SoHum Health

Southern Humboldt Community Healthcare District

MEETING NOTICE
Governing Board

A regular meeting of the Board of Directors of the Southern Humboldt Community Healthcare District will be held on June 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. 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 Agenda
	D. Public Comment on Non-Agendized Items **See below for Public Comment Guidelines**
	E. Board Member Comments **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.**
	F. Announcements

G. Consent Agenda –

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1. Approval of Previous Minutes
   a. a. Special Governing Board Meeting, March 2, 2026
   b. b. Governing Board Meeting, March 26, 2026
   c. c. Special Governing Board Meeting, March 30, 2026
   d. d. Governing Board Meeting, May 28, 2026

2. SHCHD New and Updated Policies - See Supplemental Packet

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SNF

a. Admission Documentation Requirements
b. Cohabitation in Skilled Nursing Facility
c. Providers' Medication Orders
d. Monthly Medication Orders
e. Staffing and Coverage
f. Insulin Utilization

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Radiology

g. Infection Prevention
h. Mandatory Reporting.
i. Exams with IV Contrast
j. MRI Safety
k. Contrast Administration and Supervision

52 - 55

ER

l. Assessment and Measurement of a Pediatric Patient with a Temperature Greater than 38 °C
m. Assessment and Management of a Pediatric Patient with Vomiting

56

Medical Staff

n. TeleMedicine Credentialing

57 - 58

Nursing

o. Swing Bed and SNF Weights

61 - 63

HR

p. Flex Fill-In Pool
q. Multi-Department Work

3. Quarterly Reports - (Feb, May, Aug, Nov) - None
   a. Human Resources – Season Bradley Koskinen, HR Manager
   b. Foundation – Chelsea Brown, Outreach Manager
   c. Operations – Kent Scown, Chief Operations Officer

Approval of Consent Agenda

H. Last Action Items for Discussion

1. Southern Humboldt Poll Results – Larry Trametola
2. Approval of Medical Staff Bylaw Revisions — 64

I. Correspondence, Suggestions, or Written Comments to the Board

J. Administrator's Report – Matt Rees, CEO

1. Department Updates
   a. Milestones
   b. June Employee Anniversaries
      1 Year: Retail Pharmacist Christie Babowski, Credentialing Specialist Aeryn Thompsan, and Nurse Robin Rose
      5 Years: Security Guard Ray Rigby and Materials Clerk Neicha McConnell
      10 Years: Judy Hollifield
   c. CNO Report – Adela Yanez – See Report — 65 - 70
   d. Approval of May Financials – See Report — 71 - 84
   e. Family Resource Center – Amy Terrones – Mar and Oct - None

K. Old Business

1. None

L. New Business

1. Approval of the 2026-2027 Fiscal Year Operating Budget — See Supplemental Packet

M. Parking Lot -None

N. Meeting Evaluation

O. New Action Items

P. Next Meetings

1. Medical Staff Committee – Thursday, July 9, 2026, art 12:320 p.m.
2. Policy Development Committee – Tuesday, July 14, 2026, at 10 a.m.
3. QAPI Meeting – Wednesday, July 8, 2026, at 1:00 p.m.
4. Finance Committee – Friday, July 24, 2026, at 10:00 a.m.
5. Governing Board Meeting – Thursday, July 30, 2026, 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. Quarterly Reports - None
   a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec. – See Report
   b. Patient Safety – Mar., June, Sept., Dec. – See Report
   c. Medication Error – Feb., May, Aug., Dec. - None
5. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**]
   a. Ethan Kent, LCSW-C-(SLS) Appointment as Provisional status in Mental Health Counselor/Therapist Privileges from July 1, 2026, to June 30, 2027.
6. 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

ACHD	Association of California Healthcare Districts	*ACLS*	Advanced Cardiac Life Support Certification
AR	Accounts Receivable	*BLS*	Basic Life Support Certification

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

Posted June 22, 2026

Special Governing Board Meeting

Date: Monday, March 2, 2026
Time: 1:00 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

Governing Board: Corinne Stromstad, Yvonne Hendrix, Chris Schille, and Kevin Church in-person

Not Present: Galen Latsko

Also in person: Darrin Guerra, CNO, Adela Yanez, Chief of Staff, Snehal Raisoni, Compliance Lead, Coral Ciarabellini, and HR Manager, Season Bradley Koskinen

Also via Webex: CQCO Kristen Rees and Lexi Stowe

A. Call to Order – Board president Kevin Church called the meeting to order at 1:12 pm.

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

C. Approval of the Agenda –

Motion:	Yvonne Hendrix made a motion to approve the agenda.
Second:	Chris Schille
Ayes:	Corinne Stromstad, Chris Schille, Yvonne Hendrix, and Kevin Church
Noes:	Galen Latsko
Not Present:	
Motion carried	

D. Public Comment on Non-Agendized Items - None

E. Board Member Comments - None

F. Announcements - None

G. Correspondence, Suggestions, or Written Comments to the Board - None

H. New Business

1. Approval of the Updated Medical Staff Privilege Checklist
    a. Family Medicine
    b. Optometry
    c. Teleradiology
    d. Nurse Practitioner
    e. Mental Health

Motion:	Chris Schille made a motion to approve the Updated Medical Staff Privilege Checklist.
Second:	Yvonne Hendrix
Ayes:	Corinne Stromstad, Chris Schille, Yvonne Hendrix, and Kevin Church
Noes:	Galen Latsko
Not Present:	
Motion carried	

I. Board President Kevin Church Adjourned to Closed Session at 1:17.

1. Personnel Matter –Evaluation § 54957
    a. Admin 360 Evaluations

J. Kevin Church Adjourned Closed Session

K. Kevin Church Resumed Open Session

1. The following actions were taken in Closed Session
    a. No Action was taken on

L. Kevin Church Adjourned Open Session and Readjourned on March 13, 10 am to continue discussion of I. 1. A. Corinne Stromstad, Chris Schille, Kevin Church, and Season Bradley-Koskinen were all present. No action was taken.

Submitted by Darrin Guerra

Abbreviations

ACHD	Association of California Healthcare Districts	*ACLS*	Advanced Cardiac Life Support Certification
AR	Accounts Receivable	*BLS*	Basic Life Support Certification
CAIR	California Immunization Registry	*CEO*	Chief Executive Officer
CFO	Chief Financial Officer	*CMS*	Centers for Medicare and Medicaid Services
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LVN	Licensed Vocational Nurse	*MPH*	Master of Public Health
OBS	Observation	*PALS*	Pediatric Advanced Life Support Certification
PFS	Patient Financial Services	*QAPI*	Quality Assurance Performance Improvement
QIP	Quality Improvement Project/Program	*RN*	Registered Nurse
SHCC	Southern Humboldt Community Clinic	*SHCHD*	Southern Humboldt Community Healthcare District
SNF	Skilled Nursing Facility	*SWG*	Swing beds
DO	Doctor of Osteopathic Medicine		

Governing Board

Date: March 26, 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, Chris Schille, Kevin Church, Yvonne Hendrix, Galen Latsko (Arrived at 1:34 pm), and all in person

Not Present: None

Also in person: Administrative Assistant Darrin Guerra, CFO Paul Eves, CEO Matt Rees, Mike Thompson, CQCO Kristen Rees, PFS Manager Marie Brown, CHW Brandy Bremer, Piper Keener, Michelle Pouge, FRC Director Amy Terrones, and COO Kent Scown.

Also via Webex: CNO Adela Yanez, Compliance Lead Coral Ciarabellini, HIM Manager Remy Quinn, Credentialing Specialist Aeryn Thompson, Chief of Staff Dr. Raisoni, Business Development Director Ryan Staples, Doug Strout, Beth Nelson, Meghan Ryan, HR Manager Season Bradley-Koskinen, Quality Analyst Kana Voelckers, Megan Maruffo, Quality Lead Joshua Andrews, and Outreach Coordinator Heidi Holterman

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

Radiology

a. Mammography Technologist
b. Radiology Daily Procedures
c. MRI Safety

Infection Prevention

d. Definitions of Healthcare Associated Infections
e. Glucometer Cleaning
f. Infection Prevention Education

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

PFS

o. Billing Grievance

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

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

Galen Latsko arrived at 1:34 pm

H. Last Action Items for Discussion

1. Approval to add Darrin Guerra to Verify Stream as an authorized signer to approve Medical Staff Appointments and Reappointments on behalf of the Board after they have been approved in a Board Meeting.

Motion:	Yvonne Hendrix motioned to add Darrin Guerra to Verify Stream as an authorized signer to approve Medical Staff Appointments and Reappointments on behalf of the Board after they have been approved in a Board Meeting.
Second:	Christopher Schille
Ayes:	Corinne Stromstad, Christopher Schille, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	None
Motion Carried	

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

J. Administrator's Report – Matt Rees, CEO
Matt reported that the Mobile Optometry bus made its first trip to Rio Dell. In the coming months, we will be visiting various care homes and residential areas in Northern Humboldt. Additionally, the Mobile Health Clinic is scheduled to visit Shelter Cove and other areas in Southern Humboldt. Matt is currently helping to lobby multiple bills. Some of which will help guarantee earmarked funds for Critical Access Hospitals and cost-based reimbursement. We are currently working to get MRI services at the hospital and could be active as early as June.

1. Department Updates
   a. Milestones – None
   b. August Employee Anniversaries
   1 Year: HR Assistant Michelle Karlson-Siran, Nurse Jenifer LaRue, Nurse Regina Schuetzle
   10 Year: CEO Matt Rees
   c. Approval of Financials - Paul Eves – Not Received
   d. CNO Report – Adela Yanez – See Report
      i. Adela presented her staff report.
   e. Family Resource Center – Amy Terrones – Mar and Oct – See Report
      i. The FRC received two grants last year that helped fund a community event with AT&T to distribute 150 laptops and food to community members in need. The FRC announced that it served over 200 families that day. The FRC also hosted the local Community Baby Shower, Touch-a-Truck, and will be assisting in this year's fireman's games.

K. Old Business

1. Update on Medical Staff Bylaws
   a. Matt and Darrin shared that they currently have proposed changes that they will be discussing at the next Medical Staff Meeting
2. Clinic Credentialing Update.
   a. The Clinic Providers are now Credentialed with Blue Shield. More information will be provided at the next Governing Board meeting.
3. FPPE/OPPE Update
   a. The Quality and Compliance team is working with Medical Staff to create a process. There are scheduled Meetings in April. Quality will give another report at the next Governing Board Meeting.
4. Optometry Statistics According to the Budget.
   a. Matt will have a report on Optometry in the April meeting.
5. Approval of Resolution 26.02 Adopting an Initial Study/Mitigated Negative Declaration
   a. Discussion between LACCO, Administration, and the Board ensued. All public comments and responses to them were submitted to the public and the Board.

      No Action was Taken

L. New Business - None

M. Parking Lot - None

N. Meeting Evaluation – "Speedy." – Corinne

O. New Action Items

1. Resolution 26:02
2. Medical Staff Bylaws

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. Closed Session

1. Closed Session Opened at 2:43 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
   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. Kevin Church Adjourned Closed Session

S. Kevin Church Resumed Open Session

1. Action Items to Report in Open Session

Motion:	Yvonne Hendrix motioned to approve Agenda items Q.6 Medical Staff Appointments Reappointments a-n.
Second:	Christopher Schille
Ayes:	Corinne Stromstad, Christopher Schille, Galen Latsko, Yvonne Hendrix, and Kevin Church
Noes:	None
Not Present:	None
Motion Carried	

T. Kevin Church Adjourned Open Session

Submitted by Darrin Guerra

Abbreviations

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JPCH	Jerold Phelps Community Hospital	*LCSW*	Licensed Clinical Social Worker
LVN	Licensed Vocational Nurse	*MPH*	Master of Public Health
OBS	Observation	*PALS*	Pediatric Advanced Life Support Certification
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SHCC	Southern Humboldt Community Clinic	*SHCHD*	Southern Humboldt Community Healthcare District
SNF	Skilled Nursing Facility	*SWG*	Swing beds
DO	Doctor of Osteopathic Medicine		

Special Governing Board Meeting

Date: Monday, March 30, 2026
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

Governing Board: Corinne Stromstad, Yvonne Hendrix, Chris Schille, and Kevin Church in-person

Not Present: Galen Latsko

Also in person: Darrin Guerra, COO, Kent Scown, and CEO Matt Rees

Also via Webex: HR Manager Season Bradley Koskinen and Chief of Staff Snehal Raisoni

A. Call to Order – Board president Kevin Church called the meeting to order at 1:33 pm.

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

C. Approval of the Agenda –

Motion:	Chris Schille made a motion to approve the agenda.
Second:	Yvonne Hendrix
Ayes:	Corinne Stromstad, Chris Schille, Yvonne Hendrix, and Kevin Church
Noes:	Galen Latsko
Not Present:	
Motion carried	

D. Public Comment on Non-Agendized Items - None

E. Board Member Comments - None

F. Announcements - None

G. Correspondence, Suggestions, or Written Comments to the Board - None

H. New Business

1. Approval of Resolution 23:03 Grant of Easement Requested by PG&E for Underground Utilities on District Property at APN 032-051-009

Motion:	Yvonne Hendrix made a motion to approve Resolution 23:03
Second:	Chris Schille
Ayes:	Corinne Stromstad, Chris Schille, Yvonne Hendrix, and Kevin Church
Noes:	Galen Latsko
Not Present:	
Motion carried	

I. Kevin Church Adjourned Open Session at 1:36.

Submitted by Darrin Guerra

Abbreviations

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SoHum Health

Southern Humboldt Community Healthcare District Governing Board Resolution 26:03

GRANT OF EASEMENT REQUESTED BY PG&E FOR UNDERGROUND UTILITIES ON DISTRICT PROPERTY AT APN 032-051-009

WHEREAS, the Southern Humboldt Community Healthcare District (the "District") owns certain real property located in Humboldt County, State of California, for the delivery of services; and

WHEREAS, Pacific Gas and Electric Company ("PG&E") has requested the grant of certain permanent easements and rights-of-way across District-owned property to install, access, operate, maintain, replace, and upgrade utility infrastructure, including electric line and associated equipment; and

WHEREAS, the proposed easement is necessary to support utility service to District facilities and/or the surrounding community, and will not materially interfere with District operations or interests; and

WHEREAS, the terms of the easement have been reviewed and deemed acceptable by District staff, and the board finds it in the best interest of the District to grant said easement;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Southern Humboldt Community Healthcare District as follows:

1.) **Approval of Easement Grant**

The Board hereby approves the grant of the easement to PG&E as described in the attached Exhibit "A" (Map of Easement Area). Subject to the terms and conditions of the Easement Agreement on file with the District.

2.) **Authorization to Execute Documents**

The Chief Operations Officer, Kent Scown, is hereby authorized and directed to execute the Easement Agreement and any related documents necessary to effecutuate the grant of easement to PG&E, and to take such further actions as necessary or appropriate to carry out the intent of this Resolution.

3.) **Effective Date**

This Resolution shall take effect immediately upon its adoption.

PASSED AND ADOPTED by the Board of Directors of SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT, this 30th day of March, 2026, by the following vote:

Ayes: Kevin Church, Chris Schille, Yvonne Hendrix, and Corinne Stromstad

Noes: _____

Abstain: _____ Absent: Galen Latsko

Witnessed by: Kevin Church, President _____

Witnessed by: Corinne Stromstad, Vice President/Secretary Corinne Stromstad

Governing Board

Date: May 28, 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 Kevin Church, Yvonne Hendrix, Corinne Stromstad, and Galen Latsko, and all in person

Not Present: Chris Schille

Also in person: Administrative Assistant Darrin Guerra, CEO Matt Rees, CQCO Kristen Rees, PFS Manager Marie Brown, CNO Adela Yanez, HR Assistant Kiely Boyd, Coral Ciarabellini, CFO Paul Eves, and COO Kent Scown.

Also via Webex: Chief of Staff Dr. Raisoni, Business Development Director Ryan Staples, HR Manager Season Bradley-Koskinen, Quality Lead Joshua Andrews, ER Manager Melissa Hamilton, HIM Manager Remy Quinn, Clinic Manager Shawna Kloiber, COO Kent Scown, DON Katherine Anderson, Jaquelene McClure, Clinic Nurse April Barnhart, Nursing Administrative Assistant Judy Hollifield, and Outreach Manager Chelsea Brown

A. Call to Order – Board President Kevin Church called the meeting to order at 1:30 pm.

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

C. Approval of the Agenda

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

D. Public Comment on Non-Agendized Items

1. Three members of the public spoke about the Redwood Drive properties, the purpose of the Heliport at the new Hospital, questions about the recent poll and if there is going to be a ballot measure, and the purpose of releasing the ED Techs.
   Matt and the Administrative team briefly addressed these concerns.
   - We are attempting to expand services to continue to be able to afford the USDA loan after recent budget cuts from HR 1.
   - Matt explained that we currently do not have a ballot measure and have only initiated a poll to gauge the community's opinion; no decision has been made on whether to apply for a ballot measure.
   - Adela explained to the public that, unfortunately, we had to relieve our ED techs to attempt to stay in compliance with Title 22. This decision was not made lightly and impacts the District financially, as we now have two nurses in the ED, rather than a Nurse and an ED Tech.

E. Board Member Comments - None

F. Announcements - None

G. Approval of Consent Agenda

1. Approval of Previous Minutes
   a. Governing Board Meeting, April 30, 2026

2. SHCHD New and Updated Policies
   Dietary
   a. Cleaning Procedures
   b. Dishwashing Policy
   c. Safe Cooking Temperatures
   d. Safety Precautions
   e. Sanitation and Safety Standards
   f. Nutrition Orders Managed by the Registered Dietitian (RD)
   g. Nutrition Risk Screening and Assessment for Acute, Swing Bed and SNF Patients
   h. Patient Meal Service
   i. Potentially Hazardous Foods at Bedside
   j. Processing Diet Orders in Dietary
   k. Records, Maintenance, and Retention Time

   SNF

l. Activity Program
m. Resident Elopement

Nursing

n. Acuity Worksheet Guidelines
o. Lippincott and Up to Date Reference

Radiology

p. MRI Scope of Practice
q. Quality Assurance (X-ray)
r. Radiation Safety and Protection for Patients

Pharmacy

s. Pyxis Discrepancies Procedure
t. Pyxis

HIM

u. Behavior Related EHR Alerts
v. Chart Organization, Maintenance, and Scanning

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

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

H. Last Action Items for Discussion

1. Approval of the April Financials

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

2. Redwood Drive Cost Analysis
    a. Kent and Matt went over the current cost analysis. Currently, the project has used only about half of the budget originally projected.

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

J. Administrator's Report – Matt Rees, CEO
Matt reported an accounting error from the beginning of the year. Between January and March, payroll accruals were incorrect, resulting in a larger amount for salaries and wages. After changes to that and the IGT we received, we are showing a net positive of 2.6 million.

1. Department Updates
    a. Milestones – None
    b. August Employee Anniversaries
    1 Year: LVN Lily Strong, RN Regina Agas, and PFS Clerk Niki Genolio.
    c. CNO Report – Adela Yanez – See Report
        i. Adela presented her staff report.
    d. Family Resource Center – Amy Terrones – Mar and Oct – None

K. Old Business

1. Update on Medical Staff Bylaws
    a. Changes have been decided on and will be presented at the June meeting.

L. New Business - None

M. Parking Lot - None

N. Meeting Evaluation – None

O. New Action Items

1. Previous Minutes
2. Medical Staff Bylaws

P. Next Meetings

1. Medical Staff Committee – TBD
2. Medical Staff Policy Development Committee – TBD
3. QAPI Meeting – Wednesday, June 1, 2026, at 1:00 p.m.
4. Finance Committee – Friday, June 19, 2026, at 10:00 a.m.

5. Governing Board Meeting – Thursday, June 25, 2026, at 1:30 p.m.

Q. Closed Session

1. Closed Session opened 2:36
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. Quarterly Reports - None
   a. Quality and Risk Management **H&S Code § 32155** – Feb., May, Aug., Dec.
   b. Patient Safety – Mar., June, Sept., Dec.
   c. Medication Error – Feb., May, Aug., Dec.
5. Approval of Medical Staff Appointments/Reappointments [**H&S Code § 32155**]
   a. Scott Baymiller, MDDO - Reappointment as Active status in Mental Health Counselor/Therapist - Psychiatric Privileges from June 1, 2026 to May 31, 2028
   b. Amy Frazier, MDDO -Reappointment as Active status in Mental Health Counselor/Therapist - Psychiatric Privileges from June 1, 2026 to May 31, 2028
   c. Gurkiran Gill, MDDO - Reappointment as Active status in Mental Health Counselor/Therapist - Psychiatric Privileges from June 1, 2026 to May 31, 2028
   d. Patrick McCarthy, MD - (OnRad) Appointment as Provisional status in Teleradiology - Diagnostic Radiology privileges from June 1, 2026 to May 31, 2027
   e. Chris Whitney, OD, - Reappointment as Active status in Optometry privileges from June 1, 2026 to May 31, 2028
   f. Linda Candiotti, PA, - Reappointment as Active status in Physician Assistant - General Privileges from June 1, 2026 to May 31, 2028
   g. Christopher Wright, DO - Reappointment as Active status in Mental Health Counselor/Therapist - Psychiatric Privileges from June 1, 2026 to May 31, 2028
   h. Tse Anyu, MD - (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges from June 1, 2026 to May 31, 2028
   i. Keith McGuire, MD - (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges from June 1, 2026 to May 31, 2028
   j. Michael Benanti, DO - (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges July 1, 2026 to June 30, 2028
   k. Clarence Davis III, MD - (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges July 1, 2026 to June 30, 2028
   l. Arun Kumar, MD - (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges July 1, 2026 to June 30, 2028
   m. Pierre Lanthiez, MD - (OnRad) Reappointment as Active status in Teleradiology - Diagnostic Radiology privileges July 1, 2026 to June 30, 2028
6. Personnel Matter –Evaluation § 54957
   a. CQCO Kristen Rees

R. Kevin Church Adjourned Closed Session

S. Kevin Church Resumed Open Session

1. Action Items to Report in Open Session

Motion: Galen Latsko motioned to approve all medical Staff Appointments (Agenda items Q.5.a-m)
Second: Corinne Stromstad
Ayes: Galen Latsko, Corinne Stromstad, Yvonne Hendrix, and Kevin Church
Noes: None
Not Present: Christopher Schille
Motion Carried

T. Kevin Church Adjourned Open Session

Submitted by Darrin Guerra

Abbreviations

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

SoHum Health

Subject: Admission Documentation Requirements	Manual: Skilled Nursing Facility

PURPOSE:

The purpose of this policy and procedure is to delineate that data as a guideline for nursing staff's reference.

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to record specific data upon a resident's admission to the Skilled Nursing Facility (SNF).

PROCEDURE:

All required data is documented in our Electronic Medical Record (EMR), unless the form is not available electronically or the EMR system is down. Upon admission, the nurse on duty is to complete the following: SNF/Swing Admission Assessment, SNF/Swing Personal Belongings list, POLST, and the SNF/Swing Daily Assessment.

Required admission documentation includes, but is not limited to the following:

- The date and time of the resident's admission
- The resident's age, sex, race and marital status
- The name of the person accompanying the resident and his/her relationship to the resident
- From where the resident was admitted (i.e., hospital, home, other facility)
- Reason for the admission
- Current vital signs and the condition of the resident upon admission (i.e., disoriented, weak, alert, etc.)
- The time the attending physician was notified of the resident's admission
- The time the physician's orders were received and verified
- Description of any lab work completed or the time specimens were sent to the lab
- Acute conditions (i.e., hemorrhaging, comatose, etc.)
- The presence of a catheter, dressings, etc.
- The time the dietary department was notified of the diet order
- The time medications were ordered from the pharmacy
- "Body audit" (i.e., birth marks, "ostomy" site, site and size of scars, rashes, bruises, pressure signs, lesions, decubitus, burns, general cleanliness of the body, hair, nails, etc.)
- A brief description of any disabilities (i.e., blind, deaf, hemiplegia, speech impairment, paralysis, mobility, etc.)
- Any known allergies
- Prosthesis required (i.e., glasses, dentures, hearing aid, artificial limbs, eye, and etc.)

- The weight and height of the resident
- Notation of any signs or symptoms of an infectious or communicable disease
- Notation as to whether or not advance directives apply

The admission data will be maintained on our EMR system. Should a resident be discharged from and readmitted to the facility, new admission data must be recorded.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Cohabitation in Skilled Nursing Facility	**Skilled Nursing Facility**

PURPOSE:

The purpose of this policy is to provide a safe and healthy environment to the SNF residents which includes, personal hygiene, activity, food, fluids, medications, psychological needs, observation and documentation.

POLICY:

It is the policy of the southern Humboldt Community Healthcare District ("SHCHD" or "District") to comply with employees comply with the provisions of laws about cohabitation of residents who are not married or biologically related.

PROCEDURE:

According to federal regulations, each resident has the right to share a room with his or her roommate of choice, when practicable, when both residents live in the same facility and both residents' consent to the arrangement. Each patient will sign an agreement.

DEFINITIONS:

None

SoHum Health

Subject: Provider's Medication Orders	Manual: Skilled Nursing Facility

PURPOSE:

The purpose of this policy and procedure is to ensure all medication orders are given by a licensed practitioner, physician, nurse practitioner, or physician's assistant.

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide medications to residents as ordered by a licensed physician, nurse practitioner or physician's assistant.

PROCEDURE:

All medications administered to the resident must be ordered in writing by the resident's attending physician or entered into the EMR ~~Computerized Physician Order Entry (CPOE).~~

All verbal orders must be entered into the EMR ~~CPOE~~ and counter signed by the ordering physician within 48 hours of the receipt of the verbal~~telephon~~e order, or upon the physician's next scheduled visit, whichever is sooner.

Physician's orders must be~~-~~ reviewed and updated by the attending physician every 60 ~~rewritten every 45~~ days.

DEFINITIONS:

None

SoHum Health

Subject:	Manual:
Monthly Medication Regimen Review	**Hospital Pharmacy**

POLICY:

It is the policy of the Skilled Nursing Facility that a licensed pharmacist will review the resident drug regimen, including the resident chart, within 7 calendar days of admission and then at least once a month. The pharmacist may need to conduct the medication regimen review more frequently depending on the resident condition, review of skilled-nursing residents, and risk of adverse consequences. The licensed pharmacist will report any irregularities to be acted upon, in writing, to the attending physician and the director of nursing. Findings must be ~~be~~ maintained in the resident medical record.

PROCEDURE:

1. The Consultant Pharmacist will perform a drug regimen review on each resident at least once a month unless the resident condition/risk indicates a more frequent schedule. If greater drug regimen review frequency is warranted it shall be individualized and communicated between the facility clinical staff and the pharmacist.
2. This review shall be performed by evaluation of the the medical record of each resident, which contains the current Medication Regimen as documented on the most recent Physician's Order Sheets or electronic record of current orders.
3. This review shall include a physical inspection of the drugs maintained on the nursing unit.
4. Irregularities identified will be documented on a separate written report, known as the Monthly Drug Regimen Review. This report is located in each resident binder, listing the resident name, relevant drug and irregularity the pharmacist has identified. If an irregularity requires urgent action, the pharmacy consultant will immediately report the irregularity to the Director of Nursing and the attending physician by phone or Webex.
5. The attending physician will review the Drug Regimen Review Sheets at least monthly to ensure they are compliant with their review and documentation.
6. The attending physician shall act upon the Drug Regimen Review findings/recommendations in a timely manner of 7-14 days or less. The physician shall document in the resident record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician must document rationale as to why the change is not indicated.
7. Upon completion the Consultant Pharmacist shall provide written documentation of all recommendations and submit them monthly to the facility for attending physician or designee's review and response. The written documentation and prescriber response shall be considered a permanent part of each resident's medical record.

8. If the review is offsite, the pharmacist will document findings and send them electronically to the facility for inclusion in the medical record.

DEFINITIONS:
None

SoHum Health

Subject: Staffing and Coverage	Manual: Skilled Nursing Facility

~~P~~POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ensure adequate and qualified Registered Nurse (RN) coverage at all times, consistent with federal and state regulations, to meet the complex medical needs of residents and promote their highest practicable physical, mental, and psychosocial well-being. This policy outlines the facility's commitment to quality assurance and continuous performance improvement related to nurse staffing.

DEFINITIONS:

Hours per resident day (HPRD): a metric used in long-term care to measure the average amount of direct nursing and care time a patient receives in a 24-hour period. It is calculated by dividing the total productive hours worked by nursing staff by the facility's total daily resident census.

Quality Assurance and Performance Improvement (QAPI): the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving.

Payroll Based Journal (PBJ): a Centers for Medicare & Medicaid Services (CMS) reporting system. It requires long-term care and skilled nursing facilities to electronically submit highly specific, auditable direct-care staffing and daily resident census data. CMS utilizes this information to evaluate facility staffing levels, calculate employee turnover, and determine the staffing component of the Nursing Home Five-Star Quality Rating System.

PROCEDURE:

The facility has a minimum of eight hour daily Registered Nurse (RN) coverage; a RN must be on duty and physically present in the facility for at least eight consecutive hours per day, every day of the week. The facility also provides 24-hour licensed nursing services. During the 16 hours when an RN is not on duty, a Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) is on duty. The facility employs a full-time Director of Nursing (DON) who is a Registered Nurse. The Director of Nurses(DON) should work a minimal od (40) hours per week in the facility and is responsible for oversight of nursing services, staffing, regulatory compliance, and participation in Quality Assurance and performance Improvement (QAPI) activities.

The Skilled Nursing Facility conducts and documents a comprehensive facility assessment annually. This assessment determines the appropriate level of staffing needed based on the resident population's acuity, diagnoses, and care needs.

The Skilled Nursing Facility works in conjunction with the Quality Department to initiate and oversee Performance Improvement Projects, which could include nursing coverage. These projects use data to improve processes and address quality deficiencies, such as preventing avoidable falls or pressure ulcers, which may be directly related to staffing levels.

The Skilled Nursing Facility continuously monitors and analyzes staffing data, including hours per resident day (HPRD), staff turnover, and adverse event reporting, to ensure optimal staffing levels are maintained. This data is used to track progress toward quality objectives.

The Skilled Nursing Facility ensures that nursing staff receive regular, comprehensive training to maintain and enhance their skills, particularly for high-acuity residents. New staff are properly onboarded and trained on facility policies.

Input from residents, families, and staff regarding nursing care quality and staffing is regularly solicited and incorporated into QAPI initiatives as appropriate.

A documented emergency and contingency plan is in place to address unexpected staffing shortages due to call-outs, severe weather, or other emergencies to ensure continuous, safe coverage.

The total number of licensed and unlicensed nursing staff working each shift and the actual hours worked is posted daily in a public area, as required by law.

The Skilled Nursing Facility conducts regular, unannounced internal audits of staffing schedules and payroll-based journal (PBJ) data to verify compliance with staffing requirements. All staffing records is documented for state surveys and audits.

Any failure to meet minimum staffing standards will be immediately investigated, corrected, and reported to the Quality Assessment and Assurance (QAA) committee. An action plan will be developed to prevent recurrence.

~~OLICY:~~

~~It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to ensure adequate and qualified Registered Nurse (RN) coverage at all times, consistent with federal and state regulations, to meet the complex medical needs of residents and promote their highest practicable physical, mental, and psychosocial well-being. This policy outlines the facility's commitment to quality assurance and continuous performance improvement related to nurse staffing.~~

~~PROCEDURE:~~

~~**Minimum requirements:**~~

- **8-Hour Daily RN Coverage:** An RN must be on duty and physically present in the facility for at least eight consecutive hours per day, every day of the week.
- **24-Hour Licensed Nurse Coverage:** The facility will provide 24-hour licensed nursing services. During the 16 hours when an RN is not on duty, a Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) will be on duty.
- **Director of Nursing (DON):** The facility must employ a full-time Director of Nursing who is a Registered Nurse.

Staffing Management and Quality Assurance

- **Facility Assessment:** The Skilled Nursing Facility will ensure a comprehensive facility assessment is conducted and documented annually. This assessment determines the appropriate level of staffing needed based on the resident population's acuity, diagnoses, and care needs.
- **Performance Improvement Projects (PIPs):** The Skilled Nursing Facility will work in conjunction with the Quality Department to initiate and oversee Performance Improvement Projects, which could include nursing coverage. These projects will use data to improve processes and address quality deficiencies, such as preventing avoidable falls or pressure ulcers, which may be directly related to staffing levels.
- **Data Monitoring:** The Skilled Nursing Facility will continuously monitor and analyze staffing data, including hours per resident day (HPRD), staff turnover, and adverse event reporting, to ensure optimal staffing levels are maintained. This data will be used to track progress toward quality objectives.
- **Training and Competency:** The Skilled Nursing Facility will ensure nursing staff receive regular, comprehensive training to maintain and enhance their skills, particularly for high-acuity residents. New staff will be properly onboarded and trained on facility policies.
- **Resident and Family Feedback:** Input from residents, families, and staff regarding nursing care quality and staffing will be regularly solicited and incorporated into QAPI initiatives as appropriate.

- **Emergency Contingency Planning:** A documented plan will be in place to address unexpected staffing shortages due to call-outs, severe weather, or other emergencies to ensure continuous, safe coverage.

Regulatory compliance and reporting

- **Daily Posting:** The total number of licensed and unlicensed nursing staff working each shift and the actual hours worked will be posted daily in a public area, as required by law.

- **Audits and Documentation:** The Skilled Nursing Facility will conduct regular, unannounced internal audits of staffing schedules and payroll-based journal (PBJ) data to verify compliance with staffing requirements. All staffing records will be documented for state surveys and audits.

- **Reporting:** Any failure to meet minimum staffing standards will be immediately investigated, corrected, and reported to the Quality Assessment and Assurance (QAA) committee. An action plan will be developed to prevent recurrence.

None

SoHum Health

Subject:	Manual:
Insulin Utilization	Nursing

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SoHum Health", "District", "SHCHD") to detail the storage, handling, ordering, preparation, dispensing, administration, documentation, and disposal of all insulin products available at SoHum Health. In order to provide an environment conducive to patient safety, SoHum Health has implemented a protocol for the storage, dispensing, and oversight of all insulin products.

Insulin has been identified by the Institute of Safe Medication Practices (ISMP) as a "High Alert" medication. Insulin products are capable of causing patient harm and must be ordered, stored, handled, prepared, dispensed, and administered with redundant medication safety measures in order to avert potential adverse events.

DEFINITIONS:

Beyond Use Date: The date beyond which a compounded drug or preparation can no longer be safely used. It is established by the compounding pharmacy following United States Pharmacopeia (USP) guidelines.

Expiration Date: The date beyond which the manufacturer no longer guarantees the safety or potency of a drug. It is determined by the manufacturer and verified by the United States Food and Drug Administration (FDA).

PROCEDURE:

Insulin Administration

Approved insulin types (i.e. insulin lispro, insulin regular, and/or insulin glargine) are mutli-dose vials which may be available in secured Automated Dispensing Machines (ADMs) refrigerators on designated nursing units. At times insulin will be dispensed thru Garberville Pharmacy. All insulin infusions will be labeled with a patient-specific label with insulin formulation, concentration, and bar code label.

Insulin vials will be provided in the most appropriate dosage form/package size available from the manufacturer in order to reduce the risk of patient harm and minimize waste.

All insulin shall be drawn up within an insulin-syringe (or equivalent) following high risk/high alert and bar code medication administration procedures prior to administration.

Insulin vials will be labeled with a patient specific label with insulin formulation, dose, directions for use, and frequency. Vials are given a 28-day expiration date once opened or stored at room temperature. These vials may be stored at room temperature or under refrigeration when dispensed to patient care areas. The open and expiration dates shall be written on the

appropriate auxiliary label. For insulin pens the auxiliary label shall be placed onto the pen itself, not the cap.

Double Verification upon Administration or Titration:

- Insulin represents a High Alert Medication class and requires additional safeguards to prevent patient harm. For this reason, SoHum Health requires that two independent clinicians verify insulin orders prior to administration for orders containing intravenous insulin, or subcutaneous insulin.
- Two licensed SoHum Health clinicians will verify the following prior to administration: the licensed independent practitioner (LIP) order, type of insulin, dosage, route, time, and most recent blood glucose level.
- The double verification will be documented in the medication administration record (MAR).

Storage:

- Insulin vials are stored in a pharmaceutical grade refrigerators.
- Insulin vials are stored in patient-specific medication bins or designated refrigerators.
- Insulin vials stored within Pyxis will be visibly designated as High Alert Medications.
- All insulin formulations are stable in vial form at controlled room temperature for 28 days upon initial removal from refrigeration.

Disposal:

Following insulin order discontinuation and/or hospital patient discharge, all insulin vials stored in patient-specific bins will be discarded in designated universal pharmaceutical waste receptacles located by the nurse's station and/or hospital pharmacy.

Routes of Administration

Subcutaneous Insulin Injections

Insulin injections will be administered subcutaneously in the abdomen whenever possible. If the patient has a contraindication to receiving an injection subcutaneously in the abdominal area, the subcutaneous tissue located in the back of the upper arm can be used as an alternative location. Subcutaneous insulin injections into the deltoid area should be avoided due to risk of inadvertent intramuscular injection.

RN Responsibilities

If an altered level of consciousness, cognitive capability, depression/suicidal tendencies or physical limitations are noted at any time, the RN is to do all of the following:

1. Notify the Attending Physician immediately.
2. Request orders for alternative insulin delivery.
3. Check blood glucose per the physician's order.
4. Document the programmed basal rate(s) and any bolus doses, in the medical record.

5. Assess the infusion site every shift and document it in the medical record.

Intravenous Insulin Injections

Patients treated for emergent hyperkalemia may utilize insulin regular & dextrose 50% administered intravenously for the emergent treatment of hyperkalemia.

Management of Hypoglycemia

Hypoglycemia will be managed as per the SoHum Health “Hypoglycemia Management Protocol” within Epic.

Insulin dosage and/or dietary plan may be adjusted in response to hypoglycemic episodes.

SoHum Health

Subject: Infection Prevention	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that all patient contact surfaces are to be cleaned prior to each mammography patient. A pre-packaged disposable Mammography Pad shall be used with each patient and disposed of after individual patient use.

PROCEDURE:

- All patient contact surfaces are to be cleaned with a lint free cloth or pad and diluted dishwashing liquid to remove residual make-up, deodorant, body powders or other artifacts. Solution should not be sprayed.

- If more than soap and water is required to clean, use one of the disinfectants listed below followed by diluted dishwashing liquid solution. Disinfectants will be used according to manufacturer's instructions and mammography equipment guidelines.
    - 10% chlorine bleach and water solution
    - 70% isopropyl alcohol (not diluted)
    - 3% maximum concentration of hydrogen peroxide solution

- Patient contact surfaces include:
    - Compression paddle
    - Face shield
    - Underside and chest wall edge of compression paddle
    - Hand grips

- Surfaces in contact with blood, discharge from the nipple or open wounds shall be cleaned after each mammography view and disinfected with a bleach solution followed by diluted dishwashing liquid upon completion of the exam, in accordance with equipment instructions.

- The technologist shall perform appropriate hand washing technique prior to each mammography patient and wear gloves when appropriate (i.e., patients with open wounds, skin conditions, etc.).

- Patients with wounds, discharge, or potentially contagious skin conditions will be logged on the *Mammography Infection Prevention Log* and will be reviewed quarterly by the Infection Preventionist.

DEFINITIONS:
None

SoHum Health

Subject: Mandatory Reporting	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the facility will comply with all mandatory California State and federal laws of reporting.

PROCEDURE:

Except for an event that results from patient movement or interference, a facility shall report to the department an event in which the administration of radiation results in any of the following:

- Repeating of a CT examination, unless otherwise ordered by a physician or a radiologist, if one of the following dose values is exceeded:
  - 0.05 Sv (5 rem) effective dose
  - 0.5 Sv (50 rem) to an organ or tissue
  - 0.5 Sv (50 rem) shallow dose to the skin

- A CT X-ray examination for any individual for whom a physician did not provide approval for the examination if one of the following dose values is exceeded:
- 0.05 Sv (5 rem) effective dose
  - 0.5 Sv (50 rem) to an organ or tissue
  - 0.5 Sv (50 rem) shallow dose to the skin

- A CT X-ray for an examination that does not include the area of the body that was intended to be imaged by the ordering physician or radiologist if one of the following dose values is exceeded:
  - 0.05 Sv (5 rem) effective dose
  - 0.5 Sv (50 rem) to an organ or tissue
  - 0.5 Sv (50 rem) shallow dose to the skin

- CT exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

- A CT dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose, that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician.

- The facility shall, no later than five business days after the discovery of a therapeutic event ~~described in paragraphs 3 to 5, inclusive, of subdivision (a) and no later than~~

~~10 business days after discovery of an event described in paragraphs 1 to 4, inclusive, of subdivision (a)~~, provide notification of the event to the ~~department and the~~ referring physician of the person subject to the event and shall, no later than 15 business days after discovery of an event ~~described in subdivision (a),~~ provide written notification to the person who is subject to the event.

DEFINITIONS:
None

SoHum Health

Subject: Exams with IV Contrast	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that Imaging~~CT~~ exams requiring intravenous (IV) contrast follow strict guidelines.

PROCEDURE:

- MRI screening questions are required prior to scheduling and performing any MRI exam.
- Prior CT contrast questions are strongly advised to~~naire **MUST**~~ be filled out prior to scheduling and performing CT exams with IV contrast. Exceptions include but are not limited to; unconscious patients, non-verbal patients, trauma, stroke, suspected dissection. Contraindications to the use of IV contrast include:
    - Allergies to iodine or gadolinium
    - Prior contrast reactions or severe allergic reaction (anaphylaxis) to any medication
    - Asthma
    - Renal insufficiency
    - Certain cardiac conditions including
    - Extremely high anxiety
    - Sickle cell anemia
    - Diabetes mellitus
    - Dehydration

- Patients with a predisposition for contrast reaction should be pre-medicated prior to the exam to lessen the possibility of contrast reaction. The premedication medications will be prescribed by the ordering provider. The two most frequently used regimens are:
    - Prednisone – 50 mg by mouth at13 hours, 7 hours and 1 hour before contrast media injection plus Diphenhydramine (Benadryl®) – 50 mg by mouth 1 hour before contrast media injection.
      OR
    - Methylprednisolone (Medrol®) – 32 mg by mouth 12 hours and 2 hours before contrast media injection. An antihistamine (as listed in option "a") may also be added to this regimen.

- Recent (within 30 days of scheduled exam) laboratory tests including creatinine with eGFR are **required** for patients with certain conditions prior to a CT or MRI exam with IV contrast except with consent from ED physician in critical situations (see exceptions listed above). If any imaging with contrast has been performed after labs are drawn, new lab tests must be obtained prior to scheduled study. Conditions requiring laboratory tests are:

- ≥50 years of age for CT, all ages for MRI
- Hypertension
- Certain cardiac conditions including congestive heart failure or advanced cardiac disease.
- Renal insufficiency/disease
- Diabetes mellitus
- Anyone who has received IV contrast within the last 30 days of scheduled exam.

Laboratory tests including creatinine with eGFR may be required prior to an imaging ~~CT~~ exam with IV contrast.

- The creatinine level may vary according to muscle mass and size of patient. In men, a normal level is 0.7-1.3 mg/dL, in women a normal 0.6-1.1 mg/dL.
- An eGFR<29 indicates a high risk of kidney damage and contrast material is not recommended.
- A Contrast Media Consent form **must** be filled out **prior** to the injection of any contrast media unless patient is unable to do so.
- Adults: IV catheter 20 gauge or greater into antecubital area or forearm. If a 22 gauge IV catheter is used, power injector rate shall not exceed 5ml/sec.
- Pediatrics:
  - Contrast dose will be determined by weight ~~using the Breslow tape~~.
  - Contrast will be administered at a dose of 2ml/kg of patient weight.
  - If using the power injector, flow rate will be reduced.
  - Use of 24 gauge IV catheters in pediatrics is acceptable if a 22 gauge IV catheter is unable to be inserted.
  - Contrast may need to be hand injected not to exceed a rate of 2ml/sec, all infants are to be hand injected only.
- Supervision and emergency care due to contrast reaction or extravastion will be provided by the Emergency Department Physician on duty.

DEFINITIONS:
None

SoHum Health

Subject: MRI Safety Policy and Procedure	Manual: Radiology

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 note 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 devises will be reviewed through the manufacturer for MR compatibility. If exam requires contrast, labs shall be reviewed prior to scheduling to minimize risk of reaction or potential kidney damage.
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. Cryogens leaking into the room may appear as clouds of smoke.

- Only trained service personnel may handle cryogens. 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 minor contrast reaction or extravastion 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.
- Patient is to be brought to the Emergency Department for treatment

In the event of a respiratory, ~~or~~ cardiac arrest or major contrast reaction 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.

SoHum Health

Subject: Contrast Administration and Supervision	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to delineate aspects of contrast administration and to ensure that all contrast media agents are properly stored, handled, and administered.

PROCEDURE:

- All diagnostic contrast agents are considered to be medication and therefore must be securely stored, safely handled, and properly labeled prior to administration.
- The Emergency Department (ED) Physician on duty will have supervision of a patient during and after contrast is administered.
- If a reaction to intravenous (IV) contrast occurs, the patient will be treated by the ED Physician on duty.
    - A crash cart will be readily available in the CT suite at all times.
    - Oxygen will be readily available in the CT suite at all times.
    - All MRI patients **will be** removed from the MRI suite (Zone IV), and from the MRI trailer (Zone III) when possible.
    - Oxygen will be readily available in the MRI trailer at all times.
- All contrast media will be stored in locked cabinets/refrigerator, accessible by Imaging~~CT~~ or pharmacy personnel only.
- All contrast will be labeled upon transference from the original packaging to another container including a syringe, power injector or a cup.
- The Pharmacist will be available by phone for contrast related questions.
- All contrast imaging~~CT~~ study protocols shall be reviewed and approved by the interpreting radiologist or interpreting radiologist group annually or as needed.
- All contrast injected via the power injector shall be into an intravenous catheter inserted into the forearm or antecubital space and shall be a minimum of 22 gauge (with the exception of pediatric patients).

Site Limitations:

- No PICC (peripherally inserted central catheter) lines shall be used for contrast injection by technologist.
- No IO (intraosseous) lines shall be used for contrast injection.
- No port-a-cath lines shall be used for contrast injection by technologist.
- No infants shall be injected using the power injector.

Extravasation:

- In the rare case of extravasation (including amount, type, and site), incident and treatment will be documented in the exam report and in the patient's medical record. The ordering provider will also be notified.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Assessment and Management of a Pediatric Patient with a Temperature Greater than 38C	**Emergency Department**

PROTOCOL:

This protocol covers the initial assessment and management of pediatric patients with a temperature ≥ 38.0C seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications
- Temperature ≥ 38.0C

Exclusions
- Age ≤ 3 months

PROCEDURE:

- Collect and review subjective data
  - Review history and signs and symptoms of current pediatric illness
  - Sequence of preceding events and symptoms
  - Actions that relieve symptoms
  - Pertinent past medical history, current medications and allergies
  - Characteristics of any pain (PQRST); location, quality, and intensity (age-appropriate pain scale) and associated symptoms (headache, crying, irritability, decreased appetite, tachycardia)
  - Any treatments used prior to arrival
- Objective Data
  - Perform focused physical exam relevant to pediatric temperature ≥ 38.0C
  - Observe for signs of injury, infection, rash, sepsis, and characteristics of meningococcal meningitis
  - Level of consciousness (may use Pediatric Glasgow Coma Scale)
  - Obtain core temperature, measure vital signs per *Guidelines for Emergency Nursing Practice*, assess central and peripheral pulses
  - Obtain patient's weight in kg
  - Place on pulse oximetry and measure SpO2
  - Skin signs: color, temperature, moisture, and capillary refill (central and peripheral)

Plan:

1. Administer oxygen via blow by if SpO2 <94%
2. Administer acetaminophen 15 mg/kg PO/PR x 1 for Temp ≥38.0, if not contraindicated or if not previously administered within 4 hours.
3. Administer Ibuprofen 10 mg/kg PO x1 for Temp ≥38.0 only in children older than 6 months, if not contraindicated or if not previously administered within 6 hours.
4. Notify physician if anti-pyretics were administered by the ED nurse.
5. Send urinalysis. Hold specimen for urine culture. Anticipate collection of urine by catheterization for any male child less than 6 months old that is circumcised, any male child less than 12 months old that is uncircumcised, or any female child who is less than 24 months old.
6. Consultation with provider as needed, or:

• Abnormal vital signs based on patient's age
• SpO2 <92%
• New onset focal neurological symptoms, rash
• New onset listlessness, irritability, or change in Pediatric Glascow Coma scale

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Assessment and Management of a Pediatric Patient with Vomiting	**Emergency Department**

PROTOCOL

This protocol covers the initial assessment and management of pediatric patients with vomiting seen by Registered Nurses (RN) in the Emergency Department (ED).

Indications:

- Weight ≥ 8 kg
- Vomiting with past four hours
- Not tolerating liquids per history
- No antiemetic use with four hours
- No history of cardiac arrhythmia

PROCEDURE

1. Collect and review subjective data.
   - Review history and signs and symptoms of current pediatric illness
   - Sequence of preceding events and symptoms
   - Actions that relieve symptoms
   - Pertinent past medical history, current medications and allergies
   - Characteristics of any pain (PQRST); location, quality, and intensity (age appropriate pain scale) and associated symptoms (headache, crying, irritability, decreased appetite, tachycardia)
   - Any treatments used prior to arrival
2. Collect and review objective data.
   - Perform focused physical exam relevant to pediatric vomiting
     - Observe for signs of abdominal pain, injury, headache, dehydration, surgical abdomen (bilious vomiting, severe pain, distension, right lower quadrant tenderness)
   - Level of consciousness (may use Pediatric Glasgow Coma Scale)
   - Obtain core temperature, measure vital signs per *Guidelines for Emergency Nursing Practice*, assess central and peripheral pulses
   - Obtain patient's weight in kg
   - Obtain full vital signs including temperature and blood pressure
   - Skin signs: color, temperature, moisture, and capillary refill (central and peripheral)

Plan

1. Administer ondansetron oral dissolving tablet
   a. 8-15kg patient: 2mg PO/SL
   b. >15kg patient: 4 mg PO/SL

2. Notify physician if anti-emetic was administered by the ED nurse.
3. If patient has no abdominal pain, give oral liquids to allow patient to slowly hydrate 15 minutes after administration of antiemetic
4. Consultation with provider as needed, or:
    - Abnormal vital signs based on patient's age
    - New onset focal neurological symptoms or altered mental status
    - Severe abdominal pain
    - Focal right lower quadrant pain
    - New onset listlessness, irritability, or change in Pediatric Glascow Coma scale

DEFINITIONS:
None

SoHum Health

Subject: Telemedicine Credentialing & Privileging Policy	Manual: Medical Staff

PURPOSE:

This policy establishes requirements for credentialing, privileging, monitoring, and oversight of telemedicine practitioners providing services to SHCHD patients, in compliance with CMS Conditions of Participation, California law, and SHCHD Medical Staff Bylaws.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure that all telemedicine practitioners employed or utilized by the District maintain an active, unrestricted California license and appropriate professional liability insurance at all times.

DEFINITIONS:

Practitioner: Physicians, dentists, allied Health Professionals, telemedicine practitioners, Locum tenens practitioners, and others.

PROCEDURE:

Telemedicine practitioners must maintain an active, unrestricted California license and appropriate professional liability insurance at all times.

Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) may be required upon initial privileging and at any point during a practitioner's appointment or reappointment cycle, on an ongoing basis. Telemedicine privileges are privilege-specific and approved by the Governing Body upon recommendation of the Committee of the Whole.

SoHum Health may utilize credentialing by proxy when CMS requirements are met and a written agreement with the distant site entity is in place. Full credentialing is required when proxy criteria are not met.

~~All records are confidential peer review documents protected under California Evidence Code §1157.~~

~~This policy will be reviewed biennially and updated as necessary to remain compliant with Medical Staff Bylaws and regulatory requirements.~~

SoHum Health

Subject: Swing Bed and SNF Weights	Manual: Nursing

PURPOSE:

The primary purpose of a policy for taking patient weights in hospital swing beds and skilled nursing facilities (SNFs) is to monitor nutritional status, manage medication dosages, detect fluid retention (such as in heart failure), and ensure regulatory compliance. Standardized weighing ensures consistent, accurate data crucial for assessing rehabilitation progress and preventing adverse health events.

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SoHum Health", "District", "SHCHD" to obtain weights for Swing Bed Patients and Distinct Part Skilled Nursing Facility (DP-SNF) to ensure safe care for patients and residents by establishing guidelines for weight management.

DEFINITIONS:

Standardized weights: a consistent, uniform protocol for measuring a resident's body weight to ensure accuracy, facilitate tracking of weight changes, and detect nutritional or health issues early.

PROCEDURE:

This policy applies to all patients/residents in Swing Bed or SNF units and all staff involved in patient/resident care, including nursing, therapy, and Certified Nursing Assistants (CNAs).

Patient/Resident Weight Measurement

All patients/residents must have their weight assessed on admission and then weekly for four weeks from date of admission. It is expected that no longer than seven days will pass before the next weekly weight is measured. If weight is stable after four weeks, patients/residents can be weighed monthly within the first seven days of each month. Weight assessments should be documented in the resident's medical record and include the date and method of measurement.

Special attention should be given to residents with significant weight changes or mobility restrictions.

Physician orders which change weight measurement intervals (ex: daily weights) supersede weekly or monthly weight intervals.

Procedure:

Patients/Residents will be weighed upon admission to facility, and staff will use either bed scale or wheelchair scale (wheelchair scale can also be used as standing scale).

If patient/resident can stand use the wheelchair scale. Fiirst check that the scale is at zero, then assist the patient to the scale and measure the patient/resident weight. Any clothing and/or adaptive equipment (walker, cane, prosthesis) should be bagged up and measured on the scale and that weight should be subtracted from the overall weight before entering into the medical record.

If patient/resident cannot stand, but can use a wheelchair, assist them to the wheelchair scale. First check that the scale is at zero then measure patient/resident weight. Any clothing, pillows, prosthetics, etc. should be bagged up and measured on the scale with the wheelchair and that weight is to be subtracted from the overall weight before entering into the medical record.

For Swing Bed patients only: If the patient cannot get out of bed due to health status, staff should use a Hoyer lift to lift the patient off the bed, zero out the bed with contents such as pillows on the bed, then lower the patient back to the bed and measure the weight. If other equipment (ex: Wound Vac) is present, staff should hold it away from the bed during weight measurement.

Nursing will notify physician and registered dietitian if weight gain or loss is greater than or equal to 5lbs in one week.

Nursing will notify physician and registered dietitian if weight gain or loss is greater than or equal to 5% in 30 days, 7.5% in 90 days or 10% in 180 days.

SoHum Health

Subject: Flex Fill-In Pool Policy	Manual: Human Resources

PURPOSE:

To improve shift coverage, manage labor demand fluctuations, and reduce staffing shortages, particularly in healthcare.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to establish Flex Fill-In Pools for key departments to address short-term staffing shortages.

DEFINITIONS:

Flex Fill-In Pool: An employee flex fill-in pool (or float pool) is a managed group of qualified staff used to cover temporary shortages, last-minute absences, or fluctuating workloads.

PROCEDURE:

Approval Process:

1. Employees must make a written request to their supervisor and Human Resources (HR) by completing and emailing the request form found on the Intranet, along with all supporting documentation needed.
2. HR and the department administrator will keep a list of approved employees for specific departments.
3. HR will build a Community Group in the HRIS (Human Resource Information System) for each position's Flex Fill-In Pool.
4. HR, the position supervisor, and the Department Chief will be Admins on the group.
5. All approved employees ready to be scheduled will be added to the Community Group.
6. Only employees in good standing without Adverse Action within the last 90 days are permitted to be added to, or remain on, the Flex Fill-In Pool lists.
7. HR will determine that the requesting employee meets the minimum qualifications for the role and will collect all needed certifications and licenses required for the fill-in role.
8. HR will calculate what the pay rate would be for the employee to fill in for the role.
9. HR will fill out a Change of Status form for the employee. The supervisor from the employee's current department and the department that they want to join will approve the action on the Change of Status form. Supervisors for both departments must sign the Change of Status form.
10. Flex Fill-In Pool supervisor will review and obtain a signature on the job description for the fill-in role.
11. The Flex Fill-In Pool supervisor must provide the signed job description to HR.

Once steps 1-11 of the approval process have been completed, the employee can begin training in the fill-in role. The employee will not be approved for the Flex Fill-In Pool until all training has been completed and provided to HR.

Rate of Pay:

Rate of pay will be determined by the years of experience the employee has had in the fill-in role and the District's approved Step Pay Scale.

Compliance:

HR must upload to the employee's personnel file. Prior to the employee being added to the Flex Fill-In Pool, HR will upload to the employee's personnel file: a signed job description, the signed and completed Change of Status, current copies of all required licensure and certifications for the fill-in role, and documentation of all required training.

The Flex Fill-In list must be audited annually by HR to ensure compliance with training, certifications, and licensure.

SoHum Health

Subject: Multi-Department Work Policy	Manual: Human Resources

PURPOSE:

This policy establishes guidelines for employees who perform work in multiple departments within the same facility. It ensures compliance with California wage and hour laws, proper timekeeping, and clear accountability for supervision and benefits.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide guidance to employees on working across multiple departments within the District while adhering to Federal and California labor laws.

DEFINITIONS:

Flex Fill-In Pool: An employee flex fill-in pool (or float pool) is a managed group of qualified staff used to cover temporary shortages, last-minute absences, or fluctuating workloads.

PROCEDURE:

This policy applies to all non-exempt employees who perform work in more than one department within the same facility.

Managers may schedule employees from the approved list for the position's Flex Fill-In Pool.

Supervisors from both departments will work together to ensure that employee schedules are written so that they do not overlap and that hours are not scheduled to cause overtime.

Documentation shall be maintained in the Employee's personnel file.

Primary Department and Benefits

Each employee will have a designated primary (home) department. This is the department housing the job they were initially hired into and where they work the majority of their hours. The primary department is responsible for benefits administration, performance management, and primary employee supervision. The secondary department work does not change benefit eligibility unless formally reassigned.

Conflict of Interest and Safety

Employees may not work in multiple roles that create a conflict of interest or violate workplace safety regulations or scheduling limits. Management must ensure that total hours worked do not create fatigue or unsafe working conditions.

Responsibilities

Employees must obtain approval to be entered into the Flex Fill-In Pool for the department they wish to fill in for by making a written request to their supervisor and submitting the Flex Fill-In Pool Form to Human Resources (HR). Employees in the pool must accurately record time and follow scheduling rules. Employees will use the District's HRIS (Human Resource Information System) to clock in and out of the correct department.

Supervisors are responsible for reviewing and approving time records for accuracy and must approve work, monitor hours, and ensure compliance.

Payroll/HR will ensure qualifications for the role, current certification/licensure, proper wage calculations, record-keeping, and classification.

Training:

It is the responsibility of the Fill-In Supervisor to ensure that the employee being scheduled from the Flex Fill-In Pool is current in all applicable training and in-services before scheduling. The supervisor must provide HR with documentation of all training provided for upload to the employee's personnel file.

Wage and Hour Compliance

All hours worked across multiple departments will be combined for the purpose of calculating overtime. Non-exempt employees are entitled to overtime pay when working over 40 hours in a work week. If an employee works in roles with different pay rates, overtime will be calculated using the weighted average (regular rate of pay), in accordance with Federal and California law.

Rate of pay will be determined by the years of experience the employee has had in the fill-in role and the District's approved Step Pay Scale.

Payroll is responsible for ensuring accurate calculation and payment.

The District will comply with all applicable Federal and California wage and hour laws.

Workers' Compensation and Payroll Classification

Payroll must be properly classified when employees perform work in different or separable operations.

Where applicable, payroll may be separated to ensure proper workers' compensation reporting and compliance.

All classifications must align with regulatory requirements.

Compliance

Failure to follow this policy may result in disciplinary action, up to and including termination.

members for no longer than twenty-four (24) months;

(b) Meet the qualifications of Medical Staff or AHP Staff membership;

(c) Commit to support the District's patient care programs;

3.5.2 Prerogatives

Provisional Staff members may:

(a) Admit and care for patients only if granted clinical privileges to do so;

(b) Attend meetings;

(c) Provisional Active Medical Staff have the right to vote, while Provisional Associate Medical Staff have no right to vote;

(d) Provisional AHP Staff, of any staff category, may not vote unless the vote is related to credentialing, privileging, or peer review of an Allied Health Professional; and

(e) All Provisional Staff may serve on committees as requested by the CW, but may not hold positions of leadership;

3.5.3 Responsibilities

Provisional Staff members shall:

(a) Complete proctoring requirements;

(b) Fulfill all responsibilities of membership; and

(c) Actively assist the Medical Staff and Hospital, as requested;

3.5.4 Competency Validation of Provisional Staff Members

(a) Each Provisional Staff member shall undergo a period of Focused Professional Practice Evaluation (FPPE) (Proctoring) as described in these Bylaws. The purpose of this provisional period shall be to evaluate the member's proficiency in the exercise of clinical privileges initially granted, and overall eligibility for continued staff membership and advancement within staff categories. Evaluation of Provisional Staff members shall follow the frequency and format determined by the CW to be appropriate in order to adequately evaluate the Provisional Staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained.

(b) The CW shall determine the Provisional Staff member may advance to another staff category when the Provisional Staff member meets all of the qualifications for advancement; has discharged all of the responsibilities, including completion of all required proctoring; and has not exceeded or abused the prerogatives of the Provisional Staff category.

(c) A Provisional Staff member shall remain in the Provisional Staff category for a minimum of ~~three (3) months and up to~~ twelve (12) months. the governing body may extend the provisional status (after recommendation from the Chief of Staff) if further evaluation is necessary for a total period of twenty-four (24) months following appointment to the provisional staff.

(d) Failure to meet all of the qualifications for advancement within twenty-four (24) months shall result in disqualification for reappointment. Where proctoring is not timely completed only for specified clinical privileges, those clinical privileges shall automatically terminate. A Provisional Staff member is not entitled to the procedural rights of appeal as set forth in the Fair Hearing Process, unless required by law.

3.6 TELEMEDICINE STAFF

3.6.1 Practitioners who render a diagnosis or otherwise provide clinical care and

SoHum Health

CNO Board Report – June 2026

Infection Prevention

We are pleased to welcome Heather Campbell, RN, as our Infection Preventionist. Heather brings more than 20 years of nursing experience to the role and has already begun working proactively with clinical managers to support required staff training and ongoing regulatory readiness. She continues to orient to the organization and unit-specific workflows.

Emergency Department, Acute Care, and Swing Bed Program

The Emergency Department continues to provide 24/7 care to the community with strong teamwork and dedication. We have received several messages of appreciation from community members, and we are grateful for the positive feedback recognizing the care our staff provides.

Some nursing staff have expressed concerns regarding recent changes to the staffing ratio structure. Following the recent state visit, the current nursing ratios were confirmed as appropriate.

The Swing Bed Program continues to progress well, generally accommodating five to seven patients at a time. We remain focused on effective staffing to support patient access and, whenever possible, maintain census. Since Elevate assumed inpatient admission support, we have seen an increase in patient volume. Please refer to the attached chart for additional details.

The ED/Acute unit recently completed a state and federal relicensing survey, and we are awaiting the final survey report.

To strengthen continuity of care, we implemented a workflow to schedule follow-up appointments for ED patients discharged with complications related to behavioral health diagnoses.

Staffing development remains a priority. We currently have three RNs in orientation: one experienced RN cross-training in both ED and Acute Care, and two new graduate RNs with prior healthcare experience. We also have two traveling LVNs and one traveling RN supporting the department. We continue to finalize Elevate provider access for inpatient admissions and are actively recruiting, including participation in the College of the Redwoods Nursing Preceptorship Program for 2026.

Skilled Nursing Facility

The Skilled Nursing Facility remains dedicated to providing compassionate, resident-centered care and is currently operating at full capacity. The team continues to support resident engagement through meaningful activities, social opportunities, and outdoor experiences.

As the weather improves, residents are participating in additional outdoor and community-based activities, including gardening, library visits, lunches at the Healy Center, scenic drives along the Avenue, and planned outings to the Farmers Market. The resident garden continues to provide an opportunity for residents to enjoy the outdoors, tend to plants, and participate in activities that support quality of life.

We are pleased to recognize Rhonda Wilhoit, MDS Coordinator, for earning her Resident Assessment Coordinator Certification. This certification strengthens our MDS process,

We also welcomed Jen LaRue, LVN, as the new Director of Staff Development. Jen will focus on CNA orientation, mandatory training, and competency evaluations to support clinical quality, staff development, and regulatory compliance; support accurate coding and reimbursement; and contribute to quality measures, Five-Star performance, and survey readiness.

Clinic and Mobile Services

Dr. Raisoni was selected to participate in the inaugural Partnership Leadership Academy, joining 34 healthcare professionals from across Northern California. This program supports leadership development, management skills, and awareness of current healthcare trends and challenges.

The Mobile Optometry Program continues to expand access to care. Services continue at the Resource Center in Rio Dell and have been expanded this month to Silvercrest Residences in Eureka, operated by the Salvation Army. The team's professionalism and quality of care were well-received, and the Mobile Optometry Unit was requested to be featured in an upcoming Salvation Army magazine. The optometrists are also collaborating with the Quality Department on QIP measures and participating in monthly quality challenges with clinic providers.

The Medical Assistant team continues to support prior authorizations, appeals, and Partnership outreach related to QIP initiatives. While prior authorizations remain time-intensive, successful appeals have resulted in additional medication approvals for patients.

The Referrals Department continues to work closely with Patient Financial Services to improve authorization workflows and timely scheduling for mammograms, CT scans, and MRIs. The team has also assumed responsibility for obtaining eRAFs for the Mobile

Optometry Program, further supporting access to care.

Radiology

Radiology completed 195 x-ray exams, 129 CT scans, 58 ultrasounds, and 41 mammograms in May. Preventive maintenance was completed on the mammography machine, and the annual physicist review was completed for CT and mammography equipment. The department continues to work on the pending MRI project, ABN-related issues, and updates to CT codes and charges.

Laboratory

The Laboratory continues to provide seven-day-a-week services to the community. The team has increased the number of tests performed in-house, helping reduce turnaround times and support timely diagnosis, treatment, and quality of care. Lab Week activities included a blood culture presentation and a NOVA analyzer demonstration. The department is also pursuing a new analyzer to enhance diagnostic capabilities. HR has developed an employee pool to assist with staffing coverage, and the phlebotomist job description is being updated to better align with current operational needs.

We are pleased to report that the Laboratory successfully received accreditation from the Accreditation Commission for Healthcare. The team has remained stable with six staff members since 2022. The lab also provided hands-on training for two students pursuing California phlebotomist certification; those individuals, currently working in security and transportation, will be added to the phlebotomy float pool.

Pharmacy

The Pharmacy Department continues to focus on medication safety, medication availability, and support for clinical teams. Current priorities include developing

workflow aids that align with policies and procedures, collaborating with departments on processes for medication storage and refrigeration downtime, improving the formulary in partnership with the Emergency Department, coordinating with Garberville Pharmacy to support consistent ordering, and working with long-term care partners to ensure timely and accurate medication management in Epic.

Physical and Occupational Therapy

The Physical and Occupational Therapy Department is currently providing support for both inpatient and outpatient services. The team is preparing for the arrival of traveler physical therapist Isabella, who will begin treating patients as soon as she receives the necessary clearance. Additionally, there is a growing demand for pelvic floor physical therapy among outpatient clients, a service that Isabella can offer to the community. Patients are encouraged to obtain referrals before receiving these services.

The department has recognized the need for clearer information regarding equipment availability. The Emergency Department (ED) will maintain its own supply of walkers, canes, crutches, and immobilization splints. Additionally, the Acute Care side will have its own equipment to ensure there are no shortages for inpatient care and therapy services.

Senior Life Solutions

Senior Life Solutions continues to provide essential behavioral health services despite staffing challenges. An open house is planned to introduce the new location and services. The program remains focused on expanding access to behavioral health support for the community.

Thank you for your ongoing leadership, collaboration, and commitment to delivering

safe, high-quality care across the SoHum Health District.

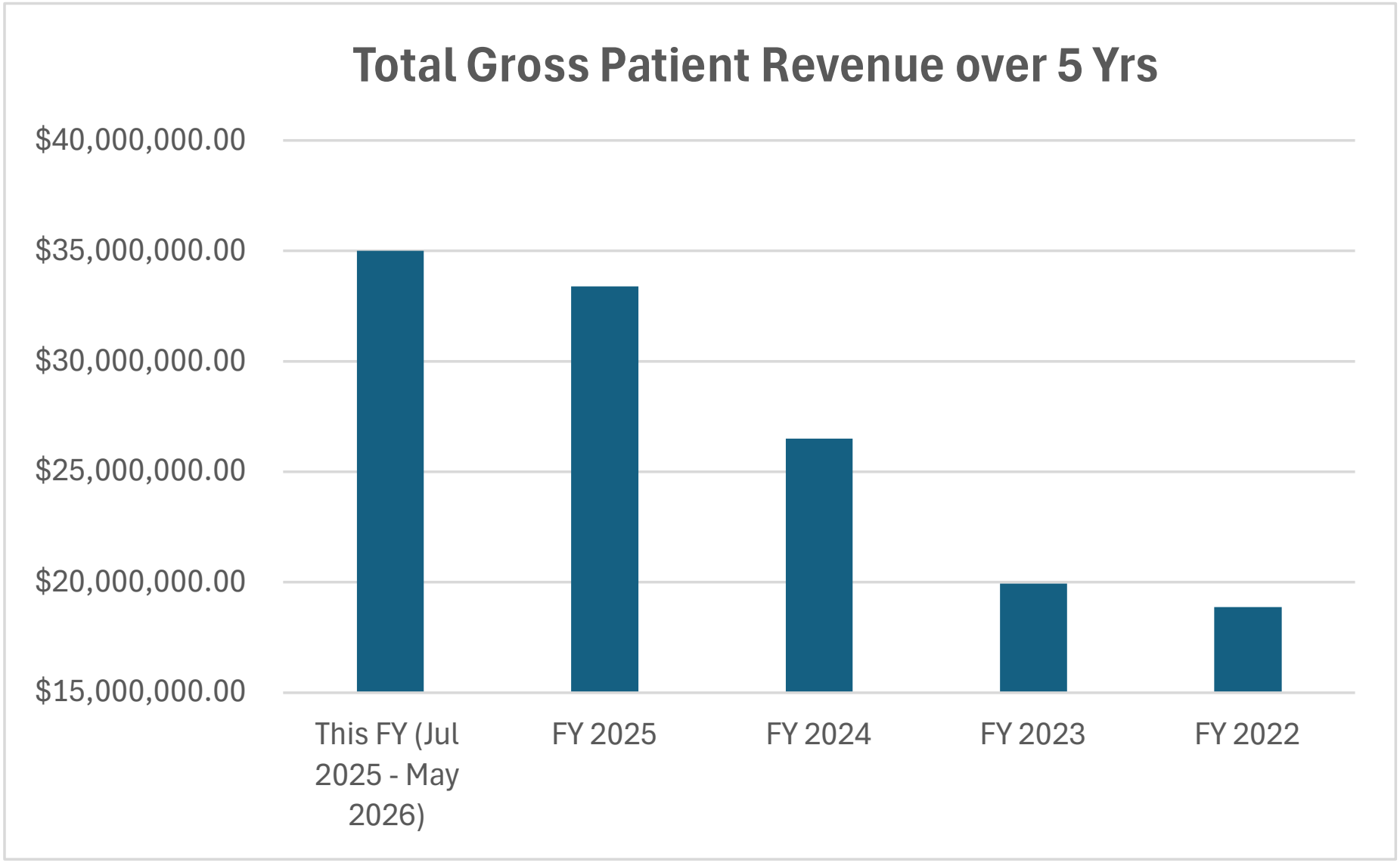
Adela Yanez, RN, BSN
Chief Nursing Officer

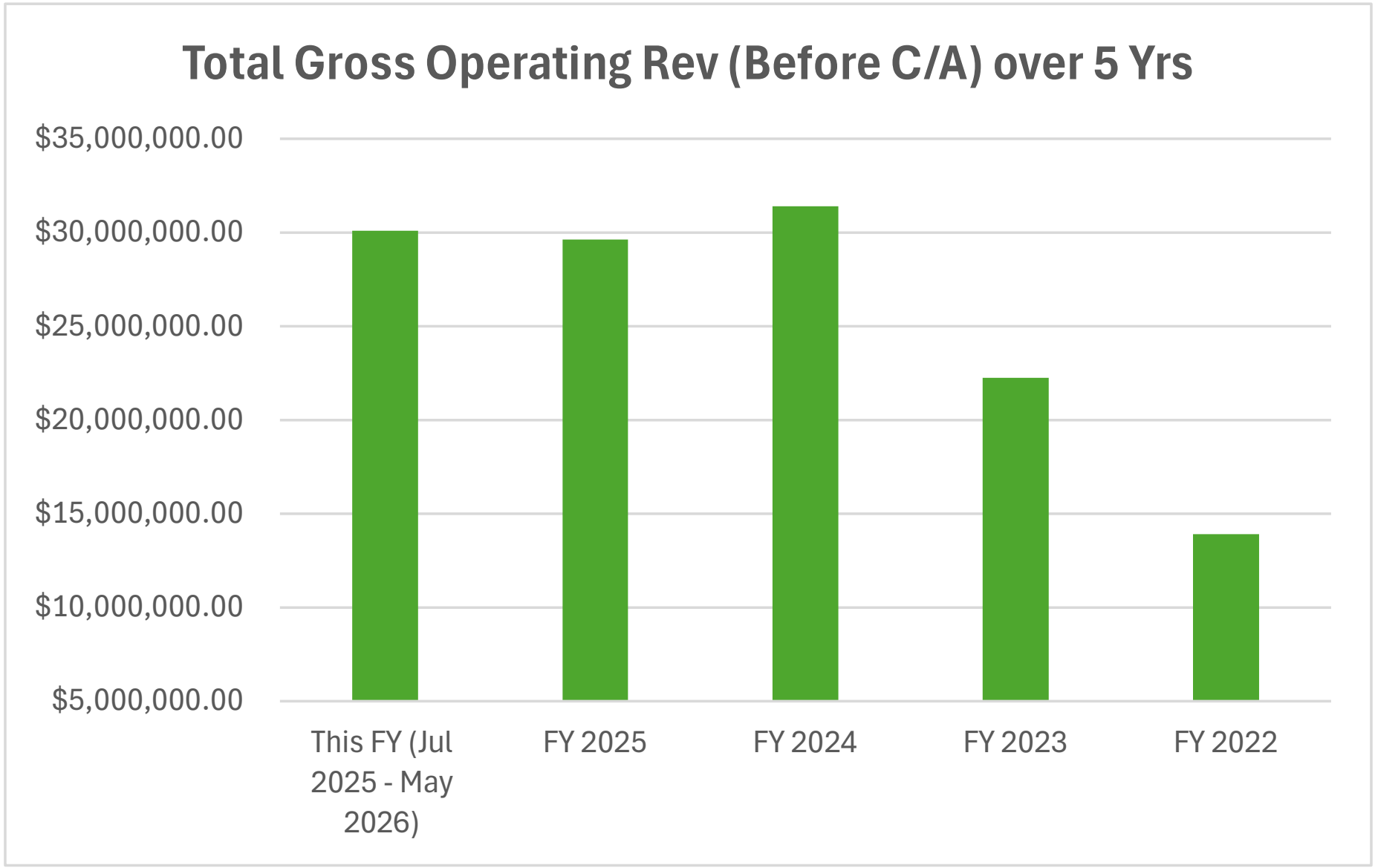
Southern Humboldt Community Healthcare District
Comparative SoHum Income Statement
5 Year Look Back - FY22 through End of May 2026

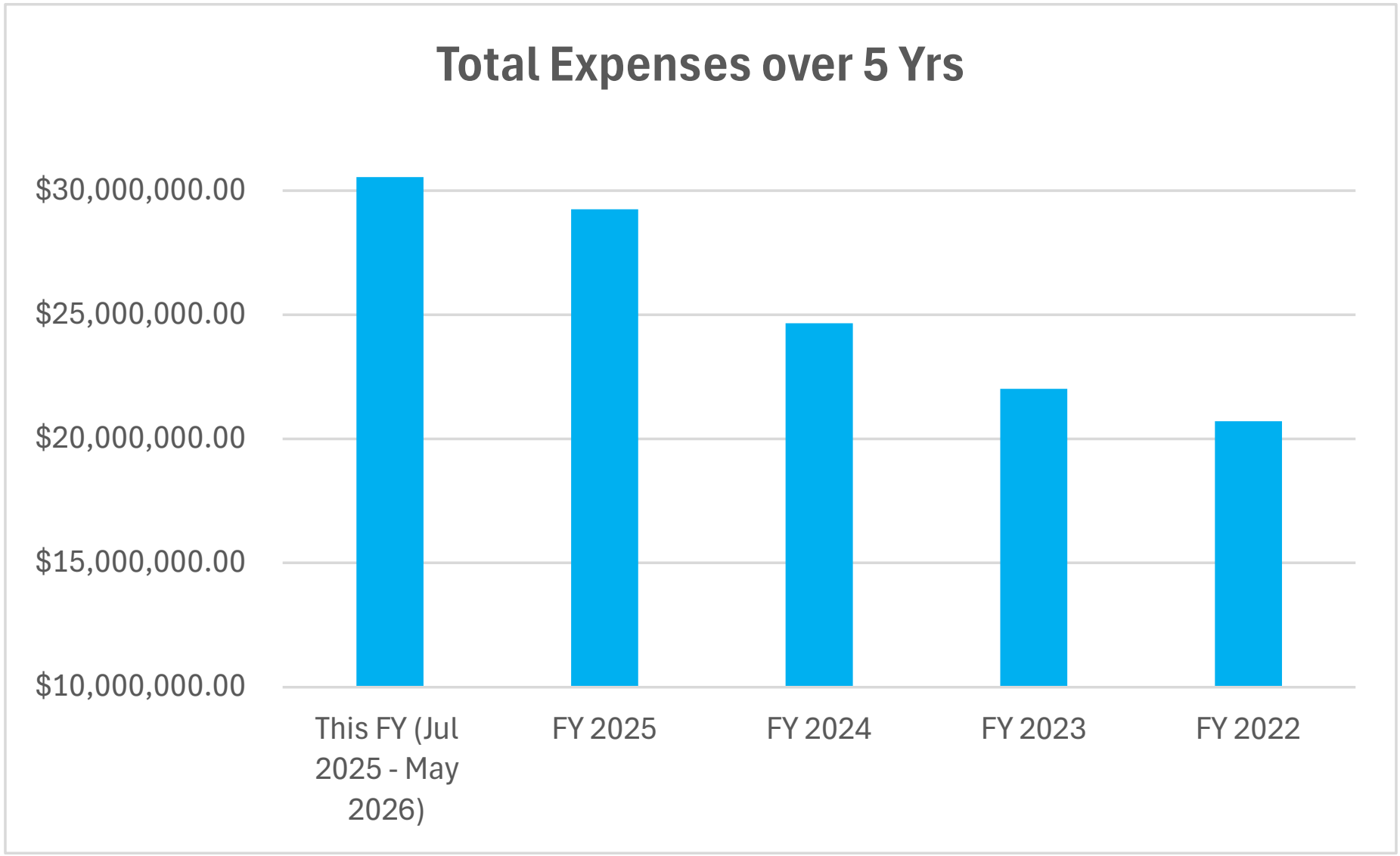
	This FY (Jul 2025 - May 2026)	FY 2025	FY 2024	FY 2023	FY 2022
Revenue					
Gross Patient Revenue					
Total - Inpatient	3,848,487	3,228,838	2,750,183	2,946,481	2,176,244
Total - Inpatient Ancillary	699,710	552,279	359,641	515,457	290,138
Total - Outpatient	21,011,857	19,509,296	15,724,614	10,154,038	15,517,764
Total - Outpatient Ancillary	9,451,151	10,098,701	7,666,152	6,321,148	883,854
Total Patient Revenue	**35,011,205**	**33,389,114**	**26,500,590**	**19,937,124**	**18,868,000**
Deductions from Revenue					
Total Operating IGTs & Supplemental	(7,256,027)	(13,511,565)	(9,497,749)	(10,815,285)	(3,600,000)
Total - Contractual Allowances	13,430,427	16,764,253	6,726,785	7,458,971	5,690,484
Total - Provision for Bad Debts	157,067	930,313	436,735	48,578	404,249
Total - Other Allowances / Deductions	316,622	525,619	(869,207)	1,143,031	1,400,263
Total - Cost Of Sales	11	(107)	-	-	-
Total Deductions	**6,648,100**	**4,708,513**	**(3,203,436)**	**(2,164,705)**	**3,894,996**
Net Patient Revenue	**28,363,105**	**28,680,601**	**29,704,026**	**22,101,829**	**13,857,000**
Total Other Operating Revenue	**1,718,825**	**942,876**	**1,690,390**	**151,855**	**-**
Total Operating Revenue	**30,081,930**	**29,623,477**	**31,394,416**	**22,253,684**	**13,896,000**
Expenses					
Total - Salaries & Wages	13,441,131	12,325,544	9,809,582	10,305,733	7,665,000
Total - Employee Benefits	5,622,575	4,553,599	3,890,153	2,235,101	2,659,000
Total - Professional Fees	4,950,626	5,334,980	3,861,034	3,198,652	2,626,000
Total - Supplies	1,181,750	1,297,197	1,752,548	1,442,106	2,514,000
Total - Repairs & Maintenance	286,608	290,700	335,812	342,050	324,000
Total - Purchased Services	2,613,642	3,063,107	2,114,981	2,224,256	2,224,000
Total - Utilities	304,310	352,329	304,523	276,547	290,000
Total - Insurance	235,915	238,076	172,820	172,223	110,000
Total - Depreciation/ Amortization	1,012,493	1,521,120	1,299,612	1,057,818	887,000
Total - Other	900,452	267,941	1,111,431	761,844	1,413,000
Total Operating Expenses	**30,549,502**	**29,244,598**	**24,652,496**	**22,016,330**	**20,712,000**
Operating Profit (Loss)	**(467,572)**	**378,879**	**6,741,920**	**237,354**	**(6,816,000)**
Total - Tax Revenue	1,168,507	1,404,861	1,084,388	1,100,133	
Total - Other Non Operating Revenue (Expense)	543,586	233,966	773,828	344,097	8,001,000
Total - Interest Income	5,438	53,857	194,029	62,545	
Net Non Operating Revenue (Expense)	**1,717,531**	**1,692,684**	**2,052,245**	**1,506,775**	**8,001,000**
Net Income (Loss)	**1,249,959**	**2,071,563**	**8,794,165**	**1,744,129**	**1,185,000**

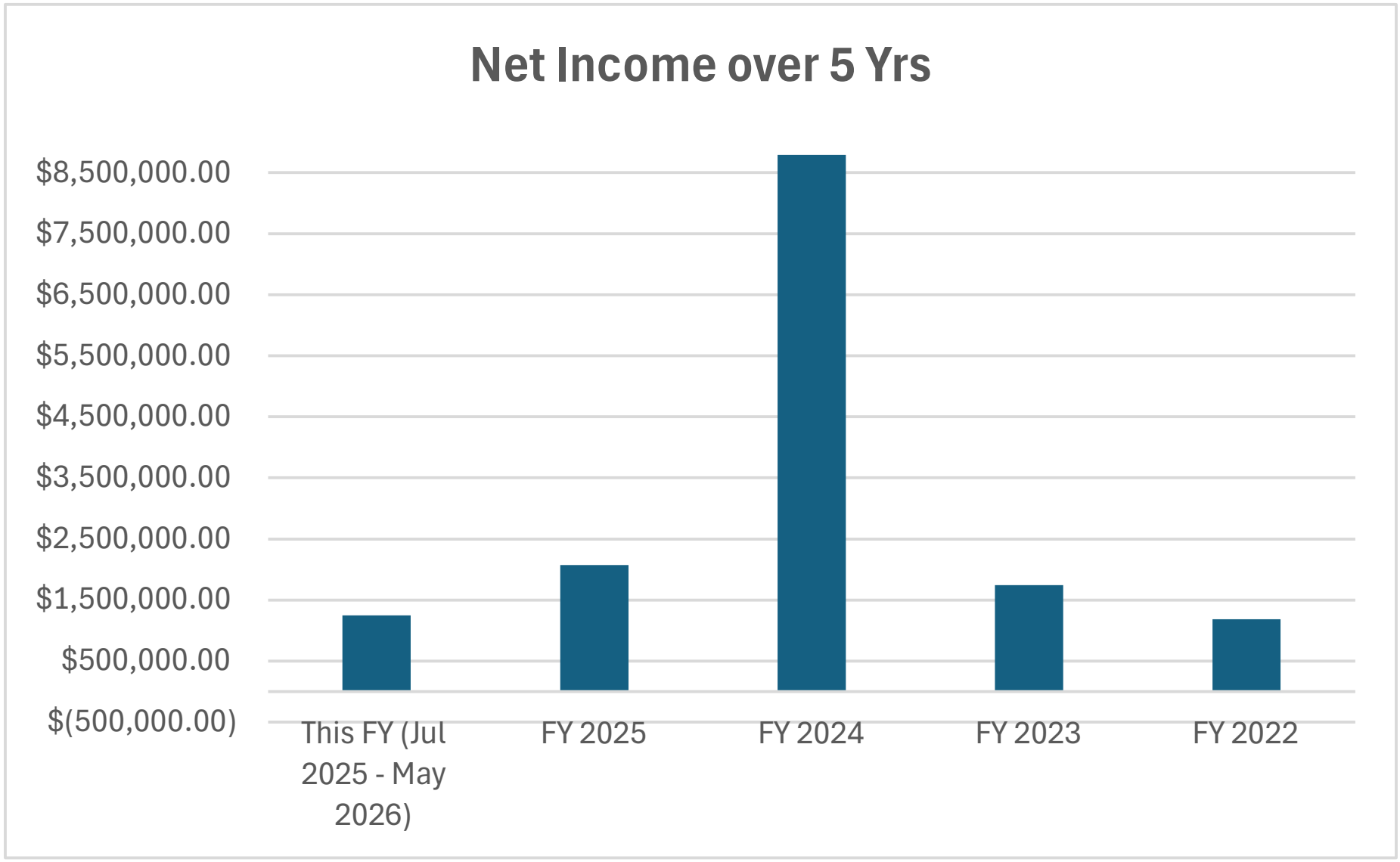
Southern Humboldt Community Healthcare District - Monthly Statistics

	May 26	April 26	Mar 26	Feb 26	Jan 26	Dec 25	Nov 25	Oct 25	Sep 25	Aug 25	July 25	June 25	May 25	Current 12 Month AVG	Year to Date- Current Year
In Patient Statistics															
Total Acute Patient Days	0	18	2	6	10	9	3	9	0	6	8	0	8		
Total Swing Patient Days	95	94	136	128	109	83	135	99	55	109	137	100	81		
Total SNF Patient Days	215	213	234	223	245	239	203	231	240	223	217	226	231		
Total Patient Days															
Total Acute Discharges	0	10	1	1	3	2	1	2	0	1	3	0	4		
Total Swing Discharges	3	5	4	6	2	6	3	4	4	9	3	3	6		
Total SNF Discharges	1	2	1	0	0	0	1	2	0	0	0	1	1		
Total Discharges															
Acute Length of Stay		3.0	5.0	3.0	3.3	5.0	3.0	5.0	0.0	7.0	2.7	0.0	11.0		
ER Admits	0	8	0	2	3	2	1	2	0	1	3	0	3		
I/P Lab Tests	153	501	225	297	528	259	234	371	419	359	439	218	369		
I/P Radiology Tests	6	27	6	28	28	14	6	7	25	10	13	12	14		
I/P CTs	0	16	6	6	21	4	2	12	12	3	18	2	6		
I/P EKG's	0	16	0	2	10	2	4	15	15	2	30	14	34		
Out Patient Statistics															
ER Visits	386	321	340	291	311	315	307	321	339	319	365	344	356		
Clinic Visits	399	371	569	405	500	486	410	472	463	528	501	593	466		
SLS Visits	63	74	52	56	55	70	97	86	45	54	49	36	22		
Outpatient Medical	23	24	47	46	26	36	25	26	46	36	34	48	29		
Laboratory Visits	306	314	365	250	307	316	277	322	286	344	349	418	288		
Behavioral Health Visits	63	99	91	106	71	53	39	48	43	36	19	12	8		
PT Visits	85	79	77	58	52	72	59	89	88	91	69	65	47		
OT Visits	36	36	32	19	20	18	11	9	5	3	0	0	0		
Optometry Visits	126	135	74	45	52	51	50	62	56	23	67	27	60		
X-Ray	196	195	251	218	214	173	175	192	185	178	234	240	184		
Mammography	37	39	0	0	15	30	24	61	41	25	14	21	23		
CT Scans	125	127	128	99	110	127	132	118	128	114	131	101	87		
Ultra Sonography	57	78	71	49	37	44	57	51	59	47	62	59	19		
EKG's	66	56	62	65	61	59	64	53	63	48	87	72	67		
Total O/P Visits															


Total Gross Patient Revenue over 5 Yrs
$40,000,000.00
$35,000,000.00
$30,000,000.00
$25,000,000.00
$20,000,000.00
$15,000,000.00
This FY (Jul 2025 - May 2026)
FY 2025
FY 2024
FY 2023
FY 2022


Total Gross Operating Rev (Before C/A) over 5 Yrs
$35,000,000.00
$30,000,000.00
$25,000,000.00
$20,000,000.00
$15,000,000.00
$10,000,000.00
$5,000,000.00
This FY (Jul 2025 - May 2026)
FY 2025
FY 2024
FY 2023
FY 2022

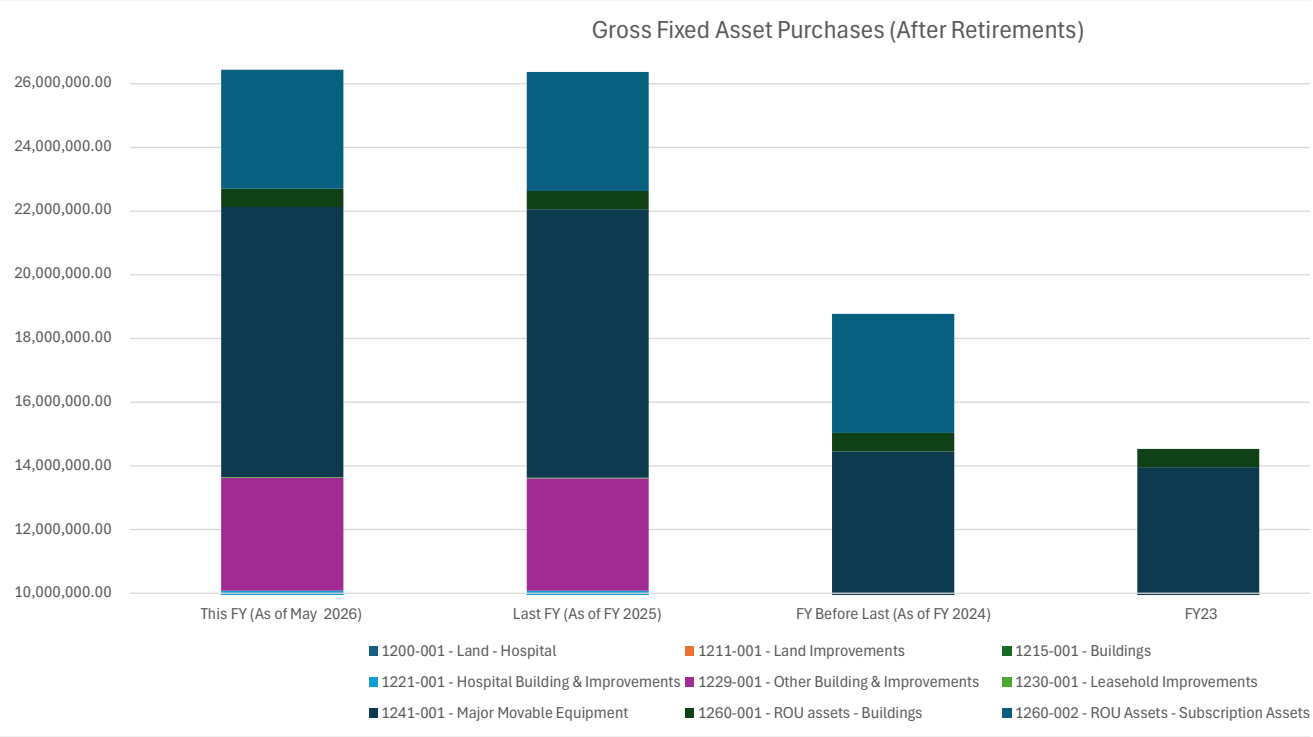

Total Expenses over 5 Yrs
$30,000,000.00
$25,000,000.00
$20,000,000.00
$15,000,000.00
$10,000,000.00
This FY (Jul 2025 - May 2026)
FY 2025
FY 2024
FY 2023
FY 2022

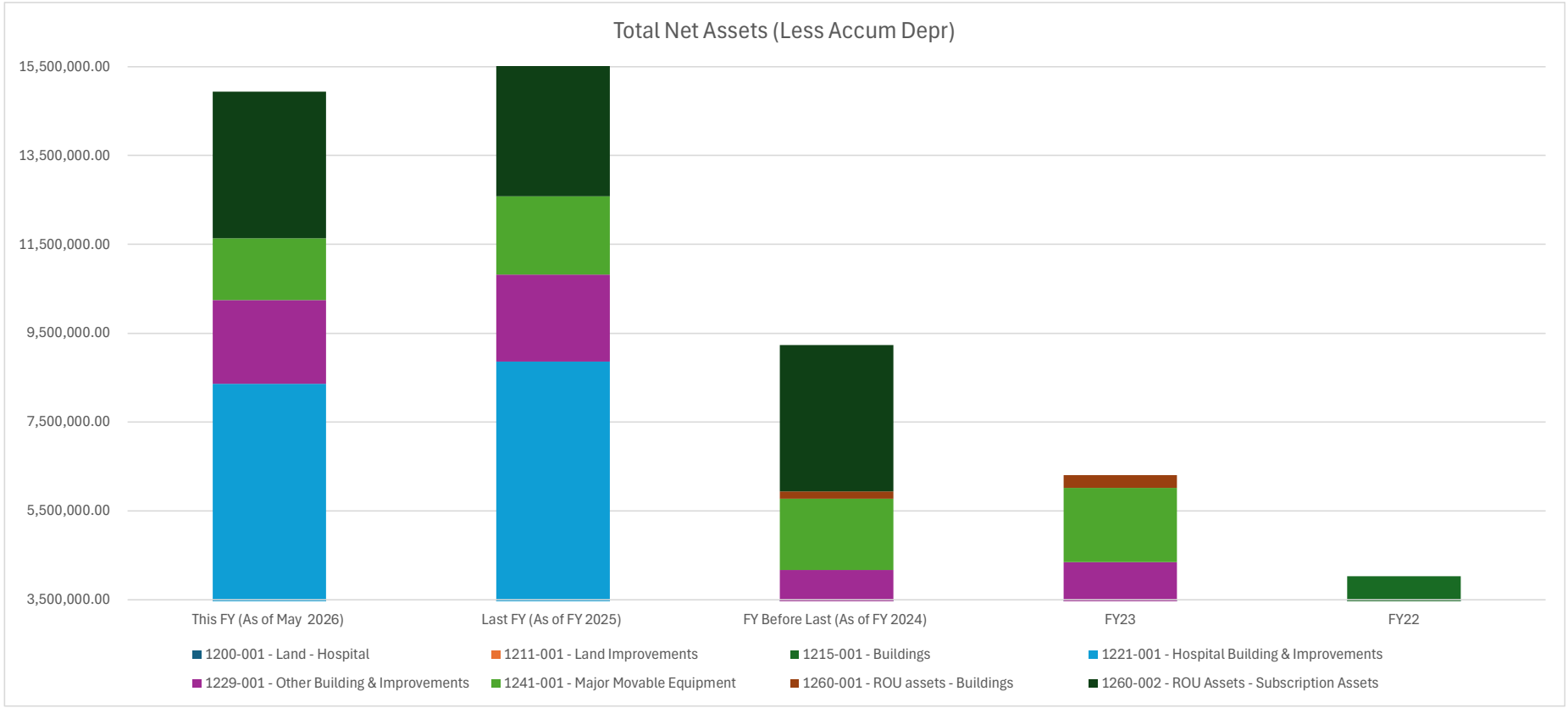

Net Income over 5 Yrs
$8,500,000.00
$7,500,000.00
$6,500,000.00
$5,500,000.00
$4,500,000.00
$3,500,000.00
$2,500,000.00
$1,500,000.00
$500,000.00
$(500,000.00)
This FY (Jul 2025 - May 2026)
FY 2025
FY 2024
FY 2023
FY 2022

Southern Humboldt Community Healthcare District
Comparative SoHum Balance Sheet
5 Year Look Back - FY22 through End of May 2026

	This FY (As of May 2026)	Last FY (As of FY 2025)	FY Before Last (As of FY 2024)	FY23	FY22
ASSETS					
Current Assets					
Total Bank	$ 1,679,347	$ 5,086,074	$ 8,242,122	$ 10,263,542	$ 12,749,303
Total Accounts Receivable	$ 7,414,591	$ 6,146,510	$ 7,312,024	$ 2,326,716	$ 1,696,446
Total Other Current Asset	$ 11,260,784	$ 11,395,578	$ 3,094,801	$ 628,810	$ -
Total Current Assets	$ 20,354,722	$ 22,628,162	$ 18,648,947	$ 13,219,068	$ 14,445,749
Fixed Assets					
1200-001 - Land - Hospital	$ 1,193,526	$ 1,193,526	$ 1,163,216	$ 1,028,216	$ 959,877
1211-001 - Land Improvements	$ 553,251	$ 553,251	$ 553,251	$ 553,251	$ 553,251
1215-001 - Buildings	$ 1,489,909	$ 1,489,909	$ 1,367,015	$ 1,474,356	$ 2,516,797
1221-001 - Hospital Building & Improvements	$ 6,846,690	$ 6,846,690	$ 119,716	$ 119,716	
1229-001 - Other Building & Improvements	$ 3,550,715	$ 3,526,173	$ 3,447,325	$ 3,387,733	
1230-001 - Leasehold Improvements	$ 12,785	$ 12,785	$ 12,785	$ 12,785	
1241-001 - Major Movable Equipment	$ 8,477,163	$ 8,433,015	$ 7,788,684	$ 7,378,269	$ 6,117,944
1250-001 - Construction In Progress	$ 9,443,023	$ 6,224,854	$ 7,683,040	$ 5,029,861	$ 3,901,331
1260-001 - ROU assets - Buildings	$ 580,234	$ 580,234	$ 580,234	$ 580,234	
1260-002 - ROU Assets - Subscription Assets	$ 3,735,812	$ 3,735,812	$ 3,735,812	$ -	
Less: Accumulated Depreciation	$ (12,068,125)	$ (11,055,632)	$ (9,534,512)	$ (8,234,901)	$ (6,345,119)
Total Fixed Assets	$ 23,814,984	$ 21,540,619	$ 16,916,567	$ 11,329,520	$ 7,704,081
Total ASSETS	**$ 44,169,706**	**$ 44,168,780**	**$ 35,565,514**	**$ 24,548,588**	**$ 24,523,000**
Liabilities & Equity					
Current Liabilities					
Total Accounts Payable	$ 752,168	$ 2,390,176	$ 959,621	$ 346,403	$ 197,742
Total Other Current Liability	$ 2,539,809	$ 1,762,548	$ 1,406,791	$ 927,074	$ 4,989,519
Total Current Liabilities	$ 3,315,417	$ 4,152,724	$ 2,366,412	$ 1,273,477	$ 4,608,252
Long Term Liabilities					
2250-020 - LEAF Data Backup Liability	$ -	$ -	$ 53,135	$ 106,365	
2250-025 - Maple Lane Loan	$ 161,904	$ 195,197	$ 227,867	$ 262,814	
2250-030 - ELGA Lease Loan	$ 1,424,301	$ 1,723,278	$ -	$ -	
2260-001 - Help II Loan	$ 1,750,438	$ 1,829,893	$ 1,907,907	$ 1,184,026	$ 511,000
2273-002 - Lease obligations	$ 730,124	$ 730,124	$ 730,124	$ 236,003	
Total Long Term Liabilities	$ 4,066,766	$ 4,478,493	$ 2,919,033	$ 1,789,208	$ 511,000
Equity					
Equity					
Total - Equity	$ 2,830,961	$ 2,830,961	$ 2,830,961	$ 2,830,961	$ 2,830,961
Retained Earnings	$ 32,706,602	$ 30,699,107	$ 18,654,947	$ 16,913,017	$ 14,808,778
Net Income	$ 1,249,959	$ 2,007,495	$ 8,794,160	$ 1,741,925	$ 1,185,000
Total Equity	$ 36,787,523	$ 35,537,564	$ 30,280,069	$ 21,485,903	$ 18,824,739
Total Liabilities & Equity	**$ 44,169,706**	**$ 44,168,780**	**$ 35,565,514**	**$ 24,548,588**	**$ 24,523,000**

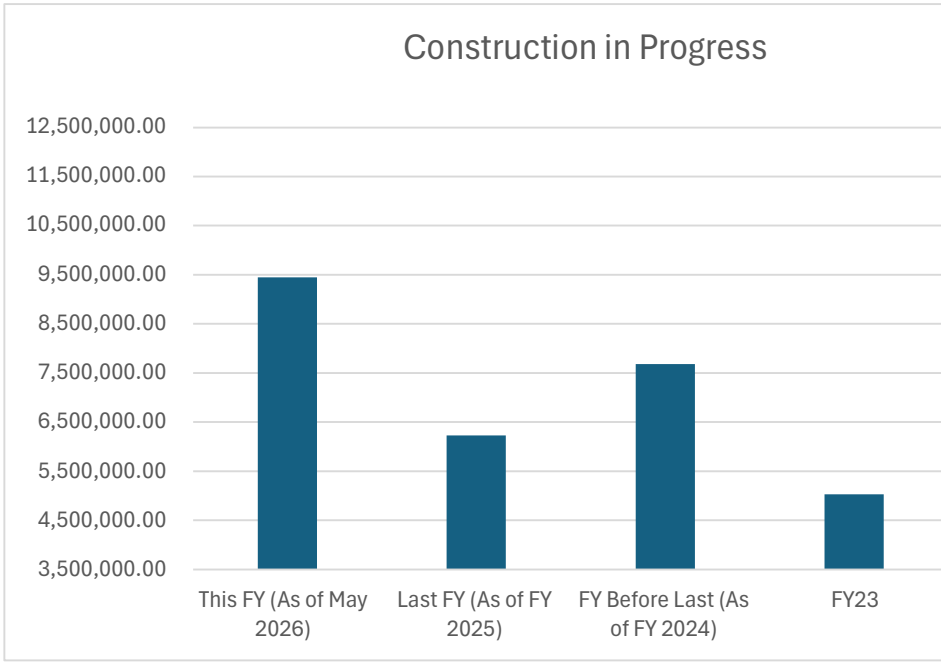
Southern Humboldt Community Healthcare District
Comparative SoHum Balance Sheet Graphs




Total Net Assets (Less Accum Depr)
15,500,000.00
13,500,000.00
11,500,000.00
9,500,000.00
7,500,000.00
5,500,000.00
3,500,000.00
This FY (As of May 2026)
Last FY (As of FY 2025)
FY Before Last (As of FY 2024)
FY23
FY22
1200-001 - Land - Hospital
1211-001 - Land Improvements
1215-001 - Buildings
1221-001 - Hospital Building & Improvements
1229-001 - Other Building & Improvements
1241-001 - Major Movable Equipment
1260-001 - ROU assets - Buildings
1260-002 - ROU Assets - Subscription Assets

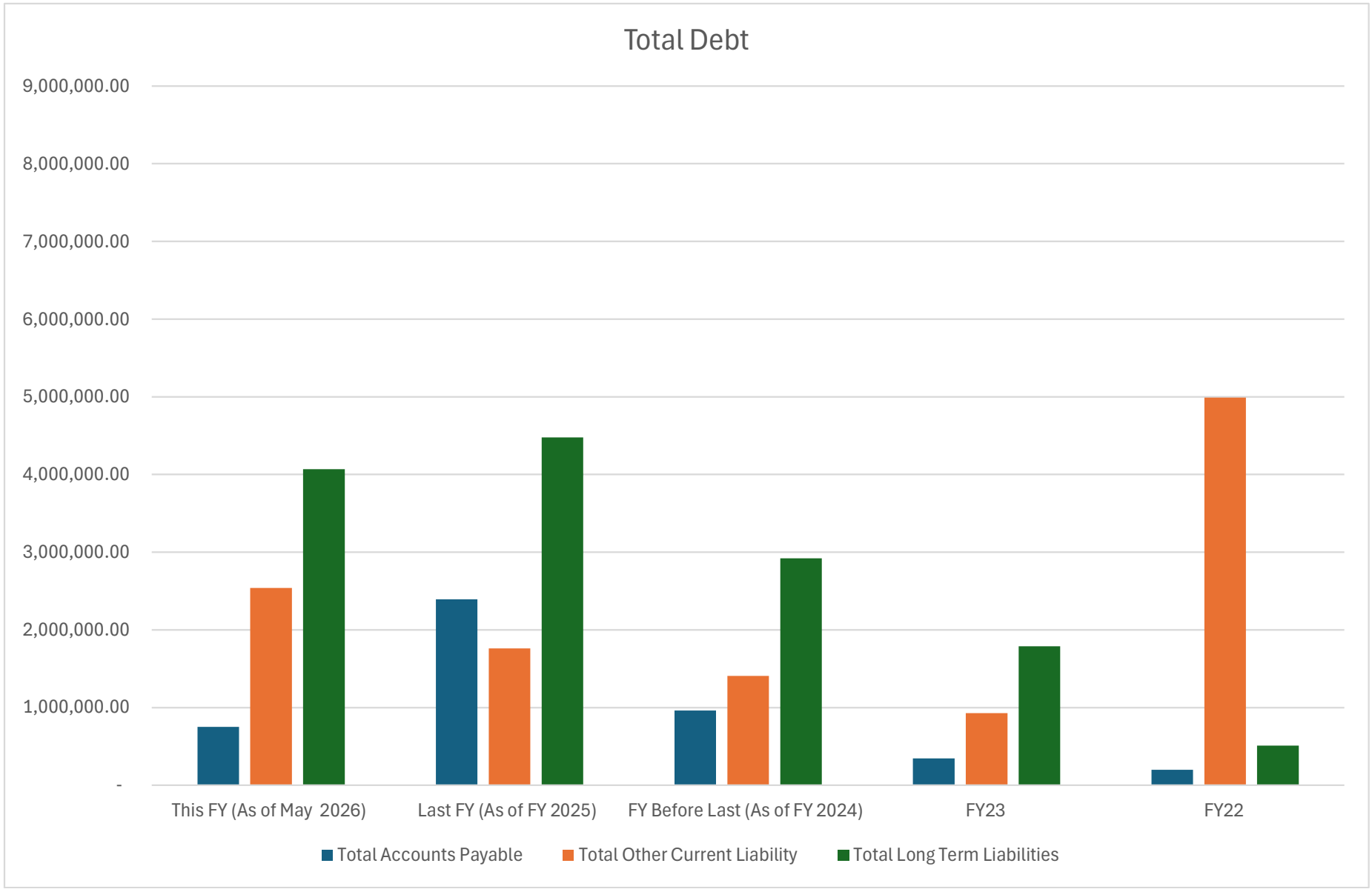
Southern Humboldt Community Healthcare District
Construction in Progress Detail/Graph

Construction In Progress Detail	Total @ 5/31/2026
NEW HOSPITAL	7,661,097.90
817-823 Redwood Drive	1,149,096.62
412 Maple Lane	279,068.10
285 SPROWEL CREEK	105,727.80
JPCH-ED HVAC Upgrade	105,221.92
Radiology Room Refresh	92,544.14
531 Elm Parking Lot Upgrade	87,335.54
286 Sprowel Creek Parking Lot	39,519.60
291 Sprowel Creek	4,700.00
819 Redwood Drive	1,829.66
887 SUNNYBANK	105.55
Book Adjustment to be made at YE	(83,224.08)
Total	**9,443,023**



817 Redwood Drive	741,790.67
823 Redwood Drive	211,237.33
819 REDWOOD DR	196,068.62
	1,149,096.62


FY22


Total Debt
9,000,000.00
8,000,000.00
7,000,000.00
6,000,000.00
5,000,000.00
4,000,000.00
3,000,000.00
2,000,000.00
1,000,000.00
-
This FY (As of May 2026)
Last FY (As of FY 2025)
FY Before Last (As of FY 2024)
FY23
FY22
Total Accounts Payable
Total Other Current Liability
Total Long Term Liabilities

Southern Humboldt Community Healthcare District
SoHum Income Statement
From Jul 2025 to May 2026

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Total
Revenue												
Gross Patient Revenue												
Total - Inpatient	317,215	307,388	246,251	320,079	303,845	300,766	661,215	215,712	381,039	457,283	337,694	3,848,487
Total - Inpatient Ancillary	124,825	71,719	30,686	62,058	35,657	46,269	87,458	26,671	61,641	110,220	42,505	699,709
Total - Outpatient	2,099,469	1,728,973	1,991,264	1,737,448	1,799,453	1,771,596	1,797,045	883,464	2,463,882	2,368,709	2,370,549	21,011,852
Total - Outpatient Ancillary	997,318	853,501	928,863	906,749	817,149	812,450	1,114,269	(238,048)	1,099,104	1,110,769	1,049,030	9,451,154
Total Patient Revenue	**3,538,827**	**2,961,582**	**3,197,065**	**3,026,335**	**2,956,104**	**2,931,080**	**3,659,987**	**887,799**	**4,005,666**	**4,046,982**	**3,799,778**	**35,011,205**
Deductions from Revenue												
Total Operating IGTs & Supplemental	(580,011)	(580,011)	(597,758)	(580,011)	(580,011)	(604,492)	(542,310)	(542,310)	(542,310)	(1,529,426)	(577,376)	(7,256,026)
Total - Contractual Allowances	1,699,311	1,328,284	1,561,715	1,517,067	1,171,659	1,536,035	1,424,213	(1,426,977)	1,666,156	1,064,362	1,888,601	13,430,426
Total - Provision for Bad Debts	41,428	97,503	7,028	23,174	5,763	-	-	(15,129)	(443)	(930)	(1,327)	157,067
Total - Other Allowances / Deductions	21,091	35,433	22,304	23,373	15,114	24,264	11,546	72,135	30,481	11,873	49,009	316,623
Total - Cost Of Sales	-	1	-	2	-	(25)	(9)	1	-	28	14	12
Total Deductions	**1,181,819**	**881,210**	**993,290**	**983,604**	**612,526**	**955,782**	**893,439**	**(1,912,281)**	**1,153,883**	**(454,093)**	**1,358,920**	**6,648,099**
Net Patient Revenue	**2,357,008**	**2,080,372**	**2,203,775**	**2,042,731**	**2,343,578**	**1,975,298**	**2,766,548**	**2,800,080**	**2,851,783**	**4,501,075**	**2,440,858**	**28,363,106**
Total Other Operating Revenue	234,655	115,055	195,768	313,412	(2,381)	281,218	93,048	52,923	175,695	210,545	48,887	1,718,825
Total Operating Revenue	**2,591,664**	**2,195,427**	**2,399,543**	**2,356,143**	**2,341,197**	**2,256,516**	**2,859,596**	**2,853,003**	**3,027,478**	**4,711,620**	**2,489,745**	**30,081,932**
Expenses												
Total - Salaries & Wages	892,169	1,117,207	1,436,827	1,328,393	1,122,776	1,188,189	1,251,495	1,193,935	1,121,116	1,284,389	1,504,633	13,441,129
Total - Employee Benefits	418,720	452,856	491,494	460,551	417,401	479,203	537,633	389,247	815,697	743,819	415,952	5,622,573
Total - Professional Fees	491,331	378,016	343,971	563,604	399,152	382,343	452,829	441,011	474,576	528,505	495,287	4,950,625
Total - Supplies	116,070	104,241	118,804	76,635	134,523	99,985	94,198	120,242	109,208	109,245	98,604	1,181,755
Total - Repairs & Maintenance	23,261	19,006	30,916	22,271	38,058	17,765	19,394	23,786	37,294	27,654	27,204	286,609
Total - Purchased Services	280,259	260,625	218,535	283,153	214,357	222,227	258,806	170,697	245,688	221,103	238,189	2,613,639
Total - Utilities	42,595	29,399	29,747	22,579	9,083	37,745	31,454	27,232	27,622	27,054	19,799	304,309
Total - Insurance	22,865	22,865	7,262	22,865	22,865	38,468	7,262	22,865	22,865	22,865	22,865	235,912
Total - Depreciation/ Amortization	92,800	92,863	93,068	93,664	93,343	92,691	90,979	90,771	90,771	90,771	90,772	1,012,493
Total - Other	69,653	63,467	108,928	70,610	104,332	90,270	47,209	63,663	67,322	60,227	159,851	905,532
Total Operating Expenses	2,449,724	2,540,546	2,879,552	2,944,325	2,555,891	2,648,887	2,791,261	2,543,448	3,012,160	3,115,634	3,073,156	30,554,584
Operating Profit (Loss)	**141,940**	**(345,119)**	**(480,009)**	**(588,182)**	**(214,694)**	**(392,371)**	**68,335**	**309,555**	**15,318**	**1,595,986**	**(583,411)**	**(472,652)**
Total - Tax Revenue	103,885	104,914	103,885	103,885	103,885	103,885	112,038	114,839	103,885	109,518	103,885	1,168,504
Total - Other Non Operating Revenue (Expense)	14,139	53,089	(7,598)	196,573	35,166	(31,164)	41,870	4,424	162,860	45,412	28,818	543,589
Total - Interest Income	44,239	1,519	1,533	12,100	1,862	1,533	5,064	(67,560)	1,535	1,985	1,628	5,438
Net Non Operating Revenue (Expense)	162,263	159,522	97,821	312,558	140,914	74,254	158,972	51,703	268,279	156,915	134,331	1,717,532
Net Income (Loss)	**304,203**	**(185,597)**	**(382,189)**	**(275,624)**	**(73,781)**	**(318,117)**	**227,307**	**361,258**	**283,598**	**1,752,901**	**(449,080)**	**1,244,879**

Southern Humboldt Community Healthcare District

May 2026

Overall A/R Health

Total A/R	Apr-26	May-26
Commercial	920,974.42	1,191,659.25
Medicaid	2,451,979.94	2,468,040.30
Medicare	2,995,712.68	2,276,536.36
Self-Pay	879,466.59	977,102.08
Government	293,506.12	315,672.17
Unbilled/Undistributed	(142,797.13)	(152,055.86)

GOAL: **55 Days**

April	May	Days
58.1	54.6	EPIC A/R
7	7.4	Self Pay
51.1	47.2	Ins A/R

We reached our days in A/R goal!

Roadblocks:

- Aetna Medicare: 32 accounts with outstanding claims totaling approximately $100,000 have been appealed. Response time is typically 30 to 60 days.
- Allied Health Employee accounts: 61 Hospital accounts with outstanding claims totaling approximately $122,000 are on hold for payor ID correction through Trizetto. After implementation of our self insured health plan, we continued to send claims to Anthem for which we were paid. However, Allied later informed us that we should be submitting these claims directly to Allied which will result in a higher reimbursement rate. However because we weren't informed upon implementation, EPIC was not properly set up to submit claims to Allied. Therefore, currently there is an open JIRA and we are working with the SoHum team to resolve. Until resolution no hospital employee claims are being submitted or paid.
- Humboldt County DA: The county has failed to pay 48 aged accounts. After several attempts by many individuals over an extended period of time to contact the county were unsuccessful, Remy finally made contact with an auditor last week. Investigation has begun and we will continue to work with the county for payment.
- TruBridge process emphases: TruBridge team continues to have challenges with the following processes, so our new revenue cycle supervisor is taking additional measures to ensure the team hits goals and reporting to SoHum weekly on the following items:
    - Follow up on claims every 30 days
    - Resolve A/R credit balances
    - Review Bad Debt Workque to submit to collections company

TruBridge®