are packaged in separate little pouches like what Amazon does. Each pouch contains up to 5 meds. in a pouch with your name, description, dose, and the time you need to take them, which is cool for a lot of people, especially in our community who live alone, are older age and don't have the help, or live farther away. So, what we would do is have this program where people sign up, maybe we kick off with 10 or 20, a manageable number of patients and overtime slowly build up on that. Of course we would run a test patient first. This is kind of the focus in Retail Pharmacy at the moment and hoping to get implemented soon. Overall, more to come.	Report at next meeting
IX. DIETITIAN REPORT	Currently, dealing with some issues with orders in Cerner coming to me to gather the patient's weight, but I as a Dietitian am not responsible for that, so I just wanted to make you guys all aware of that. That order needs to go to the patient's Providers. Also, the \$50,000 dollar insulin program, what I would like to do is see if we or Partnership can pay for the app that allows anybody to take a picture of their meal and it will tell you how many grams of carbohydrates, etc. are contained in the meal. I want to do it especially with our type 1 diabetics. The app is called SNAQ. Overall, more to come.	Report at next meeting
X. RISK MANAGEMENT REPORT	Nothing to Report.	

SUBJECT	DISCUSSION	ACTION
NEW BUSINESS XI. POLICY REVIEW & APPROVAL	The following New Business was presented for review/approval: 1. Updated Policies, July 2026 (58)	After review and discussion, a recommendation was made to implement the Updated Policies (58) presented July 2026. The recommendations were ratified by motion, second, and vote. Recommendations will be forwarded to the Governing Board for final approval.
XII. ADJOURNMENT	The meeting was adjourned at 1308.	

Lisanne Burkholder, MD Chief Medical Officer

08 | 26 | 2026
Date



AGENDA

ER COMMITTEE MEETING

On Tuesday 8/4/2026 3:00 to 4:00 p.m.

Modoc Medical Center – 1111 N. Nagle Street
Education Conference Room; Alturas, California

Subject	Discussion	Attachment
1. Call to Order		
2. Agenda Approval	Susan Sauerheber, changes, additions and /or deletions	
3. Minutes of 6/2026, ER Committee Meeting	Minutes 6/2026	Minutes of 6/2026
4. Old Business	• See attached Minutes	Minutes of 6/2026
5. New Business	• Mercy Medical Center—no ENT/OMFS coverage from August 1st-14th see Attachment • Items/Supplies on Allocation • No longer an IV Contrast Shortage • Delinda to update on Surgeons • Butterfly BVM • Roundtable	
6. Roundtable		
7. Adjournment	The next ER COMMITTEE Meeting "To be determined" in the Education Conf. Room.	



MINUTES

ER COMMITTEE MEETING

On Tuesday 8-4-2026 from 3:00 to 4:00 pm

Modoc Medical Center – 1111 N. Nagle Street
Education Conference Room; Alturas, California

Present:

- Dr. Jay Lai
- Susan Sauerheber, Acute/Er Nursing Manager
- Ed Johnson, CNO
- Sandra Brown
- Alicia Doss
- Lance Chrysler
- Megan Wright
- Delinda Gover
- Walter Dimarucut
- Lisanne Burkholder M.D.

Absent:

- Shelly Bailey
- Kevin Kramer, CEO.
- Shannon King
- Vahe Hovasapyan
- Denise King
- Walter Dimarucut
- Mary Lawrence

Subject	Discussion	Attachment
1. Call to Order – The meeting was called to order by Susan Sauerheber at 3:02 pm in the Education Conference Room.		
2. Agenda Approval	Susan Sauerheber - Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. Minutes of 6/2026 ER Committee Meeting	Susan Sauerheber – Presentation of 3/2026, ER Committee meeting minutes for approval.	All present approved the presented meeting minutes for the 6/2026

Subject	Discussion	Attachment
4. Old Business	• See attached Minutes	meeting
New business and summary of same	• Mercy Medical Center-no ENT/OMFS coverage from 8/1 to 8/14 • Items/Supplies on Allocation • No longer an IV Contrast Shortage • Delinda to update on Surgeons • Butterfly BVM • Roundtable	(see attached)
	SUMMARY	
	• <u>Mercy Medical Center-NO ENT/OMPS coverage from 8/1 to 8/14.</u> Mercy Medical Center S-bar transfers go to Enloe and U.C. Davis • <u>Items/Supplies and Allocation-</u> Allocation-primary tubing and gloves. IV-Contrast, don't know if it is still allocated but, as Marty has been ordering in bulk on a regular basis, our stock is fine. No significant backorders at this time. Discontinued items- looking at new vendors as many items are discontinued • <u>Delinda update on Surgeons-</u> Dr. Mundell and Wiles, both general surgeons, will be here 9/21 and 9/22. Ruth will do their referrals and follow ups. They will be working out of the clinic Delinda is working on order new equipment for them. They do arthroscopic procedures and we are looking at purchasing surgery equipment and tools necessary for them to perform surgery here. It has been a challenge, but they are getting it. Orthopedists may join us as well. Kevin seems to think it is very likely that this will happen. The orthopedic surgeon that is coming would be working for 4 hospitals, Plumas, Semas, Mayers and MMC. There is potential that all hospital collaborate with surgery scheduling to ensure patients are able to have their surgery promptly. The ER patients may benefit if needing a procedure when the doctor is here.	

Subject	Discussion	Attachment
	We believe he may also be able to see patients in his private office in Susanville as well. • <u>Butterfly BVM-</u> We are pushing them into stock and keeping what we have of the prior version. They will keep some of the old and some of the new in the ER. Butterfly BVM has not been added into Cerner inventory yet but after the trial period, which appears to be well, Lance will have it added. EMS and nursing staff like the Butterfly BVM and there is an online course that can be taken. Ed suggested that we input that into HealthStream as a training module for those that would be required to use it. <u>OF NOTE:</u> Cardio equipment is ordered, regular stress tests (treadmill only) can be performed, and possible ER could do some as well. Further discussion will be necessary when that station in Infusion is in place and all equipment has been cleared and put in service. New Ventilator is coming in. The old one in ER will have to be taken out of service.	
5. Roundtable – no roundtable (see attached)		
6. Adjournment 3:45	The next ER Committee Meeting will be TBD in the Education Conf. Room.	

ER COMMITTEE MEETING

On Thursday 3-26-2026 from 3:00 to 4:00 pm

**Modoc Medical Center – 1111 N. Nagle Street
Education Conference Room; Alturas, California**

ROUNDTABLE

Susan Sauerheber-

Nothing further

Alicia Doss-

Nothing at this time

Sandra Brown-

Nothing at this time

Lisanne Burkholder, M.D.-

Stress tests will be performed in infusion. ER docs could benefit from this. By the time the equipment arrives, is cleared for use and set up, it should be approximately 6 months.

Lance Chrysler-

Nothing else

Dr. Jay Lai-

Necessity to close the loop for the Zio's. Currently the reports from ER go to him. The reports for Clinic should go to the providers. It is uploaded to Cerner but needs to be physically sent to the provider here or outside providers as well, not just uploaded to Cerner.

Edward Johnson, CNO

Nothing further at this time

Walter Dimarucut-

Blood Products-Inventory increase from 3 O- to 5 and 5 O+ to 8-10 O+. We have had to do stat orders. Please remember that stat orders do not allow you to return or exchange. You have to eat the cost.

Issue with our units going with transport flight. Correction-initiate the blood before the trip. (does not have to be started just hung). (further discussions with Dr. James will ensue)

Megan Wright will compile a list of flight services that carry blood onboard and what they carry.

Urinalysis- new testing process



AGENDA

PATIENT SAFETY/SAFE LIFTING COMMITTEE MEETING

Wednesday, 7/15/2026 at 1:00 pm
Modoc Medical Center
Education Room Alturas, California

Subject	Discussion	Attachment
1. Call to Order		
2. Agenda Approval	Jay Dunn approved Agenda Items	All present approved the presented Agenda.
3. Minutes	05/2026 Minutes	See attached
4. BETA Care Funds	\$4,700 this year, submitted by 6/30/2026 - Hoyer lift and 3 slings	
5. Falls/Incidents	Amber to report	
6. Good Catch Award	3 to review	See attached
7. Old Business		
	- BETA Care Funds Hoyer and slings - Training	
8. New Business		
	- Falls/Incidents - Good Catch Award Apps to review - Open the floor to issues/ideas	-Amber See attached
9. Roundtable		
10. Adjournment	The next Patient Safety/Safe Lifting Committee Meeting will be Wednesday, September 16, 2026 @ 1:00 p.m., in the Education Conf. Room.	



MINUTES

PATIENT SAFETY/SAFE LIFTING COMMITTEE MEETING

7/15/2026 at 1:00 p.m.
Modoc Medical Center – 1111 N. Nagle Street
Education Room, Alturas, California

Present:

- Jay Dunn, Chair
- Ed Johnson, CNO
- Sandra Brown, Admin to CNO
- Megan Hays, DNO

- Amber Vucina, Chief HR Officer

Absent:

- Julie Carrillo, Manager Canby Clinic
- Susan Sauerheber, ER Nurse Manager
- San Juanita Wagner, Staff Development

- Judy Jacoby, IC Nurse
- Megan Morris-Wright, EMS Director
- CeCe Toaetolu, SNF-Nurse Manager

Subject	Discussion	Attachment
1. Call to Order – The meeting was called to order by Sandy Brown at 1:05 pm in the Education Room.		
2. Agenda Approval	Jay Dunn approved Agenda items	All present-approved
3. Minutes	7/2026	Attached-Approved
4. Old Business	See Agenda and Minutes	Attached
5. New Business	See attached Agenda	Attached
6. CARE FUNDS	Hoyer and slings this year.	
6. FALL INCIDENTS	7/10 7/14 7/12	
	- GOOD CATCH. Ed working on how we are going to present and announce. - Sandra inquiring about more info on one Application. Adjourned until next meeting	
Roundtable:		
7. Adjournment	The next Meeting will be 9/16/2026 @ 1:00 at Education Conference Room.	



MINUTES

OP INFUSION COMMITTEE MEETING

Tuesday, 7/27/2026 at 8:30-9:30 a.m.
Modoc Medical Center – 1111 N. Nagle Street
Infusion Department, Alturas, California

Present:

- Shirley Hughes, Infusion
- Linda Sawyer, Infusion Nurse
- Sandra Brown, Admin. Assistant
- Vahe Hovasapyan, Hospital Pharmacy Manager
- Ed Johnson, CNO
- Lisanne Burkholder, M.D.
- Susan Sauerheber, Committee Chair
- Delinda Gover Perez, Surgery Manager
- Erika Dorati

Absent:

Subject	Discussion	Attachment
1. Call to Order – The meeting was called to order at 8:38 am in the Infusion Room.		
2. Agenda Approval	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. Minutes	Approved	Attached hereto (4/2026)
4. Old Business	As noted on Minutes and discussed at 4/2026 OP Infusion Committee Meeting	
5. New Business		
	• Infusion Cards were ordered	
	• Omnicell working for Linda 50% of the time. Vahe troubleshooting and Vahe and Linda will get it worked out	
	• Ed and Vahe have not taken a field trip yet to see how other hospitals are handling things. Plan to do so after summer due to everything being so busy	
	• Infusion Process- not getting orders. Providers have problems reviewing history, Linda is starting missing doses. Providers are responsible for	

Subject	Discussion	Attachment
	documentation. Richert, Burkholder and Hagge can sign orders for special meds. • Nothing back from Adam on Rev Cycle. We need to try the 2 month trial with any new patients to see if we are getting paid for the fluids and flushes. • Pre-authorizations are good for 12 months from specialist. • Shirley provides hard copy to primary care doctors here in clinic and faxes same to Canby providers. • Issue with HIM (in Clinic) giving Providers pushback about scanning things in (that needs to be addressed) • Cardio docs will be coming 2 days a month to start and using the 3rd chair section of Infusion. OR IS IT FRIDAYS????? • Isolation Room in Infusion is now for Wound Care and Erika Dorati is in there.	
6. Roundtable All discussed above		
7. Adjournment 9:15 a.m.	The next OP Infusion Meeting will be Tuesday, 8/4/2026 @ 8:30 a.m. in the Infusion Department	



MINUTES

SURGERY COMMITTEE MEETING

Tuesday, 7/27/2026, at 8:30-9:30 a.m.

Modoc Medical Center - 1111 N. Nagle Street

Infusion Department Alturas, California

Present:

- Linda Sawyer, RN
- Ed Johnson, CNO
- Shirley Hughes, Infusion Clerk
- Delinda Gover Perez, Committee Chair
- Susan Sauerheber, Nursing Manager
- Lisanne Burkolder, M.D.
- Vahe Hovsapyan, Pharmacy Manager
- Katrina Murray, Surgery Tech
- Erika Dorati, Wound Care Nurse
- Sandra Brown

Absent:

- Edward Richert, M.D.
- Dale Syverson, M.D.
- Kevin Kramer, CEO
- Marty Shaffer, Facilities/EOC

Subject	Discussion	Attachment
1. Call to Order	The meeting was called to order at 9:16 am in the Infusion Room.	
2. Agenda Approval	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. Minutes	See Attached from 4/2026	
4. Old Business	See attached Minutes	
5. New Business	• Dr. Mundell and Wiles are going to be doing Procedures Here. Shannon is trying to get dates from them for 1 year but Delinda will get dates through 12/26 at least. Need to get a list for Vahe of local and meds they want to use for their procedures. He would like Par levels as well. They are looking at a tower, laparoscopic equipment and some	

Subject	Discussion	Attachment
	Robotic stuff.	
	Rural Transf. Grants (Federal Programs) should be applied for on the second round)	
	Dr. Wright (orthopedic doctor is also on board for ortho surgeries	
	It looks like docs will need to use the Clinic 2 days a month to start. Kevin said this is an important enough service for the hospital that we will have to make some allowances and move some schedules around. The build-out for clinic space is in the works. It will not inconvenience the clinic forever. The services we will receive far out way any short-term inconvenience it may cause to provider schedules.	
	Rylee will need to do some marketing. Providers will need to be briefed on surgeries and procedures available for referral.	
	Dr. Wright's goal is to work with Banner, Chester, (one other) and our facility	
	If Dr. Wright does come, he will be brining his own scrub tech with the goal of training our scrub tech's as well.	
7. Adjournment 9:40	The next Surgery Meeting will be Tuesday, 8/4/2026 @ 8:30 a.m. in the Infusion Room.	



AGENDA

OP INFUSION COMMITTEE MEETING

8/4/2026 at 8:30 a.m.

Modoc Medical Center – 1111 N. Nagle Street
Infusion Department., Alturas, California

Subject	Discussion	Attachment
1. Call to Order		
2. Agenda Approval	No changes, additions and /or deletions to the Agenda	All present approved the presented Agenda.
3. Minutes	• Attached from 7/2026	All present approved the Minutes From 7/2026
4. Old Business		
	• See Attached Minutes from 7/2026	Attached
5. New Business		
	• Open discussion for questions or comments	
6. Roundtable		
7. Adjournment	The next OUTPATIENT INFUSION COMMITTEE Meeting will be 9/11/2026, at 8:30 am in the Infusion Dept.	



MINUTES

OP INFUSION COMMITTEE MEETING

Tuesday, 8/4/2026 at 8:30-9:30 a.m.

Modoc Medical Center – 1111 N. Nagle Street
Infusion Department, Alturas, California

Present:

- Shirley Hughes, Infusion
- Linda Sawyer, Infusion Nurse
- Sandra Brown, Admin. Assistant
- Ed Johnson, CNO
- Lisanne Burkholder, M.D.
- Susan Sauerheber, Committee Chair
- Delinda Gover Perez, Surgery Manager (BY PHONE)
- Erika Dorati

Absent:

- Vahe Hovasapyan, Hospital Pharmacy Manager

Subject	Discussion	Attachment
1. Call to Order	The meeting was called to order at 8:34 am in the Infusion Room.	
2. Agenda Approval	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. Minutes	Approved	Attached hereto (7/2026)
4. Old Business	As noted on Minutes and discussed at 7/2026 OP Infusion Committee Meeting	
5. New Business	• Open Discussion and questions • Ed, Vahe and Adam have moved their field trip to the fall to Tahoe to determine how they are so successful • Still not getting orders and those received are not meeting the standard and have to be worked up • Wound Care will be doing in-service billing • Discussion about weak client getting transfusion 1 time per week. Transporting very difficult and communication between Burkholder and Tony will ensue.	

Subject	Discussion	Attachment
6. Roundtable All discussed above		
7. Adjournment 8:51 a.m.	The next OP Infusion Meeting will be Tuesday, 9/8/2026 @ 8:30 a.m. in the Infusion Department	



AGENDA

SURGERY COMMITTEE MEETING

8/4/2026 at 8:30 a.m.

Modoc Medical Center - 1111 N. Nagle Street
Infusion Dept., Alturas, California

Subject	Discussion	Attachment
1. Call to Order		
2. Agenda Approval	No changes, additions and /or deletions to the Agenda	All present approved the presented Agenda.
3. Minutes	Attached from 7/2026	All present approved the Minutes From 7/2026
4. Old Business	See Attached Minutes 4/2026	Attached
5. New Business	Floor open for questions from last meeting and follow up on new surgeons (by Delinda)	
6. Roundtable		
7. Adjournment	The next SURGERY COMMITTEE Meeting will be 9/11/2026, at 8:30 am in the Infusion Dept.	



MINUTES SURGERY COMMITTEE MEETING

Tuesday, 8/4/2026, at 8:30-9:30 a.m.
Modoc Medical Center – 1111 N. Nagle Street
Infusion Department Alturas, California

Present:

- Linda Sawyer, RN
- Ed Johnson, CNO
- Shirley Hughes, Infusion Clerk
- Delinda Gover Perez, Committee Chair
- Susan Sauerheber, Nursing Manager
- Sidney Barns
- Erika Dorati, Wound Care Nurse
- Sidney Barns
- Lisanne Burkholder, M.D.

Absent:

- Edward Richert, M.D.
- Katrina Murray, Surgery Tech
- Vahe Hovsapyan, Pharmacy Manager
- Dale Syverson, M.D.
- Kevin Kramer, CEO
- Marty Shaffer, Facilities/EOC

Subject	Discussion	Attachment
1. Call to Order – The meeting was called to order at 8:47 am in the Infusion Room.		
2. Agenda Approval	No Changes, additions and/or deletions to the Agenda.	All present approved the presented Agenda.
3. Minutes	See Attached from 7/2026	
4. Old Business	See attached Minutes	
5. New Business	- Currently spending time tracking down new equipment for the surgeons that will be joining. This has been arduous but necessary - So far only scheduled for one day in clinic.	
7. Adjournment 8:58	The next Surgery Meeting will be Tuesday, 9/8/2026 @ 8:30 a.m. in the Infusion Room.	

ATTACHMENT D

Policy and Procedures



MEMORANDUM

DATE: 8/27/2026
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 Anesthesia Services
7420.26 Categories of Surgical Outpatients
7420.26 Out Patient Surgery Patient Information
7420.26 Out Patient Surgery
7420.26 Post Operative Routine
7420.26 Pre-Operative Anti-Microbial Shower
7420.26 Surgery Charges

SKILLED NURSING FACILITIES

6580.26 End of Life Comfort Care
6580.26 Weekly Summary-Licensed Nurses
6580.26 Completion of Resident Carr Plan
6580.26 Resident Transport and Overnight Assignment

FACILITIES/EOC

8460.26 Inventory and Inspection of New Equipment

AMBULANCE

7041.26 Ambulance Personnel Condition of Employment

EMERGENCY DEPARTMENT

7010.26 Safe Surrender of Newborn Policy

Review of Departmental Policies (continued):

7010.26 Orthopedic Emergencies Policy
7010.26 Seizure Standard of Care Policy
7010.26 Outpatient Observation Policy and Procedure
7010.26 Patient and Visitor Safety in the Emergency Department
7010.26 Sentinel Event Policy
7010.26 Stab Wounds Standard of Care
7010.26 Patient Belongings and Property Policy
7010.26 Alteplase Protocol for Acute Ischemic Stroke
7010.26 Patient Discharge Medications
7010.26 Stroke Standard of Care Policy and Procedure
7010.26 Clinical Alarm Management
7010.26 Patient Identification Policy
7010.26 Suicide Risk Screening and Precautions in the Emergency Department
7010.26 Patients Requiring Psychiatric Evaluation Policy
7010.26 Interfacility Transfer of Patients to Higher Level of Care Policy
7010.26 Synchronized Cardioversion Policy
7010.26 Management of Patients Under the Influence Policy
7010.26 Pediatric Asthma Standard of Care Policy
7010.26 Transcutaneous Pacing Policy
7010.26 Pediatric Dosing Guidelines Policy
7010.26 Medication Reconciliation Policy
7010.26 Vaginal Bleeding Standard of Care Policy
7010.26 Pediatric Fever Standard of Care Policy
7010.26 Neurological Assessment Policy and Procedure
7010.26 Vital Signs Monitoring for Pediatric Patients Policy
7010.26 Pediatric Rights and Responsibilities of Parents-Guardians Policy
7010.26 Op site Wound Dressing Application and Management Policy
7010.26 Central Venous Catheter Troubleshooting
7010.26 Vomiting Standard of Care
7010.26 Release of Patient Information
7010.26 Organ Tissue Eye Donation Nursing Responsibilities
7010.26 Wound Care Standard of Care

NURSING MED/SURG

6170.26 AM Care Policy
6170.26 Anticoagulation Therapy Policy
6170.26 Application of Ward and Cold Compresses
6170.26 Assisting Patient Out of Bed
6170.26 Assisting with Examination of Patients
6170.26 Care of Patients Who are Blind or Visually Impaired
6170.26 Central Venous Catheter Removal
6170.26 Chest Tube Drainage Care
6170.26 Laboratory Specimen Collection Policy

Review of Departmental Policies (continued):

6170.26 Ostomy Care Policy

6170.26 Radiology Procedures

6170.26 Withholding or Withdrawal of Life-sustaining Measures Policy

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

CANBY MEDICAL AND DENTAL CLINICS

Memorandum

Annual Review Signature Page

INFECTION CONTROL SNF

Memorandum

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ENVIRONMENTAL SERVICES/LAUNDRY

Memorandum

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ACUTE/MED SURG

Memorandum

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TRANSFUSION

Memorandum

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LABORATORY

Memorandum

Annual Review Signature Page

EXCELL SPREAD SHEET

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.

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	7420.26 ANESTHESIA SERVICES	
DEPARTMENT:	OPERATING ROOM	REVISED 06/2026

PURPOSE:

The purpose of this policy is to define the Anesthesia Services for Modoc Medical Center (MMC).

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None

POLICY:

It is the policy of Modoc Medical Center (MMC) that Anesthesia Services will be provided according to the bylaws of MMC and any state, federal, or anesthesia association guidelines.

PROCEDURE:

Anesthesia Service:

- Anesthesia services are provided by physician anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs). State regulations require stringent safety standards, including pre-anesthesia evaluations, continuous monitoring, and structured ~~post-anesthesia~~ recovery protocols. The provision, administration, and reimbursement of these services are governed by strict state and federal frameworks:

Scope of Practice and Authorization

- Physician Anesthesiologists: Medical doctors (MDs or ~~De~~Os) who handle the most complex cases, critical care, and pain management.
- Nurse Anesthetists (CRNAs): California law outlines a comprehensive scope of practice for CRNAs. They are authorized to provide preoperative, intraoperative, and postoperative care, including the selection, adjustment, and administration of anesthesia agents, under the request of a physician, dentist, or podiatrist.
- Supervision & Opt-Out: California operates under a Medicare “supervision” opt-out. This means that hospitals and facilities may choose to use CRNAs to provide anesthesia services without the direct physical supervision of a physician, depending on facility bylaws and the practitioners’ specific credentialing.

Facility Regulations

- Hospitals: Acute care hospitals must maintain strict guidelines for space, equipment and supplies. The post anesthesia care unit (PACU) must have specialized oversight, specific floor plans (e.g., at least 80 square feet per bed), and strict grounding and environmental controls.

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	7420.26 ANESTHESIA SERVICES	
DEPARTMENT:	OPERATATING ROOM	REVISED 06/2026

REFERENCES:

Lii / legal information institute and California anesthesia professionals.

ATTACHMENTS:

None

REFERENCE # 7420.26	EFFECTIVE 04/2009
SUBJECT: 7420.26 CATAGORIES OF SURGICAL PATIENTS	
DEPARTMENT: OPERATATING ROOM	REVISED 06/2026

PURPOSE:

The purpose of this policy is to determine the level of care assigned to each surgical case.

AUDIENCE:

Department Staff

TERMS AND DEFINITIONS:

Level 1: This generally refers to a minor surgical procedure performed under topical, local, or infiltration block anesthesia. These procedures do not require preoperative sedation, and patients are typically stable and ready to go home shortly after the procedure/

Level 2: This generally refers to a minor or major procedure that requires IV sedation or regional anesthesia, falling between simple, local anesthesia procedures (Level 1) and full general anesthesia surgeries (Level 3). This classification is commonly used based on surgery guidelines that define the necessary safety standards and monitoring equipment. The patient receives IV sedation, parenteral sedation, regional anesthesia, or analgesia/dissociative drugs. These can be minor or slightly more complex procedures, such as cosmetic surgeries and pain management.

Level 3: This refers to a moderately complex, invasive procedure that requires deep sedation or general anesthesia, but is still performed on a same-day out-patient basis. These procedures carry more risks than levels 1 or 2, such as major laparoscopy or orthopedics, hysterectomies, myomectomies, cholecystectomies (gallbladder removal), and knee/hip replacements.

POLICY:

It is the policy of Modoc Medical Center (MMC) that surgical case levels will be defined by the complexity of the case being performed.

PROCEDURE:

The following outlines the steps, procedure type, risk level and recovery time for levels 1-3 categories of surgical patients.

Level 1: This generally refers to a minor surgical procedure performed under topical, local, or infiltration block anesthesia. These procedures do not require preoperative sedation, and patients are typically stable and ready to go home shortly after the procedure

- Anesthesia: Topical or local anesthetics only (no intravenous (IV) sedation or general anesthesia).
- Procedure Type: Minor surgeries (e.g., small skin lesion excision, simple mole removal).
- Risk Level: Low risk of significant complications.
- Recovery: Minimal post-operative monitoring required.

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	7420.26 CATAGORIES OF SURGICAL PATIENTS	
DEPARTMENT:	OPERATATING ROOM	REVISED 06/2026

Level 2: This generally refers to a minor or major procedure that requires IV sedation or regional anesthesia, falling between simple, local-anesthesia procedures (Level 1) and full general anesthesia surgeries (Level 3). This classification is commonly used based on surgery guidelines that define the necessary safety standards and monitoring equipment.

- Anesthesia Level: The patient receives IV sedation, parenteral sedation, regional anesthesia, or analgesia/dissociative drugs.
- Procedure Complexity: These can be minor or slightly more complex procedures, such as cosmetic surgeries, pain management injections, or endoscopic procedures.
- Monitoring Required: Because sedation is used, the patient requires more intense monitoring compared to local-only (Level 1) procedures, including monitoring of vitals and oxygenation.
- Recovery Phase: (Phase 2) In the Post Anesthesia Care Unit (PACU), Phase 2 is specifically geared toward preparing the patient for discharge to home, ensuring they are alert, have manageable pain, and have a responsible adult to drive them.

Level 3: This generally refers to a moderately complex, invasive procedure that requires deep sedation or general anesthesia, but is still performed on a same-day basis. These procedures carry more risks than levels 1 or 2, such as major laparoscopy or orthopedics.

- Procedures: Typically includes surgeries like hysterectomies, myomectomies, cholecystectomies (gallbladder removal), and knee/hip replacements.
- Anesthesia: Often requires general anesthesia or deep sedation, rather than just local anesthesia.
- Patient Status: While undergoing complex procedures, these patients are usually stable, often categorized by American Society of Anesthesiologist (ASA) as Class 1 or 2.
- Setting: Performed in a hospital or specialized ambulatory surgery center with high-level monitoring and a skilled team for safety.
- In some contexts, a "Level 3" visit might also refer to low-risk outpatient evaluation involving, for example, two or more minor problems or one stable chronic illness. However, in the context of surgery classification, it refers to the moderate complexity described above.

REFERENCES:

American osteopathic association, lii / legal information institute, and far north surgery.

ATTACHMENTS:

None

REFERENCE # 7420.26	EFFECTIVE: 04/2009
SUBJECT: 7420.26 OUT-PATIENT SURGERY PATIENT INFORMATION	REVISED: 06/2026
DEPARTMENT: OPERATING ROOM	

PURPOSE:

The purpose of this policy is to provide instructions for patients scheduled for outpatient surgery.

AUDIENCE:

Department Staff

TERMS & DEFINITIONS:

None

POLICY:

It is the policy of Modoc Medical Center (MMC) that all patients scheduled for outpatient surgical procedures or endoscopy procedures will receive written instructions and information regarding their appointment.

PROCEDURE:

All patients scheduled for outpatient procedures will be given written instructions and information.

- For all surgical procedures, a letter containing information regarding arrival time, medication instructions, fasting, pre-operative bathing and instructions for post-operative driving after sedation.
- Instructions for tobacco cessation will also be provided.
- For all endoscopy procedures instructions will be provided that go over upper endoscopy preparation and lower endoscopy preparation.
- Information on who to call for questions is also provided.

REFERENCES:

None

ATTACHMENTS:

What to expect for surgery procedures;

What to expect for upper endoscopy procedure; and

What to expect for colonoscopy procedures.

REFERENCE # 7420.26	EFFECTIVE: 04/2009
SUBJECT: 7420.26 OUT-PATIENT SURGERY	
DEPARTMENT: OPERATING ROOM	REVISED: 06/2026

PURPOSE:

The purpose of this policy is to define the procedure for admitting a patient into Out-Patient Surgery.

AUDIENCE:

Department Staff

TERMS & DEFINITIONS:

None

POLICY:

It is the policy of Modoc Medical Center (MMC) that patients scheduled for Out-Patient surgery will have met basic criterion.

PROCEDURE:

- The patient may receive surgical procedures on an out-patient basis if the surgery is of minor nature or considered minimally invasive.
- Surgeries are performed in the Procedure Room or the Operating Room.
- Anesthesia is administered according to the procedure, anesthesia provider, and surgeon.
- General anesthesia, local anesthesia, Monitored Anesthesia, and Regional Blocks can be used in the out-patient setting.

Criteria for admission to an out-patient surgery or short stay as an out-patient.

- Adequate physical condition on admission.
- Procedure based upon the risk level for a basically healthy person with an uncomplicated emergency or elective problems that require no extended in-hospital observation following recovery from surgery.
- The patient should anticipate being discharged following this procedure and an initial recovery time.
- Total admission to discharge time should not exceed 12 hours. The nursing staff is to call the patient's physician if the patient is marginal for discharge at eight to ten hours post-op for further instructions.
- Patients with chronic disease may have surgery done on an out-patient basis under the following conditions:
 - The patient's chronic diseases shall have such problems documented by the primary care provider and / or the surgeon.
 - Medication lists must be up to date.
 - The patient's physician or surgeon shall consult with the anesthesia provider and any other concerned parties, to inform them of any chronic problems the patient may have.
 - Chronic diseases such as Hypertension, Diabetes, Seizure disorders, Coronary heart disease, etc. shall be controlled and stabilized prior to out-patient surgery.
 - Medications for chronic conditions such as anti-hypertensive, anti-diabetics, anti-convulsing, anti-coagulation, and respiratory medications such as inhalers will ordinarily be continued post-surgery providing there are no contraindications.

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SUBJECT:	7420.26 OUT-PATIENT SURGERY	REVISED: 06/2026
DEPARTMENT:	OPERATING ROOM	

- Morning doses of anti-hypertensive medications and inhalers should be administered by the patient before they arrive for surgery.
- Routine medications may resume after discharge unless otherwise directed by the surgeon.

REFERENCES:

None

ATTACHMENTS:

None

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	7420.26 POST OPERATIVE ROUTINE CARE FOR A PATIENT IN THE MED/SURG UNIT.	REVISED 06/2026
DEPARTMENT:	OPERATING ROOM	

PURPOSE:

The purpose of this policy is to provide guidance to the surgery staff regarding the care of the post-operative patient.

- To anticipate the needs and wants of the post-operative patient and to administer accordingly.
- Accurately evaluate the patient's condition
- Alleviate pain and discomfort
- Prevent post-operative complications.

AUDIENCE:

Department Staff

TERMS/DEFINITION:

Blood Pressure: B/P

Intake and Output: I/O

Intravenous: IV

Arterial Oxygen Saturation: SA02

Post Anesthesia Care Unit: PACU

POLICY:

It is the policy of Modoc Medical Center (MMC) that each post-operative patient will be cared for in a manner that meets their needs in the PACU setting.

PROCEDURE:

- Before the patient enters the room, make sure the suction system is set up and functioning.
- Check to make sure all potential oxygen supplies are available.
- Have emesis bags readily available.
- Check the vital signs machine to make sure all supplies are on the cart.
- Have an IV pump and pole at the bedside.

After The Patient Enters the Med/Surg Unit:

- Check the patient's vital signs and level of consciousness.
- Apply oxygen if necessary.
- Receive report from the anesthesia provider or the circulating nurse.
- Assess the surgical site for the type of dressing, drainage, and/or drain tubes.
- Monitor vital signs every 15 minutes $\times$ 2, then every 30 minutes $\times$ 2, then hourly $\times$ 2. If stable, continue vital sign monitoring every 4 hours

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	7420.26 POST OPERATIVE ROUTINE CARE FOR A PATIENT IN THE MED/SURG UNIT.	REVISED 06/2026
DEPARTMENT:	OPERATING ROOM	

Post Operative Continued

- Encourage the patient to turn and deep breathe every hour for the first twelve hours, then every two hours thereafter.
- Instruct the patient to perform coughing and deep breathing exercises every 4 hours. Assess lung sounds routinely and report any abnormal findings to the provider.
- Remove any extra linen from underneath the patient.
- Place the call light within reach.
- Place the patient in semi-fowlers unless there are contraindications.
- Offer oral fluids as ordered by the provider.
- Allow the family to visit. Instruct the family about the patient's dietary requirements.
- Keep an accurate intake/output (I/O) of oral fluids, IV fluids, and urine output. Document I/O in the patient record
- Teach patient how to splint the abdomen with a pillow when sitting up and sitting back down.
- Encourage the use of an incentive spirometer.

Charting:

- Chart the physical assessment on admission to the Med/Surg unit. Document pain levels and the follow up assessment after pain medications are administered.
- Assess the IV site. Document IV fluids and medications administered.

REFERENCES:

None

ATTACHMENTS:

None

REFERENCE #	7420.26	EFFECTIVE:	04/2009
SUBJECT:	7420.26 PRE-OPERATIVE ANTI-MICROBIAL SHOWER	REVISED:	06/2026
DEPARTMENT:	OPERATING ROOM		

PURPOSE:

The purpose of this policy is to provide surgery staff with instructions regarding peri-operative anti-microbial showers for all surgical patients.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None

POLICY:

It is the policy of Modoc Medical Center (MMC) that all surgical patients will be given instructions and directions for peri-operative anti-microbial showering before their scheduled procedure.

PROCEDURE:

Patients should perform preoperative bathing with either soap or an antiseptic before surgery or other invasive procedures.

- All surgical patients will be instructed to shower the evening before or morning of their scheduled procedure.
- Provide clear verbal and written instructions for the patient or caregiver.
- For surgical patients that are having an open surgery, an anti-microbial soap, such as Chlorhexidine, should be used to shower with. Instruct the patient to avoid the face and eyes.
- Patients scheduled for open procedures will also be instructed to bathe with the 2% impregnated cloth products after arrival in the pre-operative area.
- Follow the instructions on the packaging for skin preparation.
- Patients that cannot perform preoperative bathing themselves should have a family member or caregiver ~~assist~~ assist them using a washcloth or cloth containing soap or antiseptic.
- Procedures on patients that include the hand or foot should be instructed to have clean and natural nails.
- Patients should also be instructed to leave hair at the surgical site in place unless they are otherwise instructed.

REFERENCES:

Guidelines for perioperative practice, 2025 edition. page 638 2.1, 639, page 640 2.1.1, 2.2, page 642, 2.5.1, 2.5.3 PAGE 644 3.1

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REFERENCE # 7420.26	EFFECTIVE: 04/2009
SUBJECT: 7420.26 PRE-OPERATIVE ANTI-MICROBIAL SHOWER	REVISED: 06/2026
DEPARTMENT: OPERATATING ROOM	

ATTACHMENTS:

None

REFERENCE #	7420.26	EFFECTIVE 04/2009
SUBJECT:	7420.26 SURGERY CHARGES	REVISED 05/2026
DEPARTMENT:	OPERATING ROOM	

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PURPOSE:

The purpose of this policy is to assist Surgery Staff in applying the correct charges for the procedures performed in this department.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

~~Electronic Medical Record: EMR~~

~~Post Anesthesia Care Unit: PACU~~

~~Emergency Room: ER~~

~~None~~

POLICY:

It is the policy of Modoc Medical Center (MMC) that a charge sheet for anesthesia services be completed by the anesthesia provider for each surgical case. All other charges will be captured through the Electronic Medical Record (EMR).

PROCEDURE:

Surgery Charge Form

- The Patient Charge Form for anesthesia must be completed on all surgical procedures where anesthesia services were provided.
- For the services provided by the surgeon, these can be captured through the EMR and the Intra-operative record.
- Procedures are categorized by the procedure performed by the physician as major or minor.
 - Major Surgery – see the procedure manual for the procedures that are considered Major.
 - Minor Surgery – see the procedure manual for the procedures that are considered Minor.
 - Emergency Surgery – these are unscheduled procedures that could lead to a life-threatening surgery.
- Determine the amount of time the patient is receiving anesthesia and physician surgical time by documenting these times on the anesthesia intra-operative form and in the intra-operative note.
- Chart the total number of minutes.
- ~~Major~~ Surgery – The charge for this category is a flat fee for the first hour and additional time charges for each fifteen minutes thereafter.
- Minor Surgery – The charge for this category is a flat fee for the first half hour and additional time charges for each fifteen minutes thereafter.
- Emergency Surgery – The charge for this category is a flat fee.
- Dirty Case Charge – For a patient with a known infectious process or disease or determined during the case to be infectious (i.e., ruptured appendix or perforated bowel) this category is marked by a (1). The charge for this category is a flat fee.

REFERENCE #	7420.26	EFFECTIVE 04/2009
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RECOVERY DEPARTMENT

- The patient is charged from the time they arrive in the Post Anesthesia Care Unit (PACU) until until they are discharged. The charge for this category is a flat fee for the first half hour and additional timecharges for each 15 minutes thereafter. The charge drops from the EMR.

PROCEDURES PERFORMED IN THE ER OR WITH AN IN-PATIENT

- Procedures performed by the surgeon or anesthesia provider in the Emergency Room (ER) or for an In-patient, will be charged according to procedures and documentation provided.
- Any urgent Endoscopy procedures will be performed in the Procedure Room and charged according to the procedure performed.

REFERENCE:

None

ATTACHMENTS:

None

REFERENCE #	6580.26	EFFECTIVE 10/2016
SUBJECT:	6580.26 END OF LIFE CARE / COMFORT CARE	REVISED 05 2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

PURPOSE:

The purpose of this policy is to ensure residents receiving comfort-focused or end-of-life care in the skilled nursing facility receive compassionate, dignified, individualized, and symptom-directed care consistent with their goals, physician orders, advance directives, and California regulatory requirements.

This policy establishes standards for:

- Comfort-focused treatment
- Symptom management
- Emotional and spiritual support
- Resident rights and informed decision-making
- Family support
- Documentation and interdisciplinary care planning
- Post-mortem care

The purpose of this policy is to establish and maintain effective resident comfort care at the end of life as determined by the resident or the resident's legal representative.

AUDIENCE

Department Wide

TERMS & DEFINITIONS

Comfort Care - A plan of care focused on relief of pain, suffering, and distressing symptoms rather than curative treatment.

End-of-Life Care - Care provided during the final phase of life that emphasizes comfort, dignity, emotional support, and symptom management.

Hospice - A Medicare-certified program providing palliative and supportive services to terminally ill individuals.

POLST - Physician Orders for Life-Sustaining Treatment form recognized in California.

REFERENCE #	6580.26	EFFECTIVE 10/2016
SUBJECT:	6580.26 END OF LIFE CARE / COMFORT CARE	
DEPARTMENT:	SKILLED NURSING FACILITIES	REVISED 05.2026

POLICY:

It is the policy of Modoc Medical Center's Skilled Nursing Facilities (SNFs) to provide or coordinate appropriate end-of-life and comfort care services that promote dignity, comfort, pain relief, and quality of life for residents with terminal illnesses, advanced chronic disease, or declining conditions.

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Residents have the right to:

- Participate in decisions regarding end-of-life care
- Refuse treatment
- Receive pain and symptom management
- Have advance directives honored
- Receive emotional, psychosocial, cultural, and spiritual support
- Receive hospice services when appropriate

The facility shall comply with:

- California Title 22 regulations
- Federal CMS Requirements of Participation
- Resident Rights regulations
- POLST and Advance Health Care Directive requirements

respect the resident's right to control decision-making, dignity, and proper comfort measures to provide the best possible quality of life at the closure of life. The following will be addressed:

1. Physical needs:
 2. Acute and chronic pain.
 3. Signs and symptoms presentation as resident's condition declines.
4. Psychological and spiritual needs.
5. Social and cultural needs.
6. Environmental needs.

REFERENCE #	6580.26	EFFECTIVE 10/2016
SUBJECT:	6580.26 END OF LIFE CARE / COMFORT CARE	REVISED 05.2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

— Intramuscular (IM) and intravenous (IV) medications will be administered in the SNF only if no other route is possible when at end of life.

DEFINITIONS

Comfort Care—A plan of care focused on relief of pain, suffering, and distressing symptoms rather than curative treatment.

End of Life Care—Care provided during the final phase of life that emphasizes comfort, dignity, emotional support, and symptom management.

Hospice—A Medicare-certified program providing palliative and supportive services to terminally ill individuals.

POLST—Physician Orders for Life-Sustaining Treatment form recognized in California.

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PROCEDURE:

1. IDENTIFICATION OF RESIDENTS APPROPRIATE FOR COMFORT CARE

Residents may be considered for comfort-focused care when:

- Diagnosed with terminal illness
- Significant functional decline is observed
- Recurrent hospitalizations occur
- Resident or responsible party requests comfort-focused treatment
- Physician recommends palliative or hospice care

Resident elects to participate in hospice services

The attending physician will indicate with an order that the resident will be on comfort care after discussion with the resident or the resident's legal representative.

The interdisciplinary team (IDT) shall evaluate the resident's goals of care and update the care plan accordingly.

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2. ADVANCE DIRECTIVES AND GOALS OF CARE

Upon admission and with significant condition changes, staff shall review the following information:

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DEPARTMENT:	SKILLED NURSING FACILITIES	REVISED 05.2026

- Advance Health Care Directive
- POLST
- Code status
- Conservator or responsible party information
- Resident wishes regarding hospitalization and life-sustaining treatment

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The facility shall:

- Honor valid advance directives
- Ensure physician orders reflect resident wishes
- Document discussions regarding goals of care
- Communicate code status clearly per facility protocol

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3. PAIN AND SYMPTOM MANAGEMENT

The facility shall provide timely assessment and management of:

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- Pain
- Dyspnea
- Anxiety
- Restlessness
- Nausea/vomiting
- Secretions
- Constipation
- Agitation
- Skin integrity concerns

The following items are Nursing Responsibilities

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Licensed nurses shall:

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- Assess pain routinely using appropriate pain scales

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SUBJECT:	6580.26 END OF LIFE CARE / COMFORT CARE	REVISED 05.2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

- Notify physician of uncontrolled symptoms
- Administer medications as ordered
- Monitor effectiveness of interventions
- Document resident response

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Non-pharmacological interventions may include:

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- Repositioning
- Keep resident clean and dry
- Calm environment
- Music therapy
- Oral care
- Therapeutic touch
- Family presence
- Spiritual support

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4. NUTRITION AND HYDRATION

Residents receiving comfort care may experience decreased intake.

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The facility shall:

- Respect resident choices regarding food and fluids
- Avoid forcing intake
- Provide comfort feeding as appropriate
- Offer preferred foods and fluids when safe
- Maintain oral comfort measures

Artificial nutrition or hydration decisions shall follow physician orders, informed consent, and resident preferences.

Notify the dietary department to supply a hospitality cart and replenish cart as necessary if the family are at the bedside.

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5. EMOTIONAL, CULTURAL, AND SPIRITUAL SUPPORT

Residents and families shall be offered:

- Emotional support
- Privacy
- Spiritual care referrals
- Clergy visitation
- Cultural accommodations when feasible

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Staff shall respect:

- Cultural beliefs
- Religious practices
- Family customs related to dying and death

6. FAMILY COMMUNICATION

The facility shall:

- Notify responsible parties of significant condition changes.
- Educate families regarding the dying process when appropriate.
- Encourage family participation in care.
- Provide opportunities for visitation consistent with resident wishes.
- Hand out information to the family on the dying process and enquire whether the family would like to discuss what to expect.

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Staff should communicate compassionately and clearly regarding expected changes and symptom progression.

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7. ENVIRONMENTAL CONSIDERATIONS

When feasible, the facility shall:

- Provide a calm and private environment
- Reduce unnecessary interruptions
- Allow personal items and comfort measures

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SUBJECT:	6580.26 END OF LIFE CARE / COMFORT CARE	REVISED 05.2026
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- Promote dignity and respect during the dying process

8. PRONOUNCEMENT OF DEATH

Only authorized personnel may pronounce death in accordance with California law and facility policy.

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Upon death:

- Physician and hospice (if applicable) shall be notified
- Responsible party shall be notified promptly.
- Organ Donation Line notified promptly.
- Required documentation shall be completed
- Personal belongings shall be inventoried and released per policy

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9. POST-MORTEM CARE

Post-mortem care shall be performed respectfully and in accordance with:

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- Resident/family cultural or religious preferences
- Infection prevention standards
- Hospice instructions when applicable
- Coroner notification requirements when indicated

Staff shall:

- Provide respectful body care
- Secure personal belongings
- Document disposition arrangements

REFERENCES

- California Code of Regulations, Title 22
- CMS State Operations Manual
- OBRA Requirements
- California POLST Guidelines

REFERENCE #	6580.26	EFFECTIVE 10/2016
SUBJECT:	6580.26 END OF LIFE CARE / COMFORT CARE	
DEPARTMENT:	SKILLED NURSING FACILITIES	REVISED 05.2026

- Medicare Hospice Regulations

- Resident Rights Regulations

4. — The attending physician will indicate with an order that the resident will be on comfort care after discussion with the resident or the resident's legal representative.

2. — Implement comfort measures:

a. — Offer the use of a private room to the resident and family:

b. — Medications as ordered to manage the appearance of signs and symptoms as condition declines.

c. — Monitoring of pain and discomfort every shift and when necessary. Notify the physician if the current pain management is ineffective.

d. — Turn and reposition every two (2) hours and when necessary if resident unable to reposition self.

e. — Resident will be kept clean and dry.

f. — Vital signs and weights will not be taken.

g. — Cater menu requests. Offer any food or moisture swabs that are appealing.

h. — Oral care will be done every two (2) hours and when necessary if resident unable to manage own oral care. Excessive secretions will be reported to the physician.

i. — Utilization of local resources for spiritual and religious needs as determined by the resident or family.

j. — Offer soothing music and gentle massages with lotions or essential oils.

k. — Value resident and family beliefs and customs.

l. — Encourage resident and family to express their opinions and concerns.

m. — Notify the dietary department to supply a hospitality cart and replenish cart as necessary if the family are at the bedside.

n. — Hand out information to the family on the dying process and enquire whether the family would like to discuss what to expect.

ATTACHMENTS:

None

REFERENCE #	6580.26	EFFECTIVE 10/1998
SUBJECT:	6580.26 WEEKLY SUMMARY – LICENSED NURSES	REVISED 5/1/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

PURPOSE

The purpose of this policy is to ensure nursing staff provides a summary of each Warnerview and Mountain View Skilled Nursing Facilities (SNF) resident's care and progress on a weekly basis.

AUDIENCE

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Department Wide

TERMS AND DEFINITIONS

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None

POLICY

It is the policy of the Skilled Nursing Facilities (SNF's) that the nursing staff will maintain written progress notes on each resident that are specific to the resident's needs, the resident's care plan and the resident's response to care and treatments given. All nurses working in the SNF will be knowledgeable about the standard of care related to weekly summaries and will be assigned selected summaries to complete.

PROCEDURE

- Weekly nurse progress notes are to be written by nurses on each patient and will be specific to the resident's needs, the resident's care plan and the resident's response to care and treatments.
- Charting will include the resident's response to care rendered as identified in the plan of care and will address the goals of care.
- Each problem will be evaluated for continued relevance and updated and/or deleted, as needed. Deletion is done by highlighting the problem or portions of it, as appropriate.
- Any new problems occurring in the previous week will be added to the care plan, if not already done, and addressed in the summary. All additions or deletions to the care plan will be added to the care plan in the resident's record.
- All goals are written with specific time frames for rectification and/or re-evaluation. These must be updated on a regular basis when doing weekly summaries. Time frames cannot exceed ninety (90) days.
- Summaries of care will be specific as to how the resident responded to care rendered. Example:
 - A resident with weight loss and poor oral intake will have all meal percentages averaged over the previous week and documented as a total percentage of dietary intakes.
 - Notation of therapy or restorative program and resident response.

REFERENCE #	6580.26	EFFECTIVE 10/1998
SUBJECT:	6580.26 WEEKLY SUMMARY – LICENSED NURSES	REVISED 5/1/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

- Assignments for weekly summaries are done according to shift/day of the week and room number at the SNF, with each shift assigned approximately three (3) residents.
- The “Weekly Summary” is considered an official part of the medical record and will be filed in the resident’s chart when completed.

REFERENCES

None

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ATTACHMENTS

None

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REFERENCE #	6580.26	EFFECTIVE 1994
SUBJECT:	6580.26 COMPLETION OF THE RESIDENT CARE PLAN	REVISED 5/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

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PURPOSE

The purpose of this policy is to provide guidance to SNF staff on how to document and review a resident's plan of care ~~related to potential or actual problems.~~

AUDIENCE

Department Wide

TERMS & DEFINITIONS

None

POLICY

It is the policy of Modoc Medical Center (MMC) that all licensed nursing staff shall be knowledgeable regarding ~~the correct documenting of how to correctly document~~ the resident care plan.

PROCEDURE

1. The resident's initial care plan shall be initiated within eight (8) hours of ~~admission~~admission, and a comprehensive care plan shall be started within ~~forty-eight~~twenty-four (24) hours of admission by a licensed nurse.
2. The initial care plan shall be completed within two (2) weeks of admission and finalized within three (3) weeks (within seven [7] days of completion of Minimum Data Set [MDS]) and shall include all actual and potential problems identified after completion of all assessment forms and discussion of the resident's needs in the resident care plan meeting with the Interdisciplinary Team.
3. Problems shall be identified by number and shall have ~~measurable~~measurable, resident-centered, and time-oriented objectives, as well as appropriate approaches and actions by the responsible lead disciplines. The problems identified should be written ~~clearly~~ in clear language that everyone can understand.
4. The care plan is to be reviewed during the documentation of the weekly summary by the licensed nurse. Newly identified problems shall be added and resolved problems marked off the care plan. The care plan will be revised, as necessary, whenever the resident's condition changes and should always reflect the current status of the resident. The care plan shall be reviewed at least quarterly during ~~interdisciplinary~~ Team ~~meetings~~ and revised as needed based on the quarterly assessment.
5. The admitting nurse ~~or admission coordinator~~ (Can an admission coordinator complete the plan of care?) is responsible for completing the admission information, as well as the plan of care. The discharge coordinator or designee is responsible for completion of the discharge plan and the quarterly reviews.
6. The resident's Activities of Daily Living (ADL) status and immediate needs are documented in the initial care plan. Other problem areas to consider providing documentation on throughout a residents

REFERENCE #	6580.26	EFFECTIVE 1994
SUBJECT:	6580.26 COMPLETION OF THE RESIDENT CARE PLAN	REVISED 5/2026
DEPARTMENT:	SKILLED NURSING FACILITIES	

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stay include relate to the resident's diagnosis or medical status, medications, bowel/bladder function, fall risk, cognitive status, sensory deficits, infection control, psychotropic or postural restraint use, discharge plan, and other problems identified during assessments.

7. Like problems may be grouped within one problem number, even though they may have more than one cause, goal, or approach. Leave several spaces between each problem.
8. Objectives will be ~~measureable~~measurable, time-oriented, and resident-centered. Re-evaluation dates and times must be identified with time frames not to exceed every three (3) months. Goal = Subject + Verb + Modifier + Time Frame. Here are some examples of objectives that meet this criteriaExamples:
 - a. Encourage Mr. Miller to ambulate 10 feet, with 1-person assist, 3 times a week.
 - b. Mrs. Brown will be encouraged to consume 2,000 cc in 24 hours.
 - c. Mr. Smith has a target of a 5 pound weight gain within ~~in~~ 60 days.
 - d. Mrs. Jones will be encouraged to engage in conversation with another resident daily.
9. Approaches/actions should be realistic and apply to the problem and objectives. The resident and/or significant other should be involved in the care plan process as much as ~~is feasible~~possible.
10. When problems have been resolved or no longer apply, the nurse is to documents the resolution date and highlights the problem to delete it.
11. All care plans and discharge plans are to be reviewed at least quarterly at the ~~i~~nterdisciplinary ~~t~~eam meetings. The disciplines involved will update and revise the care plan, as needed.
12. All direct resident care staff will have input into the care planning process and may make additions or deletions to the written care plan. Staff involved in the care planning process includes: ~~n~~Nursing, ~~d~~Dietary, ~~s~~Social ~~s~~Services, ~~a~~Activities, ~~p~~Physical ~~t~~herapy, attending ~~p~~hysicians and consultant staff. Any changes to the care plan are reported to ~~to~~ the MDS Coordinator.

REFERENCES

None

ATTACHMENTS

None

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REFERENCE #	6580.26	EFFECTIVE: 05/2025
SUBJECT:	6580.26 RESIDENT TRANSPORT AND OVERNIGHT ASSIGNMENT	
DEPARTMENT:	SKILLED NURSING FACILITIES SKILLED NURSING FACILITY	REVISED:

PURPOSE:

It is the purpose of this policy To establish guidelines for the safe transport of residents requiring staff accompaniment outside the facility, including overnight assignments, while ensuring compliance with California labor laws, resident safety standards, staffing expectations, and reimbursement procedures.

AUDIENCE:

Department wide

TERMS/DEFINITION:

Resident Transport

Any facility-authorized off-site travel involving a resident requiring employee accompaniment.

Overnight Assignment

Any resident transport or off-site assignment in which the employee remains away from the facility overnight.

Compensable Time

All hours worked or time under the control of the employer, including required supervision, travel, waiting, or availability for resident care.

Sleep Time

Designated sleeping periods during assignments exceeding twenty-four (24) hours that may be excluded from hours worked only when permitted under California law and facility policy.

POLICY:

It is the policy of Modoc Medical Center (MMC) that employees assigned to accompany residents during transport, medical appointments, hospital transfers, specialty procedures or other approved off-site activities shall be compensated in accordance with applicable federal and California wage and hour laws.

Employees assigned to resident transport remain responsible for resident safety and care throughout the assignment unless formally relieved by authorized healthcare personnel or supervisory staff.

The facility will provide clear expectations regarding:

- Employee responsibilities
- Compensation
- Sleep and rest periods
- Documentation
- Emergency procedures

REFERENCE #	6580.26	EFFECTIVE: 05/2025
SUBJECT:	6580.26 RESIDENT TRANSPORT AND OVERNIGHT ASSIGNMENT	
DEPARTMENT:	SKILLED NURSING FACILITIES SKILLED NURSING FACILITY	REVISED:

- Travel reimbursement
- Staffing authorization

SCOPE

This policy applies to:

- Registered Nurses (RNs)
- Licensed Vocational Nurses (LVNs)
- Certified Nursing Assistants (CNAs)
- Transportation aides
- Social Services staff
- Companions
- Other designated staff accompanying residents off-site

PROCEDURE:

1. Authorization

1.1 All overnight transport assignments must receive prior approval from:

- Director of Nursing (DON),
- Assistant Director of Nursing (ADON),
- Nursing Supervisor,
- or Chief Nursing Officer (CNO).

1.2 The following shall be determined prior to assignment:

- Resident acuity
- Level of supervision required
- Staffing needs
- Transportation arrangements
- Expected duration
- Lodging arrangements
- Emergency contacts

2. Employee Responsibilities

Employees accompanying residents are responsible for:

- Maintaining resident safety
- Assisting with activities of daily living as needed
- Medication oversight if assigned within scope
- Monitoring changes in condition
- Reporting emergencies immediately
- Maintaining professional conduct
- Following facility documentation requirements

REFERENCE #	6580.26	EFFECTIVE: 05/2025
SUBJECT:	6580.26 RESIDENT TRANSPORT AND OVERNIGHT ASSIGNMENT	
DEPARTMENT:	SKILLED NURSING FACILITIES SKILLED-NURSING FACILITY	REVISED:

- Adhering to HIPAA/confidentiality standards

Employees shall not leave the residents unattended unless relieved by authorized personnel.

3. Compensation

3.1 Travel Time

Employees shall be compensated for:

- Travel time during the assignment
- Resident supervision time
- Waiting time while responsible for the resident
- Required documentation activities

3.2 Overnight Assignments

Employees accompanying residents overnight are generally considered on duty and compensable when:

- Responsible for resident supervision
- Required to remain available
- Sharing accommodations with the resident
- Monitoring for safety concerns
- Unable to freely use time for personal purposes

3.3 Sleep Time Exclusion

Sleep time may only be excluded from compensable hours when ALL of the following apply:

- Assignment exceeds twenty-four (24) consecutive hours
- Adequate sleeping accommodation is provided
- Employees are substantially relieved of all duties
- Employees can typically obtain at least five (5) uninterrupted hours of sleep
- Another qualified caregiver assumes resident's responsibilities during designated sleep periods

If interruptions prevent at least five (5) hours of uninterrupted sleep, the entire sleep period shall be compensated.

3.4 Overtime

Overtime shall be compensated in accordance with California wage and hour laws and facility policy.

REFERENCE #	6580.26	EFFECTIVE: 05/2025
SUBJECT:	6580.26 RESIDENT TRANSPORT AND OVERNIGHT ASSIGNMENT	
DEPARTMENT:	SKILLED NURSING FACILITIES SKILLED NURSING FACILITY	REVISED:

Employees must obtain supervisory approval before incurring unauthorized overtime whenever possible.

4. Lodging and Meals

4.1 The facility may provide:

- Hotel accommodations
- Meal reimbursement
- Parking reimbursement
- Mileage reimbursement when applicable

4.2 Employees are expected to submit receipts in accordance with facility reimbursement procedures.

5. Transportation

5.1 Approved transportation methods may include:

- Facility vehicle
- Ambulance transport
- Medical transport services
- Commercial transportation
- Personal vehicle with prior authorization

5.2 Employees using personal vehicles must:

- Maintain valid driver's license
- Maintain proof of insurance
- Follow facility mileage reimbursement policy

6. Documentation

Employees accompanying residents must document:

- Departure and return times
- Resident condition changes
- Care provided
- Incidents or emergencies
- Medications administered if applicable
- Communication with providers or facility staff

Documentation shall be completed promptly upon return or sooner if clinically indicated.

7. Emergency Situations

In emergencies, staff shall:

REFERENCE #	6580.26	EFFECTIVE: 05/2025
SUBJECT:	6580.26 RESIDENT TRANSPORT AND OVERNIGHT ASSIGNMENT	
DEPARTMENT:	SKILLED NURSING FACILITIES SKILLED-NURSING FACILITY	REVISED:

- Call 911 when appropriate
- Notify receiving medical personnel
- Contact facility supervisor immediately
- Follow resident emergency protocols
- Complete incident reporting requirements

8. Meal and Rest Breaks

Employees shall receive meals and rest breaks consistent with California law whenever operationally feasible.

If uninterrupted meal periods cannot be provided due to resident care responsibilities, applicable meal period premiums may apply in accordance with facility policy and California labor requirements.

9. Employee Safety

The facility reserves the right to:

- Decline assignments involving unsafe conditions
- Reassign staff based on resident acuity
- Require additional personnel for high-risk transports

Employees may report safety concerns without retaliation.

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REFERENCE #	6580.26	EFFECTIVE: 05/2025
SUBJECT:	6580.26 RESIDENT TRANSPORT AND OVERNIGHT ASSIGNMENT	
DEPARTMENT:	SKILLED NURSING FACILITIES SKILLED NURSING FACILITY	REVISED:

services. <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

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ATTACHMENTS:

None

REFERENCE #	8460.26	EFFECTIVE 10/2020
SUBJECT:	8460.26 INVENTORY AND INSPECTION OF NEW EQUIPMENT	REVISED 0502/2026
DEPARTMENT:	FACILITIES	

PURPOSE:

To ensure all new, incoming, and non-hospital-owned equipment is safe for use by patients, staff and visitors by requiring proper review, inventory, inspection and testing prior to use within Modoc Medical Center (MMC).

AUDIENCE:

Facility Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center (MMC) that all new equipment and any equipment brought into the hospital shall be inventoried, inspected, and approved for safety prior to use. Equipment that fails electrical, mechanical, or safety testing shall not be approved for use until all deficiencies are corrected.

PROCEDURE:

- All requests for new equipment shall be reviewed and approved by the Facilities Department for safety features, including electrical requirements, space considerations and OSHA compliance.
- Upon receipt of new equipment:
 - Purchasing will forward the equipment for inspection.
 - Equipment will be assigned an inventory number prior to installation.
 - Maintenance will perform required electrical and mechanical safety testing.
 - Equipment that passes inspection will be placed on a preventive maintenance schedule.
- When an equipment identification number is assigned, the inspecting engineer shall document the inspection and date in the comment section of the equipment record.
- Equipment that fails required inspections or tests:
 - Shall be returned to Materials Management.
 - Will be corrected by the manufacturer.
 - Shall not receive an identification number or be placed into service until all deficiencies are corrected.
- Equipment not owned by the hospital (including items brought by patients, visitors, Medical Staff, employees, or vendors) must be inspected and approved by the Facilities Department prior to use.
 - Only hospital-owned or hospital-approved equipment is permitted for use within the facility.
 - Non-approved equipment is strongly discouraged due to potential liability exposure, lack of documented inspection, and disruption of inventory control processes.
 - It must also meet applicable NFPA fire-resistance requirements, including Class A fire rating, as defined by NFPA standards.
 - The Facilities Director is authorized to remove any equipment deemed unsafe.
- The Facilities Department shall routinely inspect hospital equipment to ensure safe operation.
 - If deficiencies are identified, the affected department director shall be notified and corrective action implemented.

REFERENCE #	8460.26	EFFECTIVE 10/2020
SUBJECT:	8460.26 INVENTORY AND INSPECTION OF NEW EQUIPMENT	
DEPARTMENT:	FACILITIES	REVISED 0502/2026

- **Equipment Removal from the Hospital:**

The following information must be documented and retained by the Facilities Department:

- Equipment name
- Serial number
- Department/location
- Name of employee packing the equipment
- Name and company receiving the equipment
- Documentation of removal and new location

- **Equipment Acceptance into the Hospital:**

The following steps must be completed:

- Identify equipment name and serial number
- Deliver equipment to Facilities Department for safety evaluation
- Identify delivering individual/company
- Identify hospital employee accepting and signing for receipt
- Document delivery, location, receiving employee, and equipment status
- Document release from Facilities Department and delivery to the appropriate department
- Store documentation in the Purchasing Department

REFERENCES:

None.

ATTACHMENTS:

None.

Healing Hands Close To Home

Last Frontier Healthcare District

REFERENCE #	7041.13	EFFECTIVE 7/2013
SUBJECT:	7041.13 AMBULANCE PERSONNEL CONDITION OF EMPLOYMENT	REVISED 5/2026
DEPARTMENT:	AMBULANCE	

PURPOSE

The purpose of this policy is to define the rules and regulations required of a new employee-or refresher for establish~~ed~~ staff.

AUDIENCE

Department Wide

TERMS AND DEFINITIONS

None

POLICY

It is the policy of Modoc Medical Center (MMC) that:

- All newly hired EMT's will be required to complete 10 days of orientation. This will include a minimum of 10 shifts and at least 5 patient contacts. This will be for their experience and education. They will be evaluated during this time to see how well they react to emergency situations and how well they relate to the other crew members.
- Any member of the ambulance crew that upgrades their licensure will be precepted by a crew member with equal or higher licensure, for a minimum of 5 patient contacts where they must use their new scope of practice.
- Extensions to new hire and upgraded license staff orientation time will be determined at the discretion of the EMS Director.
- All ambulance crew members must have a valid ambulance drivers license and a DMV physical certificate. The physical is provided by the clinic at MMC at no charge to the EMT. The physical may be taken at the EMT's private physician, in which case the EMT will be responsible for the cost.
- Each employee, while on call, must be able to respond to the ambulance garage within eight minutes during the day and night. Exceptions will be made during bad weather when caution should be used because of adverse weather.
- Two EMT's will be scheduled to cover each shift. The shift is two 24-hour consecutive shifts. One member of each shift must be an advanced life support provider. If an employee is unable to work their scheduled shift, they must contact their supervisor.

REFERENCE #	7041.13	EFFECTIVE 7/2013
SUBJECT:	7041.13 AMBULANCE PERSONNEL CONDITION OF EMPLOYMENT	REVISED 5/2026
DEPARTMENT:	AMBULANCE	

- Failure to contact your supervisor can constitute reason for discipline as does repeated failure to be available for assigned shifts.
- All requested days off must be submitted at least 10 days prior to the end of the month for requests in the next month.

REFERENCES

None

ATTACHEMENTS

None

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REFERENCE #	7010.26 Click or tap here to enter text.	EFFECTIVE: 12/2010
SUBJECT:	7010.26 SAFE SURRENDER OF NEWBORNS	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish a standardized process for the acceptance, assessment, treatment, documentation, and reporting of safely surrendered newborns in compliance with California Health and Safety Code 1255.7, California Code of Regulations Title 22, Emergency Medical Treatment and Labor Act (EMTALA) requirements, and applicable hospital regulations.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Safely Surrendered Baby: a newborn infant 72 hours old or younger voluntarily surrendered by a parent or lawful custodian to designated hospital personnel at a designated safe surrender site in accordance with California Health and Safety Code 1255.7.

Safe Surrender Site: a location designated by law to accept surrendered newborns, including licensed hospitals with emergency services.

POLICY:

It is the policy of Modoc Medical Center (MMC) that The hospital Emergency Department (ED) will accept any newborn infant who is voluntarily surrendered pursuant to California Safely Surrendered Baby Law. The hospital will provide immediate medical screening, stabilization, confidentiality protection, and required notifications in accordance with state law and regulatory requirements. No employee will refuse a safely surrendered infant or delay medical care pending registration, identification, or law enforcement involvement.

PROCEDURE:

Acceptance of Infant

- Any employee presented with a newborn for safe surrender will do the following:
 - Immediately accept physical custody of the infant.
 - Notify the ED charge nurse immediately.
 - Escort the infant to an appropriate treatment area.
- Staff will remain calm, supportive, and nonjudgmental.
- Avoid requesting identification or personal information.
- Inform the surrendering individual that participation in providing information is voluntary.
- The surrendering individual will not be detained, may leave at any time unless criminal conduct is suspected, and may voluntarily provide medical history or identifying information.
- Hospital staff will not pursue or attempt to physically stop a surrendering individual who elects to leave the hospital.

Medical Screening and Treatment

- The infant will receive an immediate Medical Screening Examination (MSE) consistent with EMTALA requirements.
- Nursing assessment will include vital signs, weight, temperature, physical assessment, and any signs of illness, trauma, neglect, withdrawal, or abuse.

REFERENCE #	7010.26 Click or tap here to enter text.	EFFECTIVE: 12/2010
SUBJECT:	7010.26 SAFE SURRENDER OF NEWBORNS	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- The ~~physician or qualified medical provider~~physician, nurse practitioner (NP) or physician assistant (PA)-will evaluate the infant's medical condition, initiate stabilization and treatment, and order diagnostic testing as clinically appropriate.

Identification Process

- Staff will apply a confidential identification band to the infant and offer the matching identification band to the surrendering individual.
- Staff will ~~explain~~explain that the identification band may assist with reunification.
- California law permits reclaiming the infant within the legally specified timeframe.
- Acceptance or refusal of the matching band will be documented.

Notification Requirements

- The charge nurse will notify social services/case management, Child Protective Services (CPS), and the nursing supervisor/administrator on call.
- Law enforcement notification will occur only as required by local ~~protocol~~protocol, and if abuse, neglect, or criminal activity is suspected.
- All notifications will be documented in the electronic medical record.

Confidentiality

- All information related to the surrender will remain confidential to the extent permitted by law.
- The staff will not photograph or record the surrendering individual, request identification, or disclose protected information except as required for treatment, reporting, or placement.
- Medical records will be secured in accordance with HIPAA and hospital privacy policies.

Documentation

- Date and time of surrender.
- Name/title of accepting staff member.
- Infant condition upon presentation
- Assessment findings
- Treatments rendered
- Identification band number
- Notifications completed
- Disposition of infant
- Documentation will remain objective and factual.

Suspected Abuse or Neglect

- If abuse or neglect is ~~suspected~~suspected, the mandated reporting laws apply.
- CPS reports will be completed immediately.
- Law enforcement will be notified when required.
- Clinical evidence of trauma or neglect will be thoroughly documented.

REFERENCE:

California Department of Social Services. (n.d.). *Safely surrendered baby program*. State of California. Retrieved May 20, 2026

California Health and Safety Code 1255.7

REFERENCE #	7010.26 Click or tap here to enter text.	EFFECTIVE: 12/2010
SUBJECT:	7010.26 SAFE SURRENDER OF NEWBORNS	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

ATTACHMENTS:

None

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

PURPOSE:

The purpose of this policy is to establish standardized procedures for the evaluation, stabilization, orthopedic consultation, transfer, and documentation of patients presenting to the Emergency Department with orthopedic emergencies, in accordance with California Title 22 regulations and Emergency Medical Treatment and Labor Act (EMTALA) requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health, serious impairment of bodily functions, or serious dysfunction of bodily organs or parts.

Stabilization: a provision of medical treatment necessary to ~~assure~~ensure, within reasonable medical probability, that no material deterioration of the patient's condition is likely during transfer.

POLICY:

It is the policy of Modoc Medical Center (MMC) to maintain written policies and procedures for the provision of emergency orthopedic services consistent with the hospital's capabilities and available resources. All patients presenting to the Emergency Department (ED) with suspected orthopedic emergencies will receive an appropriate medical screening examination (MSE); stabilization within the capability and capacity of the hospital; timely physician evaluation and specialty consultation as indicated; and/or transfer to a higher level of care when definitive orthopedic services are unavailable or exceed hospital capability.

PROCEDURE:

Initial Evaluation

- All patients presenting with orthopedic complaints will receive a medical screening examination by a qualified ~~medical provider~~MD/DO/PA/NP
- Assessment will include mechanism of injury, pain assessment, neurovascular examination, skin integrity assessment, functional status, and appropriate imaging studies.
- Patients with suspected limb-threatening conditions will receive immediate physician evaluation.

Conditions Requiring Emergent Orthopedic Consultation

- Open fractures
- Compartment syndrome
- Septic joint
- Neurovascular compromise
- Irreducible dislocation
- Spinal instability
- Pelvic fracture instability
- Multiple trauma involving orthopedic injury.
- Fractures requiring emergent operative intervention.

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

Stabilization Measures

- Prior to transfer or disposition, stabilization measures may include:
 - Splinting or immobilization
 - Reduction of fractures/dislocations within ~~provider~~ MD, DO, PA or NP competency
 - Hemorrhage control
 - Intravenous access and fluid resuscitation
 - Antibiotic administration for open fractures
 - Pain management
 - Procedural sedation when indicated.
 - Reassessment of neurovascular status

Transfer Requirements

- Higher level trauma care is indicated.
- Orthopedic ~~service requires~~ services require surgical intervention.

Prior to Transfer

- The receiving physician and facility must accept the patient.
- Risks and benefits of transfer will be documented.
- Appropriate transportation will be arranged.
- Relevant medical records and imaging will accompany the patient.

Documentation Requirements

- Time of arrival
- Triage acuity
- Medical screening examination findings
- Neurovascular assessments
- Diagnostic results
- Consultation contact times
- Consultation recommendations
- Stabilization measures
- Transfer rationale
- EMTALA documentation
- Condition of patient at discharge or transfer

REFERENCE:

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/Regulation-and-Guidance/Guidance/Manuals>

ATTACHMENTS:

None.

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

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

PURPOSE:

The purpose of this policy is to establish a standardized, evidence-based approach for rapid recognition, stabilization, treatment support, monitoring, and documentation of patients presenting with seizures or status epilepticus.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Status Epilepticus: continuous seizure activity > 5 minutes or recurrent seizures without return to baseline consciousness.

Refractory Status Epilepticus: seizures persist despite adequate doses of first-and second-line anti-seizure medications.

ABC-Approach: the assessment of airway, breathing, and circulation.

POLICY:

It is the policy of Modoc Medical Center (MMC) that Aall patients presenting to the ED with active seizure activity will receive immediate stabilization using an ABC-based approach, prompt termination of seizure activity with first line benzodiazepines, rapid escalation to second-line antiseizure medications if required, and evaluation for underlying etiologies. Delay in treatment increases morbidity and mortality and is not acceptable.

PROCEDURE:

Immediate Stabilization (0-5 minutes)

- Assess airway, breathing, and circulation (ABCs)
- Stay with the patient.
- Call for assistance and notify the ED ~~provider~~physician, nurse practitioner (NP) or physician assistant (PA)
- immediately.
- Pad side rails if available.
- Do not restrain patients unless necessary for immediate safety.
- Do not place objects in the patient's mouth.
- Place patient in lateral decubitus position.
- Administer oxygen as needed.
- Suction secretions as needed.
- Continuously monitor respiratory effort and airway patency.
- Obtain vital signs as soon as possible.
- Apply cardiac monitor and pulse oximeter.
- Establish intravenous (IV) access.
- Obtain point-of-care blood glucose immediately.
- Notify ~~provider~~physician, NP or PA

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

- of abnormal results promptly.
- If glucose if <60 milligrams/deciliter administer IV dextrose per providerphysician, NP or PA
- P order.

Medication Administration

- Administer benzodiazepines per provider order.
- Prepare and administer additional antiseizure medications as needed.
- Monitor patient for respiratory depression, hypotension, oxygen desaturation, and sedation level changes.
- Immediately notify the providerphysician, NP or PA
- of any clinical deterioration.

Ongoing Monitoring

- Continuous cardiac monitoring, pulse oximetry, respiratory assessment, and neurologic reassessment.
- Neurologic assessment to include level of consciousness, orientation, pupillary response, motor activity, speech changes, and presence of focal deficits.

Postictal Care

- Reorient patient as mental status improves.
- Maintain seizure precautions.
- Assess for injuries, tongue trauma, or incontinence.
- Maintain patient dignity and privacy.

Seizure Precautions

- Pad side rails.
- Bed in lowest position
- Suction set up at bedside
- Oxygen equipment readily available
- Ensure call light within reach when patient is alert.

Escalation of Care

- Immediately notify the ED providerphysician, NP or PA
- of any of the following:
 - Seizure lasting greater than five minutes.
 - Recurrent seizure activity.
 - Failure to return to baseline mental status.
 - Airway compromise.
 - Oxygen saturation has declined.
 - Hemodynamic instability.
- Prepare for advanced airway management if indicated.

Documentation Requirements

- Time seizure began and ended.
- Description of seizure activity
- Loss of consciousness or responsiveness

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

- Vital signs and oxygen saturation
- Medications administered (dose, route, time)
- Patient response to intervention
- Postictal assessment findings
- ~~Provider physician, NP or PA~~ notifications
- Family/witness statements if applicable

Quick Nursing Reference: ACTIVE SEIZURE

- S- Stay with patient.
- E- Ensure airway and oxygen.
- I- IV access and glucose.
- Z- Zero restraints/objects in mouth.
- U- Urgent medication administration.
- R- Reassess continuously.
- E- Escalate if seizure > 5 minutes.

REFERENCE:

Emergency Nurses Association. (2022). *Emergency nursing resource: Seizure management in the emergency department*. Emergency Nurses Association.

American College of Emergency Physicians. (2014). *Clinical policy: Critical issues in the evaluation and management of adult patients presenting to the emergency department with seizures*. *Annals of Emergency Medicine*, 63(4), 437–447.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 12/1985
SUBJECT:	7010.26 OUTPATIENT OBSERVATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized requirements for the provision, documentation, utilization review, ~~and~~ billing of outpatient observation services in compliance with Centers for Medicare & Medicaid Services (CMS), Medicare Conditions of Participation, and California Title 22 regulations.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Medicare Outpatient Observation Notice (MOON) is required for Medicare beneficiaries receiving observation services exceeding 24 hours.

POLICY:

It is the policy of Modoc Medical Center (MMC) that Ppatients requiring short-term treatment, monitoring, reassessment, or diagnostic evaluation may be placed in outpatient observation status when medically appropriate and ordered by ~~a physician or other qualified licensed practitioner acting the~~ physician, MD, DO, PA or NP within the scope of their privileges.

PROCEDURE:

Initiation of Observation Services

- Observation services will begin only upon a valid written or electronic ~~physician~~ physician, MD, DO, PA or NP order stating "Observation Status," or "Place in Observation:".
- The order will include the date and time, clinical indication, and physician authentication.
- Retroactive observation orders are prohibited.
- Observation status may originate from:
 - Emergency Department
 - Direct Admission
 - Procedural Recovery Room
 - Clinic Referral

Clinical Criteria for Observation

- The patient requires additional monitoring, testing, treatment, or reassessment.
- The ~~physician~~ attending physician, MD, DO, PA or is uncertain whether inpatient admission is medically necessary.
- The patient is expected to stabilize within a reasonable period, generally less than 24 hours.
- Observation status will not be used for convenience, for routine recovery without medical necessity or solely while awaiting placement, transportation, or social disposition.

Documentation Requirements

- ~~Physician~~ The attending physician, MD, DO, PA or Observation Order.
- History and Physical.
- Progress Note.
- Nursing Assessment.
- Reassessment Documentation.
- Treatment Provided.

REFERENCE #	7010.26	EFFECTIVE: 12/1985
SUBJECT:	7010.26 OUTPATIENT OBSERVATION	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- Discharge Summary and/or Admission Documentation.
- Documentation must support medical necessity, ongoing need for observation and physician involvement in care decisions.
- Observation time begins when a valid ~~physician~~ physician, MD, DO, PA or NP order is written and the patient is placed in observation care.
- Observation time ends when all medically necessary services are completed, including ~~physician~~ physician, MD, DO, PA or NP discharge order.

Medicare Outpatient Observation Notice (MOON)

- Medicare beneficiaries receiving observation services for more than 24 hours will receive the MOON notice not later than 36 hours after observation services begin.
- Documentation of delivery, patient signature, and/or refusal if applicable, will be maintained in the medical record.

REFERENCE:

Centers for Medicare & Medicaid Services. (2024). Medicare benefit policy manual (Pub. 100-02), Chapter 6-Hospital services covered under Part B. U.S. Department of Health and Human Services. CMS Benefit Policy Manual

State of California, Department of Public Health. (2024). California Code of Regulations, Title 22: General acute care hospital outpatient services. California Department of Public Health Title 22 Resources

ATTACHMENTS:

None.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>7010.26</u> PATIENT AND VISITOR SAFETY IN THE EMERGENCY DEPARTMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized procedures that promote and maintain the safety, security, and well-being of patients, visitors, and staff within the Emergency Department (ED), while ensuring compliance with applicable regulatory, accreditation, and organizational requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

Modoc Medical Center (MMC) is committed to providing a safe and secure environment in the Emergency Department for all patients, visitors, staff, and providers. The Emergency Department will implement safety practices designed to reduce the risk of injury, violence, infection transmission, environmental hazards, and unauthorized access. All individuals entering the Emergency Department are expected to comply with established safety and security procedures.

PROCEDURE:

Visitor Management

- Visitor access may be restricted based on patient condition, treatment requirements, infection prevention precautions, safety concerns, or emergency operations.
- Visitors may be limited in number at the discretion of the medical staff.
- All visitors will comply with hospital identification and screening procedures.

Visitor Conduct

- Visitors will conduct themselves respectfully and safely.
- Avoid disruptive, threatening, or violent behavior.
- Refrain from interfering with patient care activities.
- Follow all instructions provided by hospital staff.
- Visitors demonstrating unsafe behavior may be escorted from the premises by law enforcement.

Minor Visitors

- Children visiting the Emergency Department must always remain under direct adult supervision.
- Access to trauma, resuscitation, or high-risk treatment areas may be restricted.

Patient Safety

- Patient identification: Medical Staff will confirm with at least two approved patient identifiers prior to medication administration, diagnostic testing, procedures, patient transfer, or discharge.
- Fall prevention: patients identified as fall risk will receive fall-risk precautions, assistance with ambulation and toileting, environmental safety interventions, and ongoing reassessment.

Medication Safety

- All medications will be administered in accordance with hospital medication administration policies and applicable safety standards.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>7010.26</u> PATIENT AND VISITOR SAFETY IN THE EMERGENCY DEPARTMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Infection Prevention

- All staff, patients and visitors will adhere to hand hygiene requirements, isolation precautions, respiratory hygiene practices, and personal protective equipment (PPE) requirements when indicated.

Workplace Violence Prevention

- Zero-Tolerance Standard
 - The hospital maintains zero tolerance for physical violence, threats or intimidation, harassment, verbal abuse, aggressive or disruptive behavior.

Environmental Safety

- Clear exits and hallways
- Functional emergency equipment
- Accessible fire extinguishers and alarms
- Routine environmental safety inspections
- Appropriate lighting and signage
- Hazards will be reported and corrected promptly.

Documentation by registered nurse (RN)

- Safety incidents
- Behavioral events
- Visitor restrictions or removals
- Falls and injuries.
- Security interventions
- Use of restraints
- Incident reports (Safety First report)

Reporting Requirements

- The staff will immediately report nursing manager unsafe conditions, patient or visitor injury, workplace violence incidents, medication errors, security concerns; and near-miss events.
- Report will be placed in Safety First for the hospital incident reporting process.

REFERENCE:

Occupational Safety and Health Administration. (2024). *Guidelines for preventing workplace violence for healthcare and social service workers*. OSHA Workplace Violence Prevention Guidelines

Centers for Medicare & Medicaid Services. (2024). *State operations manual appendix A – hospital conditions of participation*. CMS Hospital Conditions of Participation

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 7/2008
SUBJECT:	7010.26 SENTINEL EVENT	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish procedures for identifying, reporting, investigating, documenting, and responding to sentinel events, adverse events, unusual occurrences, abuse allegations, and other reportable incidents in compliance with California Title 22 regulations, California Health & Safety Code, and applicable federal requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Sentinel Event: is an unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof, including but not limited to any of the following: wrong patient, procedure, or site events; suicide or attempted suicide resulting in serious injury; sexual assault; patient elopement resulting in harm; medication errors causing serious harm or death; falls resulting in serious injury or death; retained foreign objects after procedures; infant or patient abduction; severe abuse or neglect; and events requiring urgent intervention to sustain life.

Adverse Event: an incident resulting in harm to a patient, visitor, or staff member associated with care, treatment, or services.

Reportable Event: any incident required to be reported under California Title 22, Health & Safety Code sections 1279.1-1279.6, abuse reporting laws, or licensing regulations.

POLICY:

Modoc Medical Center (MMC) will maintain a comprehensive incident reporting and response system to ensure the immediate protection of patients, staff, and visitors. All sentinel events and reportable adverse events will be reported within legally required timelines and investigated promptly. MMC adopts a non-retaliatory, just-culture approach encouraging immediate reporting of safety concerns, near misses, and adverse events.

PROCEDURE:

Reporting Requirements

- All workforce members will immediately report sentinel events or suspected reportable incidents to the charge nurse, risk management, and nursing administration when applicable.
- Immediate patient safety interventions will occur without delay.

External Reporting Requirements

- MMC (risk management) will report adverse events to the California Department of Public Health (CDPH) within 24 hours for ongoing urgent or emergent threats, within 24 hours for allegations of sexual assault and within five calendar days for all other reportable adverse events.
- Suspected abuse, neglect, exploitation, or mistreatment will be reported immediately as required by mandated reporter laws, including local law enforcement, Adult Protective Services (APS) or Child Protective Services (CPS) when applicable, and licensing agency/CDPH by staff member involved.

REFERENCE #	7010.26	EFFECTIVE:7/2008
SUBJECT:	7010.26 SENTINEL EVENT	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- Serious bodily injury involving elder or dependent adult abuse will be reported within two hours when required by law.

Immediate Actions

- Upon discovery of a sentinel or adverse event ensure immediate patient safety.
- Obtain emergency medical treatment if needed.
- Secure the environment and preserve evidence.
- Notify leadership immediately.
- Remove any unsafe equipment from service is applicable.
- Document factual observations only.
- Initiate incident reporting procedures.

Investigation

- MMC (risk management) will conduct a prompt and thorough investigation including a root cause analysis (RCA), interviews with involved personnel, review of medical records and documentation, identification of contributing factors and development of corrective action plans.
- Investigations will focus on systems improvement and prevention of recurrence.

Disclosure

- Patients and/or responsible parties will be informed of adverse events as required by California law and facility policy (risk management).
- Documentation will include the date and time of disclosure, individuals notified, summary of information provided, and follow-up actions.
- California Title 22 regulations require that when an adverse event occurs, the hospital must document the date the patient or responsible party was informed, and that disclosure must occur no later than the date the event is reported to the California Department of Public Health (CDPH).

Documentation Requirements

- Date and time of occurrence.
- Individuals involved
- Description of the event
- Injuries or outcomes
- Immediate interventions
- Notifications completed
- Witness statements, if applicable
- Corrective actions initiated
- All reports will remain confidential and maintained according to applicable privacy laws.

Corrective Action and Performance Improvement

- Trend and analyze incident data.
- Implement corrective actions.
- Monitor effectiveness of interventions.
- Provide staff education and competency training.
- Report findings to Quality Assurance and governing bodies as appropriate.
- No employee will be retaliated against for good-faith reporting of safety concerns, incidents, abuse, neglect, or regulatory violations.

Staff Education

REFERENCE #	7010.26	EFFECTIVE: 7/2008
SUBJECT:	7010.26 SENTINEL EVENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

- All employees will receive education upon hire and annually regarding the following:
 - Sentinel event identification-
 - Mandatory reporting requirements
 - Abuse and neglect reporting-
 - Incident documentation
 - Patient safety practices
 - Just culture principles

Record Retention

- All records related to sentinel events, investigations, corrective actions, and reporting will be retained in accordance with California law and facility record retention policy.

REFERENCE:

California Code of Regulations, title 22, § 70972. (2024). Reporting adverse events by hospitals and acute psychiatric hospitals. California Office of Administrative Law.

<https://regulations.justia.com/states/california/title-22/division-5/chapter-1/article-11/section-70972/>

California Code of Regulations, title 22, § 87211. (2024). Reporting requirements for licensed facilities. Legal Information Institute. <https://www.law.cornell.edu/regulations/california/22-CCR-87211>

California Welfare and Institutions Code § 15630. (2024). Mandated reporting requirements under the Elder Abuse and Dependent Adult Civil Protection Act. California Legislative Information. <https://leginfo.legislature.ca.gov/>

California Health and Safety Code §§ 1279.1–1279.6. (2025). Adverse events and patient safety plans for health facilities. California Legislative Information. [California Legislative Information](#)

ATTACHMENTS:

None.

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

PURPOSE:

The purpose of this policy is to establish standardized procedures for the assessment, stabilization, treatment, consultation, transfer, and documentation of patients presenting to the Emergency Department (ED) with stab wounds or penetrating trauma in accordance with California Title 22 and Emergency Medical Treatment and Labor Act (EMTALA) requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Penetrating Trauma: any injury in which an object pierces the skin and enters underlying tissues, including stab wounds, impalements, and puncture wounds.

Hard Signs of Vascular Injury: include pulsatile bleeding, expanding hematoma, absent distal pulses, bruit/thrill, and distal ischemia.

Hemodynamically Unstable may include any of the following: systolic blood pressure less than 90 in adults, persistent tachycardia with signs of hypoperfusion, altered mental status due to suspected hemorrhage and/or need for blood product resuscitation.

POLICY:

It is the policy of Modoc Medical Center (MMC) that All patients presenting with stab wounds or penetrating trauma will receive prompt medical screening, trauma assessment, stabilization, consultation, and definitive treatment within hospital capability, and transfer when higher-level of care is required.

PROCEDURE:

Triage

- Patients with stab wounds will receive immediate triage assessment.
- Trauma activation will occur for any of the following:
 - Penetrating injury to the head, neck, chest, abdomen, pelvis, groin, or proximal extremities.
 - Hemodynamic instability
 - Active hemorrhage
 - Respiratory compromise
 - Evisceration
 - Altered mental status
 - Suspected vascular injury
 - Multiple stab wounds

Initial Assessment (Primary Survey)

- Assess airway patency.
- Apply cervical spine precautions if indicated.
- Provide advanced airway management when necessary.
- Assess respiratory effort.
- Administer oxygen.

REFERENCE	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 STAB WOUNDS STANDARD OF CARE	
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- Evaluate for pneumothorax, hemothorax, and tension physiology.
- Control hemorrhage immediately.
- Establish intravenous access.
- Initiate fluid or blood resuscitation.
- Glasgow Coma Scale (GCS).
- Conduct pPupillary examination.
- Conduct Nneurologic assessment.
- Completely expose the patient.
- Prevent hypothermia.

Secondary Survey

- Perform Ffull wound inspection.
- Conduct Neurovascular assessment.
- Complete Aassessment for any retained foreign body.
- DocumentationDocument of location, approximate depth, bleeding, and associated injuries.
- Obtain Pphotographic documentation per hospital policy. Use the iPad and upload photographs to the patient's electronic medical record.

Diagnostic Testing

- Focused Assessment with Sonography for Trauma (FAST) ultrasound
- Chest x-ray
- Pelvic x-ray
- Computed tomography (CT) angiography
- CT chest/abdomen/pelvis
- Extremity imaging

Laboratory Studies

- Complete blood count
- Complete metabolic panel or basic metabolic panel
- Lactate
- Toxicology screen if clinically indicated.
- Protime
- Arterial blood gas or venous blood gas

Consultation

- Immediate specialty consultation will occur for the following:
 - Penetrating torso trauma (Trauma surgeon)
 - Vascular injury (Vascular surgeon)
 - Penetrating chest injury (Trauma/cardiothoracic surgeon)
 - Head/neck injury (Neurosurgeon/ Ear, nose, and throat (ENT))
 - Joint involvement (Orthopedics)
 - Ocular injury (Ophthalmology)

Emergency Interventions

- Tube thoracostomy
- Needle decompression
- Intubation

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

- Massive transfusion
- Tourniquet application
- Wound exploration (within facility capability)

Operative Management Criteria (Transfer to Higher-Level of Care)

- Hemodynamic instability
- Peritonitis
- Evisceration
- Cardiac tamponade
- Massive hemothorax
- Hard signs of vascular injury
- Uncontrolled hemorrhage

Transfer Procedure

- Patients requiring services unavailable at this facility will be transferred to an appropriate trauma center. Mercy Medical Center in Redding California is our designated trauma center.
- Prior to transfer the patient will receive the following:
 - Medical screening examination
 - Stabilization within facility capability
 - Airway management if indicated-
 - Hemorrhage control
 - IV access and resuscitation
 - Copies of the electronic medical record, imaging, laboratory studies, and medication administration record will be sent to the receiving facility. Copies are also given to the transport crews.
 - Sending physician will communicate directly with the accepting physician.
 - Acceptance will be documented.
 - Complete the EMTALA form. Make sure form is signed by ER ~~provider~~physician, nurse practitioner (NP) or physician assistant (PA) and patient/family member prior to transfer.

Law Enforcement Considerations

- Medical stabilization takes priority over investigative procedures.
- Staff will comply with hospital forensic evidence policy.
- Clothing and evidence will be preserved when possible.
- Chain-of-custody procedures will be followed.

Patient Reassessment

- After interventions
- After imaging
- With any status change
- At minimum intervals consistent with patient acuity/triage level

Documentation Requirements

- Time of arrival
- Mechanism of injury
- Trauma activation level
- Primary/secondary survey findings

REFERENCE	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 STAB WOUNDS STANDARD OF CARE	
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- Wound descriptions
- Neurovascular findings
- Consultant communication
- Diagnostic results
- Procedures performed
- Disposition
- Transfer details if applicable.

REFERENCE:

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

California Code of Regulations, Title 22, Division 9, Chapter 6.1, Article 3, § 100137.01. Trauma center standards. (n.d.). California Office of Administrative Law. Retrieved May 20, 2026, from [California Title 22 §100137.01](#)

California Code of Regulations, Title 22, Division 9, Chapter 6.1, Article 5, § 100139. Interfacility transfer. (n.d.). California Office of Administrative Law. Retrieved May 20, 2026, from [California Title 22 §100139](#)

Centers for Medicare & Medicaid Services. (2024). *Emergency Medical Treatment and Labor Act (EMTALA)*. U.S. Department of Health and Human Services.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 PATIENT BELONGINGS AND PROPERTY	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish procedure for the handling, documentation, storage, and return of patient belongings in the Emergency Department (ED) to protect patient property and reduce loss or liability.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center (MMC) that patients are encouraged to bring only essential items to the Emergency Department. The hospital is not responsible for loss, theft, or damage to personal belongings that remain in the patient's possession unless formally secured by hospital staff according to this policy.

PROCEDURE:

Inventory of Belongings

- Staff will document patient belongings when appropriate, especially if the patient is:
 - Unconscious or incapacitated.
 - Admitted to the hospital.
 - Placed on a behavioral health or psychiatric hold.
- Belongings may include clothing and shoes, wallets, purses, phones, keys, jewelry, watches, glasses, dentures, hearing aids, medication and medical devices.

Secure Storage of Valuables

- Patients should send valuables home with family or friends whenever possible.
- Cash, jewelry, electronics, and other valuables may be:
 - Placed in a tamper-evident valuables envelope or belongings bag.
 - Logged and witnessed by two staff members when required.
 - Stored in hospital security or safe storage.
- A receipt or property record will be provided when items are secured.

Patient Belongings Bags

- Clothing and personal effects will be placed in a labeled patient belongings bag.
- Bags must include the patient's name, medical record number (MRN), and date and time collected.
- Belongings should accompany the patient during transfer or admission to hospital.

Medications

- Home medications brought to the ED will be reviewed by clinical staff.
- Medications may be sent home with family, stored in the pharmacy, or placed in the Omnicell under patient bin.
- Medication will be retained only if ordered by the provider.

Special Circumstances

- Trauma or Emergency Resuscitation

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 PATIENT BELONGINGS AND PROPERTY	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- Clothing may be removed or cut off for emergency treatment.
- Soiled or damaged clothing will be retained when feasible unless contaminated or unsafe.
- Psychiatric/Behavioral Health Patients
 - Potentially dangerous items (e.g., belts, shoelaces, sharp objects, cords) will be removed and secured according to safety procedures.

Return of Property

- Belongings will be returned to the patient or authorized representative upon discharge or transfer.
- Staff must verify identity before releasing secured valuables.
- Perishable, contaminated, or hazardous items will be discarded according to infection prevention policy.

REFERENCE:

None.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE 4/14/2010
SUBJECT:	7010.25 ALTEPLASE PROTOCOL FOR ACUTE BRAIN ISCHEMIC STROKE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to standardize the evaluation, eligibility determination, administration, and monitoring of intravenous (IV) Alteplase in patients with suspected acute ischemic stroke to improve outcomes and minimize complications.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Acute Ischemic Stroke (AIS): neurologic deficit caused by cerebral infarction.

Alteplase (tPA): tissue plasminogen activator used for thrombolysis.

Last known well (LKW): last time patient was known to be at baseline neurologic status.

The National Institute of Health Stroke Scale (NIHSS): a standardized neurological assessment used to evaluate stroke severity by measuring consciousness, motor function, speech, vision, and sensory.

POLICY:

It is the policy of Modoc Medical Center (MMC) to provide timely, evidence-based treatment of patients presenting with acute ischemic stroke through the safe administration of intravenous Alteplase (tPA), in accordance with current guidelines from the American Heart Association and American Stroke Association. Eligible patients will receive IV Alteplase within established therapeutic time windows, with a target door-to-needle time less than 60 minutes, unless contraindicated.

PROCEDURE:

- Initial Assessment
 - Activate stroke alert.
 - Determine the time of symptom onset/LKW.
 - Perform rapid neurologic assessment (e.g., NIHSS).
 - Obtain vital signs, blood glucose level, and IV access (2-lines preferred).
- Imaging
 - Obtain non-contrast computed tomography (CT), computed tomography angiography (CTA)
 - Exclude intracranial hemorrhage.
- Lab
 - Complete blood count (CBC)
 - International Normalized Ratio (INR) & Protime
- Eligibility Criteria
 - Inclusion
 - Diagnosis of acute ischemic stroke with measurable deficit.
 - LKW <4.5 hours (or imaging-based eligibility).
 - Age > 18 years.

REFERENCE #	7010.26	EFFECTIVE 4/14/2010
SUBJECT:	7010.25 ALTEPLASE PROTOCOL FOR ACUTE BRAIN ISCHEMIC STROKE	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

Exclusion (Absolute)

- Intracranial hemorrhage on imaging.
- Active internal bleeding.
- Recent intracranial surgery, significant head trauma, or prior stroke (< 3 months).
- Platelets < 100,000.
- INR (International Normalized Ratio) > 1.7 or significant anticoagulation.
- Persistent blood pressure > 185/110 mmHg despite treatment.

Relative Exclusions

- Mild or rapidly improving symptoms.
- Seizure at onset with residual deficits.
- Recent major surgery or bleeding.
- Blood glucose < 50 milligram (mg)/deciliter (dL) (must correct prior to treatment).
- Pre-Treatment Preparation
 - Confirm eligibility and absence of contraindications.
 - Obtain informed consent for medication administration.
 - Control blood pressure to < 185/110 mmHg.
 - Do not delay treatment for labs unless coagulopathy is suspected.
- Alteplase Administration
 - Dose: 0.9 milligram (mg)/kilogram (maximum 90 mg).
 - 10% IV bolus given over 1 minute.
 - Remaining 90% is infused over 60 minutes.
 - Ensure infusion pumps are used for medication administration and verify dose with two registered nurses prior to administration.
- Blood Pressure Management
 - Before Alteplase
 - Blood pressure must be < 185/105 mmHg.
 - After Alteplase
 - Maintain < 180/105 mmHg for 24 hours.
- Monitoring
 - Neurologic and Vital Signs
 - Every 15 minutes during infusion.
 - Every 15 minutes for 2 hours post-infusion.
 - Every 30 minutes for 6 hours post-infusion.
 - Hourly until 24 hours post-infusion.

Observe the following:

- Neurologic deterioration.
- Severe headache, nausea, and/or vomiting.
- Signs of bleeding.
- Post-Administration Care
 - Admit to intensive care unit (ICU) requires transfer to a higher level of care.
 - No antiplatelet or anticoagulant therapy for 24 hours post infusion.

REFERENCE #	7010.26	EFFECTIVE 4/14/2010
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- Repeat head CT/MRI (Magnetic Resonance Imaging) 24 hours prior to initiating antithrombotic therapy.
- Management of Complications
 - Suspected Intracranial Hemorrhage
 - Stop infusion immediately.
 - Obtain an emergent CT scan of the head.
 - Notify attending physician, PA, FNP and initiate reversal protocols.

Angioedema

- Discontinue the Alteplase.
- Administer antihistamines, steroids, and epinephrine as indicated.
- Secure the airway if necessary.
- Documentation Requirements
 - Time of symptom onset/LKW.
 - NIHSS score.
 - Inclusion/exclusion criteria.
 - Blood pressure values.
 - Dose and administration times.
 - Neurologic assessments.
 - Complications and interventions.

REFERENCE:

American Heart Association/American Stroke Association Guidelines for Early Management of Acute Ischemic Stroke

ATTACHMENTS:

None

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>PATIENT DISCHARGE MEDICATIONS</u> <u>7010.26 PATIENT DISCHARGE MEDICATIONS</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized procedures for prescribing, dispensing, furnishing, educating, and documenting discharge medications provided to patients discharged from the Emergency Department (ED) in compliance with California Title 22 regulations, California pharmacy law, Emergency Medical Treatment and Labor Act (EMTALA) requirements, and applicable federal and ~~state~~ controlled~~state-controlled~~ substance laws.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Dispensing: preparation, packaging, labeling, and furnishing of medication directly to a patient pursuant to a lawful order and in accordance with California pharmacy law.

Prescribing: issuance of a lawful medication order or prescription by an authorized licensed ~~provider~~ physician, MD, DO, PA or NP.

POLICY:

The ~~ED~~Emergency Department will ensure that discharge medications are prescribed, dispensed, and documented safely and lawfully to support continuity of care and safe patient discharge. Patients discharged from the ED will receive appropriate medication instructions, counseling, and follow-up information consistent with applicable laws and regulations. The hospital may furnish limited quantities of medications directly to discharged ED patients when clinically indicated and permitted under California law and hospital pharmacy procedures.

PROCEDURE:

Discharge Medication Prescribing

- Discharge medications will be prescribed only by authorized licensed ~~providers~~ physician, MD, DO, PA or NP
- The provider will evaluate clinical necessity, patient allergies, drug interactions, renal and hepatic ~~consideration~~function, pregnancy status when appropriate, and potential medication duplication.
- Prescription will include patient name, medication name, strength, dose, route, frequency, duration, quantity, and refills if applicable.
- Electronic prescribing will be utilized in accordance with California law.

Dispensing/Furnishing of Medications from the ED

- Limited quantities of medications may be dispensed directly from the ED when:
 - Immediate therapy is clinically necessary.
 - Delays in obtaining medication may adversely affect patient care.
 - Community pharmacy access is unavailable or delayed.
 - The medication is authorized under hospital pharmacy procedures.
- All dispensed medications will be properly labeled for outpatient use, include required patient instructions, documented in the electronic medical record, and dispensed pursuant to a lawful provider order.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>PATIENT DISCHARGE MEDICATIONS7010.26 PATIENT DISCHARGE MEDICATIONS</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

- Medication labels will include the patient's name, medication name and strength, direction for use, date dispensed, hospital identification information, and beyond-use or expiration date when required.
- Controlled substances dispensed from the ED will comply with the Board of Pharmacy regulations, California Health & Safety Code, hospital-controlled substance policy, and Drug Enforcement Administration (DEA) requirements.

Patient Education

- Prior to discharge, the patient and/or caregiver will receive education from MD/DO/PA/NP/RN/LVN and/or pharmacist regarding:
 - Medication purpose.
 - Dose and administration.
 - Duration of therapy.
 - Potential side effects.
 - Drug interactions when appropriate.
 - Storage requirements.
 - Return precautions.
 - Follow up instructions.
- Education will be provided in a language and manner understandable to the patient.
- Interpreter services will be provided when indicated.
- Patient understanding will be documented in the medical record.

REFERENCE:

California Health and Safety Code. (2025). *Controlled substances and pharmacy laws*. State of California. <https://leginfo.legislature.ca.gov>

California Board of Pharmacy. (n.d.). *California State Board of Pharmacy*. State of California Department of Consumer Affairs. <https://www.pharmacy.ca.gov>

California Code of Regulations, Title 22, Division 5. (2025). *Hospital licensing regulations*. State of California. <https://govt.westlaw.com/calregs>

California Department of Public Health. (n.d.). *Licensing and certification program*. <https://www.cdph.ca.gov/Programs/CHCQ/LCP>

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE:
SUBJECT:	7010.26 STROKE STANDARD OF CARE	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish a standardized, evidence-based process for the rapid identification, evaluation, treatment, stabilization, and transfer of patients with suspected acute stroke, in order to reduce morbidity and mortality.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Stroke Alert: a rapid response protocol activated for suspected acute stroke.

Last Known Well (LKW): the last time the patient was known to be at baseline neurological function.

Door-to-Needle Time: time from patient arrival to initiation of thrombolytic therapy; the goal is less than sixty minutes.

NIH Stroke Scale (NIHSS): a standardized assessment tool used to quantify neurological deficit.

POLICY:

It is the policy of Modoc Medical Center (**MMC**) to rapidly identify and initiate a Stroke Alert for patients with suspected stroke and provide timely diagnostic evaluation and treatment in accordance with current clinical guidelines.

PROCEDURE:

1. Triage and Activation

- Patients presenting with signs/symptoms of stroke (e.g., facial droop, arm weakness, speech difficulties, sudden neurological deficit) will be triaged as high acuity.
- A Stroke Alert will be activated immediately upon suspicion.
- The following will be documented: time of arrival and last known well (LKW).
- Immediate notification will be made to the Emergency Room (ER) provider, [radiology](#), and laboratory.

2. Initial Assessment (within 10 minutes)

- Perform primary survey (airway, breathing, circulation).
- Obtain point-of-care blood glucose.
- Establish at least one (preferably two) intravenous (IV) lines.
- Obtain vital signs and patient weight.
- Perform and document NIH Stroke Scale (NIHSS).

3. Diagnostic Evaluation (within 20 minutes)

- Obtain a STAT non-contrast computed tomography (CT) of the head.
- Obtain the following lab studies: complete blood count (CBC), coagulation studies, comprehensive metabolic panel (CMP), additional labs as indicated.
- Electrocardiograms (EKG) may be obtained but should not delay CT imaging.

REFERENCE #	7010.26	EFFECTIVE:
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4. Image Interpretation (within 45 minutes)

- CT images will be reviewed immediately by the ER provider and/or radiologist. (ER nurse may need to contact ~~radiology~~the radiology department if there is a delay in reading of image, especially after hours).
- Hemorrhage must be ruled out prior to thrombolytic administration.

5. Thrombolytic Therapy

- Patients meeting eligibility criteria for IV alteplase (tPA) will receive treatment as soon as possible.
- Inclusion criteria include diagnosis of acute ischemic stroke; symptom onset within 4.5 hours of LKW.
- Contraindications will be assessed and documented.
- Informed consent will be obtained according to the hospital policy.
- Door-to-needle time goal is < 60 minutes.

6. Transfer to Higher Level of Care

- Due to limited resources, patients requiring advanced stroke care will be transferred promptly.
- Indications for transfer include suspected large vessel occlusion, neurosurgical or interventional care, and intensive care beyond facility capability.
- ~~Transfer~~The transfer process will include physician-to-physician communication, arrangement of transportation, and transmission of medical records, imaging, and laboratory studies.
- Stabilization measures will continue pending transfer.

7. Monitoring and Reassessment

- Neurological assessment will continue to be performed every 15 minutes during and immediately after tPA infusion, then according to hospital protocol.
- Blood pressure will be monitored and controlled per guidelines.
- Patients will be monitored for complications, including hemorrhage and neurological deterioration.
- Inform ER provider immediately if any changes occur with the ~~patients~~patient's neurological assessment.

8. Documentation (The following must be documented in the electronic medical record)

- Time of patient arrival.
- Stroke Alert activation time.
- Last Known Well (LKW).
- NIHSS Score.
- Time of CT completion and interpretation.
- Thrombolytic decision and administration time.
- Transfer decision and time (if applicable).

REFERENCES:

American Heart Association. (2019). Guidelines for the early management of patients with acute ischemic stroke: 2019 update to the 2018 guidelines. Stroke, 50(12), e344-e418.
<https://doi.org/10.1161/STR.0000000000000211>

REFERENCE #	7010.26	EFFECTIVE:
SUBJECT:	7010.26 STROKE STANDARD OF CARE	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

American Stroke Association. (n.d.). Stroke guidelines and resources. Retrieved May 5, 2026, from <https://www.stroke.org>

Centers for Disease Control and Prevention. (2024). Stroke resources for healthcare professionals. Retrieved May 5, 2026, from <https://www.cdc.gov/stroke>

ATTACHMENTS:

NIH Stroke Scale (NIHSS) Tool

tPA Inclusion/Exclusion Criteria

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 CLINICAL ALARM MANAGEMENT	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish standardized practices for the safe, effective, and appropriate use of clinical alarms on medical equipment in the Emergency Department (ED), thereby promoting timely clinical response, reducing alarm fatigue, and enhancing patient safety.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Clinical Alarm: audible and/or visual signal indicating a change in patient status or device function requiring clinician awareness or intervention.

POLICY:

It is the policy of Modoc Medical Center (MMC) that All clinical alarms will be appropriately configured, individualized to patient condition, continuously operational, and responded to in a timely manner by nursing staff. Alarm systems will not be disabled or ignored without clinical justification and documentation.

PROCEDURE:

Alarm Setup and Configuration

- All patients requiring monitoring will have alarm parameters set upon initiation of monitoring.
- Alarm limits can be individualized based on patient age, diagnosis, and clinical condition.
- Default alarm settings may be used only when clinically appropriate and must be reassessed promptly.
- Alarm audibility and visibility will be verified upon setup and with any room or device change.

Response to Alarms

- Staff must respond to all alarms in a timely manner.
- Alarms will not be silenced or paused without verification of patient condition, implementation of appropriate clinical action or temporary suspension during procedure with clinical justification.

Alarm Fatigue Mitigation

- Alarm thresholds will be reviewed regularly to minimize non-actionable alarms.
- Non-essential monitoring will be discontinued when clinically appropriate.
- Alarm delays or escalations may be utilized per device capability and clinical judgment.

Escalation of Care

If an alarm indicates patient deterioration, staff will immediately perform a bedside assessment, initiate emergency response procedures as indicated, and notify responsible provider-physician, nurse practitioner (NP) or physician assistant (PA)

- without delay.
- Failure to respond appropriately to life-threatening alarms will be reported as a patient safety event.

Equipment Function and Maintenance

- Alarm-equipped devices will undergo routine inspection and preventative maintenance by Biomedical Engineering.
- Malfunctioning alarms or devices will be removed from service immediately and reported.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 CLINICAL ALARM MANAGEMENT	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

Documentation

- Alarm parameter changes when clinically significant.
- Patient response to clinically relevant alarm events.
- Interventions initiated in response to alarms.
- Escalation actions when applicable.

Incident Reporting

- Missed alarms.
- Delayed responses.
- Equipment malfunction.
- Patient harm or near misses.
- All alarm-related incidents will be reported through the hospital event reporting system immediately.

REFERENCE:

Association for the Advancement of Medical Instrumentation (AAMI) Clinical Alarm Management Guidance

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	PATIENT IDENTIFICATION FOR CLINICAL CARE AND TREATMENT 7010.26 PATIENT IDENTIFICATION FOR CLINICAL CARE AND TREATMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish a standardized process for accurate patient identification to promote patient safety, reduce the risk of errors, and ensure compliance with California Title 22 regulations and applicable accreditation standards.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Identification Band: a hospital-issued wristband or approved alternative identification device containing patient-specific identifying information.

Two Patient Identifiers: identifiers may include full legal name, birthdate, medical record number, or account number. Room numbers will not be used as an identifier.

POLICY:

It is the policy of Modoc Medical Center (MMC) to accurately identify all patients prior to the provision of care, treatment, services, medication administration, specimen collection, diagnostic testing, transfer, and discharge. All Emergency Department (ED) patients will receive a hospital-approved identification band as soon as possible upon presentation and registration. A minimum of two patient identifiers will be used prior to any patient care activity whenever clinically feasible. In emergency situations where immediate lifesaving intervention is required, patient care will not be delayed; however, patient identification will be completed as soon as the patient's condition permits. Room number, bed assignment, or physical location will not be used as patient identifiers.

PROCEDURE:

Patient Registration and Initial Identification

- Upon presentation to the Emergency Department~~ED~~, clinical personnel will obtain the patient's full legal name, date of birth, ~~government, and government~~-issued identification when available.
- Patients or family members will be asked to complete the Emergency Department~~ED~~ registration forms.
- A hospital-approved identification band will be applied immediately upon registration or triage when feasible.
- The identification band will contain the patient's full name, medical record number, date of birth, and date and time of admission.
- Staff members will verify the accuracy of identification information with the patient or accompanying family member whenever possible.

Triage and Emergency Care

- Clinical staff will use at least two patient identifiers prior to the following:
 - Medication administration
 - Blood product administration
 - Specimen collection
 - Diagnostic procedures

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- Imaging studies
- Treatments and procedures
- Patient transfer or discharge.
- Verification will include comparison of patient statements, identification band, physician orders, electronic medical record, and medication administration record (MAR)
- In emergent or life-threatening situations, treatment will not be delayed for full registration processes; however, identification procedures will be completed as soon as clinically appropriate.

Trauma or Unidentified Patients

- Patients arriving unidentified will be assigned a temporary identification number according to ~~Emergency Department~~ EDER registration procedures.
- A temporary identification band will be applied immediately.
- All orders, specimens, medications, blood products, and documentation will utilize the assigned identification number until positive patient identification is confirmed.
- Once confirmed, the patient record will be updated according to Health Information Management procedures.

Patients Unable to Communicate

- For patients unable to verbally confirm identity due to medical condition, altered mental status, language barrier, behavioral emergency, or unconsciousness, staff will verify identity using the identification band, medical record number, family/caregiver confirmation when available, law enforcement information when applicable or emergency medical services (EMS) documentation.

Specimen Collection and Medication Administration

- Specimens will be labeled in the presence of the patient immediately after collection.
- Nursing staff will scan the patient's identification band and labels at the bedside to positively identify the patient.
- Staff administering medications or blood products will verify two patient identifiers prior to administration.
- Barcode scanning will be utilized.

Missing, Incorrect, or Illegible Identification Bands

- Staff identifying a missing or inaccurate band will immediately stop non-emergency care activities, re-verify the patient's identity, and replace the identification band promptly.
- The discrepancy and corrective action will be documented according to departmental procedures.

Refusal to Wear Identification Band

- Patients refusing identification bands will be educated regarding patient safety risks.
- Refusal will be documented in the electronic medical record.
- The charge nurse and ~~provider~~ physician, MD, DO, NP or PA will be notified.
- Alternative identification measures may be implemented when appropriate.

REFERENCE:

California Code of Regulations, Title 22, § 70707. (2025). *Patients' rights*. State of California.
<https://govt.westlaw.com/calregs/>

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	PATIENT IDENTIFICATION FOR CLINICAL CARE AND TREATMENT <u>7010.26 PATIENT IDENTIFICATION FOR CLINICAL CARE AND TREATMENT</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Centers for Medicare & Medicaid Services (CMS). (2024). *State operations manual: Appendix A – Survey protocol, regulations, and interpretive guidelines for hospitals*. U.S. Department of Health and Human Services.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 5/2026
SUBJECT:	7010.26 SUICIDE RISK SCREENING AND PRECAUTIONS IN THE EMERGENCY DEPARTMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized procedures for the identification, assessment, management, and safe disposition of patients presenting to the Emergency Department (ED) with suicidal ideation, suicide attempt, or behaviors indicating risk of self-harm. This policy ensures compliance with Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs), including Emergency Medical Treatment and Labor Act (EMTALA) requirements for medical screening and stabilization, California Code of Regulations, Title 22, Division 5, acute care hospital licensing requirements and applicable state mental health statutes governing involuntary detention (e.g., 5150 criteria where applicable).

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Suicide Risk: presence of suicidal ideation, intent, plan, preparatory behavior, or recent attempt.

Medical Screening Examination (MSE): evaluation required under EMTALA to determine whether an emergency medical condition exists, including psychiatric emergencies.

Emergency Medical Condition (EMC): a condition manifested by acute symptoms (including behavioral health crisis) such that absence of immediate medical attention could reasonably result in serious harm.

Suicide Precautions: a set of environmental, clinical, and monitoring interventions designed to reduce risk of self-harm.

POLICY:

It is the policy of Modoc Medical Center (MMC) that All patients presenting to the ED will be screened for suicide risk at triage. Patients identified as at risk for self-harm will receive immediate safety interventions, appropriate clinical evaluation, and continuous observation based on assessed risk level. The hospital will ensure a safe environment and appropriate psychiatric evaluation or disposition prior to discharge or transfer.

PROCEDURE:

Screening

- All ED patients will be screened for suicide risk using a validated tool (Columbia-Suicidal Severity Rating Scale) at triage and/or during the MSE.

Suicide Risk Assessment

- A comprehensive suicide risk assessment will be completed by a qualified provider/attending nurse and must include the following:
 - Current suicidal ideation.
 - Intent and plan
 - Access to lethal means
 - History of suicide attempts or self-harm
 - Psychiatric and substance use history
 - Protective factors

REFERENCE #	7010.26	EFFECTIVE: 5/2026
SUBJECT:	7010.26 SUICIDE RISK SCREENING AND PRECAUTIONS IN THE EMERGENCY DEPARTMENT	REVISED: 5/2026
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Initiation of Suicide Precautions

- Moderate or High Risk- the following interventions will be initiated immediately:
 - Placement in a safe or ligature-resistant room when available. Room 3 in the ED is used for 5150 holds due to continuous visualization with video monitoring.
 - Lock cabinets and drawers in ~~room~~ the room to prevent patient access.
 - Removal of personal belongings and hazardous items.
 - ~~Provision of~~ Provide suicide-safe attire (paper scrubs).
 - Initiation of 1:1 continuous observation.
 - Notification of ED provider/physician, MD/DO/PA/NP and behavioral health services.
 - ~~Place p~~ Psychiatric consultation request.
- Low Risk
 - Standard precautions with documented reassessment.
 - Increased monitoring as clinically indicated.

Environmental Safety Requirements

- Remove or secure all potential ligature or self-harm instruments, including but not limited to cords, belts, sharp objects, and medical tubing when not clinically necessary.
- Restrict access to unsafe bathroom environments as clinically indicated.
- Maintain continuous visualization for high-risk patients without interruption.
- ~~Provide n~~ Meals will be provided on safety tray from dietary. This includes paper products and plastic utensils.

Observation Standards

- Low risk: routine ED monitoring
- Moderate risk: frequent documented checks.
- High risk/imminent: continuous 1:1 observation without lapse by a sitter

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Legal Status and Involuntary Hold

- When a patient meets criteria for danger to self or others, a licensed provider/physician, nurse practitioner (NP) or physician assistant (PA)
- may initiate involuntary psychiatric hold per applicable state law (e.g., California Welfare & Institutions Code 5150).
- Must occur prior to disposition unless emergency transfer is required.

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Disposition Requirements

- Patients are no longer at imminent risk of self-harm and any hold is released.
- A documented safety plan is completed.
- Follow up care arrangements.
- Patient capacity and understanding are assessed and documented.
- This portion of care is completed by behavioral health clinicians.

Education

- All patients treated for psychiatric, emotional or behavioral disorders will receive the following information and instructions in written form upon discharge:
- "If you feel unsafe or feel that you might harm yourself or others you can:
 - Call 1-800-273-8255 for the National Suicide Prevention Lifeline.

REFERENCE #	7010.26	EFFECTIVE: <u>5/2026</u>
SUBJECT:	7010.26 SUICIDE RISK SCREENING AND PRECAUTIONS IN THE EMERGENCY DEPARTMENT	REVISED: <u>5/2026</u>
DEPARTMENT:	EMERGENCY DEPARTMENT	

- Call 911 or go to your nearest emergency room.
- Call Modoc County Behavioral Health Crisis Lines 24/7 at 1-530-233-6312.
- If you are in a life-threatening emergency situation, dial 911-1-1.

Documentation Requirements

- Suicide screening results.
- Full risk assessment and clinical formulation.
- Observation level and precautions implemented.
- Environmental safety interventions.
- Psychiatric consultation findings (if applicable).
- Disposition decision-making rationale.
- Safety plan (if discharged).

REFERENCE:

Centers for Medicare & Medicaid Services. (2024). *State operations manual: Appendix A—Survey protocol, regulations and interpretive guidelines for hospitals*. U.S. Department of Health and Human Services. <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-a-survey-protocol-regulations-and-interpretive-guidelines-for-hospitals.pdf>

Centers for Medicare & Medicaid Services. (n.d.). *Emergency Medical Treatment and Labor Act (EMTALA)*. U.S. Department of Health and Human Services. <https://www.cms.gov/medicare/regulations-guidance/legislation/emtala>

California Department of Public Health. (2024). *California Code of Regulations, Title 22, Division 5: Licensing and certification of health facilities, home health agencies, clinics, and referral agencies*. State of California. <https://govt.westlaw.com/calregs>

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	PATIENTS REQUIRING PSYCHIATRIC EVALUATION 7010.26 PATIENTS REQUIRING PSYCHIATRIC EVALUATION	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish standardized procedures for the identification, evaluation, stabilization, and disposition of Emergency Department (ED) patients presenting with suspected or confirmed behavioral health conditions requiring psychiatric assessment, in compliance with federal and California regulatory requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Medical Screening Examination (MSE): evaluation to determine whether an emergency medical condition exists, including psychiatric conditions.

Gravely Disabled: inability to provide for basic personal needs due to a mental or physical disorder.

Behavioral Health Hold: legal detention under applicable California law for psychiatric evaluation (e.g., involuntary hold criteria when applicable).

POLICY:

It is the policy of Modoc Medical Center (MMC) to provide timely medical screening, psychiatric evaluation, stabilization, and appropriate disposition for all ED patients with behavioral health needs. Care will comply with federal Emergency Medical Treatment and Labor Act (EMTALA) obligations, Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and California Title 22 regulations. Patients presenting with psychiatric symptoms will receive a medical screening examination, and, when indicated, a psychiatric evaluation without undue delay.

PROCEDURE:

Identification and Triage

- All patients will undergo behavioral health screening during triage.
- Any indication of suicidal ideation or attempt, homicidal ideation, psychosis or severe agitation, and/or inability to care for self, triggers immediate escalation to the ED provider.

Medical Screening Examination

- An ED physician or ~~qualified provider~~physician, nurse practitioner (NP) or physician assistant (PA)-will perform a MSE promptly.
- Medical causes of psychiatric symptoms must be ruled out (e.g., intoxication, delirium, metabolic disorders).
- Documentation must clearly state whether an emergency medical condition exists.

Psychiatric Evaluation

- Psychiatric consultation will be requested with any of the following:
 - Suicide or violence risk is identified.
 - Acute psychosis or severe behavioral disturbance is present.
 - Clinical uncertainty regarding disposition existences.
- Psychiatric evaluation must occur in a timely manner based on acuity:

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DEPARTMENT:	EMERGENCY DEPARTMENT	

- Emergent: immediate
- Urgent: within hospital-defined time limit

Patient Safety and Observation

- Patients determined to be at risk will be placed on an appropriate observation level (e.g., 1:1 sitter).
- Environmental safety precautions will be implemented:
 - Removal of ligature risks and hazardous items
- Security involvement will be used only when clinically indicated. (e.g., maintenance crew, local law enforcement).

Restrain and Seclusion

- May be used only when less restrictive interventions fail or are not feasible.
- Requires the following:
 - ~~Physician or authorized provider~~physician, NP or PA order.
 - Time-limited authorization per regulation.
 - Continuous monitoring and documentation.
 - Must comply with CMS restraint/security requirements/standards.

Disposition

- Based on medical and psychiatric evaluation, disposition may include:
 - Discharge with outpatient follow-up plan.
 - Admission to medical service.
 - Transfer to external psychiatric facility.
 - Initiation of involuntary psychiatric hold procedures when legally indicated and remain in the ED until hold is lifted or transferred.

Patient Rights

- Patients will be informed of their rights, including legal rights under involuntary statutes if applicable.
- Confidentiality will be maintained in accordance with Health Insurance Portability and Accountability Act (HIPAA) and hospital policies.
- Least restrictive treatment environment will be prioritized.

Documentation Requirements

- Triage behavioral health screening results.
- Medical screening examination findings.
- Suicide/violence risk assessment.
- Psychiatric consultation notes.
- Observation level and safety measures implemented.
- Restraint/seclusion documentation if used.
- Final disposition and rationale.

REFERENCES:

Centers for Medicare & Medicaid Services. (n.d.). *State operations manual: Appendix A – Survey protocol, regulations, and interpretive guidelines for hospitals*. U.S. Department of Health & Human Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	<u>PATIENTS REQUIRING PSYCHIATRIC EVALUATION</u> 7010.26 PATIENTS REQUIRING PSYCHIATRIC EVALUATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

California Department of Public Health. (n.d.). *California Code of Regulations, Title 22: Social Security*.
<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LawsRegs.aspx>

ATTACHMENTS:

None

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>7010.26</u> INTERFACILITY TRANSFER OF PATIENTS TO HIGHER LEVEL OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish a standardized process for the safe, timely, and legally compliant transfer of patients from Modoc Medical Center to a higher level of care facility, in accordance with the Emergency Medical Treatment and Labor Act (EMTALA) and California Title 22 regulations.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Appropriate Transfer (EMTALA): a transfer that meets all federal requirements including medical necessity, receiving hospital acceptance, stabilization efforts, and proper documentation.

Higher Level of Care: a facility capable of providing services not available at this hospital (e.g., ICU, specialty surgery, interventional cardiology, neurosurgery).

POLICY:

It is the policy of Modoc Medical Center (MMC) that Patients requiring diagnostic or therapeutic services beyond the capability of this facility will be transferred to an appropriate receiving hospital capable of providing the required level of care. All transfers will comply with EMTALA requirements for appropriate transfer and California Title 22 documentation and operational standards. Transfers will not be based on financial considerations, insurance status, census, or convenience.

PROCEDURE:

Medical Screening and Stabilization (EMTALA Requirement)

A qualified medical provider physician, nurse practitioner (NP) or physician assistant (PA)

- will perform a Medical Screening Examination (MSE).
- Stabilizing treatment will be initiated within facility capabilities.

The provider physician, NP or PA

- will determine whether the patient is stabilized for transfer.

Determination of Need for Transfer

- The attending provider attending physician, PA, FNP will document the clinical indication for higher a higher level of care transfer.
- The specific capability gap requiring transfer will be clearly identified.
- The decision will be based solely on patient clinical needs.

Receiving Facility Acceptance

The transferring provider physician, NP or PA

- will contact an appropriate receiving facility.

Verbal acceptance must be obtained from a licensed provider physician, NP or PA

- at the receiving facility.
- The receiving facility must confirm capability and capacity.

Physician Certification (Unstable Patients)

- For patients not fully stabilized, the attending physician must certify that risks of transfer are outweighed by expected clinical benefits, and transfer is medically necessary.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>7010.26</u> INTERFACILITY TRANSFER OF PATIENTS TO HIGHER LEVEL OF CARE	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- Certification must be documented in the electronic medical record.

Transport Arrangements

- Appropriate level of transport will be determined based on patient condition:
 - Basic life support (BLS), advanced life support (ALS), critical care transport, or air transport.
- Continuous monitoring and interventions required during transport must be ensured.

Transfer of Medical Information

- The following must accompany the patient:
 - Medical Screening Examination documentation
 - Diagnostic results
 - Medication administration record
 - Physician orders and progress notes
 - Vital signs and treatment record
 - EMTALA transfer certification (if applicable).

Communication Requirements

- Direct physician-to-physician communication is required for all transfers.
- Nursing-to-nursing report will be completed prior to departure.

Documentation Requirements (Title 22 Compliance)

- The medical record must include the following:
 - Time and date of transfer decision
 - Reason for transfer to higher level of care
 - Condition of patient at time of transfer

Name of accepting facility and provider physician, NP or PA

-
- Confirmation of notification to receiving facility
- Transport method and level of care.

Responsibilities

Attending Provider physician, NP or PA

- will perform MSE and stabilization, determine medical necessity for transfer, obtain accepting accepting physician, and complete the EMTALA documentation.
- Nursing staff will assist with stabilization and monitoring, prepare transfer documentation packet, and provide verbal handoff reports.
- Administration will maintain transfer agreements with receiving hospitals and ensure compliance with EMTALA and Title 22 requirements.

Quality and Compliance

- All transfers are subject to internal audit and peer review, EMTALA compliance review, state licensing review (Title 22), and Medical Executive Committee oversight.
- Noncompliance may result in corrective action and reporting as required by law.

REFERENCE:

Centers for Medicare & Medicaid Services. (n.d.). *Emergency Medical Treatment and Labor Act (EMTALA) requirements and interpretive guidelines*. U.S. Department of Health and Human Services.
<https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA>

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>7010.26</u> INTERFACILITY TRANSFER OF PATIENTS TO HIGHER LEVEL OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Cornell Law School, Legal Information Institute. (n.d.). 22 CCR § 79789 – *Hospital transfer policies and procedures (California Code of Regulations, Title 22)*.

<https://www.law.cornell.edu/regulations/california/22-CCR-79789>

Cornell Law School, Legal Information Institute. (n.d.). 22 CCR § 70717 – *Hospital policies and procedures (California Code of Regulations, Title 22)*.

<https://www.law.cornell.edu/regulations/california/22-CCR-70717>

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 SYNCHRONIZED CARDIOVERSION	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish a standardized process for the safe and effective performance of synchronized cardioversion using the LIFEPAK 15 monitor/defibrillator for patients with unstable tachyarrhythmias requiring electrical therapy.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center (MMC) that Ssynchronized cardioversion will be performed by qualified providers credentialed in Advanced Cardiac Life Support (ACLS) and trained in the operation of the LIFEPAK 15 monitor/defibrillator. The procedure will be conducted according to current ACLS guidelines, manufacturer recommendations; and hospital sedation and patient safety policies.

PROCEDURE:

Patient Assessment and Preparation

- Assess airway, breathing; and circulation.
- Confirm presence of tachyarrhythmia with a pulse.
- Assess for signs of hemodynamic instability.
- Obtain and document baseline vital signs.
- Establish intravenous access.
- Apply supplemental oxygen as indicated.
- Explain procedure to patient and/or family when feasible.
- Obtain informed consent when patient condition permits.
- Administer procedural sedation and analgesia in accordance with hospital sedation policy when clinically appropriate.

Equipment Setup

- Apply the QUIK-COMBO defibrillator pads in anterior-lateral or anterior-posterior position.
- Ensure skin is dry and free of medication patches.
- Connect the pads directly to the LIFEPAK 15 monitor.
- Ensure continuous cardiac monitoring.

Activation of Synchronized Cardioversion

- Turn selector to MONITOR or DEFIB mode.
- Press the SYNC button on LIFEPAK 15.
- Verify synchronization markers appear over each QRS complex.
- Confirm markers correspond appropriately with R waves prior to shock delivery.
- If synchronization markers are inconsistent:
 - Reassess the pad placement.
 - Adjust the ECG size/gain.
 - Select alternate monitoring lead if necessary.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 SYNCHRONIZED CARDIOVERSION	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

Energy Selection

- Press ENERGY SELECT or rotate the SPEED DIAL to select the desired energy.

Shock Delivery

- Charge the defibrillator to the selected energy level.
- Verbally announce “CLEAR” and ensure all personnel are clear of the patient, stretcher, and equipment.
- Deliver synchronized shock by pressing and holding the shock button until discharge occurs.
- Immediately reassess cardiac rhythm, pulse, blood pressure, and patient condition.
- To disarm (cancel a charge), press the SPEED DIAL. The defibrillator disarms automatically if shock buttons are not pressed within 60 seconds, or if you change the energy selection after charging begins.

Repeat Cardioversion

- Re-enable SYNC mode prior to each additional cardioversion attempt, as the LIFEPAK 15 may default out of synchronization mode after shock delivery.
- Escalate energy settings as clinically indicated.
- Repeat synchronized cardioversion, as necessary.

Safety Considerations

- Synchronization markers must be confirmed prior to shock delivery.
- Failure to synchronize appropriately may precipitate ventricular fibrillation.
- If the patient becomes pulseless, initiate immediate ACLS resuscitation and unsynchronized defibrillation as indicated.
- No staff member will remain in physical contact with the patient or stretcher during shock delivery.
- Continuous monitoring and reassessment are required throughout the procedure.

Documentation

- Indication for cardioversion
- Pre-procedure rhythm and patient status
- Informed consent when applicable
- Sedation medications and patient response
- Energy levels administered
- Number of synchronized shocks delivered.
- Post-procedure rhythm and patient condition
- Complications and interventions
- Names and credentials of providers involved.

REFERENCE:

American Heart Association. (2020). *2020 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care*. *Circulation*, 142(16_suppl_2).
<https://doi.org/10.1161/CIR.0000000000000918>

Stryker. (2018). *LIFEPAK 15 monitor/defibrillator operating instructions*. Physio-Control Operations, Inc.
[LIFEPAK 15 Operating Instructions](#)

REFERENCE #	7010.26	EFFECTIVE; 10/2007
SUBJECT:	7010.26 SYNCHRONIZED CARDIOVERSION	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

ATTACHMENTS:

None

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 MANAGEMENT OF PATIENTS UNDER THE INFLUENCE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish a standardized process for the assessment, stabilization, monitoring, treatment, and disposition of patients presenting to the Emergency Department (ED) under the influence of alcohol, illicit drugs, prescription medications, or other intoxicating substances, while ensuring patient dignity, staff safety and compliance with legal and regulatory requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Intoxication: a reversible condition resulting from recent substance ingestion causing altered mental status, impaired judgment, or physiologic instability.

Behavioral Disturbance: agitation, aggression, confusion, psychosis, or unsafe conduct associated with intoxication.

POLICY:

It is the policy of Modoc Medical Center (MMC) that The Emergency Department will provide safe, respectful, evidence-based care to patients suspected or confirmed to be under the influence of intoxicating substances. All patients will receive appropriate medical screening and treatment regardless of intoxication status. The least restrictive interventions will be utilized at all times, with emphasis on verbal de-escalation, patient safety, and continuous reassessment.

PROCEDURE:

Triage and Initial Assessment

- Primary assessment to include airway, breathing, circulation, and level of consciousness.
- Initial observations to include temperature, heart rate, respiratory rate, blood pressure, oxygen saturation, blood glucose levels, and pain assessment.
- Clinical assessment and history to include the suspected substance used, quantity and time of ingestion, co-ingestion of substances, trauma or injury, suicide or self-harm risk, risk of aggression, and presence of medical comorbidities.

High-risk indicators require immediate notification to the physician/provider: physician, nurse practitioner (NP) or physician assistant (PA)

- - Respiratory depression.
 - Altered or deteriorating consciousness.
 - Head injury.
 - Seizure activity.
 - Chest pain.
 - Severe agitation.
 - Psychosis.
 - Suspected overdose.
 - Suicidal ideation.
 - Pregnancy-related concerns.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 MANAGEMENT OF PATIENTS UNDER THE INFLUENCE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Safety Management

- Reduce environmental hazards.
- Limit patient Access to monitoring equipment.
- Assure sSafe staff exit routes.
- Remove ~~ef~~ dangerous objects when necessary.
- Assure VersaBadge on and with easy access for the employee.

Medical Evaluation

The treating provider physician, NP or PA

- will assess for potential underlying or concurrent conditions including trauma, hypoglycemia, stroke, infection/sepsis, electrolyte abnormalities, psychiatric illness, toxic syndromes, and withdrawal status.
- Diagnostic testing may include the following:
 - Blood alcohol level.
 - Toxicology screening.
 - Complete blood count.
 - Electrolytes and renal function.
 - Liver function tests.
 - Electrocardiogram.
 - Pregnancy testing .
 - Computed tomography (CT) imaging.
 - Blood gas analysis.

Monitoring and Observation

- Patients under the influence will receive ongoing reassessment appropriate to clinical status such as vital signs, neurologic, oxygen saturation, cardiac monitoring, behavioral observation and fall precautions.

Management of Agitation

- Calm verbal communication.
- Reduction of environmental stimuli.
- Reorientation and reassurance.
- Provision of hydration and comfort measures.
- Sedation may be administered when the patient poses immediate danger to self or others, non-pharmacological interventions are ineffective, or urgent medical treatment cannot otherwise be provided.
- All sedated patients will receive continuous monitoring, airway assessment, and documentation of indication and response.

Restraint Use

- Restraints will only be used as a last resort, for the minimum duration necessary and to prevent immediate harm.

Capacity and Consent

- Patients under the influence will be assessed for decision-making capacity.
- Where capacity is impaired and urgent treatment is necessary to prevent harm, treatment may proceed in accordance with applicable laws and emergency treatment provisions.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 MANAGEMENT OF PATIENTS UNDER THE INFLUENCE	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

Mental Health Assessment

- Mental health consultation will be obtained for patients presenting with any of the following:
 - Suicidal ideation.
 - Self-harm behavior.
 - Psychosis.
 - Severe behavioral disturbance.
 - Persistent altered mental status.
- Psychiatric assessment should occur once the patient is clinically appropriate for evaluation unless emergent intervention is required sooner.

Disposition

- Patients may be discharged when medically stable, clinically sober, or appropriately supervised, ambulating safely when appropriate, free from immediate risk to self or others, and provided with discharge instructions and follow-up recommendations.

Admission Criteria

- Persistent altered mental status.
- Severe intoxication.
- Withdrawal risk.
- Medical complications.
- Psychiatric instability.
- Unsafe discharge circumstances.
- Patients may be kept for extended periods of time in the ED for observation or may require transfer to higher-level of care.

Documentation

- Initial presentation and assessment.
- Vital signs.
- Mental status.
- Risk assessments.
- Interventions performed.
- Medications administered.
- Sedation/restraint documentation.
- Reassessment findings.
- Disposition and discharge planning.

REFERENCE:

Emergency Nurses Association. (2022). *Emergency nursing standards and practices* (7th ed.). [Emergency Nurses Association](#)

ATTACHMENTS:

None.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>7010.26PEDIATRIC ASTHMA STANDARD OF CARE</u> <u>PEDIATRIC ASTHMA STANDARD OF CARE</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish a standardized, evidence-based nursing approach for the assessment, stabilization, treatment, monitoring, education, and disposition of pediatric patients presenting to the Emergency Department (ED) with asthma exacerbation or wheezing-associated respiratory distress.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Asthma Exacerbation: an acute or subacute episode of worsening bronchospasm resulting in respiratory distress, wheezing, cough, chest tightness, or decreased airflow.

POLICY:

It is the policy of Modoc Medical Center (MMC) that All nursing staff caring for pediatric patients with suspected or confirmed asthma exacerbation will provide a timely assessment, initiate approved standing orders/protocols, administer prescribed therapies safely, monitor patient response, recognize clinical deterioration, and provide discharge education consistent with current pediatric asthma guidelines and institutional standards.

PROCEDURE:

Initial Triage and Assessment

- Perform a rapid airway, breathing and circulation (ABC) assessment immediately upon arrival.
- Obtain and document the respiratory rate, heart rate, blood pressure, temperature, pulse oximetry, and weight in kilograms.
- Assess breath sounds, wheezing, retractions/accessory muscle use, air movement, mental status, and hydration status.
- Determine severity using approved asthma scoring tool:
 - Pediatric Asthma Severity Score (PASS)
 - Pediatric Respiratory Assessment Measure (PRAM)
 - Clinical Asthma Score (CAS), per facility standard
- Identify high-risk history:
 - Prior intubation
 - Intensive care unit (ICU) admission
 - Frequent ED visits/hospitalizations
 - Recent steroid use
 - Poor medication adherence

Triage Priority

- Severe respiratory distress will receive immediate room placement and provider notification.
- Impending respiratory failure requires activation of pediatric emergency response.

Protocol Initiation

- Per approved ED protocol, nursing staff may initiate the following:
 - Pulse oximetry
 - Oxygen therapy

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

- Nebulized bronchodilator therapy (needs provider approval/order)
- Continuous cardiac monitoring
- Intravenous (IV) access for moderate/severe exacerbations (needs provider approval/order).

Oxygen Administration

- Oxygen will be administered for oxygen saturation less than 94% unless otherwise ordered.
- Methods of oxygen delivery may include nasal cannula, face mask, and high-flow nasal cannula (needs provider approval/order).
- Continuous pulse oximetry will be maintained for moderate to severe exacerbations, patients receiving continuous ~~nebulization~~nebulization, and patients receiving supplemental oxygen.

Bronchodilator Therapy and steroid therapy

- Administer albuterol via nebulizer or metered-dose inhaler (MDI) with spacer per provider order.
- Monitor patient response following administration.
- Monitor for adverse effects including tachycardia, tremors, agitation, and hypokalemia.
- Ipratropium may be administered in combination with albuterol for moderate or severe exacerbations per provider order.
- Systemic corticosteroids will be administered as ordered--as early as clinically feasible.
- Medications may include dexamethasone, prednisolone, prednisone, or intravenous methyl prednisolone.

Advanced/Adjunct Therapies

- The nurse will assist with administration and monitoring of advanced therapies as ordered, including intravenous magnesium sulfate, terbutaline, epinephrine, non-invasive ventilation, and high-flow oxygen therapy.
- Continuous cardiac monitoring will be maintained when clinically indicated.

Reassessment and Monitoring

- The nurse will reassess and document respiratory status, vital signs, oxygen saturation, asthma severity score, and response to interventions.

Minimum Reassessment Frequency

- Severe exacerbation: Every 15 minutes or continuous
- Moderate exacerbation: Every 30-60 minutes
- Mild exacerbation: per departmental standard

Escalation Criteria

- Immediate ~~provider~~physician, nurse practitioner (NP) or physician assistant (PA) notification is required for the following:
 - Worsening respiratory distress
 - Silent chest (unable to auscultate breath sounds)
 - Persistent hypoxemia
 - Decreased responsiveness
 - Cyanosis
 - Bradycardia
 - Signs of fatigue or impending respiratory failure
 - Failure to improve following initial treatment.
 - The nurse should prepare for transfer to a higher level of care as indicated.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>7010.26PEDIATRIC ASTHMA STANDARD OF CARE</u> <u>PEDIATRIC ASTHMA STANDARD OF CARE</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Disposition

- Patients may require transfer of care for admission for persistent oxygen requirement, ongoing respiratory distress, need for frequent bronchodilator therapy, inadequate response to ED treatment, or social concerns impacting a safe discharge.
- Prior to discharge, the nurse will verify stable respiratory status, adequate oxygen saturation on room air, tolerance of spaced bronchodilator treatments, completion of discharge education, and caregiver understanding of home management plan.

Documentation

- Initial assessment findings
- Asthma severity score
- Vital signs
- Medication administration
- Patient response to therapy
- Oxygen administration
- Providerphysician, NP or PA
- notifications
- Education provided
- Patient disposition
- Documentation will be completed in the electronic medical record (EMR) in accordance with hospital policy.

REFERENCE:

None.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE <u>05/2026</u>
SUBJECT:	7010.26 PACING <i>Transcutaneous</i>	REVISED: <u>5/2026</u>
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized procedures for the safe and effective use of transcutaneous cardiac pacing (TCP) utilizing the LIFEPAK 15 monitor/defibrillator in patients requiring emergent cardiac pacing.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Transcutaneous Pacing (TCP): a temporary noninvasive method of cardiac pacing utilizing external pacing electrodes to deliver electrical impulses through the chest wall to stimulate myocardial depolarization.

Electrical Capture: evidence on the cardiac monitor demonstrating pacing spikes followed by ventricular depolarization (QRS complex).

Mechanical Capture: confirmation of effective cardiac output demonstrated by palpable pulse, measurable blood pressure, or improved perfusion following electrical capture.

POLICY:

It is the policy of Modoc Medical Center (MMC) that ~~T~~TCPtranscutaneous pacing may be performed by appropriately credentialed healthcare personnel for patients experiencing symptomatic bradycardia or unstable cardiac conduction disturbances when clinically indicated. TCP will be performed in accordance with Advanced Cardiac Life Support (ACLS) guidelines, manufacturer recommendations, and hospital standards of care.

PROCEDURE:

Patient Assessment

- Assess airway, breathing, circulation, and level of consciousness.
- Obtain baseline heart rate and rhythm, blood pressure, oxygen saturation, and pain assessment.
- Establish intravenous or intraosseous access when feasible.
- Explain procedure to patient and/or family if patient condition permits.

Electrode Placement

- Apply QUIK-COMBO electrodes according to manufacturer instructions.
- Electrode placement options include anterior-lateral placement, or anterior-posterior placement.
- Ensure skin is clean and dry, excessive chest hair is removed if needed, and electrodes are firmly adhered.
- Connect QUIK-COMBO cable securely to the LIFEPAK 15 device.

Initiation of Pacing

- Turn on the LIFEPAK 15 monitor/defibrillator.
- Press the PACER function key.
- Select pacing mode per ~~manufacturer~~manufacturer's instructions.
- Set initial pacing rate:
 - Adults: typically, 60-80 pulses per minute (ppm).

REFERENCE #	7010.26	EFFECTIVE <u>05/2026</u>
SUBJECT:	7010.26 PACING	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: <u>5/2026</u>

- Press RATE or rotate the SPEED DIAL to select the desired pacing rate.
- Gradually increase pacing current (mA) until electrical capture is achieved. Press CURRENT or rotate the SPEED DIAL to increase current until electrical capture occurs.
- Confirm electrical capture by observing the pacing spikes followed by wide QRS complexes.
- Confirm mechanical capture by a palpable pulse, improved blood pressure, and improvement in perfusion or mental status.
- To change rate or current during pacing, press RATE or CURRENT. The RATE and CURRENT buttons allow changes in increments of ten; the SPEED DIAL allows changes in increments of five.
- To interrupt pacing and view the patient's intrinsic rhythm, press and hold PAUSE. This causes the pacer to pace at 25% of the set rate. Release PAUSE to resume pacing at the set rate.
- To stop pacing, reduce current to zero or press PACER.
- To defibrillate and stop noninvasive pacing, press CHARGE. Pacing automatically stops. Proceed with defibrillation.

Sedation and Analgesia

- TCP may cause significant patient discomfort. Analgesia and/or sedation should be administered when clinically appropriate and hemodynamically tolerated.
- All medication administrations will comply with hospital sedation and monitoring policies.

Monitoring

- Continuous monitoring will include cardiac rhythm, pulse and blood pressure, oxygen saturation, mental status, skin integrity beneath electrodes, and patient comfort and pain assessment.
- Capture will be reassessed frequently during pacing therapy.

Documentation

- Clinical indication for pacing
- Initial cardiac rhythm
- Electrode placement location
- Time pacing initiated
- Pacing rate and current settings
- Capture threshold
- Confirmation of mechanical capture
- Vital signs and patient response
- Medications administered
- Adverse events or complications
- Time pacing discontinued

REFERENCE:

Stryker. (n.d.). *LIFEPAK 15 monitor/defibrillator operating instructions*.
https://www.stryker.com/content/dam/stryker/ems/resources/operating-instructions/lifepak_15_operating_instructions_en.pdf

American Heart Association. (2020). *Adult basic and advanced life support: 2020 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care*.
<https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-and-advanced-life-support>

REFERENCE #	7010.26	EFFECTIVE <u>05/2026</u>
SUBJECT:	7010.26 PACING	REVISED: <u>5/2026</u>
DEPARTMENT:	EMERGENCY DEPARTMENT	

ATTACHMENTS:

None

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>PEDIATRIC DOSING GUIDELINES</u> <u>7010.26 PEDIATRIC DOSING GUIDELINES</u>	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish standardized requirements for safe pediatric medication dosing, preparation, verification, administration, and documentation in the Emergency Department (ED) in compliance with California Title 22 regulations, applicable nursing standards, pharmacy standards, and Pediatric Advanced Life Support (PALS) recommendations.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Weight-Based Dosing: medication dosing calculated using patient weight in kilograms (kg).

High-Alert Medication: a medication bearing increased risk of significant patient harm when used in error.

Independent Double Check: a separate verification process performed independently by two qualified licensed clinicians.

POLICY:

The Emergency Department will maintain standardized pediatric medication dosing practices designed to reduce medication errors and promote safe administration of medications to neonates, infants, children, and adolescents. All pediatric medications will be ordered and administered in metric units only, be weight-based when clinically indicated, be independently verified for high-alert medications, be documented in accordance with hospital policy and California Title 22 requirements and be administered only by personnel authorized within their scope of practice. Medication administration will comply with California Title 22 requirements that medications will be administered only on authorized orders, be administered as prescribed, include patient identification prior to administration, be prepared and administered by authorized personnel and be documented appropriately.

PROCEDURE:

Weight Documentation

- Pediatric patient weight will be obtained and documented in kilograms (kg) only.
- Pounds will not be used for medication dosing.
- Weight will be entered in the electronic medical record prior to medication administration whenever feasible.

Emergency Situations

- If an actual weight cannot be obtained:
 - Caregiver-reported weight may be used temporarily.
 - Approved length-based resuscitation systems may be utilized.
 - Estimated weights will be clearly identified as estimated.

Medication Ordering Requirements

- Medication orders for pediatric patients will include the medication name, dose, route, frequency, weight-based calculation when applicable, and maximum dose when clinically indicated.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>PEDIATRIC DOSING GUIDELINES</u> <u>7010.26 PEDIATRIC DOSING GUIDELINES</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Medication Verification

- Independent Double Check Required
 - High-alert medications
 - Intravenous infusions
 - Resuscitation medications
 - Continuous vasoactive infusions
 - Procedural sedation medications
- Double Check Elements
 - Correct patient
 - Weight in kilograms
 - Medication concentration
 - Dose calculation
 - Route
 - Pump settings, if applicable
 - Time and indication

Pediatric Emergency Resuscitation

- Emergency medication dosing will utilize current PALS guidelines.
- Approved pediatric dosing references.
- Length-based emergency systems when indicated.
- Standardized emergency medication charts when available.

Medication Administration

- Administered only by licensed personnel authorized within scope of practice.
- Administered as prescribed.
- Administered promptly after preparation.
- Documented immediately following administration when feasible.
- Patient identity will be verified prior to medication administration in accordance with Title 22 requirements.

Documentation

- Weight source
- Medication name
- Dose administered
- Route
- Time administered
- Patient response
- Adverse reactions if any
- Independent double-check completion when applicable.

REFERENCE:

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 7, § 70453. Comprehensive emergency medical service general requirements. (2024). California Office of Administrative Law. California Code of Regulations – Section 70453

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	PEDIATRIC DOSING GUIDELINES <u>7010.26 PEDIATRIC DOSING GUIDELINES</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 9, § 70537. Pediatric service general requirements. (2024). California Office of Administrative Law. California Code of Regulations – Section 70537

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 11, § 72313. Administration of medications and treatments. (2024). California Office of Administrative Law. California Code of Regulations – Section 72313

American Heart Association. (2020). *Pediatric advanced life support provider manual*. American Heart Association.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 7/2014
SUBJECT:	7010.26 MEDICATION RECONCILIATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish a standardized process for medication reconciliation to ensure accurate and complete medication information is communicated consistently across transitions of care in compliance with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and California Title 22 regulations.

This policy is intended to reduce medication errors, omissions, duplications, adverse drug interactions, contraindications, and inappropriate medication use.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Medication Reconciliation: process of obtaining and maintaining a complete and accurate list of all medications a patient is taking and comparing that list with ~~physician/provider~~ physician, nurse practitioner (NP) or physician assistant (PA) orders at every transition of care.

Transition of Care: any movement of a patient between healthcare ~~provider~~ physician, nurse practitioner (NP) or physician assistant (PA) s, ~~setting~~ settings, services, or levels of care.

POLICY:

It is the policy of Modoc Medical Center (MMC) to perform medication reconciliation for all patients upon admission or start of care, upon transfer between units or levels of care, upon discharge, and/or following a significant change in condition or treatment. An accurate and current medication list will be maintained in the medical records at all times. All discrepancies identified during the reconciliation process will be clarified and resolved by the licensed ~~nurse, MD, DO, provider~~ physician, nurse practitioner (NP) or physician assistant (PA) responsible for the patient's care.

PROCEDURE:

Admission Medication Reconciliation

- Upon admission or start of care, licensed nursing personnel will obtain and document a complete medication history including:
 - Prescription medications
 - Over-the-counter medications
 - Herbal supplements
 - Vitamins
 - Allergies and adverse reactions
 - Medication dose, route, frequency, and indication
- Sources used to verify medication information may include:
 - Patient interview
 - Family or caregiver interview

REFERENCE #	7010.26	EFFECTIVE: 7/2014
SUBJECT:	7010.26 MEDICATION RECONCILIATION	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- Pharmacy records
- Transfer records
- Medication bottles

Physician/provider physician, nurse practitioner (NP) or physician assistant (PA)

- documentation

- The attending physician/provider attending MD, DO, PA, NP will review the medication history and reconcile medications by determining which medications will be continued, modified, held, and/or discontinued.
- Clarification of discrepancies will occur prior to medication administration whenever possible.

Transfer Medication Reconciliation

- When a patient transfers between levels of care or units, the transferring nurse and receiving nurse will review the following:
 - Current medication orders
 - Recently discontinued medications
 - New medications
 - High-risk medications
- The provider attending MD, DO, PA, NP is responsible will reconcile transfer medication orders prior to administration.
- All transfer reconciliation activities will be documented in the medical record.

Discharge Medication Reconciliation

- Prior to discharge, the provider attending MD, DO, PA, NP will complete a final reconciliation of medications.
- The nurse will provide the patient and caregiver education regarding the medication administration, side effects, any precautions and follow-up instructions.

Documentation

- The medical record will contain documentation of the following:
 - Medication history
 - Allergies and adverse reactions
 - Medication reconciliation completion
 - Provider Attending physician, MD, DO, PA, NP review and authorization
 - Clarified discrepancies.
 - Patient education
 - Discharge medication instructions.
- Documentation will be completed in accordance with facility policy, CMS requirements, and California Title 22 regulations.

REFERENCE:

Centers for Medicare & Medicaid Services. (2023). Medication reconciliation condition of participation standards. U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services

California Department of Public Health. (2024). California Code of Regulations, Title 22, Division 5. State of California. California Department of Public Health

REFERENCE #	7010.26	EFFECTIVE: 7/2014
SUBJECT:	7010.26 MEDICATION RECONCILIATION	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

ATTACHMENTS:

None.

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

PURPOSE:

The purpose of this policy is to establish a standardized approach for the assessment, stabilization, diagnosis, treatment, and disposition of patients presenting to the Emergency Department with vaginal bleeding.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center (M MC) that aAll patients presenting with vaginal bleeding will receive timely triage, hemodynamic assessment, pregnancy evaluation when applicable, focused history and physical examination, appropriate laboratory and imaging studies, stabilization of acute hemorrhage, and specialty consultation when indicated. Pregnancy status must be determined in all patients of reproductive age. Hemodynamically unstable patients require immediate resuscitation and emergent physician evaluation.

PROCEDURE:

Triage and Initial Assessment

- Assess for the following conditions:
 - hHemodynamic instability
 - Active hemorrhage
 - Signs of shock
 - Severe abdominal/pelvic pain
 - Syncope
 - Fever or sepsis
 - Pregnancy-related emergencies
- Obtain vital signs to include blood pressure, heart rate, respiratory rate, temperature, oxygen saturation, and orthostatic vital signs if indicated.
- Immediate physician evaluation is required for patients with hypotension, tachycardia, altered mental status, heavy bleeding >1pad/hour, suspected ectopic pregnancy, pregnancy > 20 weeks with bleeding, and severe anemia symptoms.

Nursing Interventions

- Establish intravenous (IV) access with two large-bore IVs if patient is unstable.
- Place patient on monitor if patient is unstable.
- Quantify blood loss.
- Obtain pad count/history.
- Keep patient NPO (nothing by mouth) if surgery possible.
- Obtain urine sample.
- Administer oxygen if indicated.

History

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 BLEEDING STANDARD OF CARE <u>7010.26 VAGINAL BLEEDING STANDARD OF CARE</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

- Obtain focused history to include onset/duration of bleeding, quantity of bleeding/clots, last menstrual period, pregnancy status, gravida/par history, pelvic pain/cramping, syncope/dizziness, contraceptive use, history of fibroids/endometriosis, anticoagulant use, trauma or assault, sexually transmitted infection history, and menopausal status.

Physical Examination

- General appearance
- Abdominal examination
- Pelvic examination when indicated.
- Pelvic exam may be deferred in selected stable patients depending on clinical presentation and imaging availability.

Laboratory Studies

- Urine or serum pregnancy
- Complete blood count
- Type and screen/crossmatch.
- Complete metabolic panel
- Protime/International Normalized Ratio/Partial Thromboplastin Time
- Fibrinogen
- Blood cultures
- Quantitative pregnancy testing
- Sexually transmitted infection (STI) testing
- Rh typing
- Pregnancy testing is standard in all reproductive age patients with vaginal bleeding.

Imaging

- Transvaginal ultrasound or transabdominal ultrasound is preferred.
- Assess for intrauterine pregnancy, ectopic pregnancy, retained products, fibroids/polyps, ovarian pathology, and endometrial abnormalities.

Management of the Hemodynamically Unstable Patient

- Initiate IV crystalloids.
- Blood transfusion as indicated.
- Massive transfusion protocol if necessary
- Immediate Obstetrics and Gynecology (OB/GYN) consultation
- Surgical preparation if hemorrhage uncontrolled (transfer to higher level of care).

Management of the Hemodynamically Stable Patient

- Hormonal therapy
- Nonsteroidal anti-inflammatory drug (NSAIDs) if appropriate
- Tranexamic acid if indicated.
- Treatment for infection
- Outpatient gynecology follow-up

Pregnant Patients

- Evaluate for threatened abortion, inevitable abortion, incomplete abortion, ectopic pregnancy, and/or placental pathology.
- Administer Rh immune globulin when indicated.

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

Consultation Criteria

- Suspected ectopic pregnancy
- Hemodynamic instability
- Severe hemorrhage
- Need for operative intervention
- Pregnancy greater than 20 weeks
- Retained products of conception.
- Significant anemia/transfusion
- Postmenopausal bleeding concerning for malignancy.

Disposition

- Patients may be discharged if hemodynamically stable, bleeding controlled, hemoglobin stable, no emergent pathology identified and reliable follow up available.
- Discharge instructions to return immediately if increased bleeding, syncope, fever, severe pain, passage of large clots, and shortness of breath.

Documentation Requirements

- Quantity of bleeding
- Pregnancy status
- Vital signs
- Pelvic exam findings
- Laboratory/imaging results
- Reassessment
- Consultation discussions
- Disposition rationale

REFERENCE:

Post, T. W. (Ed.). (2024). *Approach to the adult with vaginal bleeding in the emergency department*. UpToDate. <https://www.uptodate.com>

ATTACHMENTS:

None.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>PEDIATRIC FEVER STANDARD OF CARE</u> <u>7010.26 PEDIATRIC FEVER STANDARD OF CARE</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized nursing care practices for pediatric patients presenting with fever in the Emergency Department (ED) to ensure timely assessment, intervention, escalation of care, patient safety, and compliance with evidence-based pediatric emergency care standards.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Fever: is defined as a rectal temperature >38.0 Celsius (100.4 Fahrenheit) in infants and young children.

Toxic Appearance: clinical signs suggestive of severe illness including lethargy, poor perfusion, cyanosis, hypoventilation or hyperventilation, altered mental status, and/or inconsolability.

Pediatric Sepsis: life-threatening organ dysfunction caused by dysregulated host response to infection.

POLICY:

It is the policy of Modoc Medical Center (MMC) that all pediatric patients presenting to the EDmergency Department with fever or history of fever will receive prompt triage, comprehensive nursing assessment, age-appropriate interventions, ongoing reassessment, caregiver education, and escalation of care when clinically indicated.

PROCEDURE:

Nurse Triage Assessment

- Initial Assessment
 - Temperature
 - Heart rate
 - Respiratory rate
 - Blood pressure
 - Oxygen saturation
 - Weight in kilograms
- Assess the following:
 - General appearance
 - Airway patency
 - Work of breathing
 - Circulation/perfusion
 - Hydration status
 - Level of consciousness
 - Pain level
 - Presence of rash
 - Capillary refill
- Assign Emergency Severity Index (ESI) level.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>PEDIATRIC FEVER STANDARD OF CARE7010.26PEDIATRIC FEVER STANDARD OF CARE</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

High-Risk Criteria

- Immediate ~~provider~~physician, nurse practitioner (NP) or physician assistant (PA), notification is required for the following:
 - Age less than 3 months with fever
 - Toxic appearance
 - Altered mental status
 - Respiratory distress
 - Petechiae or purpura
 - Seizure activity
 - Signs of dehydration
 - Persistent tachycardia
 - Hypotension
 - Immunocompromised condition
 - Suspected sepsis

History Collection

- Duration of fever
- Maximum recorded temperature
- Method of temperature measurement
- Recent antipyretic administration
- Oral intake
- Urine output
- Immunization status
- Exposure to ill contacts
- Recent travel
- Associated symptoms such as vomiting, diarrhea, cough, rash, ear pain, dysuria, neck stiffness, or seizures.

Temperature Measurement

- Less than 3 months old- rectal temperature preferred
- 3 months to 4 years old- rectal, temporal, or axillary temperature
- Greater than 4 years old- oral temperature preferred
- Rectal temperatures will not be performed in patients with contraindications including neutropenia, anorectal abnormalities, or recent rectal surgery.

Nursing Interventions

- Remove excessive clothing or blankets.
- Encourage oral hydration if tolerated.
- Initiate intravenous access if indicated (with ~~provider~~physician, NP or PA order).
- Administer antipyretics as ordered.
- Reassess patient ~~responseresponses~~ to interventions.
- Maintain age-appropriate safety measures.
- Implement isolation precautions per infection prevention policy.

Medication Administration (with ~~provider~~ physician, NP or PA order)

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	PEDIATRIC FEVER STANDARD OF CARE <u>7010.26 PEDIATRIC FEVER STANDARD OF CARE</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

- Acetaminophen standard pediatric dosing is 15~~fifteen~~ milligrams/kilograms/dose.
- Ibuprofen for patients 6 months and older standard dose is 10~~ten~~ milligrams/kilograms/dose.

Medication Safety

- The nurse will verify patient weight in kilograms.
- Confirm allergy history.
- Use the five rights of medication administration.
- Monitor for adverse reactions.
- Avoid aspirin administration in pediatric patients unless specifically ordered.

Febrile Infants < 60 days old

- Notify ~~provider~~ the provider physician, NP or PA
- immediately.
- Initiate continuous monitoring.
- Prepare for septic workup including blood cultures, urine specimen collection, and lumbar puncture assistance.
- Obtain intravenous access.
- Administer ordered fluids and antibiotics promptly.

Sepsis Screening

- All febrile pediatric patients will be screened for sepsis.

Sepsis Indicators

- Altered mental status
- Delayed capillary refill
- Tachycardia
- Hypotension
- Mottled skin
- Respiratory distress
- Decreased urine output
- Lethargy

Reassessment

- Vital signs
- Pain level
- Neurologic status
- Hydration status
- Respiratory status
- Medication effectiveness
- Reassessment frequency
 - Critical/unstable patient is continuous.
 - Moderate acuity is every 30-60 minutes.
 - Stable is prior to discharge.

Documentation

- Initial assessment findings
- Vital signs
- Interventions performed

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	PEDIATRIC FEVER STANDARD OF CARE <u>7010.26PEDIATRIC FEVER STANDARD OF CARE</u>	REVISED: 5/2026
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- Medication administration
- Reassessment findings
- Providerphysician, NP or PA
- notification
- Education provided
- Patient disposition

REFERENCE:

Emergency Nurses Association. (2023). *Emergency nursing pediatric course (ENPC) provider manual*.

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 ASSESSMENT 7010.26 NEUROLOGICAL ASSESSMENT	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish standardized requirements for neurological assessment, monitoring, documentation, escalation, and treatment of patients presenting to the Emergency Department (ED) with neurological symptoms or suspected neurological emergencies.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

physician, nurse practitioner (NP) or physician assistant (PA)

~~All ED emergency Department patients presenting with altered mental status, stroke symptoms, head injury, seizure activity, focal neurological deficits, spinal cord symptoms, or acute neurological deterioration will receive a timely neurological assessment performed by qualified licensed personnel.~~

Modoc Medical Center will maintain written policies and procedures governing emergency neurological care in accordance with California Title 22 regulations.

PROCEDURE:

Initial Neurological Screening

- A neurological screening assessment will be completed:
 - At triage for all patients with neurological complaints.
 - Immediately upon identification of neurological deterioration.
 - After trauma involving ~~head~~the head or spine.
 - Following seizure activity.
 - For all suspected stroke patients.
- The assessment will include:
 - Glasgow Coma Scale (GCS)
 - Pupils
 - Motor strength
 - Speech
 - Orientation
 - Sensory deficits
 - Vital signs

Stroke Assessment

- For suspected stroke:
 - Activate Stroke Alert per protocol.
 - Perform National Institute of Health Stroke Scale (NIHSS)
 - Establish "last known well" time.
 - Obtain point-of-care glucose.
 - Expedite ~~eat~~CT scan ~~/CTA~~eat scan angiogram imaging.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 ASSESSMENT 7010.26 NEUROLOGICAL ASSESSMENT	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

Frequency of Neurological Reassessment

- Neurological reassessments ~~by nurse, physician, MD, DO, PA, NP~~ will occur:
 - With any status change
 - After medication administration affecting neurological status
 - Post-procedure
 - During boarding in the ED
 - At intervals defined by acuity
- Suggested minimum frequencies:
 - Critical unstable neuro patient: every 15 minutes
 - Stroke/thrombolytic patient: per stroke protocol.
 - Moderate acuity neuro patient: every 1 hour
 - Stable patient: every 2-4 hours

Escalation Criteria

- Immediate ~~physician~~ notification to physician, MD, DO, PA, NP required for the following:
 - Decrease in GCS > 2 points.
 - New focal deficit
 - Unequal pupils
 - Seizure activity
 - Airway compromise
 - Sudden Severe headache
 - Acute agitation or unresponsiveness

Documentation Requirements

- Time of assessment
- Neurological findings
- NIHSS/GCS scores
- Changes from baseline
- Physician notification
- Interventions performed
- Response to treatment

REFERENCE:

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 6, 70455. Emergency medical services policies and procedures. (2026). Westlaw. <https://govt.westlaw.com/calregs/>

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 6, 70413. Nursing service-General requirements. (2026). Westlaw. <https://govt.westlaw.com/calregs/>

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 ASSESSMENT 7010.26 NEUROLOGICAL ASSESSMENT	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	010.26 VITAL SIGNS MONITORING FOR PEDIATRIC PATIENTS 7010.26 VITAL SIGNS MONITORING FOR PEDIATRIC PATIENTS	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish standardized procedures for assessment, monitoring, documentation, escalation, and reassessment of vital signs in pediatric patients presenting to the Emergency Department (ED), ensuring early recognition of clinical deterioration and timely intervention.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Emergency Severity Index (ESI) Levels is a 5-level triage system used in Emergency Departments to categorize patients based on severity/acuity of illness or injury and expected resource utilization.

POLICY:

~~It is the policy of Modoc Medical Center (MMC) that a~~All pediatric patients presenting to the Emergency Department will receive age-appropriate vital sign assessment upon arrival and ongoing reassessment based on acuity, condition, treatment interventions, and provider orders.

Vital sign monitoring frequency will increase with higher acuity levels, abnormal findings, administration of high-risk medications, procedural sedation, respiratory compromise, fever in young infants, trauma, sepsis risk, or clinical deterioration.

PROCEDURE:

Initial Assessment

- Vital signs will be obtained and documented at triage, upon placement in treatment room, prior to ~~provider~~physician, nurse practitioner (NP) or physician assistant (PA) evaluation when feasible, and before discharge or transfer.
- Vital signs include temperature, heart rate, respiratory rate, blood pressure, oxygen saturation, weight in kilograms, and pain score using ~~agean~~ age-appropriate scale.
- Staff will use appropriately sized blood pressures cuffs, pulse oximeter probes, and thermometers.

Frequency of Vital Sign Monitoring

- ESI Level 1 (Critical)-Continuous monitoring
- ESI Level 2- Every 15-30 minutes
- ESI Level 3- Every 1 hour
- ESI Level 4-5- Every 2-4 hours or prior to discharge
- Procedural Sedation-Per sedation protocol
- Post-medication/intervention- Within 15-60 minutes as clinically indicated.
- Patients with unstable or worsening conditions require more frequent monitoring at ~~provider~~physician, NP or PA discretion.

Continuous Monitoring Criteria

- Continuous cardiac and pulse oximetry monitoring will be used for pediatric patients with respiratory distress, oxygen requirement, seizures, altered mental status, sepsis concern, significant trauma, arrhythmias, procedural sedation, high-risk medication administration, and hemodynamic instability.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	010.26 VITAL SIGNS MONITORING FOR PEDIATRIC PATIENTS 7010.26 VITAL SIGNS MONITORING FOR PEDIATRIC PATIENTS	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Escalation of Care

- The nurse will immediately notify the ~~provider~~physician, NP or PA for any of the following:
 - Critically abnormal vital signs
 - Significant change from baseline
 - Persistent tachycardia or bradycardia
 - Respiratory distress
 - Hypoxia
 - Hypotension
 - Fever in infants less than 3 months old
 - Altered mental status.
 - Signs of sepsis or shock
- Activation of rapid response or resuscitation protocols will occur when clinically indicated.

Documentation Requirements

- Time vital signs obtained.
- All vital sign values
- Method/device if clinically relevant
- Patient behavior affects sing accuracy.
- Interventions performed
- Provider notification
- Reassessment after interventions
- All documentation will be entered into the electronic medical record (EMR) promptly.

Discharge Requirements

- Prior to discharge vital signs will be reassessed and documented.
- Abnormal findings must be addressed by the provider.
- Discharge may be delayed if the patient ~~demonstrated~~demonstrates unresolved instability.

Neonates and Young Infants

- Patients under three months with fever require immediate ~~provider~~physician, NP or PA evaluation and enhanced monitoring.

REFERENCE:

American Academy of Pediatrics, & American College of Emergency Physicians. (2018). *Guidelines for care of children in the emergency department*. *Pediatrics*, 142(5), e20182459.

<https://doi.org/10.1542/peds.2018-2459>

Emergency Nurses Association. (2023). *Emergency Severity Index (ESI) triage algorithm*. [Emergency Nurses Association](#)

American Heart Association. (2020). *Pediatric Advanced Life Support (PALS) provider manual*. [American Heart Association](#)

ATTACHMENTS:

None.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	010.26 VITAL SIGNS MONITORING FOR PEDIATRIC PATIENTS 7010.26 VITAL SIGNS MONITORING FOR PEDIATRIC PATIENTS	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 PEDIATRIC RIGHTS AND RESPONSIBILITIES OF PARENTS/GUARDIANS	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish guidelines for recognizing and protecting the rights of pediatric patients and defining the responsibilities of parents/guardians in the Emergency Department (ED) in accordance with California Title 22 regulations, Emergency Medical Treatment and Labor Act (EMTALA) requirements, patient rights standards and applicable state and federal laws.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Parent/Guardian: an individual legally authorized to consent for healthcare treatment of a minor patient.

Emergency Medical Conditions: a medical condition manifesting acute symptoms of sufficient severity such that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health or bodily functions.

POLICY:

It is the policy of Modoc Medical Center (MMC) that the Emergency Department will provide pediatric emergency care in a safe, respectful, family-centered, and developmentally appropriate manner. Pediatric patients and their parents/guardians will be informed of patient rights and responsibilities upon presentation to the Emergency Department whenever feasible. Emergency medical screening examinations and stabilizing treatment will be provided without discrimination and without delay for financial or custodial reasons.

PROCEDURE:

Patient Rights

- Pediatric patients and their parents/guardians have the right to the following:
 - Receive an appropriate medical screening examination and stabilizing treatment in accordance with EMTALA requirements.
 - Receive care in a safe, respectful and non-discriminatory environment regardless of race, color, religion, national origin, disability, sex, gender identity, sexual orientation, insurance status, and/or ability to pay.
 - Be treated with dignity, consideration, and respect for personal values, beliefs, and cultural preferences.
 - Participate in care decisions consistent with the patient's age, developmental level, and legal authority of the parent/guardian.
 - Receive information regarding diagnosis, treatment options, risks and benefits, alternatives to treatment, expected outcomes, and discharge instructions.
 - Receive information in a language or communication format understandable to the patient and family, including interpreter services when necessary.
 - Privacy and confidentiality of medical information in accordance with applicable laws governing minor consent and protected health information.
 - Pain assessment and appropriate pain management interventions.

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 PEDIATRIC RIGHTS AND RESPONSIBILITIES OF PARENTS/GUARDIANS	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- Family presence during treatment and resuscitation when clinically appropriate and operationally feasible.
- Protection from abuse, neglect, exploitation, harassment, or unnecessary restraint.
- Appropriate transfer to another facility when specialized pediatric services are required and unavailable at this facility.
- Access to the [hospital's](#) grievance process without fear of retaliation.

Responsibilities of Parents/Guardians

- Providing accurate and complete information regarding medical history, allergies, medications, immunization status, previous [treatments](#), and emergency contact information.
- Providing legal documentation regarding custody, guardianship, or healthcare decision-making authority when applicable.
- Participating in treatment planning and discharge education.
- Following hospital safety, infection prevention, and visitation requirements.
- Supervising pediatric patients when appropriate.
- Treating staff, providers, and other patients respectfully.
- Asking questions when treatment plans or instructions are unclear.
- Complying with discharge instructions and arranging recommended follow-up care.
- Informing staff immediately of changes in the patient's condition.
- Refraining from threatening, abusive, or disruptive behavior.

Consent for Treatment

- Consent for non-emergent treatment will be obtained from the parent or legal guardian whenever possible.
- Emergency treatment will not be delayed when immediate intervention is necessary to prevent serious harm or deterioration.
- Telephone consent may be accepted following hospital policy and documentation requirements.
- Minor consent services permitted under California law will be honored in accordance with applicable [statutes](#) and confidentiality requirements.
- All consent discussions and attempts to contact parent/guardians will be documented in the medical record.

Documentation

- The following will be documented in the electronic medical record as applicable:
 - Consent for treatment
 - Parent/guardian involvement
 - Education provided
 - Interpreter utilization
 - Refusal of care
 - Transfer arrangements
 - Abuse reporting
 - Discharge instructions

REFERENCE:

California Department of Public Health. (2024). *California Code of Regulations, Title 22, Division 5: Licensing and certification of health facilities*. [California Department of Public Health Title 22 Regulations](#)

REFERENCE #	7010.26	EFFECTIVE: 10/2007
SUBJECT:	7010.26 PEDIATRIC RIGHTS AND RESPONSIBILITIES OF PARENTS/GUARDIANS	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

Centers for Medicare & Medicaid Services. (2024). *State operations manual appendix V – Interpretive guidelines: Responsibilities of Medicare participating hospitals in emergency cases (EMTALA)*. [Centers for Medicare & Medicaid Services](#)

ATTACHMENTS:

None.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 9/2006
SUBJECT:	OPSITE WOUND DRESSING APPLICATION AND MANAGEMENT <u>7010.26 OPSITE WOUND DRESSING APPLICATION AND MANAGEMENT</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish a standardized procedure for the application, maintenance, monitoring, and removal of OPSITE wound dressings by nursing staff to promote optimal wound healing, minimize infection risk, and ensure patient safety and comfort.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

OPSITE Dressing: a transparent adhesive film dressing designed to provide a waterproof bacterial barrier while maintaining a moist wound healing environment.

Aseptic Technique: practices and procedures performed to minimize contamination by pathogens.

POLICY:

It is the policy of Modoc Medical Center (MMC) that OPSITE wound dressings will be applied and managed by trained healthcare personnel using aseptic techniques and in accordance with physician orders, manufacturer guidelines, and established wound care standards. OPSITE dressings will be used only for appropriate wound types and will be monitored routinely for effectiveness, integrity, and signs of complications.

PROCEDURE:

Preparation

- Verify physician or authorized ~~provider~~ physician, MD, DO, PA or NP order.
- Identify patient using approved identifiers.
- Explain procedure to the patient.
- Perform hand hygiene.
- Assemble required supplies.
- Apply gloves and appropriate personal protective equipment (PPE) as indicated.

Wound Assessment

- The ~~healthcare provider~~ nurse, physician, MD, DO, PA or NP will assess and document the following:
 - Wound location
 - Size and depth
 - Tissue appearance
 - Amount and type of drainage.
 - Condition of surrounding skin
 - Presence of odor, redness, swelling, or other signs of infection
 - Photograph wound using the IPAD to upload photos to the patient's electronic medical record.

Cleansing Procedure

- Remove old dressing carefully (if applicable).
- Dispose of dressing according to infection control procedures.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 9/2006
SUBJECT:	OPSITE WOUND DRESSING APPLICATION AND MANAGEMENT <u>7010.26 OPSITE WOUND DRESSING APPLICATION AND MANAGEMENT</u>	
DEPARTMENT:	EMERGENCY DEPARTMENT	REVISED: 5/2026

- Cleanse wound with normal saline or prescribed solution.
- Dry surrounding skin thoroughly.
- Maintain aseptic technique throughout procedure.

OPSITE Dressing Application

- Open sterile dressing package carefully.
- Remove backing from dressing without contaminating adhesive surface.
- Center dressing over wound with at least 2–3-centimeter border on intact skin.
- Smooth dressing from center outward to remove wrinkles and air pockets.
- Ensure dressing edges are secure.
- Date and initial dressing.

Dressing Changes

- Every 3-7 days as clinically indicated or immediately if dressing becomes loose, saturated, leaking, soiled, or damaged.
- More frequent dressing changes may be required for wounds with increased drainage or signs of infection.

Dressing Removal

- Perform hand hygiene and don gloves.
- Gently lift one edge of dressing.
- Stretch dressing horizontally parallel to the skin to release adhesive.
- Avoid pulling upward to minimize skin trauma.
- Dispose of dressing appropriately.
- Reassess wound condition.

Documentation

- Date and time of dressing application/change.
- Wound assessment findings
- Type and size of dressing used.
- Drainage characteristics
- Patient tolerance of procedure
- Education provided
- Any complications or provider notifications
- Photographs uploaded to patient's electronic medical record.

REFERENCE:

Smith & Nephew. (n.d.). *OPSITE post-op wound dressings*. Smith & Nephew. <https://www.smith-nephew.com/en/health-care-professionals/products/advanced-wound-management/opsite-post-op-global>

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CENTRAL VENOUS CATHETER- TROUBLESHOOTING AND MANAGEMENT OF CATHETER DYSFUNCTION	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to provide a standardized approach for assessment and management of central venous catheter malfunction while minimizing risks of infection, thrombosis, catheter damage, and treatment delays.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Central Venous Catheter (CVC): a vascular access device with the catheter tip terminating in the superior vena cava, inferior vena cava, or right atrium.

Catheter Dysfunction: an inability to infuse fluids, withdraw blood, or both, through a central venous catheter.

POLICY:

It is the policy of Modoc Medical Center (MMC) that patients with central venous catheters will receive consistent, evidence-based assessment and management when catheter dysfunction occurs. A systematic approach to troubleshooting will be used to identify and address mechanical, positional, thrombotic, infectious, or device-related causes of catheter malfunction.

PROCEDURE:

Initial Assessment

- Stop the infusion if resistance, pain, leakage, or swelling is observed.
- Assess the patient for pain, swelling, redness, fever, chills, shortness of breath, neck, facial, or extremity edema.
- Inspect the catheter and administration set for kinks, closed clamps, loose connections, cracks or damage, and external catheter migration.
- Verify correct positioning of all needleless connectors and extension tubing.

Mechanical and Positional Troubleshooting

- If no evidence of catheter damage is identified:
 - Reposition the patient by raising the arm on the affected side, turning the head side to side, having the patient cough, having the patient take deep breaths and changing from supine to upright position.
- Attempt gentle aspiration for blood return.
- If blood return is obtained, assess catheter function, and resume use as clinically appropriate.

Suspected Catheter Occlusion

- Partial Occlusion indicators include:
 - Sluggish flushing.
 - Sluggish blood return.
 - Intermittent infusion flow.
- Reassess for mechanical or positional causes.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CENTRAL VENOUS CATHETER-TROUBLESHOOTING AND MANAGEMENT OF CATHETER DYSFUNCTION	REVISED: 6/2026
DEPARTMENT:	NURSING -MED SURG	

- Notify the ~~provider~~physician, nurse practitioner (NP) or physician assistant (PA) if it is unresolved.
- Follow ~~provider~~ physician, NP or PA orders regarding catheter clearance or additional evaluation.

Complete Occlusion

- Indicators include:
 - Inability to flush.
 - Inability to aspirate blood.
- Do not use the catheter.
- Notify the ~~provider~~ physician, NP or PA promptly.
- Follow the ~~provider~~ physician, NP or PA orders for treatment of diagnostic evaluation.

Suspected Catheter Migration or Thrombosis

- Signs and symptoms may include the following:
 - Change in external catheter length.
 - Arm swelling.
 - Neck swelling.
 - Facial swelling.
 - Pain during infusion.
 - Loss of blood return.
- Discontinue catheter use.
- Notify the ~~provider~~physician, NP or PA immediately.
- Obtain diagnostic studies as ordered.
- Do not manipulate or advance the catheter.

Suspected Catheter-Related Infection

- Signs and symptoms include fever, chills, erythema at the insertion site, tenderness, drainage, or unexplained sepsis.
- Notify the ~~provider~~physician, NP or PA immediately.
- Obtain cultures and laboratory studies as ordered.
- Follow hospital infection prevention and bloodstream infection protocols.
- Administer treatment as ordered.

Prohibited Practices

- Forcing fluid into an occluded catheter.
- Using excessive pressure when flushing.
- Using syringes smaller than ten milliliters (mL) for catheter flushing unless specifically approved by the catheter manufacturer.
- Attempting catheter repair unless authorized by hospital policy and manufacturer instructions.
- Using a catheter with suspected rupture, migration, or damage.

~~Provider~~ Physician, NP or PA Notification

- Inability to flush or aspirate.
- Catheter leakage.
- Suspected catheter rupture.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CENTRAL VENOUS CATHETER- TROUBLESHOOTING AND MANAGEMENT OF CATHETER DYSFUNCTION	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

- Suspected thrombosis.
- Suspected catheter migration.
- Signs of bloodstream infection.
- New swelling of the arm, neck, chest, or face.
- Patient pain is associated with catheter use.

Documentation

- Date and time of assessment.
- Patient signs and symptoms.
- Catheter type and location.
- Troubleshooting measures performed.
- Presence or absence of blood return.
- Patency assessment findings.
- ~~Provider~~ Physician, NP, PA notification.
- Orders received.
- Interventions performed.
- Patient response to interventions.

REFERENCE:

Centers for Disease Control and Prevention. (2024). *Guidelines for the prevention of intravascular catheter-related infections*. U.S. Department of Health and Human Services. <https://www.cdc.gov/infection-control/hcp/intravascular-catheter-related-infection/>

Infusion Nurses Society. (2024). *Infusion therapy standards of practice* (9th ed.). Infusion Nurses Society.

ATTACHMENTS:

None.

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

PURPOSE:

The purpose of this policy is to establish a standardized approach for the assessment, diagnosis, treatment, and disposition of patients presenting to the Emergency Department with vomiting, ensuring timely identification of life-threatening conditions and appropriate management of symptoms and underlying causes.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center (MMC) that All patients presenting with vomiting will undergo prompt triage, focused clinical assessment, and risk stratification to identify emergent or life-threatening etiologies. Management will be directed toward stabilization, symptom control, correction of physiologic derangements, and identification of the underlying cause.

PROCEDURE:

Triage and Initial Assessment

- All patients presenting with vomiting will undergo immediate nursing triage including vital signs, pain score assessment and assessment of hydration status and mental status.
- Patients exhibiting any of the following require immediate physician evaluation:
 - Hemodynamic instability (hypotension, tachycardia, shock)
 - Altered mental status.
 - Hematemesis or coffee-ground emesis
 - Severe or focal abdominal pain
 - Signs of peritonitis
 - Suspected bowel obstruction (bilious vomiting, abdominal distension)
 - Neurologic symptoms (severe headache, focal deficit)
 - Pregnancy with concerning symptoms
 - Inability to tolerate oral intake with dehydration.

Medical Screening Evaluation (provider)

- Obtain history to include onset, duration, frequency, and character of vomiting.
- Associated symptoms (pain, fever, diarrhea, neurologic symptoms)
- Medication and toxin exposure
- Substance use history.
- Surgical history (especially abdominal surgery)
- Pregnancy risk assessment when applicable
- General appearance and hydration status
- Abdominal examination (tenderness, distention, bowel sounds)
- Neurologic evaluation when indicated.
- Cardiopulmonary assessment as clinically indicated.

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

Diagnostic Testing

- Urine or serum pregnancy test for all patients of childbearing potential
- Complete blood count
- Comprehensive metabolic panel
- Liver function tests and lipase when indicated.
- Urinalysis
- Serum glucose
- Computed tomography (CT) abdomen/pelvis for suspected surgical abdomen, obstruction, or unclear diagnosis
- Ultrasound for hepatobiliary disease or pregnancy-related pathology
- Neuroimaging for concerning neurologic findings.

Treatment and Management

- Establish intravenous access as indicated/ordered.
- Administer isotonic intravenous fluids for dehydration as ordered.
- Correct electrolyte abnormalities
- Antiemetic therapy per provider discretion
- Maintain NPO (nothing by mouth) status if surgical pathology is suspected.
- Treatment will be directed at the underlying cause when identified, including but not limited to:
 - Gastroenteritis: supportive care and hydration
 - Bowel obstruction: surgical consultation and decompression
 - Metabolic disorders: correction of underlying abnormality
 - Migraine-associated vomiting: migraine-specific therapy
 - Cannabinoid hyperemesis syndrome: antiemetics, hydration, supportive care

Reassessment and Monitoring

- Patients will be reassessed following initial therapy.
- Response to antiemetic therapy and fluid resuscitation must be documented.
- Oral intake tolerance will be evaluated prior to discharge when appropriate.
- Serial abdominal examinations will be performed when indicated.

Disposition Criteria

- Patients may be discharged when all the following are met:
 - Hemodynamically stable
 - Symptoms improved or resolved.
 - Able to tolerate oral intake.
 - No emergent or surgical diagnosis [identifiedis identified.](#)
 - Appropriate follow-up arranged

Admission Criteria

- Persistent or intractable vomiting
- Electrolyte abnormalities require correction.
- Suspected or confirmed surgical abdomen (transfer to higher level of care)
- Inability to maintain hydration orally.
- Uncertain diagnosis requiring further evaluation.
- High-risk patient populations (elderly, immunocompromised, pregnancy complications)

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

Documentation Requirements

- History and physical examination findings
- Differential diagnosis considerations
- Diagnostic reasoning for tests ordered or deferred.
- Treatment provided and patient response
- Disposition decision-making rationale.

REFERENCE:

UpToDate. (2025). *Approach to the adult with nausea and vomiting*. Wolters Kluwer.

<https://www.uptodate.com>

American College of Emergency Physicians. (2019). *Clinical policy: Critical issues in the evaluation and management of emergency department patients with abdominal pain*. <https://www.acep.org>

ATTACHMENTS:

None.

REFERENCE #	<u>7010.26</u>	EFFECTIVE: 10/2007
SUBJECT:	<u>RELEASE OF PATIENT INFORMATION</u> <u>7010.26 RELEASE OF PATIENT INFORMATION</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish guidelines and procedures for the protection, use, disclosure, and release of patient protected health information (PHI) in compliance with Health Insurance Portability and Accountability Act (HIPAA), California Code of Regulations, Title 22, California Health & Safety Code, and other applicable federal and state confidentiality laws. This policy ensures the confidentiality, integrity, and security of patient information while permitting lawful and authorized disclosures.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Protected Health Information (PHI): individually identifiable health information maintained or transmitted in any form or medium.

Release of Information (ROI): the authorized disclosure of patient health information to patients, representatives, agencies, or third parties.

Minimum Necessary Standard: limiting use, disclosure, or requests for PHI to the minimum amount necessary to accomplish the intended purpose.

POLICY:

It is the policy of Modoc Medical Center (MMC) that Aall patient medical records and protected health information (PHI) maintained by this facility are confidential and will be released only in accordance with applicable federal and state laws and regulations. Protected health information may be disclosed only with a valid written authorization from the patient or legally authorized representative; as permitted or required by law; for treatment, payment, or healthcare operations; pursuant to court order, subpoena, or authorized government request; or under mandatory reporting obligations. Modoc Medical Center will implement safeguards to prevent unauthorized access, use, disclosure, alteration, or destruction of PHI.

PROCEDURE:

Authorization for Release of Information

- A valid authorization for release of information must include the following:
 - Patient full name and date of birth.
 - Specific description of information to be disclosed.
 - Name of person or entity authorized to disclose information.
 - Name of recipient or receiving entity.
 - Purpose of disclosure.
 - Expiration date or event.
 - Patient or legal representative signature.
 - Date signed.
 - Documentation or representation authority, if applicable.

Revocation

- Patients may revoke authorization in writing at any time except to the extent that action has already been taken in reliance upon the authorization.

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DEPARTMENT:	EMERGENCY DEPARTMENT	

Verification of Identity

- Prior to releasing PHI, staff will verify the identity and authority of the requesting party/agency.
- Acceptable verification includes:
 - Government-issued photo identification
 - Matching demographic information.
 - Legal documentation establishing authority.
- Examples include:
 - Durable Power of Attorney
 - Guardianship papers
 - Conservatorship documents
 - Executor documentation
 - Parent/legal guardian verification for minors

Disclosures Without Authorization

- PHI may be disclosed without patient authorization as permitted by law for the following:
 - Coordination and management of healthcare among providers.
 - Billing, claims processing, insurance verification, and reimbursement activities.
 - Quality assessment, accreditation, compliance, training, and auditing activities.
 - Public Health and Legal Requirements including but not limited to the following:
 - Reporting abuse or neglect.
 - Communicable disease reporting.
 - Coroner or medical examiner requests.
 - Law enforcement requests as authorized by law.
 - Court orders and subpoenas.
 - Disaster relief purposes.

Special Confidential Records

- Additional protections apply to the following:
 - Mental health records.
 - Substance use disorder treatment records.
 - Human Immunodeficiency Virus (HIV)/acquired immunodeficiency syndrome (AIDS) related information.
 - Genetic testing records.
 - Psychotherapy notes.
 - Sexual Assaults/Exams.
- These records will not be released without appropriate authorization or legal review as required by law.

Processing Requests

- Requests for access or copies of records will be processed within timelines required by HIPAA and California law.
- All requests for release of information should be processed through the Medical Records department.
- The following will be documented for each disclosure:
 - Date of disclosure.
 - Recipient name.
 - Description of records disclosed.

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- Purpose of the disclosure.
- Method of transmission.
- Staff member processing request.
- Disclosure logs will be maintained in accordance with regulatory requirements. The log is maintained by the Medical Records department.

Methods of Release

- Secure electronic transmission.
- Encrypted email.
- Secure fax transmission.
- Certified mail.
- In-person pickup with identification verification.
- Unsecured transmission methods will only be used upon a documented patient request and acknowledgment of associated risks.

Denial of Requests

- Requests for release of information may be denied with the following:
 - Authorization is incomplete or invalid.
 - Identity cannot be verified.
 - Disclosure is prohibited by law.
 - Requested records are exempt from access.
 - Disclosure may endanger the patient or another individual.
- Denials will be documented and communicated in accordance with legal requirements.

REFERENCES:

Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936 (1996).

U.S. Department of Health & Human Services, Office for Civil Rights. (n.d.). *Summary of the HIPAA Privacy Rule*. <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

ATTACHMENTS:

None

REFERENCE #	7010.26 Click or tap here to enter text.	EFFECTIVE: 10/2007
SUBJECT:	ORGAN/TISSUE/EYE DONATION NURSING STAFF RESPONSIBILITIES7010.26 ORGAN/TISSUE/EYE DONATION NURSING STAFF RESPONSIBILITIES	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized procedures for the identification, referral, management, and support of potential organ and tissue donors in compliance with applicable California law, Title 22 regulations, federal requirements, and standards of practice.

AUDIENCE:

Department Wide

TERMS AND DEFINITIONS: ~~DEFINITION:~~

Organ Procurement Organization (OPO): the federally designated organization responsible for organ and tissue donation coordination within the hospital service area.

Brain Death: irreversible cessation of all functions of the entire brain, including the brain stem, determined in accordance with accepted medical standards and hospital policy.

POLICY:

It is the policy of Modoc Medical Center ([MMC](#)) to support organ and tissue donation in accordance with California Health and Safety Code 7184, California Title 22, Division 5, Federal Centers for Medicare & Medicaid Services (CMS) Conditions of Participation, Organ Procurement Organization (OPO) requirements, and accepted ethical and professional nursing standards. All nursing personnel will participate in the timely identification and referral of potential organ and tissue donors while ensuring compassionate care, patient dignity, family support, confidentiality, and compliance with applicable laws and regulations.

PROCEDURE:

Identification of Potential Donors

- Nursing staff will notify the OPO immediately when any of the following occur:
 - Imminent death
 - Severe neurologic injury
 - Glasgow Coma Scale (GCS) indicating grave prognosis.
 - Ventilator dependency with poor neurologic status
 - Planned withdrawal of life-sustaining treatment
 - Brain death evaluation initiation
 - Cardiac death meeting tissue donation criteria
- Referrals will occur in accordance with hospital-defined clinical triggers and OPO agreements.

Organ Procurement Organization Notification

- The nurse will contact the designated OPO as soon as clinical triggers are identified.
- The following information will be provided:
 - Patient demographics
 - Clinical condition
 - Ventilator status
 - Neurologic findings
 - Current treatment measures

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DEPARTMENT:	EMERGENCY DEPARTMENT	

- Documentation of referral will include date and time of notification, name of OPO representative and any instructions received.

Maintenance of Potential Donor

- Until donation eligibility is determined and/or authorization status is clarified, nursing staff will (if possible) maintain hemodynamic stability, oxygenation and ventilation, maintain body temperature and tissue perfusion, continue infection prevention measures, administer medications and fluids as ordered, and monitor laboratory values and urine output.
- Care will continue in collaboration with the attending physician and OPO representatives.

Family Communication and Support

- Nursing staff will provide emotional support and compassionate care to the patient's family or legal representative.
- Discussions regarding prognosis and end-of-life decisions will occur separately from donation discussions whenever possible.
- Donation authorization discussions will be conducted by trained OPO personnel or authorized requestors.
- Cultural, religious, and spiritual beliefs will be respected at all times.
- Chaplaincy, social services, and interpreter services will be offered as appropriate.

Brain Death Determination

- Brain death determination will be performed only by qualified physicians in accordance with hospital policy and accepted medical standards.
- Nursing staff will assist with neurologic assessments, preparation for testing and physiologic support during evaluation.
- Documentation will contain all assessments, interventions, and physician determinations.

Documentation Requirements

- Clinical triggers identified
- Date and time of OPO notification.
- Name of the OPO coordinator
- Family support interventions
- Physician notifications
- Orders implemented
- Physiologic support measures
- Donation outcomes when applicable

REFERENCE:

Centers for Medicare & Medicaid Services. (2023). *State operations manual appendix A – Survey protocol, regulations, and interpretive guidelines for hospitals*. U.S. Department of Health and Human Services. <https://www.cms.gov/>

California Code of Regulations, Title 22, Division 5, Chapter 3. General acute care hospitals. (2024). California Office of Administrative Law. <https://govt.westlaw.com/calregs/>

REFERENCE #	7010.26 Click or tap here to enter text.	EFFECTIVE: 10/2007
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DEPARTMENT:	EMERGENCY DEPARTMENT	

ATTACHMENTS:

None.

REFERENCE #	<u>7010.26</u> Click or tap here to enter text.	EFFECTIVE: 10/2007
SUBJECT:	WOUND CARE STANDARD OF CARE <u>7010.26 WOUND CARE STANDARD OF CARE</u>	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

PURPOSE:

The purpose of this policy is to establish standardized clinical guidelines for the assessment, treatment, documentation, and follow-up care of patients presenting to the Emergency Department with acute wounds, in accordance with current evidence-based practice, regulatory standards, and patient safety requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Primary Closure: immediate approximation of wound edges using suture, staples, tissue adhesive, or adhesive strips.

Delayed Primary Closure: closure performed after a period of observation due to increased risk of infection.

Secondary Intention: allowing a wound to heal naturally without surgical closure.

POLICY:

~~It is the policy of Modoc Medical Center (MMC)~~It is the policy of that the Emergency Department ~~to~~ provide timely, safe, and evidence-based wound care management to all patients presenting with traumatic or non-traumatic wounds. Wound care interventions will be performed by qualified personnel within their scope of practice. All wounds will be assessed for severity, contamination, neurovascular compromise, infection risk, and need for specialty consultation.

PROCEDURE:

Initial Assessment

- Patients presenting with wounds will receive triage assessment according to Emergency Severity Index (ESI) criteria.
- Active hemorrhage will receive immediate intervention.

Nursing Assessment

- The nurse will document mechanism of injury, time of injury, pain assessment, wound location and dimensions, bleeding status, presence of contamination, neurovascular status, allergies, and tetanus immunization status.

Provider Assessment

- ~~The provider~~physician, nurse practitioner (NP) or physician assistant (PA) will assess the depth and extent of injury, tendon, nerve, vascular, or joint involvement, presence of foreign bodies, signs of infection, or need for imaging or specialty consultation.

Infection Control

- Standard precautions will be observed for all wound care procedures.
- Appropriate personal protective equipment (PPE) will be utilized based on anticipated exposure risk.
- Sterile techniques will be maintained during invasive wound procedures.

Pain Management

- Analgesia will be provided based on patient condition and procedural requirements.

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- Local anesthetics, topical anesthetics, oral analgesics, intravenous analgesics, or procedural sedation may be utilized as clinically indicated.
- Pain reassessment will be documented following intervention.

Wound Cleansing and Irrigation

- Gross contamination and debris will be removed prior to closure.
- Wounds will be irrigated using sterile saline or approved irrigation solutions.
- High-pressure irrigation will be used when appropriate for contaminated wounds.
- Devitalized tissue will be debrided when clinically indicated.
- Cytotoxic agents will not be routinely used within the wound bed unless specifically indicated.

Diagnostic Studies

- May be ordered for suspected retained foreign body, associated fractures, joint penetration, deep tissue injury, or vascular injury.
- Imaging modalities may include radiography, ultrasound, or computed tomography.

Wound Closure

- Acceptable closure methods include sutures, staples, tissue adhesive, adhesive strips, and packing/open management.
- Contraindications to primary closure may include gross contamination, established infection, delayed presentationpresentation, or extensive tissue devitalization.

Dressings

- Appropriate dressings will be applied following wound treatment.
- Dressings will promote protection, moisture balance, and hemostasis.
- Splinting or immobilization may be applied when clinically indicated.

Medication Management

- Tetanus Prophylaxis will be advised and given w/patient consent
- Antibiotic therapy may be prescribed for bite wounds, open fractures, grossly contaminated wounds, immunocompromised patients, or high-risk puncture wounds.

Discharge Instructions

- Wound care
- Dressing changes
- Medication Administration
- Signs and symptoms of infection
- Activity restrictions
- Follow-up appointments
- Return precautions
- Suture or staple removal time frame
- Patient understanding will be documented.

Documentation

- Assessment finding
- Neurovascular status before and after treatment
- Procedure details
- Irrigation solution and volume
- Anesthesia administered

REFERENCE #	7010.26 Click or tap here to enter text.	EFFECTIVE: 10/2007
SUBJECT:	WOUND CARE STANDARD OF CARE 7010.26 WOUND CARE STANDARD OF CARE	REVISED: 5/2026
DEPARTMENT:	EMERGENCY DEPARTMENT	

- Wound closure material
- Dressing type
- Patient tolerance
- Medications administered
- Tetanus status
- Discharge instructions
- Follow-up plan

REFERENCE:

Centers for Disease Control and Prevention. (2024). *Clinical guidance for wound management to prevent tetanus*. [Centers for Disease Control and Prevention – Tetanus Wound Management](#)

Emergency Nurses Association. (2023). *Emergency nursing scope and standards of practice* (3rd ed.). [Emergency Nurses Association](#)

ATTACHMENTS:

None

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 AM CARE POLICY	REVISED: 5/2026
DEPARTMENT:	NURSING -MED SURG	

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PURPOSE:

The purpose of this policy is to provide consistent, safe, patient-centered morning care to medical/surgical patients that ~~promotes~~promote hygiene, comfort, dignity, infection prevention, mobility, and readiness for daily treatments.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center (MMC) that all medical/surgical patients admitted to Modoc Medical Center (MMC) will receive individualized morning care according to their physical condition, provider orders, infection prevention precautions, and personal preferences. Morning care will be delivered in a manner that maintains patient dignity and privacy, promotes skin integrity and comfort, encourages independence, when possible, supports fall prevention and patient safety, meets infection control standards and prepares patients for meals, therapies, testing and provider rounds.

PROCEDURE:

Initial Assessment

- The assigned nurse will assess the patient's level of consciousness, mobility status, ability to perform self-care, pain level, fall risk, skin condition, and infection control precautions.
- Determine the level of assistance required.

Preparation

- Perform hand hygiene before and after patient care.
- Verify patient identity using two identifiers.
- Explain the procedure to the patient.
- Provide privacy using curtains and doors.
- Gather required supplies before beginning care.

Components of Morning Care

- Oral hygiene/denture care.
- Face and hand washing.
- Bathing or shower assistance.
- Perineal care.
- Grooming and hair care.
- Shaving if requested and appropriate.
- Linen and gown change.
- Toileting assistance.
- Ambulation or repositioning.
- Skin assessment
- Application of prescribed lotions or treatments.
- Emptying drainage devices as indicated.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 AM CARE POLICY	REVISED: 5/2026
DEPARTMENT:	NURSING -MED SURG	

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- Ensuring assistive devices are accessible.

Safety Measures

- Maintain bed in low position when unattended.
- Use gait belts or assistive devices as indicated.
- Follow fall precautions.
- Ensure call light is within reach.
- Observe for dizziness, weakness, pain, or intolerance to activity.
- Stop care and notify the nurse responsible for patient/provider if patient condition changes.

Infection Prevention

- Follow standard precautions and transmission-based precautions as indicated.
- Use proper personal protective equipment.
- Avoid cross-contamination of supplies.
- Dispose of linens and waste per hospital infection control policy.

Patient Participation

- Patients will be encouraged to perform self-care activities to the maximum extent possible unless contraindicated.

Documentation

- Type of care provided.
- Level of assistance required.
- Patient tolerance/response.
- Skin abnormalities.
- Mobility status.
- Refusal of care.
- Education provided.
- Safety concerns or changes in condition.

REFERENCE:

Centers for Medicare & Medicaid Services. (n.d.). *Critical access hospitals*. U.S. Department of Health & Human Services. <https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals>

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 10/2007
SUBJECT:	6170.26 ANTICOAGULATION THERAPY	
DEPARTMENT:	NURSING -MED SURG	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish a standardized procedure for the safe prescribing, administration, monitoring, reversal, and documentation of anticoagulation therapy to minimize the risk of bleeding, thromboembolic events and medication-related adverse outcomes.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Anticoagulation Therapy: is the administration of medication intended to prevent or threat thromboembolic disorders.

Therapeutic Anticoagulation: anticoagulant dosing intended to achieve systemic anticoagulation for treatment or prevention of thrombosis.

High-Alert Medications: are medications that bear a heightened risk of causing significant patient harm when used in error.

POLICY:

It is the policy of Modoc Medical Center (MMC) that all anticoagulation therapy will be managed using evidence-based protocols, standardized monitoring practices, and interdisciplinary collaboration to ensure safe and effective patient care.

Anticoagulants are designated as high-alert medications and will be prescribed by the physician, nurse practitioner (NP) or physician assistant (PA) and administered, monitored and documented by licensed nursing staff in accordance with this policy and applicable regulatory standards.

PROCEDURE:

Baseline Assessment Prior to Initiation by ~~attending~~-physician, PNA, FNPA

- Prior to initiating anticoagulation therapy, the following will be completed when clinically feasible:
 - Baseline laboratory testing to include complete blood count (CBC), prothrombin time (PT)/international normalized ratio (INR), partial thromboplastin time (aPTT), serum creatinine, and liver function test.
 - Assessment to include bleeding history, fall risk, renal impairment, hepatitis impairment, concurrent medications, allergies, and prior history of heparin-induced thrombocytopenia (HIT).

Medication Management by Nursing Staff

- Unfractionated Heparin (UFH)
 - Intravenous heparin will be administered using standardized dosing protocols.
 - Infusions will utilize infusion pumps for administration.
 - Independent double-checks will be completed prior to initiation and rate changes.
 - Monitoring will include aPTT per protocol, CBC per provider order, and platelet monitoring for HIT risk.

REFERENCE #	6170.26	EFFECTIVE: 10/2007
SUBJECT:	6170.26 ANTICOAGULATION THERAPY	
DEPARTMENT:	NURSING -MED SURG	REVISED: 5/2026

- Low Molecular Weight Heparin (LMWH)
 - Dosing will be weight-based and adjusted for renal function.
 - Renal functions will be reviewed prior to administration.
- Warfarin
 - Baseline INR will be obtained prior to initiation when feasible.
 - INR monitoring will be performed according to provider order and protocol.
 - Dietary interactions and medication interactions will be evaluated and documented.
 - The provider will document therapeutic INR range.
- Direct Oral Anticoagulants (DOACs)
 - Renal function will be assessed prior to initiation and periodically thereafter.
 - Dosing will follow manufacturer recommendations and approved protocols.
 - Patients will be monitored for signs and symptoms of bleeding.

Monitoring Requirements

- Patients receiving anticoagulation therapy will be monitored for the following:
 - Signs and symptoms of bleeding.
 - Changes in hemoglobin/hematocrit and platelets.
 - Vital sign instability.
 - Thromboembolic complications.
 - Medication interactions.
 - Adverse drug reactions.
- Critical laboratory values will be reported immediately to the provider responsible.

Reversal of Anticoagulation

- The hospital will maintain current protocols for anticoagulation reversal.
- Reversal agents may include the following:
 - Vitamin K
 - Protamine sulfate
 - Fresh frozen plasma (FFP)
 - Kcentra
- Patients with life-threatening bleeding will receive immediate evaluation and stabilization.
- Transfer to a higher level of care will be initiated when patient needs exceed the hospital's capabilities.

Perioperative Management

- Patients requiring interruption of anticoagulation therapy for procedures will be managed according to approved perioperative anticoagulation protocols addressing the following:
 - Timing of medication interruption.
 - Bridging therapy indications.
 - Timing of medication restart.
 - Procedure-specific bleeding risk.

Patient Education

- Prior to discharge, patients and/or caregivers will receive education regarding:
 - Medication purpose and dosing.
 - Signs and symptoms of bleeding.
 - Medication and dietary interactions.

REFERENCE #	6170.26	EFFECTIVE: 10/2007
SUBJECT:	6170.26 ANTICOAGULATION THERAPY	REVISED: 5/2026
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- Follow-up laboratory monitoring.
- When to seek emergency medical attention.

Documentation

- The following information will be documented in the patient's electronic medical record by the **attending** physician, **PNA**, **FNPA**
 - Indication for anticoagulation by **attending** physician, **PNA**, **FNPA**
 - Medication dose and administration by pharmacist.
 - Laboratory results by **attending** physician, **PNA**, **FNPA**
 - Patient assessments by nurse.
 - Patient education by nurse.
 - Adverse events and interventions by **attending** physician, **PNA**, **FNPA**
 - Provider notifications by nursing staff.

REFERENCE:

Centers for Medicare & Medicaid Services. (2024). *Critical access hospitals*. U.S. Department of Health & Human Services. [CMS Critical Access Hospitals](#)

Centers for Medicare & Medicaid Services. (2024). *State operations manual appendix W – survey protocol, regulations and interpretive guidelines for critical access hospitals (CAHs)*. U.S. Department of Health & Human Services. [CMS State Operations Manual Appendix W](#)

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 APPLICATION OF WARM AND COLD COMPRESSES	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to provide standardized guidelines for the safe and effective application of warm and cold compress therapy by nursing staff to promote patient comfort, reduce pain, minimize swelling and support healing while preventing thermal injury.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Warm Compress: a therapeutic application of moist or dry heat to a localized body area to increase circulation, relieve discomfort, and promote healing. Indications for use include muscle spasm and stiffness, chronic musculoskeletal pain, promotion of drainage from localized infections as ordered, enhancement of circulation to localized tissues and subacute or chronic inflammatory conditions.

~~Warm compresses will not be applied to areas of active bleeding, acute trauma within the first 24-48 hours unless ordered, areas with impaired sensation or circulation, suspected deep vein thrombosis, malignant tumors, skin with significant breakdown or burns unless prescribed.~~

Cold Compress: a therapeutic application of cold to a localized body area to reduce pain, inflammation, edema, and bleeding. Indications include acute injuries, swelling and edema, pain relief, minor bleeding or bruising, and post-procedural or post-operative inflammation.

~~Cold compresses will not be applied to areas with impaired circulation or sensation, areas of tissue ischemia, severe peripheral vascular disease and/or patients with known cold hypersensitivity.~~

POLICY:

It is the policy of Modoc Medical Center (MMC) that warm and cold compresses will be applied only when clinically indicated and in accordance with a provider physician, nurse practitioner (NP) or physician assistant (PA)'s order, approved nursing protocol, or facility-approved treatment plan. Patients will be assessed before, during and after therapy to ensure safety and effectiveness. Appropriate precautions will be taken to prevent tissue injury.

PROCEDURE:

Pre-Procedural Assessment

Verify the provider physician, NP or PA

- order or approved protocol.
- Confirm patient identity using approved identifiers.
- Explain the procedure to the patient.
- Assess and document skin integrity, color and temperature of skin, circulation, sensation, presence of edema and pain level.

Warm Compress Application

- Prepare warm compress according to manufacturer instructions.
- Verify temperature is within safe limits and not excessive.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 APPLICATION OF WARM AND COLD COMPRESSES	REVISED: 6/2026
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- Place a protective barrier between the compress and the patient's skin.
- Apply to the affected area.
- Maintain application for 15-20 minutes unless otherwise ordered.
- Assess the treatment site periodically for excessive redness, pain, discomfort and/or evidence of thermal injury.
- Remove compress immediately if adverse effects occur.

Cold Compress Application

- Prepare cold pack according to manufacturer instructions.
- Ensure a protective barrier is placed between the cold source and skin.
- Apply to the affected area.
- Maintain application for 15-20 minutes unless otherwise ordered.
- Assess periodically for excessive pallor, cyanosis, numbness, pain and/or skin injury.
- Remove immediately if adverse effects occur.

Special Precautions

- Additional caution will be exercised for pediatric patients, geriatric patients, patients with diabetes, neuropathy, impaired cognition, receiving sedating ~~medications~~medications, and patients that are unable to report discomfort.
- Heat or cold will never be applied directly to the skin.
- Warm compresses will not be applied to areas of active bleeding, acute trauma within the first 24-48 hours unless ordered, areas with impaired sensation or circulation, suspected deep vein thrombosis, malignant tumors, skin with significant breakdown or burns unless prescribed.
- Cold compresses will not be applied to areas with impaired circulation or sensation, areas of tissue ischemia, severe peripheral vascular disease and/or patients with known cold hypersensitivity

Patient Monitoring

- Monitor patient tolerance throughout therapy.
- Reassess pain and symptoms following treatment.
- Evaluate effectiveness of therapy.

Report any adverse reactions to the ~~provider~~ physician, NP or PA

Documentation

- Date and time of application.
- Type of therapy (warm or cold).
- Anatomical location.
- Duration of treatment.
- Skin assessment before and after treatment.
- Patient response and tolerance.
- Any adverse findings and interventions taken.
- Any thermal injury, adverse reaction, or unexpected outcome related to compress therapy will be reported according to the facility's incident reporting policy and patient safety procedures.

REFERENCE:

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 APPLICATION OF WARM AND COLD COMPRESSES	REVISED: 6/2026
DEPARTMENT:	NURSING -MED SURG	

Centers for Medicare & Medicaid Services. (2024). *State operations manual: Appendix A—Survey protocol, regulations and interpretive guidelines for hospitals*. U.S. Department of Health and Human Services.
<https://www.cms.gov>

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 ASSISTING PATIENT OUT OF BED	
DEPARTMENT:	NURSING -MED SURG	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to promote patient safety, prevent falls and injuries and ensure safe mobilization of medical-surgical patients.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center (MMC) that all medical/surgical patients will be assessed by nursing staff for mobility status and fall risk prior to ambulation or transfer out of bed. Staff will use appropriate assistance devices and personnel based on patient condition and institutional safe patient handling guidelines.

PROCEDURE:

Initial and Ongoing Assessment

- Level of consciousness/orientation.
- Vital signs stability.
- Weight-bearing ability.
- Strength and balance.
- Presence of dizziness or orthostatic hypotension.
- Fall risk status.
- Pain level.
- Drains, tubes, intravenous lines, and oxygen equipment.
- Sedation or recent anesthesia/opioid administration.
- Activity orders/restrictions.
- Do not ambulate patients who are unstable without provider physician, nurse practitioner (NP) or physician assistant (PA)
- evaluation.
- Assessment will occur on admission, once per shift, after any change in patient condition, after any procedures/anesthesia, or after any fall event.

Determine Assistance Level

- Independent
 - Patient safely transfers/ambulates without help.
 - Supervision may still be required for fall-risk patients.
- Standby Assist
 - Staff present for safety.
 - No physical lifting is required.
- One-Person Assist
 - Patients bear most weight.
 - Use gait belt unless contraindicated.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 ASSISTING PATIENT OUT OF BED	
DEPARTMENT:	NURSING -MED SURG	REVISED: 5/2026

- Two-Person Assist
 - Patient weak, unsteady, or partially weight-bearing.
 - Required for high fall-risk or post-op patients as indicated.
- Mechanical Lift Required
 - Patients who cannot bear weight.
 - Require extensive assistance.
 - Have unpredictable movements.
 - Exceed safe manual lifting limits.

Safety Measures

- Before getting the patient out of bed do the following:
 - Verify [provider physician, NP or PA](#)
 - activity orders.
 - Apply non-skid footwear.
 - Lock bed and wheelchair brakes.
 - Lower bed to safe height.
 - Ensure environment is clear of clutter.
 - Secure lines/tubes/drains.
 - Use gait belts per facility policy.
 - Ensure call light accessibility.
 - Have assistive devices available (walkers, canes, etc.).

Stepwise Mobilization

- Explain procedure to the patient.
- Raise head of bed slowly.
- Assist patient to sitting position.
- Dangle at bedside for 1-2 minutes.
- Assess any dizziness, pallor, weakness, orthostatic symptoms.
- Assist to standing position.
- Transfer or ambulate with appropriate support.
- Monitor continuously for any dizziness, weakness, instability, dyspnea, or change in mental status.
- If symptoms occur, return patient safely to bed/chair.

Documentation

- Mobility assessment.
- Assistance level required.
- Distance ambulated/transferred.
- Assistive devices used.
- Patient tolerance.
- Symptoms during activity.
- Education provided.
- Any fall or near-fall events.

REFERENCE:

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 ASSISTING PATIENT OUT OF BED	
DEPARTMENT:	NURSING -MED SURG	REVISED: 5/2026

Centers for Medicare & Medicaid Services. (2024). *State operations manual appendix A – Survey protocol, regulations and interpretive guidelines for hospitals*. U.S. Department of Health and Human Services. [CMS Conditions of Participation](#)

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 ASSISTING WITH EXAMINATION OF PATIENTS	
DEPARTMENT:	NURSING -MED SURG	REVISED: 5/2026

PURPOSE:

The purpose of this policy is to establish standardized guidelines for the Registered Nurse (RN) in assisting the provider during patient examinations and procedures, ensuring safe, respectful and compliant patient care in accordance with Centers for Medicare & Medicaid Services (CMS) Conditions of Participation, state Nurse Practice Act, and hospital policy.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None

POLICY:

It is the policy of Modoc Medical Center (MMC) that all nursing staff may assist providers in patient examinations and procedures only within their scope of practice, competency validation, and hospital-assigned duties. All assistance will prioritize patient safety, privacy, dignity, infection prevention, and informed consent.

PROCEDURE:

Patient Preparation

- Verify patient identification using two identifiers per hospital policy.
- Explain nursing role in assisting with the examination or procedure.
- Prepare and position the patient appropriately for the examination.
- Provide appropriate draping to maintain privacy and dignity.
- Ensure examination room readiness, including required equipment and supplies.

Assistance During Examination/Procedure

- Provide direct physical assistance with patient positioning and stabilization.
- Function as a chaperone during sensitive examinations per patient request or hospital policy.
- Hand instruments and supplies to the provider during procedures.
- Obtain and document vital signs as ordered or indicated.
- Collect and label specimens as ordered and within scope of practice.
- Monitor patient status during the procedure and immediately report changes to the provider.
- Nursing staff will not do any of the following:
 - Independently interpret findings or provide medical diagnosis.
 - Perform procedures outside scope of practice or competency.
 - Substitute for the provider medical decision-making.

Consent and Patient Rights

- The provider is responsible for obtaining informed consent for examinations and procedures as required.
- Patients must be informed of the nurse's role in assisting.
- Patients have the right to request a chaperone.
- A chaperone will be offered for all sensitive examinations (e.g., breast, pelvic, genital, rectal exams).

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 ASSISTING WITH EXAMINATION OF PATIENTS	
DEPARTMENT:	NURSING -MED SURG	REVISED: 5/2026

- Reasonable efforts will be made to provide a chaperone of the patient's preferred gender when requested and available.

Infection Prevention and Safety

- Standard precautions will be followed at all times.
- Appropriate personal protective equipment will be used based on anticipated exposure risk.
- Sterile technique will be maintained for sterile procedures.
- Sharps safety and biohazard disposal procedures will be followed per hospital policy.

Documentation

- Patient preparation and tolerance of procedure/exam.
- Nursing assistance provided during the procedure.
- Specimen collection and disposition.
- Patient education provided within nursing scope.
- Any adverse events, patient distress, or safety concerns.
- Notification made to the provider regarding changes in patient condition.

REFERENCE:

Centers for Medicare & Medicaid Services. (2024). *Critical access hospitals (CAHs): Conditions of participation*. U.S. Department of Health & Human Services. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485>

Centers for Medicare & Medicaid Services. (2024). *Medicare program: Hospital conditions of participation—Patients' rights*. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482>

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

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CARE OF PATIENTS WHO ARE BLIND OR VISUALLY IMPAIRED	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to ensure that patients who are blind or visually impaired receive safe, equitable, accessible and patient-centered care; effective communication; and reasonable accommodations necessary for full participation in healthcare decisions and treatment.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Auxiliary Aids and Services: accessible communication methods including, but not limited to, large-print materials, audio formats, electronic accessible documents, reader assistance and other accommodations appropriate to the patient's needs.

POLICY:

It is the policy of Modoc Medical Center (MMC) to provide appropriate accommodation and auxiliary aids to patients who are blind or visually impaired to ensure effective communication, patient safety, informed consent, privacy, dignity and equal access to all healthcare services.

PROCEDURE:

Identification and Assessment

- Upon admission, registration, or initial encounter, staff will identify and document any visual impairment and any requested accommodations.
- Staff will ask the patient about preferred communication methods and assistance needs.
- Staff will document any accommodation requirements ~~will be documented~~ in the medical record and communicated to relevant care team members.

Communication

- Staff will communicate directly with the patient whenever possible.
- Staff will provide ~~C~~linical information, treatment plans, discharge instructions, consent discussions, and educational materials will be provided in a format accessible to the patient.
- Staff will verbally explain written materials when necessary and provide opportunities for questions and clarification.

Informed Consent

- Informed consent discussions will be conducted in a manner that allows the patient to understand the nature, risks, benefits, and alternatives of proposed treatment.
- Blindness or visual impairment alone will not be considered evidence of impaired decision-making capacity.
- Documentation will reflect the method used to communicate consent information and the patient's understanding.

Patient Safety

- Staff will orient patients to their surroundings, including room layout, call system, bathroom location, and emergency exit as appropriate.
- Staff will maintain ~~T~~he environment ~~will be maintained~~ free of unnecessary obstacles and hazards.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CARE OF PATIENTS WHO ARE BLIND OR VISUALLY IMPAIRED	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

- ~~Staff will notify the patient b~~Before moving equipment, furniture, or personal belongings, ~~staff will notify the patient.~~
- Staff will identify themselves upon entering the room and explain procedures before initiating care.

Assistance and Mobility

- Staff will offer assistance but will respect the patient's preferences regarding mobility and independence.
- When guiding a patient, staff will use approved sighted-guide techniques and provide verbal descriptions of environmental changes when appropriate.
- Service animals accompanying patients will be accommodated in accordance with applicable laws and hospital policies.

Discharge Planning

- ~~Staff will provide D~~discharge instructions, medication information, follow-up appointments, and care plans ~~will be provided~~ in an accessible format.
- Staff will verify patient understanding using appropriate communication methods.

REFERENCE:

California Code of Regulations. (2024). *Title 22: Social security, Division 5—Licensing and certification of health facilities, clinics, and referral agencies*. California Office of Administrative Law.

<https://www.oal.ca.gov>

California Department of Public Health. (n.d.). *Hospital licensing and certification program*.

<https://www.cdph.ca.gov>

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CENTRAL VENOUS CATHETER REMOVAL	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to establish a standardized, evidence-based procedure for the safe removal of central venous catheters by nursing staff, minimizing risks of infection, bleeding and air embolism, and ensuring proper post-removal monitoring and documentation.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

None.

POLICY:

It is the policy of Modoc Medical Center that central venous catheters will be removed only upon a provider- physician, nurse practitioner (NP) or physician assistant (PA) s order unless otherwise authorized by facility protocol. Removal must be performed by trained and competent personnel using aseptic technique and adherence to patient safety standards.

PROCEDURE:

Verify provider physician, NP or PA

- order for catheter removal.
- Identify patient using two identifiers.
- Explain procedure and obtain verbal consent if required.
- Review coagulation status and anticoagulant therapy if clinically indicated.
- Perform hand hygiene and don appropriate personal protective equipment (PPE).
- Position patient supine this is the preferred position; Trendelenburg position for internal jugular or subclavian lines unless contraindicated.
- Clamp catheter lumen if applicable.

Catheter Removal Technique

- Perform hand hygiene and don sterile gloves.
- Remove dressing and assess insertion site.
- Clean site with chlorhexidine using aseptic technique.
- Instruct the patient to perform Valsalva maneuver or hold breath during end-expiration.
- Slowly withdraw catheter in a steady motion without force.
- Immediately apply sterile gauze with firm pressure to the infection site upon removal.

Post-Removal Care

- Maintain direct pressure for a minimum of two to five minutes or longer if anticoagulated.
- Inspect catheter tip to ensure integrity.
- Apply sterile occlusive dressing (airtight seal required).
- Keep dressing in place for 24-72 hours per facility protocol.
- Dispose of catheter per biohazard policy.

Post-Procedure Monitoring

- Monitor the patient for signs of air embolism (dyspnea, chest pain, hypotension, altered mental status).

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CENTRAL VENOUS CATHETER REMOVAL	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

- Monitor the patient for signs of Bbleeding or hematoma at site.
- Monitor the site for signs of linfection (erythema, drainage, fever).
- Monitor vVital signs should be monitored by unit standard following removal.

Complication Management

- Suspected air embolism
 - Place patient in left lateral decubitus and Trendelenburg position.
 - Administer oxygen.
 - Activate the rapid response team.
- Uncontrolled bleeding
 - Apply direct pressure.

Notify ~~provider~~the provider-physician, NP or PA

- immediately.

- Catheter fracture or missing tip
 - Do not discard ~~catheter~~the catheter.

Notify ~~provider~~physician, NP or PA

- and obtain imaging as ordered.

Documentation

The ~~provider~~provider physician, NP or PA

- s order for removal.
- Catheter type and insertion site.
- Date and time of removal.
- Condition of catheter tip (intact/not intact).
- Patient tolerance to procedure.
- Dressing type applied.
- Post-procedure assessment findings.
- Any complications and interventions.

REFERENCE:

Infusion Nurses Society. (2024). *Infusion therapy standards of practice* (9th ed.). Author.

ATTACHMENTS:

None

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CHEST TUBE DRAINAGE CARE	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to provide standardized nursing care for patients with chest tubes and pleural drainage systems to promote lung re-expansion; facilitate removal of air, blood, fluid, or other pleural contents; prevent complications; ensure compliance with provider orders, nursing standards of practice and California Title 22 requirements.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Chest Tube: a sterile catheter inserted into the pleural space to evacuate air, fluid, blood, or pus.

Water Seal Chamber: a one-way valve system preventing atmospheric air from entering the pleural space.

Air Leak: presence of air entering the drainage system from the pleural space or system connections.

POLICY:

It is the policy of Modoc Medical Center (MMC) that patients with chest tubes will receive assessment, monitoring and management by nursing personnel who are competent in chest tube drainage care.

PROCEDURE:

Initial Assessment

- Verify provider orders.
- Assess respiratory rate and effort, breath sounds, oxygen saturation, pain level and hemodynamic status.
- Confirm tube placement, drainage system integrity, suction settings if ordered.
- Obtain baseline drainage amount and characteristics.

Ongoing Monitoring

- Assess at minimum every shift and as clinically indicated the following:
 - Respiratory status.
 - Chest tube insertion site.
 - Dressing integrity.
 - Presence of crepitus/subcutaneous emphysema.
 - Drainage characteristics: amount, color, and consistency.
 - Water-seal chamber function.
 - Presence or absence of air leak.

Drainage System Management

- Maintain drainage unit below chest level.
- Keep drainage unit upright.
- Ensure tubing remains free from kinks, dependent loops and compression.
- Secure all connections.
- Maintain prescribed suction level when ordered.
- Do not routinely strip or milk tubing.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CHEST TUBE DRAINAGE CARE	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

Dressing Care

- Maintain occlusive sterile dressing.
- Change dressing per provider order, per protocol, and/or when loose, wet, or soiled.
- Utilize aseptic technique.

Ambulation and Activity

- Encourage coughing and deep breathing.
- Utilize incentive spirometry as ordered.
- Ambulate the patient when clinically appropriate.
- Maintain drainage system below chest during transport and ambulation.

Accidental Disconnection

- Immediately place tube end into sterile water if disconnected from drainage system and reconnect as soon as possible.
- Notify provider.
- Assess respiratory status.

Accidental Tube Removal

- Apply sterile occlusive dressing.
- Cover insertion site and secure on three sides if directed by facility protocol.
- Activate emergency/rapid response as indicated.
- Notify provider immediately.

Tension Pneumothorax Suspected

- Signs include acute respiratory distress, tracheal deviation, hypotension, and absent breath sounds.
- Actions include activating rapid response, notifying provider immediately and preparing for emergent intervention.

Notification Criteria

- Sudden increase in drainage.
- Bright red bleeding.
- New or worsening air leak.
- Sudden cessation of drainage when obstruction suspected.
- Respiratory deterioration.
- Tube dislodgement.
- Subcutaneous emphysema progression.

Documentation

- Respiratory assessment.
- Chest tube location and status.
- Drainage amount and characteristics.
- Water-seal and suction findings.
- Air leak assessment.
- Dressing condition.
- Patient tolerance.
- Provider notifications and orders.
- Interventions and outcomes.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 CHEST TUBE DRAINAGE CARE	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

REFERENCE:

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, § 70203. (2025). *Medical service general requirements*. Westlaw/California Code of Regulations.

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, § 70217. (2025). *Nursing service staff*. Westlaw/California Code of Regulations.

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 6, § 70403. (2025). *Acute respiratory care service general requirements*. Westlaw/California Code of Regulations.

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 6, § 70615. (2025). *Respiratory care service definition*. Westlaw/California Code of Regulations.

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 LABORATORY SPECIMEN COLLECTION	REVISED: 6/2026
DEPARTMENT:	NURSING -MED SURG	

PURPOSE:

The purpose of this policy is to establish a standardized process for the safe, accurate and timely collection, labeling, documentation, transportation, and handling of laboratory specimens by lab and nursing staff to ensure patient safety, specimen integrity, regulatory compliance and accurate test results.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Critical Value: laboratory results indicating a potentially life-threatening condition requiring immediate notification.

Positive Patient Identification: verification of patient identity using at least two approved identifiers before specimen collection.

POLICY:

It is the policy of Modoc Medical Center (MMC) that all laboratory specimens will be collected, identified, labeled, documented, transported, and processed according to hospital standards, applicable federal and state regulations, Clinical Laboratory Improvement Amendments (CLIA) requirements, accreditation standards and manufacturer instructions. Positive patient identification and specimen labeling at the point of collection are required for all specimens.

The Cerner Electronic Medical Record (EMR) will be utilized for laboratory order verification, specimen collection documentation, and tracking whenever operationally available.

PROCEDURE:

Order Verification

- Verify that an active laboratory order exists in Cerner EMR prior to specimen collection.
- Review the following:
 - Patient identification.
 - Ordered tests.
 - Collection requirements.
 - Specimen type.
 - Priority status.
 - Collection time requirements.
- Clarify discrepancies with the ordering provider before collecting specimen.

Patient Identification

- Use two approved patient identifiers, such as full name, date of birth, and/or medical record number.
- Compare identifiers against patient's wristband and EMR order information.
- For conscious patients, request the patient to state their name and date of birth whenever possible.
- Do not use room numbers for patient identification.

Specimen Collection

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 LABORATORY SPECIMEN COLLECTION	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

- Collect specimens according to approved laboratory procedures. The patient's wristband and laboratory label will be scanned at the patient's bedside for proper identification and collection.
- Follow standard precautions and infection prevention procedures.
- Utilize appropriate collection devices and containers.
- Observe proper order of draw for blood collection.
- Adhere to test-specific collection requirements.

Specimen Labeling

- All specimens will be labeled in the presence of the patient immediately following collection.
- Labels will contain the patient's name, second patient identifier, date of collection, times of collection, collector identification, and additional information as required by laboratory protocol.
- Pre-labeling of collection containers is prohibited except if approved by laboratory leadership for specific procedures.
- Unlabeled specimens will not be accepted for testing except under approved exceptional circumstances documented by the laboratory director or designee.

Documentation

- Collection date.
- Collection time.
- Collector identification.
- Collection status.
- Comments when appropriate.
- Patient wristband scanning will be performed when available.
- Specimen labels will be generated through the EMR.
- Barcode verification will be utilized according to hospital procedures.

Specimen Transport

- Specimens will be transported promptly to the laboratory.
- Temperature requirements will be maintained during transport.
- Time-sensitive specimens will be delivered immediately.
- Specimens designated for referral laboratories will be packaged and shipped according to applicable regulations and laboratory procedures.

Specimen Acceptance and Rejection

- The laboratory may reject specimens for reasons including:
 - Missing patient identifiers.
 - Mislabeled specimens.
 - Unlabeled specimens.
 - Hemolysis affecting testing.
 - Insufficient quantity.
 - Improper container.
 - Improper storage or transport.
 - Exceeded stability limits.
- Rejected specimens will be documented according to laboratory procedures.

Critical Results

- Will be reported promptly according to hospital critical value procedures.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 LABORATORY SPECIMEN COLLECTION	REVISED: 6/2026
DEPARTMENT:	NURSING -MED SURG	

- Will be communicated to the ~~provider~~ physician, nurse practitioner (NP) or physician assistant (PA)
- Will be documented in accordance with hospital policy by the registered nurse (RN);

Downtime Procedures

- When the EMR is unavailable, approved downtime forms will be utilized.
- Patient identification requirements remain in effect.
- Manual labeling requirements will be followed.
- Information will be entered into the EMR once system functionality is restored.

REFERENCE:

Clinical Laboratory Improvement Amendments of 1988, 42 C.F.R. Part 493 (2024).

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-493>

Centers for Medicare & Medicaid Services. (2024). *State operations manual: Appendix W—Survey protocol, regulations, and interpretive guidelines for critical access hospitals (CAHs)*. U.S. Department of Health and Human Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_w_cah.pdf

Centers for Medicare & Medicaid Services. (2024). *Critical access hospitals*. U.S. Department of Health and Human Services. <https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals>

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 OSTOMY CARE MANAGEMENT	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to establish standards for nursing assessment, management, monitoring, documentation and patient education of individuals with ostomies to promote patient safety, maintain skin integrity, prevent complications, support patient self-management and ensure compliance with applicable state and federal regulations and professional standards of practice.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Ostomy: a surgically created opening connecting an internal organ to the body's surface.

Stoma: the visible portion of the ostomy protruding through the abdominal wall.

Peristomal Skin: the skin surrounding the stoma.

POLICY:

It is the policy of Modoc Medical Center (MMC) that patients with a colostomy, ileostomy, urostomy, or other surgically created ostomy will receive nursing care by qualified healthcare personnel in accordance with provider orders, nursing standards of practice, infection prevention principles and hospital policies. Ostomy care will be individualized to patient needs and documented in electronic medical records.

PROCEDURE:

Assessment

- Type and location of ostomy.
- Date of surgery if known.
- Stoma location.
- Stoma appearance (color, size, protrusion, edema).
- Peristomal skin condition.
- Characteristics and amount of drainage/output.
- Appliance integrity and leakage.
- Patient's ability to perform self-care.
- Pain or complications.

Ongoing Assessment

- Color and viability of stoma.
- Bleeding.
- Output volume and characteristics.
- Leakage.
- Appliance integrity.
- Skin irritation or breakdown.
- Signs of infection.
- Patient tolerance and comfort.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 OSTOMY CARE MANAGEMENT	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

Ostomy Care

- Perform hand hygiene.
- Verify patient identity according to hospital policy.
- Explain procedure to patient.
- Provide privacy.
- Don appropriate personal protective equipment.
- Remove existing pouching system gently.
- Inspect stoma and peristomal skin.
- Cleanse area using warm water or approved cleansing agent.
- Pat the skin dry thoroughly.
- Measure stoma as needed.
- Apply skin barrier products as indicated.
- Apply appropriately sized pouching system.
- Ensure secure seal without tension on skin.
- Dispose of waste according to infection prevention procedures.
- Remove gloves and perform hand hygiene.
- Document care provided.

Monitoring for Complications

- Nursing staff will promptly assess and report any of the following:
 - Pale, dusky, purple, gray, or black stoma.
 - Excessive bleeding.
 - Persistent leakage.
 - Severe peristomal skin breakdown.
 - Stomal prolapse.
 - Stomal retraction.
 - Suspected bowel obstruction.
 - Sudden change in output.
 - Signs of infection.
 - Severe pain.

Provider Notification

- The provider will be notified promptly of the following:
 - Suspected ischemia or necrosis.
 - Significant bleeding.
 - New stoma complications.
 - Signs of infection.
 - Obstruction symptoms.
 - Severe skin breakdown.
 - Other clinically significant findings.
- Documentation of provider notification and received orders will be entered into the electronic medical record.

Documentation

- Ostomy assessments

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 OSTOMY CARE MANAGEMENT	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

- Characteristics of stoma and output.
- Peristomal skin condition.
- Interventions performed.
- Appliance changes.
- Patient response to treatment.
- Education provided.
- Patient or caregiver competency assessment.
- Provider notifications and orders.
- Discharge planning activities.

Infection Prevention

- Follow hand hygiene requirements.
- Use appropriate personal protective equipment.
- Adhere to standard precautions.
- Dispose of waste according to hospital infection prevention policies.
- Clean reusable equipment according to hospital procedures.

REFERENCE:

California Department of Public Health. (2025). *California Code of Regulations, Title 22, Division 5, Chapter 1, General Acute Care Hospitals*. Sacramento, CA: Author.

Centers for Medicare & Medicaid Services. (2024). *State operations manual: Appendix A—Survey protocol, regulations and interpretive guidelines for hospitals*. [Centers for Medicare & Medicaid Services](#)

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 RADIOLOGY PROCEDURES	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to establish a standardized process for preparing patients for diagnostic and interventional radiology procedures to ensure patient safety, accurate diagnostic outcomes, regulatory compliance and adherence to applicable federal and state regulations, including the Medicare Conditions of Participation (CoPs) for the hospital.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Diagnostic Radiology Procedure: any imaging examination performed to assist in diagnosis or treatment, including radiography, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, fluoroscopy and mammography.

Interventional Radiology Procedure: a minimally invasive procedure under imaging guidance for diagnostic or therapeutic purposes.

Contrast Media: any oral, intravenous, or other agent administered to enhance visualization during imaging studies.

POLICY:

It is the policy of Modoc Medical Center (MMC) that all patients undergoing radiologic examinations or procedures will be appropriately assessed, screened, educated and prepared by nursing and radiology staff before the procedure is performed. Radiologic services will be provided only upon the order of a provider authorized by the Medical Staff and will be conducted by qualified radiology tech staff personnel in accordance with hospital policies, Medical Staff Rules and Regulations, applicable state law, and federal regulations.

PROCEDURE:

Order Verification

- Prior to initiating any radiologic procedure, the staff will verify the following:
 - A valid provider order is present in the electronic medical record.
 - The procedure ordered corresponds to the patient's clinical condition.
 - Required indications and supporting documentation are available.
- Questions regarding appropriateness or accuracy of an order will be resolved before the procedure is performed.

Patient Identification

- Prior to any radiology procedure, radiology tech staff will verify at least two (2) patient identifiers consistent with hospital policy.
- Acceptable identifiers include full legal name, date of birth, and medical record number.
- Room numbers will not be used as an identifier.

Patient Assessment and Screening

- Prior to the procedure, radiology tech staff will assess and document patient allergies to any medications, contrast, latex and food allergies relevant to contrast administration.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 RADIOLOGY PROCEDURES	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

- Medical history to include any relevant diagnoses, previous imaging procedures, prior adverse reactions and current medications.
- Pregnancy screening for patients of childbearing potential.
- Contrast screening for any prior contrast reactions, renal disease, recent laboratory results as required by protocol, diabetes medication when applicable and other risk factors identified by the radiologist.
- MRI screening for any cardiac devices, implanted medical devices, metallic foreign bodies, surgical clips, cochlear implants and other contraindicated materials.

Patient Preparation

- Patients will receive preparation instructions appropriate to the ordered procedure.
- Preparation may include dietary restrictions, fasting requirements, bowel preparation, medication adjustments, hydration instructions, and/or removal of metallic objects, jewelry and prosthetic devices when indicated.
- Failure to comply with required preparation will be communicated to the radiologist and/or radiology department for determination of whether the procedure may proceed.

Patient Education

- Prior to the procedure, ordering MD, DO, PA, FNP will provide information regarding purpose of the examination, expected duration, preparation requirements, potential risks and benefits, and post-procedure expectations.
- Education will be provided in a manner that accommodates the patient's language, communication, and cognitive needs.

Informed Consent

- Written informed consent will be obtained by the MD, DO, PA, FNP before procedures requiring consent under hospital policy, medical staff rules, or applicable law.
- Consent documentation will be completed before the procedure begins and maintained in the electronic medical record.

Post-Procedure Care

- Nurse to assess patient condition.
- Nurse to monitor for complications or adverse reactions.
- Radiology Tech and/or nurse to provide post-procedure instructions.
- MD, DO, PA, FNP to communicate pertinent findings and concerns according to hospital policy

Documentation by Radiology Tech as follows:

- Procedure order verification.
- Patient identification verification.
- Screening assessments.
- Pregnancy screening results.
- Consent documentation.
- Patient education.
- Contrast administration details.
- Adverse reactions or complications.
- Completion of procedure.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 RADIOLOGY PROCEDURES	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

REFERENCE:

Centers for Medicare & Medicaid Services. (2024). *State operations manual: Appendix A—Survey protocol, regulations and interpretive guidelines for hospitals*. U.S. Department of Health and Human Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_a_hospitals.pdf

Centers for Medicare & Medicaid Services. (2025). *42 CFR Part 482—Conditions of participation for hospitals*. U.S. Department of Health and Human Services. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482>

ATTACHMENTS:

None.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 WITHHOLDING OR WITHDRAWAL OF LIFE SUSTAINING MEASURES	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PURPOSE:

The purpose of this policy is to establish guidelines for honoring patient rights regarding decisions to withhold or withdraw life-sustaining treatment in accordance with applicable California law, including the California Health Care Decisions Law and relevant provisions of California Code of Regulations, Title 22, while ensuring ethical, legal and professional standards of care.

AUDIENCE:

Department Wide

TERMS/DEFINITION:

Life-Sustaining Treatment: any medical intervention that serves principally to prolong life by supporting or replacing an essential bodily function, including but not limited to mechanical ventilation, cardiopulmonary resuscitation, artificial nutrition and hydration, dialysis, vasopressor therapy and other treatments intended primarily to sustain life when death is otherwise imminent.

Withholding Treatment: the decision not to initiate a life-sustaining intervention.

Withdrawal of Treatment: the discontinuation of a life-sustaining intervention that has already been initiated.

Decision-Making Capacity: the ability to understand relevant information, appreciate consequences, reason regarding treatment choices, and communicate a decision.

Surrogate Decision-Maker: an individual authorized under California law to make health care decisions on behalf of an incapacitated patient.

Informed Consent and Refusal of Treatment: Title 22 recognizes a patient's right to accept or refuse proposed treatment. The informed-consent process must include disclosure of alternatives, risks, benefits, and the patient's right to revoke consent. Decisions to withhold or withdraw life-sustaining measures should be made through this framework of informed decision-making or through a legally authorized surrogate decision-maker when the patient lacks capacity.

POLICY:

It is the policy of Modoc Medical Center (MMC) to recognize the right of competent adult patients to make decisions regarding their medical care, including the refusal, withholding, or withdrawal of life-sustaining treatment. The hospital will honor valid advance health care directives, Physician Orders for Life-Sustaining Treatment (POLST), Do-Not-Resuscitate (DNR) orders and decisions made by legally authorized surrogate decision-makers in accordance with California law.

- Decisions to withhold or withdraw life-sustaining treatment will be made through an informed decision-making process, between a patient or their surrogate decision maker(s) and their ~~attending provider~~ physician, nurse practitioner (NP) or physician assistant (PA)

and documented in the medical record, communicated to the interdisciplinary care team and implemented in a manner that respects patient autonomy, dignity, and comfort.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 WITHHOLDING OR WITHDRAWAL OF LIFE SUSTAINING MEASURES	
DEPARTMENT:	NURSING -MED SURG	REVISED: 6/2026

PROCEDURE:

Patient Has Decision-Making Capacity

- When a patient possesses decision-making capacity, the attending providerphysician, NA or PA will provide information regarding diagnosis, prognosis, expected benefits and burdens of treatment and alternatives, including comfort-focused care.
- The patient's decision to withhold or withdraw life-sustaining treatment will be documented in the medical record.
- Appropriate provider-physician, NA or PA orders will be entered into the medical record and communicated to all members of the care team.

Patient Without Decision-Making Capacity

- The providerattending physician, NA or PA will identify the legally authorized decision-maker.
- Existing advanced directives, POLST forms, or other written expressions of the patient's wishes will guide decision-making.
- Decisions will be based on the patient's known wishes or the patient's best interests when wishes are unknown.

Withdrawal of Life-Sustaining Treatment

- When a decision is made to withdraw life-sustaining treatment appropriate medical orders will be written.
- The patient and family will receive information regarding expected outcomes.
- Comfort-focused and palliative care measures will be initiated or continued.
- Pain and symptom management will be prioritized.
- Spiritual, psychosocial, and emotional support services will be offered.

Conflict Resolution

- If disagreement exists among providerphysician, NA or PAs, family members, or surrogate decision-makers the providerphysician, NA or PA will attempt resolution through discussion.
- Consultation with risk management, and/or the Ethics Committee may be requested.
- Legal counsel may be consulted if/when necessary.

Emergency Situations

- Existing DNR orders, POLST forms, and advanced directives will be honored to the extent permitted by law.
- When documentation is unavailable and patient wishes are unknown, emergency treatment will be provided until appropriate information becomes available.

Documentation Requirements

- Assessment of decision-making capacity.
- Copies of advanced directives, POLST forms, and DNR order, when available.
- Names and authority of surrogate decision makers.
- Discussions regarding goals of care.
- Informed consent or informed refusal documentation.
- Medical orders regarding withholding or withdrawal of treatment.
- Ethics consultation findings, if applicable.

REFERENCE #	6170.26	EFFECTIVE: 9/2006
SUBJECT:	6170.26 WITHHOLDING OR WITHDRAWAL OF LIFE SUSTAINING MEASURES	REVISED: 6/2026
DEPARTMENT:	NURSING -MED SURG	

REFERENCE:

California Code of Regulations, Title 22. (2025). *Division 5: Licensing and certification of health facilities, home health agencies, clinics, and referral agencies*. California Department of Public Health.

<https://govt.westlaw.com/calregs>

California Legislature. (2025). *California Probate Code §§ 4600–4806: Health care decisions law*.

California Legislative Information. <https://leginfo.legislature.ca.gov>

Centers for Medicare & Medicaid Services (CMS). (2024). *State operations manual: Appendix A—Survey protocol, regulations and interpretive guidelines for hospitals*. U.S. Department of Health and Human Services.

California Code of Regulation, Title 22, 73524(c)- requires documentation of decisions concerning withdrawal or withholding of life-sustaining treatment.

California Code of Regulations, Title 22, 87469- addresses advance directives, DNR orders, and requests regarding resuscitative measures in residential care facilities for the elderly.

ATTACHMENTS:

None.

ATTACHMENT E

Departmental Manuals

YEARLY MEMO/SIGNATURE PAGES

CANBY MEDICAL/DENTAL CLINICS



MEMORANDUM

DATE: 8/7/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: JULIE CARRILLO, CLINIC MANAGER
SUBJECT: ANNUAL POLICY MANUAL REVIEW

I have completed the manual review for the MMC Canby Medical/Dental Clinic Manual.

The Manual is in good shape and it is my recommendation that the Board approve it at this time.

The attached revising/archived list is accurate, and any revision will be completed within 120 days of the date of this Memorandum.

Thank you for your attention to the above.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read 'Julie Carrillo', is written over a light blue horizontal line.

JULIE CARRILLO
CLINIC MANAGER
MMC CANBY CLINIC
JC/sab

Enc.



CANBY MEDICAL/DENTAL CLINIC POLICY & PROCEDURE MANUAL 2026

The Canby Medical/Dental Clinic Manual has been reviewed and is approved for use at Modoc Medical Center.



Julie Carrillo, Clinic Manager



Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

INFECTION CONTROL

SNF



MEMORANDUM

DATE: 8/3/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: SUZANNE JOHNSON SNF-INFECTION CONTROL
SUBJECT: ANNUAL MANUAL REVIEW

Gentlepersons:

I have completed the review for the SNF-Infection Control Manual Review.

The Manual is in good shape and it is my recommendation that the Board approve the manual at this time. There are no archives or updates at this time.

Thank you for your attention to the above.

Respectfully Submitted,

SUZANNE JOHNSON
SNF-INFECTION CONTROL
SJ/sab



SNF-INFECTION CONTROL SERVICES POLICY MANUAL 2026

SNF-INFECTION CONTROL Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

SNF-INFECTION CONTROL MANAGER

Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

ENVIRONMETNAL SERVICES/LAUNDRY



MEMORANDUM

DATE: 7/31/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: ENVIRONMENTAL SERVICE/LAUNDRY
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the yearly review for the Environmental Service/Laundry Manual.

The Manual has been updated and is in good shape.

I request that the Manual be approved by the BoD at this time.

Thank you for your attention to the above.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Michael Appletoft", is written over the printed name.

MICHAEL APPLETOFT

ENVIRONMENTAL SERVICE/LAUNDRY MANAGER

MA/SAB



ENVIRONMENTAL SERVICES/LAUNDRY POLICY MANUAL 2026

Environmental Services/Laundry Policy Manual has been reviewed and is approved for use at Modoc Medical Center.



Environmental Services/Laundry Manager

7-31-26

Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

NURSING MED/SURG



MEMORANDUM

DATE: 7/28/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: SUSAN SAUERHEBER, ACUTE-ER NURSE MANAGER
SUBJECT: ANNUAL ACUTE/MED/SURG POLICY MANUAL REVIEW

I have completed the policy manual review for the Acute/Med/Surg Department.

Overall, the manual is in good shape and it is my recommendation that the Board approve the manual at this time. Attached is a list of any/all outstanding policies requiring amendments. I will have these policies completed within the next 120 days

Thank you for your time and attention to the above.

Respectfully Submitted,

SUSAN SAUERHEBER
Acute-ER Nursing Manager
SS/sab



ACUTE-MED/SURGERY POLICY & PROCEDURE MANUAL 2026

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

Susan Saueheber, Acute-ER Nursing Manager

7/28/26

Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

DIETARY ACUTE



MEMORANDUM

DATE: 7/24/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: JEREMY MURRAY-DIETARY ACUTE
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the yearly review for the Dietary Acute Manual.

The Dietary SNF Manual has been updated and is in good shape.

I request that the Manual be approved by the BoD at this time.

Thank you for your attention to the above.

Respectfully Submitted,

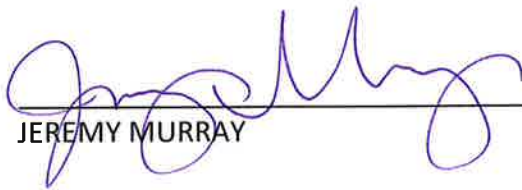
A handwritten signature in blue ink, appearing to read "Jeremy Murray", is written over the printed name.

JEREMY MURRAY
CERTIFIED DIETARY MANAGER
JM/sab



MODOC MEDICAL DIETARY/ACUTE POLICY & PROCEDURE MANUAL 2026

The Modoc Medical Dietary/Acute Manual has been reviewed and is approved for use at Modoc Medical Center.


JEREMY MURRAY

7.24.26

Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

EMERGENCY



MEMORANDUM

DATE: 7/23/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: SUSAN SAUERHEBER-EMERGENCY NURSING MANAGER
SUBJECT: EMERGENCY DEPARTMENT

I have completed the review for the Emergency Department Manual.

The Manual has been completely reviewed and everything is updated at this time.

Thank you for your attention to the above.

Respectfully Submitted,

A handwritten signature in blue ink, appearing to be 'SS', is written over the text 'Respectfully Submitted,'.

SUSAN SAUERHEBER
EMERGENCY NURSING MANAGER
SS/sab



MODOC MEDICAL CENTER EMERGENCY DEPARTMENT 2026

The Modoc Medical Center EMERGENCY DEPARTMENT MANUAL has been reviewed and is approved for use at Modoc Medical Center.

SUSAN SAUERHEBER

Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

DIETARY SNF



MEMORANDUM

DATE: 7/20/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: RAVEN SPARKS-DIETARY SNF
SUBJECT: ANNUAL MANUAL REVIEW

I have completed the yearly review for the Dietary SNF Manual.

The Dietary SNF Manual has been updated and is in good shape.

I request that the Manual be approved by the BoD at this time.

Thank you for your attention to the above.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read 'Raven Sparks', is written over the printed name.

RAVEN SPARKS

CERTIFIED DIETARY MANAGER

RS/sab



MODOC MEDICAL CENTER DIETARY SNF 2026

The Modoc Medical Center DIETARY-SNF Manual has been reviewed and is approved for use at Modoc Medical Center.


RAVEN SPARKS

7/20/26
Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

TRANSFUSION



MEMORANDUM

DATE: 7/17/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: WALTER DIMARUCUT
SUBJECT: ANNUAL TRANSFUSION POLICY MANUAL REVIEW

I have completed the manual review for all TRANSFUSION SERVICES.

All policies have been updated and it is my recommendation that the Board approve the manual as is.

There are various policies that are being pushed through SharePoint for final approval by the Board but none that have not been updated at this time.

Respectfully Submitted,

WALTER DIMARUCUT
TRANSFUSION DEPARTMENT MANAGER
WD/sab



TRANSFUSION POLICY MANUAL 2026

The Transfusion Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

Transfusion Department Manager

7/20/2026

Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

LABORATORY



MEMORANDUM

DATE: 7/17/2026
TO: LAST FRONTIER HEALTHCARE DISTRICT BOARD OF DIRECTORS
FROM: WALTER DIMARUCUT
SUBJECT: ANNUAL LABORATORY POLICY MANUAL REVIEW

I have completed the manual review for all LABORATORY SERVICES.

All policies have been updated and it is my recommendation that the Board approve the manual as is.

There are various policies that are being pushed through SharePoint for final approval by the Board but none that have not been updated at this time.

Respectfully Submitted,

WALTER DIMARUCUT
LABORATORY DEPARTMENT MANAGER
WD/sab



LABORATORY POLICY MANUAL 2026

The Laboratory Policy Manual has been reviewed and is approved for use at Modoc Medical Center.

Laboratory Department Manager

7/20/2026

Date

Chief Executive Officer

Date

Chair, Board of Directors

Date

SPREADSHEET

Susan Sauerheber	7010.26 SUICIDE RISK SCREENING AND PRECAUTIONS IN THE EMERGENCY DEPART	Edward Johnson
Susan Sauerheber	7010.26 Patients Requiring Psychiatric Evaluation Policy.docx	Alex Cole
Susan Sauerheber	7010.26 Interfacility Transfer of Patients to Higher Level of Care Policy.docx	Edward Johnson
Susan Sauerheber	6170.26 Central Venous Catheter Removal Policy.docx	Edward Johnson
Susan Sauerheber	7010.26 Synchronized Cardioversion Policy.docx	Kevin Kramer
Susan Sauerheber	7010.26 Management of Patients Under the Influence Policy.docx	Mallory Adams
Susan Sauerheber	7010.26 Pediatric Asthma Standard of Care Policy.docx	Mallory Adams
Susan Sauerheber	6170.26 Chest Tube Drainage Care.docx	Alicia Doss
Susan Sauerheber	7010.26 Transcutaneous Pacing Policy.docx	Kevin Kramer
Susan Sauerheber	7010.26 Pediatric Dosing Guidelines Policy.docx	Alicia Doss
Susan Sauerheber	7010.26 Medication Reconciliation Policy.docx	Alicia Doss
Susan Sauerheber	6170.26 Laboratory Specimen Collection Policy.docx	Alicia Doss
Susan Sauerheber	7010.26 Vaginal Bleeding Standard of Care Policy.docx	Kevin Kramer
Susan Sauerheber	7010.26 Pediatric Fever Standard of Care Policy.docx	Edward Johnson
Susan Sauerheber	7010.26 Neurological Assessment Policy and Procedure.docx	Edward Johnson
Susan Sauerheber	7010.26 Vital Signs Monitoring for Pediatric Patients Policy.docx	Edward Johnson
Susan Sauerheber	6170.26 Ostomy Care Policy.docx	Alicia Doss
Susan Sauerheber	7010.26 Pediatric Rights and Responsibilities of Parents-Guardians Policy.docx	Edward Johnson
Susan Sauerheber	7010.26 Opsite Wound Dressing Application and Management Policy.docx	Alicia Doss
Susan Sauerheber	Central Venous Catheter Troubleshooting Policy.docx	Alicia Doss
Susan Sauerheber	7010.26 Vomiting Standard of Care Policy.docx	Amber Vucina
Susan Sauerheber	6170.26 Radiology Procedures.docx	Mallory Adams
Susan Sauerheber	7010.26 Release of Patient Information Policy.docx	Alex Cole
Susan Sauerheber	7010.26 Organ Tissue Eye Donation Nursing Responsibilities Policy.docx	Amber Vucina
Susan Sauerheber	7010.26 Wound Care Standard of Care Policy.docx	Alicia Doss
Susan Sauerheber	6170.26 Withholding or Withdrawal of Life-Sustaining Measures Policy.docx	Kevin Kramer

DATED: _____

APPROVED BY BoD _____

Contact	Name	Tech Reader Approval
Delinda Gover	7420.26 Anesthesia Services June 2026.docx	Alex Cole
Delinda Gover	7420.26 Catorgies of Surgical Outpatients.docx	Mallory Adams
Delinda Gover	7420.26 Out Patient Surgery Patient Information.docx	Kevin Kramer
Delinda Gover	7420.26 OUT-PATIENT SURGERY.docx	Amber Vucina
Delinda Gover	7420.26 Post Operative Routine.docx	Alicia Doss
Delinda Gover	7420.26 Pre-Operative Anti-Microbial Shower.docx	Edward Johnson
Delinda Gover	7420.26 Sugery Charges.docx	Alex Cole
Edward Johnson	6580.16 End of Life Comfort Care (5283).docx	Kevin Kramer
Edward Johnson	6580.19 Weekly Summary - Licensed Nurses (6440).docx	Amber Vucina
Edward Johnson	6580.26 Completion of the Resident Care Plan (34).docx	Kevin Kramer
Edward Johnson	6580.26 Resident Transport and Overnight Assignment 1.docx	Kevin Kramer
Marty Shaffer	8460.26 INVENTORY AND INSPECTION OF NEW EQUIPMENT.docx	Alex Cole
Megan Wright	7041.26 Ambulance Personnel Condition of Employment (233).docx	Alex Cole
Susan Sauerheber	6170.26 AM Care Policy.docx	Alex Cole
Susan Sauerheber	7010.26 Safe Surrender of Newborns Policy.docx	Edward Johnson
Susan Sauerheber	7010.26 Orthopedic Emergencies Policy.docx	Edward Johnson
Susan Sauerheber	7010.26 Seizure Standard of Care Policy.docx	Kevin Kramer
Susan Sauerheber	7010.26 Outpatient Observation Policy and Procedure.docx	Mallory Adams
Susan Sauerheber	6170.26 Anticoagulation Therapy Policy.docx	Alicia Doss
Susan Sauerheber	7010.26 Patient and Visitor Safety in the Emergency Department Policy.docx	Alex Cole
Susan Sauerheber	6170.26 Application of Warm and Cold Compresses Policy.docx	Mallory Adams
Susan Sauerheber	7010.26 Sentinel Event Policy.docx	Kevin Kramer
Susan Sauerheber	7010.26 Stab Wounds Standard of Care Policy.docx	Kevin Kramer
Susan Sauerheber	7010.26 Patient Belongings and Property Policy.docx	Amber Vucina
Susan Sauerheber	6170.26 Assisting Patient Out of Bed Policy.docx	Mallory Adams
Susan Sauerheber	7010.26 Alteplase Protocol for Acute Ischemic Stroke.docx	Edward Johnson
Susan Sauerheber	7010.26 Patient Discharge Medications Policy.docx	Edward Johnson
Susan Sauerheber	7010.26 Stroke Standard of Care Policy and Procedure.docx	Edward Johnson
Susan Sauerheber	6170.26 Assisting with Examination of Patients Policy.docx	Alicia Doss
Susan Sauerheber	7010.26 Clinical Alarm Management Policy.docx	Mallory Adams
Susan Sauerheber	7010.26 Patient Identification Policy.docx	Amber Vucina
Susan Sauerheber	6170.26 Care of Patients Who Are Blind or Visually Impaired Policy.docx	Alicia Doss

ATTACHMENT F
August 2026 LFHD
Financial Statement
(unaudited)

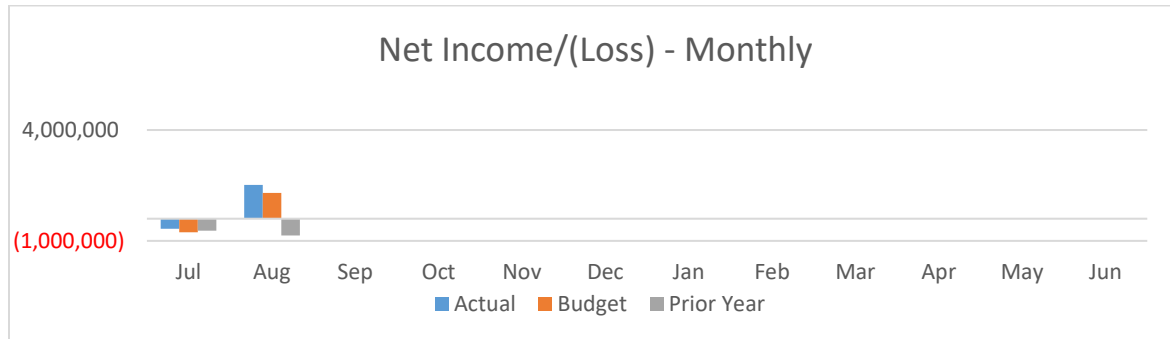


Modoc Medical Center
Financial Narrative
For the Month of August 2026

Prepared by Jin Lin, Finance Director

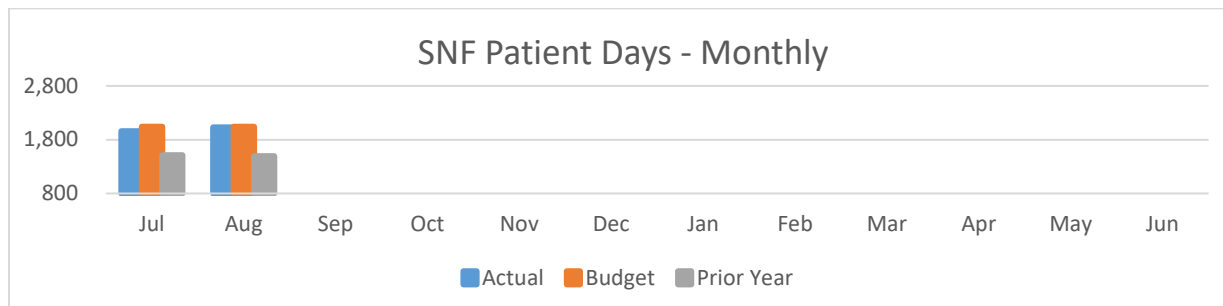
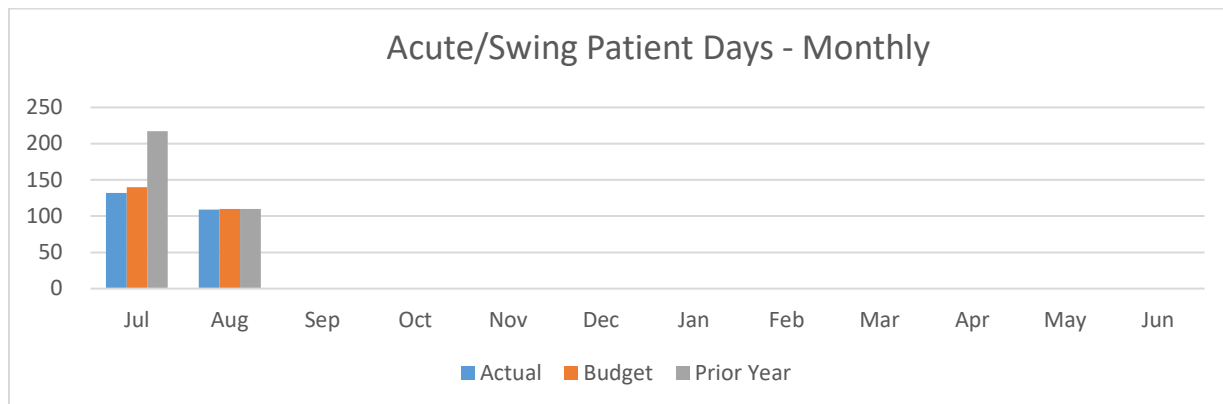
Summary

During the month of August, Modoc Medical Center reported income from operations of \$1.34 million, outperforming the budget that anticipated an operating income of \$1.19 million. Inpatient revenue was above the budget by \$10K. Outpatient revenue was above budget by \$274K for the month. Total patient revenue was \$5.62 million, above budget of \$285K. Modoc Medical Center shows a net income of \$1.53 million that was \$358K favorable to budget.



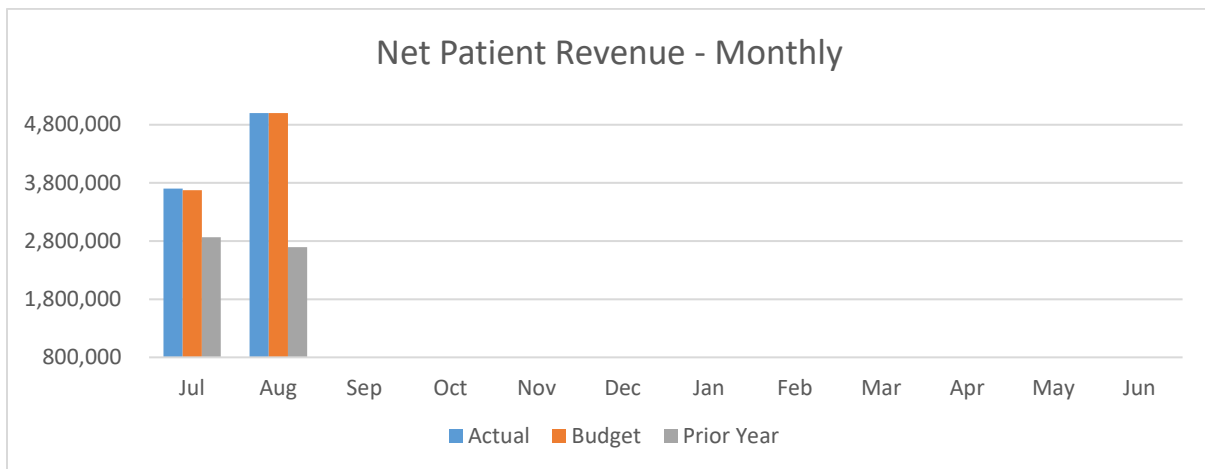
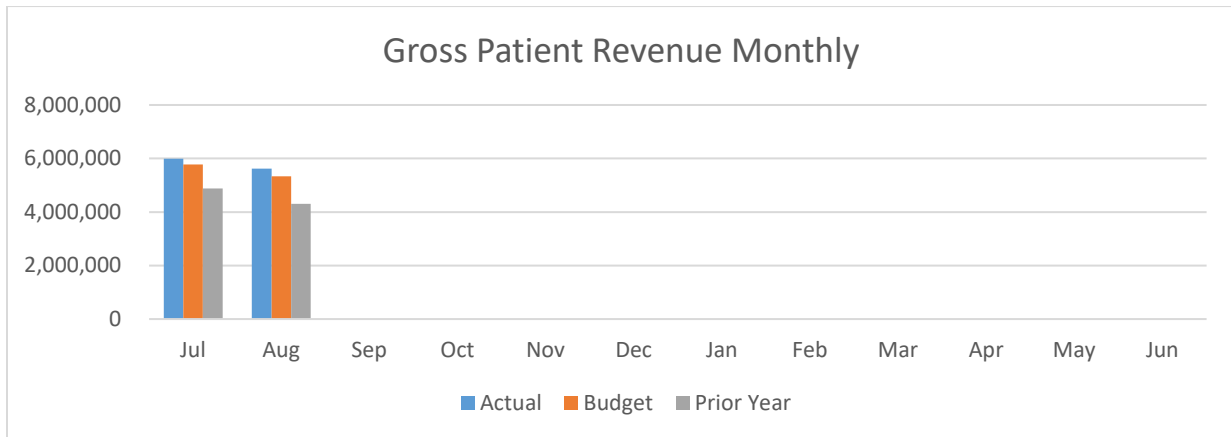
Patient Volumes

Combined Acute Days were in line with the budget for the month. SNF Patient Days were 2,030 for the month. Overall Inpatient and SNF Days were below budget by 11 days (2,139 actual vs. 2,150 budget). Most outpatient visits were above budget; however, Surgery and Ultrasounds were below budget.



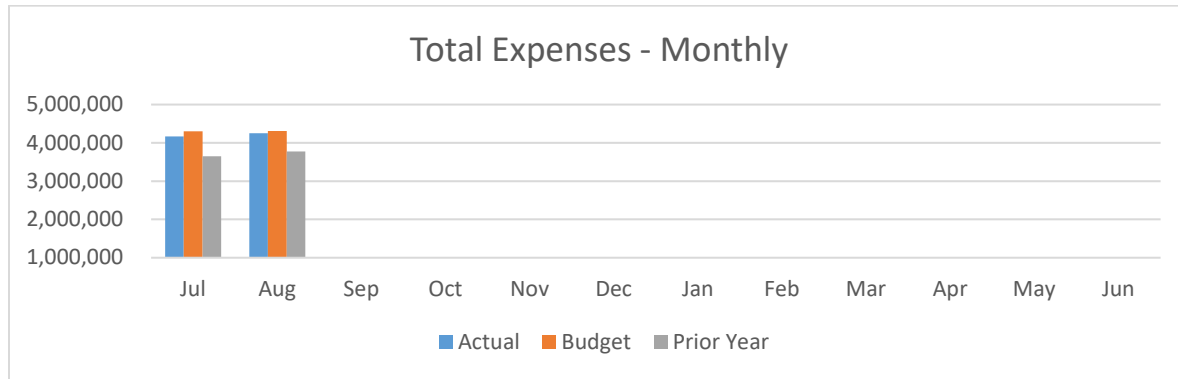
Revenues

During the month of August, gross revenue (total patient revenue plus other revenue) exceeded budget by \$302K. Net revenue was above budget by \$92K. Gross Patient Revenue was \$5.62 million vs \$5.34 million budgeted. Inpatient Revenue was \$1.79 million vs \$1.77 million budgeted; and Outpatient Revenue was \$3.83 million vs \$3.56 million budgeted. Total deductions from revenue were \$57K and unfavorable to the budget of \$209K. Net patient Revenue was \$5.56 million which was above budget by \$76K.



Expenses

Total operating expenses were \$4.25 million for the month and finished \$57K favorable to the expense budget.

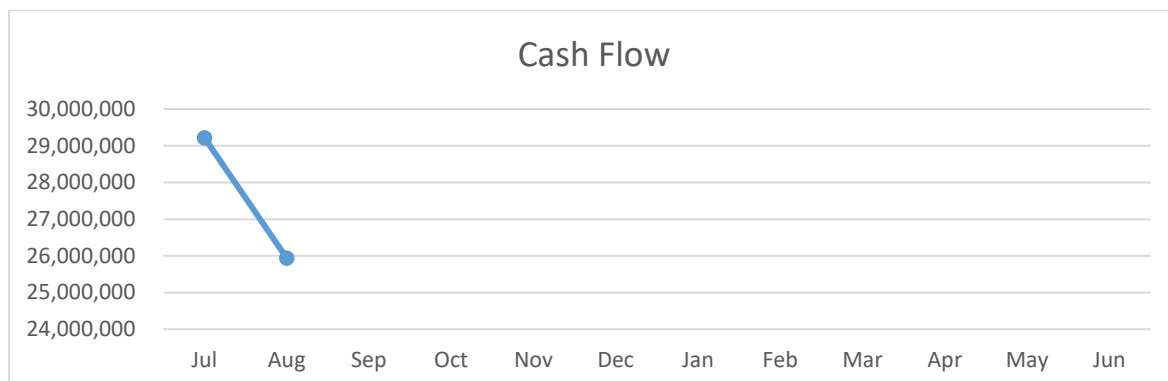


Non-Operating Activity

Non-Operating activities for the month were as follows: Property tax revenue was \$58K. Accrued Interest expense from USDA Loan was \$160K. Interest income of \$21K was earned from CDs. The retail pharmacy showed a profit of \$266K. District vouchers were \$4K. Total non-operating net income for the month was \$182K vs net loss of \$26K budgeted.

Balance Sheet

Cash for the month was 25.94 million. Cash was down \$3 million from the prior month due to the IGT funding. The total current liabilities were \$4.84 million. Days in Cash totaled 188. Days in AP totaled 13. Days in AR totaled 59. The current ratio was 8.03. Net AR as a percentage of gross AR was 42.26%.



Modoc Medical Center
Income Statement Trend

	FYE 2026 YTD July-August	Jul-25	Aug-25	FYE 2027 YTD July-August	Jul-26	Aug-26
Revenues						
Room & Board - Acute	1,214,896	685,444	529,453	1,176,995	597,488	579,507
Room & Board - SNF	1,734,807	841,152	893,655	2,430,291	1,224,573	1,205,718
	0	-	-	-	-	-
<u>Total Inpatient Revenue</u>	<u>2,949,703</u>	<u>1,526,595</u>	<u>1,423,108</u>	<u>3,607,286</u>	<u>1,822,061</u>	<u>1,785,225</u>
Outpatient Revenue	6,230,550	3,351,869	2,878,680	7,999,015	4,164,442	3,834,573
<u>Total Patient Revenue</u>	<u>9,180,253</u>	<u>4,878,465</u>	<u>4,301,788</u>	<u>11,606,301</u>	<u>5,986,503</u>	<u>5,619,798</u>
Bad Debts	185,777	84,182	101,595	205,368	(1,500)	206,868
Contractual Adjs	3,400,397	1,918,848	1,481,549	1,943,172	2,120,590	-177,418
Admin Aids	36,602	12,361	24,241	190,226	162,821	27,405
<u>Total Revenue Deductions</u>	<u>3,622,776</u>	<u>2,015,392</u>	<u>1,607,384</u>	<u>2,338,767</u>	<u>2,281,911</u>	<u>56,856</u>
<u>Net Patient Revenue</u>	<u>5,557,477</u>	<u>2,863,073</u>	<u>2,694,403</u>	<u>9,267,534</u>	<u>3,704,592</u>	<u>5,562,942</u>
% of Charges	60.5%	58.7%	62.6%	79.8%	61.9%	99.0%
Other Revenue	52,246	37,741	14,505	94,446	61,641	32,805
<u>Total Net Revenue</u>	<u>5,609,722</u>	<u>2,900,814</u>	<u>2,708,908</u>	<u>9,361,981</u>	<u>3,766,233</u>	<u>5,595,748</u>
Expenses						
Salaries	3,475,773	1,785,419	1,690,354	3,726,412	1,921,069	1,805,343
Benefits and Taxes	759,993	377,349	382,644	909,167	477,366	431,801
Registry	469,630	262,589	207,040	656,095	207,441	448,654
Professional Fees	868,159	379,442	488,717	1,036,759	466,740	570,019
Purchased Services	268,619	58,880	209,739	364,726	238,274	126,452
Supplies	741,660	397,284	344,376	673,031	339,429	333,602
Repairs and Maint	113,131	32,193	80,938	92,559	53,881	38,678
Lease and Rental	4,076	2,393	1,683	7,650	3,804	3,846
Utilities	119,836	59,208	60,628	162,923	80,748	82,175
Insurance	87,522	43,282	44,241	71,515	27,708	43,807
Depreciation	367,717	183,888	183,829	546,516	272,244	274,272
Other	147,790	70,025	77,764	181,763	88,387	93,376
<u>Total Operating Expenses</u>	<u>7,423,906</u>	<u>3,651,953</u>	<u>3,771,953</u>	<u>8,429,114</u>	<u>4,177,091</u>	<u>4,252,023</u>
<u>Income from Operations</u>	<u>(1,814,184)</u>	<u>(751,139)</u>	<u>(1,063,045)</u>	<u>932,867</u>	<u>(410,858)</u>	<u>1,343,725</u>
Property Tax Revenue	61,179	0	61,179	58,273	0	58,273
Interest Income	318,439	214,111	104,327	55,647	34,215	21,432
Interest Expense	(165,688)	(83,144)	(82,545)	(317,906)	(157,425)	(160,481)
Gain/Loss on Asset Disposal/Forte	0	0	0	0	0	0
Retail Pharmacy Net Activity	329,474	93,595	235,880	348,999	82,782	266,217
DISTRICT VOUCHERS AND OTHER	(15,404)	(7,186)	(8,218)	(9,369)	(5,753)	(3,616)
<u>Total Non-Operating Revenue</u>	<u>527,999</u>	<u>217,376</u>	<u>310,623</u>	<u>135,643</u>	<u>(46,181)</u>	<u>181,824</u>
<u>Net Income</u>	<u>(1,286,184)</u>	<u>(533,763)</u>	<u>(752,421)</u>	<u>1,068,510</u>	<u>(457,039)</u>	<u>1,525,549</u>
<u>EBIDA</u>	<u>(752,779)</u>	<u>(266,732)</u>	<u>(486,048)</u>	<u>1,932,932</u>	<u>(27,370)</u>	<u>1,960,302</u>
Operating Margin %	-32.3%	-25.9%	-39.2%	10.0%	-10.9%	24.0%
Net Margin %	-22.9%	-18.4%	-27.8%	11.4%	-12.1%	27.3%
EBIDA Margin %	-13.4%	-9.2%	-17.9%	20.6%	-0.7%	35.0%

Modoc Medical Center
Income Statement
For the month of August 2026

	Month	Aug-26 Budget	Variance	Prior Year Month	2027 YTD	2027 YTD Budget	Variance	Prior Year YTD
Revenues								
Room & Board - Acute	579,507	555,921	23,586	529,453	1,176,995	1,269,393	(92,398)	1,214,896
Room & Board - SNF	1,205,718	1,219,075	(13,357)	893,655	2,430,291	2,438,150	(7,859)	1,734,807
<u>Total Inpatient Revenue</u>	<u>1,785,225</u>	<u>1,774,996</u>	<u>10,229</u>	<u>1,423,108</u>	<u>3,607,286</u>	<u>3,707,543</u>	<u>(100,257)</u>	<u>2,949,703</u>
Outpatient Revenue	3,834,573	3,560,286	274,287	2,878,680	7,999,015	7,399,169	599,846	6,230,550
<u>Total Patient Revenue</u>	<u>5,619,798</u>	<u>5,335,282</u>	<u>284,516</u>	<u>4,301,788</u>	<u>11,606,301</u>	<u>11,106,712</u>	<u>499,589</u>	<u>9,180,253</u>
Bad Debts (580000,580011,58010)	206,868	102,251	104,617	101,595	205,368	212,860	(7,492)	185,777
Contractuals Adjs	(177,418)	(368,451)	191,033	1,481,549	1,943,172	1,480,880	462,292	3,400,397
Admin Adjs (5930002-593001,598)	27,405	114,185	(86,780)	24,241	190,226	250,066	(59,840)	36,602
<u>Total Revenue Deductions</u>	<u>56,856</u>	<u>(152,015)</u>	<u>208,871</u>	<u>1,607,384</u>	<u>2,338,767</u>	<u>1,943,806</u>	<u>394,960</u>	<u>3,622,776</u>
<u>Net Patient Revenue</u>	<u>5,562,942</u>	<u>5,487,297</u>	<u>75,645</u>	<u>2,694,403</u>	<u>9,267,534</u>	<u>9,162,906</u>	<u>104,629</u>	<u>5,557,477</u>
% of Charges	99.0%	102.8%	-3.9%	62.6%	79.8%	1	-2.6%	60.5%
Other Revenue	32,805	15,508	17,297	14,505	94,446	53,249	41,198	52,246
<u>Total Net Revenue</u>	<u>5,595,748</u>	<u>5,502,805</u>	<u>92,942</u>	<u>2,708,908</u>	<u>9,361,981</u>	<u>9,216,154</u>	<u>145,826</u>	<u>5,609,722</u>
Expenses								
Salaries	1,805,343	1,921,563	(116,221)	1,690,354	3,726,412	3,841,598	(115,187)	3,475,773
Benefits and Taxes	431,801	403,943	27,858	382,644	909,167	807,761	101,406	759,993
Registry	448,654	329,734	118,920	207,040	656,095	659,468	(3,373)	469,630
Professional Fees	570,019	523,611	46,408	488,717	1,036,759	1,047,222	(10,463)	868,159
Purchased Services	126,452	144,198	(17,746)	209,739	364,726	288,365	76,360	268,619
Supplies	333,602	415,144	(81,543)	344,376	673,031	830,289	(157,258)	741,660
Repairs and Maint	38,678	39,752	(1,074)	80,938	92,559	78,353	14,206	113,131
Lease and Rental	3,846	4,361	(515)	1,683	7,650	8,722	(1,072)	4,076
Utilities	82,175	92,818	(10,643)	60,628	162,923	185,636	(22,714)	119,836
Insurance	43,807	41,020	2,787	44,241	71,515	82,040	(10,525)	87,522
Depreciation	274,272	311,193	(36,921)	183,829	546,516	622,386	(75,870)	367,717
Other	93,376	81,775	11,600	77,764	181,763	162,337	19,426	147,790
<u>Total Operating Expenses</u>	<u>4,252,023</u>	<u>4,309,113</u>	<u>(57,090)</u>	<u>3,771,953</u>	<u>8,429,114</u>	<u>8,614,177</u>	<u>(185,063)</u>	<u>7,423,906</u>
<u>Income from Operations</u>	<u>1,343,725</u>	<u>1,193,693</u>	<u>150,032</u>	<u>(1,063,045)</u>	<u>932,867</u>	<u>601,977</u>	<u>330,890</u>	<u>(1,814,184)</u>
Property Tax Revenue	58,273	0	58,273	61,179	58,273	0	58,273	61,179
Interest Income	21,432	80,263	(58,831)	104,327	55,647	160,525	(104,879)	318,439
Interest Expense	(160,481)	(151,552)	(8,929)	(82,545)	(317,906)	-303,188	(14,718)	(165,688)
Gain/Loss on Asset Disposal/Forte	0	0	0	0	0	0	0	0
Retail Pharmacy Net Activity	266,217	50,994	215,223	235,880	348,999	101,988	247,011	329,474
DISTRICT VOUCHERS AND OTHER	(3,616)	(5,903)	2,287	(8,218)	(9,369)	-11,807	2,438	(15,404)
<u>Total Non-Operating Revenue</u>	<u>181,824</u>	<u>(26,199)</u>	<u>208,022</u>	<u>310,623</u>	<u>135,643</u>	<u>-52,482</u>	<u>188,124</u>	<u>527,999</u>
<u>Net Income/(Loss)</u>	<u>1,525,549</u>	<u>1,167,494</u>	<u>358,055</u>	<u>(752,421)</u>	<u>1,068,510</u>	<u>549,495</u>	<u>519,014</u>	<u>(1,286,184)</u>
<u>EBIDA</u>	<u>1,960,302</u>	<u>1,630,239</u>	<u>330,063</u>	<u>(486,048)</u>	<u>1,932,932</u>	<u>1,475,070</u>	<u>457,862</u>	<u>(752,779)</u>
Operating Margin %	24.0%	21.7%	2.3%	-39.2%	10.0%	6.5%	3.4%	-32.3%
Net Margin %	27.3%	21.2%	6.0%	-27.8%	11.4%	6.0%	5.5%	-22.9%
EBIDA Margin %	35.0%	29.6%	5.4%	-17.9%	20.6%	16.0%	4.6%	-13.4%

Modoc Medical Center
Balance Sheet
For the month of August 2026

	Unaudited <u>8/31/2026</u>	Unaudited <u>7/31/2026</u>	Unaudited <u>6/30/2026</u>
Cash	555,519	755,711	1,879,867
Investments	23,326,952	26,412,621	26,985,025
Designated Funds	2,057,622	2,050,688	2,044,269
Total Cash	<u>25,940,092</u>	<u>29,219,019</u>	<u>30,909,161</u>
Gross Patient AR (Patient AR-I	10,718,330	11,346,763	10,708,215
Allowances	(6,188,493)	(6,222,498)	(5,969,738)
Net Patient AR	<u>4,529,837</u>	<u>5,124,265</u>	<u>4,738,476</u>
% of Gross	42.3%	45.2%	44.3%
Third Party Receivable	5,778,589	147,637	119,517
Other AR	1,032,168	1,013,913	905,739
Inventory	615,732	621,732	600,312
Prepays	929,396	888,634	808,023
Total Current Assets	<u>38,825,814</u>	<u>37,015,201</u>	<u>38,081,228</u>
Land (120000-120900)	713,540	713,540	713,540
Bldg & Improvements (12110	104,957,482	104,953,797	104,953,797
Equipment (124100-124204)	16,993,974	16,670,814	16,670,814
Construction In Progress (125	2,509,684	2,407,321	2,335,463
Fixed Assets	<u>125,174,680</u>	<u>124,745,472</u>	<u>124,673,614</u>
Accum Depreciation	(23,858,675)	(23,584,205)	(23,311,763)
Net Fixed Assets	<u>101,316,005</u>	<u>101,161,267</u>	<u>101,361,851</u>
Other Assets	0	0	0
Total Assets	<u>140,141,819</u>	<u>138,176,468</u>	<u>139,443,079</u>
Accounts Payable	1,648,645	1,398,960	1,447,470
Accrued Payroll	2,187,444	2,040,737	1,822,787
Patient Trust Accounts	11,755	11,890	11,890
Third Party Payables	554,000	554,000	554,000
Accrued Interest			
Current Portion Liabilities	263,132	263,132	263,132
Other Current Liabilities/Accr	172,564	95,407	481,903
Total Current Liabilities	<u>4,837,539</u>	<u>4,364,125</u>	<u>4,581,181</u>
Long Term Liabilities	54,686,470	54,713,576	55,312,597
Total Liabilities	<u>59,524,010</u>	<u>59,077,701</u>	<u>59,893,778</u>
Fund Balance	79,549,300	79,549,300	79,549,300
Current Year Income/(Loss)	1,068,509	(450,534)	
Total Equity	<u>80,617,810</u>	<u>79,098,766</u>	<u>79,549,300</u>
Total Liabilities and Equity	<u>140,141,819</u>	<u>138,176,467</u>	<u>139,443,078</u>
Days in Cash	188	217	241
Days in AR (Gross)	59	59	58
Days in AP	13	11	12
Current Ratio	8.03	8.48	8.31
Net AR as a percentage of gro	42.26%	45.16%	44.25%

STATEMENT OF CASH FLOWS

August-26

	CURRENT MONTH	FISCAL YEAR YTD
CASH FLOWS FROM OPERATING ACTIVITIES		
NET INCOME	1,525,549	1,068,510
ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
DEPRECIATION EXPENSE	274,469	546,909
CHANGE IN PATIENT ACCOUNTS RECEIVABLE	594,427	208,640
CHANGE IN OTHER RECEIVABLES	-5,649,206	-5,785,501
CHANGE IN INVENTORIES	6,000	-15,420
CHANGE IN PREPAID EXPENSES	-40,762	-121,373
CHANGE IN ACCOUNTS PAYABLE	243,180	201,175
CHANGE IN ACCRUED SALARIES AND RELATED TAXES	146,707	364,657
CHANGE IN OTHER PAYABLES	0	0
NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	-4,425,184	-4,600,914
CASH FLOWS FROM INVESTMENT ACTIVITIES		
PURCHASE OF EQUIPMENT/CIP	-429,208	-501,065
CUSTODIAL HOLDINGS	-135	-135
NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES	-429,343	-501,200
CASH FROM FINANCING ACTIVITIES		
Current Liability	77,157	-309,339
Long Term Liability	-27,106	-626,127
NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES	50,051	-935,466
CASH AT BEGINNING OF PERIOD	29,219,019	30,909,161
NET INCREASE (DECREASE) IN CASH	-3,278,927	-4,969,070
CASH AT END OF PERIOD	25,940,092	25,940,092

MODOC MEDICAL CENTER																											
"KEY STATISTICS"																											
Twelve Months Ending August 31st, 2026																											
	Aug-26		Jul-26		Jun-26		May-26		Apr-26		Mar-26		Feb-26		Jan-26		Dec-25		Nov-25		Oct-25		Sep-25		FY 27 YTD	FY 26 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	50	49	71	53	61	64	40	81	53	76	45	64	89	48	49	56	69	64	56	83	52	75	47	86	121	102	682
Swing	59	61	61	87	54	58	20	56	59	59	87	65	98	73	54	57	124	70	92	46	38	76	74	49	120	225	820
SNF	2,030	2,040	1,958	2,040	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	3,988	3,002	20,694
Total "Patient Days"	2,139	2,150	2,090	2,180	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	4,229	3,329	22,196
ADC																											
Adults/Peds	1.61	1.58	2.29	1.71	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	1.95	1.65	1.87
Swing	1.90	1.97	1.97	2.81	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	1.94	3.63	2.25
SNF	65.48	65.81	63.16	65.81	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	64.32	48.42	56.70
Total "Average Daily Census"	69.00	69.35	67.42	70.32	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	68.21	53.69	60.81
ALOS																											
Adults/Peds	1.00		0.95		2.77		2.67		2.94		3.46		3.30		2.72		3.63		3.50		3.06		2.94		0.97	3.29	2.23
Swing	7.38		7.63		4.50		4.00		6.56		8.70		7.00		10.80		10.33		9.20		7.60		14.80		7.50	11.84	7.96
Admissions																											
Adults/Peds	50	14	75	17	22	14	15	17	18	20	13	20	27	17	18	17	19	19	16	8	17	20	16	28	125	31	306
Swing	8	7	8	12	12	8	5	10	9	4	10	11	14	6	5	6	12	9	10	10	5	5	5	8	16	19	103
SNF	2	1	2	5	4	3	6	4	7	1	10	2	3	-	2	2	-	2	5	2	-	2	-	2	4	6	41
Total "Admissions"	60	22	85	34	38	25	26	31	34	25	33	33	44	23	25	25	31	30	31	20	22	27	21	38	145	56	450
Discharges																											
SNF	1		2		4		3		7		3		1		1		2		1		1	-			3	3	26
Days in Period	31		31		30		31		30		31		28		31		31		30		31		30		62	62	365
Amulatory Service Statistics																											
Emergency Visits	523	494	515	487	514	468	532	439	440	518	485	510	444	482	485	440	486	510	474	421	550	474	471	476	1,038	981	5,919
Ambulance Runs Visits	77	82	74	106	77	87	71	86	56	92	65	99	78	95	73	87	107	93	90	93	78	91	94	83	151	188	940
Clinic Visits	861	827	999	959	946	903	901	932	972	905	1,112	872	968	790	805	970	772	684	808	813	837	923	791	809	1,860	1,786	10,772
Canby Clinic Visits	354	248	293	312	321	208	293	227	276	257	216	872	220	243	222	290	290	251	202	264	233	268	210	225	647	560	3,130
Canby Dental	173	169	196	169	204	174	168	173	347	163	170	171	158	133	178	185	145	147	129	171	183	200	195	180	369	338	2,246
Observation Admits	3	1	3	2	6	5	6	5	6	5	1	3	4	2	7		1	5	5	4	2	2	-	5	6	3	44
Observation Care Hours	82.1	26	96.5	145	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	179	171	1,604
Ancillary Services Statistics																											
Surgeries	2	3	2	2	-	2	2	11	5	2	8	3	4	4	4	10	3	11	4	2	3	3	10	4	4	5	47
Endoscopies	17	24	24	17	21	25	22	19	26	21	17	21	16	20	21	28	23	20	23	21	35	20	21	25	41	41	266
Surgery & Recovery Minutes	489	638	618	414	428	802	643	869	835	767	541	623	732	666	632	682	658	731	577	462	1,016	566	716	498	1,107	1,052	7,885
Anesthesia Minutes	729	1,014	976	667	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	1,705	1,681	11,754
Laboratory Tests	5,117	4,772	5,776	5,241	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	10,893	10,013	60,050
EKG Tests-Acute Proc																									-	-	-
EKG Tests-Clinic Proc																									-	-	-
Radiology-Diagnostic Proc	281	267	329	330	333	272	292	289	304	227	345	258	348	301		282	287	256	236	261	307	285	244	267	610	597	3,306
Ultrasounds Proc	111	114	125	156	143	89	98	86	135	92	127	75	96	105		92	126	86	73	53	138	106	112	99	236	270	1,284
CT Scans Proc	184	181	190	196	187	146	184	140	166	167	142	149	181	153		127	182	145	160	152	149	152	168	128	374	377	1,893
MRI Proc	41	38	42	38	47		49		38		38		39				45		21	15		-			83	-	360
Physical Therapy Sessions	796	660	880	660	840	613	709	627	497	763	873	745	409	517	469	569	545	429	450	542	582	552	851	573	1,676	2,199	7,901
Retail Pharmacy-Scripts	4,458	3,555		3,441	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	4,458	6,996	49,129

MODOC MEDICAL CENTER "FULL TIME EQUIVALENT REPORT" Twelve Months Ending: August 31, 2026													
Department	Aug-26	Jul-26	Jun-26	May-26	Apr-26	Mar-26	Feb-26	Jan-26	Dec-25	Nov-25	Oct-25	Sep-25	12 Mo Ave
Med / Surg	16.66	17.19	16.65	16.55	16.98	18.32	19.24	18.35	16.90	17.36	15.63	15.21	17.09
Comm Disease Care Swing Beds													
Long Term - SNF	71.11	75.09	75.87	74.52	69.35	69.30	61.27	59.65	37.41	64.09	59.56	56.28	64.46
Mountainview - SNF	16.67	3.47	2.52	3.25	3.31	2.91	9.79	10.26	31.66				9.32
Emergency Dept	14.32	14.17	13.46	13.80	12.79	11.46	13.66	12.26	11.60	12.19	12.93	12.49	12.93
Ambulance - Alturas	11.88	11.96	11.67	11.82	12.65	10.99	11.90	10.55	11.55	10.79	10.86	11.31	11.49
Clinic	20.61	21.84	22.33	19.97	21.74	21.85	20.74	17.92	17.28	19.78	19.45	20.43	20.33
Canby Clinic	11.78	11.31	11.49	11.37	11.31	9.29	9.48	9.04	10.54	11.49	12.06	11.47	10.89
Canby Dental	3.96	3.98	3.77	3.89	3.94	4.59	4.60	4.43	4.66	5.11	4.75	4.86	4.38
Surgery	3.95	3.78	3.64	3.90	3.97	4.10	4.45	3.67	4.33	5.05	4.12	3.97	4.08
IRR													
Lab	8.93	8.46	8.68	8.20	8.94	8.29	8.32	8.65	8.51	8.90	8.94	9.08	8.66
Radiology	5.46	5.25	5.73	5.49	5.77	5.56	6.49	6.05	6.86	7.13	5.37	5.05	5.85
MRI													
Ultrasound	1.43	1.39	1.46	1.24	1.33	1.36	1.42	1.70	1.39	1.33	1.37	1.31	1.39
CT	1.14	1.24	1.54	1.18	1.24	1.31	1.58	1.34	1.51	1.81	1.29	1.62	1.40
Pharmacy	2.11	2.02	2.10	2.09	2.13	2.24	2.12	2.01	2.05	2.00	1.96	2.16	2.08
Physical Therapy	6.53	7.46	7.08	6.49	6.65	6.25	7.35	6.30	6.61	7.38	6.40	4.84	6.61
Other PT													
Dietary	19.04	18.67	18.17	18.38	19.02	17.10	18.14	19.07	13.72	16.43	12.85	12.25	16.90
Dietary - MV SNF	4.79	4.86	4.65	4.20	3.73	2.98	3.10	2.33	5.89				4.06
Dietary Acute	8.82	8.76	8.08	9.68	9.62	8.29	7.52	7.35	7.48	7.08	8.43	8.17	8.27
Laundry	1.00	1.07	1.01	1.06	1.05	1.01	1.02	1.01	1.00	1.10	1.00	1.01	1.03
Activities	6.18	5.71	5.58	5.14	5.59	5.75	5.87	5.21	5.11	5.72	5.67	4.74	5.52
Social Services	3.60	3.89	3.97	4.00	3.07	2.77	1.96	2.16	1.79	1.97	2.02	1.82	2.75
Purchasing	3.00	2.96	3.03	2.98	3.01	2.99	2.98	3.01	3.01	3.01	2.92	3.00	2.99
Housekeeping	18.40	18.76	18.95	19.87	20.37	20.55	18.65	16.81	17.10	15.12	13.97	13.67	17.69
Maintenance	6.06	6.08	5.99	5.77	5.94	5.91	5.99	6.03	6.06	5.93	6.05	5.80	5.97
Data Processing	4.75	4.49	4.68	4.72	4.41	4.11	4.21	4.16	4.07	4.87	4.68	4.69	4.49
General Accounting	3.24	3.53	3.29	3.54	2.88	3.84	3.86	4.21	4.14	3.92	3.94	3.71	3.68
Patient Accounting	7.93	7.84	8.73	8.97	9.08	9.34	8.45	9.48	9.13	9.30	8.46	7.67	8.70
Administration	3.62	3.32	3.47	3.65	3.27	3.51	3.44	3.21	3.38	3.37	3.49	3.43	3.43
Human Resources	2.96	2.95	2.98	2.93	2.85	2.88	2.12	2.89	2.99	3.01	2.97	2.85	2.87
Medical Records	8.55	8.72	8.70	8.65	8.75	8.74	8.81	8.52	8.58	8.70	7.76	7.96	8.54
Nurse Administration	3.23	3.00	3.02	3.16	3.02	3.11	2.77	2.93	2.91	2.78	3.07	3.02	3.00
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
Utilization Review	1.44	1.45	1.45	1.47	1.49	1.43	1.50	1.44	1.48	1.49	1.49	1.44	1.46
Quality Assurance	0.50	0.50	0.50	0.51	0.50	0.50	0.50	0.50	0.50	0.50	0.51	0.50	0.50
Infection Control	0.64	0.40	0.58	0.59	0.60	0.59	0.60	0.59	0.59	0.61	0.69	0.64	0.59
Retail Pharmacy	6.41	6.94	5.63	6.60	6.43	6.16	6.41	7.15	6.41	6.39	6.67	6.17	6.45
TOTAL	311.70	303.51	301.45	300.63	297.78	290.38	291.31	281.24	279.20	276.71	262.33	253.62	287.49

ATTACHMENT G

Budget Amendment

Modoc Medical Center
3 year Capital Budget starting FYE 2027

<u>Description</u>	<u>Budget Amount</u>	<u>Department</u>	<u>Funding Source</u>	<u>Fiscal Year</u>
Server Upgrades	\$ 25,000	Data Processing	District	FYE 2027
Computers (50)	\$ 85,000	Data Processing	District	FYE 2027
Omni Cell Replace	\$ 750,000	Pharmacy	District	FYE 2027
Remainder of NMR drawings for Clinic Expansion	\$ 380,000	Alturas Clinic	District	FYE 2027
Remainder of Hospital Generator Project	\$ 300,000	Maintenance	District	FYE 2027
Pictures for New SNF	\$ 60,000	Mountainview	District	FYE 2027
Canby Clinic - New Outdoor Signs	\$ 30,000	Canby Clinic	District	FYE 2027
Hospital Intersection Lighting Project and New Signage	\$ 40,000	Maintenance	District	FYE 2027
Remainder of Canby Clinic Remodel	\$ 50,000	Canby Clinic	District	FYE 2027
Street Test Treadmill	\$ 15,000	Maintenance	District	FYE 2027
New EKG Machines	\$ 10,000	Emergency Room	District	FYE 2027
Tiny Home/Sleep Room ER Physicians	\$ 200,000	Emergency Room	District	FYE 2027
Pharmacy Remodel/ER Sleep Room Conversion	\$ 100,000	Hospital Pharmacy	District	FYE 2027
Tray Cart	\$ 10,000	Acute Dietary	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
Side Walk - Support Service	\$ 25,000	Maintenance	District	FYE 2027
Snow Plow for Pickup	\$ 15,000	Maintenance	District	FYE 2027
Canby Well House - Remodel	\$ 5,000	Canby Clinic	District	FYE 2027
Mobile MRI Machine (Shared with Collaborative)	\$ 350,000	Radiology	District	FYE 2027
Metal Storage Building	\$ 500,000	Purchasing	District	FYE 2027
Drawings Support Svcs Office Building	\$ 350,000	Administration	District	FYE 2027
Warnerview Remodel	\$ 100,000	Warnerview	District	FYE 2027
Landscaping Improvements	\$ 40,000	Multiple	District	FYE 2027
Solar Proposal/Design/Bidding	\$ 300,000	Maintenance	District	FYE 2027
Wash & Dry Machines	\$ 5,000	Laundry	District	FYE 2027
Laparoscopic Camera and Tower	\$ 97,349	Surgery	District	FYE 2027
Drawings Support Svcs Office Building	\$ 350,000	Administration	District	FYE 2027
Pediatric Colonoscope	\$ 30,037	Surgery	District	FYE 2027
Acquire More Staff Housing	\$ 500,000	Multiple	District	FYE 2027
PHILIPS US W/Cardiovascular MACHINE	\$ 275,472	US	District	FYE 2027
Subtotal FYE 2027	\$ 5,202,857			

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			

Modoc Medical Center - Budget FY 27

Income Statement Compared to Annualized FY 26 Performance

	<u>YTD March 2026</u>		<u>Annualized</u>	<u>FYE 2027 BudgetTotal</u>
IP Acute Rev	5,409,624		7,274,374	7,274,373
IP SNF Rev	8,331,712		15,457,750	15,457,750
IP Ancillary Rev	0		0	
<u>Total IP Rev</u>	<u>13,741,336</u>		<u>22,732,124</u>	<u>22,732,123</u>
OP Rev	31,808,006		44,425,261	44,571,920
<u>Total Pt Rev</u>	<u>45,549,343</u>		<u>67,157,385</u>	<u>67,304,043</u>
BD	1,158,550		1,544,733	1,675,814
Contractual Allowance	6,183,314		8,244,419	10,840,093
Admin	(34,546)		(46,061)	439,424
<u>Total Deducs</u>	<u>7,307,318</u>		<u>9,743,091</u>	<u>12,955,331</u>
<u>Net Pt Rev</u>	<u>38,242,024</u>		<u>57,414,294</u>	<u>54,348,713</u>
% of Gross	83.96%		85.49%	80.75%
Other Rev	360,162		485,018	485,018
Total Net Rev	38,602,186		57,899,311	54,833,730
Salaries	16,633,597		20,758,729	22,900,587
Benefits	3,626,642		4,526,049	4,835,571
Registry	2,196,204		2,635,445	3,956,808
Pro Fees	4,210,164		5,252,197	5,605,002
Purch Svcs	1,311,838		1,574,205	2,468,076
Supplies	3,429,585		4,321,278	5,007,802
Repairs	366,240		439,488	468,827
Lease	63,349		76,018	71,018
Utils	715,774		927,643	951,817
Ins	413,646		496,376	492,242
Depr	2,059,927		2,471,913	3,500,183
Other	698,460		838,152	873,013
Total Op Exp	35,725,427		44,317,493	51,130,946
Income from Operations	2,876,759		13,581,819	3,702,784
Prop Tax	2,341,416		2,554,272	2,336,521
Int Income	882,890		963,153	963,153
Int Exp	(2,023,801)		(2,207,783)	(1,796,717)
Gain/Loss	0		0	0
Retail Rx	791,716		863,691	608,100
District Vouchers	65,945		71,940	(70,840)
Total Non-Op	2,058,166		2,245,272	2,040,217
Total Net Income	4,934,926		15,827,091	5,743,001

ATTACHMENT H
Dr. Julie Torman
Contract



EMPLOYMENT AGREEMENT

THIS AGREEMENT is made and entered into as of 9/28/2026, by and between **Last Frontier Healthcare District dba Modoc Medical Center** (“Employer”) and **Julie Torman, MD** (“Employee”).

STATEMENT OF BACKGROUND INFORMATION

- A. Employer is a Healthcare District that operates two Rural Health Clinics, Critical Access Hospital and Skilled Nursing Facility with medical offices located in Alturas, California and Canby, California.
- B. Employee is a physician licensed to practice medicine in the State of California.
- C. Employer desires to employ Employee as a practicing physician specializing in Gastroenterology, and Employee desires to be employed in such capacity, in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants, agreements and conditions hereinafter set forth, the parties hereto agree as follows:

STATEMENT OF AGREEMENTS

- A. EMPLOYMENT.** Employer hereby employs Employee as a practicing physician, and Employee hereby accepts such employment subject to the supervision of Employer and otherwise in accordance with the terms of this Agreement. Employee’s first day of employment under this Agreement shall be 9/28/2026.

- B. RESPONSIBILITIES OF EMPLOYER.**

- 1. Compensation.** Employee shall be paid an hourly rate of \$343.24 per hour for hours worked under this Agreement. Employee shall be paid on a bi-weekly basis. Employee shall be given a 3.5% increase on the 1st day of June of each year served under this contract. Employee shall also receive a 0.5% increase in wage rate during the first full pay period following her annual anniversary date under this Agreement.

Compensation paid under this Paragraph shall be subject to mandatory State and Federal withholdings.

- 2. Additional Compensation.** In addition to the compensation provided for in Paragraph B.1 herein, Employee shall be provided housing by Employer or shall be reimbursed for housing by Employer. Employer will also reimburse Employee the IRS mileage rate for traveling to and from work from Employee’s primary place of residence.
 - 3. Benefits.** Employer shall not provide Employee with health insurance, retirement, paid time off, or any other benefits normally provided to full-time employees of Employer.

4. **Professional Liability Insurance Agreement.** During the term of this Agreement, Employer shall obtain and maintain liability insurance for the practice of medicine by Employee on behalf of Employer. Such insurance shall be for the same amount as provided for all physicians for Employer. Insurance coverage shall be maintained to provide physician with continuous coverage for services provided by Employee under this contract, even after this agreement is terminated by either party.
5. **Support Services.** Employer shall furnish to Employee all of the necessary support services, including but not limited to, equipment, facilities, supplies, medical support employees, secretaries and other personnel reasonably needed by Employee to perform Employee's obligations created by this Agreement. The cost of providing these support services shall be borne solely by Employer.
6. **Employer's Authority.** Employer shall exercise direction over and give support to Employee in regard to standards, policies, record keeping and other operational matters; such direction and support shall not interfere with the normal physician-patient relationship nor be in violation of acceptable medical ethics. Such direction will not be exercised over patient care and the practice of medicine by Employee. Patient care and the practice of medicine by Employee will be overseen, reviewed and monitored by the Medical Staff Committee and Medical Executive Committee. Employer shall have the right to determine which staff person(s) will render support to Employee for operational procedures that are the Employer's responsibility.

C. RESPONSIBILITIES OF EMPLOYEE.

1. **Professional Services.** While working for Employer under this Agreement, Employee shall devote full-time, all his or her professional time and efforts to and for the benefit of Employer and shall not, directly or indirectly, render professional, medical, managerial or directive services to any person, whether or not for compensation, except as an Employee of Employer, unless Employee shall first have obtained the written consent of Employer. Passive and personal investments and the conduct of private business affairs by Employee that are not inconsistent with the restrictions of this Paragraph shall not be prohibited hereunder. Employee shall be committed to enhancement of Employer's practice and shall use his or her best efforts to further the goals of and to promote the medical practice of the Employer. The expenditure of reasonable amounts of time for teaching, personal, charitable and professional activities shall not be deemed a breach of this Agreement provided such activities do not materially interfere with the services required to be rendered to Employer hereunder.

Employee shall work 2-5 days per month for Employer, based upon the demand for medical services and Employee's availability to work. Employee shall provide care and consults/visits to outpatients in the hospital and in the rural health clinic, while on duty as a physician specializing in Gastroenterology.

2. **Standards of Practice.** Employee shall devote his or her utmost knowledge and best skill to the care of Employer's patients, which are entrusted to him or her and shall perform such other duties as may be assigned to him or her by Employer. Employee understands that all patients are accepted by Employer regardless of their race, color, national origin, handicap or age.
3. **Ethical Conduct.** Employee shall engage in the practice of medicine in accordance with the Principles of Medical Ethics of the American Medical Association, and the customs and rules of ethical conduct prescribed by Employer in the Medical Staff Bylaws and Rules.
4. **License.** Employee shall maintain an unrestricted license to practice medicine in California.
5. **Privileges.** Employee agrees that Employee shall use best efforts to obtain and continue to maintain staff privileges that allow Employee to deliver services under this Agreement as a physician specializing in Gastroenterology at Modoc Medical Center.



6. **Medical Staff Policies and Procedures.** Employee shall abide by all policies and procedures for the Medical Staff as may be established from time to time by Employer.
7. **Billing.** Employee agrees and acknowledges that Employer alone has the right to bill and receive payment from patients and third-party payors, including all government-sponsored programs, for physician services rendered by Employee hereunder, and Employee shall not bill any patient or third-party payor for such services. All income or fees for physician services rendered by Employee shall belong to, and be the property of, the Employer.
8. **Surrender of Books and Records.** Employee acknowledges that all lists, books, records and any other materials owned by Employer or used by it in connection with the conduct of its business, shall at all times remain the property of the Employer, and that upon termination of employment hereunder, irrespective of the time, manner or cause of said termination, Employee will surrender to Employer all such lists, books, records and other materials. Paragraph C.8 herein shall survive termination of this Agreement.
9. **Use of Employee's Name.** Employer shall have the right to use Employee's name in connection with Employer's marketing and contracting activities, and in any oral or written communication with patients or third-party payors. Upon termination of this Agreement Employer must discontinue all marketing and contracting activities that contain Employee's name in oral or, written format.
10. **Medical Records.** Employee shall prepare and maintain for the benefit of Employer medical records for patients in accordance with accepted standards of practice in the community, applicable laws regarding confidentiality of medical reports, the policies and procedures established by Employer and the terms of any third-party payor agreements. Employee acknowledges and agrees that all such medical records are the property of Employer. To the extent permitted by law, Employee shall cooperate and communicate freely with other healthcare providers who provide professional services to patients of Employer.
11. **Reimbursement Contracts.** In the event that Employer elects to participate as a provider in an HMO, PPO, IPA or other care-delivery system, then Employee shall also be required to join.
12. **Relationship with Patients.** Employee shall not during the term of this Agreement:
 - a. Directly or indirectly induce or advise any patient of Employer to withdraw, curtail, withhold or cancel the patient's relationship with Employer; and
 - b. Directly or indirectly disclose to any person, firm, corporation or any other entity the names or addresses of any patients of Employer.

D. TERM AND TERMINATION

1. **Term.** This Agreement shall commence as of the date hereof, and shall continue for a period of two (2) years unless sooner terminated pursuant to this Agreement. Both parties agree to meet prior to expiration of this Agreement to discuss the extension of this Agreement and any contract language changes that are necessary to extend the Agreement. Any Agreement extension or amendments to the Agreement must be agreed to in writing by both parties.
2. **Termination.** This Agreement shall be terminated upon the happening of any of the following:
 - a. Whenever Employee shall not be duly licensed or otherwise legally authorized to practice medicine in the State of California.
 - b. Death of the Employee or the determination by either the Board of Directors of Employer or the



Courts, of the incompetence of Employee.

- c. Termination of Employer's medical group practice.
- d. At Employer's option, if Employee shall be disabled for one hundred and eighty (180) days or more, provided that such option shall be exercised in writing, delivered to the Employee, and shall be effective on delivery.
- e. The suspension, expulsion or any other disciplinary action finally taken by the Medical Board of California or an equivalent regulatory body.
- f. At the Employer's option, if Employee fails to obtain or continue to maintain privileges to practice at Employer's facilities.
- g. Employee bills third-party payors or accepts funds from either patients or third-party payors for Employee's own use.
- h. Conviction of a felony crime.
- i. Other actions determined by a neutral arbitrator to endanger the professional standing of the Employer's practice.
- j. Employee's failure to rectify a breach of any material term that is not specifically enumerated in Paragraph D.2 hereof, within thirty (30) days after written notice thereof from Employer.
- k. Notwithstanding any of the provisions of this Agreement, upon sixty (60) days prior written notice by either Employee or Employer to the other.

E. GENERAL PROVISIONS

1. **Notice.** Any notice required to be given pursuant to this Agreement shall be in writing and shall be sent by registered or certified mail, return receipt requested, postage prepaid, to the addresses set forth herein. Either party may, by notice given as aforesaid, change their address for all subsequent notices, except that neither party may require notices be sent to more than two addresses. Notices shall be deemed given when mailed in the manner provided in Section E.1 hereof.
2. **Severability.** Should one or more of the provisions contained in this Agreement for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement. Such invalid, illegal or unenforceable provision shall, to the extent permitted by law, be deemed amended and given such interpretation as to achieve the intent of this Agreement.
3. **Waiver.** Any party hereto may waive any right under this Agreement without invalidating the Agreement or waiving any other rights hereunder.
4. **Captions.** The captions used herein are for convenience only and are not a part of this Agreement and do not in any way limit or amplify the terms and provisions hereof.
5. **Non-Assignability.** This Agreement for personal services shall not be assignable, except to the parties hereto.
6. **Arbitration of Claims.** Following exhaustion of all dispute resolution procedures provided for under the



terms of this Agreement or under the policies and procedures of Employer, the Parties shall submit such disputes to binding arbitration in accordance with the applicable arbitration rules of the American Arbitration Association. The proceeding shall be held in Modoc County, California.

7. **Governing Law.** This Agreement shall be interpreted in the laws of the State of California.
8. **Entire Agreement.** This Agreement, and any attachments incorporated herein, constitute the entire Agreement between Employer and Employee with respect to the subject matter hereof and supersede all prior offers and negotiations, oral and written. This Agreement may not be amended or modified in any respect whatsoever, except by an instrument in writing signed by Employer and Employee.

INTENDING TO BE BOUND, the parties hereto have caused this Agreement to be duly executed and delivered as of the day and year first above written.

LAST FRONTIER HEALTHCARE DISTRICT dba MODOC MEDICAL CENTER

By: _____ Date: _____
Kevin Kramer, Chief Executive Officer
1111 North Nagle Street
P.O. Box 190
Alturas, CA 96101
k.kramer@modocmedicalcenter.org
530-708-8801

Julie Torman, MD

By: _____ Date: _____
Julie Torman, MD
PO Box 2652
Olympic Valley, CA 96146
julietormanmd@gmail.com
914-588-5315

ATTACHMENT I
Dr. Gustavo Galeano
Employment Agreement



LAST FRONTIER HEALTHCARE DISTRICT
A Public Entity

EMPLOYMENT AGREEMENT

THIS AGREEMENT is made and entered into as of this [REDACTED] day of [REDACTED] 2026, by and between **Last Frontier Healthcare District dba Modoc Medical Center** ("Employer") and Gustavo Galeano, MD ("Employee").

STATEMENT OF BACKGROUND INFORMATION

- A. Employer is a Healthcare District that operates a Rural Health Clinic, Critical Access Hospital and Skilled Nursing Facility with medical offices located in Alturas and Canby, California.
- B. Employee is a physician licensed to practice medicine in the State of California.
- C. Employer desires to employ Employee as a practicing family medicine physician in the Canby Clinic, and Employee desires to be employed in such capacity, in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants, agreements and conditions hereinafter set forth, the parties hereto agree as follows:

STATEMENT OF AGREEMENTS

A. EMPLOYMENT. Employer hereby employs Employee as a practicing physician, and Employee hereby accepts such employment subject to the supervision of Employer and otherwise in accordance with the terms of this Agreement. Employee's first day of employment shall be [REDACTED].

B. RESPONSIBILITIES OF EMPLOYER.

- 1. Annual Compensation.** Employee shall be paid an annual salary of \$345,000.00 plus fringe benefits in Employee's first year of employment with Employer, assuming that full time hours (2080 hours per year) are worked during the year. Employee shall be paid \$1,658.70 per 10-hour day worked in the clinic. Fringe benefits will include those benefits as set forth in Paragraphs B.3, B.4, B.5, and B.6 below ("Fringe Benefits"). Employee shall be paid on a bi-weekly basis. Employee shall be given a 3.5% increase on June 1 of every year for the term of

this agreement. Employee shall also be eligible for an additional 0.5% increase during the first full pay period following the Employee's anniversary date with Employer. Employee shall also be paid a stipend of three hundred dollars (\$300.00) per week that Employee takes after hours call for the clinic.

Salary paid under this Paragraph shall be subject to mandatory State and Federal withholdings.

2. Additional Compensation. In addition to the annual salary and Fringe Benefits provided for in Paragraph B.1 herein, Employee shall receive bonuses throughout the term of this Agreement according to the following schedule:

- (a) \$20,000.00 bonus paid during the first full pay period of employment with the Employer.
- (b) \$20,000.00 bonus paid during the first full pay period following 90 days of employment with the Employer.
- (c) \$20,000.00 bonus paid during the first full pay period following one year of employment with the Employer.
- (d) \$20,000.00 bonus paid during the first full pay period following two years of employment with the Employer.
- (e) \$20,000.00 bonus paid during the first full pay period following three years of employment with the Employer.
- (f) \$20,000.00 bonus paid during the first full pay period following four years of employment with the Employer.
- (g) \$20,000.00 bonus paid during the first full pay period following five years of employment with the Employer.

Employee shall also be eligible to be reimbursed up to Fifteen Thousand Dollars (\$15,000.00) for relocation expenses upon providing receipts of eligible expenses to administration. Eligible expenses include moving company fees, moving truck rental fees, dolly rental fees, car dolly rental fees, moving trailer rental fees, lodging during the move, moving boxes, packing tape, protective blanket rental, and up to two months of storage rental for items that have to be stored prior to moving. Employee shall not be reimbursed for the purchase of furniture or permanent vehicles/equipment related to relocation under this contract provision.

3. Benefits. Employer shall provide Employee with the following benefits which will start per benefit plan documents and the Memorandum of Understanding with UPEC.

- a. Temporary housing to be provided by Employer at no expense to the Employee for up to three months.
- b. Participation in the regular health insurance offerings of Employer to full-time benefited non-union employees of the Employer.
- c. Participation in 457-B retirement plan.
- d. Participation in all other benefits programs offered to full-time, benefited non-union employees of the Employer.

Employee's rights with respect to such benefits shall be subject to:

- a. The provisions of the existing and future relevant contracts, policies or plans providing such benefits, and
- b. The right of Employer to amend, modify or terminate any such plan or benefit with respect to all classes of employees covered by a given plan or benefit when proper notice is provided to Employee.

4. Vacation and Personal Leave. Employee shall be entitled to the following paid leave each year during which the Employee's compensation shall continue to be paid in full:

- a. Paid Time Off (PTO) to accrue at the following tiers (all days represent 8-hour days) based on your length of service with MMC. PTO accumulates at these rates over the course of a year based on the number of hours you work. The accumulation rates listed below are based on 2,080 hours being worked over the course of a full year, so the days listed below will build up as hours are worked during the year to the amount of hours shown:

0 to 1 year	22, 10-hour days (220 hours)
1 to 5 years	26, 10-hour days (260 hours)
5 to 10 years	30, 10-hour days (300 hours)
10 plus years	34, 10-hour days (340 hours)

- b. Five days of paid CME leave per year, only to be used when attending a CME event in person or remotely. Proof of participating in CME event must be provided to utilize these paid days.

5. Reimbursable Expenses. Employer shall reimburse Employee for the following approved expenses incurred during the course of Employee's employment:

- a. Up to Three Thousand Five Hundred Dollars (\$3,500) of reimbursable CME expenses, including travel, room and board and registration per year.
- b. Fees associated with maintaining California Licensure.
- c. As needed other necessary expenses that are approved prior to expending funds by Employer.

Payments shall be made to Employee for reimbursable expenses upon submission of applicable bills, receipts or other documentation required by Employer and submitted in proper expense report format as set forth by Employer.

6. Professional Liability Insurance Agreement. During the term of this Agreement, Employer shall obtain and maintain liability insurance for the practice of medicine by Employee on behalf of Employer. Such insurance shall be for the same amount as provided for all physicians for Employer who are within the same specialty as Employee. Insurance coverage shall be maintained to provide physician with continuous coverage for services provided by Employee under this contract, even after this agreement is terminated by either party.

- 7. Support Services.** Employer shall furnish to Employee all of the necessary support services, including but not limited to, equipment, facilities, supplies, medical support employees, secretaries and other personnel reasonably needed by Employee to perform Employee's obligations created by this Agreement. The cost of providing these support services shall be borne solely by Employer.
- 8. Employer's Authority.** Employer shall exercise direction over and give support to Employee in regard to standards, policies, record keeping and other operational matters; such direction and support shall not interfere with the normal physician-patient relationship nor be in violation of acceptable medical ethics. Such direction will not be exercised over patient care and the practice of medicine by Employee. Patient care and the practice of medicine by Employee will be overseen, reviewed and monitored by the Medical Staff Committee and Medical Executive Committee. Employer shall have the right to determine which staff person(s) will render support to Employee for operational procedures that are the Employer's responsibility.
- 9. Employment Outside the Practice.** Employee is not authorized to enter into an agreement with another agency providing similar services within Modoc County. All employment requiring a medical license in the State of California outside the Employer's physician practice must be approved by the Employer, which approval shall not be unreasonably withheld. Employee may engage in any employment activity outside the practice of medicine without seeking prior approval as long as it does not interfere with Employee's ability to perform services under this agreement.

C. RESPONSIBILITIES OF EMPLOYEE.

- 1. Professional Services.** During the term of this Agreement, Employee shall devote full-time, all his or her professional time and efforts to and for the benefit of Employer and shall not, directly or indirectly, render professional, medical, managerial or directive services to any person, whether or not for compensation, except as an Employee of Employer, unless Employee shall first have obtained the written consent of Employer. Passive and personal investments and the conduct of private business affairs by Employee that are not inconsistent with the restrictions of this Paragraph shall not be prohibited hereunder. Employee shall be committed to enhancement of Employer's practice and shall use his or her best efforts to further the goals of and to promote the medical practice of the Employer. The expenditure of reasonable amounts of time for teaching, personal, charitable and professional activities shall not be deemed a breach of this Agreement provided such activities do not materially interfere with the services required to be rendered to Employer hereunder.

Employee shall work four (4), ten-hour days per week in the Canby rural health clinic of Employer. The Employee shall also provide supervision to midlevel providers at the rural health clinic, as required by the Employer. Employee may be credentialed and receive privileges to practice in the hospital and skilled nursing facility as well if Employee chooses to do so and successfully credentials to provide these services. Employee will also take call coverage on a rotational basis with other physicians and allied health professionals in the clinics, as needed.

- 2. Standards of Practice.** Full-time practice is defined as a minimum of thirty-two (32) scheduled patient hours per week at the Employer's Rural Health Clinic. Employee shall devote his or her

utmost knowledge and best skill to the care of Employer's patients, which are entrusted to him or her and shall perform such other duties as may be assigned to him or her by Employer. Employee understands that all patients are accepted by Employer regardless of their race, color, national origin, handicap or age. Dismissal of an established patient from continued care must be justified by a cause for dismissal due to patient noncompliance with physician directives or office procedures, and must be discharged in accordance with established legal protocols and the policies and procedures of the Employer.

3. **Ethical Conduct.** Employee shall engage in the practice of medicine in accordance with the Principles of Medical Ethics of the American Medical Association, and the customs and rules of ethical conduct prescribed by Employer in the Medical Staff Bylaws and Rules.
4. **License.** Employee shall maintain an unrestricted license to practice medicine in California.
5. **Privileges.** Employee agrees that Employee shall use best efforts to obtain and continue to maintain staff privileges that allow Employee to deliver services under this agreement.

Employee's duties and responsibilities include, but are not limited to, providing primary care services at the rural health clinic and providing supervision to midlevel providers at the rural health clinic.

6. **Medical Staff Policies and Procedures.** Employee shall abide by all policies and procedures for the Medical Staff as may be established from time to time by Employer.
7. **Billing.** Employee agrees and acknowledges that Employer alone has the right to bill and receive payment from patients and third-party payors, including all government-sponsored programs, for physician services rendered by Employee hereunder, and Employee shall not bill any patient or third-party payor for such services. All income or fees for physician services rendered by Employee shall belong to, and be the property of, the Employer.
8. **Surrender of Books and Records.** Employee acknowledges that all lists, books, records and any other materials owned by Employer or used by it in connection with the conduct of its business, shall at all times remain the property of the Employer, and that upon termination of employment hereunder, irrespective of the time, manner or cause of said termination, Employee will surrender to Employer all such lists, books, records and other materials. Paragraph C.9 herein shall survive termination of this Agreement.
9. **Use of Employee's Name.** Employer shall have the right to use Employee's name in connection with Employer's marketing and contracting activities, and in any oral or written communication with patients or third-party payors. Upon termination of this agreement Employer must discontinue all marketing and contracting activities that contain Employee's name in oral or, written format.
10. **Medical Records.** Employee shall prepare and maintain for the benefit of Employer medical records for patients in accordance with accepted standards of practice in the community, applicable laws regarding confidentiality of medical reports, the policies and procedures established by Employer and the terms of any third-party payor agreements. Employee

acknowledges and agrees that all such medical records are the property of Employer. To the extent permitted by law, Employee shall cooperate and communicate freely with other healthcare providers who provide professional services to patients of Employer.

11. Reimbursement Contracts. In the event that Employer elects to participate as a provider in an HMO, PPO, IPA or other care-delivery system, then Employee shall also be required to join.

12. Relationship with Patients. Employee shall not during the term of this Agreement:

- a. Directly or indirectly induce or advise any patient of Employer to withdraw, curtail, withhold or cancel the patient's relationship with Employer; and
- b. Directly or indirectly disclose to any person, firm, corporation or any other entity the names or addresses of any patients of Employer.

D. TERM AND TERMINATION

1. Term. This Agreement shall commence as of the date hereof and shall continue for a period of five (5) years unless sooner terminated pursuant to this Agreement. Both parties agree to meet prior to expiration of this agreement to discuss the extension of this agreement and any contract language changes that are necessary to extend the agreement. Any agreement extension or amendments to the agreement must be agreed to in writing by both parties.

2. Termination. This Agreement shall be terminated upon the happening of any of the following:

- a. Whenever Employee shall not be duly licensed or otherwise legally authorized to practice medicine in the State of California;
- b. Death of the Employee or the determination by either the Board of Directors of Employer or the Courts, of the incompetence of Employee;
- c. Termination of Employer's medical group practice;
- d. At Employer's option, if Employee shall be disabled for one hundred and eighty (180) days or more, provided that such option shall be exercised in writing, delivered to the Employee, and shall be effective on delivery;
- e. The suspension, expulsion or any other disciplinary action finally taken by the Medical Board of California or an equivalent regulatory body;
- f. At the Employer's option, if Employee fails to obtain or continue to maintain privileges to practice at Employer's facilities;
- g. Employee bills third-party payors or accepts funds from either patients or third-party payors for Employee's own use.
- h. Conviction of a felony crime;

- i. Other actions determined by a neutral arbitrator to endanger the professional standing of the practice;
- j. Employee's failure to rectify a breach of any material term that is not specifically enumerated in Paragraph D.2 hereof, within thirty (30) days after written notice thereof from Employer; and
- k. Notwithstanding any of the provisions of this Agreement, upon ninety (90) days prior written notice by either Employee or Employer to the other.

E. GENERAL PROVISIONS

- 1. Notice.** Any notice required to be given pursuant to this Agreement shall be in writing and shall be sent by registered or certified mail, return receipt requested, postage prepaid, to the addresses set forth herein. Either party may, by notice given as aforesaid, change their address for all subsequent notices, except that neither party may require notices be sent to more than two addresses. Notices shall be deemed given when mailed in the manner provided in Section E.1 hereof.
- 2. Severability.** Should one or more of the provisions contained in this Agreement for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement. Such invalid, illegal or unenforceable provision shall, to the extent permitted by law, be deemed amended and given such interpretation as to achieve the intent of this Agreement.
- 3. Waiver.** Any party hereto may waive any right under this Agreement without invalidating the Agreement or waiving any other rights hereunder.
- 4. Captions.** The captions used herein are for convenience only and are not a part of this Agreement and do not in any way limit or amplify the terms and provisions hereof.
- 5. Non-Assignability.** This Agreement for personal services shall not be assignable, except to the parties hereto.
- 6. Arbitration of Claims.** Following exhaustion of all dispute resolution procedures provided for under the terms of this Agreement or under the policies and procedures of Employer, the Parties shall submit such disputes to binding arbitration in accordance with the applicable arbitration rules of the American Arbitration Association. The proceeding shall be held in Modoc County, California.
- 7. Governing Law.** This Agreement shall be interpreted in the laws of the State of California.
- 8. Entire Agreement.** This Agreement, and any attachments incorporated herein, constitute the entire Agreement between Employer and Employee with respect to the subject matter hereof and supersede all prior offers and negotiations, oral and written. This Agreement may not be amended or modified in any respect whatsoever, except by an instrument in writing signed by Employer and Employee.

INTENDING TO BE BOUND, the parties hereto have caused this Agreement to be duly executed and delivered as of the day and year first above written.

LAST FRONTIER HEALTHCARE DISTRICT dba MODOC MEDICAL CENTER

By: _____ Date: _____
Kevin Kramer, Chief Executive Officer
1111 N. Nagle Street
Alturas, CA 96101
k.kramer@modocmedicalcenter.org
530-708-8801

GUSTAVO GALEANO, M.D.

By: _____ Date: 09/03/2026
 
Gustavo Galeano, MD
123 Hillary Circle
Wentzville, MO 63385
gmg262@gmail.com
209-541-7360