Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

January 13, 2021 1:00 PM
Zoom Meeting: LINK
Call In Number: 1-669-900-9128
Meeting ID: 919 0177 6230

Attendees

Jeanne Utterback, Board President, Quality Committee Chair
Tom Guyn, Board Secretary

Louis Ward, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**		Chair Jeanne Utterback			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – November 11, 2020		Attachment A	**Action Item**	2 min.
4	**REPORTS: QUALITY FACILITIES: NO REPORTS**					
5	**REPORTS: QUALITY STAFF**					
	5.1	Personnel	Libby Mee	Attachment B	Report	10 min.
	5.2	Worker's Comp Quarterly	Libby Mee	Attachment C	Report	10 min.
6	**REPORTS: QUALITY PATIENT SERVICES**					
	6.1	Emergency Department	JD Phipps	Attachment D	Report	5 min.
	6.2	Laboratory	Neil Coplea	Attachment E	Report	5 min.
	6.3	Radiology	Alan Northington	Attachment F	Report	5 min.
	6.4	HIM	Lori Stephenson/Travis Lakey	Attachment G	Report	5 min.
	6.5	SNF	Diana Groendyke	Attachment H	Report	5 min.
	6.6	SNF Events/Survey	Candy Detchon		Report	5 min.
	6.7	Infection Control	Dawn Jacobson		Report	5 min.
7	**REPORTS: QUALITY FINANCES**				Report	5 min.
	7.1	Business Office	Danielle Olson	Attachment I	Report	5 min.

	7.2	Finance	Travis Lakey	Attachment J	Report	5 min.
8	**DIRECTOR OF QUALITY**		Jack Hathaway	Attachment K	Report	10 min.
9	**OLD BUSINESS**					
	9.1	Patient Safety First Report			Discussion	5 min.
10	**NEW BUSINESS**					
	10.1	POLICIES: Hospice Patient Bill of Rights		Attachment L	**Action Item**	5 min.
	10.2	ENV Services Report	Keith Earnest	Attachment M	Report	2 min.
	10.3	Community Member Appointment to Quality Committee: Recommendation to be reviewed and voted at full board meeting.			**Action Item**	5 min.
11	**ADMINISTRATIVE REPORT**			Louis Ward	Report	10 min.
12	**OTHER INFORMATION/ANNOUNCEMENTS**				Information	5 min.
13	**ANNOUNCEMENT OF CLOSED SESSION**					
	13.1	**Medical Staff Credentials Government Code 54962** **List of Credentials:** **STAFF STATUS CHANGE** Dan Dahle, MD – Move to Inactive **AHP REAPPOINTMENT** Erica Haedrich, PA – Family Medicine **MEDICAL STAFF REAPPOINTMENT** Jeremy Austin, MD – Emergency Medicine Paul Davainis, MD – Emergency Medicine Javeed Siddiqui, MD – Infectious Disease Richard Granese, MD - Psychiatry **MEDICAL STAFF APPOINTMENT** Danford Bickmore, MD – Radiology Gregory Shaw, MD – Radiology			**Action Item**	
14	**RECONVENE OPEN SESSION** – Report closed session action				Information	
15	**ADJOURNMENT:** Next Regular Meeting – February 10, 2021 – Zoom Meeting					

Board of Directors
Quality Committee
Minutes
November 11, 2020 @ 1:00 PM
Fully Remote Zoom Meeting

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

1	**CALL MEETING TO ORDER:** Board Chair Laura Beyer called the meeting to order at 1:00 pm on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Laura Beyer, Secretary Jeanne Utterback, Director		Candy Vculek, CNO Jack Hathaway, Director of Quality Jessica DeCoito, Board Clerk Val Lakey, ED of CR & BD Brigid Doyle, Staff Development Barbara Spaulding, Volunteer Services Sondra Camacho, Activities	
	ABSENT:			
2	**CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
	None			
3	**APPROVAL OF MINUTES**			
	3.1	A motion/second carried; committee members accepted the minutes of October 14, 2020	***Utterback, Hathaway***	**Beyer – Y** **Utterback – Y**
4	**REPORTS: QUALITY FACILITIES: NO DEPARTMENT REPORTS**			
5	**REPORTS: QUALITY FINANCES: NO DEPARTMENT REPORTS**			
6	**REPORTS: QUALITY**			
	6.1	**MARKETING:** A lot of education and messaging on COVID has been the focus. Community Newsletter goes out every Wednesday with a lot of links for more information, county information – 5 people in last week and now we are up to 52 people from around the community who are receiving this newsletter. Text message group with updates has been created. Helping Social Services and Activities and all other departments to help keep our residents, resident families, patients and community members up to date.		
	6.2	**SAFETY QUARTERLY REPORT:** COVID report is completed each day of the week. PPE Bill AB2537 will go into effect soon and we must have reports available and stock pile set up soon. Dana Hauge has been a huge help in the safety planning for employees. Installing a PANIC button in certain locations throughout the facility.		
	6.3	**VOLUNTEER SERVICES:** Not a whole lot going on because of the COVID restrictions. Keeping everyone up to date with things. Worries are what our volunteer numbers will look like after COVID restrictions are taken down.		
7	**REPORTS: QUALITY STAFF**			
		STAFF DEVELOPMENT: 100% re-certified with our CNA staff. Lots of adjustments in trainings and learning have been made with COVID restrictions. COVID content is provided and required for staff and it has been seen in the data that staff choose more		

		COVID modules than the others. New Staff Orientation was created through Relias to help with COVID restrictions in on boarding.		
8	**REPORTS: QUALITY PATIENT SERVICES**			
	8.1	**ACTIVITIES:** Hand glove visit is a huge success with residents and families. A lot of parades have been set up so we can provide an activity and an opportunity to families to see their loves ones from afar. Still doing window visits, Zoom calls and we now have a lap top set up for families and residents to send emails back and forth. Competency assessment and validation has been a huge priority.		
	8.2	**SOCIAL SERVICES:** no questions or comments from submitted written report.		
	8.3	**SNF Events/Survey:** Hope to begin communal in person visits with residents and families. Still lots of restrictions that will have to be followed. Plans are being put into place. Prepping for survey – double checking and working through new processes. With more COVID positives in the area, we are being extra careful and planning on extra staff with the help of Registry.		
	8.4	**INFECTION CONTROL & EMPLOYEE HEALTH:** High participation in the flu shot for employees.		
9	**DIRECTOR OF QUALITY**			
	9.1	CMS Core Measures: HCAHPs is the persistent issue and getting it worked out. Our HCAHPS numbers look really good. STARS: made it to 3 stars!! Great job team! To get to 4 stars we have three measures we are going to focus on 1) Residents with a decline in Activities of Daily Living 2) Antipsychotics prescribed 3) loss of mobility. So close to 4 Stars – just need to focus on making more improvements.		
10	**New Business**			
	10.1	**Policies:** Conflict of Interest	***Utterback, Beyer***	**Beyer – Y** **Utterback – Y**
	10.2	**Patient Safety First:** complete some more research and return to next meeting with additional thoughts. Is this required? Are we already reporting on this in another report?		
11	**ADMINISTRATIVE REPORT:** NO REPORT THIS MONTH. LOUIS WARD IS IN A HOSPITAL COUNCIL MEETING.			
12	**OTHER INFORMATION/ANNOUNCEMENTS**:			
13	**ADJOURNMENT: 2:24pm** - Next Regular Meeting – December 9th			

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	Wednesday January 13, 20201
Department:	Human Resources
Submitted By:	Libby Mee – Director of Human Resources
List up to three things that are going well in your department.	
We have continued to on-board new staff throughout the pandemic. We have also retained more staff this year than previous years. (I will have a full hire and turnover report at the full board meeting) We have put multiple support and resource programs in place to help employees in need.	
Do you have any current quality improvement projects/activities underway? Please provide a brief description. **Is this a LEAN project? NO**	
One of my primary daily duties currently is tracking and communicating with employees that are out on a COVID related Quarantine or Isolation. I work closely with the infection prevention team when we are made aware of new exposures. I communicate with staff for follow testing requirements, return to work dates and how to appropriately use their COVID related resources and benefits.	
How does this impact on patients? Do you think this is acceptable?	
MMHD has been very proactive in removing exposed staff from the work environment in efforts to stop the spread of the virus, which is acceptable.	
How does this impact on staff? Do you think this is acceptable?	
When staff has to be off work, MMHD has multiple support programs in place. We have implemented a Telecommuting policy, use of COVID Supplemental Sick hours, PTO cash out programs and allowing employees to take their PTO banks into the negative. Employee's with exposures that are work related, that have exhausted their Supplemental Sick Bank are also eligible for Lost Time through our work comp insurance.	
What progress has been made on these projects since the last quality committee meeting?	
We have implemented our Manager Training Program. We are currently tracking for compliance and have put our last 2 newly hired managers through the New Manager Training Program.	
Has anyone in particular been instrumental in helping to progress/improve the problem?	
HR Generalist – Shay Herndon	
Which Strategic Goal does your quality issue BEST relate to (choose one)?	
Outstanding Staff	
Have any new quality-related issues arisen? Briefly describe.	
With employees having to be off on Quarantine and Isolation, we have to work hard to fill holes in the schedules. We had attempted to get ahead of this issue by bringing in registry, but most other facilities are in the same position so registry resources are slim. We have pulled in alter companies and raised our bill rates. We have also offered incentives to current staff that pick up alternate shifts.	
Are there any other issues to be discussed with the Committee?	
Not at this time	

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	Wednesday October 13, 2021
Department:	Worker's Comp
Submitted By:	Libby Mee – Director of Human Resources

List up to three things that are going well in your department.

MMHD continues to have very low claim volume
Working with Dana Hauge, Employee Health Coordinator, on implementation of Ergonomic Program
Also working with Dana on updating Workplace Violence Prevention Program.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? NO

Implementation of the Ergonomic Program. Dana is in the process of completing certification as Ergonomics Assessment Specialist. This certification will equip Dana with the knowledge to evaluate employees in their workspace and provide solutions and recommendations to employees to be sure that their workspace is conducive to safe and quality work.

How does this impact on patients? Do you think this is acceptable?

This initiative promotes safe and responsible behavior creating an atmosphere that can provide the best patient care.

How does this impact on staff? Do you think this is acceptable?

By providing these resources, employees should experience less injury, illness and exposure resulting in less days away from work.

What progress has been made on these projects since the last quality committee meeting?

We have had follow up meeting with our counterpart with BETA to be sure the project is on track, as well have shared and updated policies back and forth.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Our support from BETA has been very helpful, and Dana's eagerness and interest in the program is very exciting.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding Staff and Finances which both lead to better Patient Care

Have any new quality-related issues arisen? Briefly describe.

I have started having conversations with the Clinic Manager to be sure that we begin thinking about building a process for injured employees to be able to do their follow-up visit with the Mayers Clinic. Current follow-up visit are happening at MVHC.

Are there any other issues to be discussed with the Committee?

2020 Injury and Illness Data:
First Aide Injuries – 14 resulting in 5 days away from work
Reportable Injuries – 8 resulting in 70 days away from work

2019 Injury and Illness Date for comparison:
First Aide Injuries – 12 resulting in 0 days away from work
Reportable Injuries – 5 resulting in 59 days away from work

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	
Department:	Emergency
Submitted By:	JD Phipps/Alexis Cureton

List up to three things that are going well in your department.

1) Documentation of vitals and pain reassessment reached a consistent level allowing for audits to cease
2) Audits of the ED log where by MD and nurses were not assigned and/or use of "other" for complaint was sufficiently curved to meet standard allowing for audits to cease
3) Transition in practice for smooth operations in the new wing has gone well and staff are now comfortable

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

ESI triage level – All patients presenting to the ED are assigned a triage level that is a snapshot of their status and needs upon arrival. We have found that our assignment of triage level is not in alignment with standards. This was identified

How does this impact on patients? Do you think this is acceptable?

At a facility our size it does not impact patients as we are able to provide care without having to prioritize it to a vast group of "waiting" patients. However, it is regulatory and therefore not negotiable.

How does this impact on staff? Do you think this is acceptable?

This process does not increase workload or add steps. It is merely the appropriate application of information

What progress has been made on these projects since the last quality committee meeting?

Official training through Relias was completed including post tests. Ongoing audit of results and sharing of those results with staff at staff meetings.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Alexis took ownership of this by completing all the audits and has been creating emails to the staff to 1) challenge them with different scenarios to apply the new knowledge 2) keep it in staff forefront. Audit data shows a dramatic improvement in compliance but not yet to the point of target achievement.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding patient services

Have any new quality-related issues arisen? Briefly describe.

We have implemented protocols for Stroke and Sepsis and need to start audit processes to evaluate our care against those protocols.

Are there any other issues to be discussed with the Committee?

Not at this time

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	January 6, 2021
Department:	Laboratory
Submitted By:	Neil Coplea

List up to three things that are going well in your department.

1. The current lab staff is working hard, and willing to improve lab services.
2. We are keeping up with the current workload. It is a struggle at times, especially with all of the extra workload caused by Covid testing, but the staff have stepped up.
3. We are making steady improvements in Lab Policies, Procedures, Protocols, and Processes.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

1. We are revising or writing all lab Policies, Procedures, and Protocols. The lab can have up to 12 Manuals, and 1,200 policies and procedures. Only a fraction of these can be found on MCN Policy Manager.
2. We are reorganizing the entire lab, and streamlining processes.
3. We are also assuring that we meet or exceed all regulatory guidelines.
4. We will be "Going Live" on our new Vitek (for Culture ID and Sensitivity), and our new BacT/ALERT Blood Culture instruments.
    a. The Vitek will reduce the TAT for ID and Sensitivity. It will provide much better and more precise results.
    b. The BacT/ALERT will present a positive blood culture in as little as 6-8 hours. This is a huge time savings over our current manual system. Time is of the essence when dealing with bacteremia.
5. Neil will be introducing a QI Manual, and Indicators for each area of the lab that will be tracked from month to month.
6. All Microbiology is now being performed in the new Micro area. Up until last week, all Micro was performed in the old lab area, causing the techs to have to walk back and forth.

How does this impact on patients? Do you think this is acceptable?

The above mentioned items will positively impact patients. They will also help to lessen LOS for the hospital.

How does this impact on staff? Do you think this is acceptable?

The above mentioned items will actually lessen the workload on the staff, while assuring that we put out quality results. The items will decrease TAT while increasing productivity.

What progress has been made on these projects since the last quality committee meeting?

All of the items mentioned were started since the last quality committee meeting.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Lab Personnel, Maintenance, Admin, Purchasing, HR, Pam (MCN), and other hospital personnel were all part of helping the above items come to fruition.

Which Strategic Goal does your quality issue BEST relate to (choose one)?
Getting the lab up to a good maintenance level, that meets or exceeds regulatory guidelines.
Have any new quality-related issues arisen? Briefly describe.
All of the items mentioned above were quality issues that needed to be addressed.
Are there any other issues to be discussed with the Committee?
In spite of the challenges with staffing, training, and processes, we are moving forward in the lab. I feel that we are putting out quality results, in a timely manner.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	December 9, 2020
Department:	Imaging
Submitted By:	Alan B. Northington
List up to three things that are going well in your department.	
Do you have any current quality improvement projects/activities underway? Please provide a brief description. **Is this a LEAN project? Y/N**	
1. Connecting Ambra PACS to the ED Physicians work software, which will allow PACS access directly from their work platform without exiting. 2. Complete the digital information link with vRad, which will allow reports to directly populate our PACS with HL7 reports. 3. Fix lighting in the new X-ray and CT Suites. 4. Install automatic door opener on the new CT Suite Door, which is also a safety, and patient care issue. 5. Install a proper CD Burner to produce CD's for facilities and providers not linked to our PACS. 6. Purchase an additional digital receptor for the R/F Room. 7. Built protocols for taking portable X-rays through the glass of the isolation room so the machine doesn't have to enter the room. This has a direct effect on and reduces the chance of spreading infection outside the isolation room. Also provides a higher level of safety to staff.	
How does this impact on patients? Do you think this is acceptable?	
All projects will have an effect on patients and provide a higher level of quality care and work product.	
How does this impact on staff? Do you think this is acceptable?	
All projects will have a direct effect on staff and reduce frustration.	
What progress has been made on these projects since the last quality committee meeting?	
Progress has been slow.	
Has anyone in particular been instrumental in helping to progress/improve the problem?	
Which Strategic Goal does your quality issue BEST relate to (choose one)?	
Outstanding Patient Services	
Have any new quality-related issues arisen? Briefly describe.	
Are there any other issues to be discussed with the Committee?	

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	January 13th 2021
Department:	HIM
Submitted By:	Travis Lakey CFO

List up to three things that are going well in your department.

Release of Information requests
Physician Chart Completions
Timely coding so bills get dropped within five days

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

We are currently working to determine whether to allow the local clinics access into our EMR. Both Redding Facilities allow Clinics to attest that they are the patient's provider so they can access health info without going through the request process.

How does this impact on patients? Do you think this is acceptable?

It allows a timelier sharing of pertinent patient information. As we have no way of accessing the clinics EMR it's difficult to audit whether their access has been appropriate.

How does this impact on staff? Do you think this is acceptable?

It would actually reduce workload as the ROI requests would decrease.

What progress has been made on these projects since the last quality committee meeting?

This is a new project so no progress has been made yet.

Has anyone in particular been instrumental in helping to progress/improve the problem?

No

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding Patient Services

Have any new quality-related issues arisen? Briefly describe.

Workflow related issues with increased Covid testing and staffing due to a Covid quarantine.

Are there any other issues to be discussed with the Committee?

No

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	1/6/2021
Department:	SNF
Submitted By:	Diana Groendyke, RN, DON SNF

List up to three things that are going well in your department.

1) All CDPH Focused Surveys (Infection Control) in SNF for 2020 have been deficiency-free.
2) Our Star Rating has risen from 1 Star to 3 Stars.
3) Our revenue is up and our registry staff expenses have gone down for the first Quarter of 2021.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

1) We continue to maintain increased RN hours via permanent and contract staff, as well as explore new opportunities to improve our Star Rating – possible solutions for increased Restorative Nursing hours.
2) We are creating a more formal clinical orientation in SNF for Nurses and CNA's being brought on-board – SMART GOAL.
3) Covid-19 Vaccinations will be given 1/9/21 and the second on 1/30/21 for SNF Residents. Burney Annex is now in the 'Green Zone' Covid-free. Station 2 has been in the 'green zone' for several weeks (we had to test our 'back hall' Residents this week and await those results).

How does this impact on patients? Do you think this is acceptable?

The more formal clinical orientation for Nurses & CNA's ultimately provides higher quality of care for our Residents. Additional RN hours increases the quality of care in SNF for the Residents. Additional Restorative Nursing hours help Residents maintain their independence and mobility (higher quality of care).

How does this impact on staff? Do you think this is acceptable?

Staff will benefit heavily from a more formal clinical orientation and on-boarding process in SNF. The new Staff are better prepared to perform their new job and succeed once their orientation is over.

What progress has been made on these projects since the last quality committee meeting?

Our Star Rating increased from 1 Star to 3 Stars since last Quality Meeting.

Has anyone in particular been instrumental in helping to progress/improve the problem?

All SNF RN's, as well as Candy Detchon, CNO and Jack Hathaway.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding Patient Services by 2025

Have any new quality-related issues arisen? Briefly describe.

During the 'test of change' for shift change times – it has been decided that the 7-7 times did not provide the benefits that we had hoped therefore the shift change times will return to 5-5 at the first of the new year.

Are there any other issues to be discussed with the Committee?

Not at this time.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	January 13, 2021
Department:	Business Office
Submitted By:	Danielle Olson
List up to three things that are going well in your department.	
Clinic implementation AR Days are coming down Dr. Watson relinked Online pricing tool as required by CMS	
Do you have any current quality improvement projects/activities underway? Please provide a brief description. **Is this a LEAN project? Y/N**	
New clinic opening in 4 months Getting Dr linking processes more streamlined Online payment portal	
How does this impact on patients? Do you think this is acceptable?	
New and better Primary care access. Patient accounts being processed through Medicare in a timely manner. Patients will have access to an easier payment process	
How does this impact on staff? Do you think this is acceptable?	
I do not think it will have too much impact on current staff.	
What progress has been made on these projects since the last quality committee meeting?	
We have just started with OCHIN and Trizetto we have quite a ways to go. Online payment portal is in the works we are waiting on pricing.	
Has anyone in particular been instrumental in helping to progress/improve the problem?	
Amanda Ponti has been an extreme help with the new clinic implementation.	
Which Strategic Goal does your quality issue BEST relate to (choose one)?	
Outstanding Finances	
Have any new quality-related issues arisen? Briefly describe.	
Navigating the ever changing rules in regards to COVID-19. Figuring out how to bill for these specific patients have been challenging as rules are changing weekly for different payers. It is also interpreted differently with different points of view.	
Are there any other issues to be discussed with the Committee?	

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	1/13/21
Department:	Finance
Submitted By:	Travis Lakey CFO

List up to three things that are going well in your department.

1. Training with our new accountant has been progressing well.
2. Scanning documentation into One Content for AP.
3. Audit processes between Medicare, Medi-Cal, District Audit, and OSHPD reports have been going smoothly.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

No quality projects underway.

How does this impact on patients? Do you think this is acceptable?

N/A

How does this impact on staff? Do you think this is acceptable?

N/A

What progress has been made on these projects since the last quality committee meeting?

N/A

Has anyone in particular been instrumental in helping to progress/improve the problem?

N/A

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Outstanding Finances

Have any new quality-related issues arisen? Briefly describe.

My only issue is the same issue that every hospital CFO has with having to report on the Cares Act with little to no guidance on how to report.

Are there any other issues to be discussed with the Committee?

No

MAYERS MEMORIAL HOSPITAL DISTRICT COMPLIANCE REPORT

05/30/19 FOR 2020

TRAINING AND EDUCATION

Type	Completion Target	Actual
New Hire Compliance	100%	100%
POC Education	100%	100%

EXCLUDED PROVIDERS

Type	Number
Employees	0
Physicians/Providers	0
Vendors	0

EXPIRED LICENSES

Expired licenses
0

PAYROLL-BASED JOURNAL (PBJ) FOR MOST RECENT AVAILABLE QUARTER

PBJ Issue	Number
Total Nurse Staffing	4 hours 28 minutes – last 5 Star report
Total RN	30 minutes – last 5 Star report
Total CNA	2 hours 46 minutes – last 5 star report
Days No RN Coverage	0 – last PBJ report
Staffing Domain Star Rating	4 star – See attached 5 Star Report
Overall Star Rating	3 star – See attached 5 Star Report

INVESTIGATIONS BY INTAKE

Type	Number
Hotline	0
Direct to Compliance	37
RL6	145

REPORTS AND INVESTIGATIONS BY TYPE

Issue	New	Open	Closed	Unsubstantiated	Substantiated	Terminations
Abuse/Neglect	13	0	13	11	2	0
Code of Ethics/ Policy	0	0	0	0	0	0
Documentation	0	0	0	0	0	0
Elder Justice	0	0	0	0	0	0
False Claims	0	0	0	0	0	0
Gifts	0	0	0	0	0	0
HIPAA	0	0	0	0	0	0
Licensure	0	0	0	0	0	0
OIG Investigations	0	0	0	0	0	0
COVID	5	0	5	5	0	0
Resident Rights	0	0	0	0	0	0
Resident Charges	0	0	0	0	0	0
Non-Monetary	0	0	0	0	0	0
STARK	0	0	0	0	0	0
Total	18	0	18	16	2	0

COMPLAINTS & INVESTIGATIONS

Type	New	Open	Closed	Unsubstantiated	Substantiated	Terminations
Professional Liability	0	1	0	0	0	0
Loss of Property	1	0	1	1	0	0
Total	1	1	1	1	0	0

One important note: currently I am working on finding and implementing an electronic system for intake and tracking of complaints from the public. As that goal continues I will keep you updated on how it goes.

Also – currently I am not reporting on all of the complaints I receive from people who do not want to pay their bill – unless there is an issue with care or another reason that would lead me to believe that the hospital has some kind of exposure. Would you like that to continue or would you like a number of all complaints regardless of their validity?

Thank you,

JH

Nursing Home Compare Five-Star Ratings of Nursing Homes

Provider Rating Report for October 2020

Ratings for Mayers Memorial Hospital (056416) Fall River Mills, California				
Overall Quality	**Health Inspection**	**Quality Measures**	**Staffing**	**RN Staffing**
★★★	★★	★★★	★★★★	★★★★

The October 2020 Five-Star ratings provided above will be displayed for your nursing home on the Nursing Home Compare (NHC) website on or around October 28, 2020. The health inspection rating is based on health inspections conducted on or before March 3, 2020. The time periods for each of the quality measures that contribute to the Quality Measure (QM) rating can be found in the QM tables located later in this report. The Staffing and RN Staffing Ratings are based on Payroll-based journal staffing data reported for the second calendar quarter of 2020.

Your facility has been cited for abuse at harm or higher in the last survey cycle, or at least once at potential harm or higher in each of the last two survey cycles. NHC displays an icon for nursing homes with instances of non-compliance related to abuse and their health inspection rating is capped at two stars. For more details, please see the Five-Star Quality Rating Technical Users' Guide that is available at the link on the References page of this report.

Helpline

The Five-Star Helpline will operate Monday - Friday, **October 26, 2020 - October 30, 2020.** Hours of operation will be from 9 am - 5 pm ET, 8 am - 4 pm CT, 7 am - 3 pm MT, and 6 am - 2 pm PT. The Helpline number is 1-800-839-9290. The Helpline will be available again **November 30, 2020 - December 4, 2020.** During other times, direct inquiries to BetterCare@cms.hhs.gov as Helpline staff help respond to e-mail inquiries when the telephone Helpline is not operational.

Important News

CMS Memorandum

On June 25, 2020 CMS released memorandum QSO 20-34-NH providing updates related to the staffing and quality measures used on the NHC website and in the Five-Star Quality Rating System. Additional details are listed below in the Staffing and Quality Measures sections of the Important News updates. A link to the full memo can be found on the References page of this report.

Quality Measures

Minimum Data Set (MDS) information

CMS waived requirements at 42 CFR 483.20 related to the timelines for completing and submitting resident assessment (MDS) information. This information provides the underlying data used to calculate the QMs reported on the NHC website and used in the Five-Star Quality Rating System. CMS believes that data from resident assessments conducted prior to January 1, 2020, can still be used to calculate QMs. However, CMS is concerned that data from resident assessments conducted after January 1, 2020 were impacted by the waiver and the public health emergency. Therefore, beginning July 29, 2020, QMs based on the data collection period ending December 31, 2019 will be held constant. QMs based on a data collection period prior to December 31, 2019 (e.g., ending September 30, 2019), however, will continue to be updated until the underlying data reaches December 31, 2019. The only measure data updating with the October 2020 refresh are the data used for the short-stay measure, "Rate of Successful Return to Home and Community from a SNF".

Skin Integrity Quality Measure

Beginning with the October 2020 NHC refresh, a new Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) measure, S038.02 "Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury" measure, will replace the current short-stay SNF pressure ulcer measure on the NHC website and in the Five-Star Quality Rating System. The new SNF QRP measure will be listed as "Percentage of SNF Residents with Pressure Ulcers/Injuries that are New or Worsened" on the provider preview reports and on the NHC website.

Links for more information about public reporting of the SNF QRP measures as well as the technical specifications for all of the QMs reported on NHC can be found in the Quality of Resident Care Section on the References page of this report. A link to The Five-Star Quality Rating Technical Users' Guide, which details the rating methodology and includes the scoring cut-points for all of the QMs is also on the References page.

Staffing

PBJ Data Submission

CMS ended the blanket emergency waiver of 42 CFR 483.70(q), and all nursing homes are required to resume submission of staffing data through the PBJ system as required by the regulation. Staffing measures and ratings will be updated in October 2020 based on the Calendar Quarter 2 data submitted by August 14, 2020.

Facilities are able to submit data for Calendar Quarter 1 (January - March) 2020 through the PBJ system until November 14, 2020, which is the Calendar Quarter 3 (July - August) 2020 deadline. Though Calendar Quarter 1 data will not be used to calculate staffing measures or ratings, these data will be posted in a public use file on data.cms.gov.

Health Inspections

In March 2020, CMS announced a new, targeted inspection (i.e. survey) plan designed to help keep nursing home residents safe in the face of the COVID-19 pandemic. The plan called for focused inspections on urgent patient safety threats (called "immediate jeopardy") and infection control. These targeted inspections allow CMS to focus inspections on the most urgent situations, so the agency can get the information it needs to ensure safety, while not getting in the way of patient care.

Due to this change, there has been a great shift in the number of nursing homes inspected, and how the inspections are being conducted. Without action, this would have disrupted the inspection domain of the Five-Star Quality Rating System because many nursing homes that would normally be inspected, will not, thereby over-weighting and impacting the ratings of those facilities that are inspected. This could then potentially mislead consumers. **Since the NHC refresh in April 2020 and until further notice, the health inspection domain of the rating system is being held constant to include only data from surveys that occurred on or before March 3, 2020. Results of health inspections conducted after that date will be posted publicly, but not be used to calculate a nursing home's health inspection star ratings.** These targeted surveys (occurring after March 3, 2020) will be posted through a link in the Spotlight section on the front page of the NHC website as the survey data are finalized and uploaded.

CMS will continue to monitor inspections, including the restarting of certain inspections per CMS memorandum QSO-20-31-ALL (https://www.cms.gov/files/document/qso-20-31-all.pdf). CMS will restart the inspection ratings as soon as possible and will communicate any changes to stakeholders in advance of updating the NHC website.

Health Inspections

The Five-Star health inspection rating listed on the first page of this report is based on 3 cycles of survey data and 3 years of complaint inspections. Please note that the health inspection rating includes data only from surveys that were conducted on or before March 3, 2020. Surveys conducted after that date are not being used to calculate the health inspection rating at this time. Any new surveys or changes to survey results that were conducted on or before March 3, 2020 that enter the national database will be included in the health inspection rating calculation, potentially causing a change in the health inspection rating for an individual facility. Citations from complaint surveys will not be moving between rating cycles (or dropping out of the calculation) while new health inspections are not being included in the health inspection rating calculation.

Your Health Inspection Rating

Provided below are the survey dates included in the calculation of the Five-Star health inspection rating for your facility. For more detailed information about the deficiencies cited on each survey, please visit: https://data.medicare.gov/data/nursing-home-compare. This website updates on the same day as the Nursing Home Compare website. Any additional revisit points can be found in the 'Provider Info' table at the link provided above.

Health Inspection Rating Cycle 1 Survey Dates:

October 10, 2019 January 7, 2020

Health Inspection Rating Cycle 2 Survey Dates:

April 17, 2018 August 20, 2018 November 29, 2018

Health Inspection Rating Cycle 3 Survey Dates:

October 9, 2017 November 17, 2017 February 1, 2018
February 7, 2018

Total weighted health inspection score for your facility: 76.7

State-level Health Inspection Cut Points for California				
1 Star	**2 Stars**	**3 Stars**	**4 Stars**	**5 Stars**
>113.83	75.34-113.83	50.68-75.33	26.68-50.67	0.00-26.67

Please note that the state cut points are recalculated each month, but the total weighted health inspection score for your facility is compared to the cut points only if there is a change in your score.

Long-Stay Quality Measures that are Included in the QM Rating

	Provider 056416						CA	US
	2019Q1	2019Q2	2019Q3	2019Q4	4Q avg	Rating Points	4Q avg	4Q avg
MDS Long-Stay Measures								
Lower percentages are better.								
Percentage of residents experiencing one or more falls with major injury	0.0%	0.0%	2.7%	2.9%	1.4%	80	1.8%	3.4%
Percentage of high-risk residents with pressure sores	1.8%	5.7%	5.7%	6.5%	4.8%	80	7.0%	7.3%
Percentage of residents with a urinary tract infection	2.6%	5.4%	1.4%	2.9%	3.1%	40	1.7%	2.6%
Percentage of residents with a catheter inserted and left in their bladder[1]	4.7%	3.3%	0.0%	0.0%	2.1%	60	1.8%	1.8%
Percentage of residents whose need for help with daily activities has increased	14.1%	15.5%	16.7%	9.0%	13.9%	90	9.2%	14.5%
Percentage of residents who received an antipsychotic medication	23.0%	20.0%	23.3%	26.1%	23.0%	30	10.4%	14.2%
Percentage of residents whose ability to move independently worsened[1]	32.5%	17.1%	28.4%	19.1%	24.7%	30	13.0%	17.1%

[1]These measures are risk adjusted.
[2]This measure includes some imputed data because there are fewer than 20 resident assessments or stays across the four quarters. This value is used in calculating the QM points and used in the QM rating calculation but will not be displayed on Nursing Home Compare.

	Provider 056416				CA	US	
	Observed Rate[3]	Expected Rate[3]	Risk-Adjusted Rate[3]	Rating Points	Risk-Adjusted Rate	Observed Rate	Risk-Adjusted Rate
Claims-Based Long-Stay Measures							
Lower rates are better. The time period for data used in reporting is 1/1/2019 through 12/31/2019.							
Number of hospitalizations per 1,000 long-stay resident days[1]	0.78	1.35	1.02	135	1.88	1.753	1.68
Number of emergency department visits per 1,000 long-stay resident days[1]	1.43	1.92	1.09	60	0.83	1.460	0.95

[1]These measures are risk adjusted.
[2]This measure includes some imputed data because there are fewer than 20 resident assessments or stays across the four quarters. This value is used in calculating the QM points and used in the QM rating calculation but will not be displayed on NHC.
*[3]The observed rate is the actual rate observed for the facility without any risk-adjustment; the expected rate is the rate that would be expected for the facility given the risk-adjustment profile of the facility; and the risk-adjusted rate is adjusted for the expected rate of the outcome and is calculated as (observed rate for facility / expected rate for facility) * US observed rate. Only the risk-adjusted rate will appear on NHC.*

Total Long-Stay Quality Measure Score	605
Long-Stay Quality Measure Star Rating	★★★

Short-Stay Quality Measures that are Included in the QM Rating

	Provider 056416						CA	US
	2019Q1	2019Q2	2019Q3	2019Q4	4Q avg	Rating Points	4Q avg	4Q avg
MDS Short-Stay Measures								
Higher percentages are better.								
Percentage of residents who made improvements in function[1]	d<20	d<20	d<20	d<20	NA	NA	71.9%	67.8%
Lower percentages are better.								
Percentage of residents who newly received an antipsychotic medication	d<20	d<20	d<20	d<20	NA	NA	1.4%	1.8%
NEW: Percentage of SNF residents with pressure ulcers/injuries that are new or worsened[1]	NR	NR	NR	NR	NA	NA	2.0%	3.9%

NR = Not Reported. This measure is not calculated for individual quarters.

	Provider 056416				CA	US	
	Observed Rate[3]	Expected Rate[3]	Risk-Adjusted Rate[3]	Rating Points	Risk-Adjusted Rate	Observed Rate	Risk-Adjusted Rate
Claims-Based Short-Stay Measures							
Higher percentages are better. The time period for data used in reporting is 10/1/2017 through 9/30/2019.							
Rate of successful return to home and community from a SNF[1]	NA	NR	NA	NA	49.8%	50.1%	50.1%[4]
Lower percentages are better. The time period for data used in reporting is 1/1/2019 through 12/31/2019.							
Percentage of residents who were re-hospitalized after a nursing home admission[1]	NA	NA	NA	NA	20.8%	21.9%	20.8%
Percentage of residents who had an outpatient emergency department visit[1]	NA	NA	NA	NA	9.8%	10.0%	10.3%

[1]These measures are risk adjusted.
[2]This measure includes some imputed data because there are fewer than 20 resident assessments or stays across the four quarters. This value is used in calculating the QM points and used in the QM rating calculation but will not be displayed on NHC.
*[3]The observed rate is the actual rate observed for the facility without any risk-adjustment; the expected rate is the rate that would be expected for the facility given the risk-adjustment profile of the facility. For successful community discharge, the risk-adjusted rate is calculated as (predicted rate / expected rate) * US Observed rate and is referred to as the risk-standardized rate. For rehospitalization and emergency department visits, the risk-adjusted rate is calculated as (observed rate / expected rate) * US observed rate. Only the risk-adjusted or risk-standardized rate will appear on NHC.*
[4]For this measure, this value is the National Benchmark, rather than the national average of the risk-adjusted rate.
NR = Not Reported. The expected rate is not reported for this measure.

Unadjusted Short-Stay Quality Measure Score	NA
Total Short-Stay Quality Measure Score (unadjusted short-stay QM score*1150/800)[1]	NA
Short-Stay Quality Measure Star Rating	Not Available
Total Quality Measure Score[2]	NA
Overall Quality Measure Star Rating	★★★

[1]An adjustment factor of 1150/800 is applied to the unadjusted total short-stay score to allow the long- and short-stay QMs to count equally in the total QM score.
[2]The total quality measure score is the sum of the total long-stay score and the total short-stay score. If a provider has only a long-stay score or only a short-stay score, then no total score is calculated and their overall QM rating is the same as the long-stay or short-stay QM rating, depending on which is available.

Quality Measures that are Not Included in the QM Rating

	Provider 056416					CA	US
	2019Q1	2019Q2	2019Q3	2019Q4	4Q avg	4Q avg	4Q avg
MDS Long-Stay Measures							
Higher percentages are better.							
Percentage of residents assessed and appropriately given the seasonal influenza vaccine	100%	100%	100%	100%	100%	97.6%	96.0%
Percentage of residents assessed and appropriately given the pneumococcal vaccine	94.7%	96.1%	98.6%	100%	97.3%	97.6%	93.9%
Lower percentages are better.							
Percentage of residents who were physically restrained	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.2%
Percentage of low-risk residents who lose control of their bowels or bladder	42.9%	37.5%	34.5%	44.4%	39.8%	40.2%	48.4%
Percentage of residents who lose too much weight	13.9%	4.2%	6.9%	5.8%	7.7%	4.5%	5.5%
Percentage of residents who have depressive symptoms	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	5.1%
Percentage of residents who received an antianxiety or hypnotic medication	12.3%	13.3%	22.2%	12.9%	15.2%	14.2%	19.7%
MDS Short-Stay Measures							
Higher percentages are better.							
Percentage of residents assessed and appropriately given the seasonal influenza vaccine	d<20	d<20	d<20	d<20	92.3%	90.3%	82.9%
Percentage of residents assessed and appropriately given the pneumococcal vaccine	d<20	d<20	d<20	d<20	85.5%	92.3%	83.9%

Additional Notes Regarding the Quality Measure Tables

"d<20". For individual quarters for the MDS-based QMs, d<20 means the denominator for the measure (the number of eligible resident assessments) is too small to report. A four quarter average may be displayed if there are at least 20 eligible resident assessments summed across the four quarters.

"NA". "NA" will be reported for quality measures not included in the QM Rating: 1) for which data are not available or 2) for which the total number of eligible resident assessments summed across the four quarters is less than 20.

SNF QRP Measures:

Two of the short-stay QMs used in the Five-Star QM rating calculation are SNF QRP measures: "Percentage of SNF Residents with Pressure Ulcers/Injuries that are New or Worsened" and "Rate of Successful Return to Home and Community from a SNF". There are additional SNF QRP measures that are not included in the Five-Star ratings but are displayed on NHC. Information about these measures can be found on separate provider preview reports that are located in the QIES mailbox. Please watch for communication from CMS on the availability of these reports. Additional information about the SNF QRP measures can be found in the Quality of Resident Care section on the References page of this report.

Staffing Information

PBJ data for **April 1, 2020 to June 30, 2020** (submitted and accepted by the **August 14, 2020** deadline) are being used to calculate the staffing ratings for three months starting with the **October 2020** NHC website update. The data listed below include the reported, expected and adjusted staffing levels for your facility, using the PBJ data for **April 1, 2020 to June 30, 2020** and the average MDS-based resident census for your facility. The expected staffing values are based on resident acuity levels using RUG-IV data. The Five-Star Rating Technical Users' Guide contains a detailed explanation of the staffing rating and the case-mix adjustment methodology.

PBJ Nurse Staffing Information for April 1, 2020 to June 30, 2020 for Provider Number 056416				
	Reported Hours per Resident per Day (HRD)	**Reported Hours per Resident per Day (HRD) (Decimal)**	**Case-Mix HRD**	**Case-Mix Adjusted HRD**
Total number of licensed nurse staff hours per resident per day	1 hour and 42 minutes			
RN hours per resident per day	30 minutes	0.503	0.263	**0.738**[1]
LPN/LVN hours per resident per day	1 hour and 12 minutes	1.200	0.617	1.435
Nurse aide hours per resident per day	2 hours and 46 minutes	2.765	2.047	2.789
Total number of nurse staff (RN, LPN/LVN, and Nurse Aide) hours per resident per day	4 hours and 28 minutes	4.468	2.927	**4.867**[1]
Physical therapist[2] hours per resident per day	0 minutes			

[1]Please see the staffing tables located in the Technical Users' Guide (link provided below) for the specific cut points utilized with the bold case-mix adjusted values.
[2]Physical therapist staffing is not included in the staffing rating calculation.

The average number of residents for your facility (based on the MDS census) is 78.8.

Availability of Reported Staffing Data

Some providers will see 'Not Available' for the reported hours per resident per day in the table above and a staffing rating may not be displayed for these facilities. There are several reasons this could occur:
1. No MDS census data were available for the facility.
2. No on-time PBJ staffing data were submitted for the facility.
3. Criterion no longer used.
4. The total reported staffing HRD were excessively low (<1.5 HRD).
5. The total reported staffing HRD were excessively high (>12.0 HRD).
6. The total reported nurse aide HRD were excessively high (>5.25 HRD).
7. A CMS audit identified significant discrepancies between the hours reported and the hours verified, or the nursing home failed to respond to an audit request.
8. Other reason.

Scoring Exceptions for the Staffing Rating

The following criteria have been added to the usual scoring rules for assigning the staffing rating and the RN staffing rating.
1. Providers that fail to submit any staffing data by the required deadline will receive a one-star rating for overall staff and RN staffing for the quarter.
2. Providers that submit staffing data indicating that there were four or more days in the quarter with no RN staffing hours (job codes 5-7) on days when there were one or more residents in the facility, regardless of reported staffing levels, will receive a one-star rating for overall staff and RN staffing for the quarter.
3. CMS conducts audits of nursing homes to verify the data submitted and to ensure accuracy. Facilities for which the audit identifies significant discrepancies between the hours reported and the hours verified or those who fail to respond to an audit request will receive a one-star rating for overall staff and RN staffing for three months.

References

Technical Details on NHC and the Five-Star Quality Rating System

The Five-Star Quality Rating System Technical Users' Guide includes detailed methodology for all domains of the rating system and can be found at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

All of the data posted on the NHC Website as well as additional details on some domains and measures are available for download on the data.medicare.gov website.
https://data.medicare.gov/data/nursing-home-compare

June 25, 2020 Memorandum (QSO 20-34-NH)
https://www.cms.gov/files/document/qso-20-34-nh.pdf

April 2019 Revisions to the Five-Star Rating System

More detailed information on the April 2019 changes can be found in the CMS memorandum:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-08-NH.pdf

Staffing

For information on recent Payroll Based Journal (PBJ) Policy Manual Updates, Notification to States regarding staffing levels and New Minimum Data Set (MDS) Census Reports see Memorandum QSO-19-02-NH, at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-02-NH.pdf

More information about the use of PBJ staffing data in the Five-Star Rating system is in the Quality, Safety and Oversight memorandum, QSO-18-17-NH, at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-17-NH.pdf

Information about staffing data submission is available on the CMS website at:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

For additional assistance with or questions related to the PBJ registration process, please contact the QTSO Help Desk at 877-201-4721 or via email at help@qtso.com.

More information on the Staffing PUF can be found in a CMS survey and certification memo at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-45.pdf

Health Inspections

More information about Phase 2 of the Requirements for Participation is in the S&C memorandum 18-04-NH at:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

Quality of Resident Care

Detailed specifications (including risk-adjustment) for the MDS-based QMs, claims-based QMs and SNF QRP measures can be found under ‘User Manuals’ in the downloads section at:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html

Additional information about Public Reporting of the SNF QRP Quality Measures can be found at:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Public-Reporting

For questions about the SNF QRP measures please contact:
SNFQualityQuestions@cms.hhs.gov

PBJ Deadlines

Submission Deadline	PBJ Reporting Period	Posted on NHC and used for Staffing Ratings
August 14, 2020	April 1, 2020 - June 30, 2020	October 2020 - December 2020
November 14, 2020	July 1, 2020 - September 30, 2020	January 2021 - March 2021
February 14, 2021	October 1, 2020 - December 31, 2020	April 2021 - June 2021
May 14, 2021	January 1, 2021 - March 31, 2021	July 2021 - September 30 2021

Quality Department Overview

The quality department here at Mayers encompasses quality improvement and assurance, risk management, and compliance. They are three large roles, however, they are connected in many ways so they all can work harmoniously the vast majority of the time. This is a general overview, or an interdiction, I would be more than happy to expand as needed on anything that you would like further information on.

Under **Quality** the department handles reporting to agencies, state and federal, for various required programs. We report for SNF and Acute to CMS different metrics to stay compliant with CoP (Conditions of Participation) that are created by CMS and are necessary for us to bill federal and state insurance programs. As we have transitioned to managed care models in the state we have similar reporting structures for Partnership (our managed care provider). The largest difference between state and federal programs at this point is the state programs have additional incentives for achievement, while the federal programs have penalties potentially for non-compliance. Some of the programs/surveys that we are reporting for are as follows:

PBJ – Parole based journal – this is a SNF reporting that happens quarterly that allows CMS to assess our nurse staffing. This report plays a role in our star rating for CMS.

SNF COVID Reporting – This is a daily report that goes to CDPH (California Department of Public Health) and then to NHSN (National Healthcare Safety Network) that creates a public facing report showing our COVID exposures and outcomes for residents and staff in the SNF. NHSN is managed by the CDC and DHQP (Centers for Disease Control and Prevention and Division of Healthcare Quality Promotion)

SNF Testing Reporting – this is a weekly report that goes to CDPH then to NHSN that also goes into the public facing report showing our testing capacity and compliance for the testing mandates from CDPH.

State/Federal SNF COVID surveys – This happens every 3 to 4 weeks where a surveyor from CDPH comes out and checks our compliance with the mitigation we put together and submitted to CDPH in the end of May 2020.

State/Federal Reoccurring Surveys (SNF & Acute) – These are meant to happen annually, however, with COVID things have changed due to the fact that some of the regulations governing the SNF have been suspended to allow us to manage COVID at a facility level. Some of those regulations are coming back into play and we expect to see a return to normal for surveys within the year (assuming that we start to see some light at the end of the pandemic tunnel).

Promoting Interoperability (PI) (used to be Meaningful Use) – This was an incentive program in the beginning that was encouraging facilities like ours to get an electronic health record (EHR) – since the beginning of that program the incentive has gone away and it has been replaced by a penalty. However, it is an annual report that has to be completed showing compliance with various metrics that measure how well we use and communicate with our EHR. This program consists of a handful of measures that

range from measuring e-prescribing out of the ED to informing patients that we have a patient portal and allowing them to opt in or out of using it and capturing that in the patient profile.

MBQIP – The Medicare Beneficiary Quality Improvement Program is a program that encompasses a few separate reports for the Hospital side of things. It includes HCAHPS and various other metrics that can then be reported for the Star Rating for the hospital. **Note:** This is a current project that I am working on to try to begin to lift the star rating for the hospital as we have been able to do for the SNF.

On top of the reporting that cycles on a quarterly basis, there are also the quality improvement activities that we try to work on – or as has been the case recently the mandated regulatory changes that have been handed down from the state. Quality has played a role in creating and maintaining the following mitigation plans for the district:

SNF COVID Mitigation plan – This mitigation plan was mandated by an AFL (All Facilities Letter) published by CDPH back in May. The plan is a document given to the state that informs them of how we are carrying out the various mandates that cover the SNF – from staff and resident testing for surveillance or in response to a positive result from those surveillance tests – to how we will manage PPE – to how we will manage quarantine or positive residents while still ensuring the safety of the others in the building. Remembering that there is no shield from liability in CA for COVID this plan is essential in showing that we are doing all we can to ensure the safety of our residents.

HCP (Healthcare Personnel) Testing Plan – This plan is similar to the SNF COVID Mitigation Plan as it was a mandate from CDHP published through an AFL – this will be the subject of new F-Tags (F-Tags are the deficiency tags that are cited during federal surveys) and will be looked at in depth upon the next survey cycle.

The department has also assisted with other LEAN project plans for putting things in place like the Surge Capacity Plan that we submitted to the state back in March, or the updated plan for quarantine that we submitted to OSHPD recently. These project plans are just maps for accomplishing larger tasks and the work includes almost all departments – really we just document and track how the plan moves while implemented by those that actually preform care or serve the patients or residents face to face.

Under **Risk** the department works with BETA for all professional liability claims and with the attorneys that they assign to us to be sure that all appropriate and best defenses can be put forward. We also look at abuse reports and assist navigating the State response visits that come after we make a self-report, or a complaint has been filed. Risk also takes a role in responding to patient complaints and working with community individuals who loge those complaints in order to help quality identify deficiencies and work to make them better.

As a part of the Promoting Interoperability that was mentioned above – Risk preforms a **SRA** (security risk assessment) annually with IT to be sure that we are covering all of the requirements for maintain the security and privacy that is required under law for a covered entity (any care provider that is a custodian or record for patient health information is a covered entity).

Risk would like to be able to accomplish the following to round out the Risk program for the District;

1. Create an Enterprise Risk Management (ERM) plan – that lays out what risk is capable of and where risk lies. This will allow Risk to be able to find weak points and create mitigation plans to address those weaknesses allowing us to identify potential liability before it becomes something that we have to involve BETA in. This work will be valuable for the District, however, it is not required work at this time and with priorities being as they are it is work that can wait until the department has capacity to build it appropriately for the District as a whole.
2. Complete an annual District Risk assessment – this would be a precursor to the ERM plan – again it will come as capacity begins to normalize.

Under Risk we also have been using an electronic platform called RL6 to report quality/risk/compliance issues that can be documented and investigated. These reports come in and it is up to us as a leadership team to filter them and ensure that any issues are addressed. I get to manage all of the reports and ensure that there is follow-up and closure on them case by case.

Compliance has a more ambiguous place in the District – there certain guidelines published by the Office of Inspector General (OIG) that are "recommendations" for the hospital to have incorporated into the Compliance Plan. The Compliance plan has not been able to come before the board and pass a vote to become official in the past few years. So we have a plan – but it is old and needs to be updated. The department will continue to work with the board to bring a plan together that will pass with board approval. Considering that it is a requirement for SNF now it will be something that you can all expect to see early in the year. We always work to write something that will encompass the requirements for SNF and serve the district as a whole – so be on the lookout for that before the end of Q1 (calendar not fiscal) of 2021.

Compliance also has some other work that has to become more normalized moving forward – there is a conflict of interest questionnaire that is meant to go out annually for the board and the leadership team – there is also education that is supposed to be presented to the board on a monthly basis to ensure that the board understands its role in compliance and the responsibility that the OIG believes that you all have in playing a role in compliance.

There is also contract work that Compliance is meant to be completing. Compliance is meant to review all contracts on a biannual basis to ensure that the contracts that the district maintains have meaningful and measurable indicators in them to ensure compliance by all documented signatories.

It is safe to say that Compliance has the most work to do to become a meaningful and measurable program for the district. Being that it has the least required aspects it is understandable that it sees the least priority, however, that will be continuing to change and as the landscape changes we will have to adjust priorities and make the required changes. Currently the contract work is something that could be brought up in a hospital survey – and the SNF compliance plan will be part of the SNF surveys moving forward – so we will start with those 2 things and improve as necessary to maintain an acceptable status quo.

That is a brief introduction into what the Director of Quality oversees and works on in your district. Like I said before, I will be happy to elaborate on anything that you like as much as I can, and whatever I do not know off the top I will be sure to look up and get to you post haste.

Thank you – JH

INTERMOUNTAIN HOSPICE PATIENTS' BILL OF RIGHTS/INFORMED CONSENT

Patients have the right to be notified in writing of their rights and obligations before their hospice care begins. Consistent with state laws, the patient's family or guardian may exercise the patient's rights when the patient is unable to do so. Hospice organizations have an obligation to protect and promote the rights of their patients, including the following:

PATIENTS AND PROVIDERS HAVE A RIGHT TO DIGNITY AND RESPECT

Patients and their hospice caregivers have a right to mutual respect and dignity. Caregivers are prohibited from accepting personal gifts and borrowing from patients/families/primary caregivers.

Patients have the right:

- To have a relationship with Hospice that is based on honesty and ethical standards of conduct
- To be informed of procedure they can follow to lodge complaints with Hospice about the care that is, or fails to be furnished, and regarding a lack of respect of person, privacy, or property; (To lodge complaints, you may call the director of Mayers Memorial Hospital at 530-336-5522 ext. 1200, or contact the State of California Dept. of Health Services, Licensing and Certification Division, located at 1367 E. Lassen Avenue, Suite B1, Chico, CA 95973, 24 hours a day, at 1-800-554-0350.)
- To know of disposition of such complaints;
- To voice their grievances without fear of discrimination or reprisal for having done so.
- Complaints concerning advance directive notification and/or implementation can be filed with the state licensing and certification office by using the above 24 hour hotline number.

QUALITY OF CARE

Patients have the right:

- To be cared for by a team of professionals who will provide high quality comprehensive hospice services as needed and appropriate for them and their family (including extended and alternative family);
- To receive appropriate and compassionate care regardless of age, creed, race, gender, sexual orientation, diagnosis, disability, or the ability to pay for the services rendered;
- To have a clear understanding of availability of and access to hospice services and the hospice team 24 hours a day, seven days a week;
- To be told what to do in case of an emergency;
- To have family and/or other caregivers trained in effective ways of providing care when self-care is no longer possible.
- To be fully informed, as evidence by the patient's or his/her appointed representative's written acknowledgement prior to or at the time of admission of these rights and of all rules and regulations governing patient conduct.
- To be fully informed, prior to or at the time of admission, of services available within hospice and of related charges, including any charges for services not covered under Titles XVIII or XIX of the Social Security Act.
- To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- To be advices of what hospice services are to be rendered and by what discipline, e.g., registered nurse, counselor, chaplain, etc.
- To be advised in advance of any change in treatment.
- To be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
- To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
- To not be subjected to verbal or physical abuse of any kind and to be informed that corporal punishment is prohibited.
- To be informed by the license of the provisions of the law regarding complaints and procedures for registering complaints confidentially, including, but not limited to, the address and telephone number of the local District office of the Department.
- To be informed of the provisions of law pertaining to advanced directives, including but not limited to living wills, durable power of attorney for health care, withdrawal or withholding of treatment and/or life support.

- To be assured the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

Hospice shall ensure that:

- All medically related hospice care is provided in accordance with physicians' orders and that a plan of care which is developed by the patient's physician and the hospice interdisciplinary group specifies the services to be provided and their frequency and duration;
- All medically related personal care is provided by an appropriately trained home health aide who is supervised by a nurse.

DECISION-MAKING

Patients have the right:

- To participate in the planning of their care and in planning changes in their care, and to be advised that they have the right to do so;
- To be fully informed regarding their health status in order to participate in the planning of their care;
- To be fully informed regarding the potential benefits and risks of all medical treatments and/or services suggested;
- To refuse services and to be advised of the consequences of refusing care.
- To request a change in caregiver without fear of reprisal or discrimination.

The hospice professional team will:

- Assist the patient and family in identifying which services and treatments will help attain the patient's goals;
- Provide information pursuant to the Patient Self Determination Act about ways to make the patient's wishes known to those caring for him or her.

The hospice or the patient's physician may be forced to refer to the patient to another source of care if the client's refusal to comply with the plan of care threatens to compromise the provider's commitment to quality care.

PRIVACY

Patients have the right:

- To confidentiality with regard to information about their health, social, and financial circumstances and about what takes place in the home;
- To expect the hospice to release information only as consistent with its internal policy, required by law, or authorized by the client.

FINANCIAL

Patients have the right:

- To be informed in advance of any fees or charges for which they may be liable;
- To access any insurance or entitlement program for which they may be eligible;
- To have access, upon request to all bills for services they have received regardless of whether the bills are to be paid out-of-pocket or by another party;
- To be informed of the hospice's ownership status and its affiliation with any entities to whom the patient is referred.

PATIENT'S RESPONSIBILITIES

Patients have the right:

- To remain under a doctor's care while receiving hospice services.
- To inform the hospice of any advance directives or any changes in advance directives and provide the hospice with a copy.
- To cooperate with the primary doctor, hospice staff and other caregivers.
- To advise the hospice of any problems or dissatisfaction with patient care.
- To notify of address or telephone number changes or when unable to keep appointments.

- To provide a safe home environment in which care can be given. Conduct such that the patient's or staff's welfare or safety is threatened service may be terminated.
- To obtain medications, supplies and equipment ordered by the patient's physician if they cannot be obtained or supplied by the hospice.
- To treat hospice personnel with respect and consideration.
- To sign the required consents and releases for insurance billing and provide insurance and financial records as requested.
- To accept the consequences for any refusal of treatment or choice of non-compliance.

Intermountain Hospice
Mayers Memorial Hospital
43563 Hwy 299E
Fall River Mills, CA 96028
530-336-5511 Ext. 1200

INFORMED CONSENT

We, the patient and caregiver, requested admission to Mayers Memorial Intermountain Hospice Program and understand and agree to the following conditions:

Introduction: We understand that the Hospice program is palliative, not curative in its goal. The program emphasizes the relief symptoms such as pain and physical discomfort, and addresses the spiritual and psychosocial needs which may accompany a life-threatening illness. Medical care and treatment are under the direction of a local attending physician.

Caregivers: We understand that Hospice services are not intended to take place of care by family members or others who are important to the patient, but rather to support them in the care of the patient. With the help of Hospice, the person designated as "caregiver" will provide arrange for around-the-clock care to the patient at home when deemed necessary by Hospice for the safety and well-being of the patient. The caregiver will also participate in decisions about care provided to the patient at home and/or in the inpatient setting.

Provision of Care: We understand that home care is the main focus of the Hospice program. Services are provided in the patient's place of residence by a team of Hospice staff and volunteers through scheduled visits. We understand that we will have a choice about the care provided to us. We may participate in the plan of care that guides Hospice services and, if we desire, may refuse a particular treatment or services offered. We consent to examination and any agreed upon treatment, procedures, or services rendered under the plan of care ordered by the physician. It is understood that treatment or procedures (including resuscitation) not aimed at palliation of pain or other physical symptoms will not be provided by Hospice. Emergency consultation and visits are available 24 hours a day, 7 days a week. We understand that if admission to an inpatient setting occurs, Hospice will continue contacts, assure continuity of care, and provide assistance to us in making discharge plans.

Records: We authorize Intermountain Hospice to keep records which include necessary personal information about patient's condition, family, and finances during the time in which we are under the care of the Hospice program. We permit the release of necessary information and medical records to or from any appropriate agency or medical person/physician as require to assure coordination and continuity of care and as necessary for reimbursement. Permission is granted for the use of facsimiles (fax) transmission as the mode of conveyance of this information. Except as required for patient care, reimbursement, or quality control, such records will not be released to persons outside Hospice without our written consent.

General Responsibilities: As an Intermountain Hospice patient/family, we have the responsibility to: 1) give accurate and complete health information concerning illness, medications, allergies, and other pertinent facts; 2) give information to a Hospice staff member regarding any new concerns or problems that may affect care; 3)adhere to the plan of care as agreed upon; 4) request further information concerning anything we do not understand; 5) assist in developing and maintaining a safe environment.

Financial Responsibility: The estimated cost and expected reimbursement of Hospice care has been explained to us. We have been given a chance to discuss our financial needs with a representative of Hospice. We understand that the patient will not be denied admission to the program if we are not about to pay, but that we are required to meet financial responsibilities to the extent possible.

Financial Agreement: Medicare: I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize release of all records required to act on this request. Insurance: I hereby authorize direct payment to

the Hospice agency of any insurance benefits payable to me for services rendered at a rate not to exceed the agency's regular charges. It is agreed that payment to the agency, pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment.

Complaints: we understand we may address complaint regarding agency services by contacting the employee's immediate supervisor at 530-336-5511, ext. 1200. The complaint will be handled confidentially and without coercion, discrimination, reprisal, or unreasonable interruption of services.

Patient Grievance Procedure: it is policy of Intermountain Hospice not to discriminate on the basis of race, color, religion, sex, marital status, age, national origin, or diagnosis, as provided by law. An internal grievance procedure has been adopted to provide prompt and equitable resolutions of complaints alleging such action. A client wishing to initiate a grievance should write a letter stating: 1) The name and address of the person filing the complaint; 2) The name of the patient's physician; 3) A specific description of the problem or alleged discrimination; 4) Dates and times considered pertinent to the problem or incident; 5) Names of persons involved; 6) The remedy or relief sought. The letter should be mailed to:

Intermountain Hospice
Mayers Memorial Hospital
530-336-5511 ext. 1200
43563 Hwy 299E
Fall River Mills, CA 96028

State of California
Dept. of Public Health Services
Licensing & Certification Div.
126 Mission Ranch Blvd.
Chico, CA 95973

If the complaint is not handled to our satisfaction, we may then call the Director of Intermountain Hospice at 530-336-5511 ext. 1153. If matters are still not resolved, we may call the State Department of Public Health Services, Licensing Certification Division, 24 hours a day, at 1-800-554-0350.

Withdrawal/Discharge: We accept the conditions of Intermountain Hospice as described, understanding that we may choose not to remain in the program. This means there will be no further liability to us or Intermountain Hospice. We may also be discharged from the program when any of the following apply: 1) The patient or caregiver chooses not to follow the plan of care or to comply with the General Responsibilities described above; 2) The patient no longer meets Hospice criteria; 3) The patient's care is transferred to another agency.

The patient or caregiver has received and read the Informed Consent and has had all questions answered to their satisfaction.

The patient/caregiver has received and been instructed in this agency's policy on Medication Management of Controlled Substances.

We have received and understand the Hospice Patient's Bill of Rights and information on Advance Directives (Durable Power of Attorney for Health Care, Living Will), including a description of California State law, and have had our questions answered to our satisfaction.

Patient has Executed Advanced Directive: ☐Yes ☐ No Copy to hospice: ☐ Yes ☐ No

_____

Patient's Name Account #

_____

Signature of Patient or Legal Guardian Date

_____

Signature of Caregiver, Relationship to Patient Date

_____

Signature of Hospice Representative Date

2880 Bergey Road, Ste. K
Hatfield, PA 19440
www.envservices.com
800 - 345 - 6094

Presents:

Biological Sampling Report

Control ID #: 6008-233195-26176V

Prepared for:

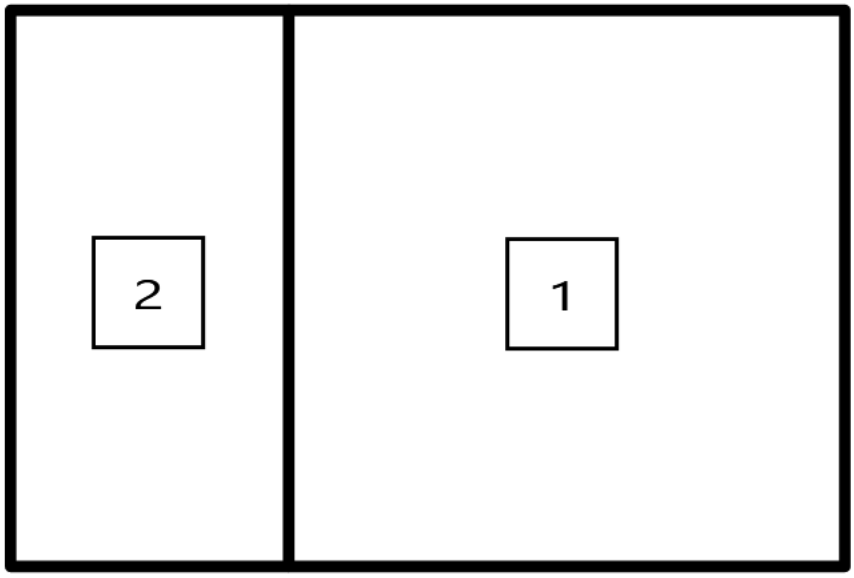
MAYERS MEMORIAL HOSPITAL
43563 HWY 299 EAST
FALL RIVER MILLS, CA 96028

Location Tested:
PHARMACY

Date(s) Tested:
DEC 07, 2020
Field Service Technician(s):
TARENCE GLASKER

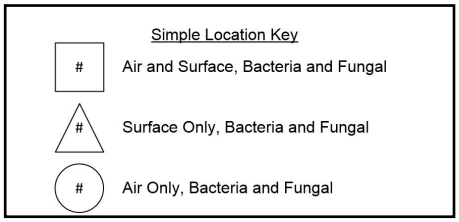
BIOLOGICAL SAMPLING LOCATIONS

OPERATIONAL / DYNAMIC



CENTER OF PHARMACY ROOM

TOP OF TABLE



Test Result
For Reference Only

TEST EQUIPMENT

MAYERS MEMORIAL HOSPITAL
FALL RIVER MILLS, CA 96028
PHARMACY

Equipment Name	Manufacturer	Model	Serial	Calibration Due Date
AIR SAMPLER	PBI	SAS DUO 360	16-D-11431	01 DEC 21

All testing is performed by qualified personnel using instrumentation, procedures and methods which ensure measurements observed are reliable. When specified, testing is performed in accordance with current ISO-17025, ISO-14644, USP-<797> and ENV's Quality Manual. Specifications comply with One or More of the following; applicable IEST recommended practices, CETA CAG-009-2011v3, Manufacturer Recommendations, and/or customer determined specifications. Measurement instruments used are traceable to The National Institute of Standards and Technology (NIST). Results obtained apply to the specific room or equipment and are reflective of conditions at the time of this test.

Test equipment calibration certificates available upon request.
Company ID: CA0434-001 Unique ID: 587201

RP20121803

M-BioLabs

ISO/IEC 17025:2017 Accredited
PJLA Accreditation # 94315
Testing

12815 Wetmore Rd., San Antonio, TX 78247 | Toll: (877) 659-4353 | Fax: (844) 849-5313 | www.mbiolabs.com

USP <797>Viable Sample Report

Client Project ID:

6008-233195 CA0434-001 MAYERS MEMORIAL HOSPITAL

Reported To:

Client Name: ENV Services, Inc
Client Address: 2880 Bergey Road, Suite K
City, State, Zip: Hatfield, PA 19940
Attn: Reports Dept
Sample(s) Condition: Acceptable

Sampling Date: 12/07/2020
Date Received: 12/09/2020
Bacterial Read: 12/11/2020
Fungal Read: 12/14/2020
Report Generation: 12/18/2020
Job ID: 20120912

Overall Comments: Growth Found.

Above Action Level Sample Summary

COC No.	Room	Description	Test Method	ISO Class	Result (Total CFUs)	Comments

* Samples with microorganisms above the recommended action levels per USP <797> or deemed highly pathogenic. Refer to sample page below for detailed results.

USP <797> Recommended Action Levels for Microbial Contamination

ISO Class	Particulate Size ($0.5m/m^3$)	Air (400-1000L) (CFU/m^3/plate)	Surface (CFU/plate)	Post Media-Fill Gloved Fingertip (CFU/plate, combined hands, all risk levels)	Gloved Fingertip (CFU/plate, combined hands, all risk levels)	Media-Fill Test
5	3,520	>1	>3	>3	0	+ or -
7	352,000	>10	>5	N/A	N/A	N/A
8 or worse	3,520,000	>100	>100	N/A	N/A	N/A

Authorized By:

Luis Gutierrez, B.S.
Laboratory Analyst

M-BioLabs
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Client Name: ENV Services, Inc

Client Project ID: 6008-233195 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20120912
Bacterial Read: 12/11/2020
Fungal Read: 12/14/2020
Report Generation: 12/18/2020

Pass (<1 CFU): No visible growth present, less than the limit of detection.

Under Action Levels (UAL): Microorganisms under the recommended action levels per USP <797>.

Above Action Levels (AAL): Microorganisms above the recommended action levels per USP <797> or deemed highly Pathogenic.

Unclassified (N/A): non-HEPA filtered area.

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
1	Pass	<1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	BACTERIA - AIR USP	1000 (L)	20120912.01	1

Comments :

1	Pass	<1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	FUNGAL - AIR USP	1000 (L)	20120912.02	1

Comments :

1	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	BACTERIA - SURFACE USP	25cm²	20120912.03	1

Comments :

1	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 MAIN CHAMBER	FUNGAL - SURFACE USP	25cm²	20120912.04	1

Comments :

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Client Name: ENV Services, Inc

Client Project ID: 6008-233195 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20120912
Bacterial Read: 12/11/2020
Fungal Read: 12/14/2020
Report Generation: 12/18/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
2	Pass	<1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	BACTERIA - AIR USP	1000 (L)	20120912.05	1

Comments :

2	Pass	<1 (CFU/m³)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	FUNGAL - AIR USP	1000 (L)	20120912.06	1

Comments :

2	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	BACTERIA - SURFACE USP	25cm²	20120912.07	1

Comments :

2	Pass	<1 (CFU/25cm²)	5	PHARMACY	GERMFREE LFGI-3USP S/N: 3S-15-LGU-12218 PASS THRU	FUNGAL - SURFACE USP	25cm²	20120912.08	1

Comments :

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Client Name: ENV Services, Inc

Client Project ID: 6008-233195 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20120912
Bacterial Read: 12/11/2020
Fungal Read: 12/14/2020
Report Generation: 12/18/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
3	N/A	39 (CFU/m³)	N/A	PHARMACY	CENTER OF PHARMACY ROOM	BACTERIA - AIR USP	1000 (L)	20120912.09	1

	Raw CFU	CFU/m³	Organism Id Date
Bacillus atrophaeus (bact)	2	2	12/14/2020
Acinetobacter (bact, GNR)	3	3	12/15/2020
Micrococcus luteus (bact)	31	34	12/11/2020

Comments :

3	N/A	12 (CFU/m³)	N/A	PHARMACY	CENTER OF PHARMACY ROOM	FUNGAL - AIR USP	1000 (L)	20120912.10	1

	Raw CFU	CFU/m³	Organism Id Date
Non-Sporulating Colony (mold)	1	1	12/14/2020
Penicillium (mold)	1	1	12/14/2020
Bacillus halosaccharovorans (bact)	3	3	12/17/2020
Dermacoccus (bact)	6	6	12/14/2020
Coagulase-Neg. Staphylococcus (bact, CoNS)	1	1	12/14/2020

Comments :

4	N/A	<1 (CFU/25cm²)	N/A	PHARMACY	TOP OF TABLE	BACTERIA - SURFACE USP	25cm²	20120912.11	1

Comments :

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Client Name: ENV Services, Inc

Client Project ID: 6008-233195 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20120912
Bacterial Read: 12/11/2020
Fungal Read: 12/14/2020
Report Generation: 12/18/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
4	N/A	<1 (CFU/25cm²)	N/A	PHARMACY	TOP OF TABLE	FUNGAL - SURFACE USP	25cm²	20120912.12	1

Comments :

N/A	N/A	<1	N/A	N/A	(-) Controls	(-) BACTERIA CONTROL USP	0 (L)	20120912.13	1

Comments :

N/A	N/A	<1	N/A	N/A	(-) Controls	(-) FUNGAL CONTROL USP	0 (L)	20120912.14	1

Comments :

N/A	N/A	Growth	N/A	N/A	(+) Controls	(+) BACTERIA CONTROL USP	0 (L)	20120912.15	1

Comments :

12815 Wetmore Rd., San Antonio, TX 78247 | Toll: (877) 659-4353 | Fax: (844) 849-5313 | www.mbiolabs.com

Client Name: ENV Services, Inc

Client Project ID: 6008-233195 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20120912
Bacterial Read: 12/11/2020
Fungal Read: 12/14/2020
Report Generation: 12/18/2020

COC No.	Status	Result (Total CFUs)	ISO Class	Room	Description	Test Method	Sampling	Lab Sample ID	MRL
N/A	N/A	Growth	N/A	N/A	(+) Controls	(+) FUNGAL CONTROL USP	0 (L)	20120912.16	1

Comments :

Media Information

Test Parameter	Media	Manufacturer	Lot#	Exp. Date
BACTERIA - MEDIA	TSA	Remel	149539	01/11/2021
FUNGAL - MEDIA	SabDex	Remel	163400	01/07/2021

12815 Wetmore Rd., San Antonio, TX 78247 | Toll: (877) 659-4353 | Fax: (844) 849-5313 | www.mbiolabs.com

Client Name: ENV Services, Inc

Client Project ID: 6008-233195 CA0434-001 MAYERS MEMORIAL HOSPITAL

Job ID: 20120912
Bacterial Read: 12/11/2020
Fungal Read: 12/14/2020
Report Generation: 12/18/2020

USP <797>Supplemental Information

1. Growth Media
   - 1.1. Single-Plate Method
     - 1.1.1. The sample undergoes two incubations periods at times and temperatures to promote growth of bacteria and fungi.
       - 1.1.1.1. The sample is incubated inverted at 30°-35° for no less than 48 hours.
       - 1.1.1.2. The sample is examined for growth and results are recorded.
       - 1.1.1.3. Then the sample is incubated inverted at 26°-30° for no less than 5 additional days.
       - 1.1.1.4. The sample is again examined for growth and results are recorded.
   - 1.2. Dual-Plate Method
     - 1.2.1. Bacteria media device is incubated inverted at 30°-35° for no less than 48 hours.
     - 1.2.2. Fungal media device is incubated inverted at 26°-30° for no less than 5 days

2. Viable Sampling Testing
   - 2.1. Air:
     - 2.1.1. Results are reported as CFU/m^3 of air.
   - 2.2. Surface:
     - 2.2.1. Results are reported as CFU per device.

3. Media-Filled Testing
   - 3.1. Media-filled vial or IV bag is incubated for 7 days at 20°-25° followed by 7 days at 30°-35°.

4. Gloved Fingertip and Thumb Testing
   - 4.1. The sampling device is incubated inverted at a temperature range of 30°-35°C for no less than 48 hours and then at 26°-30°C for no less than 5 additional days.
   - 4.2. Are reported separately as number of CFU per employee per hand (left hand, right hand).

5. Reporting Information
   - 5.1. Positive controls are unopened samples submitted for growth promotion testing (inoculation) which eliminates false negatives. Negative controls are unopened samples submitted for incubation solely which eliminates false positives.
   - 5.2. MRL is the minimum reporting limit for a sample.
   - 5.3. Results found in this report are solely tied to the project above and the samples therein.
   - 5.4. A positive-hole correction factor has been applied to all applicable air samples. The positive-hole correction factor accounts for the statistical possibility that multiple viable particles can pass through the same hole of an air sampler head. The positive hole correction factor is applied to the total plate colony count, therefore the sum of individual organism calculated counts may be reported as less that the total plate corrected count.

6. References

- Jorgensen H., James, et al. Manual of Clinical Microbiology: 11th Edition. ASM Press, 2015.
- Holt G., John, et al. Bergey's Manual of Determinative Bacteriology: 9th Edition. Williams & Wilkins, 1994.
- St-Germain, Guy, and Richard Summerbell. Identifying Fungi: A Clinical Laboratory Handbook 2nd Edition. Star Publishing Company, 2011.
- Sciortino, Jr. V., Carmen. Atlas of Clinically Important Fungi. Wiley Blackwell, 2017.
- de Hoog S., G., et al. Atlas of Clinical Fungi: The ultimate benchtool for diagnostics, USB Version 4.1. Centraalbureau voor
- Schimmelcultures, Utrecht, The Netherlands.

Note: All incubation times and temperatures listed above are not applicable to samples that have been "client incubated" prior to delivery to M-BioLabs.