MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Agenda
May 28, 2025 @ 1:00 PM
Mayers Memorial Healthcare District
Burney Annex Boardroom
20647 Commerce Way
Burney, CA 96013

Mission Statement
Leading rural healthcare for a lifetime of wellbeing.

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

						Approx. Time Allotted
1	**CALL MEETING TO ORDER**					
2	2.1	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS** Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board, 43563 Highway 299 East, Fall River Mills, or in the Boardroom). If you have documents to present for the members of the Board of Directors to review, please provide a minimum of nine copies. When the President announces the public comment period, requestors will be called upon one-at-a time, please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.) action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.				
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – April 23, 2025		***Attachment A***	**Action Item**	1 min.
4	**DEPARTMENT/QUARTERLY REPORTS/RECOGNITIONS:**					
	4.3	Resolution 2025.07 – April Employee of the Month- Diablo Pergakis		***Attachment B***	**Action Item**	1 min.
	4.4	Resolution 2025.08 – May Employee of the Month- Haiiley Choate		***Attachment C***	**Action Item**	1 min.
	4.5	Hospice Quarterly	Keith Earnest	***Attachment D***	Report	2 min.
	4.6	Mayers Foundation Quarterly	Michele King	***Attachment E***	Report	2 min.
	4.7	Acute	Moriah Padilla	***Attachment F***	Report	2 min.
	4.8	Emergency	Bridget Bernier	***Attachment G***	Report	2 min.
5	**BOARD COMMITTEES**					
	5.1	**Finance Committee**				
		5.1.1 Committee Meeting Report: Chair Humphry			Report	5 min.
		5.1.2 Credit Line Letter from Cornerstone Bank		***Attachment H***	**Action Item**	5 min.
		5.1.3 May 2025 Financial Review, AP, AR and Acceptance of Financials			**Action Item**	5 min.
	5.2	**Quality Committee**				

	5.2.1	May Quality Meeting Committee Report		Report	5 min.
	5.3	**Strategic Planning Committee**			
	5.3.1	May Strategic Planning Committee Report		Report	5 min.
	5.3.2	Updated Strategic Plan FY2025-FY2029	***Attachment I***	Report	5 min.
6	**OLD BUSINESS**				
	6.1	TCCN Phase 3 Architects Estimate		Discussion/ **Action Item**	5 min.
	6.2	Resolution 2025.04- Declaring property to be Surplus and Exempt from CEQA	***Attachment J***	**Action Item**	5 min.
	6.3	Resolution 2025.05- Authorizing the Sale of Real Property to the MHF and Approving the Commercial Purchase Agreement	***Attachment K***	**Action Item**	5 min.
7	**NEW BUSINESS**				
	7. 1	ACHC Plan of Correction	***Attachment L***		
		Policies and Procedures			
	7.2	Patient Care Policies and Procedures- Development, Revision and Approval	***Attachment M***	**Action Item**	5 min.
8	**ADMINISTRATIVE REPORTS**				
	8.1	Chief's Reports – ***Written reports provided. Questions pertaining to written report and verbal report of any new items***	***Attachment N***		
	8.1.1	Director of Operations- Jessica DeCoito		Report	5 min.
	8.1.2	Chief Financial Officer – Travis Lakey		Report	5 min.
	8.1.3	Chief Human Resources Officer – Libby Mee		Report	5 min.
	8.1.4	Chief Public Relations Officer – Val Lakey		Report	5 min.
	8.1.5	Chief Clinical Officer – Keith Earnest		Report	5 min.
	8.1.6	Chief Nursing Officer – Theresa Overton		Report	5 min.
	8.1.7	Chief Executive Officer – Ryan Harris		Report	5 min.
9	**OTHER INFORMATION/ANNOUNCEMENTS**				
	9.1	Board Member Message: Points to highlight in message		Discussion	2 min.
	9.2	Board Education: Chapter 20-25		Discussion	10 min.
10	**MOVE INTO CLOSED SESSION**				
	10.1	Conference with Real Estate Negotiators (54956.8) Property: Masonic Lodge, Fall River Mills CA Real Estate Negotiator: Ryan Harris APN: 018-200-006			
	10.2	Conference with Real Estate Negotiators (54956.8) Property: Vacant lot, Burney CA 96013 Real Estate Negotiator: Ryan Harris APN: 028-340-015			
	10.3	Conference with Real Estate Negotiators (54956.8) Property: Medical office building-20623 Commerce Way. Burney CA 96013 Real Estate Negotiator: Ryan Harris APN: 028-340-016			
	10.4	Public Employment (§54957)			
	10.5	Conference with legal counsel regarding pending litigation (§54956.9)			
11	**RECONVENE OPEN SESSION**				

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

12 **ADJOURNMENT:** Next Meeting June 25, 2025 in Burney

Posted:

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MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Regular Meeting Minutes
April 23, 2025 @ 1:00 PM
Mayers Memorial Healthcare District
Burney Annex Boardroom
20647 Commerce Way
Burney, CA 96013

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

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

BOARD MEMBERS PRESENT:	**STAFF PRESENT:**
Jeanne Utterback, President	Ryan Harris, CEO
Abe Hathaway, Vice President	Travis Lakey, CFO
Lester Cufaude, Director	Libby Mee, CHRO
Jim Ferguson, Director	Theresa Overton, CNO
	Keith Earnest, CCO
ABSENT:	Jessica DeCoito, Director of Operations
Jack Hathaway, Director of Quality	Ashley Nelson, Board Clerk
Valerie Lakey, CPRO	Kimberly Westlund, Rural Health Clinic Manager
Tami Humphry, Treasurer	Danielle Olson, Director of Revenue Cycle

2 CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS: NONE.

3 APPROVAL OF MINUTES

3.1	A motion made and carried; Board of Directors accepted the Regular Board Meeting minutes of March 26, 2025.	***Cufaude, Utterback***	***Approved by All***
3.2	A motion made and carried; Board of Directors accepted the Special Meeting minutes of April 07, 2025.	***Cufaude, Ferguson***	***Approved by All***

4 DEPARTMENT/OPERATIONS REPORTS/RECOGNITIONS

4.1 Safety Quarterly:
Dana submitted her report. She is currently enrolled in both her BA and MA program. Depending on the FEMA cuts on a national level, she will attend a week long training in Alabama.

4.2 Lab:
Sophia submitted her report. She added that the biggest challenge is that since the lab added Cerner, providers are forgetting to include the correct codes in the system. Training to providers is planned, with the request that a Cerner Super User trains them. Heather Corr will be attending a training call on how to train providers best from a clinic standpoint. She is currently working on fixing QuantiFERON testing.

4.3 Radiology:
Harold submitted his report. He explained that he is working on fire safety for the new MRI trailers. The scan link in Cerner is now live, for all patients to access their scans. Echo training is underway for his staff, with the assistance of Dr. Frye.

4.4 Food and Nutrition Services:

Susan and Jen submitted their report. Susan added that the week of deep cleaning went very well, and staff are beginning training on "Meal Suite"- the new meal technology that syncs with Point Click Care. The Board asked Harold to return in June, for a more in-depth report regarding services.

5 BOARD COMMITTEES

5.1 **Finance Committee**

5.1.1 Committee Meeting Report:
Tami reported that the AR days are coming down and the AR dept is working hard to rectify errors.

5.1.2 March 2025 Financial Review — ***Humphry, Hathaway*** — ***Approved by All***
Motion moved, seconded and approved.

5.2 **Quality Committee**

5.2.1 April Quality Meeting Committee Report:
Les reported that Jack's report outlined the mortality rate, and data based on various depts. There is also a satisfaction survey of the ED staff included- which outlined the areas for growth. He explained the committee's idea to rectify med errors in SNF.
Ryan explained how the Patient Experience program leadership is participating in, will directly affect that data.
Keith explained that he reviews that Medication Record weekly, with nurses ordering and administering medication to patients.

5.3 **Strategic Planning Committee Report**

5.3.1 No meeting in April.

6 NEW BUSINESS

6.1 Proposal to move September's 2025 Regular Board meeting from September 24th to September 17th. — ***Hathaway, Ferguson*** — ***Approved by All***
The meeting was approved to move to September 17th 2025.

6.2 Policy and Procedure Summary:
The list was submitted. The next board meeting will reflect the policies on the policies. Moving forward, Ryan can approve most policies and then the Board will receive a quarterly Policy Summary of the approved policies. Some policies will still need to come to that full Board.

7 ADMINISTRATIVE REPORTS

7.1 **Chief's Reports: written reports provided in packet**

7.1.1 **DOO:** written report submitted.
Jessica explained that the solar project is going well and the workers are setting concrete today. Legal is reviewing the agreement for the Project Management proposal.

7.1.2 **CFO:**
Travis explained length of stay data. The FY22 audit is underway, slowly.

7.1.3 **CHRO:** written report submitted.
Libby explained that since the CNA program is back, the 22 open positions for
SNF CNA's will be much less after a few graduating classes. She explained that Meal Premiums have decreased in the last 3 weeks from $12,000 to $6,000 per pay period. Employee Engagement surveys will be happening soon, as well. She will also be working on CA minimum wage increases.

7.1.4 **CHPRO:** Written report submitted.
Val explained that the Volunteer Luncheon was on Monday and went very well. Phase 3 at TCCN- plans are with the county. FR Arts Building- the resolution will be on next month's agenda for approval. High school students are currently being certified in CPR, thanks to the Mayers Foundation and TCCN.

7.1.5 **CCO**: written report submitted.
Keith explained that the Retail Pharmacy traveler company MMHD has been using for years, is no longer able to provide us staffing. Another traveler was found. Keith also explained the challenges with Respiratory Therapist staffing through travel agencies. He hired a new perm Retail Pharmacist, who can hopefully start in Sept once she obtains her CA license.

7.1.6 **CNO**: written report submitted.
Theresa further explained the challenge with ZOLL defibrillator software and set up.
She also explained the staffing changes in the Acute and ED.

	7.1.7	**CEO:** written report submitted. Ryan met with some representatives in Sacramento, regarding budget cuts. Ryan also announced that MHHD is now officially ACHC accredited.
8	**OTHER INFORMATION/ANNOUNCEMENTS**	
	8.1	Board Member Message: ACHC accredited, solar project update, community and spring scholarships, Health Fair, Golf Tournament, TCCN upcoming events, quarterly digital newsletter, CNA program starting in June, Senior high school internship program- apps due May 1st
	8.2	Board Education: Ch 16-20 was assigned.
11	**Adjournment:** 3:37 pm. Next Meeting is May 28, 2025 in Burney.	

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

_____ _____

Board Member Board Clerk

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MAYERS MEMORIAL
HEALTHCARE DISTRICT

RESOLUTION NO. 2025-07

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

Diablo Pergakis

As March 2025 EMPLOYEE OF THE MONTH

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

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

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

NOW, THEREFORE, BE IT RESOLVED that, Diablo Pergaskis is hereby named Mayers Memorial Healthcare District Employee of the Month for March 2025; and

DULY PASSED AND ADOPTED this 28th day of May by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

MAYERS MEMORIAL
HEALTHCARE DISTRICT

RESOLUTION NO. 2025-08

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

Haiiley Choate

As May 2025 EMPLOYEE OF THE MONTH

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

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

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

NOW, THEREFORE, BE IT RESOLVED that, Haiiley Choate is hereby named Mayers Memorial Healthcare District Employee of the Month for May 2025; and

DULY PASSED AND ADOPTED this 28th day of May by the Board of Trustees of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

Hospice Quarterly Report (Q3)—May 2025

Prepared by Keith Earnest, CCO.
Lindsey Crum, RN—Hospice Manager, is out on medical leave.

Hospice Survey

Hospice had its Licensing and Certification Survey from April 4 to 10.
The Statement of Deficiencies (2567) was received. The Plan of Corrections was submitted on May 2 and accepted. Here is a summary of the tags:

- L0522 Initial Assessment
- L0531 and L0532 Content of Comprehensive Assessment
- L0543 Plan of Care
- L0547 Content of Plan of Care
- L0655 Professional Management Responsibilities
- L0677 Initial Certification of Terminal Illness
- L0825 Physical Environment

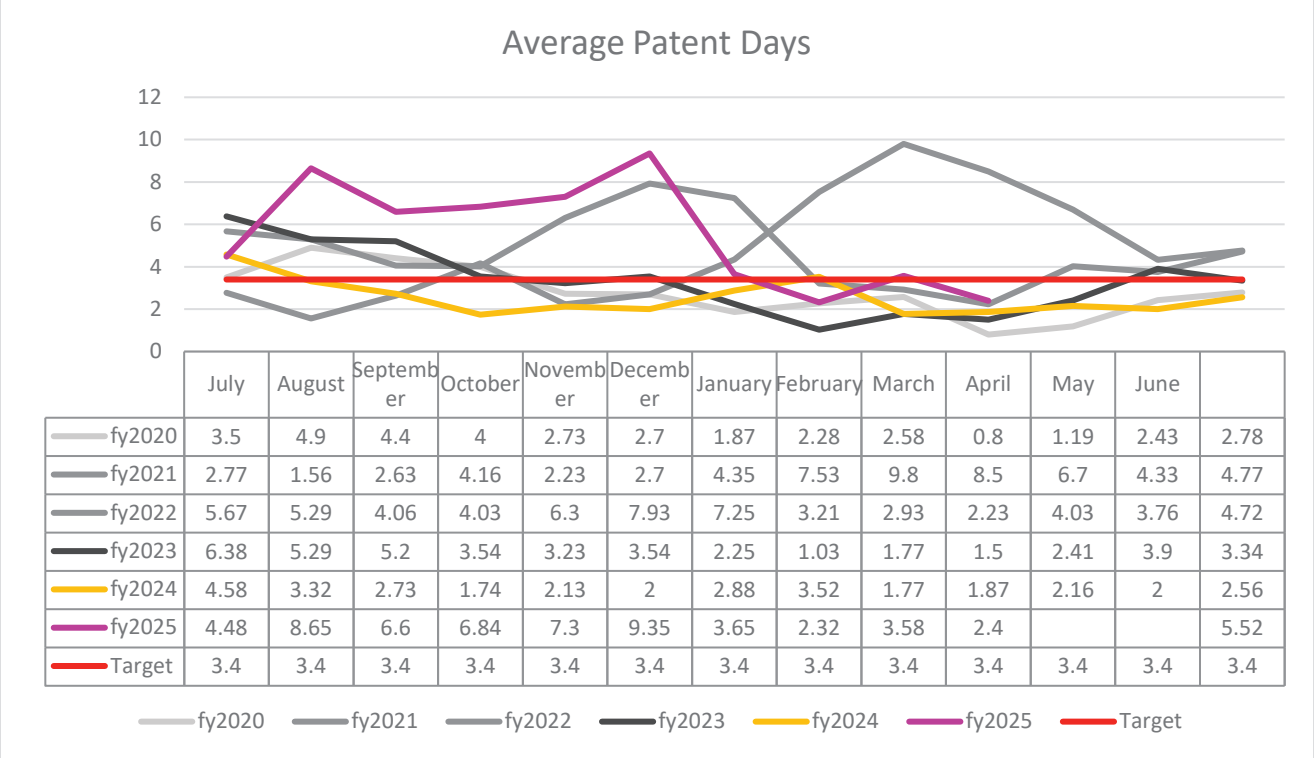
Plan of Correction

- The following policies were revised, and staff were educated on the changes:
  - Assessment of the Hospice Patient
  - Plan of Care
  - Certification of Terminal Illness
  - Medication Management
  - Medication Errors
  - Hospice Safety Plan
  - Wound Management—Hospice (New Policy)

- Additional Relias training was assigned to staff and has been completed.
- Nurse competencies are in draft form.
- An audit tool has been created to monitor charts to ensure compliance with the Plan of Corrections.
- Many of the corrections involved learning how to use the MatrixCare® software. Marsha Rugene and Yarely Contrares figured out solutions in the software to meet the standards. Jim Friday, Hospice Volunteer, was vital in pulling records and reports from MatrixCare® during the survey and making corrections.
- Dana Hauge, Safety Officer, was integral in updating the Safety Plan.

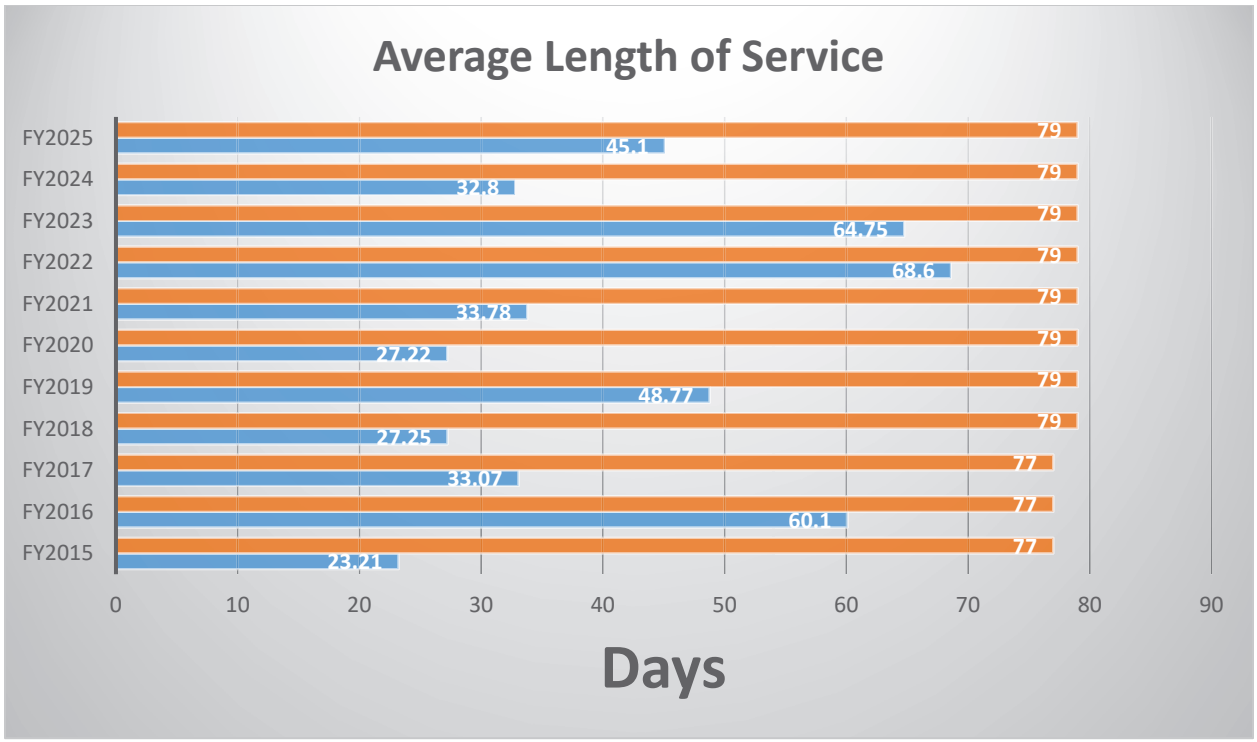
Statistics

Average Patient Days are historically in line with Q3 and lower than the budget.



	July	August	September	October	November	December	January	February	March	April	May	June	
fy2020	3.5	4.9	4.4	4	2.73	2.7	1.87	2.28	2.58	0.8	1.19	2.43	2.78
fy2021	2.77	1.56	2.63	4.16	2.23	2.7	4.35	7.53	9.8	8.5	6.7	4.33	4.77
fy2022	5.67	5.29	4.06	4.03	6.3	7.93	7.25	3.21	2.93	2.23	4.03	3.76	4.72
fy2023	6.38	5.29	5.2	3.54	3.23	3.54	2.25	1.03	1.77	1.5	2.41	3.9	3.34
fy2024	4.58	3.32	2.73	1.74	2.13	2	2.88	3.52	1.77	1.87	2.16	2	2.56
fy2025	4.48	8.65	6.6	6.84	7.3	9.35	3.65	2.32	3.58	2.4			5.52
Target	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4

Average Length of Service remains well below the national average but is longer than FY24.


Average Length of Service
FY2025
FY2024
FY2023
FY2022
FY2021
FY2020
FY2019
FY2018
FY2017
FY2016
FY2015
79
45.1
79
32.8
79
64.75
79
68.6
79
33.78
79
27.22
79
48.77
79
27.25
77
33.07
77
60.1
77
23.21
0
10
20
30
40
50
60
70
80
90
Days

Department Reporting
Managers' Meeting and Regular Board Meeting

Manager & Department: Michele King | MHF Program Director

Reporting Month & Year: May 2025

Summary:

The start to this 2025 year has been busy. Starting with the Denim and Diamonds Winter Gala in January, then on to the planning of the 2025 Health and Wellness Fair on June 14th, the 25th Annual Mayer Healthcare Foundation Golf Tournament on August 2nd, and the oversightAugust 2nd of the operations of the Lucky Finds Thrift Store since December 2024.

Top Projects (1-3):

(1) MHF Health and Wellness Fair
(2) 25th Annual Golf Tournament
(3) Lucky Finds Thrift & Gift Store

Wins (1-2):

(1) MHF Health and Wellness Fair, we have secured the Intermountain fairgrounds for June 14th, 2025. This event coincides with this year's McArthur Street Fair, which includes a car show, shine, and live music. Invitation letters have been sent to community partners, MMHD department managers, and our event table registration form to be completed and turned into MHF by May 30th. We are looking forward to this fun event; last year was amazing with the addition of TCCN's Kid Fit Kick-Off event, The Mayers Rural Health Clinic Sports Physicals, and the Community partners' support. Please encourage all to come out and participate!

(2) MHF 25th Anniversary Golf Tournament: We are pleased to announce that the 25th Anniversary MHF Golf Tournament will be held on Saturday, August 2nd, 2025. The venue has been secured, and planning efforts are well underway. A new website to register sponsorships, golfer foursomes, and pairs has been built for this year's Anniversary Tournament. We look forward to another beautiful day on the course.

Challenge (1): The one challenge we have and continue to have is the need for additional volunteers to help with the MHF Thrift Store, programs, projects, and events. This continues to be our greatest challenge as we depend on volunteers for so many of our fund-raising efforts. We have worked to streamline the process to move volunteers through quickly and effortlessly.

Respectfully submitted,

Michele King

MAYERS MEMORIAL HEALTHCARE DISTRICT

Department Reporting
Managers Meeting and Regular Board Meeting

Manager & Department: Moriah Padilla, Acute Care Reporting Month & Year: May 2025

Summary:

Over the past year, Acute Care has focused on elevating staff competency, leadership development, and onboarding training processes to align with ACHC standards and internal quality benchmarks. Three core priority initiatives were executed with measurable outcomes: staff training completion, leadership advancement, and professional preceptorship participation.

Top Projects (1-3):

ACHC Competency Compliance Initiative – Ensured 90% of Acute Services staff completed in-person training across five key areas (Restraints, EMTALA, Ligature Risk, Care Planning, Patient Rights), with Relias tracking implemented for ongoing hires.

Leadership Development – Acute Charge Nurse completed an external leadership development conference and a 12-module Swing Bed course through HealthTech.

Preceptorship Program – Two RNs completed an external preceptor training course (IONRP), submitted learning reflections, and began integrating principles into clinical mentorship.

Wins (1-2):

Successfully partnered with OPM and ED leadership to roll out RN Skills Events and HALO Training. HALO (High Acuity, Low Occurrence) sessions were designed for Emergency Department staff but offered to Acute Care team members interested in advancing their clinical skills. This initiative led to full compliance with state-mandated training and competency checkoffs.

The Acute Team successfully met all three departmental priority goals. We achieved 100% compliance with ACHC-mandated training. Our Charge Nurse completed her external leadership development goal by attending the AONL Conference and remains on track to complete a comprehensive 12-module Swing Bed course. Additionally, two acute RNs completed preceptor certification and applied key mentorship strategies to new staff. These accomplishments reflect our commitment to regulatory compliance, clinical excellence, and leadership development.

Challenge (1):

Achieving 100% compliance with mandatory educational events is challenging due to the limited size of our units and the need to manage staff across multiple departments. Some staff work in as many as four departments across five separate units—Med/Surg, ED, OPS, OPM, and Hospice—requiring them to maintain compliance for each

department. This creates scheduling difficulties, as we must ensure that employees can attend training for all units they work in without overburdening them.

MAYERS MEMORIAL HEALTHCARE DISTRICT

Department Reporting
Manager's Meeting and Regular Board Meeting

Manager & Department:

Bridget Bernier- Emergency

Reporting Month & Year:

May 2025

Summary:

This year, the Emergency Department prioritized team education, leadership development, and enhanced community outreach. These three focus areas were strategically developed and executed with clearly defined measures to ensure completion and accuracy. Through these efforts, we have strengthened internal capabilities while expanding our impact within the community.

Top Projects (1-3):

Community Outreach: We developed and launched an ED nurse call-back system to ensure discharged patients receive follow-up communication. This initiative provides an opportunity to review their care, address concerns, and offer continued support after leaving the Emergency Department.

Education—Annual Training Event: We implemented a comprehensive training program that included HALO (High Acuity, Low Occurrence) scenarios to better prepare staff for critical but infrequent events.

Professional Development – TNCC Certification: To expand the clinical knowledge and capabilities of our ED nurses, we introduced the Trauma Nursing Core Course (TNCC). The course was offered in mid-September and made available to all RNs.

Wins (1-2):

Successful Nurse Call-Back Program: Our new follow-up system has received overwhelmingly positive feedback from patients, who praise both nurses and providers for their continued care. Enhanced post-discharge communication has helped reduce patient anxiety and clarify the next steps in their recovery.

Training and Certification Achievements: The annual training event, HALO sessions, and OPM initiatives were highly successful. We achieved 100% compliance with all mandatory online training modules (Relias and Lippincott) and completed all in-person skill validations, including per diem staff. Additionally, every ED RN successfully obtained TNCC certification—an essential advancement for our rural emergency team.

Challenge (1):

Staffing has been our most significant challenge. With two full-time RNs on leave of absence and others managing family emergencies and scheduled time off, maintaining adequate shift coverage proved difficult. These staffing shortages created obstacles in coordinating educational initiatives and completing community outreach efforts, all while ensuring consistent, high-quality care in the department. Balancing these demands required flexibility from the entire team. Despite these constraints, we worked diligently to ensure continuity of care and fulfillment of our training goals.

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CORNERSTONE
COMMUNITY BANK

BUSINESS LOAN AGREEMENT

Principal	Loan Date	Maturity	Loan No	Call / Coll	Account	Officer	Initials
$100,000.00	07-23-2024	07-23-2026	400416700	4 / 028		***	

References in the boxes above are for Lender's use only and do not limit the applicability of this document to any particular loan or item.
Any item above containing "****" has been omitted due to text length limitations.

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

Lender: Cornerstone Community Bank
Redding Branch
192 Hartnell Ave.
Redding, CA 96002

THIS BUSINESS LOAN AGREEMENT dated May 5, 2025, is made and executed between Mayers Memorial Hospital District ("Borrower") and Cornerstone Community Bank ("Lender") on the following terms and conditions. Borrower has received prior commercial loans from Lender or has applied to Lender for a commercial loan or loans or other financial accommodations, including those which may be described on any exhibit or schedule attached to this Agreement. Borrower understands and agrees that: (A) in granting, renewing, or extending any Loan, Lender is relying upon Borrower's representations, warranties, and agreements as set forth in this Agreement; (B) the granting, renewing, or extending of any Loan by Lender at all times shall be subject to Lender's sole judgment and discretion; and (C) all such Loans shall be and remain subject to the terms and conditions of this Agreement.

TERM. This Agreement shall be effective as of May 5, 2025, and shall continue in full force and effect until such time as all of Borrower's Loans in favor of Lender have been paid in full, including principal, interest, costs, expenses, attorneys' fees, and other fees and charges, or until such time as the parties may agree in writing to terminate this Agreement.

LINE OF CREDIT. The Indebtedness contemplates multiple loan advances to be made from time to time on a non-self-replenishing basis. Advances under the Indebtedness, as well as directions for payment from Borrower's accounts, may be requested only in writing by Borrower or as provided in the "Advance Authority" section below. Borrower agrees to be liable for all sums either: (A) advanced in accordance with the instructions of an authorized person as described in the "Advance Authority" section below or (B) credited to any of Borrower's accounts with Lender.

ADVANCE AUTHORITY. The following person or persons are authorized, except as provided in this paragraph, to request advances and authorize payments under the line of credit until Lender receives from Borrower, at Lender's address shown above, written notice of revocation of such authority: **Advances may be made only to satisfy requests for draws vs. Letter of Credit No. 2024009 issued on July 23, 2024 in favor of the BETA Healthcare Group, in connection with the Agreement between Mayers Memorial Hospital District and BETA Healthcare Group. . Advances against this line of credit will be restricted from the Borrower's use and will be made for the sole purpose of supporting advances by the BETA Healthcare Group, its successors and/or assigns ("Beneficiary") of the Irrevocable Standby Letter of Credit No. 2024009.**

CONDITIONS PRECEDENT TO EACH ADVANCE. Lender's obligation to make the initial Advance and each subsequent Advance under this Agreement shall be subject to the fulfillment to Lender's satisfaction of all of the conditions set forth in this Agreement and in the Related Documents.

Loan Documents. Borrower shall provide to Lender the following documents for the Loan: (1) the Note; (2) together with all such Related Documents as Lender may require for the Loan; all in form and substance satisfactory to Lender and Lender's counsel.

Borrower's Authorization. Borrower shall have provided in form and substance satisfactory to Lender properly certified resolutions, duly authorizing the execution and delivery of this Agreement, the Note and the Related Documents. In addition, Borrower shall have provided such other resolutions, authorizations, documents and instruments as Lender or its counsel, may require.

Payment of Fees and Expenses. Borrower shall have paid to Lender all fees, charges, and other expenses which are then due and payable as specified in this Agreement or any Related Document.

Representations and Warranties. The representations and warranties set forth in this Agreement, in the Related Documents, and in any document or certificate delivered to Lender under this Agreement are true and correct.

No Event of Default. There shall not exist at the time of any Advance a condition which would constitute an Event of Default under this Agreement or under any Related Document.

REPRESENTATIONS AND WARRANTIES. Borrower represents and warrants to Lender, as of the date of this Agreement, as of the date of each disbursement of loan proceeds, as of the date of any renewal, extension or modification of any Loan, and at all times any Indebtedness exists:

Organization. Borrower is a non-profit corporation which is, and at all times shall be, duly organized, validly existing, and in good standing under and by virtue of the laws of the State of California. Borrower is duly authorized to transact business in all other states in which Borrower is doing business, having obtained all necessary filings, governmental licenses and approvals for each state in which Borrower is doing business. Specifically, Borrower is, and at all times shall be, duly qualified as a foreign corporation in all states in which the failure to so qualify would have a material adverse effect on its business or financial condition. Borrower has the full power and authority to own its properties and to transact the business in which it is presently engaged or presently proposes to engage. Borrower maintains an office at 43563 Hwy 299 E, Fall River Mills, CA 96028-9787. Unless Borrower has designated otherwise in writing, the principal office is the office at which Borrower keeps its books and records including its records concerning the Collateral. Borrower will notify Lender prior to any change in the location of Borrower's state of organization or any change in Borrower's name. Borrower shall do all things necessary to preserve and to keep in full force and effect its existence, rights and privileges, and shall comply with all regulations, rules, ordinances, statutes, orders and decrees of any governmental or quasi-governmental authority or court applicable to Borrower and Borrower's business activities.

Assumed Business Names. Borrower has filed or recorded all documents or filings required by law relating to all assumed business names used by Borrower. Excluding the name of Borrower, the following is a complete list of all assumed business names under which Borrower does business: **None.**

Authorization. Borrower's execution, delivery, and performance of this Agreement and all the Related Documents have been duly authorized by all necessary action by Borrower and do not conflict with, result in a violation of, or constitute a default under (1) any provision of (a) Borrower's articles of incorporation or organization, or bylaws, or (b) any agreement or other instrument binding upon Borrower or (2) any law, governmental regulation, court decree, or order applicable to Borrower or to Borrower's properties.

Financial Information. Each of Borrower's financial statements supplied to Lender truly and completely disclosed Borrower's financial condition as of the date of the statement, and there has been no material adverse change in Borrower's financial condition subsequent to the date of the most recent financial statement supplied to Lender. Borrower has no material contingent obligations except as disclosed in such financial statements.

Legal Effect. This Agreement constitutes, and any instrument or agreement Borrower is required to give under this Agreement when delivered will constitute legal, valid, and binding obligations of Borrower enforceable against Borrower in accordance with their respective terms.

No Prohibited Activities. Borrower is not engaged in and none of the Collateral is created by or used in connection with any Prohibited Activities. Borrower shall not make any payments to Lender from funds derived from Prohibited Activities. Borrower agrees to indemnify, defend, and hold harmless Lender against any and all claims, losses, liabilities, damages, penalties, and expenses which Lender may directly or indirectly sustain or suffer resulting from a breach of this section of the Agreement. Notwithstanding any provision in this Agreement or any Related Documents to the contrary, no direct or indirect disclosure to Lender and no knowledge of Lender of the existence of any Prohibited Activities shall estop Lender or waive any right of Lender to invoke any remedy under the Agreement or any Related Documents for any Prohibited Activities.

Properties. Except as contemplated by this Agreement or as previously disclosed in Borrower's financial statements or in writing to Lender and as accepted by Lender, and except for property tax liens for taxes not presently due and payable, Borrower owns and has good title to all of Borrower's properties free and clear of all Security Interests, and has not executed any security documents or financing statements relating to such properties. All of Borrower's properties are titled in Borrower's legal name, and Borrower has not used or filed a financing statement under any other name for at least the last five (5) years.

Hazardous Substances. Except as disclosed to and acknowledged by Lender in writing, Borrower represents and warrants that: (1) During the period of Borrower's ownership of the Collateral, there has been no use, generation, manufacture, storage, treatment, disposal, release or threatened release of any Hazardous Substance by any person on, under, about or from any of the Collateral. (2) Borrower has no knowledge of, or reason to believe that there has been (a) any breach or violation of any Environmental Laws; (b) any use, generation, manufacture, storage, treatment, disposal, release or threatened release of any Hazardous Substance on, under, about or from the Collateral by any prior owners or occupants of any of the Collateral; or (c) any actual or threatened litigation or claims of any kind by any person relating to such matters. (3) Neither Borrower nor any tenant, contractor, agent or other authorized user of any of the Collateral shall use, generate, manufacture, store, treat, dispose of or release any Hazardous Substance on, under, about or from any of the Collateral; and any such activity shall be conducted in compliance with all applicable federal, state, and local laws, regulations, and ordinances, including without limitation all Environmental Laws. Borrower authorizes Lender and its agents to enter upon the Collateral to make such inspections and tests as Lender may deem appropriate to determine compliance of the Collateral with this section of the Agreement. Any inspections or tests made by Lender shall be at Borrower's expense and for Lender's purposes only and shall not be construed to create any responsibility or liability on the part of Lender to Borrower or to any other person. The representations and warranties contained herein are based on Borrower's due diligence in investigating the Collateral for hazardous waste and Hazardous Substances. Borrower hereby (1) releases and waives any future claims against Lender for indemnity or contribution in the event Borrower becomes liable for cleanup or other costs under any such laws, and (2) agrees to indemnify, defend, and hold harmless Lender against any and all claims, losses, liabilities, damages, penalties, and expenses which Lender may directly or indirectly sustain or suffer resulting from a breach of this section of the Agreement or as a consequence of any use, generation, manufacture, storage, disposal, release or threatened release of a hazardous waste or substance on the Collateral. The provisions of this section of the Agreement, including the obligation to indemnify and defend, shall survive the payment of the Indebtedness and the termination, expiration or satisfaction of this Agreement and shall not be affected by Lender's acquisition of any interest in any of the Collateral, whether by foreclosure or otherwise.

Litigation and Claims. No litigation, claim, investigation, administrative proceeding or similar action (including those for unpaid taxes) against Borrower is pending or threatened, and no other event has occurred which may materially adversely affect Borrower's financial condition or properties, other than litigation, claims, or other events, if any, that have been disclosed to and acknowledged by Lender in writing.

Taxes. To the best of Borrower's knowledge, all of Borrower's tax returns and reports that are or were required to be filed, have been filed, and all taxes, assessments and other governmental charges have been paid in full, except those presently being or to be contested by Borrower in good faith in the ordinary course of business and for which adequate reserves have been provided.

Lien Priority. Unless otherwise previously disclosed to Lender in writing, Borrower has not entered into or granted any Security Agreements, or permitted the filing or attachment of any Security Interests on or affecting any of the Collateral directly or indirectly securing repayment of Borrower's Loan and Note, that would be prior or that may in any way be superior to Lender's Security Interests and rights in and to such Collateral.

Binding Effect. This Agreement, the Note, all Security Agreements (if any), and all Related Documents are binding upon the signers thereof, as well as upon their successors, representatives and assigns, and are legally enforceable in accordance with their respective terms.

AFFIRMATIVE COVENANTS. Borrower covenants and agrees with Lender that, so long as this Agreement remains in effect, Borrower will:

Notices of Claims and Litigation. Promptly inform Lender in writing of (1) all material adverse changes in Borrower's financial condition, and (2) all existing and all threatened litigation, claims, investigations, administrative proceedings or similar actions affecting Borrower or any Guarantor which could materially affect the financial condition of Borrower or the financial condition of any Guarantor.

Financial Records. Maintain its books and records in accordance with GAAP, or an OCBOA acceptable to Lender, applied on a consistent basis, and permit Lender to examine and audit Borrower's books and records at all reasonable times.

Financial Statements. Furnish Lender with such financial statements and other related information at such frequencies and in such detail as Lender may reasonably request.

Additional Information. Furnish such additional information and statements, as Lender may request from time to time.

Insurance. Maintain fire and other risk insurance, public liability insurance, and such other insurance as Lender may require with respect to Borrower's properties and operations, in form, amounts, coverages and with insurance companies acceptable to Lender. Borrower, upon request of Lender, will deliver to Lender from time to time the policies or certificates of insurance in form satisfactory to Lender, including stipulations that coverages will not be cancelled or diminished without at least ten (10) days prior written notice to Lender. Each insurance policy also shall include an endorsement providing that coverage in favor of Lender will not be impaired in any way by any act, omission or default of Borrower or any other person. In connection with all policies covering assets in which Lender holds or is offered a security interest for the Loans, Borrower will provide Lender with such lender's loss payable or other endorsements as Lender may require.

Insurance Reports. Furnish to Lender, upon request of Lender, reports on each existing insurance policy showing such information as Lender may reasonably request, including without limitation the following: (1) the name of the insurer; (2) the risks insured; (3) the amount of the policy; (4) the properties insured; (5) the then current property values on the basis of which insurance has been obtained, and the manner of determining those values; and (6) the expiration date of the policy. In addition, upon request of Lender (however not more often than annually), Borrower will have an independent appraiser satisfactory to Lender determine, as applicable, the actual cash value or replacement cost of any Collateral. The cost of such appraisal shall be paid by Borrower.

Other Agreements. Comply with all terms and conditions of all other agreements, whether now or hereafter existing, between Borrower and any other party and notify Lender immediately in writing of any default in connection with any other such agreements.

Loan Proceeds. Use all Loan proceeds solely for Borrower's business operations, unless specifically consented to the contrary by Lender in writing.

Taxes, Charges and Liens. Pay and discharge when due all of its indebtedness and obligations, including without limitation all assessments, taxes, governmental charges, levies and liens, of every kind and nature, imposed upon Borrower or its properties, income, or profits, prior to the date on which penalties would attach, and all lawful claims that, if unpaid, might become a lien or charge upon any of Borrower's properties, income, or profits. Provided however, Borrower will not be required to pay and discharge any such assessment, tax, charge, levy, lien or claim so long as (1) the legality of the same shall be contested in good faith by appropriate proceedings, and (2) Borrower shall have established on Borrower's books adequate reserves with respect to such contested assessment, tax, charge, levy, lien, or claim in accordance with GAAP or an OCBOA acceptable to Lender.

Performance. Perform and comply, in a timely manner, with all terms, conditions, and provisions set forth in this Agreement, in the Related Documents, and in all other instruments and agreements between Borrower and Lender. Borrower shall notify Lender immediately in writing of any default in connection with any agreement.

Operations. Maintain executive and management personnel with substantially the same qualifications and experience as the present executive and management personnel; provide written notice to Lender of any change in executive and management personnel; conduct its business affairs in a reasonable and prudent manner.

Environmental Studies. Promptly conduct and complete, at Borrower's expense, all such investigations, studies, samplings and testings as may be requested by Lender or any governmental authority relative to any substance, or any waste or by-product of any substance defined as toxic or a hazardous substance under applicable federal, state, or local law, rule, regulation, order or directive, at or affecting any property or any facility owned, leased or used by Borrower.

Compliance with Governmental Requirements. Comply with all laws, ordinances, and regulations, now or hereafter in effect, of all governmental authorities applicable to the conduct of Borrower's properties, businesses and operations, and to the use or occupancy of the Collateral, including without limitation, the Americans With Disabilities Act. Borrower may contest in good faith any such law, ordinance, or regulation and withhold compliance during any proceeding, including appropriate appeals, so long as Borrower has notified Lender in writing prior to doing so and so long as, in Lender's sole opinion, Lender's interests in the Collateral are not jeopardized. Lender may require Borrower to post adequate security or a surety bond, reasonably satisfactory to Lender, to protect Lender's interest.

Beneficial Ownership Information. Comply with all beneficial ownership information reporting requirements of the Corporate Transparency Act and its implementing regulations (collectively the CTA), if applicable to that Borrower. Any Borrower that is or becomes a reporting company as defined in the CTA: (1) has filed, or will file within required timeframes a complete and accurate report of its beneficial ownership information with the Financial Crimes Enforcement Network (FinCEN) as required by the CTA; (2) will update or correct its beneficial ownership information with FinCEN within required timeframes upon any change in its beneficial ownership information; (3) will provide Lender with a copy of its beneficial ownership information report filed with FinCEN upon request; (4) consents to allow Lender to obtain from FinCEN beneficial ownership information filed by Borrower; and (5) will notify Lender in writing of any change in its beneficial ownership information within 30 days of such change.

Inspection. Permit employees or agents of Lender at any reasonable time to inspect any and all Collateral for the Loan or Loans and Borrower's other properties and to examine or audit Borrower's books, accounts, and records and to make copies and memoranda of Borrower's books, accounts, and records. If Borrower now or at any time hereafter maintains any records (including without limitation computer generated records and computer software programs for the generation of such records) in the possession of a third party, Borrower, upon request of Lender, shall notify such party to permit Lender free access to such records at all reasonable times and to provide Lender with copies of any records it may request, all at Borrower's expense.

Compliance Certificates. Unless waived in writing by Lender, provide Lender at least annually, with a certificate executed by Borrower's chief financial officer, or other officer or person acceptable to Lender, certifying that the representations and warranties set forth in this Agreement are true and correct as of the date of the certificate and further certifying that, as of the date of the certificate, no Event of Default exists under this Agreement.

Environmental Compliance and Reports. Borrower shall comply in all respects with any and all Environmental Laws; not cause or permit to exist, as a result of an intentional or unintentional action or omission on Borrower's part or on the part of any third party, on property owned and/or occupied by Borrower, any environmental activity where damage may result to the environment, unless such environmental activity is pursuant to and in compliance with the conditions of a permit issued by the appropriate federal, state or local governmental authorities; shall furnish to Lender promptly and in any event within thirty (30) days after receipt thereof a copy of any notice, summons, lien, citation, directive, letter or other communication from any governmental agency or instrumentality concerning any intentional or unintentional action or omission on Borrower's part in connection with any environmental activity whether or not there is damage to the environment and/or other natural resources.

Additional Assurances. Make, execute and deliver to Lender such promissory notes, mortgages, deeds of trust, security agreements, assignments, financing statements, instruments, documents and other agreements as Lender or its attorneys may reasonably request to evidence and secure the Loans and to perfect all Security Interests.

RECOVERY OF ADDITIONAL COSTS. If the imposition of or any change in any law, rule, regulation, guideline, or generally accepted accounting

principle, or the interpretation or application of any thereof by any court, administrative or governmental authority, or standard-setting organization (including any request or policy not having the force of law) shall impose, modify or make applicable any taxes (except federal, state or local income or franchise taxes imposed on Lender), reserve requirements, capital adequacy requirements or other obligations which would (A) increase the cost to Lender for extending or maintaining the credit facilities to which this Agreement relates, (B) reduce the amounts payable to Lender under this Agreement or the Related Documents, or (C) reduce the rate of return on Lender's capital as a consequence of Lender's obligations with respect to the credit facilities to which this Agreement relates, then Borrower agrees to pay Lender such additional amounts as will compensate Lender therefor, within five (5) days after Lender's written demand for such payment, which demand shall be accompanied by an explanation of such imposition or charge and a calculation in reasonable detail of the additional amounts payable by Borrower, which explanation and calculations shall be conclusive in the absence of manifest error.

LENDER'S EXPENDITURES. If any action or proceeding is commenced that would materially affect Lender's interest in the Collateral or if Borrower fails to comply with any provision of this Agreement or any Related Documents, including but not limited to Borrower's failure to discharge or pay when due any amounts Borrower is required to discharge or pay under this Agreement or any Related Documents, Lender on Borrower's behalf may (but shall not be obligated to) take any action that Lender deems appropriate, including but not limited to discharging or paying all taxes, liens, security interests, encumbrances and other claims, at any time levied or placed on any Collateral and paying all costs for insuring, maintaining and preserving any Collateral. All such expenditures incurred or paid by Lender for such purposes will then bear interest at the rate charged under the Note from the date incurred or paid by Lender to the date of repayment by Borrower. All such expenses will become a part of the Indebtedness and, at Lender's option, will (A) be payable on demand; (B) be added to the balance of the Note and be apportioned among and be payable with any installment payments to become due during either (1) the term of any applicable insurance policy; or (2) the remaining term of the Note; or (C) be treated as a balloon payment which will be due and payable at the Note's maturity.

NEGATIVE COVENANTS. Borrower covenants and agrees with Lender that while this Agreement is in effect, Borrower shall not, without the prior written consent of Lender:

Indebtedness and Liens. (1) Except for trade debt incurred in the normal course of business and indebtedness to Lender contemplated by this Agreement, create, incur or assume indebtedness for borrowed money, including finance leases, (2) sell, transfer, mortgage, assign, pledge, lease, grant a security interest in, or encumber any of Borrower's assets (except as allowed as Permitted Liens), or (3) sell with recourse any of Borrower's accounts receivable, except to Lender.

Continuity of Operations. (1) Engage in any business activities substantially different than those in which Borrower is presently engaged, (2) cease operations, liquidate, merge or restructure as a legal entity (whether by division or otherwise), consolidate with or acquire any other entity, change its name, convert to another type of entity or redomesticate, dissolve or transfer or sell Collateral out of the ordinary course of business, or (3) pay any dividends on Borrower's stock (other than dividends payable in its stock), provided, however that notwithstanding the foregoing, but only so long as no Event of Default has occurred and is continuing or would result from the payment of dividends, if Borrower is a "Subchapter S Corporation" (as defined in the Internal Revenue Code of 1986, as amended), Borrower may pay cash dividends on its stock to its shareholders from time to time in amounts necessary to enable the shareholders to pay income taxes and make estimated income tax payments to satisfy their liabilities under federal and state law which arise solely from their status as Shareholders of a Subchapter S Corporation because of their ownership of shares of Borrower's stock, or purchase or retire any of Borrower's outstanding shares or alter or amend Borrower's capital structure.

Prohibited Activities. Engage in, or permit the Collateral to be created by or used in connection with, any Prohibited Activities.

Agreements. Enter into any agreement containing any provisions which would be violated or breached by the performance of Borrower's obligations under this Agreement or in connection herewith.

CESSATION OF ADVANCES. If Lender has made any commitment to make any Loan to Borrower, whether under this Agreement or under any other agreement, Lender shall have no obligation to make Loan Advances or to disburse Loan proceeds if: (A) Borrower or any Guarantor is in default under the terms of this Agreement or any of the Related Documents or any other agreement that Borrower or any Guarantor has with Lender; (B) Borrower or any Guarantor dies, becomes incompetent or becomes insolvent, files a petition in bankruptcy or similar proceedings, or is adjudged a bankrupt; (C) there occurs a material adverse change in Borrower's financial condition, in the financial condition of any Guarantor, or in the value of any Collateral securing any Loan; or (D) any Guarantor seeks, claims or otherwise attempts to limit, modify or revoke such Guarantor's guaranty of the Loan or any other loan with Lender; or (E) Lender in good faith deems itself insecure, even though no Event of Default shall have occurred.

RIGHT OF SETOFF. To the extent permitted by applicable law, Lender reserves a right of setoff in all Borrower's accounts with Lender (whether checking, savings, or some other account). This includes all accounts Borrower holds jointly with someone else and all accounts Borrower may open in the future. However, this does not include any IRA or Keogh accounts, or any trust accounts for which setoff would be prohibited by law. Borrower authorizes Lender, to the extent permitted by applicable law, to charge or setoff all sums owing on the debt against any and all such accounts.

DEFAULT. Each of the following shall constitute an Event of Default under this Agreement:

Payment Default. Borrower fails to make any payment when due under the Loan.

Other Defaults. Borrower fails to comply with or to perform any other term, obligation, covenant or condition contained in this Agreement or in any of the Related Documents or to comply with or to perform any term, obligation, covenant or condition contained in any other agreement between Lender and Borrower.

Default in Favor of Third Parties. Borrower or any Grantor defaults under any loan, extension of credit, security agreement, purchase or sales agreement, or any other agreement, in favor of any other creditor or person that may materially affect any of Borrower's or any Grantor's property or Borrower's or any Grantor's ability to repay the Loans or perform their respective obligations under this Agreement or any of the Related Documents.

False Statements. Any warranty, representation or statement made or furnished to Lender by Borrower or on Borrower's behalf under this Agreement or the Related Documents is false or misleading in any material respect, either now or at the time made or furnished or becomes false or misleading at any time thereafter.

Insolvency. The dissolution or termination of Borrower's existence as a going business, the insolvency of Borrower, the appointment of a receiver for any part of Borrower's property, any assignment for the benefit of creditors, any type of creditor workout, or the commencement of any proceeding under any bankruptcy or insolvency laws by or against Borrower.

Defective Collateralization. This Agreement or any of the Related Documents ceases to be in full force and effect (including failure of any collateral document to create a valid and perfected security interest or lien) at any time and for any reason.

Creditor or Forfeiture Proceedings. Commencement of foreclosure or forfeiture proceedings, whether by judicial proceeding, self-help, repossession or any other method, by any creditor of Borrower or by any governmental agency against any collateral securing the Loan.

This includes a garnishment of any of Borrower's accounts, including deposit accounts, with Lender. However, this Event of Default shall not apply if there is a good faith dispute by Borrower as to the validity or reasonableness of the claim which is the basis of the creditor or forfeiture proceeding and if Borrower gives Lender written notice of the creditor or forfeiture proceeding and deposits with Lender monies or a surety bond for the creditor or forfeiture proceeding, in an amount determined by Lender, in its sole discretion, as being an adequate reserve or bond for the dispute.

Change in Ownership. Any change in ownership of twenty-five percent (25%) or more of the common stock of Borrower.

Adverse Change. A material adverse change occurs in Borrower's financial condition, or Lender believes the prospect of payment or performance of the Loan is impaired.

Insecurity. Lender in good faith believes itself insecure.

Events Affecting Guarantor. Any of the preceding events occurs with respect to any Guarantor of any of the Indebtedness or any Guarantor dies or becomes incompetent, or revokes or disputes the validity of, or liability under, any Guaranty of the Indebtedness.

EFFECT OF AN EVENT OF DEFAULT. If any Event of Default shall occur, except where otherwise provided in this Agreement or the Related Documents, all commitments and obligations of Lender under this Agreement or the Related Documents or any other agreement immediately will terminate (including any obligation to make further Loan Advances or disbursements), and, at Lender's option, all Indebtedness immediately will become due and payable, all without notice of any kind to Borrower, except that in the case of an Event of Default of the type described in the "Insolvency" subsection above, such acceleration shall be automatic and not optional. In addition, Lender shall have all the rights and remedies provided in the Related Documents or available at law, in equity, or otherwise. Except as may be prohibited by applicable law, all of Lender's rights and remedies shall be cumulative and may be exercised singularly or concurrently. Election by Lender to pursue any remedy shall not exclude pursuit of any other remedy, and an election to make expenditures or to take action to perform an obligation of Borrower or of any Grantor shall not affect Lender's right to declare a default and to exercise its rights and remedies.

MISCELLANEOUS PROVISIONS. The following miscellaneous provisions are a part of this Agreement:

Amendments. This Agreement, together with any Related Documents, constitutes the entire understanding and agreement of the parties as to the matters set forth in this Agreement. No alteration of or amendment to this Agreement shall be effective unless given in writing and signed by the party or parties sought to be charged or bound by the alteration or amendment.

Arbitration. Borrower and Lender agree that all disputes, claims and controversies between them whether individual, joint, or class in nature, arising from this Agreement or otherwise, including without limitation contract and tort disputes, shall be arbitrated pursuant to the Commercial Arbitration Rules of the American Arbitration Association in effect at the time the claim is filed, upon request of either party. No act to take or dispose of any Collateral shall constitute a waiver of this arbitration agreement or be prohibited by this arbitration agreement. This includes, without limitation, obtaining injunctive relief or a temporary restraining order; invoking a power of sale under any deed of trust or mortgage; obtaining a writ of attachment or imposition of a receiver; or exercising any rights relating to personal property, including taking or disposing of such property with or without judicial process pursuant to Article 9 of the Uniform Commercial Code. Any disputes, claims, or controversies concerning the lawfulness or reasonableness of any act, or exercise of any right, concerning any Collateral, including any claim to rescind, reform, or otherwise modify any agreement relating to the Collateral, shall also be arbitrated, provided however that no arbitrator shall have the right or the power to enjoin or restrain any act of any party. Borrower and Lender agree that in the event of an action for judicial foreclosure pursuant to California Code of Civil Procedure Section 726, or any similar provision in any other state, the commencement of such an action will not constitute a waiver of the right to arbitrate and the court shall refer to arbitration as much of such action, including counterclaims, as lawfully may be referred to arbitration. Judgment upon any award rendered by any arbitrator may be entered in any court having jurisdiction. Nothing in this Agreement shall preclude any party from seeking equitable relief from a court of competent jurisdiction. The statute of limitations, estoppel, waiver, laches, and similar doctrines which would otherwise be applicable in an action brought by a party shall be applicable in any arbitration proceeding, and the commencement of an arbitration proceeding shall be deemed the commencement of an action for these purposes. The Federal Arbitration Act shall apply to the construction, interpretation, and enforcement of this arbitration provision.

Attorneys' Fees; Expenses. Borrower agrees to pay upon demand all of Lender's costs and expenses, including Lender's attorneys' fees and Lender's legal expenses, incurred in connection with the enforcement of this Agreement. Lender may hire or pay someone else to help enforce this Agreement, and Borrower shall pay the costs and expenses of such enforcement. Costs and expenses include Lender's attorneys' fees and legal expenses whether or not there is a lawsuit, including attorneys' fees and legal expenses for bankruptcy proceedings (including efforts to modify or vacate any automatic stay or injunction), appeals, and any anticipated post-judgment collection services. Borrower also shall pay all court costs and such additional fees as may be directed by the court.

Caption Headings. Caption headings in this Agreement are for convenience purposes only and are not to be used to interpret or define the provisions of this Agreement.

Consent to Loan Participation. Borrower agrees and consents to Lender's sale or transfer, whether now or later, of one or more participation interests in the Loan to one or more purchasers, whether related or unrelated to Lender. Lender may provide, without any limitation whatsoever, to any one or more purchasers, or potential purchasers, any information or knowledge Lender may have about Borrower or about any other matter relating to the Loan, and Borrower hereby waives any rights to privacy Borrower may have with respect to such matters. Borrower additionally waives any and all notices of sale of participation interests, as well as all notices of any repurchase of such participation interests. Borrower also agrees that the purchasers of any such participation interests will be considered as the absolute owners of such interests in the Loan and will have all the rights granted under the participation agreement or agreements governing the sale of such participation interests. Borrower further waives all rights of offset or counterclaim that it may have now or later against Lender or against any purchaser of such a participation interest and unconditionally agrees that either Lender or such purchaser may enforce Borrower's obligation under the Loan irrespective of the failure or insolvency of any holder of any interest in the Loan. Borrower further agrees that the purchaser of any such participation interests may enforce its interests irrespective of any personal claims or defenses that Borrower may have against Lender.

Governing Law. This Agreement will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of California without regard to its conflicts of law provisions. This Agreement has been accepted by Lender in the State of California.

No Waiver by Lender. Lender shall not be deemed to have waived any rights under this Agreement unless such waiver is given in writing and signed by Lender. No delay or omission on the part of Lender in exercising any right shall operate as a waiver of such right or any other right. A waiver by Lender of a provision of this Agreement shall not prejudice or constitute a waiver of Lender's right otherwise to demand strict compliance with that provision or any other provision of this Agreement. No prior waiver by Lender, nor any course of dealing between Lender and Borrower, or between Lender and any Grantor, shall constitute a waiver of any of Lender's rights or of any of Borrower's or any Grantor's obligations as to any future transactions. Whenever the consent of Lender is required under this Agreement, the granting of such consent by Lender in any instance shall not constitute continuing consent to subsequent instances where such consent

is required and in all cases such consent may be granted or withheld in the sole discretion of Lender.

Notices. Any notice required to be given under this Agreement shall be given in writing, and shall be effective when actually delivered, when actually received by telefacsimile (unless otherwise required by law), when deposited with a nationally recognized overnight courier, or, if mailed, when deposited in the United States mail, as first class, certified or registered mail postage prepaid, directed to the addresses shown near the beginning of this Agreement. Any party may change its address for notices under this Agreement by giving formal written notice to the other parties, specifying that the purpose of the notice is to change the party's address. For notice purposes, Borrower agrees to keep Lender informed at all times of Borrower's current address. Unless otherwise provided or required by law, if there is more than one Borrower, any notice given by Lender to any Borrower is deemed to be notice given to all Borrowers.

Prohibited Activities. Notwithstanding anything to the contrary in this Agreement, Borrower shall not be entitled to receive any notice of or right to cure an Event of Default related to any Prohibited Activities.

Severability. If a court of competent jurisdiction finds any provision of this Agreement to be illegal, invalid, or unenforceable as to any circumstance, that finding shall not make the offending provision illegal, invalid, or unenforceable as to any other circumstance. If feasible, the offending provision shall be considered modified so that it becomes legal, valid and enforceable. If the offending provision cannot be so modified, it shall be considered deleted from this Agreement. Unless otherwise required by law, the illegality, invalidity, or unenforceability of any provision of this Agreement shall not affect the legality, validity or enforceability of any other provision of this Agreement.

Subsidiaries and Affiliates of Borrower. To the extent the context of any provisions of this Agreement makes it appropriate, including without limitation any representation, warranty or covenant, the word "Borrower" as used in this Agreement shall include all of Borrower's subsidiaries and affiliates. Notwithstanding the foregoing however, under no circumstances shall this Agreement be construed to require Lender to make any Loan or other financial accommodation to any of Borrower's subsidiaries or affiliates.

Successors and Assigns. All covenants and agreements by or on behalf of Borrower contained in this Agreement or any Related Documents shall bind Borrower's successors and assigns and shall inure to the benefit of Lender and its successors and assigns. Borrower shall not, however, have the right to assign Borrower's rights under this Agreement or any interest therein, without the prior written consent of Lender.

Survival of Representations and Warranties. Borrower understands and agrees that in extending Loan Advances, Lender is relying on all representations, warranties, and covenants made by Borrower in this Agreement or in any certificate or other instrument delivered by Borrower to Lender under this Agreement or the Related Documents. Borrower further agrees that regardless of any investigation made by Lender, all such representations, warranties and covenants will survive the extension of Loan Advances and delivery to Lender of the Related Documents, shall be continuing in nature, shall be deemed made and redated by Borrower at the time each Loan Advance is made, and shall remain in full force and effect until such time as Borrower's Indebtedness shall be paid in full, or until this Agreement shall be terminated in the manner provided above, whichever is the last to occur.

Time is of the Essence. Time is of the essence in the performance of this Agreement.

DEFINITIONS. The following capitalized words and terms shall have the following meanings when used in this Agreement. Unless specifically stated to the contrary, all references to dollar amounts shall mean amounts in lawful money of the United States of America. Words and terms used in the singular shall include the plural, and the plural shall include the singular, as the context may require. Words and terms not otherwise defined in this Agreement shall have the meanings attributed to such terms in the Uniform Commercial Code. Accounting words and terms not otherwise defined in this Agreement shall have the meanings assigned to them in accordance with generally accepted accounting principles as in effect on the date of this Agreement:

Advance. The word "Advance" means a disbursement of Loan funds made, or to be made, to Borrower or on Borrower's behalf on a line of credit or multiple advance basis under the terms and conditions of this Agreement.

Agreement. The word "Agreement" means this Business Loan Agreement, as this Business Loan Agreement may be amended or modified from time to time, together with all exhibits and schedules attached to this Business Loan Agreement from time to time.

Borrower. The word "Borrower" means Mayers Memorial Hospital District and includes all co-signers and co-makers signing the Note and all their successors and assigns.

Collateral. The word "Collateral" means all property and assets granted as collateral security for a Loan, whether real or personal property, whether granted directly or indirectly, whether granted now or in the future, and whether granted in the form of a security interest, mortgage, collateral mortgage, deed of trust, assignment, pledge, crop pledge, chattel mortgage, collateral chattel mortgage, chattel trust, factor's lien, equipment trust, conditional sale, trust receipt, lien, charge, lien or title retention contract, lease or consignment intended as a security device, or any other security or lien interest whatsoever, whether created by law, contract, or otherwise.

Environmental Laws. The words "Environmental Laws" mean any and all state, federal and local statutes, regulations and ordinances relating to the protection of human health or the environment, including without limitation the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, 42 U.S.C. Section 9601, et seq. ("CERCLA"), the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499 ("SARA"), the Hazardous Materials Transportation Act, 49 U.S.C. Section 1801, et seq., the Resource Conservation and Recovery Act, 42 U.S.C. Section 6901, et seq., Chapters 6.5 through 7.7 of Division 20 of the California Health and Safety Code, Section 25100, et seq., or other applicable state or federal laws, rules, or regulations adopted pursuant thereto.

Event of Default. The words "Event of Default" mean any of the events of default set forth in this Agreement in the default section of this Agreement.

GAAP. The word "GAAP" means generally accepted accounting principles.

Grantor. The word "Grantor" means each and all of the persons or entities granting a Security Interest in any Collateral for the Loan, including without limitation all Borrowers granting such a Security Interest.

Guarantor. The word "Guarantor" means any guarantor, surety, or accommodation party of any or all of the Loan.

Guaranty. The word "Guaranty" means the guaranty from Guarantor to Lender, including without limitation a guaranty of all or part of the Note.

Hazardous Substances. The words "Hazardous Substances" mean materials that, because of their quantity, concentration or physical, chemical or infectious characteristics, may cause or pose a present or potential hazard to human health or the environment when improperly used, treated, stored, disposed of, generated, manufactured, transported or otherwise handled. The words "Hazardous Substances" are used in their very broadest sense and include without limitation any and all hazardous or toxic substances, materials or waste as defined by or listed under the Environmental Laws. The term "Hazardous Substances" also includes, without limitation, petroleum and petroleum by-products or any fraction thereof and asbestos.

Indebtedness. The word "Indebtedness" means the indebtedness evidenced by the Note or Related Documents, including all principal and interest together with all other indebtedness and costs and expenses for which Borrower is responsible under this Agreement or under any of the Related Documents.

Lender. The word "Lender" means Cornerstone Community Bank, its successors and assigns.

Loan. The word "Loan" means any and all loans and financial accommodations from Lender to Borrower whether now or hereafter existing, and however evidenced, including without limitation those loans and financial accommodations described herein or described on any exhibit or schedule attached to this Agreement from time to time.

Note. The word "Note" means the Note dated May 5, 2025 and executed by Mayers Memorial Hospital District in the principal amount of $100,000.00, together with all renewals of, extensions of, modifications of, refinancings of, consolidations of, and substitutions for the note or credit agreement.

OCBOA. The term "OCBOA" means Other Comprehensive Basis of Accounting, as designated by Lender in writing as an acceptable alternative to GAAP.

Permitted Liens. The words "Permitted Liens" mean (1) liens and security interests securing Indebtedness owed by Borrower to Lender; (2) liens for taxes, assessments, or similar charges either not yet due or being contested in good faith; (3) liens of materialmen, mechanics, warehousemen, or carriers, or other like liens arising in the ordinary course of business and securing obligations which are not yet delinquent; (4) purchase money liens or purchase money security interests upon or in any property acquired or held by Borrower in the ordinary course of business to secure indebtedness outstanding on the date of this Agreement or permitted to be incurred under the paragraph of this Agreement titled "Indebtedness and Liens"; (5) liens and security interests which, as of the date of this Agreement, have been disclosed to and approved by the Lender in writing; and (6) those liens and security interests which in the aggregate constitute an immaterial and insignificant monetary amount with respect to the net value of Borrower's assets.

Prohibited Activities. The words "Prohibited Activities" mean any activity relating to the use, sale, possession, cultivation, manufacture, storage, distribution, or marketing of cannabis, marijuana, or marijuana-based products which constitutes in any manner a violation of any applicable federal, state, or local law or regulation, regardless of whether applicable conflicting law permits the same.

Related Documents. The words "Related Documents" mean all promissory notes, credit agreements, loan agreements, environmental agreements, guaranties, security agreements, mortgages, deeds of trust, security deeds, collateral mortgages, and all other instruments, agreements and documents, whether now or hereafter existing, executed in connection with the Loan.

Security Agreement. The words "Security Agreement" mean and include without limitation any agreements, promises, covenants, arrangements, understandings or other agreements, whether created by law, contract, or otherwise, evidencing, governing, representing, or creating a Security Interest.

Security Interest. The words "Security Interest" mean, without limitation, any and all types of collateral security, present and future, whether in the form of a lien, charge, encumbrance, mortgage, deed of trust, security deed, assignment, pledge, crop pledge, chattel mortgage, collateral chattel mortgage, chattel trust, factor's lien, equipment trust, conditional sale, trust receipt, lien or title retention contract, lease or consignment intended as a security device, or any other security or lien interest whatsoever whether created by law, contract, or otherwise.

BORROWER ACKNOWLEDGES HAVING READ ALL THE PROVISIONS OF THIS BUSINESS LOAN AGREEMENT AND BORROWER AGREES TO ITS TERMS. THIS BUSINESS LOAN AGREEMENT IS DATED MAY 5, 2025.

BORROWER:

MAYERS MEMORIAL HOSPITAL DISTRICT

By: _____
Ryan J Ramon Harris, CEO of Mayers Memorial Hospital District

By: _____
Travis Lakey, Chief Financial Officer of Mayers Memorial Hospital District

LENDER:

CORNERSTONE COMMUNITY BANK

By: _____
Matt Moseley, President/CEO

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CORNERSTONE
COMMUNITY BANK

IRREVOCABLE LETTER OF CREDIT

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

Lender: Cornerstone Community Bank
Redding Branch
192 Hartnell Ave.
Redding, CA 96002

Beneficiary: BETA Healthcare Group
1443 Danville Boulevard
Alamo, CA 94507-1911

NO.: 2024009

EXPIRATION DATE. This letter of credit shall expire upon the close of business on 07-23-2026 and all drafts and accompanying statements or documents must be presented to Lender on or before that time (the "Expiration Date").

AMOUNT OF CREDIT. Lender hereby establishes at the request and for the account of Borrower, an Irrevocable Letter of Credit in favor of Beneficiary for a sum of One Hundred Thousand & 00/100 Dollars ($100,000.00) (the "Letter of Credit"). These funds shall be made available to Beneficiary upon Lender's receipt from Beneficiary of sight drafts drawn on Lender at Lender's address indicated above (or other such address that Lender may provide Beneficiary in writing) during regular business hours and accompanied by the signed written statements or documents indicated below.

WARNING TO BENEFICIARY: PLEASE EXAMINE THIS LETTER OF CREDIT AT ONCE. IF YOU FEEL UNABLE TO MEET ANY OF ITS REQUIREMENTS, EITHER SINGLY OR TOGETHER, YOU SHOULD CONTACT BORROWER IMMEDIATELY TO SEE IF THE LETTER OF CREDIT CAN BE AMENDED. OTHERWISE, YOU WILL RISK LOSING PAYMENT UNDER THIS LETTER OF CREDIT FOR FAILURE TO COMPLY STRICTLY WITH ITS TERMS AS WRITTEN.

DRAFT TERMS AND CONDITIONS. Lender shall honor drafts submitted by Beneficiary under the following terms and conditions: **Advances against this line of credit will be restricted from the Borrower's use and will be made for the sole purpose of supporting advances by the BETA Healthcare Group, its successors and/or assigns ("Beneficiary") of the Irrevocable Standby Letter of Credit No. 2024009**

Upon Lender's honor of such drafts, Lender shall be fully discharged of Lender's obligations under this Letter of Credit and shall not be obligated to make any further payments under this Letter of Credit once the full amount of credit available under this Letter of Credit has been drawn.

Beneficiary shall have no recourse against Lender for any amount paid under this Letter of Credit once Lender has honored any draft or other document which complies strictly with this Letter of Credit, and which on its face appears otherwise in order but which is signed, issued, or presented by a party or under the name of a party purporting to act for Beneficiary, purporting to claim through Beneficiary, or posing as Beneficiary without Beneficiary's authorization. By paying an amount demanded in accordance with this Letter of Credit, Lender makes no representation as to the correctness of the amount demanded and Lender shall not be liable to Beneficiary, or any other person, for any amount paid or disbursed for any reason whatsoever, including, without limitation, any nonapplication or misapplication by Beneficiary of the proceeds of such payment. By presenting upon Lender or a confirming bank, Beneficiary certifies that Beneficiary has not and will not present upon the other, unless and until Beneficiary meets with dishonor. Beneficiary promises to return to Lender any funds received by Beneficiary in excess of the Letter of Credit's maximum drawing amount.

USE RESTRICTIONS. All drafts must be marked "DRAWN UNDER Cornerstone Community Bank IRREVOCABLE LETTER OF CREDIT NO. 2024009 DATED 07-23-2025," and the amount of each draft shall be marked on the draft. Only Beneficiary may complete a draft and accompanying statements or documents required by this Letter of Credit and make a draw under this Letter of Credit. This original Letter of Credit must accompany any draft drawn hereunder.

Partial draws are not permitted under this Letter of Credit.

PERMITTED TRANSFEREES. The right to draw under this Letter of Credit shall be nontransferable, except for:

A. A transfer (in its entirety, but not in part) by direct operation of law to the administrator, executor, bankruptcy trustee, receiver, liquidator, successor, or other representative at law of the original Beneficiary; and

B. The first immediate transfer (in its entirety, but not in part) by such legal representative to a third party after express approval of a governmental body (judicial, administrative, or executive).

TRANSFEREES REQUIRED DOCUMENTS. When the presenter is a permitted transferee (i) by operation of law or (ii) a third party receiving transfer from a legal representative, as described above, the documents required for a draw shall include a certified copy of the one or more documents which show the presenter's authority to claim through or to act with authority for the original Beneficiary.

COMPLIANCE BURDEN. Lender is not responsible for any impossibility or other difficulty in achieving strict compliance with the requirements of this Letter of Credit precisely as written. Beneficiary understands and acknowledges: (i) that unless and until the present wording of this Letter of Credit is amended with Lender's prior written consent, the burden of complying strictly with such wording remains solely upon Beneficiary, and (ii) that Lender is relying upon the lack of such amendment as constituting Beneficiary's initial and continued approval of such wording.

NON-SEVERABILITY. If any aspect of this Letter of Credit is ever declared unenforceable for any reason by any court or governmental body having jurisdiction, Lender's entire engagement under this Letter of Credit shall be deemed null and void ab initio, and both Lender and Beneficiary shall be restored to the position each would have occupied with all rights available as though this Letter of Credit had never occurred. This non-severability provision shall override all other provisions in this Letter of Credit, no matter where such provision appears within this Letter of Credit.

GOVERNING LAW. This Agreement will be governed by federal law applicable to Lender and, to the extent not preempted by federal law, the laws of the State of California without regard to its conflicts of law provisions, and except to the extent such laws are inconsistent with the 2007 Revision of the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, ICC Publication No. 600. This Agreement has been accepted by Lender in the State of California.

EXPIRATION. Lender hereby agrees with Beneficiary that drafts drawn under and in compliance with the terms of this Letter of Credit will be

duly honored if presented to Lender on or before the Expiration Date unless otherwise provided for above.

Dated: May 5, 2025

LENDER:

CORNERSTONE COMMUNITY BANK

By: _____
Matt Moseley, President/CEO

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CORNERSTONE
COMMUNITY BANK

CHANGE IN TERMS AGREEMENT

Principal	Loan Date	Maturity	Loan No	Call / Coll	Account	Officer	Initials
$100,000.00	07-23-2024	07-23-2026	400416700	4 / 028		***	

References in the boxes above are for Lender's use only and do not limit the applicability of this document to any particular loan or item.
Any item above containing "***" has been omitted due to text length limitations.

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

Lender: Cornerstone Community Bank
Redding Branch
192 Hartnell Ave.
Redding, CA 96002

Principal Amount: $100,000.00 **Date of Agreement: May 5, 2025**

DESCRIPTION OF EXISTING INDEBTEDNESS.

This Change in Terms Agreement is in revision of, but not in satisfaction of, the original Promissory Note dated July 23, 2024 in the amount of $100,000.00 with a maturity date of July 23, 2025 as well as subsequent renewals, extensions and modifications.

DESCRIPTION OF COLLATERAL.

Unsecured.

DESCRIPTION OF CHANGE IN TERMS.

Effective with this Agreement:

The maturity date is extended from July 23, 2025 to July 23, 2026.

A loan fee in the amount of $500.00 shall be due and payable upon the execution of this Agreement.

All of the terms, provisions, conditions, representations, warranties and covenants of the Promissory Note as amended or modified hereby, are ratified, acknowledged, confirmed and continued in full force and effect as if fully restated herein.

PAYMENT. Borrower will pay this loan in one payment of all outstanding principal plus all accrued unpaid interest on July 23, 2026. In addition, Borrower will pay regular monthly payments of all accrued unpaid interest due as of each payment date, beginning May 23, 2025, with all subsequent interest payments to be due on the same day of each month after that.

VARIABLE INTEREST RATE. The interest rate on this loan is subject to change from time to time based on changes in an independent index which is the Prime Rate as published in the Wall Street Journal. When a range of rates has been published, the higher of the rates will be used (the "Index"). The Index is not necessarily the lowest rate charged by Lender on its loans. Lender will tell Borrower the current Index rate upon Borrower's request. The interest rate change will not occur more often than each day. Borrower understands that Lender may make loans based on other rates as well. **The Index currently is 7.500% per annum.** Interest on the unpaid principal balance of this loan will be calculated as described in the "INTEREST CALCULATION METHOD" paragraph using a rate equal to the Index, adjusted if necessary for any minimum and maximum rate limitations described below, resulting in an initial rate of 7.500%. If Lender determines, in its sole discretion, that the Index has become unavailable or unreliable, either temporarily, indefinitely, or permanently, during the term of this loan, Lender may amend this loan by designating a substantially similar substitute index. Lender may also amend and add a positive or negative margin (percentage added to or subtracted from the substitute index value) as part of the rate determination. In making these amendments, Lender may take into consideration any then-prevailing market convention for selecting a substitute index and margin for the specific Index that is unavailable or unreliable. Such an amendment to the terms of this loan will become effective and bind Borrower 10 business days after Lender gives written notice to Borrower without any action or consent of the Borrower. NOTICE: Under no circumstances will the interest rate on this loan be less than 5.000% per annum or more than the maximum rate allowed by applicable law.

INTEREST CALCULATION METHOD. Interest on this loan is computed on a 365/360 basis; that is, by applying the ratio of the interest rate over a year of 360 days, multiplied by the outstanding principal balance, multiplied by the actual number of days the principal balance is outstanding (but not including February 29 in leap years). All interest payable under this loan is computed using this method.

CONTINUING VALIDITY. Except as expressly changed by this Agreement, the terms of the original obligation or obligations, including all agreements evidenced or securing the obligation(s), remain unchanged and in full force and effect. Consent by Lender to this Agreement does not waive Lender's right to strict performance of the obligation(s) as changed, nor obligate Lender to make any future change in terms. Nothing in this Agreement will constitute a satisfaction of the obligation(s). It is the intention of Lender to retain as liable parties all makers and endorsers of the original obligation(s), including accommodation parties, unless a party is expressly released by Lender in writing. Any maker or endorser, including accommodation makers, will not be released by virtue of this Agreement. If any person who signed the original obligation does not sign this Agreement below, then all persons signing below acknowledge that this Agreement is given conditionally, based on the representation to Lender that the non-signing party consents to the changes and provisions of this Agreement or otherwise will not be released by it. This waiver applies not only to any initial extension, modification or release, but also to all such subsequent actions.

PRIOR TO SIGNING THIS AGREEMENT, BORROWER READ AND UNDERSTOOD ALL THE PROVISIONS OF THIS AGREEMENT, INCLUDING THE VARIABLE INTEREST RATE PROVISIONS. BORROWER AGREES TO THE TERMS OF THE AGREEMENT.

BORROWER:

MAYERS MEMORIAL HOSPITAL DISTRICT

By: _____
Ryan J Ramon Harris, CEO of Mayers Memorial Hospital District

By: _____
Travis Lakey, Chief Financial Officer of Mayers Memorial Hospital District

LENDER:

CORNERSTONE COMMUNITY BANK

X _____
Matt Moseley, President/CEO

Mayers Memorial Healthcare District

Strategic Plan
FY2025 – FY2029

(updated 05-27-2025)

Message from the Board of Directors

The Mayers Memorial Hospital District Board of Directors is pleased to present this refreshed strategic plan for 2025-2029, building upon the success of our original plan developed in 2016. Since its inception, we have made significant strides in enhancing our facilities and services, including the addition of a new wing featuring a state-of-the-art emergency room, retail pharmacy, rural health clinic, and mobile clinic. We have also implemented a new electronic medical record system to improve patient care.

As we look to the future, our commitment to delivering exceptional patient care, fostering a safe and motivated work environment for our employees, and being fiscally responsible remains unwavering. This updated plan serves as a guiding framework for the District Board and administration over the next five years. It outlines our goals, objectives, and strategies to ensure that we continue to meet the evolving needs of our community while maintaining our reputation for excellence in patient care.

Introduction

The purpose of this Strategic Plan is to define the critical objectives that the Board of Directors aims to achieve by FYE 2029. This comprehensive plan serves as a bridge, connecting Mayers Memorial Healthcare District's Mission, Vision, and Values to the daily work of our talented and dedicated staff, providing a clear direction and focus for their efforts.

Mission
Leading rural healthcare for a lifetime of wellbeing.

Vision
Build the healthiest rural community through exceptional and accessible care.

Values
I-RESPECT: Integrity, Reliability, Excellence, Stewardship, Partnership, Equity, Compassion, Teamwork

This Plan will outline the strategic pillars, and the priorities needed to achieve our mission, vision, and values to ensure success toward those objectives, the risks to the objectives, implementation, monitoring, and evaluation.

Strategic Pillars

To progress toward the achievement of our Mission, Vision, and Values over the next five years, we will work toward the following five (5) strategic pillars:

1. Quality/Service: At Mayers Memorial Healthcare District, we are committed to delivering exceptional patient-centered care, exceeding expectations, and driving continuous improvement. We will achieve this by:
    a. Providing high-quality, safe, and efficient care that is personalized to the unique needs of each patient.
    b. Fostering a culture of quality and safety through ongoing education, training, and accountability.
    c. Collecting and acting on patient feedback to improve the overall patient experience.
    d. Implementing evidence-based practices and guidelines through ACHC to ensure best-in-class care.
    e. Leveraging technology and innovation to streamline processes and enhance outcomes.

    Our goal is to be a trusted and respected healthcare partner in our community, known for delivering care that exceeds patient expectations and improves health outcomes.

2. People: At Mayers Memorial Healthcare District, we are committed to fostering a culture of compassion, inclusivity, and growth, where every employee is valued, empowered, and supported to deliver exceptional patient care and achieve their full potential. We will achieve this by:
    a. Recruiting and retaining top talent through competitive compensation, comprehensive benefits, and opportunities for professional development.

b. Providing ongoing training and education to enhance skills and knowledge.
c. Encouraging open communication, diversity, and inclusion across all levels of the organization.
d. Fostering a sense of community and teamwork through recognition and rewards programs.
e. Embracing innovation and creativity in our work environment.

Our goal is to create a culture that empowers employees to deliver exceptional patient care and achieve their full potential.

3. Growth: At Mayers Memorial Healthcare District, we are committed to driving strategic growth and innovation, expanding our reach and impact, and building a sustainable future for our organization. We will achieve this by:
    a. Developing and executing strategic plans that align with our mission, vision, and values.
    b. Fostering a culture of innovation.
    c. Investing in cutting-edge technology and infrastructure to drive efficiency and effectiveness.
    d. Building strong partnerships with community stakeholders, payers, and vendors to advance our goals.
    e. Attracting and retaining top talent and providing opportunities for professional growth and development.
    f. Drive consistent departmental growth to achieve a sustainable future.

Our goal is to position Mayers Memorial Healthcare District as a leader in the rural healthcare industry, known for its forward-thinking approach, strategic partnerships, and commitment to driving positive change.

4. Communication: At Mayers Memorial Healthcare District, we are dedicated to fostering a culture of transparency, collaboration, and open communication. We believe that effective communication is essential to building trust, driving understanding, and achieving our goals. We will achieve this by:
    a. Providing timely and clear information to patients, families, and staff about our services, the patient's care, our policies, and initiatives.
    b. Fostering open and respectful dialogue among team members, leadership, and stakeholders.
    c. Utilizing multiple channels to communicate with diverse audiences, including digital media, print materials, and in-person interactions.
    d. Encouraging active listening and feedback from all stakeholders to inform our decisions and actions.
    e. Celebrating successes and learning from setbacks through regular recognition and continuous improvement.

Our goal is to be a model for transparent and effective communication in the healthcare industry, where information flows freely, concerns are heard and addressed, and everyone feels valued and informed.

5. Finance: At Mayers Memorial Healthcare District, we are committed to maintaining a strong financial foundation that supports our mission and enables us to deliver high-quality patient care. We will achieve this by:
    a. Developing and managing budgets that align with our strategic priorities and goals.
    b. Analyzing financial performance regularly to identify areas for improvement and make data-driven decisions.

c. Maintaining a culture of fiscal responsibility and accountability among all staff members.
d. Investing in financial systems and processes that support transparency, accuracy, and efficiency.
e. Building strong relationships with donors, philanthropic organizations, and other funding partners to secure necessary resources.

Our goal is to be a financially sustainable organization that can invest in the future of healthcare, drive innovation, and provide exceptional care to our patients.

Success Indicators

Fiscal Year 2025 Priorities

To ensure we achieve our strategic pillars by FYE 2029, we will focus on the following priorities in FY 2025, marking key milestones on our journey toward success. Our annual priorities for FY2026-2029 will be reviewed and approved by the Board of Directors annually to ensure alignment with our long-term goals and continued progress toward achieving our strategic vision.

Priority 1. Quality Service

Specific:

- By June 30, 2025, implement and refine the infection prevention program to achieve a minimum hand hygiene adherence rate of 60% among healthcare workers.

Measurable:

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

Achievable:

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

Relevant:

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

Time-bound:

- The goal must be achieved by June 30, 2025, to ensure that the enhanced infection prevention program is fully implemented and effective in improving hand hygiene adherence rates.

Summary:

In May 2025, the MMHD team successfully reached this goal with a compliance rate of 63% in April. This achievement was driven by a combination of campaigns, incentives, education, observations, real-time coaching, and continuous monitoring. One of the key challenges the team encountered was the need to shift from relying on technology to monitor staff, due to the high costs associated with the necessary equipment for our facility. Moving forward, we remain committed to ongoing efforts to

improve our scores, aiming to maintain them above 60% to prevent the spread of illness within our facilities.

Priority 2. People

Specific:

- By June 30, 2025, a minimum of 13 leadership team members from the Mayers Memorial Healthcare District, comprising a mix of managers and directors, will complete the Healthcare Leadership Institute Management Training program.

Measurable:

- The success of the goal will be measured by the number of leadership team members who complete the program, specifically at least 13 participants.

Achievable:

- This goal is achievable based on the availability of the program and the interest expressed by the leadership team members.

Relevant:

- The goal is relevant to the People pillar by providing ongoing training and education to enhance skills and knowledge.

Time-bound:

- The goal must be completed by June 30, 2025, to ensure timely completion and evaluation of the program's effectiveness.

Summary:

In May 2025, the MMHD team successfully achieved this goal, with 14 out of 15 managers and directors enrolling in and completing the Healthcare Leadership Institute Management Training program. MMHD leadership was notified that these 14 managers and directors would receive their certificates. Despite challenges related to turnover and participation, the team remained engaged and valued the opportunity to develop into stronger, better-trained leaders.

Priority 3. Growth

Specific:

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

Measurable:

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

Achievable:

- This goal is achievable through the implementation of targeted strategies such as marketing campaigns, community outreach initiatives, patient engagement programs, care coordination, and staff training to improve patient flow and wait times.

Relevant:

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

Time-bound:

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

Summary:

This year, we achieved significant progress toward our growth objectives. Strengthening relationships with local providers and implementing targeted marketing strategies contributed to growth across many outpatient departments. By the end of April 2025, the RHC, Outpatient Medical, Surgery, and Physical Therapy departments are all projected to surpass their 5% growth targets. Radiology is close to reaching its 5% goal. However, Lab, Cardiac Rehab, and Respiratory Services are projected to fall short of their 5% growth targets. The Lab has faced challenges in recovering post-COVID volumes, as referral patterns continue to shift to out-of-area competitors due to cost concerns, despite the district maintaining the same rates for several years. Delays in onboarding a cardiologist temporarily impacted Cardiac Rehab's ability to increase numbers, and staff changes in Respiratory Therapy made it difficult to increase volumes in that department. Final numbers will be calculated in July of 2025 to determine the exact amount of growth each department obtained.

Priority 4. Communication

Specific:

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

Measurable:

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

Achievable:

- These objectives are realistic, given thorough strategic planning, effective resource allocation, and collaboration among all stakeholders.

Relevant:

- This initiative supports MMHD's commitment to enhancing patient care and satisfaction, ultimately improving health outcomes in the community.

Time-bound:

- The completion of this goal is targeted for June 30, 2025, with key milestones set for achievement by June 30, 2024.

Summary:

In May 2025, the team successfully completed this goal. We received our initial patient experience scores for the clinic and emergency room based on patient surveys, establishing a baseline for future improvement. We have selected the Custom Learning Systems Services Experience Initiative as our patient satisfaction program, and work has already begun on this project. Additionally, new referral and clinic workflows have been implemented, resulting in a significant reduction in our referral queue, improved referral timeliness, and enhanced patient experience. We have hired a Director of Clinical Services and established a new Department of Health Navigation Services. Job postings are currently open for care coordinators. We also partnered with Luma Health as our new outpatient communication vendor, making it easier for patients to connect with staff regarding upcoming appointments and their needs.

Priority 5. Finance

Specific:

- By June 30, 2025, MMHD will achieve 50% compliance by meeting one of the California Department of Health Care Services (DHCS) Quality Improvement Program (QIP) measures or 100% compliance by meeting two QIP measures and submitting accurate and complete data for audit.

Measurable:

- The success of the goal will be measured by achieving the specified compliance rates with the DHCS QIP measures and submitting accurate and complete data for audit.

Achievable:

- This goal is achievable through a focused effort to review and improve processes, train staff on quality improvement strategies, and implement corrective actions to address any deficiencies or gaps in compliance.

Relevant:

- The goal is relevant to the Finance pillar to analyze financial performance regularly to identify areas for improvement and make data-driven decisions.

Time-bound:

- The goal must be achieved by June 30, 2025, to ensure that the necessary improvements are made and that data is submitted in a timely manner for audit.

Summary:

In December 2025, the team successfully completed the PY7 QIP measures. Following internal audits from January – May of 2026, we determined that the team fully met two of the QIP measures, well-child

visits and flu shots, achieving complete compliance with this priority. This marked a significant milestone, as it was the first non-COVID year in which we saw such success. The team focused on increasing awareness of the measures, educating providers on our target goals, and expanding technology through I2I to support achievement. This accomplishment reflects success both financially and in terms of quality.

Fiscal Year 2026 Priorities

Priority 1. Quality Service

Specific:

- By June 30, 2026, Mayers Memorial Healthcare District will complete Year 1 of the Service Excellence Initiative according to our established roadmap.

Measurable:

- Successful completion of Year 1 as outlined in our roadmap.

Achievable:

- It will involve organized training sessions and workshops throughout the year, following a roadmap of milestones.

Relevant:

- This priority is relevant to our Quality Service pillar to foster a culture of quality and safety through ongoing education, training, and accountability.

Time-bound:

- The goal must be achieved by June 30, 2026.

Priority 2. People

Specific:

- By June 30, 2026, an additional 13 leadership team members from the Mayers Memorial Healthcare District, comprising a mix of managers and directors, will complete the Healthcare Leadership Institute Management Training program.

Measurable:

- The success of the goal will be measured by the number of leadership team members who complete the program, specifically at least 13 participants.

Achievable:

- This goal is achievable based on the availability of the program and the interest expressed by the leadership team members.

Relevant:

- The goal is relevant to the People pillar by providing ongoing training and education to enhance skills and knowledge.

Time-bound:

- The goal must be completed by June 30, 2026, to ensure timely completion and evaluation of the program's effectiveness.

Priority 3. Growth

Specific:

- By June 30, 2026, Mayers Memorial Healthcare District will strategically enhance or introduce, at a minimum, three (3) new services, such as Cardiac Stress Testing, DOT Drug Testing, Calcium Scoring, DEXA Scans, Home Health PT, Occupational Therapy, Diabetic Eye Exams, Podiatry, MRI services, visiting nurse services, substance abuse treatment programs, behavioral health services, Burney Retail Pharmacy or care coordination.

Measurable:

- At least one patient will receive services for each of the three (3) services by the end of FY26.

Achievable:

- Viability studies will be conducted prior to implementation to ensure resources and demand align.

Relevant:

- This priority is relevant to our Growth pillar by driving consistent departmental growth to achieve a sustainable future.

Time-bound:

- The goal must be achieved by June 30, 2026.

Priority 4. Communication

Specific:

- By June 30, 2026, we will revamp our social media program and website to increase service visibility.

Measurable:

- Success will be assessed by completing both the social media and website revamp projects and through increased web traffic analytics and engagement metrics on social media.

Achievable:

- A dedicated team, including marketing and management, will be established to oversee the website redesign and social media strategy implementation.

Relevant:

- This priority is relevant to our communication pillar by utilizing multiple channels to communicate with diverse audiences, including digital media, print materials, and in-person interactions.

Time-bound:

- All improvements will be finalized by June 30, 2026.

Priority 5. Finance

Specific:

- By June 30, 2026, we will reduce our overall accounts receivable (AR) days to 65 or fewer to improve financial performance.

Measurable:

- This will be tracked through monthly financial reports and AR aging analysis.

Achievable:

- Strategies will be implemented to streamline billing processes and follow-ups on receivables.

Relevant:

- This priority is relevant to our Finance pillar by regularly analyzing financial performance to identify improvement areas and make data-driven decisions.

Time-bound:

- The goal is set to be achieved by June 30, 2026.

Risk Management Plan for Mayers Memorial Healthcare District (MMHD) Strategic Priorities

Scope:

This risk management plan addresses the five strategic priorities of MMHD, covering People, Quality Service, Growth, Communication, and Finance. The plan aims to identify, assess, and mitigate potential risks that may impact the achievement of these priorities.

Fiscal Year 2025 Risk Identification:

1. Quality Service:
   - Risk: Technical issues with the technology used to track hand hygiene adherence may compromise data accuracy.
   - Risk: Cost of hand hygiene tracking solutions may compromise the use of technology.
   - Risk: Inadequate staff training on infection prevention practices may lead to decreased adherence rates.
2. People:
   - Risk: Insufficient training or lack of buy-in from leadership team members may impact the success of the Healthcare Leadership Institute management training program.
   - Risk: Inadequate employee engagement and motivation may hinder the achievement of program goals.
3. Growth:
   - Risk: Competition from other healthcare providers in the region may impact MMHD's ability to increase outpatient visits.
   - Risk: Insufficient capacity or resources to accommodate increased patient volume, leading to decreased quality of care and patient satisfaction.

4. Communication:
    - Risk: Poor communication between care coordination team members may lead to misaligned goals and ineffective care delivery.
    - Risk: Resistance to change from staff or providers may hinder the implementation of new communication protocols.
5. Finance:
    - Risk: Failure to meet the minimum patient volume requirements for the DHCS QIP measures, resulting in non-compliance and financial loss.

Fiscal Year 2025 Risk Assessment and Mitigation Strategies:

1. Quality Service:
    - Conduct regular compliance system checks to ensure data accuracy and integrity.
    - Provide ongoing staff training in infection prevention practices and technology use.
    - Establish regular reporting to quality committee to monitor hand hygiene adherence rates and identify areas for improvement.
2. People:
    - Implement a comprehensive onboarding program for leadership team members participating in the Healthcare Leadership Institute management training program.
    - Establish a mentorship program to provide ongoing support and guidance for participants.
    - Conduct regular feedback sessions to ensure employee engagement and motivation.
3. Growth:
    - Conduct market research to identify competitor strengths and weaknesses.
    - Conduct market research on the outmigration of services.
    - Develop targeted marketing campaigns to attract new patients.
    - Establish partnerships with local organizations to promote MMHD's services.
4. Communication:
    - Develop clear communication protocols, job descriptions, and guidelines for care coordination team members.
    - Provide ongoing training and coaching for care coordination team members.
    - Establish a feedback mechanism for patients and staff to provide input on communication effectiveness.
5. Finance:
    - Regularly monitor patient volume and adjust strategies, as needed, to ensure compliance with QIP measures.

Fiscal Year 2026 Risk Identification:

1. Quality Services:
    - Risk: Staff resistance or change fatigue affecting participation in training and compliance.
    - Risk: Insufficient monitoring of milestones leading to delayed implementation of project, which will delay the identification of service quality issues.
2. People:
    - Risk: Insufficient training or lack of buy-in from leadership team members may impact the success of the Healthcare Leadership Institute management training program.

- Risk: Inadequate employee engagement and motivation may hinder the achievement of program goals.

3. Growth:
   - Risk: Regulatory hurdles or delays in licensing and accreditation processes.
   - Risk: Resource constraints (staffing, infrastructure) impeding new service implementation.
4. Communication:
   - Cost of website upgrades makes the project cost-prohibitive.
   - Staff resistance to change, leading to low engagement in our website and social media upgrades.
5. Finance:
   - Risk: Failure to meet financial performance milestones affecting cash flow.
   - Risk: Electronic health record partners are unable to perform or make corrections to their systems to improve AR days.

Fiscal Year 2026 Risk Assessment and Mitigation Strategies:

1. Quality Service:
   - Leverage proven strategies from Initiative partners to maintain staff engagement.
   - Create real-time monitoring dashboards to showcase results.
2. People:
   - Implement a comprehensive onboarding program for leadership team members participating in the Healthcare Leadership Institute management training program.
   - Establish a mentorship program to provide ongoing support and guidance for participants.
   - Conduct regular feedback sessions to ensure employee engagement and motivation.
3. Growth:
   - Conduct thorough resource planning and capacity analysis prior to launching new services.
   - Develop competitive market analysis and community outreach strategies.
   - Engage regulatory experts early in the process for licensing and compliance.
4. Communication:
   - Secure cost estimates early to provide sufficient time to pivot to alternative vendors or strategies.
   - Foster a culture of openness to reduce resistance, with leadership modeling change acceptance.
5. Finance
   - Strengthen revenue cycle management and accounts receivable processes.
   - Hold stakeholder meetings to ensure adherence to our clinically driven revenue cycle.
   - Outsource where appropriate and hold vendors responsible for delivering results.

Responsibility and Accountability

The MMHD Strategic Plan is a five-year roadmap set by the Board of Directors, representing the collective vision of the public's elected representatives. As such, the Board is accountable to its constituents and responsible for ensuring the success of this plan. This accountability is reflected in two key layers:

Layer 1: Board of Directors to the Public

The Board of Directors, elected by the public, is accountable to its constituents for the success of the Strategic Plan. The public can measure the Board's performance by assessing the progress towards achieving the objectives outlined in this Plan. The Board's accountability to the public serves as a fundamental mechanism to ensure transparency and effective governance.

Layer 2: Chief Executive Officer (CEO) to the Board of Directors

The CEO is accountable to the Board of Directors for implementing the Strategic Plan successfully. The Board has entrusted the CEO with the responsibility to manage and execute each objective outlined in this Plan, as well as identify and mitigate risks associated with these objectives. The CEO is responsible for:

- Assigning management tasks to other managers and teams as needed.
- Reporting progress to the Board on a regular basis.
- Ensuring that management reporting accurately reflects the implementation status of the plan.

While the CEO may delegate tasks further down the organizational structure, they remain ultimately accountable to the Board for the successful execution of this Plan. This dual-layer accountability structure ensures that both the Board and CEO are committed to delivering on the promises outlined in this Strategic Plan, ultimately benefiting the community served by MMHD.

Ensuring Successful Implementation

For the MMHD Strategic Plan to be successful, it is essential that all layers of management and staff are aware of the Plan and work together to achieve its objectives. To achieve this, we will implement the following key strategies:

Alignment and Communication

- Align departmental annual priorities with the strategic pillars to ensure a unified focus on achieving the plan's objectives.
- Regular management/departmental meetings will emphasize the critical role each staff member plays in contributing to the success of the strategic pillars.
- Foster an open-door policy, encouraging top-down and bottom-up communication throughout the organization.

Risk Management and Transparency

- Regularly review and update risk management plans to identify potential obstacles and develop mitigation strategies.
- Encourage a culture of reporting risks, ensuring that concerns are addressed promptly and effectively.

CEO Communication and Oversight

- The CEO will regularly communicate with all staff regarding the progress of the Strategic Plan, keeping everyone informed of our progress towards achieving our objectives.

Effective Monitoring

- Establish a robust monitoring system to track progress against key performance indicators (KPIs) and make data-driven decisions to adjust our approach as needed.

Monitoring

To ensure this Plan is being implemented successfully, it is necessary to have monitoring mechanisms in place. At the Board level, monitoring consists of reporting yearly by each department manager. At the operational level, monthly reporting will take place to discuss progress and monitor issues on the strategic pillars and priorities. These mechanisms are the responsibility of the CEO and/or other management and staff, as designated by the CEO.

The monitoring of this Plan will be done in two layers: first, to the Strategic Planning Committee and second, to the Board of Directors. The reporting requirements of each layer are described in more detail below.

Reporting to the Strategic Planning Committee
The CEO will report to the Strategic Planning Committee at least every other month.

The CEO will provide the Committee with a written report on the progress of each Strategic Pillar. The report will include:

- Tracking on current success indicator.
- Risk management, including the mitigation strategies for unacceptable risks, any changes in risk, and reporting of any emerging risks.
- Issues encountered.
- Relevant documentation.

The Committee will determine whether any specific issues in the report from the CEO need to be reported to the Board of Directors.

Reporting to the Board of Directors
In conjunction with the Strategic Planning Committee Board Members, the CEO will provide an overall report every other month to the full Board following the Committee meeting regarding the progress of the Plan. The report will include:

- Overall progress.
- Changes in risk.
- Issues of note as determined by the Committee.

The Board will determine whether any changes in risk level and/or new risks are acceptable or not.

The Board may request additional reporting on any aspect of the Plan as deemed necessary.

Evaluation

It is the responsibility of the Board of Directors to evaluate the overall success of the Plan. This Plan is not static and as such, the Board must evaluate whether any changes are required. At a minimum, the Board will evaluate this Plan annually to determine whether it still meets the needs of the Board.

At the end of the Plan, in 2030, the Board will conduct a thorough evaluation of the success of this Plan. This evaluation will be included in the next iteration of the Strategic Plan as part of the statement from the President of the Board of Directors. The evaluation will include:

- Statement of successes.

- Statement of unanticipated/poorly managed risks.
- Lessons learned.

In addition to the other elements of this Plan described above, a thorough evaluation will lead to even stronger and more successful Strategic Plans in the future, which will ultimately lead to better services for those in the Mayers Memorial Healthcare District.

MAYERS MEMORIAL
HEALTHCARE DISTRICT

RESOLUTION NO. 2025-04

A RESOLUTION OF THE BOARD OF DIRECTORS OF MAYERS MEMORIAL HEALTHCARE DISTRICT DECLARING THAT CERTAIN REAL PROPERTY IS EXEMPT SURPLUS LAND AND FINDING THAT SUCH DECLARATION IS NOT A PROJECT SUBJECT TO ENVIRONMENTAL REVIEW UNDER THE CALIFORNIA ENVIRONMENTAL QUALITY ACT

WHEREAS, the Mayers Memorial Healthcare District (the "District") is a local public healthcare district of the State of California that was formed and operates pursuant to The Local Health Care District Law, Health and Safety Code §§ 32000 and following; and

WHEREAS, the District is the owner in fee simple of that certain real property located at 43514 Highway 299, Fall River Mills, CA 96208 which is described in Exhibit "A", attached hereto and incorporated herein, and known as APN 018-200-014 ("Property"); and

WHEREAS, the Property is one-half acre in area and it is not contiguous to land owned by a state or local agency that is used for open-space or low- and moderate-income housing purposes; and

WHEREAS, when the District acquired the Property it had been being used for commercial retail purposes, including office and storage space, and the District intended to use it for physical therapy, cardiac rehab and a gym; and

WHEREAS, the District's planned uses for the Property changed and the District has only used the Property for storage and office space for the Mayers Healthcare Foundation ("Foundation"); and

WHEREAS, the District has determined that Property is surplus and is no longer necessary for the District's use; and

WHEREAS, the Foundation was created in 1997 as a California nonprofit public benefit corporation and has obtained status as a 501(c)(3) charitable organization by the Internal Revenue Service; and

WHEREAS, Article II.B of the Foundation's Articles of Incorporation, as amended, states,

"The specific purpose of this corporation is to engage in developing fundraising programs for Mayers Memorial Health Care District, receiving contributions from the general public,

and making donations to the District and related tax-exempt entities for programs and projects approved by the District which are designed to improve the health of the population of the District and access for such population to tax-exempt healthcare facilities within and without the District."; and

WHEREAS, Article III, of the Foundation's Bylaws states,

"The Corporation shall have one (1) principal beneficiary, namely Mayers Memorial Hospital District."; and

WHEREAS, the mission of the Foundation is to support the mission of the District and the Foundation is committed to developing and distributing resources to support and enhance the continuation of the District's services; and

WHEREAS, since its creation the Foundation has engaged in developing fundraising programs for the District, received contributions from the general public, and made donations to the District for programs and projects approved by the District which are designed to improve the health of the population of the District and access for such population to tax-exempt healthcare facilities within and without the District in accordance with its Article of Incorporation, Bylaws, and mission; and

WHEREAS, the Foundation desires to purchase the Property and use it for its office and a retail thrift store so that the Foundation can continue to provide valuable funding and volunteer support to the District and the District desires to sell the Property to the Foundation; and'

WHEREAS, the District's sale of the Property to the Foundation and the Foundation's use of the Property will directly further the express purpose of the District's, work, operations and mission; and

WHEREAS, Health and Safety Code § 32121.2 provides that,

"Except as provided in this section, by resolution, the board of directors of a local hospital district may authorize the disposition of any surplus property of the district at fair market value by any method determined appropriate by the board.

The board of directors of a local hospital district may donate or sell, at less than fair market value, any surplus property to another local hospital district in California."; and

WHEREAS, the Surplus Land Act, Government Code sections 54220 *et seq*. (as amended, the "Act"), applies when a local agency disposes of "surplus land," as that term is defined in Government Code section 54221; and

WHEREAS, the Property is "surplus land" under the Act, because it is land owned in fee simple by the District for which the Board of Directors will take formal action (in the form of adoption of this Resolution) in a regular public meeting declaring that the land is surplus and is not necessary for the District's use; and

WHEREAS, section 54222.3 of the Act states that this article shall not apply to the

disposal of exempt surplus land as defined in Section 54221 by any local agency; and

WHEREAS, in accordance with §§ 54221(t)(l) and 54222.3 of the Act, exempt surplus land does not fall under the notice and negotiation requirements of the Act; and

WHEREAS, section 54221(f)(l)(N) of the Act states that real property that is used by a district for the district's use, as expressly authorized in subdivision (c) of section 54221, is exempt surplus land; and

WHEREAS, Section 54221(c)(2)(B)(i) of the Act provides that in the case of a local agency, excepting those whose primary mission or purpose is to supply the public with a transportation system, "agency's use" may include commercial or industrial uses or activities, including nongovernmental retail, entertainment, or office development or be for the sole purpose of investment or generation of revenue if the agency's governing body takes action in a public meeting declaring that the use of the site will directly further the express purpose of agency work or operations.

NOW, THEREFORE BE IT RESOLVED by the Board of Directors of the Mayers Memorial Healthcare District as follows:

Section 1. The above recitals are true and correct and are a substantive part of this Resolution and findings of the Board of Directors.

Section 2. The Board of Directors hereby finds that: (i) the Property is no longer necessary for the District's use; (ii) since its creation the Foundation has directly furthered the express purpose of the District's work, operations and mission by developing fundraising programs for the District, receiving contributions from the general public, and making donations to the District for programs and projects approved by the District which are designed to improve the health of the population of the District and access for such population to tax-exempt healthcare facilities within and without the District in accordance with its Article of Incorporation, Bylaws, and mission; and (iii) the District's sale of the Property to the Foundation and the Foundation's purchase and use of the Property for its retail thrift shop and office space will directly further the express purpose of the District's, work, operations and mission.

Section 3. The Board of Directors therefore declares that the Property is exempt surplus land pursuant to section 54221(c)(2)(B)(i) of the Act.

Section 4. This Resolution has been reviewed with respect to the applicability of the California Environmental Quality Act (Public Resources Code Section 21000 et seq.) ("CEQA"). District staff has determined that the mere designation of the Property as exempt surplus land and authorization for the Chief Executive Officer to comply with the Act do not qualify as a "project" as defined in State CEQA Guidelines section 15378. Section 15378 defines a project as an activity that "has a potential for resulting in either a direct physical change in the environment, or a reasonably foreseeable indirect physical change in the environment." (State CEQA Guidelines, § 15378(a).) Here, the action is to declare the Property as exempt surplus, which will not result in either a direct physical change in the environment or a reasonably foreseeable indirect physical

change in the environment. Accordingly, the action is not a "project" subject to CEQA. (State CEQA Guidelines, § 15060(c).) Also, Section 15378 explicitly excludes from its definition of "project" the following: "organizational or administrative activities of governments that will not result in direct or indirect physical changes in the environment." (State CEQA Guidelines, § 15378(b)(5).) The action to designate the Property as exempt surplus land constitutes an organizational or administrative activity that will not result in a physical change in the environment, and it therefore is not subject to CEQA. This Resolution does not constitute a binding commitment to any particular use of the Property.

Section 5. The Chief Executive Officer or designee is hereby authorized and directed to send a copy of this Resolution to the California Department of Housing and Community Development in accordance with the requirements of Section 400(e) of the SLA Guidelines and to take such other actions as necessary or appropriate to comply with the Act.

Section 6. The Chief Executive Officer or designee is hereby authorized and directed to prepare and file a Notice of Exemption stating that the declaration that the Property is exempt surplus land is exempt from further environmental review under CEQA and file it with the Shasta County Clerk and the State Clearinghouse within five (5) days after passage and adoption of this Resolution.

Section 7. If any section, subsection, paragraph, sentence, clause or phrase of this Resolution is declared by a court of competent jurisdiction to be unconstitutional or otherwise invalid, such decision shall not affect the validity of the remaining portions of this Resolution.

DULY PASSED AND ADOPTED this ____ day of _____ by the Board of Directors of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

RESOLUTION NO. 2025-05

A RESOLUTION OF THE BOARD OF DIRECTORS OF MAYERS MEMORIAL HEALTHCARE DISTRICT AUTHORIZING THE SALE OF CERTAIN REAL PROPERTY TO THE MAYERS HEALTHCARE FOUNDATION, APPROVING THE COMMERCIAL PURCHASE AGREEMENT, AND FINDING THAT SUCH DECLARATION IS NOT A PROJECT SUBJECT TO ENVIRONMENTAL REVIEW UNDER THE CALIFORNIA ENVIRONMENTAL QUALITY ACT

WHEREAS, the Mayers Memorial Healthcare District (the "District") is a local public healthcare district of the State of California that was formed and operates pursuant to The Local Health Care District Law, Health and Safety Code §§ 32000 and following; and

WHEREAS, the District is the owner in fee simple of that certain real property located at 43514 Highway 299, Fall River Mills, CA 96208 which is described in Exhibit "A", attached hereto and incorporated herein, and known as APN 018-200-014 ("Property"); and

WHEREAS, when the District acquired the Property it had been being used for commercial retail purposes, including office and storage space, and the District intended to use it for physical therapy, cardia rehab and a gym; and

WHEREAS, the District's planned uses for the Property changed and the District has only used the Property for storage and office space for the Mayers Healthcare Foundation ("Foundation"); and

WHEREAS, the District has determined that Property is exempt surplus land and is no longer necessary for the District's use pursuant to the Surplus Land Act, Government Code sections 54220 *et seq.* (as amended, the "Act"); and

WHEREAS, Health and Safety Code § 32121.2 provides that,

> "Except as provided in this section, by resolution, the board of directors of a local hospital district may authorize the disposition of any surplus property of the district at fair market value by any method determined appropriate by the board.
>
> The board of directors of a local hospital district may donate or sell, at less than fair market value, any surplus property to another local hospital district in California."; and

WHEREAS, the Foundation was created in 1997 as a California nonprofit public benefit corporation and has obtained status as a 501(c)(3) charitable organization by the Internal Revenue Service; and

WHEREAS, Article II.B of the Foundation's Articles of Incorporation, as amended, states,

> "The specific purpose of this corporation is to engage in developing fundraising programs for Mayers Memorial Health Care District, receiving contributions from the general public, and making donations to the District and related tax-exempt entities for programs and projects approved by the District which are designed to improve the health of the population of the District and access for such population to tax-exempt healthcare facilities within and without the District."; and

WHEREAS, Article III, of the Foundation's Bylaws states,

> "The Corporation shall have one (1) principal beneficiary, namely Mayers Memorial Hospital District."; and

WHEREAS, the mission of the Foundation is to support the mission of the District and the Foundation is committed to developing and distributing resources to support and enhance the continuation of the District's services; and

WHEREAS, since its creation the Foundation has engaged in developing fundraising programs for the District, received contributions from the general public, and made donations to the District for programs and projects approved by the District which are designed to improve the health of the population of the District and access for such population to tax-exempt healthcare facilities within and without the District in accordance with its Article of Incorporation, Bylaws, and mission; and

WHEREAS, the Foundation desires to purchase the Property and use it for its office and a retail thrift store so that the Foundation can continue to provide valuable funding and volunteer support to the District and the District desires to sell the Property to the Foundation; and'

WHEREAS, the District's sale of the Property to the Foundation and the Foundation's use of the Property will directly further the express purpose of the District's, work, operations and mission and therefore serves a public purpose; and

WHEREAS, the District and Foundation have negotiated the terms pursuant to which the District will sell the Property to the Foundation, including the purchase price which the District and Foundation agree to be the fair market value of the Property, and said terms are set forth in the Commercial Purchase Agreement and Joint Escrow Instructions by and between the District and the Foundation attached hereto ("Commercial Purchase Agreement").

NOW, THEREFORE BE IT RESOLVED by the Board of Directors of the Mayers Memorial Healthcare District as follows:

Section 1. The above recitals are true and correct and are a substantive part of this Resolution and findings of the Board of Directors.

Section 2. The Board of Directors hereby finds that: (i) the Property is no longer necessary for the District's use and has declared the property to be exempt surplus land pursuant to the Act; (ii) the District's sale of the Property to the Foundation and the Foundation's purchase and use of the Property for its retail thrift shop and office space will directly further the express purpose of the District's, work, operations and mission and serves a public purpose; and (iii) the purchase price set forth in the Commercial Purchase Agreement is the fair market value of the Property.

Section 3. The Board of Directors therefore declares that the Property is exempt surplus land pursuant to section 54221(c)(2)(B)(i) of the Act.

Section 4. This Resolution has been reviewed with respect to the applicability of the California Environmental Quality Act (Public Resources Code Section 21000 et seq.) ("CEQA"). District staff has determined that the sale of the Property as exempt surplus land and authorization for the Chief Executive Officer to execute the Commercial Purchase Agreement and complete the sale of the Property do not qualify as a "project" as defined in State CEQA Guidelines section 15378. Section 15378 defines a project as an activity that "has a potential for resulting in either a direct physical change in the environment, or a reasonably foreseeable indirect physical change in the environment." (State CEQA Guidelines, § 15378(a).) Here, the action to sell the Property will not result in either a direct physical change in the environment or a reasonably foreseeable indirect physical change in the environment. Accordingly, the action is not a "project" subject to CEQA. (State CEQA Guidelines, § 15060(c).) Also, the State CEQA Guidelines determine that certain classes of activities are categorically exempt from CEQA, including class 12 which consists of the sale of surplus government property (State CEQA Guidelines, § 15312.) The action to sell the Property as exempt surplus land constitutes is categorically exempt and is not subject to CEQA.

Section 5. The Chief Executive Officer or designee is hereby authorized and directed to execute the Commercial Purchase Agreement and to take such other actions as necessary or appropriate to complete the sale of the Property to the Foundation.

Section 6. The Chief Executive Officer or designee is hereby authorized and directed to prepare and file a Notice of Exemption stating that the sale of the Property is exempt from further environmental review under CEQA and file it with the Shasta County Clerk within five (5) days after passage and adoption of this Resolution.

Section 7. If any section, subsection, paragraph, sentence, clause or phrase of this Resolution is declared by a court of competent jurisdiction to be unconstitutional or otherwise invalid, such decision shall not affect the validity of the remaining portions of this Resolution.

DULY PASSED AND ADOPTED this ____ day of _____ by the Board of Directors of Mayers Memorial Healthcare District by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

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

ATTEST:

_____
Ashley Nelson
Clerk of the Board of Directors

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Attachment L

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.00.03 Equipment Availability *The items available must include the following:* • *Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.* §485.618(b)(2) Tag C-**0888**	This standard is not met as evidenced by: Based on a review of the crash cart policies and interview, the facility has not designated anyone responsible for cleaning the crash carts. This finding was verified by the Emergency Room Staff.
Date of POC (date written, date revised)	02/13/25, revised 03/07/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. All staff involved in the process (EVS staff and ED staff) will be educated on the change in process around cleaning the crash carts.	EVS / ED manager /DON Acute	03/31/25	In Progress
2. Cleaning Logs and policies will be updated to include the changes made in process.	DON Acute	03/31/25	In Progress
3. The crash cart was cleaned by EVS staff shortly after the deficiency was noted in survey.	EVS Staff	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All policy and log changes and action items have been approved by the CNO and put into process for approval through the policy committee process.	CNO	02/28/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education was delivered in person to the EVS staff on the change in process and the additions to the logs.	EVS Manager	02/28/25	Completed
2. Education for nursing staff is currently underway and all staff involved in emergency response will be educated on their responsibilities for cleaning the crash cart after use in critical events.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. This process will be monitored by our internal quality committee and progress will be reported to the Board Quality Committee to ensure oversight and visibility for the governing Board of Directors.	DON Acute	04/01/25 12/31/25	Monthly
2. This monitoring will consist of auditing the cleaning logs to confirm that crash carts are cleaned regularly per policy and on schedule.	EVS Manager	04/01/25 12/31/25	Monthly
3. The monitoring process will also include infection prevention conducting "magic pen" audits with a black light marker to ensure that the carts are cleaned thoroughly.	Infection Prevention	04/01/25 12/31/25	Quarterly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.01.00 Additional Required Policies The Emergency Services must have policies addressing: 1. The mechanism for initial evaluation and triage of patients. (See 489.20 and 489.24 for EMTALA Standards.) 2. Mechanisms for providing sufficient diagnostic and stabilization services for persons whose care will be managed by transfer to another acute care facility. 3. The determination of the level of service to be provided is under the direction of a physician member of the medical staff. 4. The assessment of each patient by a registered nurse. 5. The provision of services appropriate to the assessed needs of the patient, which results in a disposition plan. 6. The mechanisms for evaluating the quality and appropriateness of emergency services provided. 7. 7Provision of care for disasters. 8. The mechanism for management of medical emergencies in non-Emergency Department (ED) settings on the hospital main	This standard is not met as evidenced by: Based on interviews and a review of policies in the Emergency Room, the Emergency Services policies are silent on the initial evaluation and triage of patients in the non-ED main campus location of the parking lot. This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

campus, unless present in a non-Emergency Services hospital policy.	
Date of POC (date written, date revised)	02/13/25, revised 03/07/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The Code Blue policy has been updated to include specific procedures for responding to medical emergencies in the parking lot.	DON Acute	02/28/25	Completed
2. A notification process has been implemented to ensure rapid response, requiring staff to page "Code Blue - Parking Lot" and notify the Nursing Supervisor in the event of an emergency.	DON Acute	03/31/25	In Progress
3. A Relias read and sign education module has been assigned to all relevant staff to acknowledge and understand the policy change and additional notification.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. The updated Code Blue policy was reviewed and approved by the DON Acute and is currently in the policy approval process.	DON Acute	03/26/25	In Progress
2. All action plans and education have been approved by the CNO.	CNO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Staff responsible for emergency responses have been trained on their specific roles and responsibilities, including CPR initiation, emergency notification, and patient transport.	DON Acute	03/31/25	In Progress
2. A Relias read and sign module has been assigned requiring staff to read and acknowledge the policy and process updates.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Education will be tracked and reported from our Relias learning platform to ensure that all staff have been made aware of and acknowledged the policy and process changes.	DON Acute	04/01/25 – 12/31/25	Quarterly
2. This process will be monitored by the internal quality committee in the code blue review.	Director of Quality	04/01/25 – 12/31/25	Monthly

PLAN OF CORRECTION

3. This process will be monitored in the mortality rate review to Board Quality committee to ensure oversight and visibility to our governing Board of Directors.	Director of Quality	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.01.03 Emergency Room Log Permanent logs shall be maintained of persons seeking emergency care. These may be manual or electronic with periodic back up. The register provides data regarding: 1. Date, time and mode of arrival. 2. Age, sex, and name of patient. 3. Nature of complaint. 4. Name of physician responsible for care. 5. Brief description of services provided. 6. Disposition (treated/released, admitted to facility, transferred to another acute facility, or death in ER). 7. Condition on discharge. 8. Time of discharge.	This standard is not met as evidenced by: Based on interview and review of the Emergency Room Log, the description of services provided and condition on discharge was missing. This finding was verified by the Emergency Room Registered Nurse.
Date of POC (date written, date revised)	02/13/25, revised 03/07/25

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Initial efforts made to add the missing fields to our Cerner ED log by the ED manager and the Director of Quality we unsuccessful.	Director of Quality	02/28/25	In Progress
2. An SR ticket is in the process of being created to elevate the issue to our Cerner support team to assist in the addition.	Director of Quality (DOQ)	03/07/25	In Progress
3. As a short term fix - the missing elements of the ED log have been found in other reports by the ED manager and the information is available upon request when or if the need arises.	ED Manager	02/28/25	Completed
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. All of the corrective actions for this issue have been approved by the CNO	CNO	04/06/25	In Progress
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			

PLAN OF CORRECTION

1. When the log fix is completed with the SR ticket staff will be alerted to the change and we will educate on how to run the fixed complete report.	ED Manager / DON Acute	04/06/25	In Progress
2. Staff will be educated by the ED Manager on how to find the missing elements in the other reports so the information can be available when / if necessary.	ED Manager / DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Progress on the SR ticket will be monitored by the internal quality committee weekly until completion.	DOQ	03/03/25 04/06/25	Weekly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.01.04 Change in Treatment Plan Log A separate log is maintained as part of the quality management program for the emergency service. The log provides information about patients whose initial treatment plan later resulted in the need for modification based upon significant variation in the final interpretation of radiographic, cardiographic, or laboratory findings.	This standard is not met as evidenced by: Based on the interview and a review of the "Change in Treatment Log," the required radiographic and cardiographic elements were missing. This finding was verified by the Emergency Room Staff.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. A SR ticket was created with Cerner to help us get this change in treatment log working for Radiology.	ER Manager	02/28/25	Completed

PLAN OF CORRECTION

2. All of the cardiology reports that are done in our ED (EKGs) are read by the providers who are in the ED. The EKG reads completed by the ED providers in the ED are final reads. There are no other reads completed on the EKGs that could cause a discrepancy that would require a change in treatment for those patients.	ED Manager	02/28/25	Completed
3. To address the issue with radiology in the short term, a log will be created to capture all of the radiology reports that come in as final.	ED Manager	03/31/25	In Progress
4. The created log will be used to alert providers when the treatment that they documented for their ED patient is inconsistent with the final radiology reports that come back from our radiology group as final reads.	ED Manager	03/31/25	In Progress
5. ED staff will be responsible for comparing the treatment plans documented by the ED providers and the final reads that come back from our radiology group and documenting changes in the log created.	ED Manager	03/31/25	In Progress
6. This process will be in place until we can get a long term fix from Cerner to show that the change in treatment log will capture that necessary radiology studies.	ED Manager	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All corrective actions were approved by the CNO	CNO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the log will be done face to face by the ED manager to ED staff who will be managing the new process.	ED Manager	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The ED change in treatment log will be monitored monthly, and audited by the number of final reads received from our radiology group.	ED Manager	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

03.01.10 Eyewash Stations and Emergency Showers Where the eyes or body of any person may be exposed to injurious corrosive materials, ASNI Z358.1-2014 approved eyewash stations and/or emergency showers shall be provided within the work area for immediate emergency use. §485.623(b)(1) C-0914	This standard is not met as evidenced by: 1. Based on the building tour, the eyewash stations in the following areas were not ANSI compliant. Neither of them was configured with mixing valves: a. Kitchen eyewash station b. Outpatient Medical Unit eyewash station 2. Based on document review, the annual inspection of eyewash stations and emergency showers was not available. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

1. The kitchen weekly and annual eyewash inspections were located and will continue to be the basis of our safety and compliance reviews moving forward.	Facilities Manager	02/28/25	Completed
2. The OPM eyewash station was removed after a risk assessment was performed and approved by our safety officer.	Facilities Manager	02/28/25	Completed
3. Weekly and annual inspections of the eyewash station in the kitchen will be conducted.	Facilities Manager	03/31/25	In Progress
4. The mixing valve was configured for the eyewash station in the kitchen and is in working order - pending completion of the drain.	Facilities Manager	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. These corrective actions were approved by the Director of Operations.	Director of Operations (DOO)	02/28/25	Completed
2. The risk assessment was approved by the safety officer.	Safety Officer	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the steps and timing of the weekly and annual eyewash inspections will be conducted in person by the facilities manager.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Weekly eyewash inspection logs will be audited monthly and reported to our safety committee.	Facilities Manager	04/01/25 12/31/25	Monthly
2. The facilities manager will report on the results of the audit quarterly to the quality committee, so that all of the information can be reported up to Board Quality so the governing Board of Directors have visibility and oversight on all findings and actions taken.	Facilities Manager	04/01/25 12/31/25	Quarterly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

03.06.09 Plant Equipment and Systems-Maintenance There is an established, scheduled preventive maintenance program for plant equipment and systems, maintained and tested periodically in accordance with the manufacturers' recommendations. As an alternative approach, CAHs may choose to employ alternative maintenance activities and/or schedules provided they develop, implement, and maintain a documented Alternate Equipment Management (AEM) Program, to minimize risks to patients and others in the CAH associated with the use of facility equipment. *All essential mechanical and electrical equipment is maintained in safe operating condition.* §485.623(b) §485.623(b)(1) **Tag C-0914**	This standard is not met as evidenced by: Based on document review, the annual inspection of the Line Isolation Monitors was not available. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Annual inspections of the line isolation monitors will be kept and available for inspection upon request.	Facilities Manager	02/28/25	Completed
2. Annual inspections will be calendared and done in accordance with all applicable standards.	Facilities Manager	02/28/25	Completed
3. A log was created and an entry was made for the annual inspection of the line isolation monitors.	Facilities Manager	02/28/25	Completed
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. All corrective actions have been approved by the DOO	DOO	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the timing and requirements around the annual inspection of the line isolation monitors will be conducted in person to facilities personnel by the facilities manager.	Facilities Manager	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Facilities manager will report out on the line isolation monitors annual inspection as it becomes time to have that annual inspection completed.	Facilities Manager	04/01/25 / 04/01/26	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

03.07.03 Ventilation, Light, and Temperature Controls *There must be proper ventilation, lighting, and temperature controls in pharmaceutical, patient care, and food preparation areas.* §485.623(b)(5) **Tag C-0926**	This standard is not met as evidenced by: Based on the building tour and document review, the following issues were identified. 1. The Biohazard Storage Room at Station 3 Hall was neutral pressure to the corridor and should be negative pressure. Upon observation, there was no exhaust fan in the room. 2. The Scope Cleaning Room was neutral pressure to the OR corridor and should be negative pressure. 3. The Organization has elected to apply the Categorical Waiver for 20% relative humidity in its policy but has not performed the required risk assessment to assess the equipment and supplies used in the OR. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The biohazard room has been moved to a compliant space in a different part of the hospital. The space that was non-compliant for biohazard storage because of lacking ventilation will now be used for normal storage. All equipment (hopper and sharps containers) has been removed from the non-compliant space and relocated to the compliant space (sharps container) or removed completely from facility (hopper).	Facilities Manager	03/31/25	In Progress
2. The issue with the motor responsible for making the scope cleaning room has been repaired.	Facilities Manager	02/28/25	Completed
3. A weekly log and inspection schedule have been created to ensure that the motor responsible for making the scope cleaning room negative pressure has been created.	Facilities Manager	02/28/25	Completed
4. OR has had a risk assessment completed, as a short term fix. Noting that there is no surgery conducted in the space and weighing the risks involved with the procedures that are conducted there.	Safety Officer	02/28/25	Completed
5. The facilities manager is assessing the scope of work necessary to repair the existing disconnected and dysfunctional humidity system that would feed our surgery space.	Facilities Manager	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. These corrective actions were approved by the DOO and CEO	DOO	02/28/25	Completed

PLAN OF CORRECTION

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. All staff have been alerted to the fact that the biohazard room has been moved.	Facilities Manager	02/28/25	Completed
2. Facilities staff have been educated to the new log and schedule for inspection of the motor that maintains the negative pressure for the scope cleaning room.	Facilities Manager	02/28/25	Completed
3. Surgery staff understand the nature of the risk assessment and the work that will be necessary to update their space and the impact that this could / will have on their space.	Facilities Manager / Surgery Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Inspection logs will be reported monthly to safety.	Facilities Manager	04/01/25 / 12/31/25	Monthly
2. Facilities manager will report to quality committee quarterly with the results of the inspection log audit.	Facilities Manager	04/01/25 / 12/31/25	Quarterly
3. All of the reports from quality committee move forward to Board Quality and to the governing Board of Directors to ensure visibility and oversight.	Director of Quality	04/01/25 / 12/31/25	Monthly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.01.00 Periodic Appraisal of Members *The Medical Staff must periodically conduct appraisals of its members.* §482.22(a)(1)	This standard is not met as evidenced by: A. Based on a review of six (6) initial credential files, in one of six (1/6) files, the Medical Executive Committee and the Governing Body granted admitting privileges to a Physician's Assistant, which is outside the scope of practice. B. Based on a review of seven (7) reappointment credential files, in three of seven (3/7) files, the Medical Executive Committee and the Governing Body privileges to physicians which were inconsistent with the hospital's current services or the applicant's requested privileges (for example, general surgery). These findings were verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. Corrections to the privileges and services were made for physicians and midlevel providers.	Director of Quality	02/28/25	Completed
2. New credentialing packages for midlevel providers have been created based on the scope of services provided by the hospital to align with privilege requests. These changes have been reviewed by the Med Staff Coordinator and put into place.	Director of Quality	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. These corrective actions were approved by the Director of Quality.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. All packages updated and ready for use. Education on and around the new credentialing packets was given in person to the medical staff services department by the Medical Staff Coordinator.	DOQ	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

1. Credentialing packages and services will be reviewed as the providers come up for re-credentialing, to ensure that they are current, reflect services provided, and are compliant to the scope of the provider. The results of this review will be reported to Board Quality and the Board of Directors.	DOQ	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.01.13 Required Application-Initial and Reapplication Information for Review. Information covering each of the following areas must be reviewed for each applicant/re-applicant during the review and approval process. A. Licensure History: current license(s), licensure sanction(s), state(s) of current practice or intended practice, and all previous licenses held. B. Medical Education and Postgraduate Training C. Malpractice Insurance and History: 5-year history. D. Specialty Board Status: (if applicable). E. Sanctions or Disciplinary Actions: actions taken by healthcare facilities, specialty boards, federal or state agencies, malpractice carriers. F. Criminal History: felony convictions/ criminal history (7-10 years). G. Healthcare Employment History: healthcare related employment/ appointment history (work history).	This standard is not met as evidenced by: Based on review of initial appointment credential files and interview, the following documents were missing from the files: 1. DO-Rheumatology-malpractice insurance 2. MD-Oncology-work history 3. NP-Family Medicine-one (1) peer reference 4. Clinical Activity was missing on the following: a. MD-Radiology Telemedicine x2 b. NP-Family Medicine c. MD-Emergency Room d. DO-Rheumatology These findings were verified by the Medical Staff Coordinator.

PLAN OF CORRECTION

H. Professional References: current competence and peer recommendations/references, ability to perform privileges requested (health status). For physicians seeking reapplication, peer references include: peers familiar with their practice of medicine, reviews under the hospital's peer review activities, reviews by the hospital's Credentials Committee, Department Chair, or Medical Executive Committee. I. Clinical Activity: procedure logs with outcomes to support privilege requests for procedures not attested to in postgraduate references. J. Information Verified for Comparison: comparison of applicant - provided information and verified information. K. Meeting Attendance is required consistent with the medical staff bylaws.	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. All of the following cited practitioners credential files were updated to ensure documentation is contained within the respective file as follows: 1. DO Rheumatology: malpractice insurance 2. MD Oncology: work history 3. NP Family Medicine: one peer reference 4. MD Radiology Telemedicine x 2: clinical activity logs 5. NP Family Medicine: clinical activity logs 6. MD Emergency Medicine: clinical activity logs 7. DO Rheumatology: clinical activity logs	Med Staff Coordinator	02/28/25	Completed
2. A check list was updated to ensure that all of the required documents were on the list and placed in provider files.	Med Staff Coordinator	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All corrective actions were approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. The Medical Staff Coordinator educated the DOQ to her process changes so they could both know and understand the changes made and the necessity behind them.	Medical Staff Coordinator	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

PLAN OF CORRECTION

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. All provider files will be reviewed as they come up for re-credentialing by Board Quality and the Board of Directors to ensure compliance.	DOQ	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.01.23 Ongoing Professional Practice Evaluation (OPPE) Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), and/or to revoke an existing privilege prior to or at the time of renewal.	This standard is not met as evidenced by: Based on review of seven (7) reappointment credential files, seven of seven (7 of 7) files lacked evidence of OPPE documentation in the following files: a. MD-Family Medicine b. MD-Hospitalist c. MD-General Surgeon d. MD-Infectious Disease x2 e. MD-Pathologist f. Physician's Assistant These findings were verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. The OPPE work was reinitiated for the following cited providers: 1. MD Family Medicine 2. MD Hospitalist 3. MD General Surgeon 4. MD Infectious Disease x 2 5. MD Pathologist 6. Physician's Assistant	DOQ	02/28/25	Completed
2. We have received one OPPE form back and have sent ticklers to the participating providers to ensure that the other forms are completed.	DOQ	03/31/25	In Progress
3. We have calendared the cycle for OPPE and will follow up with providers to ensure that the program moves forward as necessary.	DOQ	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All corrective actions were approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education around the OPPE process was completed at the medical executive committee meeting.	DOQ	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

PLAN OF CORRECTION

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. OPPE is tracked as an ongoing part of our OPPE/FPPE/ Peer Review process and reported to Board Quality and the Board of Directors monthly.	DOQ	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.01 Rapid Response System The medical staff has approved a written policy for the early recognition and response to signs of patient deterioration, ensuring prompt rescue and treatment.	This standard is not met as evidenced by: Based on review of hospital policies and interview, the "Rapid Response" policy has not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Part A. What actions will you take (Add rows if needed.)

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
1. This Rapid Response Systems policy was placed into the policy process to be approved through MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The Rapid Response Policy shall be reviewed by the medical staff via MEC on a annual basis.	DOQ	04/01/25 / 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.02 Blood Transfusion Administration Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.	This standard is not met as evidenced by: Based on the interview and document review, the "Blood Transfusion Administration" policy had not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. This Blood Transfusion Administration policy was placed into the policy process to be approved through MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The Blood Transfusion Administration Policy shall be reviewed by the medical staff via MEC on an annual basis.	DOQ	04/01/25 – 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.03 Ventilator Bundle. The medical staff has approved a written policy or protocol for the care of patients on a mechanical ventilator.	This standard is not met as evidenced by: Based on document review, hospital policy, "Ventilator Bundle" has not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The Ventilator Bundle policy was placed was placed into the policy process to be approved via MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The Ventilator Bundle policy shall be reviewed by the medical staff via MEC on an annual basis.	DOQ	04/01/25 – 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.04 Venous Thromboembolism (VTE) The medical staff has approved a written policy or protocol for the assessment, prevention, and treatment of venous thromboembolism (VTE).	This standard is not met as evidenced by: Based on interview and document review, the "Venous Thromboembolism" policy had not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The Venous Thromboembolism policy was placed into the policy process to be approved via MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. The DOQ approved of this corrective action.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The Venous Thromboembolism policy shall be reviewed by the medical staff via the MEC annually.	DOQ	04/01/25 – 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.06 Prevention of Pressure Ulcers The medical staff has approved a written policy or protocol for the assessment, prevention, and treatment of pressure ulcers.	This standard is not met as evidenced by: Based on interview and document review, the "Prevention of Pressure Ulcer" policy had not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The Prevention of Pressure Ulcers policy was placed into the policy process to be approved via the MEC and Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. The Prevention of Pressure Ulcers policy shall be reviewed by the medical staff via MEC on an annual basis.	DOQ	04/01/25 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.00.02 Policy Development.

The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of ***standard 05.00.01****.*

These policies are reviewed at least ***biennially*** *by the professional personnel* ***indicated above*** *and* ***updated*** *as necessary by the CAH.*

§485.635(a)(2)

§485.635(a)(4)

Tag C-0272

This standard is not me as evidenced by:

Based on interview and review of policies, the following were observed:

A. All patient care policies are not referred to the Governing Board for consideration after the Policy and Procedure Committee (the Advisory Group) makes its recommendations as required by standard 06.00.02.

B. The following policies have not been reviewed/approved within the past two (2) years:

1. Automatic Stop Orders: last reviewed 6/2020
2. Drug Samples: last reviewed 1/2020
3. Warfarin: last reviewed 9/2020
4. Controlled Drug Distribution: last reviewed 8/2020
5. CAH-Staffing and Staff Responsibilities: last reviewed 7/2020
6. Dietary policies (for example - Dietary Quality of Care - last reviewed in 2021,
7. Rehab Therapy - no policies have been updated since 2021/22
8. Human Resources policies (example - Reference Check last reviewed 9/2021, Hiring Process last reviewed 11/2022)

PLAN OF CORRECTION

	These findings were verified by the Pharmacist, Medical Staff, Dietary Manager, Director of Clinical Services, and Human Resource Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The process for policy development has been updated to ensure that all patient care policies and other policies around the operation of the hospital move through our policy advisory group and the MEC and Governing Body on the appropriate schedule.	DOQ	04/01/25	In Progress
2. The following cited policies have been reviewed by the MEC and Governing Body: 1. Automatic Stop Orders 2. Drug Samples 3. Warfarin 4. Controlled Drug Distribution 5. CAH-Staffing and Staff Responsibilities 6. Dietary policies 7. Rehab Therapy 8. Human Resources Policies	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ.	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process and the expectations around that process will be reeducated to all managers through the Relias platform to ensure that all understand their part in the process as a whole.	DOQ	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. All policies manuals will be reviewed annually as a part of our annual program evaluation by the medical staff via the MEC and Governing Body.	DOQ	04/01/25 04/30/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.07.06 List of Contracted Services (3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided. §485.635(c)(3) §482.12(e)(2) Tag C-0291	This standard is not met as evidenced by: Based on document review and interview, the facility's contracted service list did not contain: 1. The service (s) being offered 2. Whether the services are offered on- or off-site. 3. Whether there is any limit on the volume or frequency of the services provided. 4. When the service(s) are available. This finding was verified by the Directory of Quality.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

PLAN OF CORRECTION

1. The contract review template was updated to include all of the required elements to be compliant with the standard.	DOQ	02/28/25	Completed
2. The updated template will be used moving forward to ensure that all reviewed contracts are reviewed using all of the required elements to meet the standard.	DOQ	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. The DOQ re-read the standard and applied his learning to updating the template he uses for contract review.	DOQ	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. Contract review will be completed as contracts come up for renewal - evergreening contracts are being phased out by the district as they come up for review. This process will be reported on quarterly to Board Quality and the governing Board of Directors.	DOQ	04/01/25	Quarterly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

		12/31/25	

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.08.03 Nursing Plan of Care *A nursing care plan must be developed and kept current for each inpatient.* §485.635(d)(4) §482.23(b)(4) Tag C-0296	This standard is not met as evidenced by: Based on medical records review, five of five (5/5) records did not include care plans related to the admitting diagnosis/treatment plan or assessment for the following: a. C-diff - no isolation or infection control plan b. COPD, respiratory compromised - no respiratory plan c. High risk for aspiration - no identified plan d. High risk for falls - no identified plan e. COPD, Lung deficits - No respiratory plan These findings were reviewed by the Director of Nursing.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. A new policy has been developed outlining the Individualized Plan of Care (IPOC) process for nursing	DON Acute	03/31/25	In Progress
2. A meeting was held with a Cerner Representative where we were able to add 8 new care plan options to ensure alignment with standards.	DON Acute	03/31/25	In Progress
3. Education was provided in-person to all Med/Surg RN's at our staff meeting on February 20th and an additional training document was sent virtually to include expectations and the new policy.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The new policy, Developing Nursing Care Plans (IPOC) has been reviewed and approved by the Director of Nursing and is currently undergoing the Committee Advisory Process and will be reviewed by the Board of Directors by March 26th for final approval.	CNO	04/01/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Training sessions will be scheduled to ensure staff understand how to document and implement IPOCs within Cerner, including options for individualization.	DON Acute	03/31/25	In Progress
2. Additional guidance and support resources will be provided for nurses to improve compliance and consistency in care planning.	DON Acute	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Care plans will be audited in the following way, ten medical records will be audited for documentation compliance that the care plans are related to the admitting diagnosis and treatment plans/assessment monthly. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.08.10 Patients at Risk The facility has a written policy for identifying patients on admission that are at-risk for developing the following complications: 1. Pressure ulcers 2. Deep vein thrombosis (DVT/venous thromboembolism (VTE) 3. Aspiration 4. Malnutrition 5. Fall Risk/Prevention	This standard is not met as evidenced by: Based on documentation review, medical records review, and interview, the following issues were identified: 1. Two of five (2/5) medical records did not contain a DVT risk assessment. 2. The DVT policy indicated that nurses were to notify the physician after completing a risk assessment of the numeric score. However, five of five (5/5) records did not contain evidence that a physician was notified of the assessment. 3. The DVT Policy did not identify the meaning of the "numeric score" or the preventative measures that would be implemented for patients considered at risk. Additionally, staff were unable to articulate an understanding of these processes. 4. Five of five (5/5) records lacked evidence that the physician participated in the DVT risk assessment or ordered preventative measures as appropriate based on a DVT risk assessment. These findings were verified by the Director of Nursing.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Our current policy was updated to reflect the process for performing VTE assessments on adult patients, updated VTE scoring criteria, communication with the provider, and proper documentation.	DON Acute	03/31/25	In Progress
2. An option has been identified to the bottom of the assessment tab for documenting the provider's notification, ensuring clear communication between nursing staff and the healthcare team.	DON Acute	03/31/25	In Progress
3. We have standardized the way in which we complete the VTE assessment, ensuring that all team members are documenting in the same place.	DON Acute	03/31/25	In Progress
4. Education was provided in-person to all Med/Surg RNs at our staff meeting on February 20th, and an additional training document was sent virtually to include expectations and the new policy.	DON Acute	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. 1. The updated policy, "Venous Thromboembolism – Prevention," has been reviewed and approved by the Director of Nursing and is undergoing the Committee Advisory Process. It will be reviewed by the Board of Directors for final approval on March 26th.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Our training plan has already been executed as discussed in action items. Education was provided in-person to all Med/Surg RNs at our staff meeting on February 20th, and an additional training document was sent virtually to include expectations and the updated policy.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. VTE scores and documentation compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of VTE scores. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.10.01 Notice of patient rights ***A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under state law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.*** **§ 485.614(a)** **§ 485.614(a)(1)**	This standard is not met as evidenced by: Based on policy review, observation, and interview the Facility is in violation of its policy, "EMTALA Signage," which states, "The hospital will post signage that, at a minimum, meets the following requirements: a. "Signage must be conspicuously posted in any place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department (e.g., entrance, admitting area, waiting room, labor and delivery, and other treatment areas located on hospital property." b. "Signage must be readable from anywhere in the area." c. "Wording on signage must be clear and in simple terms in a language(s) that is/are understandable by the population the hospital serves." There was an EMTALA sign located at the main entrance in a glass case on the bottom shelf, which was in English only. There were no signs posted in the other areas listed in the policy. These findings were verified by the Chief Nursing Officer.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Date of POC (date written, date revised)	02/13/25, revised 03/11/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. EMTALA signs and Patient's Rights signs were blown up and placed in all appropriate places to be in compliance with hospital policy.	DOQ	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. This corrective action was approved by the DOQ	DOQ	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the EMTALA signage policy was reviewed by the DOQ to ensure that the signs and placement would be in compliance with the policy.	DOQ	02/28/25	Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Signs and placement will be monitored on EOC rounds monthly.	DOQ	04/01/25 – 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.10.02 Notice and promotion of patient rights **The Patient's Rights document includes, at a minimum, that the patient has:** • ***The right to participate in the development and implementation of his or her plan of care.*** **§485.614(b)(1)** • ***Or his or her representative (as allowed under state law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.*** **§485.614(b)(2)** • ***The right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §§489.100, 489.102, and 489.104 of this chapter.***	This standard is not met as evidenced by: Based on documentation review, observation, and interviews, the following were observed related to Patient Rights: 1. Notices of Patient Rights are not prominently displayed as they are located in an enclosed glass case and cannot be easily read in this location. 2. California law requires hospital documents to have a minimum font size of 12 points for patient readability. The Patient Rights document provided to patients is smaller than a 12-point font. These findings were verified by the Chief Nursing Officer and Hospital Leadership.

PLAN OF CORRECTION

§485.614(b)(3)

- ***The right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.***

§485.614(b)(4)

- ***The right to personal privacy.***

§485.614(c)(1)

- ***The right to receive care in a safe setting.***

§485.614(c)(2)

- ***The right to be free from all forms of abuse or harassment.***

§485.614(c)(3)

- ***The right to the confidentiality of his or her clinical records.***

§485.614(d)(1)

- ***The right to access their medical records, including current medical records, upon an oral or written request, in the form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form and format as agreed by the***

PLAN OF CORRECTION

facility and the individual and within a reasonable time frame. The hospital must not frustrate the legitimate efforts of the individual to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits. **§485.614(d)(2)** • ***The right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.*** **§485.614(e)** • ***The right to safe implementation of restraint or seclusion by trained staff.*** **§485.614(f)** ***A CAH must*** • ***Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or***	

PLAN OF CORRECTION

limitation on such rights, when he or she is informed of his or her other rights under this section. **§485.614(h)(1)** ***Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.*** **§485.614(h)(2)** • ***Not restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.*** **§485.614(h)(3)** • ***Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.*** **§485.614(h)(4)**	
Date of POC (date written, date revised)	02/13/25, revised 03/11/25

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Patient's rights signs were blown up to meet the size requirements for reading and were placed around the hospital in prominent places to ensure that patient's rights were promoted appropriately.	DOQ	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. The DOQ approved of this corrective action	DOQ	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education of patient's rights will be included to the onboarding education for new hires that is conducted by the DOQ so staff is aware of the appropriate promotion of patient's rights.	DOQ	03/31/25	In Progress

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Placement and promotion of patient's rights will be monitored on EOC rounds by the DOQ.	DOQ	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.10.08 Patient and safety: Safe setting *The patient has the right to receive care in a safe setting.* §485.614(c) §485.614(c)(2)	This standard is not met as evidenced by: Based on tour, medical records review, and interview, the following were observed: A. Five of five (5/5) Emergency Room patient records lacked evidence that patients were screened for harm to others. B. Unsecure needles and syringes (35+) were found in the Preoperative area. These findings were verified by the Director of Nursing and the Surgery Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. Needles have been relocated to a locked cabinet to ensure compliance with safety standards.	DON Acute	03/31/25	In Progress
2. Additional keys have been ordered and distributed to nursing staff to maintain accessibility while ensuring security.	DON Acute	03/31/25	In Progress
3. The Triage of Emergency Patients policy was updated to include the requirement for assessing assault and homicidal risk factors.	DON Acute	03/31/25	In Progress
4. The Adhoc form in Cerner – Assault and Homicide Risk Assessment was identified as the standard tool for documentation.	DON Acute	03/31/25	In Progress
5. Training has been distributed virtually, with a required read/sign of the associated policy.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The revisions made to the Triage of Emergency Patients policy have been reviewed and approved by the Director of Nursing and are currently undergoing the Committee Advisory Process. The policy will be presented to the Board of Directors for final approval on March 26, 2025.	DON Acute	03/31/25	In Progress
2. The updated process around needles has been reviewed and approved by the Surgery Manager and Director of Nursing.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the new secured storage process has been provided virtually. In-person training for reinforcement will occur the week of March 10th, the next available date for surgery.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Staff are responsible for ensuring all needles remain locked and for reporting any security concerns immediately			
2. Education on completing the Adhoc form – Assault and Homicide Risk Assessment has been distributed virtually to reinforce expectations and the new policy. In – person pop up sessions will be scheduled as needed based on audit results. Monitoring and reinforcement will be ongoing to ensure successful implementation and sustainability of this change in practice	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. This will be monitored in the following way, ten medical records will be audited monthly for documentation compliance of screening for harm to others. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

08.00.01 Scope of Services The surgery department has a written scope of services. §482.51(a) §485.639 Tag C-**1140**	This standard is not met as evidenced by: Based on interview and document review, the surgical scope of services did not reflect the scope currently provided in the operating room. The facility had plans to do more General Surgery cases, but due to unforeseen circumstances, they are only performing scope procedures. This finding was verified by the Surgery Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Part A. What actions will you take (Add rows if needed.)

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
1. The scope of services around the scope of our surgical services will be updated to reflect the services that are being provided currently.	DON Acute	03/31/25	In Progress
2. The updated scope of services will be taken to the Board of Directors for approval.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. These corrective active plans will be approved by the CEO and the Board of Directors during the March meeting.	CEO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the scope of services standard and alignment of our services will be provided to the management team to allow us to assess and align as necessary.	DOQ	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. The hospital scope of services plan shall be reviewed by the MEC and Governing Body on an annual basis.	DOQ	04/01/25 – 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

08.01.00 Anesthesia Risk and Evaluation *(1) A qualified practitioner, as specified above in 42 CFR §485.639(a), must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.* *(2) A qualified practitioner, as specified below in 42 CFR §485.639(c), must examine each patient before surgery to evaluate the risk of anesthesia.* *(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified below in 42 CFR §485.639(c).* §482.51(b)(1) §482.52(b)(1)(ii) §482.52(b)(3) §485.639(b) §485.639(b)(1-3) Tag C-**1144**	This standard is not met as evidenced by: Based on a review of postoperative patient records and interview, two of five (2/5) records lacked a post-op anesthesia evaluation. This finding was verified by the Surgery Manager.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. A read/sign has been developed to ensure compliance with the post anesthesia risk and evaluation standards.	DON Acute	03/31/25	In Progress
2. The Anesthesia Record has been amended to provide clarity regarding the required charting elements, ensuring accuracy and consistency in documentation.	DON Acute	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. The updated process has been reviewed and approved by the Surgery Manager and the Director of Nursing to ensure alignment with regulatory and patient safety standards.	DON Acute	03/31/25	In Progress
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			

PLAN OF CORRECTION

1. Education on the new anesthesia risk and evaluation process will be provided to the Certified Registered Nurse Anesthetist (CRNA) in person. This training is scheduled to take place during the week of March 10th, coinciding with the next available surgical schedule.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Compliance with the updated anesthesia evaluation process will be audited in the following way, ten medical records will be audited monthly for documentation compliance of the post anesthesia assessment. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	03/31/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

08.03.06 Equipment Safety All anesthetizing equipment utilized is maintained to conform to Safe Medical Devices/Food Drug Administration requirements.	This standard is not met as evidenced by: Based on a review of post-op patient records and interviews, five of five (5/5) records lacked evidence that the anesthesia machine "number" was documented, and the “machine safety check” was not documented as complete prior to use. This finding was verified by the Surgery Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Each anesthesia machine has been assigned a unique name to facilitate identification and tracking.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

2. A designated area for required documentation has been added to the "Anesthesia Record" to ensure accurate and consistent record-keeping.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The updated process has been reviewed and approved by the Surgery Manager and the Director of Nursing to ensure alignment with regulatory and patient safety standards.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the new anesthesia risk and evaluation process will be provided to the Certified Registered Nurse Anesthetist (CRNA) in person. This training is scheduled to take place during the week of March 10th, coinciding with the next available surgical schedule.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Compliance with the updated anesthesia evaluation process will be audited in the following way, ten medical records will be audited monthly for documentation compliance of the anesthesia machine and completed safety check. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality	DON Acute	04/01/25 – 12/31/25	Monthly

PLAN OF CORRECTION

Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.			

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

10.00.05 Staff Education and Death Record Review *The CAH must have and implement written protocols that—* • *Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place.* • *For purpose of these standards, the term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multi visceral organs).* §485.643(e-f) §482.45(a)(5) Tag C-0349	This standard is not met as evidenced by: Based on interview, the Facility had not trained its employees on organ donation. They planned to start training on 2-1-25, but this has not come to fruition. This finding was verified by the Educator
Date of POC (date written, date revised)	02/13/25, revised 03/11/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. We have contacted our representative from the organ procurement center to obtain comprehensive training programs and resources that can be electronically embedded in our online learning system.	CCO	03/31/25	In Progress
2. The organ donation policy is accessible via the facility's internal portal, allowing staff to reference it at any time.	CCO	03/31/25	In Progress
3. We created a read/sign for all Emergency Department and Med/Surg staff for the Policy Identification of Potential Organ and/or Tissues Donors and associated form Record of Death/ Permit to Release Body.	CCO	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. The organ donation education program has been reviewed and approved by the Director of Nursing and the Chief Clinical Officer.	CCO	03/31/25	In Progress
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			

PLAN OF CORRECTION

1. The organ donation training program will be embedded in the online learning system and assigned to all required staff by March 21st. The training will include an assessment to evaluate comprehension.	CCO	03/31/25	In Progress
2. Staff will be given three weeks to complete the training, allowing time to identify and address any cases of non-compliance.	CCO	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The implementation and compliance of this education program will be monitored by the internal Quality Committee and reported to the Board Quality Committee, ensuring visibility for the governing Board of Directors.	DOQ	04/01/25 – 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

11.01.01 Resident rights

The CAH must be in substantial compliance with the following skilled nursing facility requirements:

1. *In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.*

   §483.10(b)(7)

2. *To be informed of, and participate in, his or her treatment.*

   §483.10(c)

3. *To be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.*

   §483.10(c)(1)

4. *To be informed, in advance, of changes to the plan of treatment.*

This standard is not met as evidenced by:

Based on a medical record review, five of five (5/5) records lacked evidence that the facility had provided a written list of resident rights to the resident upon admission to the program.

This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

§483.10(c)(2)(iii)

5. *To request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.*

   §483.10(c)(6)

6. *To choose his or her attending physician.*

   §483.10(d)

7. *To retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.*

   §483.10(e)(2)

8. *To share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.*

   §483.10(e)(4)

9. *To have immediate access to the resident's immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.*

   §483.10(f)(4)(ii)

PLAN OF CORRECTION

10. *To have immediate access to others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time.* §483.10(f)(4)(iii) 11. *To send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than the postal services.* §483.10(g)(8) 12. *To be informed at time of admission, when the resident becomes eligible for Medicaid, and periodically during the resident's stay of items and services included under the State plan for which the resident may not be charged; and those other items and services the facility offers for which the resident may be charged and the amount of charges for those services.* §483.10(g)(17); §483.10(g)(18) 13. *To have personal privacy and confidentiality of personal and medical records.* §483.10(h) §485.645(d)(1)	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Tag C-0361	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The admission process has been updated to ensure all residents receive the correct Resident Rights documentation upon admission for their status of care.	DON Acute	03/31/25	In Progress
2. The admission packet has been revised to include all required documentation, ensuring compliance with regulatory standards.	DON Acute	03/31/25	In Progress
3. All appropriate documentation has been changed in our policy manager system, and any inaccurate documents that have been deleted from the system are not available for use.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. The updated admission packet and process have been reviewed and approved by the Admitting/ Patient Access Manager and the Director of Nursing and is currently undergoing the Committee Advisory Process and will be reviewed by the Board of Directors by March 26th for final approval.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the revised admission packet and Resident Rights documentation will be provided to all admissions staff and will include a read/sign.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of all required elements of residence rights receipt on admission. Quality data shall be reported to the Quality Committee and Board of Directors until compliance is sustained for three consecutive months. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

.Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

11.01.06 Choice of attending physician *The resident has the right to choose his or her attending physician.* 1. *The physician must be licensed to practice, and* 2. *If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation.* 3. *The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.* 4. *The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.* 5. *If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.*	This standard is not met as evidenced by: Based on document review (including a patient rights welcome letter, welcome packet information, and medical record reviews), the facility lacked evidence that residents were informed of their right to choose a personal physician. This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

§483.10(d) §483.10(d)(1) §483.10(d)(2) §483.10(d)(3) §483.10(d)(4) §483.10(d)(5) §485.645(d)(1) Tag C-0361	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

1. The admission process has been updated to ensure all residents receive the correct Resident Rights documentation upon admission for their status of care.	DON Acute	03/31/25	In Progress
2. The admission packet has been revised to include all required documentation, ensuring compliance with regulatory standards.	DON Acute	03/31/25	In Progress
3. All appropriate documentation has been changed in our policy manager system, and any inaccurate documents that have been deleted from the system are not available for use.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The updated admission packet and process have been reviewed and approved by the Admitting/ Patient Access Manager and the Director of Nursing and is currently undergoing the Committee Advisory Process and will be reviewed by the Board of Directors by March 26th for final approval.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the revised admission packet and Resident Rights documentation will be provided to all admissions staff and will include a read/sign.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

PLAN OF CORRECTION

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. Compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of all required elements of residence rights receipt on admission. Quality data shall be reported to the Quality Committee and Board of Directors until compliance is sustained for three consecutive months. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

11.01.12 Medicare and Medicaid Notification. *The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.* *The facility must--* *(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-* *(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;* *(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and* *(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in 42 CFR 483.10(g)(17)(i)(A) and (B).* §483.10(g)(18)	This standard is not met as evidenced by: Based on documentation reviews (including patient rights welcome letter, welcome packet information, and medical record reviews), the facility lacked evidence that residents are given information regarding other items and services that the facility offers, for which the resident may be charged, and the amount of charges for those services. This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

§483.10(g)(17) §483.10(g)(17)(i) §483.10(g)(17)(i)(A) §483.10(g)(17)(i)(B)(i) §483.10(g)(17)(i)(B)(ii) §485.645(d)(1) Tag C-0361	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The admission process for swing patients has been updated and includes notice of information regarding other items and services that the facility offers, for which the resident may be charged, and the amount of charges for those services.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the CNO.	CNO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the revised admission packet and documentation will be provided to all admissions staff and will include a read/sign.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of all required elements of residence rights receipt on admission. Quality data shall be reported to the Quality Committee and Board of Directors until compliance is sustained for three consecutive months. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.01.01 Doors. Corridor doors and doors to hazardous rooms shall be provided with positive latching hardware. Roller latches are not permitted on corridor doors that are required to latch. Corridor doors shall be capable of resisting the passage of smoke. Doors in the path of egress must be side-hinged or pivot-swing type.	This standard is not met as evidenced by: Based on the building tour, 1. The Dietary entry door was fire-rated and did not close and latch. 2. The Main Mechanical Room door did not close and latch. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Corrections to latching speed have been made to ensure that latching happens as required by all applicable standards.	DOO	03/31/25	In Progress

PLAN OF CORRECTION

2. A PI measure will be created to monitor this corrective action.	DOO	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action has been approved by the DOO.	DOO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the inspection log and corrective action will take place in person and will be conducted by the Facilities Manager	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. The weekly door inspection log will be audited monthly and reported to the safety committee monthly and quality committee quarterly. This will ensure that the monitoring process will go through Board Quality to the Board of Directors.	DOO	04/01/25 / 12/31/25	Monthly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.01.03 Corridor Clutter The exit access corridor must be maintained to the full required width.	This standard is not met as evidenced by: 1. Based on the building tour, corridor clutter was observed in the following areas: A. In Med/Surg Unit 1, an IV cart was observed to be stored in the corridor. This finding was corrected on-site during the survey, but a plan of correction is still indicated. B. In the corridor leading to the OR area, a pedestal sign, a computer on wheels not in use, and a chair were observed stored. This finding was corrected on-site during the survey, but a plan of correction is still indicated. 2. Based on document review, the OR is not identified on the LS drawings as a suite, and a cart with plastic bins was observed to be stored in the corridor. This finding was corrected on-site during the survey, but a plan of correction is still indicated. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The clutter found was removed during survey.	DOO	02/28/25	Completed
2. Policy was updated and educated to staff.	DOO	03/31/25	In Progress
3. A corridor clutter log was created and this issue will be monitored by EOC rounding.	DOO	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. These corrective actions were approved by the DOO	DOO	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the policy and standard will be given in person in real time by the EOC rounding team as the issues are discovered.	EOC Team	03/31/25	In Progress
2. A read and sign will be added for the policy to our Relias platform for all staff.	DOO	03/31/25	In Progress

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Data on the clutter found during EOC will be reported to the safety committee monthly and to the quality committee quarterly.	Facilities Manager	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.01.05 Signage Exits shall be marked by an approved sign readily visible from any direction of exit access and be illuminated. Illuminated signs must be legible in both the normal and emergency lighting mode. Access to exits shall be marked by approved signs in all cases where the way to reach the exit is not readily apparent to the occupants. Exit signs shall be visually inspected monthly for operation of the illumination sources. This inspection is documented.	This standard is not met as evidenced by: Based on the building tour, 1. An exit sign was not observed indicating the rear exit from the kitchen to the outside. 2. The exit door near the Outpatient Medical Unit was observed without an exit sign. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

PLAN OF CORRECTION

1. Phot luminescent signs will be installed and staff will be educated to keep lights on as a short term fix.	Facilities Manager	03/31/25	In Progress
2. A long term solution will be to install hardwired exit signs in these spaces to be in compliance with the standard. This will be an HCAI project so it will take some time.	DOO	04/06/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	04/06/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Staff will be educated to the standard by the facilities manager in real time when compliance issues arise. EOC rounding will ensure compliance.	DOO	04/06/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. Monitoring of this plan will take place during EOC rounding and the results of the rounding will be reported to safety monthly and quality quarterly.	Facilities Manager	04/01/25	Monthly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

		12/31/25	

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.02.01 Fire Alarm System - Installation and Maintenance A fire alarm system required for life safety shall be installed and maintained in accordance with sections 18/19.3.4 of the Life Safety Code (2012 edition), and in accordance with NFPA 72, 2010 edition. §485.623(c)(1)(i-ii) C-0930	This standard is not met as evidenced by: Based on the building tour, a smoke detector was observed installed less than 36 inches from a supply diffuser in the receiving area. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Facilities will move smoke alarms that are not in compliance with the standard.	Facilities Manager	03/31/25	In Progress
2. New smoke alarms will be installed to be compliant with the standard.	Facilities Manager	03/31/25	In Progress

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard was given in person by the facilities manager.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Compliance with the standard will be monitored during EOC rounding and reported to safety monthly and quality quarterly.	Facilities Manager	04/01/25 – 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.02.02 Fire Alarm System- Testing. Fire alarm systems, and all their components, shall be tested according to NFPA 72 National Fire Alarm Code (2010 edition), Table 14.4.2.2 Test Methods, and Table 14.4.5 Testing Frequencies. All testing results are documented.	This standard is not met as evidenced by: Based on document review, the following documents for the Fire Alarm system were unavailable at the time of the survey: 1. The quarterly low air pressure switch testing documentation. 2. The annual smoke damper interconnected equipment testing documentation. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/31/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The contractor that is currently providing services will be on site in late March to preform testing.	Facilities Manager	03/31/25	In Progress

PLAN OF CORRECTION

2. While on site a conversation about the contractors ability to meet the standard will be conducted and the result of that conversation will potentially lead to compliance or finding a new vendor.	Facilities Manager	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the DOO	DOO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard will be provided by the Facilities Manager to the contractor while on site in late March.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Results of the contractor testing will be made available to the safety committee and the quality committee when available.	Facilities Manager	04/01/25 – 12/31/25	Quarterly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.03.01 Water-Based Fire Protection System: Installation and Maintenance A water-based fire protection system must be installed and maintained in accordance with section 18.3.5 of the Life Safety Code (2012 edition) in all new construction, remodeled and renovated areas. A water-based fire protection system must be installed and maintained in accordance with section 19.3.5 of the Life Safety Code (2012 edition) where required in existing construction, or renovated areas.	This standard is not met as evidenced by: Based on the building tour of the OR, a sprinkler escutcheon was observed loose from the ceiling. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The sprinkler escutcheon that was observed to be loose from the ceiling was fixed by facilities.	Facilities Manager	02/28/25	Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the DOO	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education to the standard will be provided by the facilities manager in person to his facilities team for observation.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. This standard will be monitored during EOC rounding and reported to safety on a monthly basis and quality on a quarterly basis.	Facility Manager	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.03.02 Water-Based Fire Protection System: Testing and Inspection If provided water-based fire protection systems and all their components must be tested, inspected and maintained in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 edition. All results of testing, inspection and maintenance activities are documented.	This standard is not met as evidenced by: 1. Based on document review of the sprinkler inspection report dated 6/7/24, the Main Drain quarterly inspection report was unavailable for review. 2. Based on document review, inspection and/or testing of the 50-year SR sprinkler heads were not available. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The required inspection reports needed to be in compliance with the standard will be completed and kept to be available to review upon request. These inspections will be completed by our contracted plumbing partner Murry Plumbing.	Facilities Manager	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard will be provided by the facilities manager as needed in person to ensure compliance can be maintained.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. This process will be monitored by the facilities manager and reported to safety at a cadence to maintain compliance with the standard.	Facilities Manger	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.04.07 Fire-rated Door Assemblies Fire door assemblies must meet the provisions of NFPA 80 *Standard for Fire Doors and Fire Windows*, 2010 edition. All fire-rated doors assemblies, whether they are located in a fire-rated barrier or not, must be tested and inspected on an annual basis according to NFPA 80, 2010 edition. The test and inspection are documented. §485.623(c)(1)(i-ii) C-0930	This standard is not met as evidenced by: Based on document review of the side-hinged fire door report dated 7/1/2024, 8 doors had failed inspection and had not been repaired. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. Remedi8 is scheduled for April 4th to come and repair the doors - to ensure that we are in compliance with the standard.	DOO	04/04/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	04/06/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard will be provided to our contracting partner to help them understand the needs on the standard.	DOO	04/06/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. A PI will be created and monitored by the EOC rounding. This will be reported to safety and quality as appropriate to be compliant with the standard.	Facilities Manager	04/01/25 / 12/31/25	Monthly

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.04.09 Ceilings Ceilings which are required to limit the passage of smoke, such as ceilings containing smoke or heat detectors, and sprinklers, and used in conjunction with corridors and hazardous rooms that have smoke resistant barriers, are free from cracks, holes or missing tiles.	This standard is not met as evidenced by: Based on the building tour: 1. The water heater closet area was observed to have two (2) ceiling tiles with penetrations greater than 1/8 inches. 2. Double fire doors labeled 11138370 were observed to have ceiling tiles above them with penetrations/gaps greater than 1/8 inches 3. Conduits located in Clean Utility Room #118 were observed to have ceiling tiles with greater than a 1/8-inch gap. 4. In the Satellite IT Room across from the Pharmacy, ceiling tiles were observed to have penetrations greater than a 1/8-inch gap. 5. In the Main IT room, multiple ceiling tiles (4) were observed with wires and conduit having greater than a 1/8-inch gap around them. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. All ceiling tile penetrations have been filled to be in compliance with the standard.	Facilities Manager	02/28/25	Completed
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. This corrective action plan was approved by the DOO	DOO	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the standard will be provided by the facilities manager as needed in person to ensure that we are compliant with the standard.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Ceiling tile penetrations will be monitored on EOC rounding and reported to safety monthly and quality quarterly.	Facilities Manager	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.05.10 Medical Gas Systems and Equipment: Maintenance There is a routine monitoring and maintenance system for oxygen, compressed air, and vacuum systems and equipment. CAH medical gas systems and equipment must be installed, inspected, tested and maintained in accordance with NFPA 99 (2012 edition) chapter 5 and chapter 11. Storage of all medical compressed gas cylinders must comply with NFPA 99, Standard for Health Care Facilities, 2012 edition.	This standard is not met as evidenced by: Based on the tour of the main bulk medical gas system, vehicles were observed parked less than 10 feet from the system. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/31/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. A ten (10) foot barrier will be constructed with bollards to ensure that there are no obstructions.	DOO	03/31/25	In Progress

PLAN OF CORRECTION

2. As a short term fix caution tape has been set up to designate the space that has to be cleared of obstructions.	DOO	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action has been approved by the DOO.	DOO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Staff have been made aware of the need to keep the space clear and notice has been provided about the change and requirements.	DOO	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. There will be bollards up to prevent non-compliance.	DOO	02/28/25 / 02/28/26	Annually

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

18.02.01 Risk Mitigation Measures for Infection Prevention The hospital has identified activities to mitigate risks associated with acquiring infections. *The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings.* §482.42(a)(2)	This standard is not me as evidenced by: A. During tour of the Emergency Room, the following equipment was observed to have an accumulation of dust on top: 1. Ice Machine 2. Blanket Warmer 3. Pyxis Med Supply. B. During the tour of Surgery, the following issues were identified: 1. Rust found on: a. CO2 tank b. Casters on the Bovie c. Back Table d. Trash can 2. Expired Supplies-two (2) containers of Clavicide were being used past their expiration date of 1-31-25. C. During document review and observation, the Kitchen was noted to have: 1. A significant number of corrugated boxes within the department and mixed within open items of products, including:

PLAN OF CORRECTION

	a. > 10 boxes on a small shelf unit for daily use of dry items b. > 10 boxes in refrigerator c. > 15 boxes in storage refrigerator d. >15 boxes in freezer e. > 15 boxes in the dry storage area 2. Torn opened corrugated boxes to store items in all areas addressed above. 3. The corrugated boxes risk assessment was limited regarding actions taken or considered to reduce risks. These findings were verified by the Emergency Room Staff, Surgery Manager, and the Dietary Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Dusting high spaces has been added to the EVS daily cleaning.	EVS Manager	02/28/25	Completed

PLAN OF CORRECTION

2. The areas found with dust were cleaned after they were discovered as dusty during survey.	EVS Manager	02/28/25	Completed
3. All rusted objects and expired products were removed after they were discovered during survey.	Facilities Manger	02/28/25	Completed
4. All corrugated boxes were moved and a new process was implemented to ensure that we are in compliance with the standard.	Dietary Manager	02/28/25	Completed
5. A risk assessment for corrugated boxes was completed to evaluate our facilities space and layout in the kitchen and to account for the infection prevention issues and other factors that make corrugated boxes problematic for use in that space. The risk assessment was completed to show what changes would be necessary (such as placement of corrugated boxes at the bottom of the racks), to ensure that we could have a space that met all necessary standards.	DOO	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO.	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. The standard will be educated in real time by the facilities, EVS, and dietary manager(s) as necessary to be in compliance, education was give to facilities, EVS, and dietary staff.	DOO	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. This process will be monitored via EOC rounding by the addition of dust accumulation in the ED and rust in the doors were added to EOC monthly rounds. Rounding audits shall be reported monthly to the Safety Committee and Quarterly to the Quality Committee.	DOO	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

19.00.03 Discharge planning evaluation ***A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post-CAH extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.*** **§485.642(a)(2)** **§482.43(a)(2)**	This standard is not met as evidenced by: Based on the interview and a review of the policy, "Discharge Planning," the policy does not address patient/family requests for discharge planning. This finding was verified by the Social Worker.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

PLAN OF CORRECTION

1. The Discharge Planning Policy has been reviewed and updated to ensure compliance with patient and family rights regarding discharge planning evaluations.	DON Acute	03/31/25	In Progress
2. Training has been completed in-person with the discharge planner and virtually with the nursing team.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The revised Discharge Planning Policy has been reviewed and approved by the Director of Nursing and is currently undergoing the Committee Advisory Process. The updated policy will be presented to the Board of Directors for final approval by March 26th, 2025.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. In- person education has been provided to the discharge planner and an additional reinforcement of a read/sign will be distributed.	DON Acute	03/31/25	In Progress
2. A read/sign will be obtained by all nursing staff	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

1. Compliance will be audited by verifying training completion for all required personnel by March 15th, 2025. The process will be audited monthly and reported to quality quarterly to ensure compliance.	DON Acute	04/01/25 12/31/25	Quarterly

Communication LOG:

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Patient Care Policies & Procedures: Development, Revision & Approval	POLICY# MedStaff 010
DEPARTMENT/SCOPE:	Medical Staff	Page 1 of 3
REVISIONS: 03/17/2025		EFFECTIVE: 8/11/2016
AUDIENCE		APPROVAL: 11/6/2023
OWNER: P. Sweet		APPROVER: J. Hathaway

See Also:

Policies & Procedures: Development, Revision & Approval
Policy and Procedure Flow Charts
Manual Review and Approval Form MMH289
Policies and Procedures Usable Template

DEFINITIONS:

Patient Care Policies---defined by 485.635(a) & ACHC Standard 06.00.

- A description of the services the CAH furnishes, including those furnished through agreement or arrangement.
- Policies and procedures for emergency medical services.
- Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.
- Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.
- Procedures for reporting adverse drug reactions and errors in the administration of drugs.
- Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices.
- Policies and procedures for respiratory care.
- Policies and procedures that address the post-acute care needs of patients receiving CAH services.

Governing Body: the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital. Title 22 §70035

Policy Advisory Group: A sub-committee of the medical staff consisting of at least one MD or DO and at least one non-physician practitioners.

POLICY:

Patient care policies are developed and reviewed by a multidisciplinary team. Polices are developed with the advice of members of the Mayers professional healthcare staff as part of the

SUBJECT/TITLE:	Patient Care Policies & Procedures: Development, Revision & Approval	POLICY# MedStaff 010
DEPARTMENT/SCOPE:	Medical Staff	Page 2 of 3
REVISIONS: 03/17/2025		EFFECTIVE: 8/11/2016
AUDIENCE		APPROVAL: 11/6/2023
OWNER: P. Sweet		APPROVER: J. Hathaway

policy advisory group. The policy advisory group reviews existing policies every two years and makes recommendation for new patient care policies. Final approval of patient care policies is performed by the Chief Executive Officer (CEO).

Policies and Procedures will be in a standardized format.

PROCEDURE:

1. Development of Policies and Procedures
   a. The author research applicable standards and regulations to be address by the policy.
   b. Author considers the impact of the policy may have on other departments/hospital operation and gathers input from the affected areas.
2. Policy Approval
   a. The department manager approves the policy.
   b. Each patient care policy is reviewed and approved by a medical staff sub-committee(s).
   c. Once approved by the medical staff sub-committee, the policy is forwarded to the Policy Advisory Group which consists of at least one MD or DO and at least one non-physician practitioner.
   d. The Policy Advisory Group may choose to forward the policy to the Medical Executive Committee for further approval.
   e. Once approved by the policy advisory group, the policy is sent to the CEO for final approval. The CEO may choose to forward the policy to the Governing Body for discussion and/or feedback prior to final approval.
   f. A summary of policies approved by the CEO is provided to the Governing Body. Members of the Governing Body may requestion copies of approved policies or access them electronically.
   g. Policies and Procedures requiring immediate implementation (e.g. in response to a survey as part of a plan of corrections) at the direction of the division chief are watermarked DRAFT and implemented as a pilot, then sent through the approval process.

3. Issuing
   a. Once a policy has been approved by all applicable committees/bodies it is issued by the Policy and Procedure Coordinator.
   b. The coordinator sends a list of the finished policies to all departments housing the manual in which the policy belongs.

SUBJECT/TITLE:	Patient Care Policies & Procedures: Development, Revision & Approval	POLICY# MedStaff 010
DEPARTMENT/SCOPE:	Medical Staff	Page 3 of 3
REVISIONS: 03/17/2025		EFFECTIVE: 8/11/2016
AUDIENCE		APPROVAL: 11/6/2023
OWNER: P. Sweet		APPROVER: J. Hathaway

c. It is the Department Manager's responsibility to that staff are inserviced on the policy.

4. Annual Program Evaluation
   a. Each Policy and Procedure Manual is reviewed and approved annually by all of the following:
      i. Chief Executive Officer/Division Chief
      ii. Medical Chief of Staff
      iii. Governing Board Representative
      iv. Department Manager
   b. Once reviewed the *Manual Review And Approval Form MMH289* (attached) is signed.

5. Previous Versions
   a. Previous versions of policies and procedures are stored electronically.

SPECIAL CONSIDERATIONS:

I. Preprinted orders—All preprinted orders must be approved by the Medicine/Pharmacy and Therapeutics Committee annually.
II. Permanent Record—Forms that may become part of a patient's permanent medical record are reviewed by the Health Information Management Committee prior to implementation.
III. Patient Consents—Forms used as a consent are reviewed by the Health Information Management Committee prior to implementation.

REFERENCES:

CFR 42 §485.635
CFR 42 §485.627
CCR Title 22 §70035
ACHC Standard 06.00.01 – Patient Care Policies
ACHC Standard 06.00.02 – Policy Development
ACHC Standard 06.00.03 – Policy Scope

COMMITTEE APPROVALS:

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Policies & Procedures: Development, Revision & Approval	POLICY# MedStaff 007
DEPARTMENT/SCOPE:	Medical Staff	Page 1 of 6
REVISIONS		EFFECTIVE: 8/11/2016
AUDIENCE: All hospital Staff		APPROVAL: 11/6/2023
OWNER: P. Sweet		APPROVER: J. Hathaway

With Attachments:

Flow Charts for Approval of Policies and Procedures
Manual Review and Approval Form MMH289
Policies and Procedures Usable Template

See Also:

Patient Care Policies & Procedures: Development, Revision & Approval

DEFINITIONS:

Administrative Policies—Policies generated by the Chief Executive Officer addressing an emergent situation. This type of policy is implemented immediately and then ratified by the policy and procedure process.

Personnel Policies—Policies regarding recruitment, retention and development of staff located in the *Employee Manual* and referenced in the *Employee Handbook*.

Finance Policy—Policies that set district policy in regard to monetary practice. These are not policies that explain a business office process. Examples include Charity Care Policy and Capital Expenditures Policy.

Departmental Policies—Policies that pertain to *only* the generating department (e.g., programming or calibrating a device). If a policy is kept in more than one department manual it is **not** a departmental policy.

Tool—A document or spreadsheet used by a single department to track or document quality activity, scheduling or other function that does not impact another department/process. Tools are not part of a patient's medical record. Tools are not generally reviewed by the Policy and Procedure process unless specifically referenced in a policy.

Form—A document that is used by multiple departments. Examples include flow sheets, order forms, consents and legal documents. Forms may be part of a patient's permanent record. In many cases a form has an associated Policy and Procedure clarifying use of the form.

POLICY:

Mayers Memorial Healthcare District develops and continually maintains Policies and Procedures and Policy and Procedure Manuals as appropriate to the operation of the facility and associated enterprises. Policies and Procedures are the blueprint for directing all aspects of

SUBJECT/TITLE:	Policies & Procedures: Development, Revision & Approval	POLICY# MedStaff 007
DEPARTMENT/SCOPE:	Medical Staff	Page 2 of 6
REVISIONS		EFFECTIVE: 8/11/2016
AUDIENCE: All hospital Staff		APPROVAL: 11/6/2023
OWNER: P. Sweet		APPROVER: J. Hathaway

patient care, employee relations, departmental responsibilities, administrative practices and financial practices. Each department manager is responsible to develop and maintain departmental Policies and Procedures, which reflect the department's standards of performance. All Policies and Procedures will be in a standardized format. Policies and Procedures pertaining to the Critical Access Hospital and its associated services and Policies and Procedures pertaining to the Skilled Nursing Facility are reviewed and routed through a multidisciplinary Policy and Procedure/Forms Committee which meets on a regular basis.

PROCEDURE:

I. Development of Policies and Procedures
   a. The author follows the guidelines for writing a Policy and Procedure and produces a document in approved format. See Policy and Procedure: **How to Write a Policy and Procedure**.
   b. Author considers the impact of the policy may have on other departments/hospital operation and gathers input from the affected areas.

   Once the affected areas are in agreement:

   c. If the author is other than the department manager of the generating department, the author submits the policy to the department manager for approval.
   d. The department manager submits the policy to the division chief.
   e. The division chief reviews the policy for format, screens content, and determines which medical staff committee(s) if any will review the policy. The division chief may:
      i. Return the policy to the originating department to be reworked
      ii. If the policy is appropriate, instruct the author to forward the policy electronically to the Policy and Procedure Coordinator, along with a list of the list of medical staff committee(s) that need to review the policy.
   f. The Policy and Procedure Coordinator enters the Policy and Procedure on the tracking application and routes the policy for approval.

II. Revision of Policies and Procedures
   a. Author considers the impact of the policy may have on other departments/hospital operation and gathers input from the affected areas.
   b. If the author is other than the department manager of the generating department, the author submits the policy to the department manager for approval.
   c. The department manager submits the policy to the division chief.
   d. The division chief reviews the policy for format and screens content. If the policy is appropriate, the division chief instructs the author to forward the policy electronically to the Policy and Procedure Coordinator.

SUBJECT/TITLE:	Policies & Procedures: Development, Revision & Approval	POLICY# MedStaff 007
DEPARTMENT/SCOPE:	Medical Staff	Page 3 of 6
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AUDIENCE: All hospital Staff		APPROVAL: 11/6/2023
OWNER: P. Sweet		APPROVER: J. Hathaway

e. The Policy and Procedure Coordinator enters the Policy and Procedure on the tracking application ~~document~~ and verifies the approval routing.

III. Routing/Approval (See attached *Flow Chart*)

a. All new documents and departmental policies with no sub-committee routing are reviewed by the Policy and Procedure Committee.
b. Policies and Procedures that require review and acceptance by medical staff sub-committees are placed on the committee's agenda by the Medical Staff Coordinator/Policy and Procedure Coordinator.
    i. Every patient care policy must be approved by a Medical Staff Subcommittee.
    ii. Once approved by the appropriate Medical Staff Sub-committee(s) the policy is sent to Punctuation and Grammar Group.
    iii. New or drastically revised patient care policies are routed to the Medical Executive Committee for approval where they are reviewed by the physician and midlevel practitioners.
    iv. Other policies may be directed to the Medical Executive Committee at the discretion of the physician chair of the Medical Staff Sub-committee.
c. Policies requiring Hospital Governing Board routing and **approval**
    i. Financial Policies are forwarded to the Hospital Board of Directors' Finance Committee for review and approval.
    ii. Personnel Policies are forwarded to the Hospital Board of Directors' Quality Committee for review and approval.
    iii. Policies that add or delete service lines are forwarded to the Hospital Board of Directors' Strategic Planning Committee for review and approval.
    iv. Administrative Policies are presented to the Governing Board by the Chief Executive Officer for review and approval.
    v. All new patient care policies are presented to the Governing Board for review and approval.
    vi. Skilled Nursing Policies that relate to the following areas (not included above):
        1. Patient admission, leave of absence, transfer, pass and discharge.
        2. Rates and charges
        3. Services offered
        4. Admission non-discrimination policies
        5. Patient health records policies

MAYERS MEMORIAL HEALTHCARE DISTRICT

SUBJECT/TITLE:	Policies & Procedures: Development, Revision & Approval	POLICY# MedStaff 007
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AUDIENCE: All hospital Staff		APPROVAL: 11/6/2023
OWNER: P. Sweet		APPROVER: J. Hathaway

vii. It is the division chief's responsibility that changes made in board committee are made to the electronic version of the policy and formatted correctly.
viii. Once the policy is ready for board presentation it is forwarded to Boards Administrative Assistant for inclusion in the board agenda.

d. Policies and Procedures requiring immediate implementation (e.g. in response to a survey as part of a plan of corrections) at the direction of the division chief are stamped DRAFT and implemented as a pilot, then sent through the Policy and Procedure process.

IV. Policy and Procedure Committee

a. The Policy and Procedure Committee reviews all **new** policies and procedures/policies/forms that relate to the Critical Access Hospital, Ambulance, Hospice or the Skilled Nursing Facility.
b. Policies are reviewed for the following technical aspects:
   i. Format
   ii. Spelling
   iii. Grammar
   iv. Readability
c. Policies are review for the following quality aspects
   i. Duplication/conflict—does the policy duplicate another policy or conflict with another policy?
   ii. Multidisciplinary—does the policy impact another department in a way not anticipated by the author?
   iii. Quality—are there opportunities for tracking process improvement?
   iv. Legal—are there legal considerations that need to be reviewed by counsel?
   v. Safety—does the policy use only approved abbreviations and take into account patient, employee safety and risk management?
   vi. Standard of Care/Current Practices—does the policy use current and appropriate references?
d. Policies and Procedures committee may take one of the following actions
   i. Approve the policy with or without changes and issue or send to Medical Executive Committee for review/approval prior to issuing.
   ii. Send the policy to author for complete rewrite to be returned to Policy and Procedure Committee.
   iii. Issue the policy as a draft, trial or pilot
   iv. Remove duplicate policies
e. The Policy and Procedure Committee consists of the following individuals:
   i. The Director of Nursing for Acute or designee

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OWNER: P. Sweet		APPROVER: J. Hathaway

ii. The Director of Nursing for SNF or designee
iii. The Chief Quality Officer or designee
iv. A clinical pharmacist
v. Activity director
vi. Dietary representative
vii. Health Information Management representative
viii. Housekeeping representative
ix. A community member
x. Other members as appropriate and as needed

f. The Housekeeping representative and Activity Director are required members of the Policy and Procedure Committee.

V. Process Communication

a. A summary of policies reviewed and actions taken by the Policy and Procedure Committee is provided at least quarterly to the Board of Directors to be presented at a Director's meeting.
b. Members of the Board of Directors may request copies of the policies processed by the Policy and Procedure Committee.

VI. Issuing

a. Once a policy has been approved by all applicable committees/bodies it is issued by the Policy and Procedure Coordinator.
b. The coordinator sends a list of the finished policies to all departments housing the manual in which the policy belongs.
c. It is the Department Manager's responsibility to that staff are inserviced on the policy.

VII. Annual Program Review

a. Each Policy and Procedure Manual is reviewed and approved annually by all of the following:
    i. Chief Executive Officer/Division Chief
    ii. Medical Chief of Staff
    iii. Governing Board Representative
    iv. Department Manager
b. Once reviewed the *Manual Review And Approval Form MMH289* (attached) is signed.
c. Each departmental employee reviews each manual applicable to their employment and signs the *Employee Manual Review Form* (attached). NOTE: A single employee may sign the Manual Review Form for multiple manuals (e.g., a nurse

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OWNER: P. Sweet		APPROVER: J. Hathaway

may review the Acute Manual, the IV/Medications Manual, and the Surgery Manual). This form is signed annually.

VIII. Previous Versions
   a. Previous versions of policies and procedures are stored electronically.

SPECIAL CONSIDERATIONS:

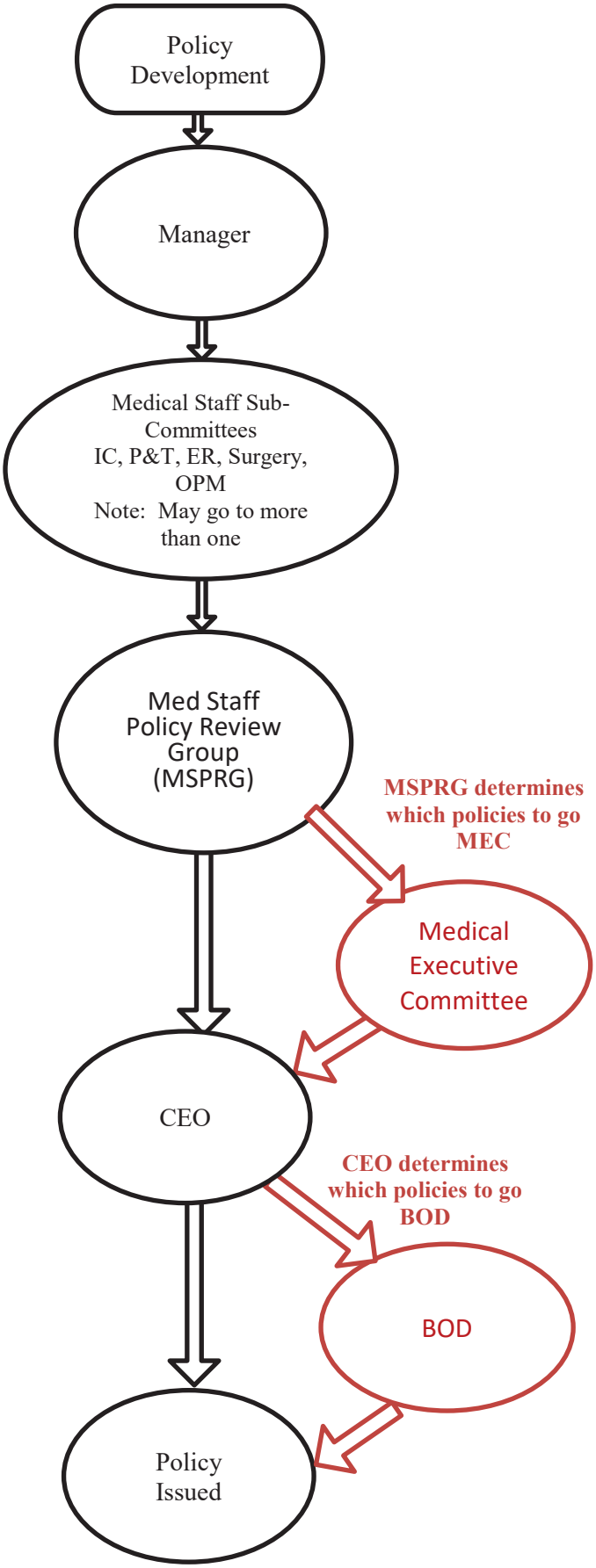
I. Preprinted orders—All preprinted orders must be approved by the Medicine/Pharmacy and Therapeutics Committee annually.
II. Permanent Record—Forms that may become part of a patient's permanent medical record are reviewed by the Health Information Management Committee prior to implementation.
III. Patient Consents—Forms used as a consent are reviewed by the Health Information Management Committee prior to implementation.

REFERENCES:

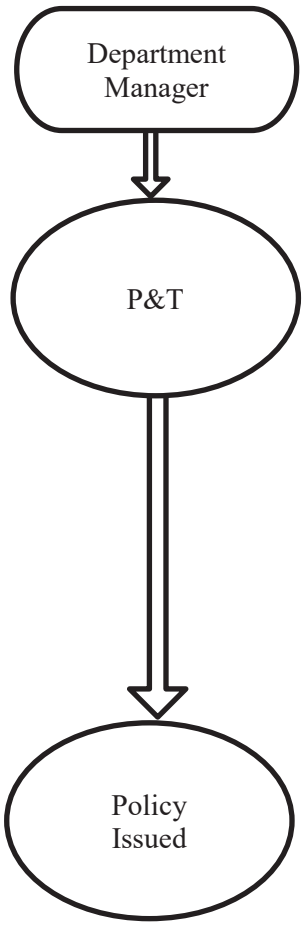
California Code of Regulations (Title 22, Division 5) §70001, §70005, §70035, §70203, §70213, §70233, §70243, §70253, §70263, §70273, §70403, §70413, §70433, §70453, §70463, §70527, §70537, §70557, §70597, §70617, §70631, §70651, §70707, §70738, §72525
California Health and Safety Code §1315 and §1316.5
CAH Conditions of Participation: C-0241 (total operation) C-0272

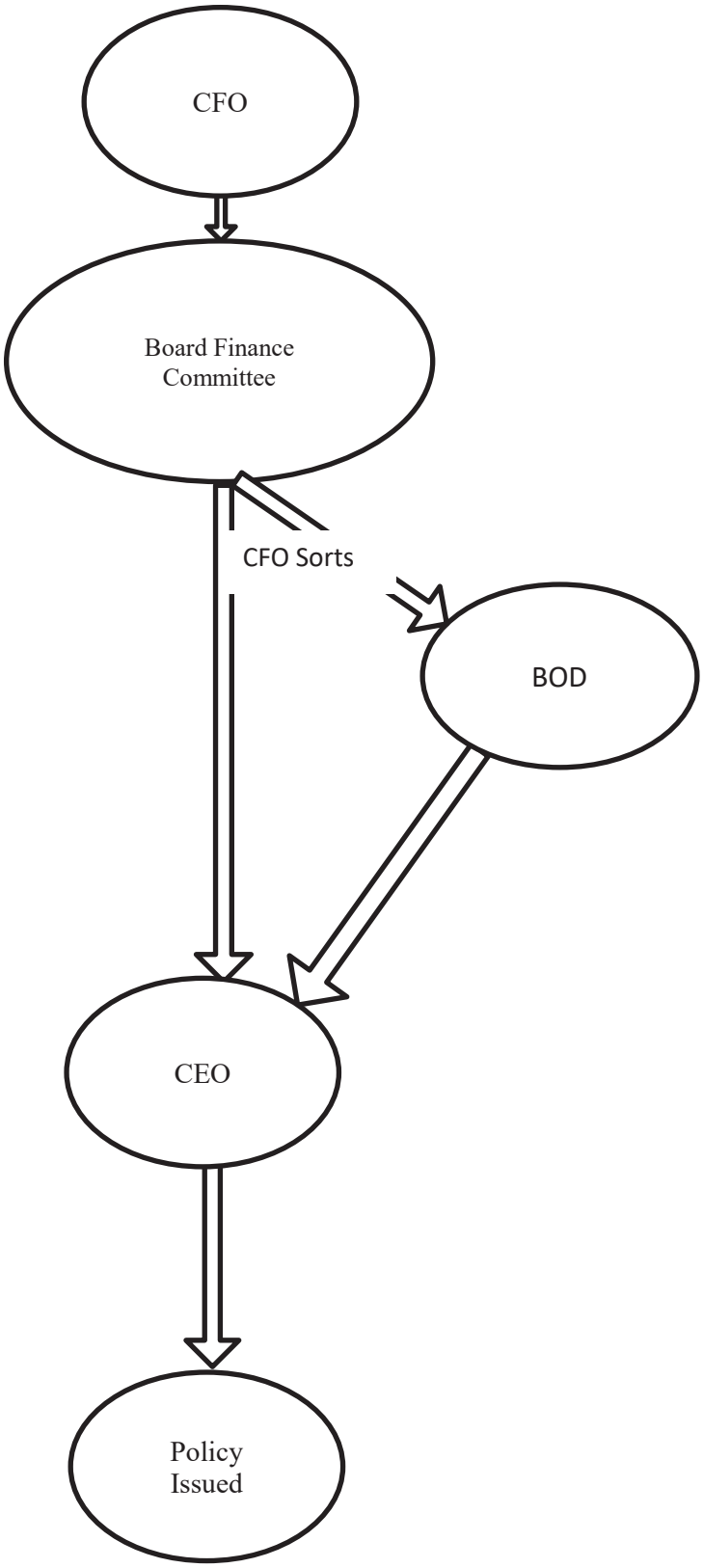
COMMITTEE APPROVALS:
Chiefs: 11/06/2023

Patient Care Policies - CAH Review Approval

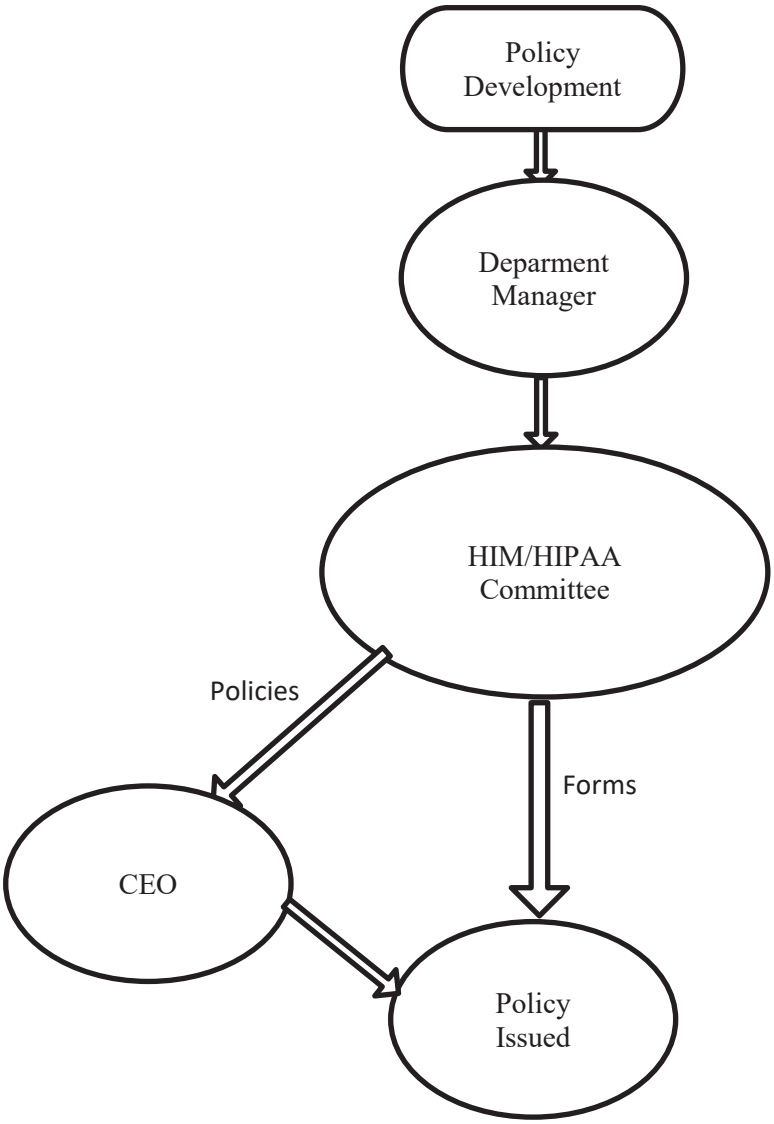


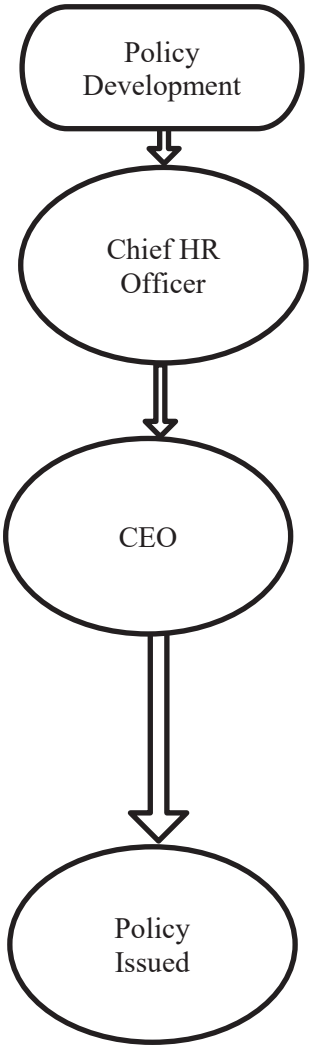
Clinical Division Procedures

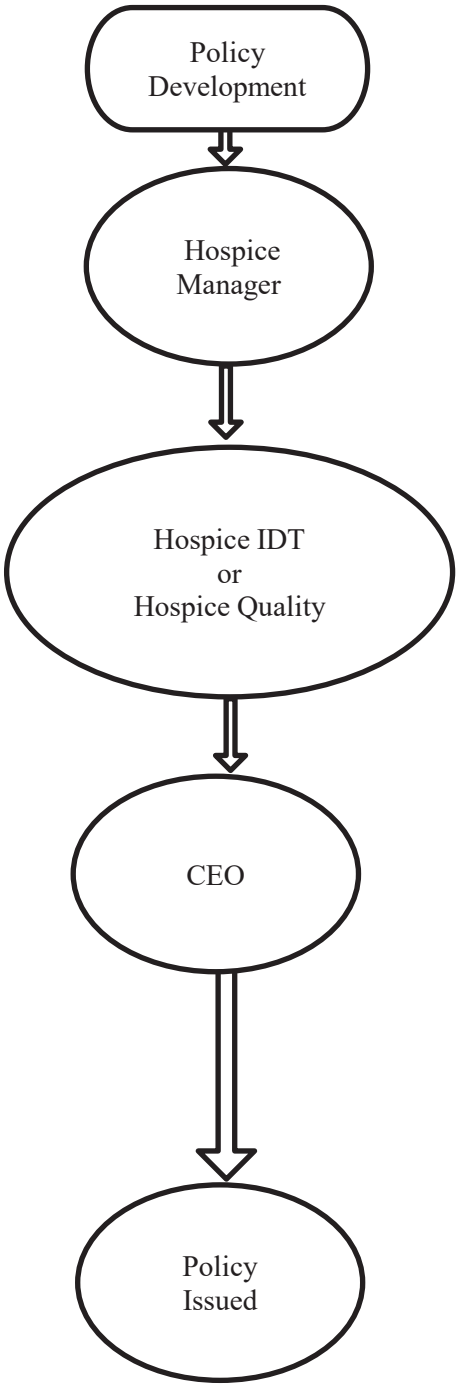



CFO
Board Finance Committee
CFO Sorts
BOD
CEO
Policy Issued

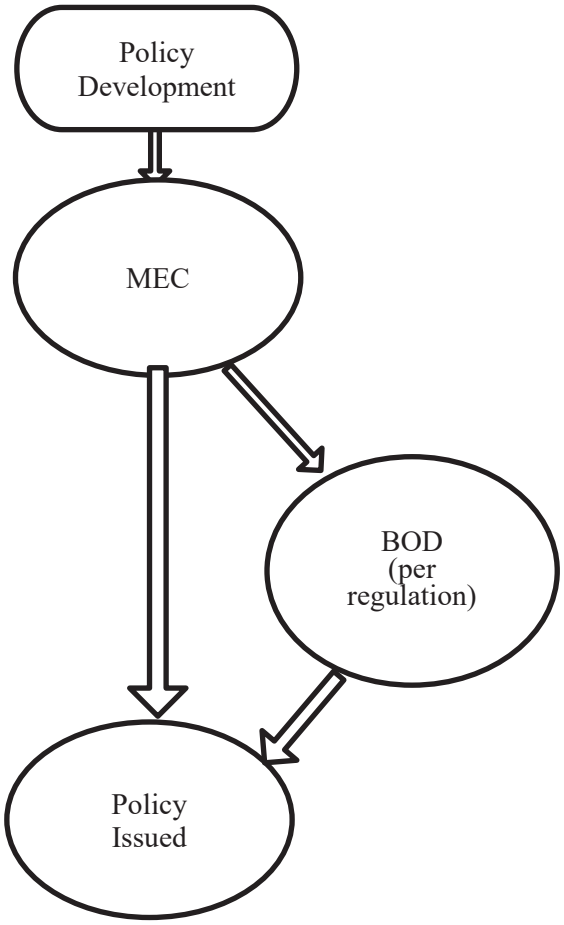
HIM/HIPAA
Policies
Consents
Any Document That is Part of the Medical Record
CAH



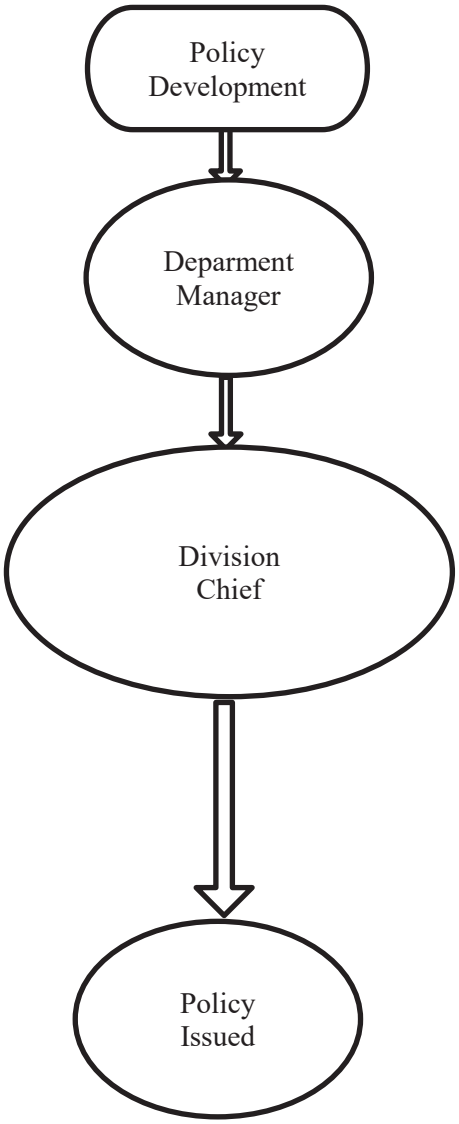

Policy Development
Chief HR Officer
CEO
Policy Issued

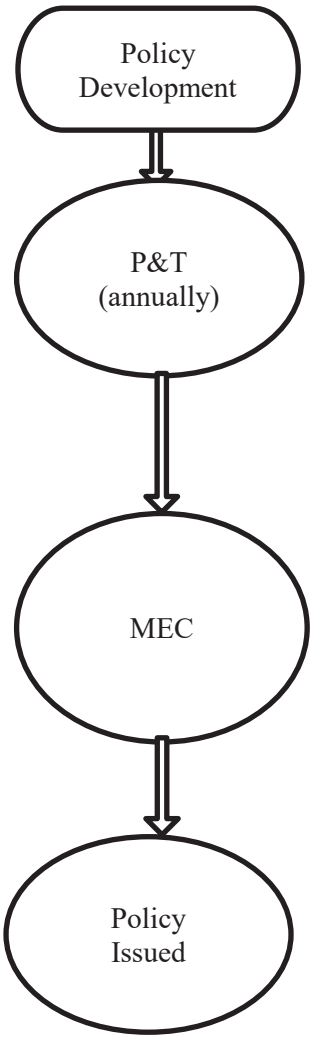

Policy
Development
Hospice
Manager
Hospice IDT
or
Hospice Quality
CEO
Policy
Issued

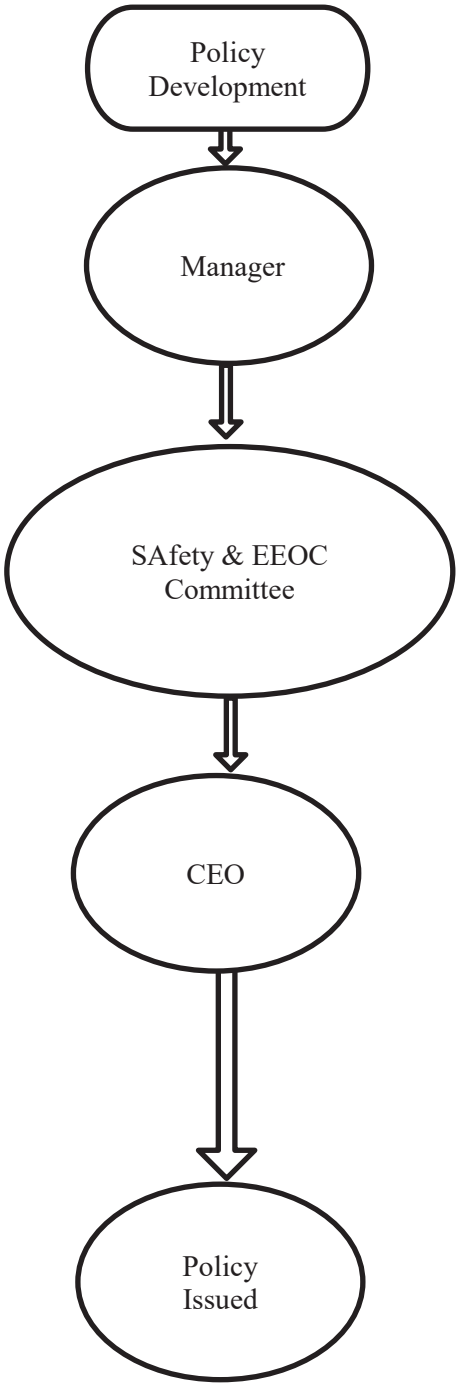
Examples:
Forms
Applications
Priviledges

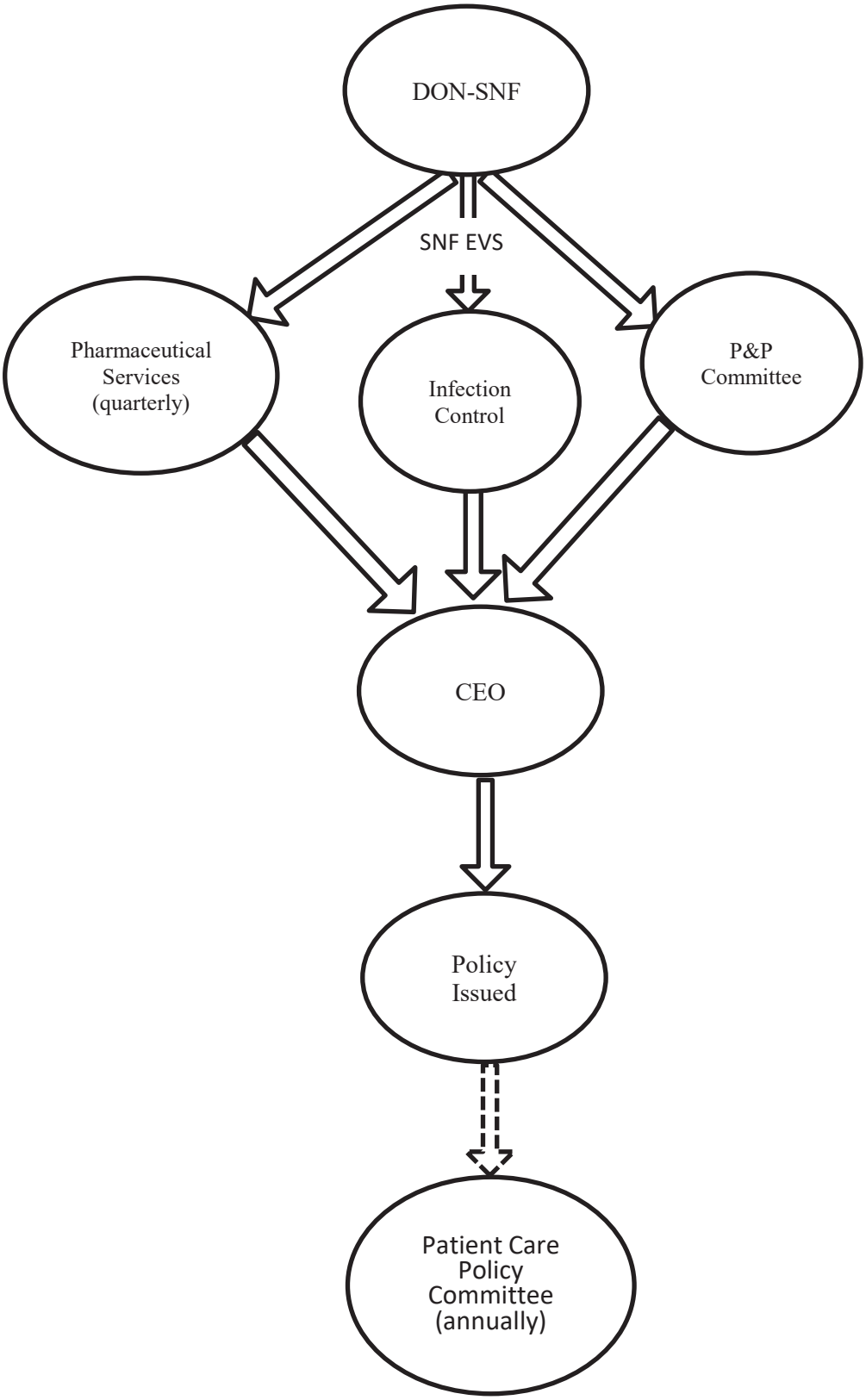


Examples:
Purchasing
Maintenance
Operations
IT




Policy
Development
P&T
(annually)
MEC
Policy
Issued


Policy Development
Manager
SAfety & EEOC Committee
CEO
Policy Issued


DON-SNF
SNF EVS
Pharmaceutical Services (quarterly)
Infection Control
P&P Committee
CEO
Policy Issued
Patient Care Policy Committee (annually)

Director of Operations Report
Prepared by: Jessica DeCoito, Director of Operations

Facilities, Engineering, and Other Construction Projects

- **TCCN Phase 3**: Aspen Street Architects resubmitted Phase 3 plans to the county earlier this week. We are now awaiting feedback—either approval or additional comments. We have also requested the architect's estimate for construction costs. Given the anticipated cost, the Board will need to review and discuss next steps.
- **FR RHC Bathrooms**: Following extensive discussions with the County and the design team, we will proceed with a revised plan including three bathrooms in the FR RHC space. The updated design, reviewed by clinic staff, will be resubmitted to the county.
- **Lot Line Adjustment**: Our architectural team is preparing the resubmittal of the lot line adjustment application, with a target date of May 23rd. Early feedback from county officials has been favorable toward our revised plan.
- **FR Fire Damper Project**: This project has been submitted to HCAI and is currently under review. We expect feedback in the coming weeks.
- **Solar Project**: Unforeseen subsurface conditions—specifically, an old concrete washout caused a delay. The affected solar panel installation area has been relocated south of Riverview House. Due to limited HCAI experience within the solar team, structural revisions are underway. A site walk with the IOR and Superintendent took place on May 20th. Given these challenges, the August 8th project closeout date is now uncertain.
- **FR Arts & Trophies Building**: Two resolutions are included in this packet for Board approval to designate the building as surplus and authorize its sale. Upon approval, the documentation will be submitted to the California Department of Housing and Community Development. Their recent responsiveness suggests minimal delay in moving forward with the process.
- **LTC Nurse Call System**: On April 30th, Alex and I conducted a site walk with WestCom and Whittington Electric for the LTC Nurse Call Project, a Deferred Maintenance initiative. Our LTC staff are eager to see this long-awaited upgrade implemented.
- **Wanderguard**: the Wanderguard system is being set up in the Burney Annex this week. The team are excited to cross this necessary safety and security requirement off their list and provide our residents and staff with peace of mind.
- **Master Plan Meeting**: On May 12th, Ryan, Travis, Alex, and I met with Kasa Healthcare Management to kick off our partnership for the Master Plan. Beyond discussions around scope, budget, and timelines, it was a valuable opportunity to connect with our new Project Managers, who are already working with legal on our RFP/RFQ process.

Dietary

- **Burney Kitchen**: A series of issues impacted the Burney kitchen in one day, including a dishwasher failure on a Saturday. Staff were quick to adapt,

handwashing all trays and dishes. Fortunately, we were already working on a replacement, which was expedited and installed within two weeks.

- **Fall River Kitchen Dishwasher**: The team is eagerly awaiting the installation of a new dishwasher after their current unit failed during a previous installation attempt. Unfortunately, an ordering error was discovered only after the new unit had been installed. Technicians temporarily reinstalled the original dishwasher, but it has since failed permanently. A correctly ordered replacement is now on an expedited delivery schedule.

Employee Housing

- The UV Light Filtration system was successfully installed this past month.

Human Resources Board Report

Reporting Period: May 2025

Prepared by: Libby Mee, Chief Human Resource Officer

Employee Support and Recruitment

As of this reporting period, the Human Resources, Payroll, and Benefits Department is supporting a total of **308 active employees** across all departments. The team continues to focus on targeted recruitment and retention strategies to meet current staffing demands and support the organization's ongoing growth.

Current Recruitment Overview

Department	Job Title	Status	Number of Positions
Ambulance	Rural Healthcare Paramedic	Per Diem	1
Dietary	Food & Nutrition Services	Full Time	1
Health Navigation Services	Care Coordinator Specialist	Full Time	1
Housekeeping (Burney)	Environmental Services Aide	Full Time	1
Housekeeping (FR)	Environmental Services Aide	Full Time	1
Laboratory	Clinical Laboratory Scientist	Full Time	***
Medical/Surgical	Med/Surg Acute CNA	Full Time	1
Medical/Surgical	Med/Surg Acute RN	Per Diem	1
Nurse Administration	Executive Assistant to Chief Nursing Officer	Full Time	1
Pharmacy	Pharmacist	Full Time	1
Respiratory Therapy	Respiratory Therapist Manager	Full Time	1
Skilled Nursing	Skilled Nursing Facility CNA	Full Time	14

Department	Job Title	Status	Number of Positions
Skilled Nursing	Skilled Nursing Facility LVN	Full Time	5
Skilled Nursing	Skilled Nursing Facility RN	Full Time	4
Skilled Nursing	Skilled Nursing Unit Assistant	Full Time	***
Surgery	Endoscopy Tech	Part Time	1

- We currently have **16 active job requisitions** posted and a total of **34 vacancies** to be filled.

Notes:

- *** The Clinical Laboratory Scientist (CLS) position is posted in accordance with our international recruitment efforts.
- *** The number of posted Unit Assistant positions fluctuates based on enrollment in our Certified Nurse Assistant (CNA) training program.

We have hired **four (4) Unit Assistants** who are currently in their probationary period as part of the Summer CNA Program.

Additionally, we have received **three (3) applications** for the 2025 Summer Internship Program. We look forward to providing local graduates with valuable work experience in a healthcare setting as they pursue their career aspirations.

Annual Employee Compliance Schedule

To ensure regulatory and policy compliance, the following schedule has been set:

- **July–August:** Annual Employee Performance Reviews
- **August–September:** Annual Re-Orientation via Relias
- **September–October:** Annual Employee Health Compliance

Community Collaboration

Shasta College is exploring the development of a **Community Health Worker (CHW)** certificate or training program. I have been invited to serve on the advisory committee, which will assess industry needs and help shape the curriculum to better support workforce development and community health initiatives.

Professional Development and Education

Jen Miley of Elite Edge Coaching completed her final quarterly leadership development session with the MMHD leadership team on **Thursday, May 9**. This session focused on **“Building Accountability and Owning Your Role as a Leader.”**

Over the past fiscal year, Jen also conducted one-on-one executive coaching sessions with **18 leadership team** members, enhancing leadership capacity and individual development.

Service Excellence Initiative

I met with the MMHD CEO and Director of Quality to develop a proposed **Organization-Wide Accountability Dashboard** as part of the **Service Excellence Initiative**. One key metric will track **Employee Retention**, with additional tools including **Employee Engagement Surveys** to be implemented in the coming months.

Chief Public Relations Officer – Valerie Lakey
May 2025 Board Report

Legislation/Advocacy

Week of May 20, 2025

Federal Update

On May 14, the House Energy and Commerce Committee proposed cutting over $715 billion from Medicaid (Medi-Cal in California) over the next 10 years. A vote could take place as soon as next week. These proposed cuts would severely impact access to care for many Californians and place further strain on hospitals.

Healthcare organizations across the state, including Mayers, are urging Congress to reject these harmful cuts. We are closely monitoring the proposal and its potential effects on our services and patients.

Additionally, the Centers for Medicare & Medicaid Services (CMS) has proposed changes to how health care-related taxes are handled under Medicaid. This could affect key funding programs in California, such as the Managed Care Organization Tax and the Hospital Quality Assurance Fee. Further analysis is underway.

CMS has also released the proposed payment rules for inpatient and long-term care hospitals for the federal fiscal year 2026. These proposals will be reviewed in upcoming briefings and webinars.

State Update

The Governor released his May state budget Revision, reflecting a $12 billion shortfall. One proposal would redirect Proposition 35 funding, which could negatively affect healthcare providers. We join others in the healthcare community in opposing this plan and will stay engaged as it moves through the Legislature.

At the state level, many bills have now been moved into the suspense file of the Assembly and Senate Appropriations Committees, with final decisions expected by May 23. One bill we're closely monitoring is SB 632 (Arreguín). We have joined efforts to oppose this legislation, which proposes expanding workers' compensation presumptions for direct patient care providers. If passed, the bill would assume a wide range of injuries, including infectious diseases, cancer, musculoskeletal issues, PTSD, SARS, COVID-19, and respiratory illnesses, are work-related unless proven otherwise. It would also extend these presumptions beyond the term of employment, which could have significant implications for healthcare providers like ours. We follow state and federal actions closely and will share additional updates as more information becomes available.

Grants/Scholarship Update (Laura Beyer)

Scholarship spring cycle applications have been assessed, and the MHF board has approved $10k for 12 recipients: 7 high school seniors, two renewals, and three employees. The pool of applicants was excellent, with various backgrounds and career interests. One of the employee awardees was a community scholarship recipient a few years back, so we are investing in growing our own.

Grants have been disappointingly minimal, but we continue onward and upward. Following some HCAI-sponsored grant training, I plan to utilize new approaches integrating AI to help assess district statistics and develop better stories that reflect who we are, what we do, and our impact.

The grant world is generally still in a state of upheaval, particularly at the federal level, but that also trickles down into local spaces. We soldier on!

Public Relations/Marketing

Hospital-Wide Brochure

The updated hospital-wide brochure is now finalized and ready for print. This new resource presents a unified overview of our services, facilities, and care options and will serve as a key communication tool for patients, families, and community partners. Distribution will begin soon across hospital locations, at community events, and online.

Department Marketing Development

To build a strong foundation for future marketing initiatives, we developed department information forms and distributed them to all departments. These forms are helping us gather consistent, accurate details to better promote services across various platforms, including social media, the website, and print materials.

Ongoing Website Review

We continue to assess and update department pages on the website for accuracy, consistency, and improved user experience. These incremental updates are part of a broader plan to refresh the site's design and functionality.

ACHC Accreditation Promotion

We are preparing materials to publicly highlight our recent ACHC accreditation. This accomplishment reflects our commitment to high-quality care and will be featured in upcoming print, digital, and social media messaging.

Pharmacy Marketing

In response to the closure of the Rite Aid pharmacy in Burney, we are actively promoting Mayers Pharmacy as a convenient, trusted alternative for residents. Outreach efforts emphasize personalized service, accessibility, and our broad pharmacy offerings.

Women's Health Promotion

We've launched a targeted campaign highlighting women's health services at the Mayers Rural Health Clinic, focusing on promoting Dr. Kelsey Sloat. The campaign includes flyers, social media outreach, and patient education about services such as cervical cancer screening, gynecological care, and fertility support.

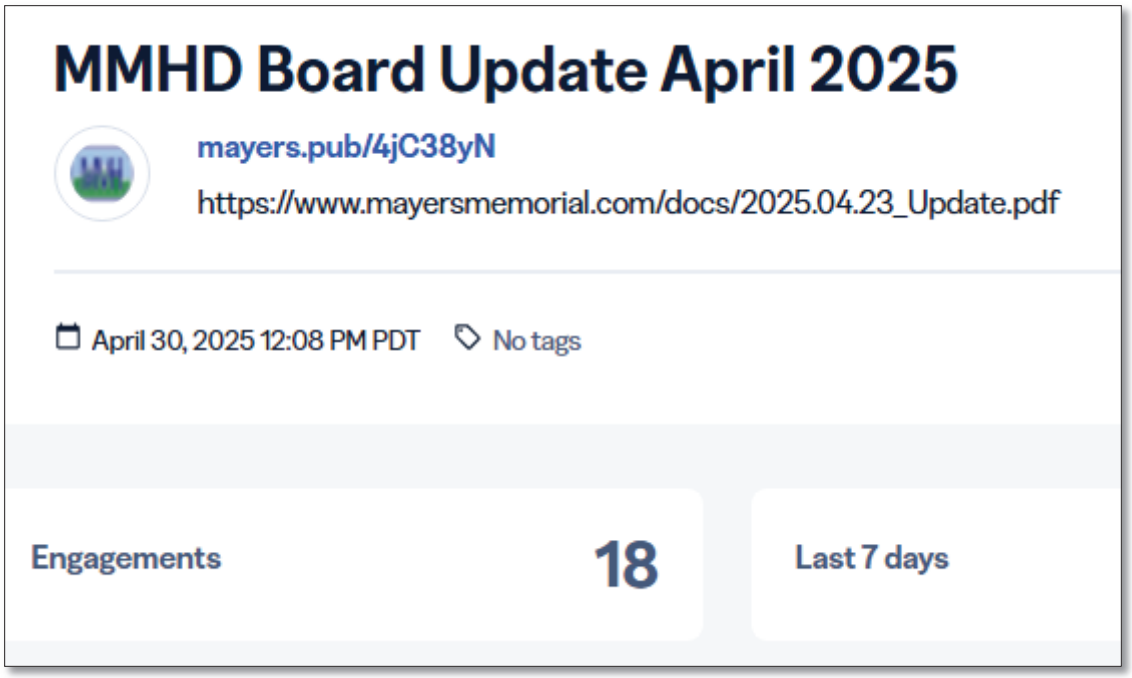
Health Fair & Monthly Campaigns

Preparations are underway for the upcoming Health & Wellness Fair. We continue to promote the event through multiple channels and align our outreach with monthly health observances to encourage community engagement and awareness of key services.

Planting Seeds/Growing Our Own Assemblies

TCCN and CPRO staff and Dana Hauge planned and facilitated assemblies at all three local elementary schools (Scheduled for May 27, 28, 29). The focus is on emergency plans for students. All students were given a "Go" Bag.

Board Updates – The link was clicked 18 times. I am working with the Intermountain News to have the Board Update published in the paper.



Tri-County Community Network

Children's Programs & Grants Report

Bright Futures

- Weekly Story Time and Tiny Tunes events continue strong in Burney. They serve TK classes across Big Valley, Fall River, Burney, and Round Mountain, reaching over 100 children and caregivers monthly.
- On April 24, Bright Futures, Burney Elementary, and Munik'chun Daycare hosted a "Parenting 101" Parent Café with 7 parents and 7 children.
- A community-wide Children's Clothing Swap was held May 11 from 1–4pm. Donations have been coming in steadily since February.

BOTVIN Life Skills Training (LST)

- The program was completed across the district, with 200 4th–6th graders participating. The final group finished April 30. It was funded by Shasta County's Asset Forfeiture Grant.

Grants & Program Initiatives

Backpacks to Home Food Pantry

- TCCN & FRJUSD applied for a $2,588 grant to launch a school-based food pantry.
- If approved, $862 worth of food will be delivered three times from Aug 2025–May 2026.
- FRJUSD will manage sustainability through student food drives.

Kid Fit

- Fully funded and scheduled for June–August 2025 across the region.
- Six events will promote health and ACEs awareness: Color Run, Take Me Fishing, Red White & Tunes concert, Water Wars, Art in the Park, and Family Swim Night.
- PG&E is sponsoring the Jr. Intern role and the community concert.

Shasta Substance Use Coalition

- TCCN joined in March, committing to ensure Intermountain youth benefit equally.
- Funded through county opioid settlement funds; TCCN's portion TBD.

Enhanced Care Management (ECM) Partnership

- $102,000 one-year contract supports services with MMHD, HANC, and Partnership HealthPlan.
- Case manager hired; onboarding pending with Partnership.
- "Wellness & Resource Hour" launched May 13, featuring weekly life skill topics led by Shay Corder.

Mindful Connections

- Secured a $2,000 private donation.
- Developing a community-based mental health response team with founder Doug Nunes and local volunteers.

Mayers Health Foundation CPR Training

- Over 60 FRJUSD seniors were certified as of April 29.
- Nearly $9,000 funded the effort.
- Zita Biehle led instruction; training completed by April 22.

HRSA Pathways Grant

- Submitted; pending response. Focuses on youth behavioral health services and career pathways.
- Partners: FRJUSD, BVUSD, MMHF, Shasta College, Siskiyous College, Shasta County Chemical People.

Community Partnerships

SMART Employment Services

- Pop-up job centers resume in spring; referrals continue year-round.

IMAGE (Intermountain Action Growth & Education)

- Met May 13 meeting at ICC. Launching the first round of community needs surveys.
- March meeting saw higher engagement; survey finalized and ready for May distribution.

PSA2

- Hosting a caregiver class May 29 at ICC from 2–4pm.

Communications & Events

Website & Social Media

- Weekly calendar updates and promotions ongoing.
- Learning library, job board, and monthly health observances coming soon.

Upcoming Events

- *Bright Futures* Weekly (0–5 years)
- *Senior Sip & Social* – Thursdays through May
- *Caregiver Class* – May 29, 2–4pm

Intermountain Community Center Update

- Offices and event space are **open**. Plans for the children's wing submitted to the county.

Mayers Healthcare Foundation

Denim & Diamonds Gala – "A Night at the Saloon"

Our annual gala was an enormous success! It was a fun and lively evening and a highly successful fundraiser. We are thrilled that the event raised **$55,114.94** for the Mayers Healthcare Foundation. A heartfelt thank-you to everyone who participated, volunteered, or contributed to making this a beautiful and impactful night.

MHF Health and Wellness Fair

Planning for this year's Health and Wellness Fair is well underway. The event is scheduled for **Saturday, June 14, 2025**, to align with and support the **Highway Garage/Ol' Merc Street Fair** on the same day.

- The venue has been secured.
- Updated invitation letters have been sent to community partners and MMHD Service Departments.
- The deadline for registration forms is **May 30, 2025**.
- We encourage everyone to share this information with others who may want to participate. Last year's event was a huge success, highlighted by **TCCN's Kid Fit Kickoff**, **Mayers Rural Health Clinic's Sports Physicals**, and the incredible support from our community partners. We're excited to see what this year brings!

MHF 25th Anniversary Golf Tournament

We are pleased to announce that the **25th Anniversary MHF Golf Tournament** will be held on **Saturday, August 2, 2025**. The venue has been secured, and planning efforts are well underway. A new website to register sponsorships, golfer foursomes, and pairs has been built for this year's Anniversary Tournament. We look forward to another beautiful day on the course.

- We request that the Board add a discussion to the **New Business** section of the agenda regarding **how the proceeds from this year's tournament should be allocated**. We also encourage everyone to share this exciting event with others who might want to support this special event this summer.

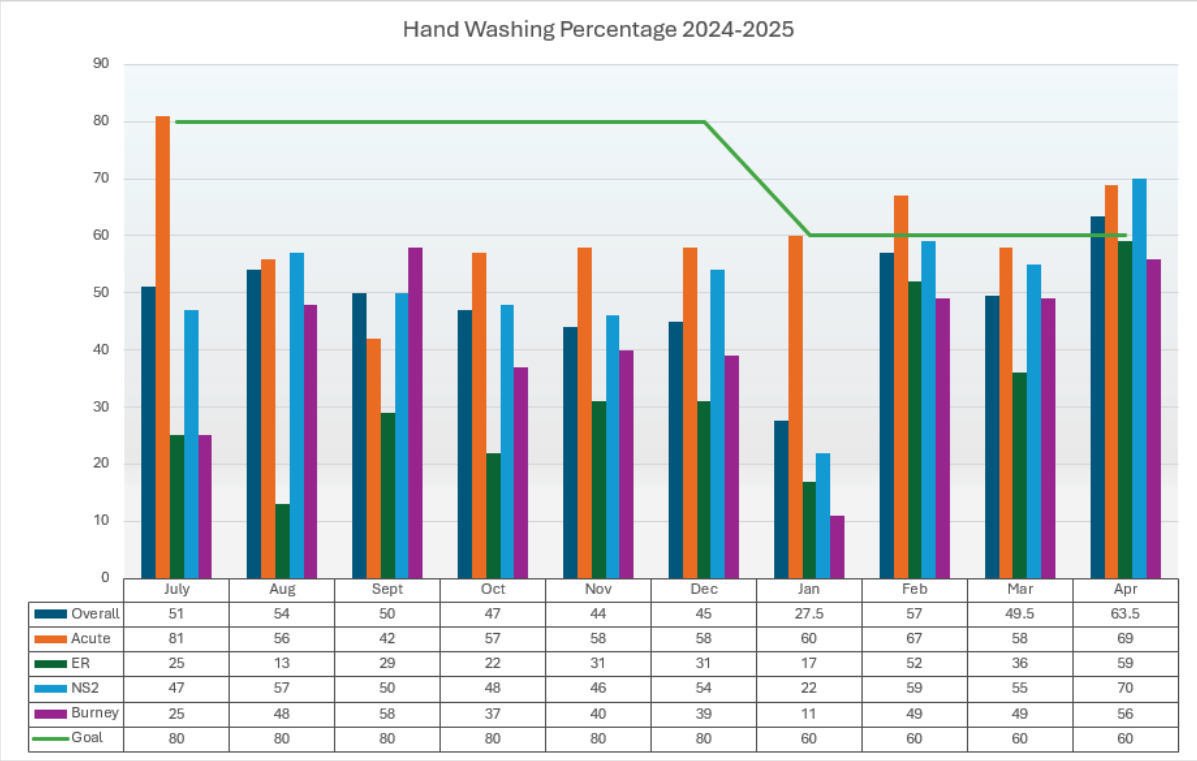
Thank you all for your continued support and dedication to the Foundation.

May Board Report

Clinical Division
5/19/2025

Infection Prevention

Mayers reached 60% hand hygiene compliance.



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Overall	51	54	50	47	44	45	27.5	57	49.5	63.5
Acute	81	56	42	57	58	58	60	67	58	69
ER	25	13	29	22	31	31	17	52	36	59
NS2	47	57	50	48	46	54	22	59	55	70
Burney	25	48	58	37	40	39	11	49	49	56
Goal	80	80	80	80	80	80	60	60	60	60

- The IP department celebrated World Hand Hygiene Day on May 05 by handing employees personal hand sanitizers and treats and offering a taco bar with ECC. IP also discussed with staff and managers the new incentive program for Hand Hygiene compliance for May and June.
- Kristen Stephenson, RN, Infection Preventionist, is working with Rowan Dietle in marketing to design a new personalized "Moments for Hand Hygiene" logo/poster that will be customized for Mayers and posted at each sink throughout the facility.
- IP has installed additional glove holders and wall bracket mounts for the sani-cloth wipes throughout the FRM and Burney LTC facilities to give them proper access to these tools to help better sanitize equipment and the environment.
- Project: IP is currently working with Dana (Safety) and Sherry (EVS) on updating the bloodborne pathogen policy and procedures for blood and chemical spills, large and small. The current (small) blood spill kits expire in September, so the goal is to complete this project by July and purchase new, updated kits that meet the proper standards.

- IP has begun rounding in clinic areas and providing them with additional wall-mounted hand sanitizers. Starting in June, it will begin monitoring HH compliance.

Retail Pharmacy

Rite Aid Closure

- Rite Aid is scheduled to close on June 16. The pharmacy team is actively working to accommodate the increased demand in preparation for an expected influx of prescriptions.
    - A second refrigerator is being brought into service from storage to handle increased volume.
    - A larger narcotic cabinet has been ordered. While an upgrade has been under discussion for some time, securing a greater inventory has made this a priority.

Security Enhancements

- Additional cameras will be installed at the retail pharmacy to enhance security and reduce the risk of diversion.

Mock Audit

- An on-site mock 340B audit is scheduled for June 16.

Mayers Pharmacy App

- The Mayers Pharmacy app is now live and available in the Apple App Store and Google Play Store. Users can search for "Mayers Pharmacy" to download it. Kristi Shultz, CPhT, Associate Manager, will be available at the Health Fair booth to assist anyone interested in signing up for the app.

Mailing Fee Update

- Due to the increased volume of 340B prescriptions from Mountain Valleys Health Center (MVHC), Kristi successfully negotiated an increased monthly mailing fee with MVHC, effective May 01.

Hospital Pharmacy

Service Excellence Initiative

- Katrina William, CPhT, is excited to volunteer as Service Excellence Advisor and looks forward to the June project orientation.

Revenue Cycle

- Katrina Williams, CPhT, updated Rev Codes on all inpatient and outpatient injectables and assigned the correct billing unit with the help of the WipFli Cerner consultant. Approximately 1200 line items were reviewed.

California Office of Healthcare Affordability

- Pharmacy staff is working with Travis Lakey, CFO, on inflationary factors related to high-cost drugs. He is also working with a committee looking for acceptable reasons for hospitals to miss their cost targets.

Imaging

Echocardiography (Echo)

- Dr. Frye met with Kim Elliot, Sonographer, on May 09 and conducted a series of studies under direct supervision. The scans were successful. The next step is for Dr. Frye to observe Kim performing scans on a patient with known cardiac abnormalities to ensure diagnostic accuracy.

Magnetic Resonance Imaging (MRI)

- The department successfully **passed** its fire inspection, enabling us to submit the required documentation to the California Department of Public Health (CDPH).

Fuji System Integration

- Providers can now view imaging directly through the Cerner platform, improving accessibility and workflow efficiency.

Ultrasound – Dr. Sloat

- Cerner orders for ultrasound have been created and are scheduled to move into production this week.

Equipment Maintenance

- Preventative maintenance was completed on both CT and X-ray (XR) systems. Physics testing is currently underway to ensure continued compliance and image quality.

Low-Dose CT Implementation

- The low-dose CT study has been configured in Cerner and the imaging modality. Once the radiologist finalizes and approves the protocol, scheduling for these studies can begin.

Clearpath Interface

- We have initiated the Clearpath project, which facilitates the delivery of imaging studies to patients and outside providers.
    - The kickoff meeting was on May 07.
    - Our internal IT team actively collaborates with Clearpath's IT team on interface development.
    - Clearpath is preparing patient-facing materials for review. Upon receipt, our Public Relations team will review and approve the content for publication.

Respiratory Therapy

RT Manager Position

- An offer for the RT Manager position has been extended, and a counteroffer has been received.
- HR is evaluating how much the offer can be increased and considering creative options, such as an additional hourly rate bump after one year of above-average performance.

Staffing

- An offer was sent to a respiratory traveler, who has accepted.
- The anticipated start date is May 27, pending timely completion of compliance requirements.

Rural Health Clinic

Providers

- Dr. Sloat is seeing an increase in her patient load week after week as word gets out.

Luma Health

- Kimberly Westlund, Clinic Manager, and Jeff Miles, IT Manager, are collaborating closely with Luma Health (a patient communication platform) to extract the required data from Cerner to launch the referral and patient reminder features by June 30.

OB Ultra-sound

- Dr. Sloat is performing ultra-sounds for OB patients in the clinic. We have process work to do in Cerner to drop the billing. Procedures are being billed manually for now.

Care Coordinator

- The job description is complete, and the position is posted.

Physical Therapy / Cardiac Rehab

High School CPR

- Our Cardiac Rehab Coordinator, Zita Biehle, represented Mayers Memorial Hospital and the cardiac rehab program by mentoring a senior project for Isiah Wortman, which this past month led to the completion of 56 high school students receiving their CPR certifications.

Holter Monitors

- Cardiac Rehab is now producing all Holter monitor clinical interpretations in-house for patients 18 years and older. Only pediatric patients are still being completed by Dr. Khan's office.

Service Excellence Initiative

- Physical therapy employees Daryl Schneider and Laura Sanders have accepted their upcoming positions in the Service Excellence Initiative as a Team Captain for Oasis: Service Standards/Keywords and Service Excellence Advisor, respectively.

Referral Process

- Physical therapy continues to be able to contact patients within 24 hours of receiving referral orders, and no orders currently without a call placed to them.

Laboratory

Cerner/PointClickCare (PCC) Integration

- The PCC/Cerner integration proposal has been submitted to the CEO for a final decision on whether to proceed with any of the options presented.

Procalcitonin

- Procalcitonin is a biomarker that detects systemic inflammation in the body and is used in diagnosing sepsis.

- Procalcitonin interface connectivity is finished as of May 02, 2025.

Quantiferon Tuberculosis Testing

- This test measures how the immune system reacts to TB proteins and is a more accurate diagnosis than traditional skin tests.
- Quantiferon TB Gold interface connectivity is finished as of May 15, 2025.
- Quantiferon TB Gold live starts on May 19, 2025.
- A draft Quantiferon TB Gold screening policy on Outpatient Medical Patients receiving immune modulators will be reviewed at the next Outpatient Medical Committee Meeting.

Charge Capture

- Billing charges for Procalcitonin, TB QuantiFERON, Yeast ID, and Gram-negative sensitivity testing are looking good, and the charges are dropping.

Staffing

- A lead Certified Phlebotomy Technician has been hired and has started working.
- An applicant for Certified Phlebotomy Technician accepted the offer, and her tentative orientation date is May 22, 2025.

Telemedicine

- See the Attached Report

NURSING SERVICES BOARD REPORT

May 2025- Reporting for April

CNO Board Report

SNF addresses staffing challenges while advancing education, policy updates, and family engagement. The ED, Surgery, and OPM teams excel in patient care and staff development, with a strong focus on documentation, training, and quality improvement. Our Ambulance and Social Services teams are stable and engaged, and our Clinical Education department has been instrumental in maintaining CEU compliance, skills validation, and staff readiness. Across the board, our teams are committed to excellence, compliance, and continuous improvement.

SNF

April 2025

Census

- Resident Census= Seventy-Three (74)
- Fall River= Thirty-two (30)
- Burney= Twenty-Two (24) general resident population and
- Burney Memory Care= Nineteen (20) residents
- Three (3) external candidates on the Memory Care waitlist
- One (1) external candidate for the general population

Staffing

- We have met regulatory staffing requirements for the month.
- The high percentage of agency utilization is a primary challenge, complicating hardwiring new implementations. To address this, we have:
- Hired four new team members: one (1) Unit Assistant, two (2) LVN's and one (1) CNA
- We will continue discussions with Nurses in Professional Healthcare (NPH) to align registry training and review role shift duties, ensuring consistency and effectiveness across the board. We will also continue aggressively screening, interviewing, and job-offering viable candidates.

Updates

- Staff Development
    - Preparation: We successfully completed 98 of 98 Policy & Procedures revisions this month.
    - Departmental Education: This month, CNA realignment orientation was completed, achieving an impressive 97% compliance, further solidifying

the commitment to exceeding the annual priority goal of eighty percent (80%).
    - Departmental Education: LVN realignment orientation was completed, achieving 98%, which again exceeded our goals of 80%
    - Departmental Education: Realignment will continue with all new hires, and a Charge Nurse Realignment will happen in June, along with the Activities Department.
- Regulatory
    - Wander Guard Alert System: Installation projected for May 19.
    - CDPH reinstated Mayers Memorial Healthcare District in collaboration with the Shasta College CNA program. The new class will start at the end of June.
    - Ninety-eight of Ninety- eight (98) policies revised in preparation of the projected May-June survey by the California Department of Public Health (CDPH).
    - CDPH Visited us last month, to review 9 outstanding self-reports from 9/2024-04/2025. The Statement of Deficiency was received, and a plan of correction was sent and approved by CDPH, one (1) deficiency was received under tag 609 for failure to report timely.
- Family engagement:
    - We canceled the Cruise Day for our residents in Fall River SNF due to a COVID outbreak. We plan to reschedule for Monday, the 12th. Burney SNF celebrated it on May 1, which included foods from Mexico, Italy, and India. It was a success for both the families and residents. A huge shout out to the Dietary staff.
    - The monthly Family Council Meetings have been a success. The Ombudsman has been present and actively engaged in them.

Acute

- Scheduled to report to Board

Emergency Services

April 2025

- Total treated patients: 377
- In-patient Admits: 22
- Transferred to higher level of care: 18
- Pediatric patients: 65
- AMA: 8
- LWBS: 0
- Present to ED vis EMS: 43

Staffing:

- Required: 8 FTE RNs, 1 PTE RNs, 2 FTE Techs, 1 PTE Tech
- Utilizing 2 FTE contracted RNs
    - One Day RNs covering LOA
    - One Noc RN to cover until NOC FTE completes orientation
- ED Manager also serves as:
    - Clinical Project Manager for Cerner
    - Learning Coordinator
        - Assigning learning journeys to new contracted and hired staff
    - Ongoing resource for clinical areas in the facility
    - Collaborating with internal teams on referral processes
    - Attended the Cerner Conference in Kansas City
- Open Positions:
    - FTE NOC: Position filled, with orientation planned for a minimum of 6 months
    - FTE ED Tech: Position filled. Planning for 6-to-8-week orientation

Updates:

- Centering staff education around ACHC guidelines:
    - Policy signs off from our new or amended policies.
- Continued education and daily auditing of charts to reduce late charges, increase captured revenue, and improve documentation standards.
    - Current DNFB for late charges is $0.00.
- Completed 100% of all ED FTE staff annual education as well as HALO (High Acuity Low Occurrence) training in April
- Our ED nurse call-back system continued to reach 30% of patients seen in the ED each month, ensuring they receive a follow-up call within 7 days of their visit.
    - Received positive feedback from the community so far.
    - Feedback and data will be used to enhance overall care and patient education.
    - Monitoring the rate of 72-hour returns to the ED to assess any decrease with the program.

Ambulance

April 2025

- 41 ambulance requests
- 7 of those were transfers
- We had several days of hands-on training as required for EMT and Paramedic Skills review. This was done along with the nursing staff.
- Ambulance Manager out on medical leave June 4.

Staffing:

- Now fully staffed

Updates:

- All Ambulances are up and running.

Surgery:

Referrals:

- 32 - Referrals received
- All referred patients have been called. 2 pending Cardiac Clearance. 5 unable to reach for scheduling.
- Appointments are scheduled 1-10 days after referrals are received. Typically, procedures can be offered within 1 month.
- 13- Total procedures performed in April 2025
- 19 were scheduled in April: 6 patients cancelled with short notice or did not show on the day of the procedure.

Staffing:

- Part-time Endoscopy Technician Position: Position approved to hire and train a Part-time endoscopy technician to support the Surgeon and tech during procedure days. No applicants currently.

ACHC Survey POC update:

- Facilities received a Survey citation related to Surgical suite air exchange and humidity levels. A plan of corrections was accepted, with a plan in place to repair or replace the current HVAC unit for the Operating room. The humidifier has been delivered, and installation is scheduled for the week of 5/12 per maintenance.

Equipment Upgrade requests update:

- Installation and in-service for new Olympus Gastroscopes, a light source, and a video processor are scheduled for 5/5. Rental equipment will be returned after the new installation.

Outpatient Medical

Updates this month for April 2025

- Census OPM: February 109 patients, March 120 patients, April 142 patients
- Continued work on policies and quality reporting, up to date on policies and quality reporting. Working more with the new Lippincott
- Conducting short education and planned teaching for small groups of staff on: PICCs, Vacs, Wound care, Ostomy care, Pressure injury prevention

- Attended skills fair to educate Acute, ED, and OPM clinical staff on PICCs/ports, Vacs, Ostomy care, and Pressure injury prevention. I have a few make up classes for staff to complete
- Working with LTC with their new orientation process to have nursing staff have a day in the wound clinic for experience and wound care training. Waiting for an update on the LTC staff schedule that will be coming to wound clinics
- Working on heath and wellness fair booth
- Training new staff that is coming into OPM to help cover absences. Working on a plan to get them up to speed on OPM processes and educating them on specialty procedures done in OPM
- Working on a spreadsheet for documentation on OPM goals and working on new goals
- We have a new increase in OPM with 33 central lines accessed in one month. Proud of the OPM team and their skillset to manage these patients
- Appreciate everyone's teamwork to cover staff OPM PTO in April and May.

Social Services

April 2025

- We did not have any admissions to LTC in April.

Updates:

- I have been starting my day at the Burney Campus to provide more support to the residents.
- We have been focusing on getting ready for our state survey in LTC.

Clinical Education

April 2025

Certifications/Licenses:

- BLS completed on 4/15/25 with 6 attendees. The following BLS class is 5/20/25, and 6 are scheduled to attend.
- ACLS-completed in April in the McArthur classroom.
- CEU collaboration dates are scheduled for CNA staff who have requested assistance. These 1:1 sessions discuss their current CEU status, potential CEU needs to meet their requirements, and assistance with compiling the pertinent forms/certificates for renewal. Each session is individualized to each CNA per their need/request.

Updates

Safe Patient Handling Refresher Course Training (Annual Training for all DHW's for title 8 §5120):

- Completed the annual SPHM refresher/initial course.
- The next refresher course for CNA staff is set for October with the CNA skills fair and validation.

In-Service/CEU's:

- March/April CNA Skills Fair/Validation and SPH: Body Mechanics:
  - Classes are completed and continued data entry is being met. Skills/topics covered were Falls, ADL's, Primary Prevention, Pressure Injuries, and SPH body mechanics. The "make up" day for those who did not attend within the annual compliance date was completed 5/6/25. The subsequent CNA Skills Fair/Validation and SPH: Body Mechanics is scheduled for October.
- Dementia and Abuse Class:
  - A 5-hour Dementia and 3-hour Abuse class was conducted on May 5, 2025. CNA staff appeared receptive to signing up for the class through Relias and then confirming with Misty in Scheduling, which assists with tracking CEUs. This class had 10 attendees.
  - The next Dementia and Abuse class is scheduled for June 16, 2025, and 10 CNAs are currently requesting to take it.
- Nutrition and Hydration Class with Lani Martin, RD:
  - 2 new dates are to be added to the Education Calendar for the year to accommodate staff in implementing the new diet standard and thickening liquids.
- Up-Coming Education Calendar Renewal for CNA's:
  - The renewal date for the CDPH-approved CEU Calendar is approaching. CNA staff are being asked for input regarding their needs with educational topics, class dates and times, or any concerns regarding CEUs. From their responses, the times and dates of classes are appreciated- no time changes or dates are needed. CNA staff have mentioned topics of interest.

Ongoing Projects:

- Continual assistance as necessary with SNF pillars/goals
- Data entry for previous CEU classes for CNA staff for CDPH and class content updating
- Continue with the bi-monthly SPHM DHW Initial Orientation course for newly hired/re-hired DHWs to assist with compliance.
- Continued collaboration with CNA staff regarding renewals/re-testing. Continued reminders to CNA staff about being mindful of CNA renewal dates and requirements.
- Continued email reminders to CNA staff regarding Evercheck notifications and maintaining BLS renewals.
- Communication with the CNA staff regarding the upcoming CEU classes calendar is posted in Relias and sent via email.

Respectfully Submitted by Theresa Overton, CNO

Chief Executive Officer Report
Prepared by: Ryan Harris, CEO

Hospital Week
The Employee Communication Committee successfully hosted Hospital Week from May 11-17, and it was a fantastic week full of engaging activities. One highlight was the Build-A-Bear activity, which Libby Mee and Ashley Nelson introduced after experiencing it at a recent conference. Staff members enjoyed creating their own Build-A-Bear kits, featuring a variety of animals. The completed bears were then donated to our residents and TCCN for distribution to local children. The event was enjoyable for our team and made a meaningful positive impact on our community.

Collaboration
Heritage MRI is actively progressing with our Mobile MRI unit's licensing and approval process. This effort is in conjunction with the work the CEO group is doing as we work towards finalizing a contract for our owned MRI between the five hospitals. Our goal is to enhance diagnostic capabilities and improve access to imaging services for our patients and residents, ensuring timely and efficient care.

Pit River Health is currently in the process of expanding its mental health services by onboarding additional therapists. Once the new staff members are hired, a logistics meeting will be scheduled with nursing and clinical leadership to discuss the process for providing talk therapy services to our residents. This collaboration aims to ensure a smooth integration of this new service into our existing resident support systems, ultimately enhancing the care and resources available to our residents.

Strategic Priorities Update
An updated strategic plan will be presented to the Board Strategic Committee later this month. It will include a summary of the progress made on FY25 priorities and proposed priorities for FY26. The updated plan also incorporates assessing key risk factors and corresponding mitigation strategies for FY26, ensuring we are prepared to address potential challenges and continue advancing our organizational goals.

Travel
This past month, I implemented a new travel process to enhance oversight and improve reporting for staff attending conferences. I am pleased to report that the new process is proving effective, allowing us to track our investments in professional development better and ensure that employee participation yields tangible benefits for the district. By establishing more straightforward guidelines and accountability measures, we foster more intentional attendance and align conference participation with our organizational goals. The success of this initiative has demonstrated its value, and the new process will be formally handed over to executive leadership in July to ensure ongoing oversight and continuous improvement.

California Meal Premiums

We continue to see the ongoing success of the changes implemented regarding California meal premiums. Thanks to the dedication of our leadership team, we have maintained a strong focus on ensuring that meal premiums are used appropriately. Their diligent monitoring of staff taking their lunches within designated timeframes and for the correct duration has been instrumental in this progress.

Starting in June, we will transition from weekly to pay period tracking to streamline the process. Staff will also be required to specify the reason for their meal premium in Paycom, giving managers clear visibility and understanding of each approval. These adjustments will help reinforce accountability and ensure continued proper utilization of meal premiums across the organization.

Service Excellence Initiative
Our Service Excellence Initiative will officially launch in June. I am excited to see our organization embrace a renewed focus on service excellence and look forward to witnessing how this program transforms our culture over the next three years.

Medication Errors
Earlier this month, we held a productive meeting focused on reducing medication errors, involving our providers, quality team, nurse leadership, and me. We developed a list of actionable items and changes that will be implemented to improve our medication error rates. These initiatives will include enhanced nursing accountability, provider order processes and formats updates, increased transparency and communication regarding medication errors, and greater consistency across departments and facilities.
I look forward to seeing positive trends emerge and sharing these improvements with the Quality Committee and the Board of Directors.

Meeting with Congressman LaMalfa
I have now met with Congressman LaMalfa's office and himself. We effectively communicated our concerns regarding how potential cuts to Medicaid (Cal) programs and supplemental payments could impact our district and critical access hospitals. We emphasized that such cuts could lead to reduced services or even the complete closure of certain hospitals, affecting not only Medicaid recipients but all patients in our communities. We also highlighted the broader implications for our local areas, explaining that hospitals and healthcare services serve as the economic backbone of many rural communities, and their closure would have far-reaching effects beyond healthcare, impacting local employment and community stability.

Overall, I think the meetings struck a good balance between addressing the concerns of large and small hospitals. The variety of hospitals represented and the complexities around reimbursement models may have caused some initial confusion—what benefits one hospital might not be suitable for another. Nonetheless, I believe these discussions were productive. While it remains uncertain whether our advocacy will influence policy decisions in the long run, I am hopeful that raising awareness about the specific challenges faced by our hospitals will help inform future considerations.

DHLF Board of Directors Meeting & Potential Medicaid Cuts
On May 23rd, Travis attended the DHLF Board of Directors meeting in person, while I participated virtually. The primary focus of the meeting was the ongoing discussions about potential Medicaid cuts. This is a fluid and evolving situation, with many uncertainties about the exact impact these cuts could have on our rural district hospital.

Recent reports indicate that proposed Medicaid reductions could significantly affect funding for hospitals like ours, potentially leading to decreased reimbursements and impacting our financial sustainability. Currently, there is no finalized decision, but the threat remains serious. Once the situation becomes clearer, we will initiate a change management project to develop an impact mitigation strategy, ensuring our healthcare district remains viable and continues to provide essential services in our communities into the future.