

## MEETING NOTICE

### Governing Board

A regular meeting of the Board of Directors of the Southern Humboldt Community Healthcare District will be held on February 25, 2026, at 1:30 p.m., by teleconference and in-person. Members of the public may participate virtually via Webex or telephone, or appear in person at the Sprowel Creek Campus at 286 Sprowel Creek Road, Garberville, California 95542.

Call-In Information: Join by phone +1-415-655-0001 US Toll

Webex Link:

<https://shchd.webex.com/shchd/j.php?MTID=m65c1024281b4ef67076bbe032ec5f0d9>

Written comments may also be sent to [boardcomments@shchd.org](mailto:boardcomments@shchd.org). Comments received no later than two hours prior to the start of the meeting will be provided to the Board or may be read aloud or summarized during the meeting. Members of the public may also comment in real time during the meeting by attending in person or via Webex or phone.

## Agenda

Page	Item
	A. Call to Order
	B. Approval of the Teleconferencing of a Board Member
	C. Approval of the Agendas
	D. Public Comment on Non-Agendized Items <b>See below for Public Comment Guidelines</b>
	E. Board Member Comments <b>Board members are invited to address issues not on the agenda and to submit items within the subject jurisdiction of the Board for future consideration. Please limit individual comments to three minutes.</b>
	F. Announcements

G. Consent Agenda –

- 8 - 12                    1. Approval of Previous Minutes  
                                 a. Governing Board Meeting, January 29, 2026
- 13 - 21                    2. SHCHD New and Updated Policies  
                                 **Radiology**  
                                 a. Mammography Technologist  
                                 b. Radiology Daily Procedures  
                                 c. MRI Safety
- 22 - 27                    **Infection Prevention**  
                                 d. Definitions of Healthcare Associated Infections  
                                 e. Glucometer Cleaning  
                                 f. Infection Prevention Education
- 28 - 41                    **Dietary**  
                                 g. Dietary Disaster Plan  
                                 h. Dietary Employee Health  
                                 i. Dietary Policy and Procedure Manual  
                                 j. Dietary Purchasing  
                                 k. Equipment Maintenance  
                                 l. Food Preparation and Preparation Area  
                                 m. Garbage and Rubbish Disposal  
                                 n. Hiring, Orientation and Training of Dietary Employees
- 42 - 43                    **PFS**  
                                 o. Billing Grievance
- 44 - 69                    **Pharmacy Obsolete Policies**  
                                 p. Pyxis Policy  
                                 q. Managing Temperature Excursion  
                                 r. Medication Administration  
                                 s. Compounding Medications  
                                 t. Drug Recall  
                                 u. High-Risk Medication  
                                 v. Defective Medications  
                                 w. Disposition of Medications  
                                 x. Furnishing Medication Orders  
                                 y. Prescription Pads  
                                 z. Crash Cart  
                                 aa. Loss and Diversion  
                                 bb. Compassionate Access to Medical Cannabis  
                                 cc. Procurement of Pharmaceuticals  
                                 dd. Patient's Own Medication  
                                 ee. Medication Monitoring and Storage

- ff. End-of-Life Comfort Care
  - gg. General Medication Room Operations
  - hh. Reporting Medication Errors and Adverse Events
  
  - 3. Quarterly Reports - (Feb, May, Aug, Nov)
    - a. Human Resources – Season Bradley Koskinen, HR Manager
    - b. Foundation – Chelsea Brown, Outreach Manager
    - c. Operations – Kent Scown, Chief Operations Officer – See Report
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## Approval of Consent Agenda

- H. Last Action Items for Discussion
    - 1. Approval to add Darrin as an authorized signer in VerifyStream to approve Medical Staff Reappointments on behalf of the Board.
  - I. Correspondence, Suggestions, or Written Comments to the Board
  - J. Administrator’s Report – Matt Rees, CEO
    - 1. Department Updates
      - a. Milestones
      - b. January Employee Anniversaries
        - 1 Year: HR Assistant Michelle Karlson-Siran, Nurse Jenifer LaRue, Nurse Regina Schuetzle
        - 10 CEO Matt Rees
      - c. Approval of the January Financials - Paul Eves – See Supplemental Packet
      - d. CNO Report – Adela Yanez – See Report
      - e. Family Resource Center – Amy Terrones – Mar and Oct – See Report
- 72 - 76  
77
- K. Old Business
    - 1. Update on Medical Staff Bylaws
    - 2. Clinic Credentialing Update.
    - 3. FPPE/OPPE Update
    - 4. Optometry Statistics According to Budget.
    - 5. Approval of Resolution 26.02 Adopting an Initial Study/Mitigated
- 78 - 88

Negative Declaration

L. New Business – None

M. Parking Lot -None

N. Meeting Evaluation

O. New Action Items

P. Next Meetings

1. Medical Staff Committee – Thursday, April 9, 2026, at 12:30 p.m
2. Medical Staff Policy Development Committee – Tuesday, April 14, 2026, 10:00 a.m
3. QAPI Meeting – Wednesday, April 8, 2026, at 10:00 a.m.
4. Finance Committee – Friday, April 24, 2026, at 10:00 a.m.
5. Governing Board Meeting – Thursday, April 30, 2025, at 1:30 p.m.

Q. Adjourn to Closed Session

1. Closed Session
2. Update on Peer Review, Credentialing, and Appointment/Reappointments – Medstaff
3. Compliance, Risk, and Reports of Quality Assurance Committees **[H&S Code § 32155]** - Kristen Rees, CQCO
4. Annual Hospital Periodic Evaluation Report FY 2025 – See Report
5. Quarterly Reports - None
  - a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec.
  - b. Patient Safety – Mar., June, Sept., Dec. – See Report
  - c. Medication Error – Feb., May, Aug., Dec. – See Report
6. Approval of Medical Staff Appointments/Reappointments **[H&S Code § 32155]**
  - a. **Atul Patel, MD** - (OnRad) Reappointment as Active status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2028
  - b. **Samuel Salen, MD** - (OnRad) Reappointment as Active status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2028
  - c. **Alix Vincent, MD** - (OnRad) Reappointment as Active status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2028

- d. **Steven White, MD** - (OnRad) Reappointment as Active status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2028
- e. **Gregory Orth, MD** - (OnRad) Reappointment as Active status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2028
- f. **Huma Qureshi, MD** - (OnRad) Reappointment as Active status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2028
- g. **Joseph George, MD** - (OnRad) Initial Appointment as Provisional status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2027
- h. **Sean Feinberg, MD** - (OnRad) Initial Appointment as Provisional status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2027
- i. **Charles B. Davis, MD** - (OnRad) Initial Appointment as Provisional status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2027
- j. **James Collins, MD** - (OnRad) Initial Appointment as Provisional status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2027
- k. **Karl Magsamen, MD** - (OnRad) Initial Appointment as Provisional status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2027
- l. **Abbas Chamsuddin, MD** - (OnRad) Initial Appointment as Provisional status in Teleradiology – Diagnostic Radiology privileges from April 1, 2026 to March 31, 2027
- m. **Lauren Beaman, ASW** - (SLS) Initial Appointment as Provisional status in Mental Health Counselor/Therapist privileges from April 1, 2026 to March 31, 2027
- n. **Justin McGee, LPCC** - (SLS) Initial Appointment as Provisional status in Mental Health Counselor/Therapist privileges from April 1, 2026 to March 31, 2027
- 7. Personnel Matter –Evaluation § 54957
  - a. 360 Evaluations Admin
- 8. Personnel Matter –Evaluation § 54957
  - a. CQCO Kristen Rees

R. Adjourn Closed Session; Report on Any Action Taken, If Needed

S. Resume Open Session

T. Adjourn

Abbreviations

<i>ACHD</i>	Association of California Healthcare Districts	<i>ACLS</i>	Advanced Cardiac Life Support Certification
<i>AR</i>	Accounts Receivable	<i>BLS</i>	Basic Life Support Certification
<i>CAIR</i>	California Immunization Registry	<i>CEO</i>	Chief Executive Officer
<i>CFO</i>	Chief Financial Officer	<i>CMS</i>	Centers for Medicare and Medicaid Services
<i>CNO</i>	Chief Nursing Officer	<i>COO</i>	Chief Operating Officer
<i>CPHO</i>	Certified Professional in Healthcare Quality	<i>COO</i>	Chief Quality and Compliance Officer
<i>EMR/EHR</i>	Electronic Medical Record/Electronic Health Record	<i>ER</i>	Emergency Room
<i>FTE</i>	Full Time Equivalent/Full Time Employee	<i>HIM</i>	Health Information Management
<i>HRG</i>	Healthcare Resource Group	<i>HVAC</i>	Heating, Ventilation and Air Conditioning system
<i>IGT</i>	Intergovernmental transfer	<i>IT</i>	Information Technology
<i>JPCH</i>	Jerold Phelps Community Hospital	<i>LCSW</i>	Licensed Clinical Social Worker
<i>LVN</i>	Licensed Vocational Nurse	<i>MPH</i>	Master of Public Health
<i>OBS</i>	Observation	<i>PALS</i>	Pediatric Advanced Life Support Certification
<i>PFS</i>	Patient Financial Services	<i>QAPI</i>	Quality Assurance Performance Improvement
<i>OIP</i>	Quality Improvement Project/Program	<i>RN</i>	Registered Nurse
<i>SHCC</i>	Southern Humboldt Community Clinic	<i>SHCHD</i>	Southern Humboldt Community Healthcare District
<i>SNF</i>	Skilled Nursing Facility	<i>SWG</i>	Swing beds
<i>DO</i>	Doctor of Osteopathic Medicine	<i>Resident</i>	Patients Residing in the Skilled Nursing Facility

**PUBLIC COMMENT ON MATTERS NOT ON THE MEETING AGENDA:** Members of the public are welcome to address the Board on items not listed on the agenda and within the jurisdiction of the Board of Directors. The Board is prohibited by law from taking action on matters not on the agenda, but may ask questions to clarify the speaker’s comment and/or briefly answer questions. The Board limits testimony on matters not on the agenda to three minutes per person and not more than ten minutes for a particular subject, at the discretion of the Chair of the Board.

**PUBLIC COMMENT ON MATTERS THAT ARE ON THE AGENDA:** Individuals wishing to address the Board regarding items on the agenda may do so after the Board has completed their initial discussion of the item and before the matter is voted on, so that the Board may have the benefit of these comments before making their decision. Please remember that it is the Board’s responsibility to discuss matters thoroughly amongst themselves and that, because of Brown Act constraints, the Board meeting is their only opportunity to do so. Comments are limited to three minutes per person per agenda item, at the discretion of the Chair of the Board.

**OTHER OPPORTUNITIES FOR PUBLIC COMMENT:** Members of the public are encouraged to submit written comments to the Board at any time by writing to SHCHD Board of Directors, 733 Cedar Street, Garberville, CA 95542. Writers who identify themselves may, at their discretion, ask that their comments be shared publicly. All other comments shall be kept confidential to the Board and appropriate staff.

**IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT,** if you require special accommodations to participate in a District meeting, please contact the District Clerk at 707-923-3921, ext. 1276 at least 48 hours prior to the meeting.”

*\*Times are estimated*

**COPIES OF OPEN SESSION AGENDA ITEMS:** Members of the public are welcome to see and obtain copies of the open session regular meeting documents by contacting SHCHD Administration at (707) 923-3921 ext. 1276 or stopping by 291 Sprowel Creek Rd, Garberville, CA 95542 during regular business hours. Copies may also be obtained on the District's website, [sohumhealth.org](http://sohumhealth.org).

*Posted March 20, 2026*

## Governing Board

**Date:** February 25, 2025  
**Time:** 1:30 p.m.  
**Location:** Sprowel Creek Campus and Via Webex Conferencing  
**Facilitator:** Board President, Kevin Church

## Minutes

**The following people attended at Sprowel Creek Campus and via Webex**

**The Governing Board consists of Corinne Stromstad, Kevin Church, Yvonne Hendrix, Galen Latsko, and all in person**

**Not Present: Chris Schille**

**Also in person:** Administrative Assistant Darrin Guerra, CFO Paul Eves, CEO Matt Rees, HR Manager Season Bradley-Koskinen, CNO Adela Yanez, and Compliance Lead Coral Ciarabellini

**Also via Webex:** HIM Manager Remy Quinn, Credentialing Specialist Aeryn Thompson, Chief of Staff Dr. Raisoni, CQCO Kristen Rees, Business Development Director Ryan Staples, and COO Kent Scown

A. Call to Order – Board President Kevin Church called the meeting to order at 1:31 pm.

B. Approval of the Teleconferencing of a Board Member - None

C. Approval of the Agenda

Motion: Corinne Stromstad motioned to approve the agenda  
Second: Galen Latsko  
Ayes: Corinne Stromstad, Galen Latsko, Yvonne Hendrix, and Kevin Church  
Noes: None  
Not Present: Christopher Schille  
Motion Carried

D. Public Comment on Non-Agendized Items - None

E. Board Member Comments - None

F. Announcements - None

G. Approval of Consent Agenda

1. Approval of Previous Minutes
  - a. Governing Board Meeting, January 29, 2026
  
2. SHCHD New and Updated Policies
  - Dietary
    - a. Cooling Large Cuts of Meat
  - Pharmacy
    - b. Defective Medications
    - c. Disposition of Medications
  - Engineering
    - d. Medical Waste Management
  
3. Quarterly Reports - (Feb, May, Aug, Nov)
  - a. Human Resources – Season Bradley Koskinen, HR Manager
  - b. Foundation – Chelsea Brown, Outreach Manager
  - c. Operations – Kent Scown, Chief Operations Officer – Not Received
    - i. This item was tabled. Kent will submit his quarterly report to the March meeting.

Kevin Church pulled G.4.b and c.

Motion: Corinne Stromstad motioned to approve the consent agenda.  
Second: Yvonne Hendrix  
Ayes: Corinne Stromstad, Galen Latsko, Yvonne Hendrix, and Kevin Church  
Noes: None  
Not Present: Christopher Schille  
Motion Carried

Motion: Corinne Stromstad motioned to approve agenda item G.4.b  
Second: Yvonne Hendrix  
Ayes: Corinne Stromstad, Galen Latsko, Yvonne Hendrix, and Kevin Church  
Noes: None  
Not Present: Christopher Schille  
Motion Carried

H. Last Action Items for Discussion

1. Optometry Statistics According to Budget
  - a. Matt was unable to acquire this information and will bring it back to the March meeting.

2. Board Credentialing by Proxy Access for Darrin
  - a. After discussion with the Credentialing team, we determined that we will be able to add Darrin to the Credentialing program to sign off on behalf of the Board. An official vote will be made at the March meeting.
3. Peer Review Policy

Motion: Galen Latsko motioned to approve the Peer Review Policy  
 Second: Yvonne Hendrix  
 Ayes: Corinne Stromstad, Galen Latsko, Yvonne Hendrix, and Kevin Church  
 Noes: None  
 Not Present: Christopher Schille  
 Motion Carried

4. VSP Update
  - a. Matt and the PFS team have had multiple meetings regarding VSP and are currently working on resolving the issues with receiving commercial.

I. Correspondence Suggestions or Written Comments to the Board – None

J. Administrator’s Report – Matt Rees, CEO

Matt shared that in 2026, they passed a regulation that insurance companies must credential providers within 90 days. We hope this will resolve the problems with Blue Shield and similar insurance companies. Matt is currently working on a project to finance the new hospital, including collaborating with WIPFLI on cost projections, budgets for new services, and new sources to secure additional cost reimbursement. We have also submitted letters to our local representatives to seek \$2.5 million from federal earmarked funds.

1. Department Updates

- a. Milestones – None
- b. August Employee Anniversaries  
 Year: ED Tech Matthew Quinton  
 10 EVS Lead Shannon Bauman
- c. Approval of the January Financials - Paul Eves – See Report
  - i. There were too many discrepancies in the January report. Financials will be brought to the March Board Meeting.
- d. CNO Report – Adela Yanez – See Report
  - i. Adela presented her staff report.
- e. Family Resource Center – Amy Terrones – Mar and Oct - None

K. Old Business - None

L. New Business - None

M. Parking Lot - None

N. Meeting Evaluation – “Speedy.” – Corinne

O. New Action Items

1. Optometry Costs and Statistics Compared to Budget
2. Board Credentialing by Proxy for Darrin Update

P. Next Meetings

1. Medical Staff Committee – Thursday, February 12, 2025, at 12:30 p.m
2. Medical Staff Policy Development Committee – Tuesday, February 17, 2025, 10:00 a.m
3. QAPI Meeting – Wednesday, February 11, 2025, at 10:00 a.m.
4. Finance Committee – Friday, February 20, 2025, at 10:00 a.m.
5. Governing Board Meeting – Wednesday, February 25, 2025, at 1:30 p.m

Q. Closed Session

1. Closed Session Opened at 2:47 p.m.
2. Update on Peer Review, Credentialing, and Appointment/Reappointments – Medstaff
3. Compliance, Risk, and Reports of Quality Assurance Committees [**H&S Code § 32155**] - Kristen Rees, CQCO
4. Annual Hospital Periodic Evaluation Report FY 2025 – See Report
5. Quarterly Reports - None
  - a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec. – Not Received
  - b. Patient Safety – Mar., June, Sept., Dec.
  - c. Medication Error – Feb., May, Aug., Dec. – Not Received
6. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**] - None
7. Personnel Matter –Evaluation § 54957
  - a. 360 Evaluations Admin
8. Personnel Matter –Evaluation § 54957
  - a. CEO Matt Rees

R. Kevin Church Adjourned Closed Session

S. Kevin Church Resumed Open Session

1. Action Items to Report in Open Session - None

T. Kevin Church Adjourned Open Session

*Submitted by Darrin Guerra*

Abbreviations

<i>ACHD</i>	Association of California Healthcare Districts	<i>ACLS</i>	Advanced Cardiac Life Support Certification
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<b>Subject:</b> <b>Mammography Quality Control (QC)Technologist</b>	<b>Manual:</b> <b>Mammography</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) that ~~at~~ Radiologic technologists performing mammography x-ray examinations shall be responsible for, but not limited to, the following:

- Possession of a current and valid California certificate in Diagnostic Radiologic Technology.
- Possession of a current and valid California certificate in Mammographic Radiologic Technology.
- Produce evidence of fifteen (15) Continuing Education Units (CEU’s) in technical and related aspects of mammography in the 36-month period immediately preceding the date of the most recent annual Mammography Quality Standards Act (MQSA) inspection.
- Perform at least two hundred (200) mammograms in the previous twenty-four (24) month period.
- Subject to *Technologist Restrictions*, meet all performance requirements listed in *Mammography Technologist Performance Requirements*.
- Perform Quality Assurance (QA) tests, compile data and make necessary adjustments. The Quality Control (QC) technologist must know when to cease mammography services when QC testing is not within standards in accordance with established QA program.
- Technologists initially qualifying on or after April 28, 1999 must meet the mammography-specific training requirements by having at least 40 hours of documented training in mammography, including:
  - Training in breast anatomy and physiology, positioning and compression, QA/QC techniques, and imaging of patients with breast implants; **and**
  - Performance of a minimum of 25 mammography examinations under direct supervision of an appropriate MQSA-qualified individual; **and**
  - **Eight hours** of training in using a mammographic modality (i.e. digital tomography) before beginning to perform mammography independently.

**PROCEDURE:**

N/A

**DEFINITIONS:**

None

**Subject:**

**Daily Procedures**

**Manual:**

**Radiology**

**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to delineate daily procedures in radiology.

**PROCEDURE:**

**Daily Procedures:**

- Turn on CT/US machine and perform warm-up exposures including daily QC tests where applicable.
- Log into the computer and launch electronic medical records.
- Check the tech worklist for any orders.
- Launch the Onrad website.
- Check the battery status of the portable x-ray detector. If charge is halfway or less, replace and recharge the battery.
- Fax any new reports to the ordering provider if from outside So Hum Health.

**Exam Procedures:**

- The technologist will be contacted via the call phone with notification of pending exam(s). The caller will identify if the exam is for the emergency department (ED), out-patient (OP), or an in-patient (IP).
- For most ED and IP exams, orders will be entered by the department requesting the exam(s).
- OP orders will be received either as a paper requisition (after being scanned by registration) or as an order in EMR. All OP CT and US exams shall be ordered utilizing a paper requisition.
- Prior to the start of all exams, the technologist will
  - Verify patient identity using two patient identifiers
  - Confirm the order is complete and correct.
- After completion of the exam(s), the technologist will:
  - Validate the study on Onrad’s website by filling out the required information. The technologist will forward any pertinent prior studies from PACS (Picture Archiving and Communications System) to Onrad.
  - Complete the order on the tech worklist in EMR.
  - Print access sheet for ED transfer as needed.
- After the exam is read and a report is received, the technologist will:
  - Fax the results to the ordering provider by request. Results shall be auto faxed by EMR.
  - Contact Onrad for any addendums or corrections.

**Miscellaneous Duties:**

- Keep area clean (please refer to Infection Control for Radiology).
- Stock supplies for the department including sheets, towels, patient gowns, pillowcases, IV start supplies, etc.

**DEFINITIONS:**

None

<b>Subject:</b> <b>MRI Safety Policy and Procedure</b>	<b>Manual:</b> <b>Radiology</b>
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PURPOSE:

The purpose of this policy is to establish clear guidelines to ensure the safety of all patients, visitors, and personnel in or around the Magnetic Resonance Imaging (MRI) environment.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ensure that only authorized and properly screened individuals are permitted to enter the MRI magnet room. MRI personnel are collectively responsible for verifying that all persons entering the magnet room have been appropriately screened for MRI safety risks.

DEFINITIONS:

**MRI:** Magnetic Resonance Imaging

**Authorized personnel:** Those personnel in compliance with education and training on safe practices in MRI.

**MRI Personnel:** Those authorized personnel that also work specifically in the MRI department.

**MRI Zones:**

Zone I – General public

Zone II - Unscreened MRI patients

Zone III – Screened MRI patients and personnel

Zone IV – Screened MRI patients under constant direct supervision of trained MRI personnel.

**Magnetic Resonance (MR) Safe:** An object that poses no known hazards in MR zones.

**MR Conditional:** An object that is safe when used in a specific manner within specific MR environments.

**MR Unsafe:** An object that poses a known threat or hazard in an MR zone.

PROCEDURE:

Patient Screening Procedure

Outpatients:

1. The patient, family member or legal guardian who will be present in MRI Zone III shall each complete the MRI Patient Screening Questionnaire.
2. The staff technologist shall review each screening questionnaire and notes any contraindications. If necessary, the patient chart will be reviewed for the most recent chest x-ray or CT scan to help ascertain pacemaker validation. All pacemakers and other implanted devices will be reviewed through the manufacturer for MR compatibility.
3. If questionnaire indicates possible metal fragments (i.e. potential for metal fragments in eyes from grinding, etc.), and x-ray of said part shall be performed prior to MRI for clearance.
4. If there are no noted contraindications, the patient proceeds to the changing room in MRI trailer (Zone III). Patient shall remove all clothing including undergarments and change into a hospital provided gown.  
All metal (including hearing aids, watches, hairpins, belts, badges, pens, credit cards, etc.) must be removed prior to entering the magnet room (Zone IV).
5. Ferromagnetic detection screening is completed via handheld detector prior to entering the magnet room. When handheld detector is used, care must be taken to hold the detector against the skin to include the hair, ears, upper chest, back, right and left side of pelvis and down the legs. Movements should be very slow and steady.
6. A person with a contraindication will not be allowed inside the magnet room as determined by the MRI technologist.
7. In cases involving pediatric patients, all pediatric patients will be screened with help of their parent or guardian.
8. If a parent or guardian is needed to accompany the patient in Zone IV, the parent or guardian will also be required to complete a screening form, change clothing and shall be wanded.

A Full Stop/Final Check will be performed by the MRI Technologist in Zone 3 Prior to entering Zone 4. Elements of this full stop will include:

- Patient identification.
- Review of MRI Patient Screening Questionnaire.
- Proper preparation, programming, or removal of implanted/on-planted devices.

Any individual undergoing an MR procedure must remove all metallic personal belongings and devices. This includes important on-planted devices such as external insulin pumps, external hearing aids, continuous glucose monitoring devices, and other similar items. Also, they shall remove watches, jewelry, pagers, cell phones, body piercings, contraceptive diaphragms, cosmetics containing metallic particles (such as eye makeup, magnetic eyelashes, hair product). It is a requirement that the patient wear hospital-supplied clothing without metal fasteners for the exam.

Any patient having a camera capsule or gastrointestinal implant that will be expelled in time inserted in the last 30 days will need an x-ray of chest and abdomen to provide assurance that the implant has been expelled through the gastrointestinal tract.

MRI may be contraindicated for persons who have a cardiac pacemaker, implantable cardiac defibrillators, cochlear implants, non-removable neurological stimulators, bone growth stimulators, implanted drug infusion pumps, ferromagnetic cerebral aneurysm clips and shrapnel. If any patient has a contraindicated device, Jerold Phelps Hospital will defer the patient to another facility.

Heating can occur in the MR scanner bore and cause damage to the patient's skin under the following circumstances:

- Electrical voltages and currents can be induced within electrically conductive materials that are inside the bore of the MR scanner and can become heated. This heat may be sufficient to cause injury to human tissue. When electrically conductive materials are required to be within the bore of the scanner, care should be taken to ensure no loops are formed within the bore during scanning. A technologist can position the materials so that they are not directly touching the patient and kept as far away from the inner walls of the bore as possible.
- Care must be taken to ensure that the patient's tissues do not come into direct contact with the inner walls of the scanner bore during scanning. Radiofrequency shielding pads shall be used to prevent burns.
- Attention needs to be on the patient's positioning during scanning to ensure that the patient's tissues do not become large conductive loops. It is necessary to have the patients not cross their arms or legs during scanning. Ensure no skin-to-skin contact occurs during the scanning process.
- Extensive and dark tattoos including tattooed eyeliner have an increased potential for heating. The patients are instructed to inform technologists immediately if they feel a burning sensation. Cold compresses may be used to alleviate the burning sensation. Although not an RF thermal concern, patients with tattoos that had been placed within 48 hours prior to the pending MR examination should be advised of the potential for a smearing or smudging of the edges of the freshly placed tattoo.
- Some drug delivery patches may contain metallic foil which may result in thermal injury to the patient. Patients are screened for patches prior to scanning and patches are required to be removed.

All patients and other individuals who are in the scan room shall be offered and encouraged to use hearing protection for their safety. If hearing protection is refused, they will be advised of the possibility of permanent hearing damage and hearing loss. In this event, the MRI staff shall:

- Use additional padding around the patient's ears.
- Document in the patient's medical record that hearing protection was offered but refused.

Patients may have issues with claustrophobia or anxiety in the event of an MRI study. Every effort should be made to make the patient as comfortable as possible to allow the study to be completed:

- Give the patient a detailed explanation of the exam.
- Allow a family member or friend to accompany the patient; any individual deemed appropriate to accompany or remain with patient will complete visitor MRI screening form and be changed into a facility provided gown.
- Provide a communication bulb to the patient during the scan and reassure them that they are in control and can be brought out of the scanner at any time.
- The technologist should communicate verbally with the patient during the study.
- If medication is required for claustrophobia, difficulty lying on their back or lying motionless, the ordering Provider must order the medication.
- Outpatients will be responsible for bringing medication ordered by their Provider to the appointment.

In the event of an MR accident, the incident will be reported to the FDA via the Medwatch program at <https://www.fda.gov/safety/medwatch/>

MRI Zones III and IV shall be clearly marked with the appropriate zone signage.

Zone IV signage shall state that the magnet is always on.

Quench Evaluation:

In the event of a quench, the patient's safety is always the first concern. Cryogenics leaking into the room may appear as clouds of smoke.

- Only trained service personnel may handle cryogenics. During cryogen fills, Zone III and Zone IV must be evacuated of all but trained service personnel.
- If pressure within the room prevents opening the door, the window to the control room should be broken.
- Ventilate adjacent areas as they may also rapidly fill with cryogen vapor.
- Evacuate the patient from the MRI room as quickly and carefully as possible. Reassure the patient of his/her safety while transporting them out of the magnet room to a safer area to prevent asphyxiation.
- Cryogen condensate (on the floor and horizontal surfaces) is extremely cold and may cause thermal injury (frostbite) on contact.
- Staff entering Zone IV to evacuate the patient, should be careful to maintain space orientation in the room by keeping the exit door in sight.
- Notify Radiology Director or Radiology Manager of the quench.
- In the event of a quench or near miss, the Radiology Director or Radiology Manager will document the incident in the Event Reporting system.

- When the helium quench is complete, MRI lead will evaluate the cryogen levels and notify the Radiology Director or Radiology Manager.
- Staff shall initiate quench of the magnet only when the object held against the MRI scanner poses an imminent threat of injury or death, such as if a patient or staff member is pinned between the object and the magnet.

In the event of a respiratory or cardiac arrest in the MRI trailer:

- The MR technologist shall remove the patient from the MRI scan room (Zone IV) and secure the door to the scan room.
- Emergency response teams shall be activated by phone
  - Page “Code Blue” and location repeat 3 times
    - Lift the handset
    - Dial 8-0-0-0
    - After an audible alert indicates the paging system is activated, announce the intended code phrase three times
  - Appropriate staff are to respond to code, but not enter Zone IV under any circumstance.
  - Patient is to be brought to the Emergency Department for treatment.

In the event of a fire:

- Remove the patient from the MRI suite (Zone IV) and secure to the door to the scan room.
- Page “Code Red” and location repeat 3 times
  - Lift the handset
  - Dial 8-0-0-0
  - After an audible alert indicates the paging system is activated, announce the intended code phrase three times
- Activate the fire plan.
  - Contact Maintenance and the Safety Officer
  - Page all clear only after being given clearance from the Safety Officer, maintenance, and/or the fire department.
- Disconnect electrical power to the MRI system by pressing the emergency “off” button (circuit breaker).
- Utilize the MRI-conditional fire extinguisher located in the MRI area.
- All responding personnel, including fire fighters, must be screened prior to entering Zone 3 and 4.

If the fire is in Zone IV and not extinguished after emptying the available extinguisher or jeopardizes your personal safety, the magnetic field must be removed by pressing the “quench” button.

## **SPECIAL CONSIDERATIONS:**

Only MRI compatible equipment will be placed inside the MRI room.

- **MR Conditional:** An object with this label warns the user that there are limitations to the usability or to the testing that was performed on it. The object may have been tested for a 1.5 Tesla system, but not for a 3.0 Tesla system. The condition shall be included on the object in its packaging, or the accompanying instructions. These objects shall be marked with a yellow MR Conditional label .
- **MR Safe:** MR safe can only be applied to objects that are 100% safe to be taken, used, or placed within all MR environments without any risk or potential harm.

The MRI technologist has absolute authority to deny any person and/or object from entering the MRI scan room.

<b>Subject:</b> <b>Definitions of Healthcare Associated Infections</b>	<b>Manual:</b> <b>Infection Prevention</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to utilize the standard definitions from the Center for Disease Control and Prevention (CDC) for defining healthcare associated infections (HAI) so that data from the District can be compared to regional and national benchmarks.

**PROCEDURE:**

The following guidelines will be used whenever a determination of healthcare associated infection is being considered within the facility’s acute care, swing bed, or Skilled Nursing Facility departments:

General acute care and swing bed guidelines are titled “CDC/NHSN Surveillance Definitions for Specific Types of Infections,” updated 2025. These were developed by the CDC and are available at the CDC website [www.cdc.gov](http://www.cdc.gov).

The Skilled Nursing Facility utilizes the revised McGeer Criteria for determination of healthcare associated infections. These guidelines are titled “Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria” and were developed jointly by the CDC and Society for Healthcare Epidemiology (SHEA). They are also available at [www.cdc.gov](http://www.cdc.gov)

**DEFINITIONS:**

None

<b>Subject:</b> <b>Glucometer Cleaning</b>	<b>Manual:</b> <b>Infection Prevention</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to clean all patient care equipment as appropriate to prevent the spread of disease.

**PROCEDURE:**

- The district uses Roche Accu-Chek GTS Data System™, a CLIA-waived point of care blood glucose testing system. This system consists of a base unit, which is plugged into electrical power, and an individual patient bedside meter. There are three systems in the facility: one in the Emergency Room, one in the Hospital Nurses’ Station, and one in the Rural Health Clinic. The meters are multi-patient use.
- In accordance with the California Department of Public Health and Center for Disease Control and Prevention guidelines, the facility uses the manufacturer’s recommendations to clean the meters **AFTER EACH PATIENT TEST**. The inside of the base (where the meter is housed) is cleaned before each quality control testing.
- The base is **NEVER** taken into the patient room. The nurse should visit the patient, explaining that he/she will be doing a test. The appropriate site should be assessed at that time. The nurse returns to the glucose monitoring system and programs the machine, so the meter is ready to perform, placing a strip into the machine. The nurse takes the handheld meter into the patient’s room and performs the test.
- Before the meter is returned to the base, it must be cleaned with an ammonium chloride product (Sani Cloth germicidal disposable wipe), being careful **NOT** to wet the meter-base connectors or base circuitry.

**Note:** Although other cleaning products are approved by the manufacturer for use on this equipment, only Sani-cloths are approved by the EPA as being effective against Hepatitis B. **Never** use another product (i.e.: bleach, alcohol) and **Never** spray anything onto the meter that could get inside its circuits. If circuits get wet, immediately dry with a tissue.

- **Important:** the cleaning solution must remain **wet** on the meter for three minutes. Reapply germicide with a fresh wipe if the first application dries before three minutes.
- Additional infection prevention guidelines when performing bedside blood glucose testing include:
  - Hand hygiene is performed by the nurse before and after testing.

- Gloves are worn by the nurse during the procedure (perform hand hygiene after removing gloves)
- A different lancet is used for each patient.
- Used lancets and test strips are deposited in sharps containers.

**DEFINITIONS:**

None

**Subject:**

**Infection Prevention Education**

**Manual:**

**Infection Prevention**

**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to educate all staff, volunteers, contracted workers, and physicians in the basic principles and practices of infection prevention, as appropriate to their job description in this facility.

**PURPOSE:**

The purpose of this policy and procedure is to delineate the methods for education in infection prevention.

**PROCEDURE:**

- All newly hired employees will receive basic infection prevention information before their work assignment commences. This basic information is in online format, or DVD format. The online format will be provided by Human Resources Manager, or the DVD format by the Infection Preventionist.

In addition, all new employees will complete the self-study and quiz on Influenza Vaccination at the beginning of the flu season.

- The infection prevention orientation will be completed by the new employee on the first day of employment. This information is contained in the self-study modules in Relias Information includes:
  - Infection Prevention Policies, including:
    - Community Acquired Infections (CAI)
    - Hospital Acquired Infections (HAIs)
    - Hand hygiene
  - Standard Precautions, including:
    - Personal Protective Equipment
    - Respiratory Hygiene
    - Cleaning and disinfection
  - Transmission Based Isolation Precautions
    - Airborne, including use of N-95 particulate respirator, if applicable
    - Contact
    - Droplet

- Aerosol Transmissible Disease Exposure Control Plan
- Bloodborne Pathogen Exposure Control Plan
- Each employee will attend an annual in-service update on infection prevention. This may be done in the form of presentation of information on storyboards, classes, DVDs, internet, or online. Completion of a post-test is required. The information presented is basically the same as a new employee orientation. The purpose of this is to reinforce previously learned knowledge. The information, is however, updated according to new standards and applicable laws.
- Periodic in-services: If at any time throughout the year it is determined there is a staff knowledge deficit in the area of infection prevention, an in-service will be provided, as appropriate. This may be due to the introduction of new products, information from surveillance and prevention activities, new or changed policies, or regulatory compliance issues. Training needs will be assessed by the Infection Preventionist to determine required in-services.
- Certain departments require specialized education. This is done by either/or both the Department Manager and the Infection Preventionist.
  - Environmental Services Department (EVS):
    - All new employees in the EVS Department will be educated in the following
      - a. the role of the environment in infection prevention
      - b. appropriate mixing and use of various chemical disinfectants
      - c. more in depth education in isolation precautions
      - d. waste management
      - e. soiled and clean linen management
      - f. donning and doffing of personal protective equipment
    - Continuing employees will have this information reinforced annually.
    - All employees who will be responsible for cleaning and sterilizing instruments and equipment must have specific training in this before they may do these procedures.
  - Laboratory personnel: It is assumed that laboratory staff, by the nature of their basic education in the laboratory sciences, know and understand the concepts of preventing the spread of disease via specimen vectors, understand standard precautions and use of personal protective equipment.

All Laboratory Department will be educated in the following upon hire:

- specific laboratory waste management streams
- the district's method of monitoring refrigerator and freezer temperatures
- preparation of cultures for the reference laboratory
- review of bloodborne pathogen standard and aerosol transmissible disease standard
- N-95 particulate respirator fit testing (performed by appropriately trained)

- staff)
- safe handling of sharps
- donning and doffing of personal protective equipment
- Nursing Department: All new nursing department employees will meet with the Infection Preventionist and be educated in the following upon hire (see attached Orientation Checklist). Annually, nursing department employees will be updated on:
  - N-95 particulate respirator fit-testing (performed by appropriately trained staff)
  - use of personal protective equipment (PPE).
  - hand hygiene
- Radiology Department: All new radiology department employees will be oriented to Infection Prevention as per departmental orientation policy. Annually, radiology department employees will be updated on:
  - N-95 particulate respirator fit-testing (performed by appropriately trained staff)
  - use of personal protective equipment (PPE)
  - hand hygiene
- Dietary Department: All new dietary department employees will be oriented to Infection Prevention as per departmental orientation policy. Annually, dietary department employees will be updated on:
  - use of personal protective equipment (PPE)
  - hand hygiene
- Ambulatory Clinic: all new Clinic employees will be oriented to Infection Prevention as per departmental orientation policy. Annually, clinic employees will be updated on:
  - the use of the N-95 particulate respirator
  - use of personal protective equipment (PPE)
  - hand hygiene

**DEFINITIONS:**

None

<b>Subject:</b> <b>Dietary Disaster Plan</b>	<b>Manual:</b> <b>Dietary</b>
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**POLICY:**

It is the policy of the Southern Humboldt Community Healthcare District (“SHCHD” or “District”) to provide a dietary disaster plan to supply food and nutritional support to patients, personnel, and volunteers in the event of a disaster. This plan is based on a need to feed a total of 75 persons for 3 days; 26 patients, 36 staff, 13 volunteers and/or family members. Only staff members that are required to stay will be provided with food. Other staff members are expected to go home after their shift and supply their own food. Community members volunteering are expected to supply their own food, but extra water is stored to meet their needs.

**PROCEDURE:**

Meals for All, Inc. Copyright 2015 3-day meal plan and food supplies are stored in the dietary department. A binder containing the emergency menus/procedures is kept with disaster food supplies in dry storage room. The binder contains detailed instructions on how to prepare emergency food items. The disaster emergency water supply is stored in Materials Management Department.

Meals for All, Inc is an outsourced company that makes non-perishable food supplies along with nutritional analysis and recipes for using preparation of non-perishable foods.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Dietary Employee Health</b>	<b>Manual:</b> <b>Dietary</b>
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**POLICY:**

It is the policy of the Southern Humboldt Community Healthcare District (“SHCHD” or “District”) that the Dietary Department will monitor employee health to prevent an outbreak of food borne illness and comply with the regulations set forth in the California Retail Food Code. Older adults and people with compromised health are more prone to the development of food borne illness. Adherence to this policy protects the health of our patients.

**PROCEDURE:**

- Dietary staff will be instructed on food safety annually.
- Dietary staff is required to report the following to their supervisor.
  - A diagnosis of:
    - Salmonella typhi
    - Salmonella spp.
    - Shigella spp.
    - Entamoeba histolytica
    - Enterohemorrhagic or Shiga toxin producing Escherichia coli
    - Hepatitis A virus
    - Norovirus
    - Other communicable diseases that are transmissible through food
  - An open or draining wound or lesion that is:
    - On the hands or wrists, unless the lesion has an impermeable cover, and a disposable glove is worn over the cover. These gloves must be changed every time the employee is required to wash their hands
    - On exposed portions of the arms, unless the lesion is protected by an impermeable cover.
    - On other parts of the body, unless the lesion is covered by a dry, durable tight-fitting bandage.
- The Certified Dietary Manager of Dietary Department will notify the Infection Preventionist when:
  - The supervisor is aware that a food service employee has been diagnosed with any of the above infectious agents.
  - When two or more of the staff are experiencing symptoms of acute gastrointestinal illness such as nausea, vomiting and diarrhea. This must be reported immediately, even if there is no specific diagnosis at that time.
  - Infection Preventionist will notify the local health department.
- The local health department will exclude the employee from the workplace if they are diagnosed with any of the above infectious agents and are still considered infectious.

The employee will not be allowed to return to work until receiving written clearance from the health department.

- If the employee was not diagnosed with any of the above infectious agents, the supervisor may allow them to return to work if they have been symptom free of any gastrointestinal illness for 24 – 48 hours. The supervisor may also allow them to remain in the facility if they are assigned duties that do not involve working with exposed foods; clean equipment, utensils or linens; or unwrapped single service or single use articles. The employee should be reminded about hand washing procedures and observed closely.
- Food service staff will comply with the exclusions or restrictions as required by the CDM Dietary Department manager/Infection Preventionist or the local health officer.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Dietary Policy and Procedure Manual</b>	<b>Manual:</b> <b>Dietary</b>
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**POLICY:**

This policy of Southern Humboldt Community Healthcare District (SHCHD) is to have all Dietary related policies reviewed by all departments affected by the content prior to approval by the Governing Board.

**PURPOSE:**

The purpose of this manual is to provide guidelines for all dietary department employees to follow while providing nutritional care including planning, preparation, and service of food. It clarifies the interdepartmental responsibilities related to this process to form a basis of understanding between departments.

**PROCEDURE:**

Policies deal with broad areas and basic issues. They represent the decisions of the Governing Board as to the direction and philosophies of the organization. Therefore, policies may only be changed with the approval of the Governing Board.

Procedures are detailed descriptions of the way in which policies are implemented. They are usually not subject to central approval, therefore, are more flexible than dietary policies.

Procedures may be changed with the expressed agreement of all departments involved, and the approval of Administration.

- Objectives:
  - To provide comprehensive nutritional care to our patients and residents meeting the standards set by Title XXII, FDA Food Code, HIPAA, Critical Access Hospital regulations, California Retail Food Code, OSHA, and all other appropriate regulatory agencies.
  - To plan and provide meals to meet the nutritional and therapeutic needs of the patients and residents in accordance with the Registered Dietitian's recommendations and physician orders.
  - To assess and monitor the patient/resident's nutritional status and make appropriate recommendations to ensure their nutritional needs are met.
  - To provide nutritional counseling and support to patients/residents regarding their diet and food choices.
  - To prepare and serve attractive and wholesome meals under high standards of sanitation, meeting all federal, state and local requirements.
  - To operate within the department budget set by Administration.



- To develop a spirit of cooperation among all dietary department employees and with other departments to effectively carry out these objectives.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Dietary Purchasing</b>	<b>Manual:</b> <b>Dietary</b>
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**PURPOSE:**

This policy provides safeguards that all foods have been handled safely prior to arrival at SHCHD, creates certainty that all products purchased are the best value for the price, and assures that food and equipment are appropriate for the menu.

**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD” or “District”) that all food and supplies to be used in dietary will be purchased from sources approved or considered satisfactory by federal, state, and local authorities. All food and/or supplies will be purchased within the facility guidelines, utilizing the vendors of the current group purchasing organization contracted with the hospital. Price, service, delivery, and availability will always be considered in purchasing products.

**PROCEDURE:**

- Food and Supply Purchasing:
  - Certified Dietary Manager (CDM) is responsible for purchasing all food and supplies.
  - To the maximum extent possible, food and supplies will be purchased from vendors who are associated with the hospital group purchasing organization.
  - Dietary staff are only allowed to charge from local markets with permission from CDM/CFFP on rare occasions. This controls cost and ensures that food is inspected/approved prior to purchase.
  - All deliveries will be checked upon delivery for quality and to assure that the delivery slip matches the items received.
  - Food and supplies will be stored according to the policy: “Food Preparation and Storage.”
  - CDM will verify that all vendor charges correspond to the receipts.
  - Credit slips will be turned into accounts payable.
  - Vendors list of names and phone number are posted in dietary.
  - CDM will compare prices and service between vendors when more than one approved vendor carries the same product.
- Purchasing of Small Equipment:
  - Small equipment will be defined as dishes, silverware, small storage containers, thermometers, etc. totaling under \$1,000 per item.
  - Registered Dietitian (RD) will consult with the CDM on specifications of small equipment needed. CDM will, in conjunction with Materials Management, be responsible for checking prices and ordering the equipment.

- Dishes and other small equipment will be replaced when they are cracked, chipped, rusted, have no appropriate handles, or has lost the glaze.
- CDM will be responsible for regularly checking all small wares to be sure they are safe for the employee to use and can be properly sanitized.
- Purchasing Enteral Feeding and Medical Nutritional Supplements:
  - Materials Management will be responsible for purchasing all enteral feeding products and infant formula products.
  - RD will consult with the Materials Management Manager to coordinate available products with recommendations to the physician.
  - To the maximum extent possible, physician orders will comply with products that are available through the group purchasing organization.
- Capital Equipment:
  - Capital equipment will be defined as any single piece of equipment costing more than \$1,000.
  - All capital equipment purchases will be purchased by COO and approved by Administration.
  - Materials Management will be consulted for possible vendors through the group purchasing organization.
  - Engineering department will be consulted for electrical and maintenance specification, and ease of accessing service and repair.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Equipment Maintenance</b>	<b>Manual:</b> <b>Dietary</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) that equipment maintenance is necessary to prevent employee injuries and to prevent unnecessary equipment repair and replacement costs.

All equipment will be subjected to preventative maintenance procedures to prevent accidents due to faulty electrical or mechanical functioning and extend the life of the equipment.

**PROCEDURE:**

- The Dietary Department manager is responsible for:
  - Training all employees in the proper use and cleaning of the equipment.
  - Establishing equipment cleaning schedules and monitoring employee compliance.
  - Instructing employees in the proper method of reporting equipment failure and/or issues to department manager and engineering department. If department manager is unavailable, report to Chief Operating Officer (COO).
  - Conducting a periodic visual inspection of all equipment, noting condition, efficiency, loose parts, or excessive wear of the equipment.
  - Routine inspection of kitchen for safety and efficiency of equipment.
  - Dietary Department manager will notify engineering department when equipment issues arise and place a work order.
- The Engineering Department is responsible for:
  - Recording the following information on all equipment:
    - Brand name
    - Model and serial number
    - Phone number of servicing agent
    - Dates of repair/service
  - Prompt and efficient emergency repair of equipment and preventative maintenance.
  - Conducting periodic service inspections of all equipment and schedule for maintenance of equipment.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Food Preparation and Preparation Area</b>	<b>Manual:</b> <b>Dietary</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (SHCHD) to make sure the Dietary Department maintains a clean, sanitary, and safe food production area and food handling procedures. The purpose of this policy is to prevent foodborne illnesses in patients and residents resulting from cross contamination and failure to hold foods at appropriate temperatures.

**PROCEDURE:**

**Facility:**

- Dish and utensil cleaning area is located in a separate area from the food production area.
- Handwashing facilities in the kitchen are separate from the food preparation and dishwashing equipment, and include hot and cold water with soap dispenser, disposable towel rack, and step-on trash cans.
- All floors in the food preparation and storage area are washable and have a non-slip finish. Walls are painted with a washable paint.

**Food handling of cold foods:**

- When preparing cold foods, chill all ingredients thoroughly before mixing. This will aid in slowing the growth of bacteria.
- Protect all products from contamination by segregating items from raw meats, fish, chicken, and unwashed fruits and vegetables.
- Use sanitized utensils and avoid hand contact. Wear plastic gloves when mixing products or use long-handled utensils.
- After mixing food such as protein containing salads, cool in 2-inch-depth containers until it reaches 40°F. After it reaches 40°F, cover, label, date, and store to maintain temperature at 40°F or less.
- Store and thaw all raw meats on the lowest shelves of the refrigerator to prevent blood contamination. If blood does contaminate other foods in the refrigerator that will not be cooked to a minimum of 165°F, discard immediately.
- Thoroughly wash all produce before using by holding produce under cold, running water, being sure all folds, crevices, and surfaces are free of dirt and contamination. Do not soak produce in a sink. Wash your hands before and after handling unwashed produce.

**Cooling of hot foods:**

- Rapid cooling of hot foods is essential to prevent foodborne illness. Hot foods will be put into pans no more than 2 inches deep.
- Large cuts of meat will be cooled according to Policy: “Cooling Large Cuts of Meat.”
- Plastic acts as an insulator, so foods should be cooled in metal containers. If not cooled in metal containers, the temperature must be checked in two hours until it is known that the food will cool in plastic within the allowable time.
- Cover and date foods after they reach 40°F. Plastic wrap and lids act as insulators and delay the cooling process.
- Never mix hot foods with cold foods during storage.

**Holding hot foods:**

- To ensure safety, hot foods must be held at 140°F or above.
- Reheat all foods to 165°F for 15 seconds.
- After food is reheated, any unused portion must be discarded.
- Foods should be rapidly reheated.
- Frequently stir foods that are being held to distribute temperature evenly. The top portion will cool faster than the food closer to the heat source.
- Cover foods being held to maintain heat and prevent contamination.
- Serving utensils will not be left in the food while it is being held.

**Thawing foods:**

- All meats must be thawed in the refrigerator at 40°F or less.
- Employees must check the menus ahead to pull the meats needed to allow time for defrosting.
- Do not leave meat in the sink to thaw at room temperature.
- All meat must be thawed on the lowest shelves of the refrigerator and other foods must be protected from blood contamination.
- All foods must be thawed by one of four acceptable methods:
  - In the refrigerator is the strongly preferred method
  - During the cooking method is also acceptable if the end product is not affected
  - In the microwave; or
  - Under cold, running, potable water. This product must be closely observed.

**Cutting boards:**

- Food grade, hard rubber or acrylic boards are preferred, however current research indicates that wood boards are also acceptable.
- Separate boards must be labeled for use with raw meats, cooked meats, and vegetables. They must be labeled or color-coded.
- All cutting boards must be sanitized after every use. They are washed and sanitized in the dishwasher.

- They must be free of seams and cracks.
- They must be non-toxic and non-absorbent.
- They must be discarded when they are stained and cannot be bleached.
- They must be discarded when the surface is worn, and sanitation cannot be assured.

**Use of disposable gloves:**

- Gloves must be used whenever you are in direct contact with food that will not be cooked prior to service.
- Gloves must be discarded after every use.
- Hands must be thoroughly washed before putting on gloves and after removing.
- Handwashing policy is the same when wearing gloves, i.e., gloves removed, and hands washed in all situations requiring handwashing.
- Plastic gloves should not be worn when working around hot surfaces.
- Gloves do not have to be worn when serving food with utensils that do not necessitate direct contact with food.

**Sanitation of food contact surfaces:**

- All food contact surfaces will be sanitized at the beginning of each shift.
- Food contact surfaces must be sanitized after every task, i.e., handling raw foods that will be cooked, cooked foods, unwashed raw foods, ready-to-serve raw foods, and after non-food items that are not sanitized have been in contact. Sanitation buckets will be located in the dish room and in the three-compartment sink with a bleach solution of ½ ounce, or 1 tablespoon, of bleach solution to one gallon of water per manufacturer's recommendation.
- Each sanitizer bucket will be marked at the one-gallon mark. The cleaning cloths will be stored in sanitizer solution buckets and used to sanitize food contact surfaces.
- The sanitizer buckets will be changed twice daily in the a.m. and p.m. Chlorine test strips will be used to measure parts per million (ppm). Chlorine test strips must read 200 ppm and results recorded in log.
- Any other sanitizer must be approved for food contact surfaces.

Trays do not leave the kitchen unless the staff is assured the food has been handled appropriately and the food looks appetizing.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Garbage and Rubbish Disposal</b>	<b>Manual:</b> <b>Dietary</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD” or “District”) that garbage and rubbish shall be disposed of in accordance with current laws regulating such matters.

**PROCEDURE:**

- All garbage and rubbish containing food wastes shall be kept in containers with tight fitting lids.
- Lids must remain on all containers when not in continuous use.
- After being emptied, the containers must be cleaned. This must be done outside the kitchen to avoid contamination of food, equipment, utensils, or food contact surfaces.
- All garbage containers in the kitchen will be lined with plastic bags. The bags will be changed every time the trash is emptied.
- Trash must be removed from the kitchen at the end of every shift. Bags must be tied and placed in an outside dumpster.
- Garbage and rubbish containing food waste shall be stored so it is inaccessible to vermin.
- Outside dumpsters must be kept closed and free of litter around the dumping area.

**DEFINITIONS:**

None



<b>Subject:</b> <b>Hiring, Orientation and Training of Dietary Employees</b>	<b>Manual:</b> <b>Dietary</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD” or “District”) that all employees will receive initial orientation and training when hired and will complete ~~the district’s an annual in-service~~ provided ~~to for~~ all hospital employees. In addition, all Dietary employees will complete quarterly in-services provided by the Certified Dietary Manager. All content of in-services provided will have prior review/approval by consultant Registered Dietitian. These will maintain the efficiency of the department and ensure the accuracy of prescribed medical nutrition therapy; all employees will be thoroughly trained before allowed to work unsupervised.

**Commented [WK1]:** Is this referring to an annual review?

**DEFINITIONS:**

**CDM:** Certified Dietary Manager.

**RD:** Registered Dietitian.

**Food Safety Manager Certification:** a certification that communicates to the food service and retail industry that a manager has the knowledge, skills, and abilities necessary to oversee the safe storage, preparation, and service of food in the workplace.

**PROCEDURE:**

- All candidates must follow the hospital personnel procedures for application.
- Personnel will screen all applications. Applications of eligible candidates are forwarded to CDM.
- The RD interviews all eligible candidates for the CDM position.
- All eligible candidates for cooks are interviewed by the CDM. The RD will be available to assist with interview and/or screening as needed.
- On-the-job training is scheduled for all cooks, ~~at a minimum of minimally one for the first week,~~ and up to ~~one the first~~ month depending on the background and skills of the new employee. This training will be under the direction of the CDM.
- If not providing the direct training, the CDM will meet at least once a week with the new employees to discuss progress and concerns for the first three months. A written work schedule for all dietary employees will be maintained by the CDM. Orientation in-service will be given to all new dietary employees by the CDM within one month of start date.
- All new employees will be evaluated by the CDM before being allowed to work a shift unsupervised.
- The CDM periodically checks the comprehension and completion of duties of all Dietary staff.
- The CDM will provide in-service training to dietary staff on a quarterly basis. All in-service content/training will have been reviewed and approved by consultant RD.

- The CDM will maintain a record of all in-services provided for each employee including date and topic.
- The CDM will maintain a Food Safety Manager Certification. This must be renewed every five years.
- The CDM will participate in hospital management training when available.
- The RD will maintain the registration with the Commission of Dietetic Registration. RD will provide services on a consultant basis and oversight to the dietary department. This will include review and approval of all dietary policies and procedures. The CDM will maintain credential and work full-time as the department manager.
- A written work schedule for all dietary employees will be maintained by the CDM. Work schedules will be posted in the dietary department with employee's name and title. It is the responsibility of each employee to check their work schedule daily.

<b>Subject:</b> <b>Billing Grievance Policy</b>	<b>Manual:</b> <b>Patient Financial Services</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “Sohum Health”) that all patients may submit a billing grievance (billing complaints or billing disputes) regarding any statement or charges that they deem incorrect or inaccurate based on the services they received or the care that was provided.

Each billing grievance will be acknowledged, investigated, and an appropriate response is provided to the patient or patient representative within a timely manner. "Timely" is defined as a written response within seven (7) days to acknowledge the grievance and within thirty (30) days for ~~the completion of the investigation and~~ a final response back to the patient.

For more complicated grievances, that cannot be addressed within the expected time frame in a timely manner, an interim response will be sent within thirty (30) days of receipt, and a final determination within sixty (60) days.

This policy applies to all SHCHD patients, ~~their families, and all employees~~.

**PURPOSE:**

The purpose of this policy is to outline explain the submission process ~~for~~ submitting billing grievances and detail what steps should be taken to resolve the grievance by the Sohum Health team.

**DEFINITIONS:**

**PFS:** Patient Financial Services

**TruBridge:** The third-party billing vendor company that handles all patient billing and statement generation for SHCHD our hospital district.

**PHP:** Performance Health Partners, SoHum’s incident reporting software.

**PROCEDURE:**

1. Patients and patient representatives must submit at their billing grievances in writing via one of the following methods: by letter or in person using the following methods:
  - a. Letter Via mail to:  
 Attn: PFS  
 733 Cedar Street  
 Garberville, CA 95542
  - b. In person delivery:  
To the Clinic or Emergency department Registration areas.

- b-c. Registration staff should bring grievance submissions to the attention of the Speak to PFS manager or supervisor. If both are unavailable at the time of arrival or while patient or representative is present, they should give a PFS staff member a the written dispute to supply to the manager or supervisor upon their return.
2. Once the PFS Manager or SupervisorSHCHD receives the billing grievance in writing~~dispute/complaint~~, they will email a copy ~~over~~ to TruBridge and have a contested hold placed on the patient's account with the balance they are disputing.
  3. The billing grievance should be filed~~letter is saved on the SHCHD to the~~ shared drive in the complaints folder as well as be scanned to~~in~~ the patient's chart in the EHR~~EPIG~~.
  4. The PFS Manager or Supervisor will submit a *Billing Only Grievance* ticket ~~will be completed~~ in PHP~~Performance Health~~ with a copy of the grievance~~received billing dispute/complaint~~ uploaded to the ticket. The Quality department will assign the correct department resources that need to review and follow-up on the grievance ~~to the ticket~~.
  5. The PFS Manager or Supervisormanagement will respond~~write a letter~~ to the patient in writing informing them that their dispute was received and is under review within seven (7) days of receipt. The response will be filed ~~PFS management will scan a copy of the received notification in the Complaints folder on the shared drive, scanned to the patient's chart into EPIG the EHR and be uploaded to~~ PHP.
  - 6.—Management of the relevant department(s) will review the complaint, come to a decision, and document that decision in PHP. ~~and t~~The PFS Manager or Supervisor or manager will then write and send a final decision letter to the patient. The final response will be filed to the Complaints folder on the shared drive, scanned to the patient's chart in the EHR, and uploaded to PHP. ~~The letter will be scanned into EPIG and PHP~~.
  6. The PFS ~~m~~Management or Supervisor will print the letter ~~out~~, sign it, and mail it~~the~~ letter to the patient. They will communicate the outcome of the grievance to TruBridge via email.
  7. Depending on the determination, TruBridge will either:
    - a. Request that an adjustment be made to the bill if necessary OR
    - b. Notify the self-pay team of the decision to resume billing the patient (if applicable) and release the contested hold.

<b>Subject:</b> <b>Pyxis</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

This policy of SHCHD is to strictly manage access and privileges to the automated medication management system (Pyxis), ensure adequate security for medications that includes controlled substances, provide proper documentation of medication use, and maintain confidentiality of patient data.

**PROCEDURE:**

N/A

**DEFINITIONS:**

None

<b>Subject:</b> <b>Managing Temperature Excursion</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to (Your Policy Here)

**PROCEDURE:**

**1) Take immediate remedial actions**

**Secure and quarantine affected stock**

- Return to refrigerated storage any vaccine vials that have been exposed to temperatures outside of +2°C to +8°C
- For room temperature excursions quarantine the affected stock and attach a "DO NOT USE" label
- For fridge temperature excursions quarantine the affected stock within the fridge by attaching a "DO NOT USE" label

**Rectify any obvious immediate cause**

- Check obvious causes e.g. the fridge door having been left open or a power switch having been turned off
- Confirm the temperature is within range or has returned to the normal range and document. i.e. +2°C to +8°C and once documented,
- Reset the min/max fridge reading
- Where no obvious rectifiable cause can be identified, take the fridge out of use until an investigation into the cause of the excursion has been concluded. The fridge should be returned to use only once it has been confirmed to be functioning correctly.

**2) Gather information**

**Establish the basics**

Record as much as you can about the incident, for example:

- What happened overall
- How warm did it get
- How cold did it get
- The time period for the excursion

**Record the details**

- Complete the **Medication Storage Troubleshooting Record Form (see Appendix A) and retain for record keeping.**

**3) Seek advice and inform**

**Contact Pharmacy**

- Pharmacy will take appropriate action (contacting manufacturers) to determine whether these medications or preparations should be used, discarded, replaced, or re-dispensed.

**4) Prevent reoccurrence**

**Train staff**

Ensure staff are trained and competent for the fridge(s) being used.

**Ensure the fridge is functioning correctly**

To prevent reoccurrence of the temperature excursion, an investigation should be undertaken to identify its cause. Effective actions should be taken to address any causes identified. Areas for consideration within your investigation should include:

- Equipment – Is there a fault with the fridge or a thermometer? A refrigerator engineer may be required to review and correct technical faults with the equipment.
- Procedures – Are procedures for use of the fridge and management of the cold chain robust and clearly documented. Procedures may require updating if weaknesses identified have led to the excursion.
- Training – Are staff effectively trained against the procedures? Retraining of staff and assessment of their understanding in the use of the fridge and management of the cold chain may be required.

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**5) Record the outcome**

All excursion incidences should be fully documented locally; as a minimum, record:

- The time and extent of the temperature excursion
- Details of the vaccines and batch numbers affected by the temperature
- Details of any advice taken and whom this was sought from
- Actions taken to prevent a future reoccurrence of the excursion

**DEFINITIONS:**

None

<b>Subject:</b> <b>Medication Administration</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to describe the basic elements of safe, efficient, medication administration at the highest standards of practice.

**PROCEDURE:**

- Active medications determined by the attending physician, prescribed by a lawfully authorized licensee, shall be administered.
- Medications are only to be administered using the electronic MAR (EMAR).
- Patients shall be identified prior to the administration of all medications by verifying 2 patient identifiers. Identifiers include Name, Medical Record Number, Date of Birth, Phone Number, Social Security Number, Address, Photo)
- Only medications listed in the hospital formulary approved by the Medical Staff and approved non-formulary medications brought from home may be used for administration.
- Only licensed personnel shall prepare, administer, and document immediately AFTER each administration by the person who administered it.
- The administration documentation shall include details such as the patient's symptoms, route, time, effect, and signature.
- No one shall administer, prepare, or document for another licensee.
- Unlicensed persons may, under the direct supervision of a licensed medical personnel and demonstrated competence, may administer topicals not associated with treatment of eyes, ears, nose, mouth, or genitourinary tract during training or after completion of training.
- Medications are to be prepared for immediate use only. Preparation of doses for more than one scheduled administration at a time shall not be permitted.
- Injectable preparations must be administered within 1 hour from the start of the preparation time and 2 hours for oral preparation.
- Single dose vials shall be discarded immediately after use.
- Multidose injectables shall have a beyond use date per the manufacturer’s expiration date or 28 days, whichever is sooner.
- Multidose tablets or liquids shall have a beyond use date of 1 year from opening.
- Medications shall be administered within one hour on either side of the time it is due for administration.
- Oral medications shall be witnessed by the administering nurse and not allowed to remain at the bedside.
- Medications supplied for one patient shall not be administered to another patient.
- If a medication is not administered, the licensee shall document it in the chart along with the cause.
- No samples will be administered to patients of the District.
- Investigational drugs must be authorized by the FDA for Emergency Use to be administered.
- Medication errors and/or drug reactions are immediately reported to the attending physician, charted in detail on the nurse's notes and described in the electronic event reporting system.

**Medication Administration Schedule**

All scheduled medications will be administered as instructed below unless specified by the provider.

Daily - 0900	PO/IV meds
BID - 0900; 2100	PO/IV meds
TID - 0900; 1500; 2100	PO meds
QID - 0900; 1300; 1700; 2100	PO meds

Q6H - 0500; 1100; 1700; 2300  
Q8H - 0000; 0800; 1600  
QHS - 2100

IV meds  
IV meds  
PO/IV meds

*Breakfast 0730 -- Lunch at 1200 -- Dinner at 1730*

½ H AC- 0700; 1130; 1700

With Meals- 0730; 1200; 1730

½H PC- 0800; 1230; 1800

\*Anti-seizure and pain medications given at evenly spaced timed intervals

\*Thyroid medications (empty stomach meds) given 1 hour before first meal of the day 0600 as its absorption is decreased when taken with other medications or food.

\* PPI's (Omeprazole, Pantoprazole) at 0700

\*Ranitidine, Famotidine, and Metoclopramide at ½H AC 0700; 1130; 1700

\*Ferrous sulfate/gluconate (Iron) given with meals

\*MOM given 1 hour before or after PO medications as it may decrease the absorption of other PO medications.

\*Daily Lantus or Basaglar given at 2100

\*Warfarin daily doses will be scheduled at 1700 for accuracy of am labs

**DEFINITIONS:**

None

<b>Subject:</b> <b>Compounding Medications</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ensure accuracy and consistency of the pharmaceuticals compounded in our hospital. No medications will be compounded in the facility, with the exception of IV admixtures. Reconstitution of powdered parenteral medications does not constitute compounding.

**PROCEDURE:**

- No medication will be compounded in the facility as there is no acceptable method available to determine the integrity of the product or to monitor the adequacy of the compounding process with the exception of IV admixtures.
- Compounding of sterile preparations in this facility means mixing medications into parenteral IV solutions. This process may be done only by properly trained registered nurses, pharmacists, physicians, physician assistants and nurse practitioners.
- Compounding of IV admixtures shall be performed using aseptic technique only at designated areas in the facility: med carts in the ER, Acute, SNF, nursing units; med room in clinic.
- Compounding area surfaces will be cleaned and disinfected at least daily, when in use, with a hospital approved germicide.
- Compounding areas will be free of clutter and obvious sources of contamination (for instance, sinks)
- Hand hygiene must be performed prior to preparation of IV admixtures.
- No products will be compounded using non-sterile chemicals.
- Compounded products will be used immediately. Administration will begin within 1 hour of starting the compounding process. There will be none stored in refrigerators for later use.
- The CNO is responsible for education of staff in regard to proper compounding of IV admixtures.
- To the maximum extent possible, commercially prepared, premixed parenteral products are used versus manually compounded sterile products.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Drug Recall</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to describe the process for handling drug recalls. By doing so we will prevent the use of recalled pharmaceuticals and process them appropriately.

**PROCEDURE:**

The following procedure will be carried out when merchandise is recalled by the manufacturer:

- The notification will be received by Pharmacy Services that such medication has been recalled for specified reason.
  - **Class I recall:** a situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.
  - **Class II recall:** a situation in which use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
  - **Class III recall:** a situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.
  - **Market withdrawal:** occurs when a product has a minor violation that would not be subject to FDA legal action. The firm removes the product from the market or corrects the violation. For example, a product removed from the market due to tampering, without evidence of manufacturing or distribution problems, would be a market withdrawal.
  - **Medical device safety alert:** issued in situations where a medical device may present an unreasonable risk of substantial harm. In some case, these situations also are considered recalls.
  
- All inventory, including floor stock, will be checked to see if the district has that item or lot number in question in all areas of the hospital or clinic.

Areas to check for recalls:

- Patient’s cubicles
- Pharmacy Services
- ER medication and crash carts
- Acute medication and crash cart
- Clinic
- SNF Medication cart
  
- If recalled medication(s) are found, all stock from Pharmacy Services and other areas where the medications are kept will be removed.
- The procedure for returning or disposing of the medication(s) as requested by the manufacturer is followed.
- If the recalled item(s) in question, is not in stock, the recall sheet is kept for a two-week period so all shipments, either direct or from the wholesaler, can be checked. Then, it is filed under “Drug Recalls”.
- If drug recalled is in stock, the amount to be returned is indicated on recall letter and dated, and then returned to manufacturer. The recall letter is filed under “Drug Recalls”.
- The “Drug Recall Disposition” chart is completed (located in the Drug Recall file) indicating the method of disposition, etc.
- Recall Procedure:
  - Notify the pharmacist of the recall.
  - Pharmacy staff shall check for any balance on hand of the recalled medication and remove from all locations.
  - The pharmacist shall check patient profiles for recent dispensation of the recalled agent.

- The pharmacist shall notify the patient's physicians of the recall and discuss therapy alternatives.
  - The pharmacist will complete a Quality Review Report (QRR), indicating the drugs and steps that were followed.
  - The pharmacist will notify nursing and the medical staff to be alert to possible Adverse Drug Events.
- The Recalls, Market Withdrawals, & Safety Alerts Verification are available on FDA's website for three years at: <https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts>

**DEFINITIONS:**

None

<b>Subject:</b> <b>High-Risk Medication</b>	<b>Manual:</b> <b>Inpatient Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to implement strategies and safeguards for high alert medications. High-Risk Medications are medications that have an inherent narrow therapeutic index and/or have the potential to cause serious adverse events when not used appropriately.

Several strategies and safeguards are instituted to ensure high alert medications are procured, stored, ordered, prepared, dispensed, and administered safely.

**PROCEDURE:**

The following medications and medication classes have been identified as being high alert at our facility:

- Adrenergics (epinephrine, norephrineine)
- Anesthetic / Sedative (ketamine, propofol)
- Antithrombotics and specific anticoagulant agents (heparin, warfarin)
- Concentrated electrolyte solutions
- Hypertonic Solutions (NaCl 3%)
- Insulin (SC and IV)
- Neuromuscular blocking agents (succinylcholine, rocuronium)
- Opioids

To improve patient safety by proactively employing additional safety measures to protect patients from harm related to high-risk medications, which bear a heightened risk of causing significant patient harm when used in error.

Current risk reduction strategies for High-Risk Medications include:

- Limiting available concentrations of these medications
- Limiting available concentrations of these medications
- Using barcode technology at the patient’s bedside
- Stocking smaller size vials
- Avoid stocking look-alike/ sound alike medications next to each other
- Using high-alert labels to identify high-risk medications
- Relevant and appropriate monitoring therapy (aPTT, INR)
- Improving access to information about these drugs (Lexi-Comp, Redbook in ER)
- Limit verbal orders for high-risk medication to true emergencies

**DEFINITIONS:**

None

<b>Subject:</b> <b>Defective Medications</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to monitor medications to assure they are not defective by assuring that defective drug products are not used, and that they are reported through the proper channels.

**PROCEDURE:**

If a drug product is suspected to be defective, contaminated, or unfit for use for any reason, the following procedures will be followed:

- Stop the use of the product in question.
- If the product has been used, notify the prescriber immediately and document.
- Notify the pharmacist and place it in the Return Bin, identifying the drug as defective.
- Pharmacy Staff will inform the drug product manufacturer if appropriate.
- Notify the FDA through the FDA-Drug Quality Reporting System if appropriate at <https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program>

**DEFINITIONS:**

None

<b>Subject:</b> <b>Disposition of Medications</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to (Your Policy Here)

**PROCEDURE:**

Disposal of discontinued medications will be divided into two categories:

- All medications will be discarded into the Cactus Smart Sink. Controlled Substances will require a witnessing nurse or Pharmacist and documented in Pyxis and or on patient log sheet.
- When a residents' order is discontinued, the medications are disposed immediately by the nurse who receives (or is made aware of) the discontinued order.
- Used medication vials and inhalers will be discarded into the blue and white pharmaceutical incineration bins, which are collected by Environmental Services when full and taken to locked storage to be picked up weekly by a licensed hauler.

Pharmacy strives to dispense only single dose vials (SDV) whenever possible to limit waste. Multi-dose vials (MDV) may be treated as single dose vial and discarded following initial use in most cases. True MDV's are good until their beyond use date (BUD) after opening, or the manufacturer's expiration date, whichever comes first. Beyond use dates for injectables will be 30 days or less than 30 days according to the manufacturer.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Furnishing Medication Orders</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide adequate pharmacy services to meet the needs of the patients and institution, as determined by the Medical Staff Pursuant to Federal and State laws.

Drugs shall be administered by licensed personnel authorized to administer drugs upon the order of a person lawfully authorized to prescribe.

Medication dispensed to inpatients will be by the unit dose system when available (oral, IM, IV, Rectal). All medications are to be prepared from a physician's order.

Verbal orders will also contain the name of the person giving and the signature of the individual receiving the order. Verbal orders for administration of medications shall be received and recorded only by those whose scope of licensure authorizes them to receive orders for medication. The prescriber shall countersign the order within 48 hours.

**PROCEDURE:**

The following procedure to be followed in furnishing of medication orders.  
Medications Orders:

- Provider enters all new medication orders into EMR.
- The pharmacist reviews the prescriber orders and interprets it to ensure accuracy and suitability of the dosage form, timing of medication administration, duplication, interactions, or allergies.
- The pharmacist clarifies any problems or questions on the order, consulting with the prescriber when necessary.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Prescription Pads</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to maintain control of provider prescription blanks to prevent fraudulent use. This policy will outline the procedure for the storage, issuance, use, and monitoring of the District’s blank prescription pads is as following:

**PROCEDURE:**

- Ordering
  - Prescription pads will be ordered by the Operations Manager.
  - Prescription pads belonging to Emergency room providers will be stored in the med room.
  - Prescription pads belonging to clinic providers will be stored in a locked cabinet in the clinic manager’s office.
  - Prescription pads are individualized for each provider and shall be used only by them.
  - Off-duty providers shall turn in their unused prescriptions pads to either the ER Nurse or Pharmacy Director who will store them until he/she returns.
  - Arriving physicians should contact the Pharmacy Director to retrieve their pad.
- Distribution
  - Each provider shall be given one prescription pad at a time.
  - Each provider is responsible for their own prescription pad. Pads must NEVER be left in a drawer in an exam room or in the ER.
  - When the pad is filled, the provider shall contact the Pharmacy Director, turn in the completed pad, and be issued a new one.
  - Final storage of the filled pads is the responsibility of the Pharmacy Director
- Use
  - All prescriptions must be written and signed in ink by a licensed independent practitioner authorized to prescribe medications.
  - A copy of the original shall be put into the patient’s medical record rather than the carbon copy, which fades with time.
  - Carbon copies of the prescription pads shall be returned to the Pharmacy for storage when the pad is completed.
- Monitoring Loss or Theft
  - Loss or theft must be reported to the local law enforcement and create an incident report.
  - The physician shall report to the Department of Justice (DOJ) Controlled Substance Utilization Review and Evaluation System (CURES) program immediately after the discovery of the theft or loss. Email [SecurityPrinter@doj.ca.gov](mailto:SecurityPrinter@doj.ca.gov)
  - The physician shall notify the California State Board of Pharmacy at [BOPcomplaint@dca.ca.gov](mailto:BOPcomplaint@dca.ca.gov)
  - The physician shall notify the Medical Board by an email to [complaint@mbc.ca.gov](mailto:complaint@mbc.ca.gov)

**DEFINITIONS:**

None

<b>Subject:</b> <b>Crash Cart</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to properly maintain and store emergency medications in our crash carts. By doing so we will ensure that our crash carts are always supplied with emergency medications and sealed properly.

Cardiac arrest medications, and medications used in medical emergencies, are immediately available in the crash cart in the emergency room, between bed 1 and 2; and the crash cart in room 109 on the Acute Floor. The Pediatric crash cart is located in the emergency room by bed 4. During a pediatric code blue, staff is to utilize the pediatric crash cart supplies in conjunction with the medications in either of the other two crash carts. The emergency drug supply is stored in a clearly marked portable container which is sealed by the pharmacist in such a manner that a seal must be broken to gain access to the medications. Contents of the medication drawers of the emergency crash cart, shall be the responsibility of the pharmacy staff or the nursing staff when the pharmacist is unavailable. Materials shall be responsible for the rest of the cart.

**PROCEDURE:**

- Nursing staff will be responsible to notify the pharmacy and materials departments via email that the crash cart has been opened.
- During operating hours, Pharmacy is responsible for restocking medications in drawers 1 & 2 in the crash carts as soon as possible and sealing them with a red plastic lock.
- The lock number on the seal will be recorded in the crash cart log along with the date and initial of the pharmacy staff who refilled it.
- In the absence of pharmacy staff, nursing staff will restock the cart using the Pyxis machine under the patient listed as “Crash Cart” and seal it with a yellow lock.
- The pharmacy staff will then verify all yellow seals and replace the seal with a red lock as outlined above.
- Materials will be restocked by the materials department.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Loss and Diversion</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to guide all SoHum Health activities related to loss, prevention, monitoring, and reporting of Controlled Substance Diversion. Controlled Substances are medications class, identified as Schedule II through V by the U.S. Drug Enforcement Agency (DEA) and/or applicable state law. Diversion means intentionally or without proper authorization using or taking possession of a medication or medical gas, including but not limited to theft, using, or taking a medication without a valid order or prescription, forging or inappropriately modifying a prescription, and taking possession of medication waste.

SoHum Health will investigate all reports of potential diversion, involving and cooperating with law enforcement as required. We will offer an intervention program to employees found diverting medications. Pharmacy, medical staff, nursing, administration, human resources, employee health, risk management, and security work together to create systems to prevent and/or detect drug Diversion of Controlled Substances. A coordinated interdisciplinary effort is necessary to ensure proper control of Controlled Substances and thorough investigation of Diversion.

**PROCEDURE:**

The prevention, detection, and reporting of drug Diversion is the responsibility of all SoHum Health employees.

- SoHum Health monitors activities related to prevention, monitoring, and reporting of Controlled Substance Diversion.
- SoHum Health will investigate all reports of potential diversion, involving and cooperating with law enforcement as required.
- If an individual becomes aware of, or suspects diversion is/has occurred, it is to be immediately reported for investigation to the Pharmacy Director, Human Resources Director, and the Chief Nursing Officer.
- Pharmacy and nursing will perform detailed audits on CS utilization & waste performed by the suspected employee.
- They will review the initial reported or observed event/behavior to determine what documentation and/or intervention is required.
- Suspected employees are sent for employee laboratory testing, assessed by a medical provider, and are placed on a temporary leave of absence.
- Additional actions that may follow include an interview with the employee, suspension and/or termination, and reporting of findings to required respective regulatory agencies.
- A root cause analysis of the incident will be conducted to assist in finding opportunities for improvement. An action plan will be developed, implemented, and evaluated as appropriate.
- If an investigation reveals that an employee on leave has diverted, they will be directed to Human Resources prior to returning to their respective departments.
- We will offer an intervention program to employees found diverting medications.

The following agencies must be formally notified within their specified timeline:

- The California Department of Health Services (Administrator or the CNO’s responsibility).
- The Board of Pharmacy within 14 days using either the DEA Form 106 <https://apps.deadiversion.usdoj.gov/> and the Pharmacy board email designated for reporting of CS Loss: [DEA106@dca.ca.gov](mailto:DEA106@dca.ca.gov) (Pharmacist’s responsibility).

- The DEA will be notified directly via DEA Form 106 to report significant losses of Controlled Substances no later than one business day. The form can be found at <https://apps.deadiversion.usdoj.gov> (Pharmacist's responsibility - form DEA 106)
- The Chief of Staff (CNO's responsibility)
- The Chairperson of the Governing Board (Administrator or the CNO's responsibility)

**DEFINITIONS:**

None

<b>Subject:</b> <b>Compassionate Access to Medical Cannabis</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to adhere to the legislative requirements set forth in the Compassionate Access to Medical Cannabis Act (Senate Bill 988). The District shall permit patient use of medicinal cannabis and shall carry out all of the following described in the corresponding procedure.

**BACKGROUND:**

Senate Bill (SB) 311 (Chapter 384, Statutes of 2021) established the Compassionate Access to Medical Cannabis Act requiring health care facilities to allow terminally ill patients to access medicinal cannabis under specified conditions.

SB 988 provides revisions to the Act.

Effective January 1<sup>st</sup>, 2023, SB 988 reiterates that for purposes of the Act the definition of a “health care facility” does NOT include, among other things, the emergency department of a General Acute Care Hospital. This means that the Act does NOT require the District’s emergency department to permit terminally ill patients access to medicinal cannabis.

**DEFINITIONS:**

Patient – means an individual who is terminally ill, NOT an individual receiving emergency services and care. Terminally ill – a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

**PROCEDURE:**

Per Senate Bill 988, the Skilled Nursing and Swing sections of SoHum Health District are in the scope of the Compassionate Access to Medical Cannabis Act. As such, they must follow the guidelines set forth by the Act:

- The patient or primary caregiver is explicitly responsible for acquiring, retrieving, and administering the medicinal cannabis.
- Healthcare professionals and facility staff are prohibited from administering medicinal cannabis or retrieving it from storage.
- Medicinal cannabis shall be securely stored at all times in a locked container in the patient’s room, other designated area, or with the patient’s primary caregiver.
- Smoking or vaping are not permissible methods of use.
- Upon discharge, patients or primary caregivers are responsible for the removal of the medicinal cannabis.
- If they are unable to remove the medicinal cannabis, it will be disposed of by a nurse and require a witnessing nurse or Pharmacist.
- Any warranted dispositions shall be documented in Pyxis in the electronic health record.

It must be stated that the Act does not require the facility to provide a patient with a recommendation to use medicinal cannabis or include medicinal cannabis in a patient’s discharge plan.

<b>Subject:</b> <b>Procurement of Pharmaceuticals</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to obtain pharmaceuticals from reputable vendors to meet the needs of our residents and patients. SHCHD is a member of a group purchasing organization (GPO) and is therefore obligated to follow purchase agreements signed by the group.

**PROCEDURE:**

The following general specifications are considered in making the purchasing decisions:

- SHCHD shall strive to fully comply with the contracts and bid prices established by the District and the GPO.
- All drugs shall meet or exceed USP, NF or FDA requirements for potency and labeling.
- Ordering of products shall primarily be through the prime vendor relationship established by the District's contracts. Other items shall be ordered directly from the manufacturers as warranted.
- If a product is not available for the immediate needs of the patients, every attempt shall be made to prescribe, borrow, or purchase the product from either local hospitals or retail pharmacies.
- If all attempts are exhausted and a medication cannot be procured, the pharmacist shall call the physician and consult regarding alternative therapies.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Patient's Own Medication</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to abate the use of home medications while receiving treatment in the District by limiting its use to non-formulary items or unavailable medications which will result in delay of treatment. All efforts will be made to use the hospital's medication supply to ensure accuracy, consistency, and proper storage and handling of medication use.

**PURPOSE:**

The purpose of this policy is to describe the procedures for the use of medications brought into the District by a patient when a physician's order warrants it.

**PROCEDURE:**

- The procedure below outlines the steps taken:
  - Only non-formulary or out of stock medications with an active order can be used as home medication.
  - No medications will be administered which do not meet proper labeling or integrity requirements.
  - Prescription medications must be presented in a vial with the original label from the pharmacy to be accepted as a home medication. Loose tablets or unlabeled vials will not be accepted.
  - The physician or pharmacist shall verify the identity and integrity of all home medications prior to their drop-off for home medication use. If neither are available to verify a medication, a nurse may verify the medication through the use of Lexicomp's "Drug I.D." function.
  - Upon accepting home medications, the receiving nurse shall enter a Note in the patient's profile detailing which medications were received and when. Controlled medications shall be counted upon receipt, the quantity documented in the notes, and then placed in the Controlled Substances safe.
  - Once verified, their medications will be labeled with a yellow, "PATIENT'S OWN MEDICATION" sticker and initialed by the verifying agent.
  - ED home meds will be stored at the ED nurse's station.
  - Inpatient home meds will be stored in the appropriate cart (Swing or SNF) at the inpatient nurse's station.
  - Nurses are not to administer Home Medications that have not been verified.
  - If the directions stated on the home medication differs from current orders, a green, "NOTE DOSE STRENGTH" sticker shall be placed on the home medication to ensure accurate administration throughout their stay.
  - The medications will be marked in the electronic record as home medications to avoid improper charges.
  - A prescription shall be sent to the contracted pharmacy for the ordered medication. Home medications shall be used until the pharmacy furnishes the order and is available on site.
  - If a home medication is discontinued, it shall be placed in a security bag and sealed. A registration label with the patient's name shall be placed on the bag and kept in the appropriate drawer labeled for "Patient's own discontinued medications".
  - A label stating "MEDICATION FROM HOME TAKEN TO PHARMACY" shall be placed on the Personal Belongings Listing form as a reminder to review any home medications taken from the patient on arrival and return them upon discharge.

- Home medications for a controlled substance shall be recorded to include the name, quantity, and dates for accuracy. They will be stored inside the safe in the Nurse's Station. A signature is required for controlled substances dropped-off and picked upon discharge.
- If the stored medications have not been picked up within 14 days of discharge or in the unfortunate event the patient expires, pharmacy staff will destroy them appropriately in the pharmaceutical waste containers.

**DEFINITIONS:**

None

<b>Subject:</b> <b>Medication Monitoring and Storage</b>	<b>Manual:</b> <b>Inpatient Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ensure that all medications are secured, stored, and disposed of in accordance with state and federal Law, manufacturer guidelines, and clinical best practices. The Pharmacy department will routinely inspect medications located in each Patient Care Areas, Pyxis Technology, Emergency Carts & Kits. The Pharmacy is responsible for the storage, integrity, security, distribution, and dispensing of all medications in accordance with state and federal Pharmacy law.

Appropriate storage and monitoring of medications promote the availability of safe medications where and when needed, minimize the risk of medication diversion or adulteration, and to decrease the risk of potential medication errors.

**PROCEDURE:**

**Monitoring of Medications**

Pharmacy and nursing staff routinely inspects medication storage areas and removes expired, damaged and/or adulterated medications. Expired medications or those approaching expiration (30 days) will be returned to the pharmacy and placed in a designated location for processing by a reverse wholesaler. Pharmacy staff complete an inspection and assessment of each patient care area where medications are stored and dispensed.

**Wireless Temperature Monitoring (Medication)**

Wireless temperature monitoring will be used to track whether medications are exposed to temperature excursions which may impair integrity and potency. Engineering, Pharmacy, and applicable departments are notified of temperature excursions through an automated email.

All pharmaceutical refrigerators and freezers are connected to emergency power in the event power is interrupted. Pyxis Technology is connected to emergency power in the event power is interrupted. In the event these Technologies are unavailable, paper temperature logs will be utilized and retained.

Any medications identified or suspected to be exposed to temperature excursions will be quarantined until they are reviewed by Pharmacy staff to determine if they can be approved for administration. In the event of a temperature excursion, follow the *Managing Temperature Excursion Procedure and complete the Medication Storage Troubleshooting Record Form*.

**Temperature Ranges**

Controlled Room Temperature	20° to 25° C (68° to 77° F) 15° to 30° C (USP Excursions) NTE 40° C for 24 Hours (per USP)
Refrigeration	2° - 8° C (36° to 46° F)
Frozen	-25° to -10° C (-13° to 14° F)

**United States Pharmacopeia (USP) 10.30.60**

"Controlled Room Temperature" indicates a temperature maintained thermostatically that encompasses the usual and customary working environment of 20 to 24 degrees C (68 to 77 degrees F); that results in a mean kinetic temperature calculated to be not more than 25 degrees C; and that allows for excursions between 15 and 30 degrees C (59 and 86 degrees F) that are experienced in pharmacies, hospitals, and warehouses.

**Provided the mean kinetic temperature remains in the allowed range, transient spikes up to 40**

**degrees C [104 F] are permitted as long as they do not exceed 24 hours. Spikes above 40 degree C may be permitted if the manufacturer so instructs.** Articles may be labeled for storage at "controlled room temperature" or at "up to 25 degree" or other wording based on the same mean kinetic temperature. The mean kinetic temperature is a calculated value that may be used as an isothermal storage temperature that simulates the non-isothermal effects of storage temperature variations.

### California State Pharmacy Law

**4119.7** Health Care Facility; Inspection of Drugs; Furnishing Per Standing Orders, etc. (a) Notwithstanding any other law, a hospital pharmacy serving a health care facility licensed under subdivision (a) of Section 1250 of the Health and Safety Code may furnish a dangerous drug or dangerous device pursuant to preprinted or electronic standing orders, order sets, and protocols established under the policies and procedures of the health care facility, as approved according to the policies of the health care facility's governing body, if the order is dated, timed, and authenticated in the medical record of the patient to whom the dangerous drug or dangerous device will be provided. (b) **A health care facility shall store and maintain drugs in accordance with national standards regarding the storage area and refrigerator or freezer temperature, and otherwise pursuant to the manufacturer's guidelines. The health care facility's policies and procedures shall specify these storage parameters.** (c) An intern pharmacist under the direct supervision and control, as defined in Section 4023.5, of a pharmacist, may inspect the drugs maintained in the health care facility at least once per month. The health care facility shall establish specific written policies and procedures for inspections pursuant to this subdivision. (d) For purposes of this section, "health care facility" means a health facility licensed under subdivision (a) of Section 1250 of the Health and Safety Code.

### Storage of Medications

At the time of initial purchase all products will be evaluated for required storage conditions prior to being stored into Pyxis. Controlled substances deliveries from a supplier, will be checked-in by the pharmacist. Medications will be stored accordingly to United States Pharmacopeia (USP), and/or manufacturer guidelines. Medications are stored in one of the following secure areas to prevent diversion or adulteration in accordance with state and federal laws.

- Hospital medications are stored inside the Medication Room located behind a locked door. Medications are available in unit dose form whenever possible. With the exception of bulk fluids, all medications are stored and distributed through Pyxis Technology. Emergency medications are stored Pyxis and in one of two Crash Carts located in the emergency department. The carts are locked with a seal at all times when not in use. The seal is inspected twice in a 24-hour period.
- Acute/Swing/Skilled Nursing Facility medications are stored in medication carts and refrigerator inside the Nurses' Station behind a locked door. They are also locked at all times, unless in use. Only authorized personnel (nursing and pharmacy staff) are permitted access to this room. Housekeeping will contact nursing staff for access for cleaning – nursing staff will remain present during cleaning. SNF overstock meds are to be stored separately based on external or internal routes. Overstock medications are to be stored separately from medications in use. The SNF and Acute/Swing medication carts may be taken into the hallway during a med pass. The cart must be locked each time a nurse leaves the cart unattended to go into a patient/resident room. At no time should the cart be left unattended if it is not locked. In addition, no medication may be left on top of the cart if it is unattended, even if it is locked. Emergency medications are stored in the Crash Cart in Room 109. This cart is locked at all times when not in use. The lock is inspected twice in a 24-hour period.
- Clinic medications are stored in a locked cabinet and a refrigerator at the Clinic Nurses' Station. The cabinet and the Nurses' Station are separately locked during the hours when the clinic is not open. Access to the cabinet is limited to Clinic Providers, Clinic Nurse Manager, Patient Care Coordinators, and pharmacy staff. This cabinet is kept locked, except during working hours. The Treatment Room door is also locked when the Clinic is not open. Additional medications for use in procedures are stored in a cabinet in the Treatment Room.
- Computed Tomography contrast agents such as Omnipaque and Visipaque for imaging stored in a locked cabinet in the computed tomography room.
- Staff will maintain the cleanliness of medication refrigerators and freezers located in each patient care area.
- Medications are handled and stored according to manufacturers' specifications, USP Guidelines

**DEFINITIONS:**

None

<b>Subject:</b> <b>End-of-Life Comfort Care</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to maintain the dignity of the patient through pain control and symptom control by supporting the best possible quality of life for patients living with a serious, chronic, or terminal illness.

Comfort Care begins when treatment or life-prolonging therapy is no longer curative, the patient or medical decision-making representative has agreed to this prognosis and the focus turns toward palliative or comfort measures. At this juncture, the Comfort Care order set will be initiated by the attending physician.

The hospital will ensure that the patient and family receive counseling regarding the interest and needs of the patient and family in a manner in which they can understand. If a health care provider does not wish to comply with his or her patient's request for information on end-of-life options, the health care provider shall transfer the patient to another health care provider that shall provide the requested information.

**PROCEDURE:**

This is accomplished by holding early discussions with patients and their families regarding end-of-life issues, their preferences of care and honoring their advance directives. The following

- Code status is addressed asap on admission.
- Educate and support patient and family on the disease process, treatment options, advance health care directives, and community support resources in a timely manner.
- Provide information about what behaviors to expect as patient progresses through the terminal stages of the disease as well as the grieving process. Instruct significant others as to the possible signs of approaching death:
  - Reduced level of consciousness
  - Reduced urine output
  - Cool, mottled extremities
  - Sometimes confusion or anxiety
  - Labored breathing or periods of no breathing
- End of Life Comfort Care orders implemented, if ordered.
- Medicated per physician's orders to maintain comfort.

**DEFINITIONS:**

None

<b>Subject:</b> <b>General Medication Room Operations</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

This policy of SHCHD is to provide adequate pharmacy services from our Medication Room to meet the needs of the patients of the District as determined by the Medical Staff pursuant to Federal and State laws. The hospital pharmacy is staffed by a registered pharmacist who is delegated the Director of Pharmacy and will attend Medical Error Reduction Program (MERP) meetings, Medical Staff meetings and other meetings as needed. The pharmacist is responsible for operating the pharmacy efficiently and smoothly and will provide the best possible service to the patient in all areas of medication utilization. In the absence of the pharmacist, a fully qualified registered pharmacist will fill in and will be given the responsibility for the operation of the pharmacy services. The pharmacist will be supported by a pharmacy technician to properly conduct Pharmacy Services in compliance with the established guidelines.

General Medication Room hours are M-F from 8:00am -4:30pm. A registered pharmacist will be available 24 hours each day for consultation.

The District has established the following Policy and Procedures outlining the general operations of the Med Room and staff.

**PROCEDURE:**

- See Crash Carts Policy
- See Defective Medication Product Policy & Procedure
- See Drug Recalls Policy & Procedure
- See End of Life Comfort Care Policy & Procedure
- See Furnishing Medication Orders Policy & Procedure
- See High Risk Medications Policy & Procedure
- See Investigational Drugs Policy & Procedure
- See Impaired Licensee Policy & Procedure
- See Medication Administration Policy & Procedure
- See Medication Procurement and Administration Policy
- See Medication Monitoring and Storage Policy
- See Patient's Own Medications Policy & Procedure
- See Prescription Policy & Procedure
- See Pyxis Policy & Procedure
- See Use of Illicit Drugs (Unaffiliated Persons) Policy & Procedure

**DEFINITIONS:**

None

<b>Subject:</b> <b>Reporting Medication Errors and Adverse Events</b>	<b>Manual:</b> <b>Hospital Pharmacy</b>
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**POLICY:**

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to report medication errors pertaining to the prescribing, administering, documentation of use of medications, and adverse reactions immediately to the manager on duty. Medication errors shall be researched to determine the root causes. State and federal agencies shall be notified according to statutory and regulatory requirements.

**PURPOSE:**

The purpose of this policy and procedure is to safeguard immediate care of patients in the case of a medication error or adverse drug reaction. It will enhance patient safety by identifying and also addressing errors and adverse reactions via a proper and timely approach. An RL Event will be completed for errors and that data collected will serve as continuous quality improvement for future deterrence.

**PROCEDURE:**

N/A

**DEFINITIONS:**

None

## Operations Report as of 03/19/2026

### Project status

**New hospital process:** CEQA hearing was rescheduled to March 26, 2026, to allow for public comment and response to be added. LACO and Ratcliff will be in attendance for presentation and discussion of the Final Initial Study and appendices. These documents are available at <https://sohumhealth.org/ceqa-notice/> We continue to work with a neighbor to iron out an easement for the property's western entry. An additional survey of the property lines was conducted, and monuments were installed at the corners for future reference.

The plans submitted to HCAI and Humboldt County have received initial comments from both agencies, and responses have been returned. Currently, the project timeline remains on track as follows, with some minor changes from my last report:

#### AGENCY REVIEW/BIDDING – 11 months (approximate)

- August 27, 2025 – July 31, 2026 – HCAI Review (11 months – approximate)
- May 1, 2026 – July 31, 2026 – Bidding (overlaps the last 3 months of HCAI review)
- We assume Agency Review/Bidding for the Clinic Building and for the small Playhouse package would occur within this time, too

#### CONSTRUCTION ADMINISTRATION – 20 months, estimated (determined by GC)

- August 1, 2026 – March 31, 2028 – CA for both the Hospital and Clinic Building – assuming 1 GC for both

#### CLOSEOUT – 2 months – April 1, 2028 – May 31, 2028

#### OWNER MOVE-IN – 5-7 months.

- START: June 1, 2028
- FINISH (EARLY) - 5 months: October 31, 2028, at the earliest
- FINISH (LATE) - 7 months: January 1, 2029

Ratcliff Architects attended a conference with a heavy attendance of healthcare construction firms, in part to garner interest in our project. Most firms had little desire to enter a full bid process, favoring a negotiated bid approach to construction.

A negotiated construction bid would allow the district to identify a single general contractor, inviting them to negotiate the project terms and costs, and subsequently award them the contract to execute the project. A flexible negotiated contract allows for changes and discussions on costs as the project evolves, but the final cost may vary.

We are conferring with legal counsel on an exception that could allow this process, assuming management and board interest.

A meeting with PG&E and the architect on March 17th was productive and helpful. Changes to the project design and electrical service to the existing schoolhouse building are being reviewed because PG&E allows only a single service per address, and serving the existing OSHPD 3 building from the new OSHPD 1 building would be less costly than undergrounding the existing service across Sprowel Creek Road.

I am currently establishing a conversation with CalTrans regarding pole placement for the incoming service location.

### **Maple Lane and Redwood Drive Properties**

**Maple Lane:** Work is progressing well on the Maple Lane/Connie's Corner Optometry facility. Roof replacement is complete. Exterior lighting is in progress. HVAC is in place. The final portion of the exterior siding is pending wiring for alarms and cameras. Rough plumbing in progress. Sewer line ready for connection to GSD. Supply water line replacement is complete. Preparations for electrical work are being finalized. The exterior gazebo area has been raised.

**Redwood Drive:** Extensive work had been done on the Redwood Drive property, including the first few phases of shoring and interior wall modifications. Concrete and soil excavation work is ongoing. The exterior façade has been removed in preparation for new framing and storefronts. Sidewalk work is coming soon. Some tree removal work has been accomplished. Inspections have been positive, with no issues or citations. The rear portion of the building has some roof and exterior wall removal in process.

### **MRI**

Preparations for MRI services are completed with Guy confirming functionality of the electrical connections. Met with company reps to discuss the proposed location and access for unit delivery.

### **ER HVAC**

A new HVAC unit for the Emergency Department has been installed, and final ducting is being fabricated, though temporary use is now approved and functional. Multiple rounds of inspections (concrete pour, bolt epoxy and pull testing, air balancing, electrical work, gas line piping, etc.) have been completed and signed off by oversight agencies.

As always, please feel free to stop by if you have questions or comments.

-Kent

## **CNO Board Report – March 2026**

### **Infection Prevention Update**

Flu season remains ongoing, and while cases continue to be reported to public health authorities, we are pleased to report that our patients and residents have remained free from both COVID-19 and influenza.

To help maintain a safe environment, we kindly encourage visitors to the hospital and Skilled Nursing Facility (SNF) who are not up to date on vaccinations to consider wearing a face mask to protect our patients and residents.

Vaccination continues to be the most effective method for reducing the risk of influenza and its complications. This season, hundreds of millions of flu vaccine doses have been distributed across the United States, contributing to broader community protection.

Prescription antiviral medications are available to treat influenza and are especially important for individuals at higher risk of severe illness. Early treatment can help reduce both the severity and duration of symptoms.

According to public health guidance:

“Vaccination is the most effective preventive measure, and everyone aged 6 months and older is strongly encouraged to receive an annual flu vaccine, particularly those at higher risk. If you have questions, please consult your healthcare provider.”

#### **Additional Tips for Preventing the Flu:**

- Cover coughs and sneezes
- Wash hands frequently with soap and water
- Avoid touching eyes, nose, and mouth
- Stay home when feeling unwell
- Maintain good ventilation in shared spaces when possible

Thank you for helping us keep our community safe.

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### **Emergency Department and Acute Care Update**

In February, the Emergency Department (ED) provided care to **298 patients**, while the Acute

Care unit managed **12 swing-bed patients** and **2 inpatients**.

Elevate ED providers continue to be well received within the community, consistently delivering high-quality care. Patient feedback has been positive and highlights the strong level of service in the Emergency Department.

The ED and Acute Care units are prioritizing updated training across all areas, including:

- Basic Life Support (BLS)
- Advanced Cardiovascular Life Support (ACLS)
- Pediatric Advanced Life Support (PALS)
- Additional competencies

Efforts are underway to streamline continuing education, including both onboarding and annual training programs. Cross-training initiatives are also expanding to ensure adequate staffing coverage across departments. Management is actively engaged in training related to the new MCG system.

There is an increasing need for traveler nurses. Currently, one traveler RN is working on the hospital side, and recruitment is underway for:

- One additional traveler RN
- One traveler LVN

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## Laboratory Update

The laboratory continues to perform strongly and achieve key milestones:

- **422 visits** in February 2026
- Successful accreditation by the Accreditation Commission for Healthcare, demonstrating commitment to high-quality standards

The laboratory team has maintained remarkable stability, with no new hires over the past three years. The team of six has remained consistent and effective since 2022.

The department also emphasized workforce development by providing hands-on training to two students, enabling them to obtain California phlebotomist certifications. While laboratory positions were not available, both individuals are now contributing to the Security and Transportation team at SoHum.

On January 7, the laboratory team held its annual kickoff meeting to:

- Review accomplishments
  - Gather interdisciplinary feedback
  - Establish goals for 2026
- 

## Skilled Nursing Facility (SNF) Update

January was a successful and engaging month for SNF residents. Holiday celebrations included gifts, stockings, and hot chocolate in December, followed by continued festive crafts and activities in January.

- Resident census remains stable at **8**
- Recent survey results were positive, reflecting continued commitment to quality care

The team continues to develop policies that uphold high operational standards, regulatory compliance, and the safety and rights of residents.

The Activity Director maintains a robust schedule, including:

- Healy Center lunches
- Friday Afternoon Music Events featuring local performers

These activities continue to strengthen community engagement and resident well-being.

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## Clinic Update

The clinic remains committed to delivering high-quality healthcare services.

In February 2026:

- **419 total patient visits**
  - **116 Behavioral Health visits**
  - **52 Mobile Optometry visits**

Operations remained steady with no major disruptions. Focus areas included preparation for upcoming initiatives and enhancing workflow efficiency through cross-department collaboration.

## **Key Initiatives:**

### **Mobile Clinic Preparation**

- Preparing for mobile clinic launch on **March 27**
- Coordinating logistics and operational readiness

### **Staff Training Coordination**

- Partnering with HIM to organize training during Diane's visit
- Identifying priorities and aligning materials and schedules
- Strengthening documentation and workflow compliance

### **Referral Workqueue Clean-Up**

- Collaborating with PFS to improve referral accuracy and processing
  - Focus areas:
    - Radiology
    - CT
    - Ultrasound
    - Physical Therapy
  - Addressing backlogs to improve patient flow and billing accuracy
- 

## **Radiology Update**

In February, Radiology performed:

- **200 X-ray exams**
- **100 CT scans**
- **49 ultrasound exams**

Mammography services were temporarily paused due to medical leave but are expected to resume in April.

Work continues on the MRI project and associated planning efforts.

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## **Pharmacy Update**

The Pharmacy Department is actively working on:

- Developing Workflow Aids to ensure compliance with policies and procedures
- Collaborating across departments to manage refrigeration downtime
- Enhancing the emergency department formulary to better meet clinical needs

The department is also:

- Partnering with Garberville Pharmacy to maintain consistent order quality
  - Strengthening coordination with Long-Term Care providers
  - Managing complexities of multiple formularies within the EPIC system
- 

## **Physical & Occupational Therapy Update**

In February 2026:

- **79 outpatient visits**, in addition to services in acute care, swing-bed, and SNF settings

The relocation to a newly expanded therapy room has improved service capacity and treatment offerings.

Recruitment is underway for a traveler physical therapist to support increasing patient demand and expand outpatient capacity.

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## **Senior Life Solutions (SLS)**

The SLS team conducted **76 visits** in February despite staffing shortages.

Plans are underway to host an open house in early 2026 to introduce the new location and program services to the community.

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**Thank you for your continued support and dedication.**

**Adela Yanez, RN, BSN, CNO**

Board Report for The Family Resource Center, March 2026

2026-27 secured funding (2025-2026 secured funding \$260,000.00)

DHHS CalFresh –	\$89,745.00 (5% cut)
Prop 64/ Public Health –	\$50,000.00
Humboldt Area Foundation –	\$15,000.00
FIRST 5 Playgroups –	\$14,000.00
Community Engagement Initiative –	\$12,500.00
Community First Credit Union –	\$10,000.00
Wild Rivers Foundation –	\$2,000.00
Humboldt Sponsors –	\$2,000.00

Continued services–

Michelle Kaufmann- Prop 64

- Youth Diversion Coordinator
- 1:1 Substance Abuse counseling for students at MJH and SFHS
- Classroom Education Sessions
- Family Meetings

Brandy Bremer- Mental Health Services Act

- Parenting Classes, 10-week course, 7 participants
- Parent support nights
- Diaper Program- 65 families
- Alderpoint Food pantry
- Nutrition Education

Piper Kenner- First 5 Playgroup leader

- Redway and Shelter Cove Playgroups, 35-45 families
- Early interventions/ Special Beginnings
- Redwood Coast Regional Center Family Services

Michelle Pogue- CalFRESH DHHS

- 25 Weekly food bags, 10 emergency bags monthly
- Fresh produce weekly
- Winter Break food support
- Myer's Flat Food Distribution

Amy Terrones- Director FRC

- Grant writing, contracts, reporting
- Child Welfare Services support
- Foster/ Homeless student support
- School- based interventions
- Coordination of collaborations

**Resolution # 26.02  
of the  
Southern Humboldt Community Hospital District  
Adopting an Initial Study/Mitigated Negative  
Declaration (IS/MND) and Mitigation Monitoring  
and Reporting Program (MMRP) for the  
Garberville Community Hospital and Medical  
Office Building Project**

**WHEREAS**, the Southern Humboldt Community Hospital District (SHCHD) Board of Directors proposes to develop a new Garberville Community Hospital and Medical Office Building (Project) in order to comply with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, and amended under Senate Bill (SB) 1953 in 1994, which mandates owners of all acute care inpatient hospitals to “demolish, replace, or change to nonhospital use, all hospital buildings that are not in substantial compliance, or seismically retrofit them so that they are in compliance with the [seismic] standards” before January 1, 2030; and

**WHEREAS**, the proposed Project would be on the properties identified as Assessor’s Parcel Numbers (APNs): 032-091-014, -016, -017, -018, -019, and 032-171-019 (Site), totaling approximately 3.52 acres and generally located at 286 Sprowel Creek Road in the unincorporated community of Garberville in Humboldt County, California. The new hospital and medical office building, to be located on the central portion of the largest project parcel (APN: 032-091-014; 2.95 acres) would replace the existing Jerold Phelps Community Hospital and Southern Humboldt Community Clinic, currently located at 733 Cedar Street (APNs: 032-011-015, 032-011-027, 032-133-002, 032-133-003, and 032-134-009) in Garberville, approximately 1,690 feet northeast of the Site. The new facility would total approximately 49,728 square feet in size and contain two stories. The new hospital and medical office facilities would provide much-needed services to the Garberville community and surrounding area, including expanded acute care and emergency room services, imaging, lab, and pharmacy services. It is estimated the new facilities would serve an average of 50 patients per day. A helistop is proposed directly south of APN: 032-091-014 on three adjacent parcels (APNs: 032-091-016, -018, and -019) for the transport of emergent patients and for training for EMS and fire department personnel. Two additional parcels (APNs: 032-091-017 and 032-171-019)

will provide additional setbacks and security control for the helistop. Following completion of the project, the existing Skilled Nursing Unit will remain at the existing hospital facility located on Cedar Street. The existing building located on-site would also be renovated; and

**WHEREAS**, the SHCHD prepared an Initial Study/Mitigated Negative Declaration (IS/MND) for the proposed Project consistent with California Environmental Quality Act (CEQA) Guidelines §15063; and

**WHEREAS**, the IS/MND was circulated for public review from October 13, 2025, to November 13, 2025, and State review from October 13, 2025, to November 13, 2025 (State Clearinghouse No. 2025100529); and

**WHEREAS**, the SHCHD received three written comments during the public and State review process, and the SHCHD has considered the comments received; and

**WHEREAS**, the SHCHD revised the IS/MND in response to the comments received during the public and State review process; and

**WHEREAS**, revisions to the IS/MND were in response to written comments on the Project's impacts identified in the IS/MND and are not new avoidable significant impacts, and therefore are not considered substantial revisions, in accordance with CEQA Guidelines §15073.5, recirculation is not required; and

**WHEREAS**, a Mitigation Monitoring and Reporting Program (MMRP), attached hereto as Exhibit A, has been prepared based upon the IS/MND, consistent with the requirements of Public Resources Code Section 21081.6, the MMRP lists all mitigations measures and is designed to ensure compliance during project implementation; and

**WHEREAS**, pursuant to CEQA Guidelines §15074, all documents and files which constitute the record of all proceedings upon which the decisions associated with the Project are on file with the SHCHD; and

**WHEREAS**, in accordance with applicable provision of law, the SHCHD Board of Directors held a public hearing on March 26, 2026, at which time the SHCHD Board of Directors heard and received all relevant testimony and evidence presented orally or in writing regarding the Project. All

interested persons were given an opportunity to hear and be heard regarding the Project; and

**WHEREAS**, the SHCHD Board of Directors has reviewed this Resolution and finds that it accurately sets forth the intentions of the SHCHD Board of Directors regarding the Project.

**NOW, THEREFORE, BE IT RESOLVED**, that the SHCHD Board of Directors make the following findings:

1. The IS/MND has been properly prepared and circulated for public review in accordance with CEQA; and
2. The SHCHD has reviewed the IS/MND and considered the document and all comments received before making a decision of the Project; and
3. On the basis on the whole record before it, including the IS/MND and comments received therein, the SHCHD Board of Directors finds that there will be no significant environmental effects resulting from the Project, provided that mitigation measures in the IS/MND are incorporated into the Project; and
4. The IS/MND reflects the SHCHD Board of Director's independent judgement and analysis of the potential environmental effects of the Project; and
5. The Project has been processed in accordance with the applicable provisions of CEQA. All noticing and review periods required by CEQA have been satisfied.
6. Kent Scown as an authorized signatory to enter into this agreement on behalf of SHCHD.

**Be it Further Resolved**, that the SHCHD hereby adopts the IS/MND and adopts the MMRP attached hereto as Exhibit A.

**ADOPTED** 26th of March 2026, by the Board of Directors of the Mendocino County Willow County Water District, by the following vote:

Kevin Church, President	Yes / No / Abstain / Absent
Corinne Stromstad, Vice President	Yes / No / Abstain / Absent
Galen Latsko, Board Member	Yes / No / Abstain / Absent
Yvonne Hendrix, Board Member	Yes / No / Abstain / Absent
Christopher Schille, Board Member	Yes / No / Abstain / Absent

Signed:

\_\_\_\_\_  
Kevin Church, Board of Directors, President

\_\_\_\_\_  
Date

Attest:

\_\_\_\_\_  
Darrin Guerra

\_\_\_\_\_  
Date

## **Exhibit A**

### **Mitigation Monitoring and Reporting Program**

# **MITIGATION MONITORING AND REPORTING PROGRAM**

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Public Resources Code, Section 21081.6 (Assembly Bill 3180) requires that mitigation measures identified in environmental review documents prepared in accordance with California Environmental Quality Act (CEQA) are implemented after a project is approved. Therefore, this Mitigation Monitoring and Reporting Program (MMRP) has been prepared to ensure compliance with the adopted mitigation measures during the implementation of the Garberville Community Hospital and Medical Office Building Project. The Southern Humboldt Community Healthcare District (SHCHD) is the agency responsible for implementation of the mitigation measures identified in the Initial Study.

This MMRP provides the SHCHD with a convenient mechanism for quickly reviewing all the mitigation measures including the ability to focus on select information such as timing. The MMRP includes the following information for each mitigation measure:

- The phase of the project during which the required mitigation measure must be implemented;
- The phase of the project during which the required mitigation measure must be monitored;
- The enforcement agency; and
- The level of significance after mitigation.

The MMRP includes a checklist to be used during the mitigation monitoring period. The checklist will verify the name of the monitor and the date of the monitoring activity.

<b>Mitigation Monitoring and Reporting Program</b>						
<b>Mitigation Measure</b>	<b>Implementation Phase</b>	<b>Monitoring Phase</b>	<b>Enforcement Agency</b>	<b>Level of Significance After Mitigation</b>	<b>Verification of Compliance</b>	
					<b>Initial</b>	<b>Date</b>
<b>Aesthetics</b>						
<b>AES-1:</b> The project shall utilize and incorporate materials and building techniques to minimize impacts from street and building lighting on day and nighttime views, including the use of: hooded flood lights to prevent off-site light pollution; low reflectivity building materials, treated windows, and muted colors to limit daytime glare; and exterior landscaping to shade buildings and decrease reflectivity to neighboring development and Highway 101.	Project Design and Construction	Project Construction	SHCHD and Humboldt County Building Division	Less Than Significant		
<b>Biological Resources</b>						
<b>BIO-1:</b> Construction activities including vegetation and tree removal shall be conducted in the non-nesting season (August 1-February 1). If any removal of heavy vegetation (including trees) is proposed during the nesting season, within seven (7) days prior to vegetation removal or construction activities, a qualified biologist shall determine the presence of vulnerable nests (within 100 feet for passerines and 300 feet for raptors). Any active nests within the above-mentioned distances shall be allowed to complete their nesting or until the biologist determines that they are no longer active before removal.	Project Construction	Project Construction	SHCHD and Qualified Biologist	Less Than Significant		
<b>BIO-2:</b> Tree removal may have potential to impact non-maternity roosting pallid or fringed myotis bats, as well as other common bat species that may be present on-site. As such, any felled trees shall be left overnight prior to removal from the Site or on-site chipping to allow any bats to exit the roost. A dusk emergence survey shall be performed by a qualified biologist any time within the maternity season (April 15 to September 1) prior to construction activities. If maternity roosting of any special status bat is identified, the roost shall be avoided until after September 15. If the roost is not a solitary roost, replacement of the maternity roost shall be provided.	Project Construction	Project Construction	SHCHD and Qualified Biologist	Less Than Significant		
<b>Cultural Resources</b>						
<b>CUL-1:</b> If archaeological resources are encountered during construction, work shall be temporarily halted in the vicinity of the discovered materials and a qualified archaeologist and the local tribes (Bear River Band of the Rohnerville Rancheria, Big Lagoon Rancheria, Hoopa Valley Tribe, Round	Project Construction	Project Construction	SHCHD, Qualified Archaeologist, and THPOs	Less Than Significant		

<b>Mitigation Monitoring and Reporting Program</b>						
<b>Mitigation Measure</b>	<b>Implementation Phase</b>	<b>Monitoring Phase</b>	<b>Enforcement Agency</b>	<b>Level of Significance After Mitigation</b>	<b>Verification of Compliance</b>	
					<b>Initial</b>	<b>Date</b>
Valley Reservation/Covelo Indian Community, and Sinkyone Tribe) shall be immediately contacted. Workers shall avoid altering the materials and their context until a qualified professional archaeologist, in collaboration with the local tribes, has evaluated the situation and provided appropriate recommendations. Project personnel shall not collect cultural resources. [Native American resources include chert or obsidian flakes, projectile points, mortars, and pestles; and dark friable soil containing shell and bone dietary debris, heat-affected rock, or human burials. Historic-period resources include stone or adobe foundations or walls; structures and remains with square nails; and refuse deposits or bottle dumps, often located in old wells or privies.]						
<b>CUL-2:</b> If human remains are encountered on-site, all work must stop in the immediate vicinity of the discovered remains and the County Coroner and a qualified archaeologist must be notified immediately so that an evaluation can be performed. If the remains are deemed to be Native American and prehistoric, the Native American Heritage Commission (NAHC) must be contacted by the Coroner so that a "Most Likely Descendant" can be designated and further recommendations regarding treatment of the remains is provided.	Project Construction	Project Construction	SHCHD, Humboldt County Coroner, Qualified Archaeologist, NAHC, and THPOs	Less Than Significant		
<b>CUL-3:</b> Any identified cultural resources shall be recorded on DPR 523 historic resource recordation forms, available online from the Office of Historic Preservation's website: <a href="http://ohp.parks.ca.gov/default.asp?page_id=1069">http://ohp.parks.ca.gov/default.asp?page_id=1069</a> .	Project Construction	Project Construction	SHCHD and Qualified Archaeologist	Less Than Significant		
<b>Geology and Soils</b>						
<b>GEO-1:</b> In the event that fossils or fossil-bearing deposits are discovered during project construction, the contractor shall notify a qualified paleontologist to examine the discovery and excavations within 50 feet of the find shall be temporarily halted or diverted. The area of discovery shall be protected to ensure that fossil are not removed, handled, altered, or damaged until the Site is properly evaluated and further action is determined. The paleontologist shall document the discovery as needed, in accordance with Society of Vertebrate Paleontology standards	Project Construction	Project Construction	SHCHD and Qualified Paleontologist	Less Than Significant		

<b>Mitigation Monitoring and Reporting Program</b>						
<b>Mitigation Measure</b>	<b>Implementation Phase</b>	<b>Monitoring Phase</b>	<b>Enforcement Agency</b>	<b>Level of Significance After Mitigation</b>	<b>Verification of Compliance</b>	
					<b>Initial</b>	<b>Date</b>
(Society of Vertebrate Paleontology 1995), evaluate the potential resource, and assess the significance of the finding under the criteria set forth in CEQA Guidelines Section 15064.5. The paleontologist shall notify the appropriate agencies to determine procedures that would be followed before construction is allowed to resume at the location of the find. If the project proponent determines that avoidance is not feasible, the paleontologist shall prepare an excavation plan for mitigating the effect of the project based on the qualities that make the resource important. The plan shall be submitted to the Board of Directors for review and approval prior to implementation.						
<b>Hazards and Hazardous Materials</b>						
<b>HAZ-1:</b> Leaks, drips, and spills of hydraulic fluid, oil, or fuel from construction equipment and emergency vehicles (including ambulance and helicopter) shall be promptly cleaned up to prevent environmental contamination, including contamination of waterways. All workers shall be properly trained in the prevention and clean-up of spills of contaminants. Protective measures shall include the following: <ol style="list-style-type: none"> <li>1. No discharge of pollutants from vehicle and equipment cleaning shall be allowed into any drainage ditches or watercourses.</li> <li>2. Spill containment kits shall be properly maintained and located within the vicinity of all operations and fueling of equipment.</li> </ol>	Project Construction	Project Construction	SHCHD	Less Than Significant		
<b>Noise</b>						
<b>NOISE-1:</b> Implementation of the following measures are required during the duration of the project construction period to reduce potential noise impacts on the nearby sensitive receptors: <ul style="list-style-type: none"> <li>• Construction noise and vibration shall be limited through operational standards. Construction activities shall be limited to between the hours of 7:00AM and 6:00PM Monday through Sunday.</li> <li>• Neighboring landowners shall be notified of the anticipated construction schedule prior to commencement of construction activities.</li> <li>• Properly muffle and maintain all construction equipment.</li> </ul>	Project Construction	Project Construction	SHCHD	Less Than Significant		

<b>Mitigation Monitoring and Reporting Program</b>						
<b>Mitigation Measure</b>	<b>Implementation Phase</b>	<b>Monitoring Phase</b>	<b>Enforcement Agency</b>	<b>Level of Significance After Mitigation</b>	<b>Verification of Compliance</b>	
					<b>Initial</b>	<b>Date</b>
<ul style="list-style-type: none"> <li>Prohibit unnecessary idling of internal combustion engines by limiting idling to 5 minutes, per State idling restrictions.</li> <li>Locate all stationary noise-generating construction equipment, such as air compressors, as far as practical from existing nearby residences and other noise-sensitive land uses.</li> </ul> <p>Designate a "construction noise disturbance coordinator" to be responsible for responding to any local complaints about construction noise. The disturbance coordinator would determine the cause of the noise complaint (e.g., starting too early, bad muffler, etc.) and would require that reasonable measures to correct the problem be implemented. Conspicuously post a telephone number for the disturbance coordinator at the construction site and include it in the notice sent to neighbors regarding the construction schedule.</p>						
<b>Tribal Cultural Resources</b>						
See Mitigation Measures CUL-1 through CUL-3.	Project Construction	Project Construction	SHCHD, Humboldt County Coroner, Qualified Archaeologist, NAHC, and THPOs	Less Than Significant		

# Notice of Determination

## Appendix D

**To:**

Office of Planning and Research  
*U.S. Mail:* \_\_\_\_\_ *Street Address:* \_\_\_\_\_  
 P.O. Box 3044 1400 Tenth St., Rm 113  
 Sacramento, CA 95812-3044 Sacramento, CA 95814

County Clerk  
 County of: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

**From:**

Southern Humboldt Community  
 Public Agency: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Contact: Kevin Church, President, Board of Directors  
 Phone: \_\_\_\_\_  
 \_\_\_\_\_  
 Lead Agency (if different from above):  
 \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**SUBJECT: Filing of Notice of Determination in compliance with Section 21108 or 21152 of the Public Resources Code.**

State Clearinghouse Number (if submitted to State Clearinghouse): \_\_\_\_\_

Project Title: \_\_\_\_\_

Project Applicant: \_\_\_\_\_

Project Location (include county): \_\_\_\_\_

Project Description:

This is to advise that the \_\_\_\_\_ has approved the above  
 (  Lead Agency or  Responsible Agency )  
 described project on \_\_\_\_\_ and has made the following determinations regarding the above  
 (date)  
 described project.

1. The project [  will  will not ] have a significant effect on the environment.
2.  An Environmental Impact Report was prepared for this project pursuant to the provisions of CEQA.  
 A Negative Declaration was prepared for this project pursuant to the provisions of CEQA.
3. Mitigation measures [  were  were not ] made a condition of the approval of the project.
4. A mitigation reporting or monitoring plan [  was  was not ] adopted for this project.
5. A statement of Overriding Considerations [  was  was not ] adopted for this project.
6. Findings [  were  were not ] made pursuant to the provisions of CEQA.

This is to certify that the final EIR with comments and responses and record of project approval, or the negative Declaration, is available to the General Public at:

\_\_\_\_\_  
 Signature (Public Agency): \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Date Received for filing at OPR: \_\_\_\_\_