2022-12-05 Regular Meeting of the Truckee Surgery Center Board of Managers

Monday, December 5, 2022 at 12:00 p.m.

Pursuant to Assembly Bill 361 and Resolution 2022-04 approved by the Tahoe Forest Hospital District, the Regular Meeting of the Truckee Surgery Center Board of Managers for December 5, 2022 will be conducted telephonically through Zoom.

Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting.

Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: https://tfhd.zoom.us/j/83182716833

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 831 8271 6833

2022-12-05 Regular Meeting of the Truckee Surgery Center Board of Managers

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No related materials.

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No related materials.

7.5. Staffing Update
No related materials.

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11. ADJOURN

TRUCKEE SURGERY CENTER
REGULAR MEETING OF THE
BOARD OF MANAGERS

AGENDA

Monday, December 5, 2022 at 12:00 p.m.

Pursuant to Assembly Bill 361 and Resolution 2022-04 approved by the Tahoe Forest Hospital District, the Regular Meeting of the Truckee Surgery Center Board of Managers for December 5, 2022 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely:
Please use this web link: https://tfhd.zoom.us/j/83182716833

Or join by phone:
If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 831 8271 6833

Public comment will also be accepted by email to mrochefort@tfhd.com. Please list the item number you wish to comment on and submit your written comments 24 hours prior to the start of the meeting.

Oral public comments will be subject to the three minute time limitation (approximately 350 words). Written comments will be distributed to the board prior to the meeting but not read at the meeting.

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT – AUDIENCE**
This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. **APPROVAL OF MINUTES OF:** 09/19/2022◈ .... ATTACHMENT

6. **ITEMS FOR BOARD ACTION**◈
6.1. Policy Review
Truckee Surgery Center Board of Managers will review the following policies:
6.1.1. Consent to Operation/Procedure and Administration of Anesthesia Form .... ATTACHMENT
6.1.2. Amended & Restated Operating Agreement of Truckee Surgery Center, LLC............ ATTACHMENT

◈ Denotes Action Item

6.1.3. Medical Staff Bylaws .... ATTACHMENT
6.1.4. Medical Staff Rules & Regulations .... ATTACHMENT

6.2. New Policy Review ◈
Truckee Surgery Center Board of Managers will review the following new policies:
6.2.1. Licensure (HR-2207) .... ATTACHMENT
6.2.2. Corporate Compliance Program (GOV-2203) .... ATTACHMENT
6.2.3. Code Gray (EOC-2201) .... ATTACHMENT
6.2.4. Code Orange (EOC-2204) .... ATTACHMENT
6.2.5. Code Purple (EOC-2206) .... ATTACHMENT
6.2.6. Code Red (EOC-2205) .... ATTACHMENT
6.2.7. Code Silver (EOC-2203) .... ATTACHMENT
6.2.8. Workplace Violence Prevention Plan (EOC-2202) .... ATTACHMENT

6.3. Policies with Significant Changes ◈
Truckee Surgery Center Board of Managers will review the following policies that have significant changes:
6.3.1. Code of Conduct (HR-2001) .... ATTACHMENT
6.3.2. Peer Review, Professional Practice Evaluation and Medical Record Review (MS-1906) .... ATTACHMENT
6.3.3. Emergency Operations Plan (EOC-1912) .... ATTACHMENT
6.3.4. Education Reimbursement (HR-2103) .... ATTACHMENT

6.4. Policies to Retire ◈
Truckee Surgery Center Board of Managers will review the following policies to be retired:
6.4.1. Use of KimGuard and KimGuard One-Step Sterilization Wrap (SP-1919) .... ATTACHMENT
6.4.2. Workplace Violence Prevention (HR-1909) .... ATTACHMENT

6.5. Frequency of Document Review ◈
Truckee Surgery Center Board of Managers will establish a frequency for review of the Medical Staff Bylaws, Rules and Regulations, and Amended & Restated Operating Agreement of Truckee Surgery Center, LLC to meet periodic review requirement set forth by ACHC accreditation standards.

6.6. Director of Anesthesia Appointment ◈
Truckee Surgery Center Board of Managers will appoint a Director of Anesthesia.

7. <u>ITEMS FOR BOARD DISCUSSION</u>

7.1. Financial Reports
Truckee Surgery Center Board of Managers will review the following financial reports:
7.1.1. Q1 FY23 Financial Statement .... ATTACHMENT
7.1.2. Surgical Notes Dashboard .... ATTACHMENT

7.2. Strategic Plan
Truckee Surgery Center Board of Managers will discuss implementation of a strategic plan.

7.3. Contract Review & Approval Process
Truckee Surgery Center Board of Managers will discuss a formal review and approval process for TSC contracts.

7.4. Facility/Equipment Update
Truckee Surgery Center Board of Managers will receive an update on facility and equipment needs.

◈ Denotes Action Item

7.5. Staffing Update
Truckee Surgery Center Board of Managers will receive an update on staffing.

8. CLOSED SESSION

8.1. Approval of Closed Session Minutes ◈
09/19/2022

8.2. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: Third Quarter 2022 Infection Control Data Summary
Number of items: One (1)

8.3. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: DMAIC Quality Dashboard
Number of items: One (1)

8.4. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: Third Quarter 2022 Quality Assurance Performance Improvement Data
Number of items: Five (5)

8.5. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: Third Quarter 2022 Ambulatory Surgery Center Association (ASCA) Clinical Benchmarking Survey
Number of items: One (1)

8.6. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: 2020-2022 Utility Risk Assessments
Number of items: Three (3)

8.7. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: 2020-2022 Hazard and Vulnerability Assessments
Number of items: Three (3)

8.8. Hearing (Health & Safety Code § 32155) ◈
Subject Matter: Medical Staff Credentials Report

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

10. ITEMS FOR NEXT MEETING

11. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

◈ Denotes Action Item

TRUCKEE SURGERY CENTER REGULAR MEETING OF THE BOARD OF MANAGERS

DRAFT MINUTES

Monday, September 19, 2022 at 12:00 p.m.

Pursuant to Assembly Bill 361 and Resolution 2022-04 approved by the Tahoe Forest Hospital District, the Regular Meeting of the Truckee Surgery Center Board of Managers for September 19, 2022 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER
Meeting was called to order at 12:01 p.m.

2. ROLL CALL
Board of Managers: Dr. Dodd, Crystal Betts, Louis Ward, Harry Weis

Staff in attendance: Courtney Leslie & Heidi Fedorchak of Truckee Surgery Center; Jan Iida, TFHD Chief Nursing Officer; Karla Weeks, TFHD Administrative Director of Surgical Services; Martina Rochefort, Clerk of the Board

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
No public comment was received.

5. APPROVAL OF MINUTES OF: 06/15/2022

ACTION: **Motion made by Dr. Jeffrey Dodd, to approve Truckee Surgery Center Board of Manager meeting minutes of June 15, 2022 as presented, seconded Louis Ward. Roll call vote taken.**
Dodd – AYE
Ward – AYE
Betts – AYE
Weis – AYE

6. ITEMS FOR BOARD ACTION
6.1. Annual Policy & Procedure Approval
Truckee Surgery Center Board of Managers reviewed the following:
6.1.1. Policy & Procedure List
6.2. New Policy Review

Truckee Surgery Center Board of Managers reviewed the following new policies:

6.2.1. Amendment to Protected Health Information (HIM-2201)
6.2.2. Collection Policy (GOV-2202)
6.2.3. Review of Accounts for Bad Debt (BO-2208)

<u>ACTION:</u> **Motion made by Dr. Jeffrey Dodd, to approve items 6.1.1 and 6.2.1 through 6.2.3. as presented, seconded Louis Ward. Roll call vote taken.**
Dodd – AYE
Ward – AYE
Betts – AYE
Weis – AYE

6.3. Policies with Significant Changes

Truckee Surgery Center Board of Managers reviewed the following policies that have significant changes:

6.3.1. Allograft Handling – Accepting, Storing and Tracking (TB-1901)
6.3.2. C-Arm Spacer Cone CA Exemption Use (DI-1902)
6.3.3. Clinical Laboratory Point of Care Testing Program (LAB-1909)
6.3.4. Clinical Laboratory Specimen Collection & Transport (LAB-1914)
6.3.5. Termination/Discharge of Patient Relationship (GOV-1910)
6.3.6. Life Safety Maintenance Program (EOC-1917)
6.3.7. Release of Protected Health Information (HIM-1903)
6.3.8. Scope of Services (GOV-1912)
6.3.9. Mission, Vision, Values and Goals (GOV-1907)
6.3.10. Procedure List (MS-1908)

Discussion was held.

<u>ACTION:</u> **Motion made by Dr. Jeffrey Dodd, to approve items 6.3.1 through 6.3.10 as presented, seconded Louis Ward. Roll call vote taken.**
Dodd – AYE
Ward – AYE
Betts – AYE
Weis – AYE

6.4. Policies to Retire

Truckee Surgery Center Board of Managers reviewed the following policies to be retired:

6.4.1. Point of Care Testing Program Overview (LAB-1910)
6.4.2. Point of Care Licensure (LAB-1913)
6.4.3. COVID-19: Facility Disinfection (IC-2003)
6.4.4. Code of Ethics (BO-1906)
6.4.5. Registered Nurse First Assistant (NS-1932)
6.4.6. Fire Staff Response (EOC-1912)

<u>ACTION:</u> **Motion made by Dr. Jeffrey Dodd, to retire items 6.4.1 through 6.4.6 as presented, seconded Louis Ward. Roll call vote taken.**
Dodd – AYE

DRAFT

Ward – AYE
Betts – AYE
Weis – AYE

6.5. Delineated Clinical Privilege Request Forms

Truckee Surgery Center Board of Managers reviewed edits to the following privilege forms:

6.5.1. Delineated Clinical Privilege Request Form – Physician Assistant
6.5.2. Delineated Clinical Privilege Request Form – Orthopedic Surgery
6.5.3. Delineated Clinical Privilege Request Form – Gynecology

ACTION: **Motion made by Dr. Jeffrey Dodd, to approve items 6.5.1 through 6.5.3 as presented, seconded Louis Ward. Roll call vote taken.**
Dodd – AYE
Ward – AYE
Betts – AYE
Weis – AYE

6.6. Semi-Annual Contracted Services Review

Truckee Surgery Center Board of Managers conducted a semi-annual review of contracted services. Discussion was held.

ACTION: **Motion made by Dr. Jeffrey Dodd, to approve the Semi-Annual Contracted Services Review as presented, seconded Louis Ward. Roll call vote taken.**
Dodd – AYE
Ward – AYE
Betts – AYE
Weis – AYE

6.7. Annual Review of Preprinted Orders

Truckee Surgery Center Board of Managers conducted an annual review of preprinted orders. Discussion was held.

ACTION: **Motion made by Dr. Jeffrey Dodd, to approve the Annual Review of Preprinted Orders as presented, seconded Louis Ward. Roll call vote taken.**
Dodd – AYE
Ward – AYE
Betts – AYE
Weis – AYE

7. ITEMS FOR BOARD DISCUSSION

7.1. Financial Reports

Truckee Surgery Center Board of Managers reviewed the following financial reports:

7.1.1. TSC Balance Sheet Q4 FY22
7.1.2. TSC Profit & Loss Q4 FY22
7.1.3. FY22 Unaudited Financial Statement

TSC Administrator commented they continued to see fluctuating net revenue.

DRAFT

TSC will need to increase volumes to meet budget.

7.1.4. Surgical Notes Dashboard

Billing was moved from Medbridge to Surgical Notes. There was a delay in billing due to interface changes. April and May billing did not begin until the end of May.

7.2. Payor Contract Update

Truckee Surgery Center Board of Managers received an update on payor contracts. Discussion was held.

TSC continued to work with Chancellor on payor contracts. The Blue Shield contract has been completed. Blue Cross and United are trying to make changes to implant reimbursement that would be detrimental to the organization.

CFO noted TSC is so small to them so their lack of willingness to move is disappointing.

7.3. Fire and Disaster Drill Update

Truckee Surgery Center Board of Managers received an update on recent fire and disaster drills.

Heidi Fedorchak, completed fire drill. A disaster drill will be completed in the next couple of weeks to comply with the annual requirement.

Updated fire extinguishers will be added to the operating room.

7.4. Facility/Equipment Update

Truckee Surgery Center Board of Managers received an update on facility and equipment needs.

TSC continued to have temperature and humidity issues with the HVAC system in sterile processing.

Air handler should be installed the first week of October but it is not yet set in stone.

TSC received two new anesthesia machines on September 8, 2022. Staff have been trained on the new machines.

The c-arm battery was replaced but there are still issues. The circuit board may need to be replaced. The mini c-arm tube went out. Replacement of the tube was expensive so there is a rental machine onsite. COO will look further into the tube replacement.

7.5. Staffing Update

Truckee Surgery Center Board of Managers received an update on staffing.

Daniel Francke is now the contracted Pharmacist-in-Charge.

The per diem surgical tech put in their resignation. Circulators continue to be trained.

DRAFT

Open Session recessed at 12:22 p.m.

8. **CLOSED SESSION**

8.1. Approval of Closed Session Minutes
06/15/2022

Discussion was held on a privileged item.

8.2. Hearing (Health & Safety Code § 32155)
Subject Matter: Second Quarter 2022 Infection Control Data Summary
Number of items: One (1)

Discussion was held on a privileged item.

8.3. Hearing (Health & Safety Code § 32155)
Subject Matter: Second Quarter 2022 Quality Assurance Performance Improvement Data
Number of items: Five (5)

Discussion was held on a privileged item.

8.4. Hearing (Health & Safety Code § 32155)
Subject Matter: 2022 Quality Assurance Performance Improvement Project Update
Number of items: One (1)

Discussion was held on a privileged item.

8.5. Hearing (Health & Safety Code § 32155)
Subject Matter: Second Quarter 2022 Ambulatory Surgery Center Association (ASCA) Clinical Benchmarking Survey
Number of items: One (1)

Discussion was held on a privileged item.

8.6. Hearing (Health & Safety Code § 32155)
Subject Matter: Annual Formulary Review
Number of items: One (1)

Discussion was held on a privileged item.

8.7. Hearing (Health & Safety Code § 32155)
Subject Matter: Medical Staff Credentials Report

Discussion was held on a privileged item.

Open Session reconvened at 12:34 p.m.

9. **REPORT OF ACTIONS TAKEN IN CLOSED SESSION**

Item 8.1. Closed Session Minutes was approved on a 4-0 vote. There was no reportable action on items 8.2. through 8.7. Item 8.7. Medical Staff Credentials Report was approved on a 4-0 vote.

10. **ITEMS FOR NEXT MEETING**

Mr. Ward is hoping to have a report out from Optum on the operating room efficiency project.

DRAFT

11. ADJOURN
Meeting adjourned at 12:36 p.m.

DRAFT

TRUCKEE SURGERY CENTER

CONSENT TO OPERATION/PROCEDURE AND ADMINISTRATION OF ANESTHESIA

PLEASE READ THE ENTIRE FORM CAREFULLY BEFORE SIGNING

PATIENT NAME:___________________________________ DATE OF BIRTH:______/_______/_______

I authorize the following physician(s) and/or practitioner(s)

____

NAME OF PHYSICIAN(S) AND/OR PRACTITIONER(S) PERFORMING OPERATION OR PROCEDURE

to perform the following operation(s) or procedure(s)

____

____

SPELL OUT ALL WORDS. DO NOT ABBREVIATE. USE SIMPLE LANGUAGE. IDENTIFY SIDE/LEVEL IF APPLICABLE.

Any operation or procedure has a risk of an unsuccessful result or complication, including but not limited to bleeding, infection, nerve/nervous system damage, injury to organs/structures, or even death from both known and unforeseen causes. You have the right to be informed about your proposed care, treatment, services, medications, interventions, operation or procedure, and its risks, benefits, side effects, potential problems related to recuperation, and the likelihood of achieving your care, treatment, and service goals.

At Truckee Surgery Center (TSC), postgraduate fellows, residents, medical students, physician assistants, surgical assistants, and approved health care practitioners may observe care, and if appropriately trained, participate in aspects of the operation or procedure. These practitioners will be under the supervision of the primary physician. If the operation or procedure involves specialized equipment or medical devices, the manufacturer's representative(s) may be present during the procedure to assist in the selection or calibration of equipment or device(s) and the related treatment.

Your signature on this form authorizes TSC to dispose, at its discretion, any blood, bodily fluid, member, organ, or other tissue removed or obtained during your operation, procedure, or treatment, allowed under legal requirements and relevant policies. The above operation or procedure will be carried out by the practitioners identified on this form along with any assistants or associates including anesthesiologists, pathologists, and radiologists from the medical staff.

PATIENT CONSENT

By my signature below, I confirm that:

1. I have read and understand the information provided on this form, and the nature and purpose of the operation or procedure have been explained to me. The risks and benefits of the operation or procedure have been explained to me. In addition, the alternatives, the risks and benefits of these alternatives, and the risks of having no treatment have been explained to me. I have had the

[PATIENT STICKER]

CONSENT TO OPERATION/PROCEDURE AND ADMINISTRATION OF ANESTHESIA

opportunity to ask questions and have received all the information I desire. I consent to the operation or procedure, together with any different or further procedures which in the opinion of my physician or surgeon may be deemed necessary.

2. I understand that in an emergency if for some reason during the operation, the physician(s) named above are not able to complete the operation, I permit a qualified substitute physician to perform or complete the operation.

3. I understand that other medical care will not be withheld if I decide to withhold or withdraw my consent to this proposed operation or procedure.

4. I understand that the operation or procedure may involve the use of a Food and Drug Administration (FDA) approved drug or device for a purpose not approved by the FDA.

5. I understand that the administration of anesthesia and associated procedures may be necessary to assure safety and comfort during the procedure, and I consent to this. I understand that certain risks and complications may be associated with the use of anesthesia, including but not limited to infection, bleeding, drug reactions, loss of vision, persistent pain/numbness/weakness, nerve damage, organ damage, stroke, and death. I understand that the appropriate physician will discuss these risks with me prior to the operation or procedure.

6. If I have signed an advance directive that contains an order to do not resuscitate (DNR) or have requested not to be resuscitated in the event of cardiac arrest, I understand that my DNR order will be temporarily suspended during the my stay at Truckee Surgery Center and will resume when I am transferred to the hospital or discharged home.

7. I consent to the taking of pictures, videos, or other electronic reproductions of my medical or surgical condition and/or treatment. I consent to the use of these pictures, videos, and/or electronic reproductions, for internal or external activities consistent with the TSC's mission, such as education and research, conducted in accordance with TSC policies.

8. In the event of an accidental exposure to my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.

9. If complications arise, I agree to be admitted and treated at a hospital mutually agreed by my physician and myself if possible.

____ ________________ ______________

PATIENT SIGNATURE **DATE** **TIME**

(OR REPRESENTATIVE/LEGAL GUARDIAN)

____ ______________________________

PATIENT NAME **RELATIONSHIP TO PATIENT**

[PATIENT STICKER]

CONSENT TO OPERATION/PROCEDURE AND ADMINISTRATION OF ANESTHESIA

(OR NAME OF SIGNATOR) (IF OTHER THAN SELF)

____ _______________ ______________

WITNESS SIGNATURE **DATE** **TIME**

(TRUCKEE SURGERY CENTER STAFF SIGNATURE)

If an interpreter was utilized to obtain consent:

_______________________________________ __________________ ___________________________

INTERPRETER NAME ID NUMBER LANGUAGE

PHYSICIAN ATTESTATION

I have discussed the operation(s) or procedure(s) described above, including:

- the risks, benefits, and alternatives;
- any adverse reactions that may reasonably be expected to occur;
- any alternative efficacious methods of treatment which may be medically viable;
- the potential problems that may occur during recuperation; and
- any research or economic interest I have regarding this treatment

with the patient and/or representative/legal guardian. I have also explained that with any procedure there is always the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any operation, procedure, or treatment.

Physician comments/addendums to consent: ____

____

____

____

I certify that the patient was encouraged to ask questions, that all questions were answered, and that the patient (or representative/legal guardian) consents to the operation(s) or procedure(s) described above.

____ _______________ ______________

PHYSICIAN SIGNATURE **DATE** **TIME**

____

PHYSICIAN NAME

[PATIENT STICKER]

AMENDED AND RESTATED OPERATING AGREEMENT

OF

TRUCKEE SURGERY CENTER, LLC

AMENDED AND RESTATED
OPERATING AGREEMENT
OF
TRUCKEE SURGERY CENTER, LLC

This Amended And Restated Operating Agreement (this "**Agreement**") of Truckee Surgery Center, LLC, a California limited liability company (the "**Company**"), is entered into as of June 3, 2019 (the "**Effective Date**"), by and among the Company and Tahoe Forest Hospital District, a California local health care district (the "**District**").

RECITALS

A. On January 12, 2010 (the "**Formation Date**"), Articles of Organization for the Company were filed with the California Secretary of State. Truckee Surgery Center, Inc. (the "**Corporation**") were the Members of the Company as of the Formation Date and the District later gained majority share purchased through Truckee Surgery Center, LLC.

B. On or about December 15, 2010, the Corporation adopted the prior Operating Agreement of the Company (the "**Prior Operating Agreement**").

C. Effective October 25, 2018, the District purchased all of the Membership Interests of the Corporation in the Company, and became the sole Member of the Company.

D. District, as a general partner is currently in the process of selling a 1% ownership interest to Dr. Jeff Dodd.

D. Section 15.13 of the Prior Operating Agreement provides that the Prior Operating Agreement may be amended by Members holding at least two-thirds (2/3's) of the issued and outstanding Units of the Company.

E. The District holds one hundred percent (100%) of the outstanding Units of the Company.

NOW, THEREFORE, the District by this Agreement wishes to set forth this Amended and Restated Operating Agreement for the Company under the laws of the State of California upon the terms and subject to the conditions of this Agreement

ARTICLE I
DEFINITIONS

When used in this Agreement, the following terms shall have the meanings set forth below:

"**Act**" means the California Beverly-Killea Limited Liability Company Act, as amended from time to time.

"**Adjusted Capital Account**" shall mean, with respect to any Member, such Member's Capital Account, adjusted as follows:

(a) credit to such Capital Account any Capital Contributions that the Member is unconditionally obligated to make and any amounts that a Member is deemed obligated to contribute pursuant to the penultimate sentence of both Regulations Section 1.704-2(g)(1) and Regulations Section 1.704-2(i)(5); and

(b) debit to such Capital Account the items described in Treasury Regulation Section 1.704-1(b)(2)(ii)(d)(4), (5) and (6).

"**Affiliate**" of a specified Person shall mean a Person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the Person specified. As used in this definition, the term "**control**" shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such specified Person, whether through ownership of voting securities, by contract or otherwise.

"**Agreement**" means this Operating Agreement, as amended from time to time.

"**Ambulatory Surgical Center**" shall mean any clinic or health facility (as defined under Section 1200 or 1250 of the California Health and Safety Code, respectively) owned by the Company and operated for the primary purpose of performing surgery on an outpatient basis and either: (i) operating under a license from the California Department of Health Services or the California Department of Public Health (or any successor agency); or (ii) lawfully operating without a license.

"**Articles**" means the Articles of Organization filed with the California Secretary of State on January 12, 2010, as amended or restated from time to time.

"**Available Cash Flow**" means all cash funds of the Company in excess of such amounts that the Board, in its reasonable discretion, determines are appropriate to hold in reserve, in light of the Company's debts and other obligations coming due and its contemplated capital investment and replacement, but not, in any event, in an amount in excess of ninety (90) days cash on hand (with "**days cash on hand**" as of any time meaning the quotient obtained by dividing the Company's cash and cash equivalents as of such time by the Company's "average daily expenses," with "**average daily expenses**" being the quotient obtained by dividing (a) the Company's aggregate operating expenses for the fiscal year most recently, as reflected on the Company's accrual method financial statements for such year, by (b) the number of days in such year).

"**Board**" shall have the meaning given to such term in Section 10.1 hereof.

"**Capital Account**" means, with respect to any Member, the account maintained by the Company for such Member in accordance with Section 7.6 of this Agreement.

"**Capital Contribution**" means, in respect of any Member, all money and other property contributed by such Member to the capital of the Company.

"**Code**" means the Internal Revenue Code of 1986, as amended, or any corresponding provisions of succeeding law in effect at such time.

"**Company**" shall have the meaning given to such term in the opening paragraph of this Agreement.

"**Company Minimum Gain**" shall have the meaning given to the term "partnership minimum gain" in Section 1.704-2(d) of the Regulations, treating the Company as a partnership.

"**Facility**" shall mean, collectively, all properties, tangible and intangible, collectively comprising the Ambulatory Surgical Center operated by the Company at 10770 Donner Pass Road, Suite 201, Truckee, California, 96161, and any other Ambulatory Surgical Center that the Company may operate in the future.

"**Fiscal Year**" shall have the meaning given to such term in Section 14.3.

"**Manager**" shall have the meaning given to such term in Section 10.1.

"**Material Breach**" shall have the meaning given to such term in Section 11.3.

"**Member**" means the District and each other Person admitted to the Company as a "member," as that term is defined in the Act. "**Members**" refers to all such Persons, collectively.

"**Member Minimum Gain**" shall have the meaning give to the term "partner nonrecourse debt minimum gain" in Section 1.704-2(i) of the Regulations, treating the Company as a partnership and a Member as a partner.

"**Member Nonrecourse Deductions**" shall have the meaning given to the term "partner nonrecourse deductions" in Regulations Section 1.704-2(i), treating the Company as a partnership and a Member as a partner.

"**Nonrecourse Deductions**" shall have the meaning given to such term by Section 1.704-2(b)(1) of the Regulations, treating the Company as a partnership.

"**Person**" means an individual, trust, estate, corporation, partnership, limited partnership, limited liability company, unincorporated association, governmental unit or other entity or association.

"**Physician**" shall a person licensed under California law as a physician and surgeon or otherwise lawfully able to perform the services of a licensed physician and surgeon in California.

"**Profits**" and "**Losses**" means, for each Fiscal Year, an amount equal to the Company's taxable income or loss for such Fiscal Year, determined in accordance with Code Section 703(a) (but, for this purpose, all items of income, gain, loss, or deduction required to be stated separately pursuant to Code Section 703(a)(1) shall be aggregated each year into a single amount of taxable income or loss), with the following adjustments:

(a) Any income of the Company that is exempt from federal income tax and not otherwise taken into account in computing Profits or Losses pursuant to this definition of "Profits" and "Losses" shall be added to such taxable income or loss;

(b) Any expenditures of the Company described in Code Section 705(a)(2)(B) or treated as Code Section 705(a)(2)(B) expenditures pursuant to Regulations Section 1.704-(1)(b)(2)(iv)(i), and not otherwise taken into account in computing Profits or Losses pursuant to this definition of "Profits" and "Losses" shall be subtracted from such taxable income or loss;

(c) If there is a:

(1) distribution of Company property (other than money) to a Member, or

(2) a contribution to the capital of the Company by a new or existing Member or there is a distribution of Company property to a Member in consideration for the issuance or redemption of a Unit or Units, other than a de minimis amount in either case;

then, to the extent and in the manner reasonably determined by the Board, the Company shall restate the value of each and every item of Company property on the books and records of the Company to equal the fair market value thereof as of such date, and the unrealized gain or loss that would have been realized had the property been sold at fair market value in a taxable transaction shall be allocated among the Members as though there had been a taxable transaction and otherwise in accordance with Section 1.704-1(b)(2)(iv)(e) and (f) of the Treasury Regulations;

(d) If the book value of any item of Company property differs from the Company's adjusted tax basis in such item of property, whether as a result of the contribution of property, a revaluation of the Company property pursuant to Paragraphs (c) or (d) of this definition of "Profits" and "Losses" or otherwise, items of income, gain, loss, depreciation, and other deductions respecting such item of property shall be calculated for purposes of determining Profits or Losses with respect to the Book Value of such property in a manner consistent with Section 1.704-1(b)(2)(iv)(g) of the Treasury Regulations; and

(e) Any items which are specially allocated pursuant to Section 9.3 hereof shall not be taken into account in computing Profits or Losses.

"**Regulations**" means the income tax regulations promulgated under the Code and codified at Title 26 of the Code of Federal Regulations, as such regulations may be amended from time to time (including corresponding provisions of succeeding regulations).

"**Supermajority Approval**" shall mean, with respect to any matter to come before the Board for decision, the approval of not less than two-thirds (2/3's) of the Managers then in office.

"**Territory**" means and includes the Counties of Placer and Nevada in the State of California and the County of Washoe in the State of Nevada, and any other county in which the Company owns and operates an Ambulatory Surgical Center.

"**Unit**" shall have the meaning given to such term in ARTICLE VI.

ARTICLE II
ORGANIZATION

2.1 Formation and Purpose of Agreement. The Company was formed by the filing of its Articles in the office of the California Secretary of State. The Company and its sole Member hereby enter into this Agreement for the purpose of replacing the Prior Operating Agreement with this Agreement. As of the Effective Date, the Prior Operating Agreement is terminated, is replaced in its entirety by this Agreement, and has no further force or effect. In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree that the rights and obligations of the parties and the administration and termination of the Company shall be governed by this Agreement, the Articles and the Act. To the extent that any provision of this Agreement is inconsistent with the Articles, the Articles shall control, and, to the extent that any provision of this Agreement is inconsistent with the Act, but not the Articles, the provisions of this Agreement shall control to the extent permitted by the Act.

2.2 Name. The name of the Company is "Truckee Surgery Center, LLC." The business of the Company shall be conducted under that name or such other name as the Board may determine in accordance with ARTICLE X.

ARTICLE III
PRINCIPAL PLACE OF BUSINESS

3.1 Principal Place of Business. The principal place of business of the Company is located at 10770 Donner Pass Road, Suite 201, Truckee, California, or at such other place as the Board may from time to time designate pursuant to ARTICLE X.

3.2 Agent for Service of Process. The Board shall designate an individual or other legally qualified person to serve as agent for service of process for the Company, to serve at the pleasure of the Board, provided that there always shall be one person who has been so designated.

ARTICLE IV
BUSINESS

4.1 Business. The Company is organized and shall be operated for the purpose of owning and lawfully operating the Facility as a Medicare-certified and/or accredited ambulatory surgery center that principally performs musculoskeletal surgery and related anesthesia services, all consistent with the purposes of the District of furthering the health care of the community. For this purpose, the Facility shall be deemed to principally perform musculoskeletal surgery and related anesthesia services during a given period of time if 80% or more of the procedures performed at the Facility during such period consist of any combination of orthopedic surgery, spinal surgery, hand surgery, podiatric surgery or anesthesia or pain management procedures. However, notwithstanding the foregoing statement of purposes, the Company, in fulfilling such purposes, may engage in, undertake and perform any and all acts and do all things that a limited liability company organized under the Act may lawfully engage consistent with this Agreement and the Articles. Any references herein to any Ambulatory Surgery Center other than the Facility

is not intended, and shall not be construed, to indicate or imply any an intent on the part of the parties hereto to acquire, develop or otherwise own another Ambulatory Surgery Center.

4.2 Compliance With Laws. The Members shall cause the Company and all of their relationships and dealings with the Company at all times to comply, to the extent applicable, with all laws, including, without limitation, all laws governing the ownership of interests in the Company by its Members, the operations and activities of public agencies of the State of California, the so-called Anti-Kickback Statute and the so-called Stark Act. If legal counsel to the Company determines, or if a Member, based on the advice of its legal counsel, determines either that the Company, or any aspect of its operations or activities, fails to comply with law or causes any Member to fail to comply with law, then any Member may provide notice of the same to all Members, and the Members thereupon shall in good faith-meet and confer and use commercially reasonable best efforts to find and implement a mutually satisfactory remedy to such noncompliance. If, after good faith efforts, the Members are unable to find a mutually satisfactory remedy to such noncompliance, any Member (the "**Electing Member**") may, by notice to the other Members, elect to cause the Company to redeem the Units then held by the Electing Member pursuant to the procedures specified in Section 11.3(a), provided, that the non-Electing Members, by vote of a majority of the Units outstanding other than the Units then held by the Electing Member, may thereupon elect to dissolve the Company pursuant to ARTICLE XII hereof, rather than redeem the Units of the. Electing Member. An election to cause the dissolution of the Company shall be effective only if notice to such effect is given to all Members within sixty (60) days of the Electing Member's notice of election to cause the redemption of its Units.

ARTICLE V
TERM

The Company's existence commenced on the date of the filing of the Articles and shall continue indefinitely until liquidated and dissolved pursuant to ARTICLE XII of this Agreement.

ARTICLE VI
MEMBERSHIP INTERESTS; UNITS

The interest of a Member: (i) in the Profits and Losses of the Company; (ii) in distributions of Company money and other property (except upon liquidation); and (iii) in exercising voting rights shall be represented by units ("**Units**"), all as provided in greater detail below. There shall be no fixed number of Units, and the Board may issue additional Units from time to time.

ARTICLE VII
CAPITAL CONTRIBUTIONS:
CAPITAL ACCOUNTS; ADDITIONAL MEMBERS

7.1 Member Capital Contributions and Ownership. Each Member's Capital Contribution, Ownership of Units and percentage interest in the Company are set forth in Exhibit A attached hereto, which Exhibit A shall be revised to reflect any additional Members and any additional Capital Contributions made by Members.

7.2 Additional Capital Contributions; Additional Members. Subject to Section 10.1(e) hereof, in the event that the Board determines at any time (or from time to time)

that the Company requires additional funds for or in respect of its business or to pay any of its obligations, expenses, costs, liabilities or expenditures, then the Board may, in its discretion: (i) approve additional Capital Contributions by the Members (evidenced by the issuance of additional Units, issued at their then fair market value, as established by the Board), (ii) authorize and direct the Company to borrow all or part of such additional funds; or (iii) authorize and direct the Company to sell additional Units at the fair market value thereof to such Person or Persons as the Board reasonably may determine, and admit such Persons as Members of the Company. If any Member fails to contribute its pro rata share of any such additional funds pursuant to clause (i) of this Section 7.2 (a "**Non-Contributing Member**"), each Member who has made its additional contribution shall be offered a pro rata opportunity to either:

(a) Make the additional contribution that the Non-Contributing Member failed to make and to be issued Units for such additional contribution as aforesaid;

(b) Make a loan to the Company in such amount, repayable with interest on the outstanding principal balance accruing monthly at the annual interest rate of two percentage points (2%) in excess of the Prime Rate shown in the Money Rates Section of the Wall Street Journal on the first business date of the month in which such loan is made, which loan shall be repayable prior to any distribution made with respect to Units, but only when and as the Company has Available Cash Flow therefor, provided that any such loan, if not previously repaid, shall be repaid not later than sixty (60) months from the date advanced; or

(c) Any combination of (a) and (b).

The Board may offer the opportunity to Members to make additional Capital Contributions and/or loans pursuant to the immediately preceding sentence until it has raised additional funds equal to the amount that all Non-Contributing Members failed to contribute.

7.3 Limited Liability. A Member shall not be bound by, or personally liable for, the expenses, liabilities or obligations of the Company, except as provided in the Act or as otherwise provided by applicable law. Notwithstanding the foregoing, in the event that a Member guarantees the Company's obligations under a loan or other agreement, the Member would be liable under the guaranty according to its terms.

7.4 Withdrawal of Capital Contributions. No .Member shall have the right to withdraw or reduce its Capital Contribution. No Member shall have the right to demand or receive property other than cash in return for its Capital Contribution, and no Member shall have priority over any other Member, either as to the return of Capital Contributions or as to allocations of Profits, Losses, or distributions, except as expressly provided otherwise in this Agreement.

7.5 Creation and Maintenance of Capital Account. The Company shall establish and maintain a Capital Account for each Member for the full term of the Company, which Capital Account shall be increased by such Member's Capital Contribution and allocations of Profits and items thereof to such Member and decreased by distributions and allocations of Losses and items thereof to such Member and otherwise maintained in accordance with the capital account maintenance rules of Regulations Section 1.704-1(b)(2)(iv). In the event the Board determines that the manner in which the Capital Accounts have been maintained fails to comply with the

standards of the Regulations Section 1.704-1(b), the Board may make such modifications as the Board determines are necessary to cause the Capital Accounts to be consistent with the standards of the Regulations. In the event a Member transfers an interest in the Company in accordance with the terms of this Agreement, the transferee shall succeed to the Capital Account of the transferor Member to the extent it relates to the transferred interest.

7.6 No Assessments; No Negative Capital Account Make-up. No Members shall be obligated to make any additional Capital Contributions or loans to the Company. Notwithstanding any other provision in this Agreement or any inference from any provision in this Agreement, no Member shall have an obligation to the Company, to the other Members or to third parties to restore a negative Capital Account balance during the existence of the Company or upon the dissolution or termination of the Company.

ARTICLE VIII
EXPENSES OF THE COMPANY

8.1 Transactions With Members and Affiliates. Subject to Section 10.1(e)(ix), the Company may contract and otherwise transact business with Members and Affiliates of Members.

ARTICLE IX
ALLOCATION OF PROFITS AND LOSSES; CASH DISTRIBUTIONS

9.1 Profits. After giving effect to the special allocations set forth in Section 9.3 for each Fiscal Year, Profits for any Fiscal Year shall be allocated as follows:

(a) First, to and among the Members in proportion to and to the extent of the amount equal to the excess, if any, of: (i) the cumulative Losses allocated to each such Member's (or such Member's predecessor in interest) pursuant to Section 9.2 for all prior Fiscal Years; over (ii) the cumulative Profits allocated to each such Member (or such Member's predecessor in interest) pursuant to this Section (a) for all prior Fiscal Years.

(b) Second, to and among the Members in proportion to the number of Units held by each.

9.2 Losses. After giving effect to the special allocations set forth in Section 9.3 for each Fiscal Year, Losses for any Fiscal Year shall be allocated as follows:

(a) First, to the extent that each Member has a positive Adjusted Capital Account balance, to and among the Members in proportion to the number of Units held by each:

(b) Second, to the extent that any Member has a positive Adjusted Capital Account balances, to and among such of the Members with a positive Adjusted Capital Account balance, to the extent thereof, in proportion to the number of Units held by each such Member; and

(c) Then, to and among all Members in proportion to the number of Units held by each.

9.3 Special Allocations. Prior to the determination or allocation of Profits or Losses in any Fiscal Year, items of income, gain, loss, expense and deduction shall be allocated to and between the Members as set forth below, to the extent applicable:

(a) Nonrecourse Deductions shall be allocated to and among the Members in proportion to the number of Units held by each.

(b) Member Nonrecourse Deductions shall be allocated to those Members who bear the economic risk of loss with respect to the liability to which such items are attributable in accordance with Section 1.704-2(i) of the Regulations.

(c) If there is a net decrease in Company Minimum Gain in any fiscal year, determined in accordance with Section 1.704-2(f) and related provisions of the Regulations, Members shall be allocated items of income or gain in the amount and in the proportions specified in such Section 1.704-2(1) and related provisions.

(d) If there is a net decrease in Member Minimum Gain in any fiscal year, each Member having a share of such Member Minimum Gain shall be allocated items of income or gain in the amount and in the proportions specified in Section 1.704-2(0(5) of the Regulations.

(e) If a Member unexpectedly receives an adjustment, allocation, or distribution described in Paragraph (4), (5) or (6) of Section i .704-1(b)(2)(ii)(d) of the Regulations that creates or increases a deficit balance in such Member's Adjusted Capital Account (determined after first tentatively applying Section 9.2 as though this Section (e) were not applicable), then, to the extent that there are then other Members with positive Adjusted Capital Account balances, the Member with the deficit Adjusted Capital Account balance shall be allocated items of income or gain (consisting of a pro rata portion of each item of Company income, including gross income, and gain for such year) in an amount and manner sufficient to eliminate such excess deficit as quickly as possible, but without creating or increasing a deficit Adjusted Capital Account balance for any other Member. In the event there is an allocation of income or gain to a Member pursuant to this Section (e) in any fiscal year, then in subsequent years, to the extent possible without once again causing the application of this Section (e), income or gain (consisting of a pro rata portion of each item of Company income, including gross income, and gain for such years) shall be allocated to other Members so that the net amount of Profits, Losses and other items of income, gain, loss and expense allocated to each Member equals, to the extent possible, the amounts thereof that would have been allocated to each Member pursuant to the provisions of this ARTICLE IX without regard to this Section (e).

9.4 Tax Allocations: Code Section 704(c). Except as is otherwise provided in this Section 9.4, the taxable income or loss of the Company for any taxable year, together with each item of income, gain, loss, deduction, or credit that is separately stated for income tax purposes, shall be allocated to and among the Members in the same proportions that Profits or Losses are allocated for such year, increased or decreased by items of income, gain, loss, or expense that are separately allocated pursuant to Section 9.3 of this Agreement. Notwithstanding the foregoing, in the event Company property is reflected in the Members' Capital Accounts at a value that differs from the Company's adjusted tax basis for the property, whether as a result of the contribution of property, a revaluation of Company property or otherwise, items of gain, loss, and expense derived

from the property for purposes of determining taxable income or loss shall be allocated to and among the Members for tax purposes in a manner consistent with the requirements of Section 704(c) Code and the Regulations thereunder, notwithstanding any other provision of this Agreement. Unless the Members otherwise agree, the Company shall use the method identified as the "traditional method" in the Treasury Regulations for complying with the principles of Section 704(c) of the Code,

9.5 Distributions of Available Cash Flow. Subject to ARTICLE VIII, the Company shall distribute any Available Cash Flow, as determined by the Board in its reasonable discretion, to the Members as follows:

(a) The Company shall distribute Available Cash Flow to and among the Members in proportion to the number of Units held by each at the time of distribution; provided, that if the Company sells its assets in exchange, in whole or in part, for an obligation to pay in the future, the Company shall distribute Available Cash Flow attributable to payments of principal and interest on any such note to and among the Members in proportion to the number of Units held by each at the time of the sale giving rise to such note. To the extent commercially reasonable, the Board shall cause distributions to be made pursuant to this Section (a) on a monthly basis.

(b) Notwithstanding the foregoing, except to the extent that the Company would be rendered unable to pay its obligations as they come due, the Company shall distribute cash to each Member quarterly, but not later than at such times that federal individual estimated income tax payments are due and payable, in an amount equal to one-fourth (114) of forty percent (40%) of the Board's estimate of such Member's allocable share of Company Profits for the Fiscal Year with respect to which paid. If the Board's estimate of a Member's allocable share of Company Profits changes from one distribution to the next, the amount distributed to the Member pursuant to this clause (b) shall be adjusted, upwards or downwards as appropriate, to offset any overages or shortfalls in prior distributions resulting from such changed estimates. The amount of any distributions otherwise required hereunder shall be offset by any distributions made pursuant to clause (a) of this Section 9.5 in the same quarter.

ARTICLE X
MANAGEMENT OF THE COMPANY

10.1 Managing Board.

(a) Except as otherwise expressly set forth herein, the business and affairs of the Company shall be managed and all Company powers shall be exercised by or under the direction of a "**Board of Managers**" (each member of such Board of Managers, a "**Manager**" and all Managers collectively, the "**Board**"), which, as a body, shall have the authority of a "**manager**," as that term is defined in the Act.

(b) The Board shall consist of three (3) Managers. The Managers shall be as set forth on Exhibit B hereto. Subsequent Managers shall be elected by the Members.

(c) If the District is the only Member, the selection, term and removal of Managers shall be governed by this Section (c):

(i) The District shall appoint the Managers.

(ii) Each Manager shall serve for an indefinite term.

(iii) A Manager may resign at any time by notice to the other Managers. A notice of resignation shall be immediately effective, or shall take effect at such later time as may be specified in the notice of resignation.

(iv) The District may at any time remove any Manager. A notice of removal shall be immediately effective, or shall take effect at such later time as may be specified in the notice of removal.

(v) In the event of a vacancy in the office of a Manager, whether due to removal, resignation, death or other cause, the District may appoint a Manager to succeed to the office of such Manager.

(d) If there are Members other than or in addition to the District , the selection, term and removal of Managers shall be governed by the provisions of this Section 10.1:

(i) The Members shall elect the Managers by cumulative voting, whereby: (A) each Member shall have a number of votes equal to the product of the number of Units held by the Member multiplied by seven (7); (B) a Member may combine and cast votes for Board nominees in any way the Member determines to be appropriate (including the casting of fractional votes); and (C) the three (3) nominees receiving the highest numbers of votes shall be the Managers.

(ii) Each Manager shall serve an indefinite term commencing immediately following his or her election as Manager and continuing until his or her resignation, death or the election of his or her successor. There shall be no limit as to the length of time a person may serve as Manager or as to the number of times a person may be elected or re-elected as Manager.

(iii) A Manager may resign at any time by notice to such effect to the other Managers. A notice of resignation shall be immediately effective, or shall take effect at such later time as may be specified in the notice of resignation.

(iv) Any Member having voting power sufficient to elect at least one Manager in an election in which three (3) Managers are to be elected may call an election for Managers, by notice to the Chair and the other Members. Within three (3) business days of the receipt of a notice of resignation or a call for election, the Chair shall schedule an election for Managers by notice to the Members (provided that if the Chair has resigned, the Member holding the largest number of Units shall schedule the election and shall simultaneously with notice thereof appoint a person to serve as Secretary of Elections, who shall thereupon carry out all acts otherwise to be performed by the Chair relative to the election until a Chair is appointed). The election shall be scheduled to take place not less than seven (7) nor more than fifteen (15) business days after the notice of resignation or call for election. At any election of Managers, the Members shall elect or re-elect three (3) Managers. Within five (5) business days of receipt of the notice of election, each Member having sufficient voting power to elect at least one (1) Manager shall submit to the

Chair a slate of nominees equal in number to the number of Managers that the Member has the power to elect. No later than two (2) days prior to the election, the Chair shall distribute a written ballot to each Member containing the names of all nominees duly submitted. The written ballot shall contain: (A) a space next to each nominee's name where a Member can enter the number of votes the Member desires to vote for a Member; and (B) a certification to be signed by the Member voting (or the Chief Executive Officer of a Member other than an individual) certifying that the votes reflected on the ballot are in fact the votes of the Member.

(e) The Board shall meet at least quarterly. At any meeting at which a quorum is present, the vote of a majority of the Managers present and voting shall constitute the act and decision of the Board, provided, that the Board may approve the following matters only by Supermajority Approval:

(i) A sale of all or substantially all of the assets of the Company, including the filing of any petition or amended petition in bankruptcy (or state law insolvency proceeding) having as its objective the liquidation of the Company;

(ii) A merger or consolidation of the Company;

(iii) Close or relocate any Ambulatory Surgical Clinic or open a new Ambulatory Surgical Clinic or other location at which health care services are rendered;

(iv) Change the purposes of the Company to include the conduct of any business or activity other than the conduct of an Ambulatory Surgical Clinic;

(v) Call for additional Capital Contributions, but only if the dollar amount of the call, when added to the dollar amount of all calls for additional Capital Contributions in the prior twelve (12) months, exceeds One Hundred Thousand Dollars ($100,000);

(vi) Approve the transfer of Units, issue new Units 'or admit a new Member;

(vii) Dissolve the Company;

(viii) Enter into any transaction with a Member, Manager or Affiliate of either, or with any officer of any Member, Manager or Affiliate of either, including the payment of any compensation or perquisite or other economic benefit of any kind whatsoever, directly or indirectly, provided, that Supermajority Approval shall not be required for: (A) any loan, sale or other transaction otherwise expressly provided for or permitted herein without Supermajority Approval; or (B) the reimbursement of expenses reasonably incurred by a Member, Manager or Affiliate of either, or officer of a Member, Manager or Affiliate of either, in the conduct of Company business, so long as pursuant to rules and procedures adopted with Supermajority Approval; and

(ix) Pay any compensation or perquisite or other economic benefit of any kind whatsoever to any officer of the Company, provided, that no Administrator appointed pursuant to Section 10.4 shall be regarded as an officer.

(f) The presence of a majority of the Managers then serving shall constitute a quorum for the transaction of business.

(g) Meetings of the Board may be called at any time by any Manager. Meetings of the Board may be held at any place within the Territory selected by the Manager calling the meeting. Notice of the time and place of meetings of the Board shall be given to each Manager pursuant to Section 15.1 at least five (5) business days prior to the time of the holding of a meeting. The Chair shall prepare and update, as necessary a Schedule of the notice addresses of all Managers and distribute copies of the same to the Managers. Notice of a meeting shall specify the general purpose of the meeting and, if any Manager present at a meeting so demands, no other business may be conducted at the meeting. Any shareholder of the Corporation and any officer of the District shall be entitled to attend meetings of the Board and, upon notice to the Chair to such effect, to receive notices of meetings of the Board given pursuant to this Section (g) and Section 15.1.

(h) The Board may meet, and any Manager may participate in a meeting, regardless of how held, by means of conference telephone or similar communications equipment, so long as all Managers participating in the meeting can hear and be heard by all other Managers participating in the meeting. Participation by means of conference telephone or similar such other equipment shall constitute attendance in person at such meeting.

(i) Except as otherwise provided in Section 10.4, concerning the appointment of Administrators, and Section 10.6, concerning the adoption of budgets, any action required or permitted to be taken at a meeting of the Board may be taken without a meeting provided that a consent or consents in writing, setting forth the action so taken, shall be signed by a majority of all Managers then in office, provided that any action that can be taken by the Board only with Supermajority Approval may be takin by written consent only if signed by Managers constituting a Supermajority Approval. Action taken by written consent under this section is effective when the requisite number of Managers have signed the consent, unless the consent expressly specifies a subsequent effective date.

10.2 Member Voting; Limitations on the Authority of Members. Except for the authority to appoint Managers and to exercise such other power and authority as are reserved to the Members by law or by this Agreement, no Member, in the capacity of a Member, shall have authority to direct, supervise or control the business and affairs of the Company, to represent the Company before third parties or to bind the Company to any contract or other commitment. Each Member shall indemnify the Company and hold it harmless from and against any and all costs, damages, claims and liabilities incurred by the Company as a result of the unauthorized action of such Member. Except as otherwise expressly provided herein whenever any matter is subject to the approval, consent or vote of the Members, the vote of a Member holding (or Members collectively holding) a majority of the issued and outstanding Units shall constitute the vote, consent or approval of the Members. A Member may exercise its voting power by written consent signed by the Member or, as to any Member that is an entity, by its chief executive officer (or person holding a comparable office). Notwithstanding the foregoing, except as otherwise set forth herein (including the rights of a non-Breaching Member or Members to cause a dissolution of the Company pursuant to the provisions of Section 11.3(b)), the Members may approve an amendment of the Articles or this Operating Agreement, or any matter that requires a Supermajority Approval

of the Board to be effective, only if approved by a Member or Members holding at least two-thirds (2/3's) of the issued and outstanding Units.

10.3 Chair, Other Officers. The Board shall designate one of the Managers to serve as Chair. The Board may, but need not, appoint one or more other officers, with such titles and with such standing or special authority as the Board may delegate (provided that an Administrator shall for no purposes hereof be deemed an officer). Any such officers other than the Chair may, but need not, be Managers. The Chair shall preside at all meetings of the Board at which he or she is present and, in the absence of a Board determination to the contrary, the Chair shall have general authority to sign agreements, instruments and other documents in the name and on behalf of the Company and to bind the Company thereto. In the event the Chair will not attend one or more meetings of the Board, the Chair shall have authority to designate another Manager to serve as vice Chair and preside at such meetings. Notwithstanding any other provision of this Agreement, the authority of the Chair and all other officers appointed by the Board shall be subject at all times to the supervision, direction and control of the Board. The Chair and all other officers appointed by the Board shall serve at the pleasure of the Board and the Board may remove and terminate the status of any officer of the Company, as such, at any time, subject to such rights, if any, of any such officer under any contract he or she may have with the Company.

10.4 Administrator. For each Ambulatory Surgical. Center, the Board shall appoint an Administrator who shall be a full time employee of the Company, provided that a single individual may serve as Administrator for more than one Ambulatory Surgical Center, and provided further that the Board may only appoint an Administrator at a duly convened meeting of the Managers and only after affording each Manager present at the meeting a reasonable opportunity to express his or her views on the matter. The Administrator shall have general authority and responsibility for the day-to-day management of each Ambulatory Surgical Center as to which he or she has been appointed, subject always to the supervision, direction and control of the Board. In addition, in the event that the Board appoints one or more officers and delegates authority to one or more of such officers that overlaps or conflicts with the authority delegated to the Administrator, the Administrator's exercise of such authority shall at all times be subject to the supervision, direction and control of the officer or officers having such overlapping or conflicting authority. Day-to-day management shall include, but is not necessarily limited to:

(a) Responsibility and authority to enter into contracts on behalf of the Company unless the Company's obligations under such a contract exceeds $10,000 in any twelve (12) month period, or is a payor contract, in which the Administrator shall not enter into such contract without Board approval (notwithstanding the foregoing, the Board hereby approves and assumes the assignment and continuation of the agreements listed on Exhibit 10.4);.

(b) Subject to the Company's employment policies and procedures, the responsibility and authority to hire, train, supervise, and discharge all non-Physician employees working for the Company;

(c) Responsibility and authority to promulgate and administer surgery scheduling policies and guidelines;

(d) Such other activities as are customarily delegated to the senior executive of an ambulatory surgical center; and

(e) Regularly reporting to the Board on the performance of management responsibilities.

10.5 Quality Committee. The Board shall establish and maintain and designate the membership of (except as otherwise set forth below) a Quality Committee, which shall have general day-to-day oversight of clinical operations at the Facility (subject always to the supervision, direction and control of the Board). The members of the Quality Committee shall consist of: (i) at least two (2) surgeons each of whom shall: (A) be appointed by the Board; (B) be board certified in orthopedic surgery; and (C) maintain active staff privileges at the Facility and at the District's acute care hospital; (ii) one (1) anesthesiologist or nurse anesthetist who shall: (A) be appointed by the Board; and (B) maintain an active anesthesia practice in the Territory and active staff privileges at the Facility; (iii) one (I) member appointed by the Corporation; and (iv) one (1) member appointed by the District. A majority of the members of the Quality Committee shall constitute a quorum for the conduct of business. Meetings of the Quality Committee may be set to occur at a regular time and place established by the Committee (and such regular meetings shall require no further notice) and may also be called by any member of the Quality Committee under the same general provisions as set forth herein for calling meetings of the Board, except that such notice need not specify the purpose of the meeting. Among the committee's responsibilities shall be:

(a) Oversight of medical staff matters, including credentialing and peer review;

(b) Development and implementation of quality improvement and utilization management policies and procedures for Board approval, and implementation of such approved policies and procedures;

(c) Review and make recommendations relating to changes in services to be provided at the Facility;

(d) Advising and making recommendations to the Board on equipment needs, and specification of equipment to be purchased by the Company, subject to approved budgets;

(e) Development of scheduling policies and guidelines, including assignment of surgical blocks, for Board approval; and

(f) Regularly reporting to the Board on the performance of the committee's oversight of clinical operations.

10.6 Budgets. The Board, in consultation with the Administrator or Administrators, shall prepare and adopt an annual budget for the Company (the "**Annual Budget**") for each Fiscal Year. No later than sixty (60) days prior to the first day of the period covered by such budget, an Annual Budget for such year shall 'be presented to the entire Board for review, comment and approval. Notwithstanding any other provision hereof, the Board shall approve an Annual Budget only at a duly convened meeting and only after first affording each Manager present a reasonable

opportunity to express his or her views on the matter. Each Annual Budget shall cover both operating expenses and capital expenditures, and shall include, at a minimum, the. following:

(a) A projected annual income statement (accrual method) on a month-by-month basis;

(b) A description of any proposed capital expenditures, including projected dates for commencement and completion of the foregoing;

(c) A description of the proposed investment of any funds of the Company which are (or are expected to become) available for investment; and

(d) A description, including the identity of the recipient (if known) and the amount and purpose of all fees and other payments proposed or expected to be paid for services rendered to the Company by third parties and which the Board anticipates will exceed $10,000 as to any one recipient in the applicable Fiscal Year.

10.7 Tax Matters Member. The Board shall designate a Member to serve as the "**Tax Matters Member**." Except as specifically set forth in this Section 10.7, all rights and powers delegated to the Tax Matters Member by the Code shall be exercised only after approval by the Board pursuant to Section 10.1. Without approval by the Board, the Tax Matters Member shall have the following duties and authority with respect to the Company:

(a) Furnish the name, address, profits interest and taxpayer identification number of each Member to the IRS;

(b) Keep each Member and Manager informed of the administrative and judicial proceedings for the adjustment of any item required to be taken into account by a Member for income tax purposes; and

(c) Within five (5) days of receiving a notice of a Company audit by the IRS, forward a copy of such notice to each Member and each Manager.

The Company shall indemnify and reimburse the Tax Matters Member for all expenses, including legal and accounting fees, claims, liabilities, losses and damages incurred in connection with any administrative or judicial proceeding with respect to the tax liability of the Members and against any and all loss, liability, cost or expense, including judgments, fines, amounts paid in settlement and attorneys' fees and expenses, incurred by the Tax Matters Member in any civil, criminal or investigative proceeding in which the Tax Matters Member is involved or threatened to be involved solely by virtue of being Tax Matters Member, except such loss, liability, cost or expense arising by virtue of the Tax Matters Member's gross negligence, fraud, malfeasance, breach of fiduciary duty or intentional misconduct, or that is not authorized by the Board as required by this Agreement. The payment of all such expenses shall be made before any distributions are made.

10.8 Medical Director. The Corporation shall use best efforts to locate and identify a duly licensed and qualified physician to serve as Medical Director for the Company in accordance

with the form of agreement referenced in Sections 6.6 and 7.10 of the Transfer Agreement, with such changes and modifications thereto as the Board of Managers determine to be appropriate.

ARTICLE XI
TRANSFER OF UNITS IN THE COMPANY; REDEMPTION OF UNITS

11.1 Transfer of Units. Unless allowed elsewhere in this Agreement, a Member may not sell, assign or otherwise transfer any or all of the Units owned by it or any interest in a Unit, unless each of the requirements set forth below is met, and any sale, assignment or other transfer of a Unit in violation of this Section 11.1 shall be null and void and of no force or effect, and shall not be recognized by the Company as having any effect whatsoever.

(a) The Board, with Supermajority Approval, shall have approved and consented in writing to the sale, assignment or transfer of a Unit, which consent and approval may be granted, conditioned, delayed or withheld in the Board's reasonable discretion, except that, without such consent and approval: (i) a Member may transfer Units to a Person so long as such Person is wholly owned by the transferring Member, and such Person agrees to be bound by all of the provisions of this Agreement and such additional provisions, if any, that the non-transferring Member reasonably may require in order not to result in loss of any the rights, powers and authority of the non-Transferring Member hereunder; (ii) the Corporation may distribute Units to its shareholders so long as the shareholders agree to be bound by all of the provisions of this Agreement and such additional provisions, if any, that the District reasonably may require in order not to result in loss of any rights, powers and authority of the District hereunder; and (iii) the District and the Corporation may transfer Units to each other.

(b) Notwithstanding the preceding sentence, any purported sale, assignment, or transfer of any Unit or the admission of any Person as a substituted Member that would, in the opinion of counsel to the Company, result in any of the following shall be impermissible unless approved by all the Managers:

(i) A termination of the Company within the meaning of the Code;

(ii) A violation of any applicable federal or state law; or

(iii) The sale, assignment or transfer of any Unit to, or the admission of, any Person involuntarily excluded or suspended from participation in any federal or state healthcare program, such as Medicare or Medicaid.

(c) The transferring Member and its purchaser, assignee or transferee must execute and deliver to the Company such instruments of transfer and assignment with respect to such transaction as are in form and substance satisfactory to the Managers, including, without limitation, the written acceptance and adoption by such transferee of the provisions of this Agreement.

(d) Such transferee or Member must pay the Company a transfer fee which is sufficient to pay all reasonable expenses of the Company in connection with such transaction.

11.2 Substituted Members. Any purchaser, assignee or transferee of a Unit in accordance with the provisions of Section 11.1 may become a substituted Member within the meaning of the Act only if:

(a) The Board, with Supermajority Approval, has consented in writing to such Person becoming a substituted Member, which consent may be granted, conditioned, delayed or withheld in the Board's sole, absolute and arbitrary discretion;

(b) Such Person executes and delivers such agreements, instruments and other documents that the Company may deem necessary or advisable to effect the admission of such Person as a substituted Member, including, without limitation, the written acceptance and adoption by such Person of the provisions of this Agreement;

(c) Such Person pays a transfer fee to the Company which is sufficient to cover all reasonable expenses connected with the admission of such Person as a substituted Member within the meaning of the Act.

Upon satisfaction of these conditions, the Board shall take any other steps which, in the opinion of the Board, are reasonably necessary to admit such Person as a substituted Member under the Act.

11.3 Redemption of Units. A Member shall have the right to cause the Company to redeem the Units of another Member as follows:

(a) If there is a transfer or issuance of shares of the Corporation in violation of the Shareholders Agreement, as the same is being amended in accordance with the Transfer Agreement (an "**Unapproved Transfer**"), and the Corporation fails to redeem the shares acquired by the transferee in the Unapproved Transfer within sixty (60) days of the District's notice to the Corporation of the Unapproved Transfer, the District shall have the right to cause the Company to redeem a portion of the Units then held by the Corporation. The number of Units that will be subject to redemption shall be the product of (i) the ratio that the number of shares involved in the Unapproved Transfer bears to the total number of shares of the Corporation outstanding as of the date of the Unapproved Transfer, multiplied by (ii) the number of Units then held by the Corporation. For example, if 10% of the outstanding shares of the Corporation are involved in an Unapproved Transfer and the Corporation at that time owns 49 Units out of a total of 100 outstanding Units, the District shall have the right to cause a redemption of 10% of the Units held by the Corporation, or 4.9 Units. Notwithstanding the foregoing, the Corporation's failure to redeem shares acquired by a transferee in an Unapproved Transfer shall not be deemed a breach of this Agreement for purposes of Section (b). In the event of an Unapproved Transfer, the District shall exercise its rights hereunder, if at all, within sixty (60) days after the Corporation's failure to redeem the shares acquired by the transferee in the Unapproved Transfer. The redemption price of each Unit repurchased by the Corporation pursuant to this Section (a) shall be fair market value, as determined pursuant to Section (c), payable in accordance with the terms and conditions set forth in Section (c).

(b) If a Material Adverse Event (as defined below) occurs with respect to a Member (the "**Breaching Member**"), any non-Breaching Member shall have the right to cause

the Company to redeem all of the Units then held by the Breaching Member by notice given to the Breaching Member and any other Members within sixty (60) days of the date that the non-Breaching Member first becomes aware of the Material Adverse Event, provided, that if, a Member or Members holding not less than a majority of the issued and outstanding Units, without regard to any Units then held by the Breaching Member, determine, either before or within thirty (30) days after the issuance of such a notice of redemption, to dissolve the Company, then, in lieu of a redemption of Units as aforesaid, the Company shall be dissolved pursuant to Section 12.1. In the event of a redemption of Units under this Section (b), the redemption price shall be sixty percent (60%) of fair market value, as determined pursuant to Section (c), payable in accordance with the terms and conditions set forth in Section (c). Notwithstanding any other provision hereof, the occurrence of a Material Adverse Event with respect to any shareholder of the Corporation shall not, in and of itself, be deemed a Material Adverse Event as to the Corporation, provided that the involuntarily exclusion or suspension of a shareholder of the Corporation from participation in any federal or state healthcare program, such as Medicare or Medicaid, shall constitute a Material Adverse Event as to the Corporation, unless such shareholder's ownership of shares in the Corporation is entirely terminated within sixty (60) days of such involuntary exclusion or suspension. For purposes of this Section (b), a **"Material Adverse Event"** shall mean and include each of the following:

(i) Any sale, assignment or transfer (or purported sale, assignment or transfer) of Units in violation of this Agreement;

(ii) The involuntary exclusion or suspension of a Member from participation in the Medicare program;

(iii) The conviction of a felony;

(iv) A breach of this Agreement and failure to cure such breach within thirty (30) days of notice of such breach given to the Breaching Member by any non-Breaching Member, or such longer period as may reasonably be required to cure such breach, but only so long as the breach is one that may be cured and the Breaching Member promptly commences and diligently prosecutes such cure; or

(v) The filing of a petition for relief under the Bankruptcy Code that is not dismissed within ninety (90) days of filing.

(c) For purposes of this Section 11.3, fair market value shall be determined by appraisal by an appraiser or appraisers knowledgeable in the valuation of ambulatory surgical centers. The Members shall endeavor to agree upon an appraiser to determine fair market value, but in the event the Members are unable to agree upon an appraiser within thirty (30) days after a Member's notice of exercise of its rights under this Section 11.3, then any Member may, upon notice to the other Member, select an appraiser and the other Member also may, upon notice to the first Member given within thirty (30) days of the first Member's notice, select another appraiser. If one appraiser has been selected, that appraiser shall determine fair market value. If one appraiser is selected, the Company and the Members each may have separate written communications with the appraiser, provided that the party making a written communication shall provide a copy of the same to the other parties, but no party otherwise shall separately communicate with the Appraiser

without the other parties being present. If two appraisers have been selected and both make a determination of fair market value within sixty (60) days of the date of the second notice appointing an appraiser, then fair market value shall be the average of the two appraisals so long as the lower valuation is within ten percent (10%) of the higher valuation and, if not, then the two appraisers shall, as soon as practicable, appoint a third appraiser whose sole function shall be to select which of the first two appraisals most closely approximates fair market value. Each Member shall bear the fees and expense of any appraiser selected by it, and one-half of the costs and expenses of any third appraiser appointed. Payment for the redemption price of Units redeemed pursuant to this Section 11.3 shall be made as follows: twenty percent (20%) on the initial payment date (the "**Initial Payment Date**"), which shall be within ninety (90) days after determination of the Redemption Price, and the remainder in four equal installments each payable on the first and following anniversaries of the Initial Payment Date, with interest on the outstanding principal balance accruing at the Prime Rate shown in the Money Rates Section of the Wall Street Journal on the first business date of the month in which the Initial Payment Date occurs. Notwithstanding payment of the redemption price in installments as aforesaid, the effective date of redemption hereunder shall be the Initial Payment Date, with all rights, powers and interests of a • Member with respect to the Units being redeemed hereunder terminating as of the Initial Purchase Date. Notwithstanding any other provision hereof, in the event of a redemption or redemptions of Units pursuant to Sections (a) and/or (b), the Company shall have no obligation to make aggregate payments in redemption of Units in any year in excess of seven and one-half percent (7.5%) of the Company's cash collections in such year. In any year in which redemption payments are owing to a former Member or Members, the Board shall determine if the foregoing limit is likely to apply based on the Board's estimates of likely cash collections, and the Board shall provide for the reduction of redemption payments otherwise payable in such year so as not to exceed seven and one-half percent (7.5%) of the Board's estimates of cash collections. If payments are so restricted in any year, payments owing to each former Member in such year shall be reduced pro rata, based on the ratio that the aggregate redemption payments otherwise owing to each former Member bears to the aggregate redemption payments owing to all such former Members. If redemption payments are so reduced in any year, the Board shall cause a determination to be made of actual cash collections in such year within thirty (30) days of year end, and if actual cash collections in such year exceed the Board's estimate for purposes of this Section (c), the Board shall, promptly after such determination is made, cause additional payments to be made to the former Member or Members whose payments were reduced, but not more than seven and one-half percent (7.5%) of the excess of actual cash collections over the Board's estimate, or the amount of the reductions, if less. Any reduction in payments made in a year pursuant to this Section (c) shall be deferred to the following year or years, until such amounts can be paid without exceeding seven and one-half (7.5%) of cash collections pursuant to this Section (c).

11.4 Buyout of Jeff Dodd. Notwithstanding anything else herein to the contrary, if the legal requirements of physician ownership are no longer necessary, if the Company dissolves or closes down, or anytime upon demand of Buyer, Tahoe Forest Hospital District, a California local health care district, shall buy out Buyer's interest in the Company for Buyer's initial investment in the Company ($5,000.00) plus 0.666% interest, compounded monthly (approximately 8% APR), calculated from the date of this Agreement.

ARTICLE XII
DISSOLUTION AND WINDING UP OF THE COMPANY

12.1 Dissolution of the Company. The Company will be dissolved upon the occurrence of any of the following events:

(a) The sale, exchange or other transfer of all or substantially all of the assets of the Company;

(b) The Supermajority Approval of the Board and consent of a Member or Members holding two-thirds of the outstanding Units;

(c) The decision of a non-Electing Member or Members to dissolve the Company pursuant to Section 4.2 following an election of the Electing Member to cause a redemption of its Units;

(d) The determination of a non-Breaching Member or Members holding a majority of the outstanding Units (without regard to Units held by a Breaching Member) pursuant to Section 11.3(b); or

(e) The entry of a decree of judicial dissolution pursuant to Corporations Code Section 17351 or the issuance of a certificate of dissolution pursuant to Corporations Code Section 17356.

12.2 Winding Up of the Company. Upon the dissolution of the Company, the Board shall take full account of the Company's assets and liabilities, and the assets shall be liquidated as promptly as is consistent with obtaining the fair value thereof. Provided that each Member is given an equal and fair opportunity to bid on the purchase of Company assets, nothing herein shall be deemed to preclude the sale of any, or of all or substantially all of the assets of the. Company to a Member or Members, provided that the same is consistent with obtaining the fair value thereof, or the most favorable price reasonably obtainable by the Company under the circumstances. During the dissolution and winding up of the Company, Profits and Losses shall .be allocated among the Members as provided in ARTICLE IX. The proceeds from the sale or other disposition of the Company's assets shall be applied to payment of all Company debts, obligations and liabilities (or creating adequate reserves therefor), and the remaining proceeds shall be distributed to the Members in accordance with their ending positive Capital Account balances after all allocations and any other Capital Account adjustments for the Fiscal Year are made.

12.3 Certificate of Dissolution. Upon the dissolution and commencement of the winding up of the Company, the Board shall cause a Certificate of Dissolution to be executed on behalf of the Company and filed with the Secretary of State. After all debts, liabilities, and obligations have been paid and discharged (or adequate provision made therefore) and all of the assets have been distributed to the Members, the Board shall cause a Certificate of Cancellation to be executed on behalf of the Company and filed with the Secretary of State. The Members and the Managers, as necessary, shall execute, acknowledge and file any and all other instruments necessary or appropriate to reflect the dissolution of the Company.

ARTICLE XIII
BOOKS OF ACCOUNT, ACCOUNTING, REPORTS, FISCAL YEAR, BANKING AND TAX ELECTION

13.1 Books of Account. The Company's books and records (including a current list of the names and addresses of all Members) and an executed copy of this Agreement, as currently in effect, shall be maintained at the principal office of the Company, and each Member shall have access thereto at all reasonable times. The books and records shall be kept by the Company using a recognized and appropriate method of accounting consistently applied as selected by the Board. The Company shall also keep adequate federal income tax records using an appropriate method of accounting applied on a consistent basis.

13.2 Financial Reports. As soon as reasonably practicable after the end of each Fiscal Year, but not later than one hundred twenty (120) days after the end of each Fiscal Year, the Board shall cause to be prepared and delivered to each Member an unaudited balance sheet of the Company as of the last day of such Fiscal Year and unaudited statements of income or loss of the Company for such year. In addition, the Company will make available to the Members as soon as is practicable unaudited quarterly summaries of its operations. All such financial statements shall be prepared on the basis of such method of accounting, consistently applied, as the Board shall determine. The Company shall also furnish to each Member not later than the last day of the month immediately preceding that in which a Member is obligated to file a federal income tax return whatever information may be necessary for such Member to file such return. The Company will also make available to each Member a copy of all state and/or local tax returns that are filed by the Company. The Company will make available to the Members any audited balance sheet of the Company, if one has been prepared.

13.3 Fiscal Year. The fiscal year of the Company shall end on such date that the Board shall determine.

13.4 Tax Election. Upon the transfer of an interest in the Company or in the event of a distribution of the Company's property, the Company may, but is not required to, elect pursuant to Code Section 754 to adjust the basis of the Company's property as allowed by Sections 734(b) and 743(b) thereof.

13.5 Tax Returns. The Board shall file or cause to be filed with the appropriate taxing federal, state and local tax authorities all returns, reports and other documentation lawfully required of the Company within the times prescribed by law (including any extensions) for such filings. Tahoe Forest Hospital District, a California local health care district, and Company shall pay for and be jointly and severally liable for Jeff Dodd's tax preparation costs incurred in conjunction with Jeff Dodd's ownership interest in the Company. Further, in the event that Jeff Dodd incurs a tax liability as a result of owning a membership interest in the Company, Tahoe Forest Hospital District and Company shall pay for and be jointly and severally liable for Jeff Dodd's tax liability resulting from Buyer's ownership interest in the Company.

ARTICLE XIV
LIABILITY AND INDEMNIFICATION

14.1 Liability. Except as otherwise expressly provided by the Act, the debts, obligations and liabilities of the Company, whether arising in contract, tort or otherwise, shall be solely the debts, obligations and liabilities of the Company, and no Manager, officer of the Company or Member shall be obligated personally for any such debt, obligation or liability of the Company solely by reason of being a Member, Manager or officer of the Company. Except as otherwise expressly required by law, a Member shall have no liability in excess of (a) the amount of its Capital Contributions, (b) its share of any assets and undistributed Profits, (c) its obligation, if any, in writing signed by the Member to make any other payments, and (d) the amount of any distributions wrongfully or erroneously distributed to the Member.

14.2 Exculpation. No Member, officer of the Company or Manager shalt be liable to the Company or any other Member, officer of the Company or Manager for any loss, damage or claim incurred by reason of any act or omission performed or omitted in good faith on behalf of the Company and in a manner reasonably believed by the Member, officer of the Company or Manager to be within the scope of authority conferred on the Member, officer of the Company or Manager by this Agreement, except that the foregoing shall not exclude or limit any Person's liability for willful misconduct. A Member, officer of the Company or Manager shall be fully protected in relying in good faith upon the records of the Company and upon such information, opinions, reports or statements presented to the Company by any Person as to matters the Member, officer or Manager reasonably believes are within such other Person's professional or expert competence and who has been selected with reasonable care by or on behalf of the Company, including information, opinions, reports or statements as to the value and amount of the assets, liabilities, profits, losses, or any other facts pertinent to the existence and amount of assets from which distributions to Members might properly be paid.

14.3 Duties and Liabilities of Covered Persons.

(a) If and to the extent that, at law or in equity, a Member, officer of the Company or Manager has duties (including fiduciary duties) and liabilities relating thereto to the Company or to any other Member, such Member, officer or Manager acting under this Agreement shall not be liable to the Company or to any other Member for its good faith reliance on the provisions of this Agreement.

(b) Unless otherwise expressly provided herein, (i) whenever a conflict of interest exists or arises between or among the Company, and any one or more Members, Managers or officers of the Company, or (ii) whenever this Agreement or any other agreement contemplated herein or therein provides that a Member, Manager or officer of the Company shall act in a manner that is, or provides terms that are, fair and reasonable to the Company or any Member, then the Member, Managers or officer of the Company shall resolve such conflict of interest, taking such action or providing such terms, under the principles set forth in Section 8.1 regarding contracts with Affiliates.

(c) Whenever in this Agreement a Member, Manager or officer of the Company is permitted or required to make a decision (i) in its "discretion" or under a grant of similar

authority or latitude without any further guidance, the Person shall exercise such discretion in the same manner as a reasonable business person under the same or similar circumstances, or (ii) in its "good faith" or under another express standard, the Person shall act under such express standard and shall not be subject to any other or different standard imposed by this Agreement or other applicable law.

14.4 Indemnification. To the fullest extent permitted by applicable law, each Member, Manager and the officer of the Company shall be entitled to indemnification from the Company for any loss, damage or claim incurred by such Person by reason of any act or omission performed or omitted by such Person in good faith on behalf of the Company and in a manner reasonably believed to be within the scope of authority conferred on such Person by this Agreement, except that no Person shall be entitled to be indemnified in respect of any loss, damage or claim incurred by such Person by reason of willful misconduct with respect to such acts or omissions; provided, however, that any indemnity under this Section 14.4 shall be provided out of and to the extent of Company assets only, and no Person other than the Company shall have any personal liability on account thereof.

14.5 Expenses. To the fullest extent permitted by applicable law, expenses (including legal fees) incurred by a Member, Manager or officer of the Company in defending any claim, demand, action, suit or proceeding (other than one brought by the Company) arising by reason of the fact that the Person is or was a Member, Manager or officer of the Company shall, from time to time, be advanced by the Company prior to the final disposition of such claim, demand, action, suit or proceeding upon receipt by the Company of an undertaking by or on behalf of the covered person to repay such amount if it shall be determined that the covered person is not entitled to be indemnified as authorized in Section 14.4 hereof.

14.6 Indemnity of Jeff Dodd. Notwithstanding any other term herein, the Company and Tahoe Forest Hospital District, a California local health care district, shall jointly and severally hold Buyer harmless from, and protect, defend, and indemnify Jeff Dodd from any and all civil, criminal, or administrative penalties, allegations, claims, damages, or causes of action arising out of or related to Jeff Dodd's ownership interest in the Company, including, but not limited to, those risks identified on Exhibit "B" DISCLOSURE STATEMENT attached to the Membership Interest Purchase Agreement executed between the parties.

14.7 Insurance. The Company may purchase and maintain insurance, to the extent and in such amounts as the Board shall, in its sole discretion, deem reasonable, on behalf of the Members, the Managers, officers of the Company and such other Persons as the Board shall determine, against any liability that may be asserted against or expenses that may be incurred by any such Person in connection with the activities of the Company or such indemnities, regardless of whether the Company would have the power to indemnify such Person against such liability under the provisions of this Agreement. The Managers and the Company may enter into indemnity contracts with any Persons and adopt written procedures pursuant to which arrangements are made for the advancement of expenses and the funding of obligations under Section 14.5 hereof and containing such other procedures regarding indemnification as are appropriate.

14.8 Ancillary Agreements. Notwithstanding anything to the contrary herein, the terms of agreements between a Member or its Affiliate and the Company regarding the duties and

obligations to be performed under such agreements and the indemnification provided for therein shall control with respect to such duties and obligations over the terms of this Agreement, including, without limitation, the terms of this ARTICLE XVI relating to indemnification, advancement of expenses, and exculpation of Members (e.g., a Member providing management services under a Management Agreement shall be responsible to the Company without reference to the exculpation provisions of this ARTICLE XVI).

ARTICLE XV
MISCELLANEOUS

15.1 Notices. Except as otherwise provided in this Agreement, any notice, payment, demand, request or communication required or permitted to be given by any provision of this Agreement shall be in writing and shall be duly given by the applicable party if given to the applicable party at its address or facsimile number set forth below:

If to the Company:	Truckee Surgery Center, LLC 10770 Donner Pass Road, Suite 201 Truckee, California 96161
If to the District:	Tahoe Forest Hospital District 10121 Pine Avenue Truckee, California 96161 Attn: Matt Mushet

or to such other address as the applicable party may from time to time specify by written notice to the Company; and

Any such notice shall, for all purposes, be deemed to be given and received:

(a) If given by facsimile, when the facsimile is transmitted to the party's facsimile number specified above and confirmation of complete receipt is received by the transmitting party during normal business hours on any business day or on the next business day if not confirmed during normal business hours;

(b) If by hand, when delivered;

(c) If given by nationally recognized and reputable overnight delivery service, the business day on which the notice is actually received or delivery refused by the party as evidenced by a receipt from such delivery service; or

(d) If given by certified mail, return receipt requested, postage prepaid, five business days after posted with the United States Postal Service.

15.2 Section Captions. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

15.3 Severability. Every provision of this Agreement is intended to be severable. If any term or provision of this Agreement is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.

15.4 Waiver of Action for Partition. Each Member irrevocably waives during the term of the Company and during the period of its liquidation following any dissolution, any right to maintain any action for partition with respect to any of the assets of the Company.

15.5 Counterpart Execution. This Agreement may be executed in one or more counterparts all of which together shall constitute one and the same Agreement.

15.6 Parties in Interest. Except as otherwise provided in this Agreement, this Agreement shall be binding upon the parties hereto and their successors, heirs, devisees, assigns, legal representatives, executors and administrators.

15.7 Compliance with Laws. The Members agree that all business activities and operations of the Company shall conform, and shall continue to conform, with applicable provisions of law including the Ethics in Patient Referral Act, 42 U.S.C. Section 1395nn *et seq.*, and the Anti-Kickback Statute, 42 U.S.C. Section 1320a-7b(b) and any similar California statutes, rules and regulations, including, but not limited to California Business and Professions Code § 650, *et seq.* and California Welfare and Institutions Code § 14107.2.

15.8 Construction of Pronouns. The feminine or neuter of the words "he," "his" and "him" used herein shall be automatically deemed to have been substituted for such words where appropriate to the particular Person, Manager or Member.

15.9 Integrated Agreement. This Agreement, including the Exhibits, constitutes the entire understanding and agreement among the Members in their capacity as Members with respect to the Company, and there are no agreements, understandings, restrictions, representations or warranties among the parties relating thereto other than those set forth herein or herein provided for.

15.10 Time is of the Essence. Time is of the essence to this Agreement and to each and all of its provisions.

15.11 Legal Counsel. The Company may benefit from legal services provided by legal counsel to one or more of its Members. Such benefits, no matter how direct, exclusive and intended, shall not cause any Member legal counsel to have any attorney-client relationship with the Company and shall not give rise to any obligation on behalf of the Company to pay a Member's legal fees. The Members are each sophisticated business organizations who have agreed to this Section 15.11 out of each Member's desire to (a) avoid the expense, inexperience, inefficiency and burden of engaging entirely separate counsel to provide legal services to the Company, and (b) maintain a relationship with their own legal counsel that is untainted by conflicts of interest, so that such counsel may advise them of their rights and duties respecting the other Members and the Company, notwithstanding that such counsel may have provided legal services that directly, exclusively and intentionally benefited the Company. Nothing herein shall prevent the Company from engaging separate and independent counsel when and as determined to be appropriate by the Board.

15.12 No Conflict. Each Member represents and warrants to the Company and to the other Member that such Member will not be in breach of any agreement, contract, decree, judgment or any other item binding such Member by reason of entering into this Agreement or fulfilling such Member's duties under this Agreement or as a Member. Each Member indemnifies and holds harmless, and will defend, the Company, each other Member, and the agents of either, from and against any cost, damage, loss or expense (including but not limited to actual attorneys' fees) arising from the inaccuracy of any of the representations and warranties set forth in this Section 15.12.

15.13 Amendment. This Agreement may be amended only by a written instrument approved by the unanimous written consent of all Members.

ARTICLE XVI
DISPUTE RESOLUTION PROCESS

16.1 Overall Scope. Except as otherwise expressly provided, this ARTICLE XVI shall apply to all disputes between the Members under this Agreement, including, without limitation, any dispute as to the existence or alleged existence of a breach of this Agreement for purposes of Section 11.3 hereof.

16.2 Purpose and Interpretation. It is the Members' intent that their disputes be resolved in an efficient and timely manner, and to limit the disruption and expense involved in resolving disputes, so that they may cooperatively contribute to improving healthcare delivery and controlling health care costs. Accordingly, in interpreting and applying the provisions of this ARTICLE XVI, the Members, and any Court of competent jurisdiction shall be guided by, and endeavor to support, the Members' agreement and goal to engage in as streamlined an approach to dispute resolution as possible given the nature of the dispute between them.

16.3 Meet and Confer. In the event of any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity hereof, the Members agree to meet and confer for a period of thirty (30) days (or such longer period as is mutually agreed upon) promptly upon a written request by any Member to resolve such dispute claim or controversy. At each meet and confer meeting, each Member shall be represented by persons with authority to finally resolve the dispute. Meet and Confer discussions and all documents prepared for those discussions such as agendas, spreadsheets, chronologies and the like shall not be subject to discovery, offered as evidence or admitted in evidence in any proceeding for any purpose. It is the Members' intent that their meet and confer proceedings be frank and open, and that they be protected to at least the same degree as they would be if they were conducted through a mediator and subject to California Evidence Code Division 9, Chapter 2; as well as California Evidence Code sections 1152 and 1154. The failure to conduct a meet and confer shall not be grounds to dismiss an action initiated by any Member(s) to resolve any dispute, but it shall constitute grounds to stay the action proceedings until, in the discretion of the Court, the meet-and-confer process is complete.

16.4 Binding Arbitration. If the parties are not able to resolve their dispute, claim or controversy pursuant to the above meet and confer process within forty-five (45) days of the initial request under Section 16.3, or within a time frame mutually agreed upon by the Parties, then either

party may, by notice to such effect to the other party, submit the dispute, claim or controversy to binding arbitration before a retired judge or attorney arbitrator with at least 10 years of experience with the arbitration held in Truckee, California. The parties shall have the right to conduct discovery in accordance with the provisions of Section 2020 *et seq.* of the California Code of Civil Procedure. The arbitrator shall apply the substantive laws of the State of California applicable to contracts negotiated, executed and performed entirely within its borders. Either party shall have the right to appeal decisions of the arbitrator on questions of law to the Superior Court. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude the parties from seeking equitable relief from a court of appropriate jurisdiction. The arbitrator may, in the Award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

[Remainder of Page Intentionally Left Blank]
[Signature Page Follows]

IN WITNESS WHEREOF, this Agreement has been executed as of the date first above written.

"DISTRICT"	**"COMPANY"**
TAHOE FOREST HOSPITAL DISTRICT	**TRUCKEE SURGERY CENTER, LLC**
By: ______________________________	By: ______________________________
Print Name: ______________________________	Print Name: ______________________________
Title: ______________________________ its authorized signatory	Title: ______________________________ its authorized signatory

"JEFF DODD"

Jeffrey Dodd, M.D.

By: ______________________________

Print Name: ______________________________

EXHIBIT A

SCHEDULE OF MEMBERS, CAPITAL CONTRIBUTIONS, UNIT OWNERSHIP, AND PERCENTAGE INTERESTS

Name	Capital Contributions	Units	Percentage Interests
Tahoe Forest Hospital District	[Add TFHD contributions]	99	99%
Jeff Dodd		1	1%

<u>EXHIBIT B</u>

INITIAL MANAGERS

Harry Weis
Crystal Betts
Judy Newland

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2022-07

RESOLUTION TO UPDATE THE BOARD OF MANAGERS OF THE TRUCKEE SURGERY CENTER, LLC

WHEREAS, TAHOE FOREST HOSPITAL DISTRICT ("District") is a hospital district duly organized and existing under the "Local Health Care District Law" of the State of California; and

WHEREAS, DISTRICT is a Ninety-Nine Percent (99%) owner of Truckee Surgery Center, LLC ("TSC");

WHEREAS, Exhibit "B" of the Operating Agreement of TSC lists the Managers as Harry Weis, Crystal Betts, and Judy Newland;

WHEREAS, Judy Newland is retiring from District and stepping down from her Manager role with TSC;

WHERAS, District as majority owner in TSC would like to replace the existing named Managers with the current executive positions that serve as officers for the District;

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District elects to replace the names on Exhibit "B" of the Operating Agreement with the titles of CEO, CFO and COO of District.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 24th day of March, 2022 by the following vote:

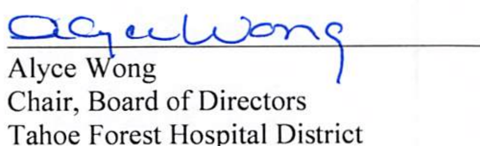
AYES: Barnett, Chamblin, McGarry, Brown, Wong

NOES: none

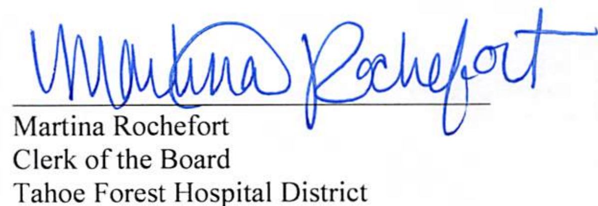
ABSENT: none

ABSTAIN: none

ATTEST:



Alyce Wong
Chair, Board of Directors
Tahoe Forest Hospital District



Martina Rochefort
Clerk of the Board
Tahoe Forest Hospital District

TRUCKEE SURGERY CENTER, LLC
MEDICAL STAFF BYLAWS

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TRUCKEE SURGERY CENTER, LLC MEDICAL STAFF BYLAWS
PREAMBLE

These bylaws create a structure to provide an efficient, democratic framework to Medical Staff of Truckee Surgery Center, LLC (TSC, LLC). The Medical Staff endeavors to improve performance while promoting professional relationships among the members, TSC, LLC staff, patients and the community.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL or AHP means a health care provider who is licensed or possesses the appropriate legal credentials, and is other than a licensed physician, dentist or podiatrist. AHPs may be granted practice prerogatives within the scope of their license/legal credential on the approval of the MEC and the Governing Board. The AHP shall exercise his/her practice prerogatives under the supervision of a physician, osteopath, podiatrist, or dentist member of the Medical Staff, when required by law, and in conformity with the law and these bylaws. AHPs are not members of the Medical Staff.

2. AUTHORIZED REPRESENTATIVE or SURGERY CENTER'S AUTHORIZED REPRESENTATIVE means the individual designated by the Governing Board and approved by the MEC to provide information to and request information from the National Practitioner Data Bank.

3. CENTER REPRESENTATIVE means a person appointed by the MEC to deliver and receive notices and any other information, or act on behalf of the Governing Board in connection with any hearing conducted pursuant to Article VII hereof.

4. CLINICAL PRIVILEGES or PRACTICE PREROGATIVES means the authorization granted by the Governing Board to a practitioner or an AHP to provide specific patient care services at the Surgery Center within defined limits, based on an individual's or AHP's license or other legal credential, education, training, experience, competence, health status and judgment.

5. CVO means an external Credentialing Verification Organization (CVO)

6. GOVERNING BOARD means the Board of Managers of TSC, LLC, as defined in the Operating Agreement of TSC, LLC.

7. INVESTIGATION means a formal appointment of a committee or a process formally initiated by a MEC when acting as a peer review body. The MEC may also appoint committees for purposes other than a formal "investigation," such as to "evaluate" a situation or a practitioner. Such evaluation shall not constitute an "investigation," for purposes of reporting obligations under **[either]** California Business and Professions Code Section 805 or the Health Care Quality Improvement Act and the National Practitioner Data Bank (NPDB).

8. MEDICAL DISCIPLINARY CAUSE OR REASON OR MDCR means that aspect of an applicant's or member's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

9. MEDICAL EXECUTIVE COMMITTEE or MEC means the Executive Committee of TSC, LLC responsible for governing the Medical Staff as described in these bylaws.

10. MEDICAL STAFF or STAFF means those M.D.s, D.O.s, Dentists, or Podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these bylaws.

11. MEDICAL STAFF YEAR means the period from January 1 to December 31.

12. PRACTITIONER means an individual who holds a current license as an M.D., D.O. or D.P.M. by the State of California.

13. SURGERY CENTER means surgery center owned and operated by TSC, LLC.

ARTICLE I. NAME, PURPOSES AND RESPONSIBILITIES

1.1 NAME

The name of this organization is the Medical Staff of TSC, LLC.

1.2 PURPOSES OF THE MEDICAL STAFF

The purposes of the Medical Staff are to:

1.2.1 be the formal organizational structure through which (1) the benefits of membership on the Medical Staff may be obtained by individual practitioners and (2) the obligations of Medical Staff membership may be fulfilled.

1.2.2 serve as the primary means for accountability to the Governing Board for the appropriateness of the professional performance and ethical conduct of its members and AHPs.

1.2.3 strive toward the continual upgrading of the quality and safety of patient care delivered at the Surgery Center.

1.2.4 provide a means through which the Medical Staff may participate in TSC, LLC's policy-making.

1.3 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff are to:

1.3.1. account to the Governing Board for the quality of patient care provided by all Medical Staff members and by all AHPs authorized pursuant to the

bylaws to practice at TSC, LLC through regular reports and recommendations concerning the implementation, operation and results of the quality review and evaluation activities, which shall be developed through the following means:

(a) Review and evaluation of the quality of patient care through a valid and reliable patient care assessment procedure.

(b) An organizational structure and mechanisms that allow concurrent monitoring of safe patient care and clinical practices.

(c) A credentials program, including mechanisms for appointment and reappointment and the granting of clinical privileges to be exercised or practice prerogatives to be performed with the verified credentials and current demonstrated performance of the applicant, Medical Staff member or AHP. Quality management information shall be included in the appraisals.

(d) Cooperation with nursing staff in development of policies relating to patient care.

1.3.2. recommend to the Governing Board action with respect to appointments, reappointments, Medical Staff category, clinical privileges, practice prerogatives and corrective action.

1.3.3 recommend to the Governing Board programs for the establishment, maintenance, continuing improvement and enforcement of a high level of professional standards in the delivery of health care at the Surgery Center.

1.3.4 account to the Governing Board for the quality of patient care through regular reports and recommendations concerning the implementation, operation and results of the quality review and evaluation activities.

1.3.5. initiate and pursue corrective action with respect to practitioners and AHPs, when warranted.

1.3.6. develop, administer, and recommend amendments to and seek compliance with these bylaws, the Medical Staff rules and regulations, and TSC, LLC policies.

ARTICLE II. MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of TSC, LLC is a privilege which shall be extended only to individuals holding degrees in medicine, osteopathy, dentistry or podiatry who continuously meet the qualifications, standards and requirements set forth in these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2.1 GENERAL QUALIFICATIONS

Only physicians, doctors of osteopathy, dentists, and podiatrists who:

(a) Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) Are determined to (1) strictly adhere to the Code of Ethics of both the surgery center and the American Medical Association, American Dental Association, American Podiatry Association, or American Osteopathic Association, whichever is applicable, as well as this Medical Staff's Bylaws and Rules and Regulations and applicable policies of the Medical Staff and the Center, (2) be able to work cooperatively with others so as not to adversely affect patient care, (3) keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) be willing to participate in and properly discharge those responsibilities determined by the Medical Staff;

(c) Maintain in force professional liability insurance in not less than One Million Dollars ($1,000,000) per occurrence and Three Million ($3,000,000) in the aggregate. The MEC, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis;

(d) Practice within the community within a reasonable distance of the Surgery Center; and

(e) Anesthesiologists, Orthopedists, General Surgeons, Urologists, and Gynecologists maintain membership or affiliation in good standing at one of the local accredited acute care hospitals of which a transfer agreement is in place.

shall be deemed to possess basic qualifications for membership on the Medical Staff. If a practitioner does not meet these basic qualifications, he/she will not be provided an application to the TSC, LLC Medical Staff.

2.2.2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership on the Medical Staff must hold an M.D. or D.O. degree, and must also hold a valid and unsuspended license to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California.

(b) Limited License Practitioners:

(1) Dentists. An applicant for dental membership on the Medical Staff must hold a D.D.S. or equivalent degree, and must also hold a valid and unsuspended certificate to practice dentistry issued by the Dental Board of California.

(2) Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree, and must hold a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California Board of Podiatric Medicine.

2.3 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, religion, ancestry, national origin, disability, medical condition, marital status or sexual orientation, or other considerations not impacting the applicant's ability to discharge the privileges for which s/he has applied or holds, if after reasonable accommodation, the applicant complies with the bylaws and Rules and Regulations.

2.4 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The ongoing responsibilities of each Medical Staff member include:

2.4.1 Providing patients with the quality of care meeting the professional standards of the Medical staff of TSC, LLC;

2.4.2 Abiding by the Medical Staff's bylaws and rules and regulations;

2.4.3 Preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the Surgery Center;

2.4.4 Abiding by the lawful ethical principles of the California Medical Association or member's professional association;

2.4.5 Working cooperatively with other members and staff so as not to adversely affect patient care; and

2,4.6 Refusing to engage in improper inducements for patient referral.

2.4.7 Not deceive a patient as to the identity of any practitioner providing care or service.

2.4.8 Not delegate the responsibility for diagnosis or care of patients to another practitioner who is not qualified to take on this responsibility.

2.4.9 Cooperate in all peer review and quality assurance review of their practice and notify the Medical Director of any corrective action initiated by other healthcare organizations, agencies or professional associations; loss of malpractice coverage and any other change in the information that an applicant for appointment or reappointment must submit.

2.4.10 Refrain from unlawful harassment or discrimination against any person based on the person's age, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation.

ARTICLE III. CATEGORIES OF MEDICAL STAFF MEMBERSHIP AND ALLIED HEALTH PROFESSIONAL STATUS

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, provisional and temporary. At each time of reappointment, the member's staff category shall be determined.

3.2 ACTIVE MEDICAL STAFF

3.2.1 QUALIFICATIONS

The Active Medical Staff shall consist of members who:

(a) Meet the general qualifications for membership set forth in Section 2.2; and

(b) Regularly provided care to at least ten (10) patients a year in the Surgery Center.

3.2.2 PREROGATIVES

Except as otherwise provided, the prerogative of an Active Medical Staff member shall be to:

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V;

(b) Attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees of which he or she is a member; and

(c) Hold staff office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

3.3 THE COURTESY MEDICAL STAFF

3.3.1 QUALIFICATIONS

The courtesy Medical Staff shall consist of members who:

(a) Meet the general qualifications for membership set forth in Section 2.2;

(b) Regularly care for (or reasonably anticipate regularly caring for) less than ten (10) patients per year in the Surgery Center;

(c) Have satisfactorily completed appointment in the provisional category.

3.3.2 PREROGATIVES

Except as otherwise provided, the courtesy Medical Staff member shall be entitled to;

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) Attend in a non-voting capacity meetings of the Medical Staff, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the Medical Staff.

3.4 PROVISIONAL STAFF

3.4.1 QUALIFICATIONS

The provisional Medical Staff shall consist of members who meeting the general Medical Staff membership qualifications set forth in Section 2.2.

3.4.2 PREROGATIVES

The provisional Medical Staff member shall be entitled to:

(a) Admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) Attend meetings of the Medical Staff, including committee meetings with the permission of the chairman, and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Provisional Medical Staff members shall not be eligible to hold office in the Medical Staff.

3.4.3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. The MEC shall establish in rules and regulations the frequency and format of observation the MEC deems 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.

3.4.4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the provisional staff until ten (10) cases have been reviewed by a physician appointed by the MEC. Five (5) of the ten (10) cases may be completed at a local Medicare-certified hospital as long as written documentation of such is provided by the member.

3.4.5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active or Courtesy Medical Staff as appropriate, on recommendation of the Medical Director to MEC and Governing Board; and

(b) In all other cases, the Medical Director and MEC make its recommendation to the Governing Board regarding a modification or termination of clinical privileges, or termination of Medical Staff membership.

3.5 TEMPORARY STAFF

3.5.1 QUALIFICATIONS

The Temporary Staff shall consist of physicians, dentists, and podiatrists who do not actively practice at the Surgery Center but are important resource individuals for non-clinical Medical Staff quality management activities (i.e. proctoring, peer review activities, consultation on quality management). Such persons shall be qualified to perform the non-clinical functions for which they are made temporary members of the staff.

3.5.2 PREROGATIVES

Temporary Medical Staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality management functions. They shall have no privileges to perform clinical services in the Surgery Center. They may not admit patients to the ambulatory care center, or hold office in the Medical Staff organization. Finally, they may attend Medical Staff meetings outside of their committees, on invitation.

3.6 ONE-TIME SURGICAL ASSIST PRIVILEGES

Only physician Medical Staff members shall be eligible for one-time surgical assist privileges. The physician must be a member in good standing at a local Medicare-certified hospital. The physician must notify the TSC, LLC authorized representative one week prior to the scheduled procedure. The following documentation must be received: 1) copy of a valid California medical license and DEA certificate, 2) copy of malpractice insurance certificate and, 3) a report of all actions by any licensing or regulatory agency, medical group, or hospital against the physician. Prior to granting the privileges, the Medical Board, the National Practitioner Data Bank, the OIG/GSA exclusion list, and the hospital where the physician holds clinical privileges shall be queried, the answers shall have been received and have been deemed acceptable by the Medical Director. The authorized representative will verify all information and the Medical Director will review and approve/disapprove the privileges. There is no application fee. The privilege will be granted for one day only and may be requested three (3) times in a twelve (12) month period.

3.7 ALLIED HEALTH PROFESSIONALS

3.7.1 DEFINITION

Allied Health Professional or AHP means a health care provider who is licensed or possesses the appropriate legal credentials, and is other than a licensed physician, dentist or podiatrist. AHPs may be granted practice prerogatives within the scope of their license/legal credential on the approval of the MEC and the Governing Board. The AHP shall exercise his/her practice prerogatives under the supervision of a physician, osteopath, podiatrist, or dentist member of the

Medical Staff, when required by law, and in conformity with the law and these bylaws. AHPs are not members of the Medical Staff.

3.7.2 QUALIFICATIONS

An AHP may be granted practice prerogatives as described in Section 3.7.1 hereof, provided he or she holds a current license or other legal credential as required by State law, and who:

(a) documents his or her experience, background, training, demonstrated ability, physical health status and mental health status, with sufficient adequacy to demonstrate that any patient treated by them shall receive care of the generally recognized professional level of quality and that they are qualified to provide a needed service at the Surgery Center; and

(b) are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others; and

(c) participates in continuing medical education applicable to their specialty; and

(d) demonstrates acceptable malpractice coverage.

3.7.3 APPLICATIONS

Applications for AHP status and practice prerogatives will be processed in a parallel manner to those for Medical Staff members, as appropriate.

3.7.4 PREROGATIVES

AHPs shall be eligible to provide services at TSC, LLC under this category. The MEC may establish particular qualifications for AHPs.

3.7.5 DURATION

The qualifications of each AHP shall be reviewed on initial application and every two (2) years thereafter.

3.7.6 PROCEDURAL RIGHTS

Nothing herein shall create any vested rights to any such AHP to receive or maintain any practice prerogatives.

Anyone entitled to impose a summary suspension pursuant to Section 6.3 has the authority to summarily suspend an AHP. Termination of AHPs shall not entitle them to any of the hearing and appeal provisions of Article VII, unless otherwise

required by law. For AHPs, a hearing with unbiased members of the MEC and an appeal to the Governing Board shall be provided if practice prerogatives have been denied, revoked, or restricted for a Medical Disciplinary Cause or Reason. In the event that an AHP has acquired AHP status by virtue of his/her employment or other relationship with a member of the Medical Staff, termination shall be automatic and simultaneous on the termination of the relationship between the Medical Staff member and TSC, LLC or the Medical Staff member and the AHP without the right to a hearing or appeal.

3.7.7 CATEGORIES

The Governing Board shall determine, based on comments of the MEC and such other information as it has before it, those categories of AHPs that shall be eligible to exercise clinical privileges or practice prerogatives in the Surgery Center. AHPs exercising practice prerogatives in a Governing Board-approved category shall be subject to supervision requirements as required by law and as recommended by the Allied Health Professionals Committee and the MEC, and approved by the Governing Board.

ARTICLE IV. APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person shall exercise clinical privileges in the Surgery Center unless that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these bylaws.

4.2 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the Medical Director to the MEC and Governing Board.

4.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the Medical Staff shall be for a period of two (2) years. Reappointments shall be for a period of two (2) years.

4.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.1.1 APPLICATION FORM

An application form shall be approved by the MEC. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) The applicant's qualifications, including, but not limited to, education, professional training and experience, current licensure, current DEA registration, and continuing medical education information related to the services to be performed by the applicant;

(b) Peer references familiar with the applicant's professional competence and ethical character;

(c) Request for specified clinical privileges;

(d) Past or pending professional disciplinary action, licensure limitation, or related matter;

(e) Physical and mental health status;

(f) Final judgments or settlements made against the applicant in professional liability cases, and any filed cases pending; and

(g) Professional liability coverage.

(h) Criminal Background Screening

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed or accompanied by an explanation of why answers are unavailable, and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws, the Medical Staff rules and regulations, and summaries of other applicable policies relating to clinical practice at the Surgery Center, if any.

4.4.2 EFFECT OF APPLICATION

By applying appointment to the Medical Staff each applicant:

(a) Signifies willingness to appear for interviews regarding the application;

(b) Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) Releases from liability, to the fullest extend permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) Consents to the disclosure to other organizations, hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that TSC, LLC or the Medical Staff may have, and releases the Medical Staff and Governing Board from liability for so doing to the fullest extent permitted by law; and

(g) Pledges to provide for continuous quality care for patients.

4.4.3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the CVO credentialing designee. An application is considered "complete" when all required application information and supporting documents have been received. The Medical Executive Committee or designee shall be notified of the application. The CVO shall seek to collect and primary source verify the references, licensure status, DEA, State DPS, State CDS if applicable, Medical malpractice insurance coverage consistent with guidelines of the Governing Body, Criminal background check, board certification, and other evidence submitted in support of the application, as indicated in the credentialing policies and procedures. TSC, LLC's authorized representative shall query the American Medical Association (AMA) or the American Osteopathic Association Physician Profiles and the Education Commission for Foreign Medical Graduates (ECFMG) if applicable, regarding the applicant or member and place in the applicant's or member's credentials file. The National Practitioner Data Bank, the OIG/GSA exclusion list, and the relevant professional licensing board shall be queried on all applicants. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification is accomplished, all such information will be given to the Medical Director for review then to the MEC for recommendation to the Governing Board. The TSC, LLC may use paper or electronic processes for applications, credentialing, and privileging.

4.4.4 MEC ACTION

At its next regular meeting after receipt of the application, or as soon thereafter as is practical, the MEC shall consider the application. The MEC may request additional information, and/or elect to interview the applicant. The MEC shall

render and forward to the Governing Board a written report and decision as to Medical Staff appointment. The MEC may also defer action on the application. The reasons for the decision shall be stated.

Recommendations concerning membership and clinical privileges shall be based on whether the applicant meets the qualifications and can carry out all of the responsibilities specified in the bylaws and TSC, LLC's ability to provide adequate support services and facilities for practitioners.

4.4.5 EFFECT OF MEC ACTION

When a final proposed action gives rise to the obligation to file an 805 report in accordance with the California Business and Professions Code § 805(b), the Governing Board shall be promptly informed in writing and the applicant shall be promptly informed by written notice in accordance with California Business and Professions Code § 809.1 and shall then be entitled to the procedural rights as provided in Article VII. AHPs do not have hearing rights as provided in these bylaws.

4.4.6 ACTION ON THE APPLICATION

The Governing Board may accept the recommendation of the MEC or may refer the matter back to the MEC for further consideration, setting the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

(a) If the MEC issues a favorable recommendation, the Governing Board shall affirm the recommendation of the MEC, refer the matter back to the MEC, or decide not to concur.

 (1) If the Governing Board concurs in that recommendation, the decision of the Governing Board shall be deemed final action.

 (2) If the final proposed action gives rise to the obligation to file an 805 report in accordance with the California Business and Professions Code § 805(b), the applicant shall be promptly informed by written notice in accordance with California Business and Professions Code § 809.1 and shall then be entitled to the procedural rights as provided in Article VII. If the applicant waives his or her procedural rights, the decision of the Governing Board shall be deemed final action.

(b) In the event the final proposed action of the MEC, or any significant part of it, gives rise to the obligation to file an 805 report in accordance with the California Business and Professions

Code § 805(b), the procedural rights set forth in Article VII shall apply.

(1) If the applicant waives his or her procedural rights, the recommendations of the MEC shall be forwarded to the Governing Board for final action, which shall affirm the recommendation of the MEC if the decision is supported by substantial evidence.

(2) If the applicant requests a hearing, the Governing Board shall take final action only after the applicant has exhausted his or her procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, subject only to the rights of appeal as set forth in these bylaws, the Governing Board shall make a final decision and shall affirm the decision of the Judicial Review Committee if it is supported by substantial evidence following a fair procedure. The Governing Board's decision shall be in writing and shall specify the reasons for the action taken.

4.4.7 NOTICE OF FINAL DECISION

(a) Notice of the final decision shall be given to the applicant in writing.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the clinical privileges granted; and (2) any special conditions attached to the appointment.

4.4.8 TIMELY PROCESSING OF APPLICATIONS

Applications for Medical Staff appointments shall be considered in a timely manner as stated in the credentialing policies and procedures. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

(a) Evaluation, review, and verification of application and all supporting documents sixty (60) days after receipt of all necessary documentation;

(b) Review and recommendation by MEC thirty (30) days after receipt of all necessary documentation.

4.5 REAPPOINTMENT

Medical staff privileges must be periodically reappraised, not less than every two (2) years. The scope of procedures performed at TSC, LLC must be periodically reviewed and amended as appropriate.

4.5.1 REAPPLICATION

At least five (5) months prior to the expiration date of the current staff appointment, a reapplication form shall be mailed or delivered to the member. At least ninety (90) days prior to the expiration date, each Medical Staff member shall submit to the CVO designee the completed application form for renewal of appointment to the staff, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.4.1, as well as other relevant matters. On receipt of the application, the information shall be processed as set forth commencing at Section 4.4.3.

4.5.2 FAILURE TO FILE REAPPOINTMENT APPLICATION

If the member fails without good cause to file a completed application within forty-five (45) days past the date it was due, the member shall be deemed to have resigned membership from the TSC, LLC Medical Staff, as of the date of expiration of his/her appointment, and the procedures set forth in Article VII shall not apply.

ARTICLE V. CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

A member providing clinical services at this surgery center shall be entitled to exercise only those clinical privileges specifically granted. These privileges and services must be organization specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon. Medical Staff privileges may be granted, continued, modified or terminated by the Governing Board of TSC, LLC after considering the recommendation of the MEC, and only for reasons directly related to quality of patient care and other provisions of the Medical Staff bylaws, and only following the procedures outlined in these bylaws.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2.1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant and are limited to those privileges currently held at an area acute care facility. A

request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2.2 BASES FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from outside sources and appropriateness of procedure for an ambulatory surgery center setting.

5.3 PROCTORING

5.3.1 GENERAL PROVISIONS

Except as otherwise determined by the MEC, all new members and all members granted new clinical privileges shall be subject to a period of review. Performance on three (3) procedures has been established by the MEC, to determine suitability to continue to perform services within the Surgery Center. Monitoring reports available at accredited local hospitals may be accepted in lieu of fifty percent (50%) of the monitoring reports required to be completed at the Surgery Center. Monitoring reports must be as described in section 3.4.3 and completed by a physician appointed by the MEC. The Medical Director will review, evaluate and make recommendations to the MEC through the use of physician monitoring records and other quality data.

5.3.2 FAILURE TO OBTAIN CERTIFICATION

If a new member or member exercising new clinical privileges fails to obtain such certification within the time allowed by the MEC those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, on request, pursuant to Article VII, if such failure is due to a Medical Disciplinary Cause or Reason.

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4.1 GENERAL EXCEPTIONS TO PREROGATIVES

Limited license members:

(a) shall exercise clinical privileges only within the scope of their licensure and as set forth below.

5.4.2 ADMISSIONS

When dentists, oral surgeons, and podiatrists provide care to patients within the ambulatory care center, the patient's primary care provider or cardiologist has completed the medical portion of the H&P exam and has provided medical clearance for the patient to be admitted to the surgery center. Alternatively, a physician member of the Medical Staff may conduct or directly supervise the care provided by the limited license practitioner, except the portion related to dentistry or podiatry, and assume responsibility for the care of the patient's medical problems, which are outside of the limited license practitioner's lawful scope of practice.

5.4.3 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of a physician member of the Medical Staff with surgical privileges.

5.4.4 MEDICAL APPRAISAL

All patients admitted for care at the Surgery Center by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists or podiatrists shall consult with a physician member to determine the patient's medical status and a need for medical evaluation.

5.5 TEMPORARY PRIVILEGES

5.5.1 CIRCUMSTANCES

(a) Temporary privileges may be granted where good cause exists to a physician for the care of specific patients but for not more than four (4) patients per calendar year provided that the procedure described in Section 5.5.2 has been followed.

(b) Following the procedures in Section 5.5.2, temporary privileges may be granted to a person serving as a locum tenens for a current member of the TSC, LLC Medical Staff. Such person may attend the patients of the member for whom the person is serving as locum tenens and only for a period not to exceed ninety (90) days per calendar year, unless the MEC recommends a longer period for good cause.

5.5.2 APPLICATION AND REVIEW

(a) On receipt of a completed application and supporting documentation from a physician, dentist, or podiatrist authorized to practice in California, the MEC may grant temporary privileges to

a practitioner who appears to have qualifications, ability and judgment, consistent with Section 2.2.1, but only after:

(1) The MEC has contacted at least one person who:

a. Has recently worked with the applicant;

b. Has directly observed the applicant's professional performance over a reasonable time; and

c. Provides reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.

(2) The appropriate licensing board, the National Practitioner Data Bank, and the OIG/GSA exclusion list have been queried, the answer shall have been received and it has been deemed acceptable by the Medical Director.

(3) The applicant's file is forwarded to the MEC.

(4) Reviewing the applicant's file and attached materials, the MEC recommends granting temporary privileges.

5.5.3 GENERAL CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the Medical Director within TSC, LLC.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the MEC or unless affirmatively renewed following the procedure as set forth in Section 5.5.2.

(c) Requirements for proctoring and monitoring including, but not limited to, those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances.

(d) Temporary privileges may at any time be terminated by the Medical Director or MEC. In such cases, the Medical Director or MEC shall assign a member of the TSC, LLC Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member. Terminations for Medical Disciplinary Cause or Reason give rise to the hearing rights specified in Article VII.

(e) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the TSC, LLC Medical Staff.

5.6 LEAVE OF ABSENCE

5.6.1 A Medical Staff member may request a voluntary leave of absence from the Medical Staff by submitting a written notice to the MEC. The request must state the approximate period of leave desired, which may not exceed one (1) year, and include the reasons for the request. Upon written request of the Medical Staff member to the MEC, and at the discretion of the MEC, an approved leave may be extended to two (2) years. During the period of leave, the Practitioner shall not exercise clinical privileges at the Surgery Center, and membership prerogatives and responsibilities shall be in abeyance. The request may be granted or denied, in whole or in part, at the discretion of the MEC with Governing Board Approval. In making its decision, the MEC shall consider the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Surgery Center by the absence of the member requesting the leave. All Medical Staff members requesting a leave of absence are expected to complete all medical records and Medical Staff and Surgery Center matters prior to commencing the leave of absence, unless, in the judgment of the MEC, the member has a physical or psychological condition that prevents him/her from completing records and/or concluding other Medical Staff or Surgery Center matters.

5.6.2 A leave of absence may be granted for any reason approved by the MEC and the Governing Board including, but not limited to, the following reasons:

(a) Medical Leave of Absence

A Medical Staff member may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or impairment.

(b) Military Leave of Absence

A Medical Staff member may request and be granted a leave of absence to fulfill military service obligations.

(c) Educational Leave of Absence

A Medical Staff member may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with these Bylaws.

(d) Personal/Family Leave of Absence

A Medical Staff member may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor) or family reasons (e.g., maternity leave).

5.6.3 Termination of Leave

At least thirty (30) days prior to the requested termination of the leave of absence, the Medical Staff member may request reinstatement of Medical Staff membership and clinical privileges by submitting a written notice to the MEC. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the criteria listed in Section 2.2 of these Bylaws or, if changes have occurred, a detailed description of the nature of the changes. In addition, the MEC may request any information or evidence it deems relevant to the decision to reinstate a Practitioner to the Medical Staff including, but not limited to, medical records of Practitioner. If so requested, the Medical Staff member shall submit a summary of relevant activities during the leave which may include, but is not limited to, the scope and nature of professional practice during the leave period and any professional training completed. The MEC may approve or deny the requested reinstatement in whole or in part and may limit or modify the requested reinstatement, including, but not limited to, imposing requirements for monitoring and/or proctoring. If the leave of absence has extended past the Practitioner's reappointment time, he/she will be required to submit an application for reappointment in accordance with these Bylaws and the reinstatement shall be processed as a reappointment.

An adverse decision regarding reinstatement of Medical Staff membership, which is not for a MDCR, shall not constitute grounds for a hearing under Article VII of these Bylaws.

5.6.4 Failure to Request Reinstatement

The Medical Director will notify the physician in writing no less than 60 days and again no less than 30 days prior to the expiration of a leave of absence. Failure, without good cause, to request reinstatement prior to the end of an approved leave of absence shall be deemed an automatic termination from the Medical Staff.

ARTICLE VI. CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND EDUCATION

The TSC, LLC Medical Staff committees are responsible for carrying out peer review and quality or performance improvement review functions. Following completion of the peer review process, the committees may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out those functions without initiating formal corrective action. Comments, suggestions, and warnings

may be issued orally or in writing. Any such actions, monitoring, or counseling shall be documented in the member's peer review file. MEC approval is not required for such actions, although the actions may be reported to the MEC. The routine monitoring and education actions described in this section shall not constitute a restriction of clinical privileges or grounds for any formal hearing or appeal rights under Article VII.

6.2 CORRECTIVE ACTION

6.2.1 CRITERIA FOR INITIATION

Any person may provide information to the MEC about the conduct, performance, or competence of Medical Staff members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Surgery Center; (2) unethical; (3) contrary to the Medical Staff bylaws and rules or regulations; (4) below applicable professional standards; (5) disruptive of Surgery Center operations; or (6) illegal, a member may request for an investigation or action against such member may be made.

[6.2.2 CRIMINAL ARREST

In the event that an individual is arrested for alleged criminal acts, an immediate investigation into the circumstances of the arrest shall be made. The MEC shall review the circumstances leading to the arrest and may determine if further action is warranted prior to the outcome of the legal action. If the MEC recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and as set forth in Article VII.]

6.2.3 INITIATION

A request for an investigation must be in writing, submitted to the MEC and supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate recordation of the reasons.

6.2.4 INVESTIGATION

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff member or committee. If the investigation is delegated to a member or committee, such person(s) shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as possible. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and on such terms as the investigating body

deems appropriate. The investigating body may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a ‘‘hearing” as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply.

Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.2.5 MEC ACTION

As soon as possible after the conclusion of the investigation, the MEC shall take action which may include, without limitation:

(a) Determining no corrective action be taken and, if the MEC determine there was not credible evidence for the complaint in the first instance, removing any adverse information from the member’s file;

(b) Deferring action for a reasonable time;

(c) Issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued, the affected member may make a written response which shall be placed in the member’s file;

(d) Recommending the imposition of terms of probation or special limitation on continued TSC, LLC Medical Staff membership including, without limitation, requirement for mandatory consultation, or monitoring; and

(e) Recommending termination of membership.

6.2.6 SUBSEQUENT ACTION

(a) If corrective action as set forth in Section 6.2 is recommended by the MEC, that recommendation shall be transmitted for information to the Governing Board.

(b) The recommendation of the MEC shall be adopted by the Governing Board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII, if applicable, or the Governing Board disagrees with the MEC.

6.2.7 ALTERNATIVE TO CORRECTIVE ACTION

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a hearing as set forth in Article VII hereof, and shall not require reporting to the State Licensure Board or the National Practitioner Data Bank, except as otherwise provide in these Bylaws or required by applicable law. Alternatives to corrective action may include:

(a) Informal discussions or formal meetings regarding the concerns raised about conduct or performance;

(b) Written letters of guidance, reprimand, or warning regarding the concerns about conduct or performance;

(c) Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

(d) Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance and which do not in any way restrict the individual's ability to exercise clinical privileges at the Surgery Center; and/or

(f) Requirements to seek assistance for any impairment.

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3.1 CRITERIA FOR INITIATION

Whenever failure to immediately suspend or restrict a practitioner may result in imminent danger to the health of any individual, the MEC or any officer thereof, may summarily suspend the membership of such member. Unless otherwise stated, such summary suspension shall become effective immediately on imposition and the person or committee responsible shall promptly give written notice to the member and the Governing Board. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

6.3.2 MEC ACTION

As soon as practical, but no later than seven (7) calendar days after such summary restriction or suspension has been imposed, a meeting of the MEC as a whole shall be convened to review and consider the action. On request, the member may attend and make a statement concerning the issues under investigation, on such

terms and conditions as the MEC may impose. In no event, however, shall any meeting of the MEC, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The MEC may modify, continue, or terminate the summary suspension, but in any event it shall furnish the member with notice of its decision.

6.3.3 PROCEDURAL RIGHTS

If the MEC does not terminate the summary suspension, the member shall be entitled to the procedural rights afforded by Article VII.

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, membership may be suspended or limited as described, and a hearing, if requested, shall be an informal hearing before the MEC limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

6.4.1 LICENSURE

(a) Revocation, Expiration, and Suspension: Whenever a member's license or other legal credential authorizing practice in this state expires, is revoked or suspended, TSC, LLC Medical Staff membership shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges exercised at the Surgery Center which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.4.2 CONTROLLED SUBSTANCES

(a) Whenever a member's DEA certificate is revoked, limited, suspended, or expires, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.4.3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails to satisfy the requirements of Section 10.6.2 shall automatically be suspended from exercising all or such portion of his/her clinical privileges in accordance with the provisions of said Section 10.6.2.

6.4.4 CONVICTION OF FELONY

A Medical Staff member who is convicted of a felony, or who has pled "guilty" or pled "no contest" or its equivalent, in any jurisdiction, to a felony shall immediately and automatically be suspended from practicing at TSC, LLC. Such suspension is effective on conviction and does not await the results of an appeal or the conviction otherwise becoming final. Such suspension shall remain in effect until the matter is resolved by subsequent action by the MEC to dissolve the suspension or to continue it and initiate further corrective action.

6.4.5 MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION CERTIFICATE, FAILURE TO SATISFY SPECIAL APPEARANCE AND FELONY CONVICTION

As soon as practicable after action is taken as described in Section 6.3.1, paragraphs (b) or (c), or in Sections 6.4.2, 6.4.3, 6.4.4and 6.4.5, the MEC shall convene to review and consider the facts on which such action was predicated. The MEC may then recommend such further corrective action as may be appropriate based on information disclosed or otherwise made available and/or may direct that an investigation be undertaken pursuant to Section 6.1.3. With regard to a felony conviction, the MEC shall make a finding of whether the felony is related to the Medical Staff member's basic qualifications, functions, duties or ethical conduct prior to deciding whether to dissolve a suspension or to continue it and initiate further corrective action. Hearing rights are subject to the provisions of Article VII.

6.4.6 CLINICAL RECORDS

Members of the Medical Staff are required to complete clinical records within such reasonable time as may be prescribed by the Medical Director or MEC and in any event, no later than thirty (30) days from the date treatment was provided. A limited suspension in the form of withdrawal of the right to treat future patients at the Surgery Center until clinical records are completed, shall be imposed by the Medical Director or MEC, after notice of delinquency for failure to complete clinical records within such period. Bona fide vacation or illness may constitute

an excuse subject to approval by the Medical Director or MEC. The suspension shall continue until lifted by the Medical Director or MEC.

6.4.7 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated and the member shall not have the right to a hearing pursuant to Article VII.

6.4.8 Misrepresentation

Whenever it is discovered that an individual materially misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, the individual's membership and clinical privileges shall be automatically terminated. The individual may not re-apply for membership or privileges until twenty-four (24) months have passed.

6.4.9 Impaired Practitioner

Should a Practitioner or Allied Health Professional appear or become impaired while providing patient care, the Medical Director or Administrator shall be notified immediately. Impaired shall mean illness, suspected drug abuse or suspected alcohol intoxication if such could reasonably interfere with the Practitioner's or Allied Health Professional's competent performance of procedures at the Surgery Center. Should the Medical Director or Administrator determine that a Practitioner or Allied Health Professional is impaired as defined above, the Practitioner or Allied Health Professional shall be denied or removed from patient contract until it has been determined that the individual is no longer impaired.

6.4.10 AUTOMATIC RESIGNATION

(1) Relocation

Unless otherwise approved by the Governing Board upon recommendation of the MEC, any Practitioner or other individual with clinical privileges who takes up permanent residence more than a reasonable distance, as determined by the Governing Board, from the Surgery Center shall be deemed to have resigned from the Medical Staff and relinquished all clinical privileges.

(2) Failure to Apply for Reappointment or Renewal of Privileges

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two (2) years. In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated. The individual shall be notified of the termination and the need to submit a new application if continued membership or clinical privileges are desired. The failure to seek reappointment or renewal of clinical privileges prior to the expiration of the current term of appointment shall not give rise to the hearing and appellate rights set forth in Article VII.

ARTICLE VII. HEARINGS AND APPELLATE REVIEWS

These procedures apply to all applicant/member physicians, dentists, and podiatrists applying to practice or practicing within the Surgery Center.

7.1 STATEMENT OF PURPOSE

The following procedures are set forth in order to help ensure that a professional review action is taken in the reasonable belief that the action is in the furtherance of quality health care; that a reasonable effort is made to obtain the facts of the matter; that adequate notice and hearing procedures are afforded to the Practitioner involved and that any action eventually taken is warranted by the facts ascertained. All committees, panels, and boards charged with responsibility under Article VII and Article IX of these Bylaws shall evaluate and improve the quality of care rendered at the Surgery Center. The procedures set forth in this Article VII shall apply exclusively to Practitioners.

7.2 INTERVIEWS

Any interviews conducted pursuant to these bylaws shall neither constitute, nor be deemed, a "hearing," as described in this Article VII, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. When the MEC or the Governing Board is considering an independent adverse recommendation, as defined in Section 7.3, or when otherwise deemed appropriate by the MEC or Governing Board, the MEC or Governing Board may offer the Medical Staff member an interview. In the event an interview occurs, the Medical Staff member may be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto. In an interview, neither the Medical Staff member nor the MEC is entitled to representation by an attorney. A record of the matters discussed and findings resulting from such interview may be made.

7.3 GROUNDS FOR HEARING

7.3.1 Recommendations or Actions Triggering Right to Hearing

The following recommendations or actions shall, if deemed adverse pursuant to Section 7.3.5 of these Bylaws, entitle the affected Practitioner to a hearing:

1. Denial of initial staff appointment for a MDCR;
2. Denial of reappointment for a MDCR;
3. Suspension of staff membership for a MDCR lasting longer than 14 days;
4. Termination or revocation of staff membership for a MDCR;
5. Denial of requested advancement in staff category for a MDCR;
6. Reduction in staff category for a MDCR;
7. Denial of requested clinical privileges for a MDCR;
8. Restriction of or reduction in clinical privileges for a cumulative total of 30 days or more in any 12-month period, for a MDCR;
9. Suspension of clinical privileges for a MDCR lasting longer than 14 days;
10. Termination or revocation of clinical privileges for a MDCR; or
11. Individual requirement of consultation for a MDCR.

7.3.2 Recommendations or Actions Not Triggering Right to Hearing

There shall be no right to a hearing in situations not listed in Section 7.3.1. These situations include, but are not limited to, a warning letter of reprimand or censure, a mandatory personal appearance, a notification requirement (which may require an individual to give reasonable notice of performance of certain procedures but does not require consultation or approval or presence of a proctor prior to the individual beginning the procedure), any voluntary resignation or relinquishment of privileges, or any action based on the individual's failure to meet minimum objective

standards for membership or any specific clinical privilege that apply to all similarly situated individuals. For example, the possession of a medical license is required for membership, and there are certain required activity levels such as numbers of particular procedures per year.

7.3.3 When Necessary Facilities and Support Are Unavailable

Additionally, there shall be no right to a hearing for a Practitioner whose application for Medical Staff membership or request for an extension of clinical privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Surgery Center. Similarly, there shall be no right to a hearing if the Surgery Center makes a policy decision (*e.g.*, closing a service, or a physical plant change) that adversely affects the staff membership or clinical privileges of any Member or any other individual.

7.3.4 Exclusive Contracting

The Surgery Center may refuse to accept an application for appointment or reappointment on the basis of an exclusive professional contract that the Surgery Center has entered into for services. Upon receipt of such an application, the Medical Director shall notify the applicant in writing that the application cannot be processed because of the existence of such an exclusive contract. No applicant whose application is denied on such a basis shall be afforded any of the procedural rights set forth in Article VII of these Bylaws. Further, no Practitioner shall be afforded any of the procedural rights set forth in Article VII of these Bylaws due to the loss of the ability to perform services at the Surgery Center as a result of the Surgery Center entering into an exclusive professional contract with other Practitioners.

7.3.5 When Deemed Adverse

A recommendation or action listed in Section 7.3.1 of these Bylaws shall be deemed adverse only when it has been:

1. Recommended by the MEC; or

2. Taken by the Governing Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

3. Taken by the Governing Board on its own initiative without benefit of a prior recommendation by the MEC.

7.4 EXHAUSTION OF REMEDIES

If any of the above adverse action is taken or recommended, the member must exhaust the remedies afforded by these procedures before resorting to legal action.

7.5 NOTICE OF REASONS/ACTION

Whenever any of the actions listed above are taken or proposed for a non-MDCR, the member shall receive a written statement of the reasons therefore. However, the Article VII sections below apply only where action was taken or proposed for a MDCR.

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 7.3.5 of these Bylaws shall promptly be given special notice of such action. Such special notice shall be sent by the Center Representative by hand or by certified or registered mail. Such notice shall:

1. Advise the Practitioner that a professional review action has been proposed to be taken against him;

2. State the reasons for the proposed action;

3. Alert the Practitioner that he has thirty (30) days following the date of receipt of notice in which to request a hearing on the proposed action and that failure to request a hearing within thirty (30) days shall constitute a waiver of his right to a hearing on the matter;

4. Advise the Practitioner that the Surgery Center may be required pursuant to Section 805 of the California Business and Professions Code to report the proposed action, if taken; and

5. Provide a summary of his rights at such a hearing under these Bylaws.

7.6 HEARING

7.6.1 Request for a Hearing

A Practitioner shall have thirty (30) days following his or her receipt of a notice pursuant to Section 7.5 to file a written request for a hearing. A Practitioner's receipt of the notice of the proposed action shall be irrebuttably presumed four (4) days after the date of the certified or registered mailing, or, if hand-delivered, on the date of delivery. Any request for a hearing must be received by the Center Representative within the thirty (30) day timeframe. The request for a hearing

shall contain a statement, signed by the Practitioner, that the Practitioner shall maintain confidentially all documents provided to him during the fair hearing process and shall not disclose or use the documents for any purpose outside of the fair hearing process or any lawsuit directly related to the hearing process.

7.6.2 Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.6.1 waives any right to such a hearing to which he might otherwise have been entitled. Such waiver in connection with:

1. An adverse action by the Governing Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Surgery Center. This decision shall be immediately effective and shall not be subject to further hearing, appellate, or judicial review.

2. An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Governing Board. The Governing Board shall consider the MEC's recommendation at its next regular meeting following waiver. In its deliberations, the Governing Board shall review all the information and material considered by the MEC and may consider all other relevant information received from any source. The Governing Board's action shall constitute the final decision of the Surgery Center. This decision shall be immediately effective and shall not be subject to further hearing, appellate, or judicial review.

The Center Representative shall promptly send the Practitioner special notice informing the Practitioner of each action taken pursuant to this Section 7.6.2 and shall notify the Governing Board of each such action. Such special notice shall be sent by hand or by certified or registered mail.

7.6.3 Number Of Hearings

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing with respect to an adverse recommendation or action.

7.7 HEARING PREREQUISITES

7.7.1 Notice Of Time And Place Of Hearing

Upon receipt of a timely request for hearing, the Center Representative shall deliver such request to the Governing Board and the MEC. At least thirty (30)

days prior to the hearing, the Center Representative shall send the Practitioner special notice of the time, place, and date of the hearing. Such special notice shall be sent by hand or by certified or registered mail. The hearing date shall be not less than thirty (30) days from the date of receipt of the request for hearing. The notice of hearing shall identify the Practitioners who will comprise the Judicial Review Committee. The notice of hearing shall also contain a list by number of the specific or representative patient records (if any) in question and a list of witnesses (if any) expected to testify at the hearing at the request of the Judicial Review Committee. These lists may be amended at a later date, and the amended list of records and witnesses shall be provided to the Practitioner prior to the hearing. Nothing in this section, however, shall preclude the Judicial Review Committee, in its sole discretion, from calling additional witnesses whose testimony is determined to be relevant by the Judicial Review Committee.

7.7.2 Appointment Of Judicial Review Committee

1. A hearing occasioned by an adverse recommendation pursuant to Section 7.3.5 shall be conducted by a Judicial Review Committee appointed by the Medical Director and composed of three (3) members of the Active Medical Staff who (1) are in good standing, (2) are unbiased with respect to the subject matter of the hearing, (3) do not stand to gain any direct financial benefit from the outcome of the hearing, and (4) have not acted as an accuser, investigator, fact finder or initial decision-maker in the same matter. Knowledge of the matter involved shall not preclude a member from serving as a member of the Judicial Review Committee. If feasible, subject to the requirements of Section 7.7.3(2) below, at least one (1) of the Judicial Review Committee members should be a Practitioner practicing in the same specialty as the Practitioner who is the subject of the hearing.

2. No Practitioner in direct economic competition with the Practitioner may serve as a Judicial Review Committee member. A Practitioner shall be disqualified from serving on a Judicial Review Committee if he has participated in initiating, investigating, or making decisions regarding the underlying matter at issue. Members who serve on the Governing Board may be appointed to serve on a Judicial Review Committee only if the Medical Director determines in good faith that the number of Active Medical Staff Members otherwise eligible to participate on the Judicial Review Committee is not sufficient to constitute a Judicial Review Committee the membership of which does not overlap with the Governing Board. In such case, any member of the Governing Board who serves on a Judicial Review Committee shall be excluded from considering and voting on the matter as a member of the Governing Board.

7.7.3 Objection To Judicial Review Committee Composition

Upon receipt of notice provided in Section 7.5, the Practitioner shall have a reasonable opportunity to *voir dire* the Judicial Review Committee members and, within five (5) days after such *voir dire*, to object in writing to the participation of any members of the Judicial Review Committee. Such written objection shall be delivered by hand or by certified or registered mail to the Hearing Officer. Any objection to the composition of the Judicial Review Committee must be based on the Practitioner's reasonable and good faith belief that one (1) or more individuals selected to serve on the Judicial Review Committee are not impartial with respect to the subject matter of the hearing or the Practitioner at issue. The Hearing Officer shall, in his or her sole discretion, determine whether new Judicial Review Committee members should be appointed to replace the members to whom the Practitioner objected. If no objection is made in writing prior to the later of five (5) days after the *voir dire* or ten (10) days after the Practitioner's receipt of the notice provided pursuant to Section 7.5 if the Practitioner has not requested a *voir dire* by such time, the Practitioner shall be deemed to have waived any objection to the Judicial Review Committee's composition.

7.10 HEARING PROCEDURE

7.10.1 Personal Presence

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause, as determined by the Judicial Review Committee in its sole discretion, to appear at such hearing shall be deemed to have waived his rights in the same manner and with the same consequence as provided in Section 7.5.2.

7.10.2 Presiding Officer

The Hearing Officer shall act as the presiding officer. The Hearing Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Hearing Officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

7.10.3 The Hearing Officer

The Governing Board on recommendation of the MEC may appoint a Hearing Officer to preside at the hearing. The Hearing Officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by TSC, LLC for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting Officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in

the hearing have a reasonable opportunity to be hard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary actions as seems warranted by the circumstances. If requested by the Judicial Review Committee, the Hearing Officer may participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but shall not be entitled to vote.

7.10.4 Notice By Practitioner

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or other person of the Practitioner's choice. At least ten (10) days prior to the hearing, the Practitioner shall provide the name of his attorney or other representative and a list of witnesses he will call. The Practitioner shall deliver such notice by hand or by certified or registered mail to the Center Representative, who shall promptly forward a copy of such notice to the Judicial Review Committee. The Practitioner's list of witnesses may be amended at any time for good cause shown. The Judicial Review Committee shall, in its sole discretion, determine whether good cause has been shown. The MEC or the Governing Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to represent the facts in support of its adverse recommendation or action, and to examine witnesses.

7.10.5 Rights Of Parties

During a hearing, each of the parties shall, as soon as practicable,:

1. Have access to all of the information made available to the Judicial Review Committee;
2. Be afforded a reasonable time to present his case by:
    a. Calling and examining witnesses;
    b. Introducing exhibits;
    c. Cross-examining any witness on any matter relevant to the issues; and
    d. Presenting and rebutting any evidence determined by the Hearing Officer to be relevant.
3. Have the right to present a written statement at the close of the hearing; and

4. Obtain a copy of the record upon payment of any reasonable charges associated with the preparation thereof and upon signing a stipulation agreeing to maintain the record confidentially.

If the Practitioner who requested the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination.

7.10.6 Access To Information and Documents

The Practitioner shall have the right to inspect and copy at his or her own expense any documentary information relevant to the action or recommendation at issue which the MEC has in its possession or under its control, as soon as practicable after the receipt of the Practitioner's request for a hearing. The MEC shall have the right to inspect and copy at the its own expense any documentary information relevant to the action or recommendation at issue which the Practitioner has in his or her possession or control as soon as practicable after receipt of the MEC's request. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners, other than the Practitioner under review. The Hearing Officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires.

When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer shall consider the following:

1. Whether the information sought may be introduced to support or defend the recommendation or action against the Practitioner;

2. The exculpatory or inculpatory nature of the information sought, if any;

3. The burden imposed on the party in possession of the information sought, if access is granted;

4. Any previous requests for access to information submitted or resisted by the parties to the same proceeding; and

5. Such other factors as the Hearing Officer deems appropriate.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitle to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the state of California, who is not also an

attorney at law, and the MEC shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The MEC shall not be represented by an attorney at law if the member is not so represented.

7.10.7 Procedure And Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs, including hearsay, shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party will file documentary evidence within ten (10) days in advance of the hearing. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. The Hearing Officer shall not allow a witness to attend the hearing and may require that a witness take an oath before testifying. A record of the hearing shall be made by use of a court reporter or an electronic recording unit. The Judicial Review Committee shall be entitled to legal counsel or other representation in all hearings and proceedings.

7.10.8 Official Notice

In reaching a decision, the Judicial Review Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Judicial Review Committee. The Judicial Review Committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

7.10.9 Burden Of Proof

The burden of presenting evidence and proof during the hearing shall be as follows:

1. The MEC or the Governing Board, depending on whose recommendation or action prompted the hearing, shall have the initial duty to present evidence which supports the recommendation or action.

2. Initial applicants shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for Medical Staff membership and clinical privileges. Initial applicants shall not be permitted to introduce information not produced during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

3. Except as provided above for initial applicants, the MEC or the Governing Board, depending on whose recommendation or action prompted the hearing, shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

7.10.10 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the time permitted in these bylaws may be permitted by the Hearing Officer on a showing of good cause, or on agreement of the parties

7.10.11 Presence Of Judicial Review Committee Members

Each member of the Judicial Review Committee must be present throughout the hearing and deliberations.

7.10.12 Recesses And Adjournment

The Judicial Review Committee or the Hearing Officer, upon consultation with the Judicial Review Committee, may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Judicial Review Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The Judicial Review Committee may seek legal counsel during its deliberations and the preparation of its report. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

7.10.13 Judicial Review Committee Report

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the parties and to the Governing Board. If the member's membership is currently suspended however, the time for the decision and report shall be fifteen (15) days. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these bylaws. On an appeal, the Appeal Board shall give great weight to the decision of the Judicial Hearing Committee and in no event shall act in an arbitrary or capricious manner in making its decision. The Appeal Board shall decide whether there was substantial compliance with these bylaws and applicable law, whether the Judicial Hearing Committee decision was supported by the evidence based on the hearing record, and if the action was taken arbitrarily, unreasonably, or capriciously. Both the member and the MEC shall be provided a written explanation of the procedure for appealing the decision.

7.11 APPEAL

7.11.1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Judicial Review Committee either the member or the MEC may request an appellate review. A written request for such review shall be delivered to the Governing Board. If a request for appellate review is not made within such period, that action or recommendation shall be affirmed by the Governing Board as the final action, if it is supported by substantial evidence following a fair procedure.

7.11.2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) Substantial non-compliance with the procedures required hereunder or applicable law which has created demonstrable prejudice;

(b) The decision was not supported by the evidence based on the hearing record or such additional information as may be permitted pursuant to Section 7.11.5, below.

7.11.3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the Appeal Board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member whose membership has been summarily suspended, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Appeal Board for good cause.

7.11.4 APPEAL BOARD

The Governing Board of TSC, LLC, or a committee thereof, shall act as the Appeal Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person was not previously involved with the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

7.11.5 APPEAL PROCEDURE

The proceedings by the Appeal Board shall be in the nature of an appellate hearing based on the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination and confrontation provided at the hearing; or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal and to personally appear and make oral argument. The Appeal Board may thereon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives.

7.11.6 DECISION

(a) Except as provided in Section (b), below within thirty (30) days after the conclusion of the appellate review proceedings, the Appeal Board shall affirm, modify, reverse, or remand for further review the Judicial Review Committee’s decision.

(b) Should the Appeal Board determine that the Judicial Review Committee's decisions are not supported by the evidence, the Appeal Board may modify or reverse the decision and may instead, or shall, where a fair procedure has not been afforded, remand the matter back for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the Appeal Board. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Appeal Board and the Judicial Review Committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the MEC and the subject of the hearing. The decision shall be final.

7.12 REAPPLICATION

Following an adverse final decision by the Governing Board, the Practitioner may not reapply for appointment to the Medical Staff or for clinical privileges, whichever is applicable, for at least twenty-four (24) months after the Governing Board's final decision or in a manner that is inconsistent with the Governing Board's final decision.

7.14 EXTERNAL REPORTING REQUIREMENTS

The Surgery Center shall submit a report regarding a final adverse action to the appropriate state professional licensure board (i.e., the state agency that issued the individual's license to practice) and all other agencies as required by all applicable Federal and/or State law(s).

ARTICLE VIII. OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1.1 IDENTIFICATION

The officers of the Medical Staff shall be a president, a secretary and a chief financial officer (but may remain vacant).

8.1.2 QUALIFICATIONS

Officers must be members of the Active Medical Staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

8.1.3 ELECTION

Officers shall be elected by the Governing Board.

8.1.4 TERM OF ELECTED OFFICE

Each officer shall serve a two (2)-year term, commencing on the first day of the Medical Staff year following his or her election. Each officer shall serve in each office until the end of that officer's term, or until a successor is appointed, unless that officer shall sooner resign or be removed from office.

8.1.5 VACANCIES IN ELECTED OFFICE

Vacancies in office occur on the death or disability, resignation, or removal of the officer, or such officer's loss of membership on the Active Medical Staff. Vacancies may be filled by appointment by the MEC until the next regular election.

8.2 MEDICAL DIRECTOR

8.2.1 SELECTION The Medical Director shall serve at the pleasure of the Governing Board as the chief officer of the Medical Staff. The Medical Director shall enter into a contract with TSC, LLC and shall be required to attain Medical Staff membership and clinical privileges as a condition of that contract. As a contractor, the Medical Director is subject to the regular personnel policies of TSC, LLC and the terms of the Medical Director contract.

8.2.2 DUTIES

The duties of the Medical Director shall include, but not be limited to:

(a) Enforcing the Medical Staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

(c) Serving as chairman of the MEC;

(d) Serving as an ex officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these bylaws;

(e) Appointing, in consultation with the MEC, committee members for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by these bylaws and,

except where otherwise indicated, designating the chairman of these committees; and

(f) Performing such other functions as may be assigned to the Medical Director by these bylaws, the Medical Staff, or by the MEC and Governing Board;

(g) Interacting with the Governing Board in all matters of mutual concern within TSC, LLC.

8.2.3 TERMINATION

(a) The Medical Director may be terminated only by the Governing Board of TSC, LLC.

(b) The Medical Director's contract prevails over these Bylaws except that the Medical Director's contract may not be terminated for a Medical Disciplinary Cause or Reason without the hearing rights provided in Article VII.

(c) If action is taken against the Medical Director that gives rise to a right to a hearing under Article VII, the provisions Article VII shall govern the action.

8.3 ANESTHESIA DIRECTOR

8.3.1 SELECTION

The Anesthesia Director shall serve at the pleasure of the Governing Board. The Anesthesia Director is a physician who has successfully completed a training program in anesthesiology accredited by the ACGME, the American Osteopathic Association or equivalent organizations. The Anesthesia Director may enter into a contract with TSC LLC and shall be required to attain Medical Staff membership and clinical privileges as a condition of that contract. As a contractor, the Anesthesia Director is subject to the regular personnel policies of TSC, LLC and the terms of the Anesthesia Director contract if a contract exists.

8.3.2 DUTIES

The duties of the Anesthesia Director shall include, but not be limited to:

(a) Oversee the anesthesia services provided at TSC;

(b) Approves the policies and procedures for administering the continuum of anesthesia;

(c) Performs Anesthesia Consults as requested by the Medical Staff or Nursing Staff;

(d) Takes appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

(e) Makes recommendations to the Medical Executive Committee and the Governing Board;

(f) Participates in quality assessment and performance improvement activities and;

(g) Serves as a member of the Medical Executive Committee.

8.3.3 TERMINATION

(a) The Anesthesia Director may be terminated only by the Governing Board of TSC, LLC.

(b) The Anesthesia Director's contract prevails over these Bylaws except that the Anesthesia Director's contract may not be terminated for a Medical Disciplinary Cause or Reason without the hearing rights provided in Article VII.

(c) If action is taken against the Anesthesia Director that gives rise to a right to a hearing under Article VII, the provisions Article VII shall govern the action.

ARTICLE IX. COMMITTEES

9.1 DESIGNATION

Medical staff committees shall include but shall not be limited to the Medical Staff meeting as a committee of the whole, meetings of committees established under this Article, and meetings of ad hoc or special committees created by the MEC.

9.2 GENERAL PROVISIONS

9.2.1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be elected for a term of one year, and shall serve until the end of this period or until the member's successor is elected, unless the member shall sooner resign or be removed from the committee.

9.2.2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, or suffers a loss or significant limitation of practice privileges, fails to attend a minimum of fifty percent (50%) of scheduled meetings, or if any other good cause exists, that member may be removed by the MEC.

9.2.3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the MEC.

9.3 MEC

9.3.1 COMPOSITION

The MEC shall consist of the Medical Director and three (3) Active Medical Staff Members elected by the Active Medical Staff Members.

9.3.2 DUTIES

The duties of the MEC shall include, but not be limited to:

(a) Coordinating and implementing the professional and organization activities and policies of the Medical Staff;

(b) Receiving and acting on reports and recommendations from Medical Staff committees;

(c) Recommending action to the Governing Board on matters of a medical-administrative nature;

(d) Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities, the procedures for termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of the Surgery Center.

(e) Maintaining members' credentials files;

(f) Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and Medical Staff members and making recommendations to the Governing Board regarding staff appointments, reappointments, and corrective action:

(g) Initiating corrective action when warranted:

(h) Designating such committees and making appointments to those committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff;

(i) Assisting in the obtaining and maintenance of accreditation;

(j) Designating TSC, LLC's authorized representative for National Practitioner Data Bank purposes, if applicable;

(k) Reviewing Medical Staff bylaws and rules and regulations as needed and making recommendations for modifications to these documents as necessary;

(l) Recommending to the Governing Board appropriate administrative policies and procedures regarding employment of personnel, fiscal concerns and the purchasing of equipment.

(m) Recommending appointments of the Medical Staff officers to the Governing Board.

(n) The MEC will perform the following Medical Staff functions: 1) clinical records; 2) utilization review; 3) pharmacy and therapeutics; 4) quality management; 5) allied health professionals; 6) patients' rights; 7) safety; and 8) infection control.

(o) Reporting to the Medical Staff, at least annually, the findings and results of all Medical Staff quality management activities.

9.3.3 MEETINGS

The MEC shall meet as often as necessary, but at least quarterly and shall maintain a record of its proceedings and actions.

9.4 <u>CLINICAL RECORDS</u>

9.4.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Reviewing and evaluating clinical records, or a representative sample, to determine whether they: (1) properly describe the condition and diagnosis, the progress of the patient, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and (2) are sufficiently complete at all times to facilitate continuity

of care and communications between individuals providing patient care services at the Surgery Center;

(b) Reviewing and making recommendations for TSC, LLC policies, rules and regulations relating to clinical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of procedure enforcement;

(c) Providing liaison between practitioners and personnel in the employ of TSC, LLC on matters relating to clinical records practices; and

(d) Formulating procedures which assure that records are treated confidentially as required by applicable law.

9.5 UTILIZATION REVIEW

9.5.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Conducting utilization review studies designed to evaluate the necessity and appropriateness of admissions to the Surgery Center, discharge practices, use of medical services and related factors which may contribute to the effective utilization of services;

(b) Establishing a utilization review plan.

(c) Obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by TSC, LLC's case management system; and

(d) Reviewing the resources of care provided at the Surgery Center with respect to:

1. The absence of duplicative diagnostic procedures;

2. The appropriateness of treatment frequency;

3. The use of the least expensive alternative resources when suitable; and

4. The use of ancillary services that are consistent with patient's needs.

9.6 PHARMACY AND THERAPEUTICS

9.6.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, disposal, and all other matters relating to drugs at the Surgery Center;

(b) Periodically developing and reviewing a formulary or drug list for use at the Surgery Center;

(c) Evaluating clinical data concerning new drugs or preparations requested for use at the Surgery Center;

(d) Reviewing and reporting adverse reactions to drugs;

(e) Monitoring medication errors and referring such for corrective action, when necessary;

(f) Evaluating the appropriateness of blood transfusions; and

(g) Developing proposed policies and procedures for the handling and administration of blood and blood components; and

(h) Assuring the maintenance of a current pharmacy license.

9.7 QUALITY MANAGEMENT

9.7.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Recommending, for approval by the Governing Board, a written plan(s) for maintaining quality patient care at TSC, LLC;

(b) Submitting regular confidential reports to the Governing Board on the quality of medical care provided and on quality review activities conducted;

(c) Collecting data related to established criteria in an ongoing manner;

(d) Periodically evaluating data to identify unacceptable or unexpected trends or occurrences that influence patient outcomes;

(e) Evaluating the frequency, severity, and source of suspected quality problems or concerns:

(f) Implementing measures to resolve quality problems or concerns that have been identified;

(g) Reevaluating quality problems or concerns to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, taking alternate corrective actions as needed to resolve the problem;

(h) Incorporating findings of quality management activities into TSC, LLC's educational activities; and

(i) Devising and implementing a procedure for the immediate transfer of patients requiring emergency medical care beyond the capabilities of the Surgery Center to a local Medicare-certified hospital and being responsible for transfer agreements to such hospitals.

9.8 <u>ALLIED HEALTH PROFESSIONALS (AHP)</u>

9.8.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include but not be limited to the following:

(a) Recommending to the Governing Board the categories of AHPs eligible to apply for AHP status and practice prerogatives at the Surgery Center;

(b) Establishing procedures regarding:

(1) The mechanism for evaluating the qualifications and credentials of AHPs;

(2) The minimum standards of training, education, character, and competence of AHPs eligible to apply to perform services;

(3) Identification of services which may be performed by an AHP, or category of AHPs, as well as any applicable terms and conditions thereon;

(4) The professional responsibilities of AHPs who have been determined eligible to perform services.

(c) Conducting appropriate monitoring, supervision, and evaluation of AHPs who perform services, provided that:

(1) AHPs not employed by TSC, LLC will be directly supervised by the operating surgeon they are employed by; and

(2) AHPs employed by TSC, LLC will be evaluated by the nurse manager.

9.9 PATIENTS' RIGHTS

9.9.1 DUTIES

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to:

(a) Formulating procedures which are available to patients and staff which require that:

(1) Patients are treated with respect, consideration, and dignity;

(2) Patients are provided appropriate privacy during interviews, examinations, treatment, and consultation;

(3) Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When a patient does not wish to receive the information, the information is provided to a surrogate decision-maker;

(4) Patients are given the opportunity to participate in decisions involving their health care; and

(5) Patients are provided with information regarding advance directives.

(b) Providing information to patients and staff concerning:

(1) Patient conduct and responsibilities;

(2) Services available at the Surgery Center;

(3) Provision for after-hour and emergency care;

(4) Fees for services and payment policies; and

(5) Methods for expressing grievances and suggestions to TSC, LLC.

(c) Insuring that marketing or advertising regarding the competence and capabilities of TSC, LLC is not misleading to patients.

9.10 SAFETY

9.10.1

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to the following:

(a) Assuring that the Surgery Center has the necessary personnel, equipment, and procedures to handle medical and other emergencies that may arise in connection with services sought or provided;

(b) Providing periodic instruction to all personnel in the proper use of safety, emergency, and fire-extinguishing equipment;

(c) Providing a comprehensive emergency plan to address internal and external emergencies, including evacuation and drill procedures;

(d) Assuring that personnel trained in cardiopulmonary resuscitation and the use of cardiac emergency equipment are present at the Surgery Center during hours of operation;

(e) Assuring that provisions are made to reasonably accommodate disabled individuals;

(f) Assuring that the Surgery Center is clean and properly maintained;

(g) Assuring that a system exists for the proper identification, management, handling, transport, treatment, and disposal of hazardous materials and wastes; and

(h) Assuring that appropriate emergency and other equipment and supplies are maintained, periodically tested and readily accessible.

9.11 INFECTION CONTROL

The duties of the MEC (or a committee duly appointed by the MEC) shall include, but not be limited to, the following:

(a) Establishing a program for identifying and preventing infections, and maintaining a sanitary environment;

(b) Devising and implementing procedures to minimize sources and transmission of infection, including adequate surveillance techniques; and

(c) Maintaining an ongoing log of reported incidents of infection.

9.12 AD HOC COMMITTEES

Special or ad hoc committees may be created by the MEC to assist with investigations or to perform other specified tasks. The chairman and members of such committees shall be appointed by, and may be removed by the Medical Director in consultation with the MEC.

ARTICLE X. MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1.1 ANNUAL MEETING

There shall be an annual meeting of the Medical Staff. Except as otherwise specified in these bylaws, the Medical Director may establish the times for the holding of the annual meeting. The MEC shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting shall be given to the members at least five (5) days prior to the meeting.

10.2 COMMITTEE MEETINGS

10.2.1 REGULAR MEETINGS

The Medical Director shall make every reasonable effort to ensure that meeting dates are disseminated to the members with adequate notice.

10.3 QUORUM

10.3.1 STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the Active Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the Medical Staff. The presence of thirty-three (33%) of such members shall constitute a quorum for all other actions.

10.3.2 COMMITTEE MEETINGS

A quorum shall consist of thirty-three percent (33%) of the voting members of a committee but in no event less than three (3) voting members.

10.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is

approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds (2/3) of the members entitled to vote.

10.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at minimum, a record of the attendance of members and the vote taken on action items. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the MEC.

10.6 ATTENDANCE REQUIREMENTS

10.6.1 Each member is encouraged to attend officially called meetings. There are no meeting attendance requirements.

10.6.2 Whenever apparent or suspected deviation from standard clinical practice or disruptive behavior is alleged, seven (7) days advance special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance at a meeting is mandatory. Such a meeting shall be limited to the members of the committee. Failure of a practitioner to appear at any such meeting with respect to which he/she was given such special notice shall, unless excused by the committee on a showing of good cause, result in a recommendation to the MEC for corrective action, to include, but not be limited to, an automatic suspension of all or a portion of the practitioner's clinical privileges. Such suspension shall remain in effect until the matter is resolved by subsequent action of the committee, the MEC or the Governing Board. At the discretion of the chairman, when a Medical Staff member's practice or conduct is scheduled for discussion at a regular committee meeting, the member may be required to attend.

ARTICLE XI. CONFIDENTIALITY OF INFORMATION

11.1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility for evaluation and improvement of quality of care rendered in this surgery center, including, but not limited to, meetings of the Medical Staff as a committee of the whole, meetings of committees, and meetings of special or ad hoc committees created by the MEC and including information regarding any member of applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

11.1.1 CONFIDENTIALITY

The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care:

(a) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered at the Surgery Center shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed persons and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the Governing Board of TSC, LLC -- in order that the Governing Board may discharge its lawful obligations and responsibilities -- shall be maintained by the Governing Board as confidential.

(d) Information contained in the credentials file of any member may be disclosed to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the MEC.

(e) A Medical Staff member shall be granted access to his/her own credentials file, subject to the following provisions:

(1) Timely notice of such shall be made by the member to the MEC.

(2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member.

(3) The review by the member shall take place during normal work hours, with a designee of the MEC present.

(4) In the event a Notice of Charges is filed against a member, access to his/her own credentials file shall be governed by Section 7.9.5.

11.1.2 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION / DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE

(a) When a member has reviewed his/her file as provided under Section 11.1.1(e) he/she may address to the MEC a written request for correction or deletion of information in his/her credentials file.

Such request shall include a statement of the basis for the action requested.

(b) The MEC shall review such request within a reasonable time and shall decide whether or not to make the correction or deletion requested.

(c) The member shall be notified promptly, in writing, of the decision of the MEC.

(d) In any case, a member shall have the right to add his/her credentials file, on written request to the MEC, a statement responding to any information contained in the file.

ARTICLE XII. ADOPTION AND AMENDMENTS OF BYLAWS, RULES AND REGULATIONS

12.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such rules and regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current Medical Staff practice. Recommended changes to the rules and regulations shall be submitted to the MEC for review and evaluation prior to presentation for consideration by the Medical Staff as a whole under such review or approval mechanism as the Medical Staff shall establish. Following adoption such rules and regulations shall become effective following approval of the Governing Board which approval shall not be withheld unreasonably, or automatically within thirty (30) days if no action is taken by the Governing Board. Applicants and members of the Medical Staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations.

12.2 BYLAWS

On the request of the MEC or on timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws. Such action shall be taken at a regular or special meeting provided (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the Medical Staff, and such changes were offered at such prior meeting and (2) notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. Both notices shall include the exact working of the existing bylaw language, if any, and the proposed change(s).

12.2.1 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmative vote of fifty-one percent (51%) of the members voting in person or by written ballot.

12.2.2 APPROVAL

Bylaw changes adopted by the Medical Staff shall become effective immediately following approval by the Governing Board, which approval shall not be withheld unreasonably. If approval is withheld, the reasons for doing so shall be specified by the Governing Board in writing, and shall be forwarded to the MEC.

These revised Bylaws were approved by the MEC on ____________, and were sent to all Medical Staff members on ____________ and were approved on ____________. The Governing Board approved them on ____________.

~~Medical Director~~	~~Date~~
~~Governing Board~~	~~Date~~

Annaul Review of the Bylaws:

The Medical Executive Committee met on ______________________________ and approved the Bylaws. The Board of managers met on ______________________________ and approved the Bylaws. The Bylaws will be reviewed and approved annually and upon any changes.

TRUCKEE SURGERY CENTER, LLC

MEDICAL STAFF

RULES & REGULATIONS

Updated: August 2020

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GENERAL RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary for the proper conduct of its work. Such Amendments shall become effective when approved by the Medical Executive Committee and Governing Body.

Admission and Discharge of Patients

A. Admission: only members of the medical staff, with admitting privileges, may admit a patient to the surgery center.
B. Medical Management: All patients entering Truckee Surgery Center, including those for pediatric and dental care, must have a medical staff physician responsible for the overall medical management of the patient, including the performance, and recording in the medical record, of an admission history and physical examination, and when indicated, the patient's ability to undergo surgery and anesthesia.
C. Exceptions: Truckee Surgery Center shall accept all outpatients for care and treatment except patients whose conduct would present a problem regarding their own or other patient's safety, care and comfort.
D. Responsibility: A member of the medical staff shall be responsible for the medical care and treatment of each patient in Truckee Surgery Center and the prompt completeness and accuracy of the medical record.
E. Patient Safety: The admitting physician shall be held responsible for giving such Information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatsoever.
F. AMA Discharges: Patients shall be discharged or transferred only on the written order of the attending physician. Should a patient leave Truckee Surgery Center against the medical advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient’s medical record. The patient should sign the appropriate release. If this release is not obtainable, the circumstances shall be documented in the medical record.
G. Transfer/Discharges: No patient shall be transferred or discharged for purposes of affecting a transfer from Truckee Surgery Center to another health facility, unless arrangements have been made in advance to such health facilities. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such a transfer or discharge would be detrimental to the patient.
H. Minors/Discharge: A minor shall be discharged only to the custody of his/her parents or legal guardian, unless such parent or guardian shall direct otherwise in writing. This shall not include emancipated minors.
I. Deaths: In the event of a death In Truckee Surgery Center, the deceased shall be pronounced dead within a reasonable time by the attending physician or his physician designee. The body shall not be released until such entry has been made and signed In the medical record of the deceased by a member of the medical staff. Policies with respect to the release of the bodies shall conform to local law.

Orders

A. Treatment Orders: All orders for treatment and diagnostic studies shall be in writing. (Written by the physician or a verbal/telephone order written by an RN or LVN)
    1. The above named individuals may only receive and record orders within their scope of practice.

2. All verbal orders shall be signed by the person to whom the order was dictated and following the name of the physician dictating the order and shall be authenticated within 48 hours. Verbal orders may be received only from members of the medical staff with clinical privileges to do so and not from an office or clinic receptionist or nurse.
3. Faxed orders with physician signatures may be accepted. Original faxes will be kept in the patient's medical record.

B. Time/Date: All Truckee Surgery Center orders shall be dated and timed. In addition, all Truckee Surgery Center personnel shall record the time when the order was transcribed.
C. Order Writing: All physicians' orders shall be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten and/or understood by the nurse.
D. Take Home Drugs: No drugs supplied by Truckee Surgery Center shall be taken from the surgery center.

Consents

A. No operation will be performed without the informed consent of the patient or his legal guardian except in documented emergencies. Appropriate informed consent for all anticipated procedures must be on the chart prior to surgery.
B. Informed Consent: It is the responsibility of the physician performing the procedure to obtain informed consent and to explain the potential risks and complications of the impending procedure and anesthesia. No preoperative medication will be given and the patient will remain in the preoperative area until the consent has been completed.
C. Content: The consent form must state the name of the physician and the name of the procedure or treatment. The physician is responsible to obtain the informed consent and it will be signed when the patient has been advised in simple terms of the risks, benefits and alternatives to surgical treatments or procedures.
D. Consent Manual: The Medical Staff of Truckee Surgery Center has adopted the California Hospital Association's Consent Manual to serve as operating policy governing all matters of consents.
E. Physicians shall see that one parent or guardian signs the consent for minors. The consent of both parents is recommended whenever possible.
F. A sterilization consent will be signed on all patients undergoing sterilization procedures as required by the Consent Manual.

The Medical Record

A. Responsibility/Content: The admitting physician shall be responsible for a complete and legible medical record for each patient. This record shall contain current and pertinent information including Identification of the patient; admission history and physical exam; consultations; diagnostic records; operative reports; pathology findings; final diagnosis; and discharge condition.
B. Preoperative Requirements: All surgical patients must have a history and physical examination, appropriate lab and diagnostic tests and appropriate consultations prior to surgery. If the history and physical has been dictated but is not on the chart, the physician must indicate this and complete a note with pertinent physical findings, history and admitting diagnosis.
C. Admission History and Physical: An admission history and physical examination shall be recorded by the attending physician on or before the day of surgery, and include all pertinent findings.
   1. When a complete history has been recorded and a physical examination performed within a week prior to the patient's surgery at Truckee Surgery Center, or when a patient is readmitted within thirty days of the last admission for the same or a related condition, a legible copy of these reports may be used in the medical record. In such instances, an interval admission note must be written addressing changes in the history or physical

    condition of the patient.
    2. An acceptable history and physical includes: chief complaint; details of present illness; relevant past social and family history; review of systems; pertinent physical findings; current physical assessment; treatment plan.
    3. If the history and physical was performed by a physician other than the physician performing the procedure, that physician must document his/her preoperative findings by way of dictated report or progress note prior to commencement of surgery.

D. Preoperative/Operative Note: The surgeon should record and authenticate a preoperative diagnosis prior to surgery in the medical record. An operative note must be written in the progress notes immediately after surgery and shall specify the type of operation performed and contain any other pertinent· information.

E. Operative Report: Operative reports will include a detailed account of the findings during the procedure and the details of the surgical technique. Operative reports will be dictated within twenty-four hours following surgery and the report promptly signed by the physician and made part of the medical record. Reports not dictated within twenty-four hours of the procedure will be ground for temporary restriction of privileges.

F. Abbreviations: Abbreviations from the Dictionary of Medical Acronyms and Abbreviations are considered current. A copy of this book is kept in the Post Anesthesia Care Unit. Addendums will be kept with the book as required.

G. Release of Information: Written consent of the patient is required for release of medical Information to persons not otherwise authorized to receive the information.

H. Removal of Records: All medical records are the property of Truckee Surgery Center and may be removed from the surgery center's safekeeping only in accordance with a court order, subpoena or statue. Any physician removing charts from the surgery center will be immediately suspended.

I. Access to Medical Records: When a patient is readmitted to the surgery center, previous records will be available for the use of the admitting physician and anesthesiologist. Physicians shall not be allowed access to the medical records of other physician's patients unless:
    a. It is an authorized study and research project approved by the Medical Executive Committee.
    b. They have been directed by the Executive Committee to review the medical record of another physician's patients.
    c. They are actively involved in the patient care.
    d. And/or the patient signs a release form.

J. Permanent File: The medical record will not be permanently filed until it is completed by the responsible physician.

K. Suspension for Incomplete Medical Records: All medical records will be completed within fourteen days of surgery/procedure.

L. Admissions While on Temporary Suspension: If a member of the medical staff has been notified according to established policies for delinquent records by a phone call from the Administrator and the physician has a surgery scheduled during the described period of suspension, the physician will be contacted at 9:00am the working day before the scheduled admission and asked to complete the medical records in question by 2:00pm or the procedure will be cancelled. The physician will be responsible for informing the patient regarding the cancellation. If the patient arrives at Truckee Surgery Center, the patient will be asked to contact his/her physician.

M. Alteration of a Medical Record: Unwanted entries should be lined through, signed and dated. Corrections should be entered in the record chronologically, signed and dated. Do not remove or obliterate entries or documents.

N. Inappropriate Chart Notes: Physicians are restricted from writing interpersonal comments that reflect upon the personality, Integrity or competence of any other physician in the patient record. Physicians who do so will be considered in violation of the Rules and Regulations and could be suspended from the Medical Staff.

O. Laboratory Tests Performed Outside Truckee Surgery Center: outside lab, test results may become part of the medical record only if such tests are performed in labs that have been certified by the

College of American Pathologists or their equivalent or licensed through the Clinical Laboratories Improvement Act of 1967. Lab results not performed in such facilities may be referred to in the admission history and physical or progress notes.

Allied Health Professional

While not qualified for membership on the Medical Staff, allied health professionals may practice in Truckee Surgery Center under the following conditions:

A. Each person shall have sufficient training, experience and demonstrated competence to:
   a. Exercise judgment within their area of competence.
   b. Participate directly in the management of patients under the supervision or direction of a member of the medical staff, within the limits established by the medical staff and consistent with state law. Entries to the medical record by· allied health professionals will be countersigned by the physician.

B. Each person will be under direct supervision of an attending physician. They may carry out their activities in conformity with Medical Staff Bylaws, Rules and Regulations and upon direct order of the attending physician.

C. Approval to practice in Truckee Surgery Center within the guidelines established above will be contingent upon recommendation of the Executive Committee and Governing Board.

Access to Credentials Files

Each member in good standing of the medical staff of Truckee Surgery Center may have access to his credentials file. This review must be requested In advance and must be accomplished in the presence of the Medical Director or his/her designee. No member of the Medical Staff will be allowed access to the information contained in another staff member's file unless it is within the scope of committee activity related to peer review or privileging functions.

Responding To Committee Inquiries

Medical staff members must respond within one month to a request from the Executive Committee, which has mailed return receipt requested, or be suspended from the staff until said response has been received or current medical staff appointment has expired.

ANESTHESIA RULES AND REGULATIONS

General Organization

Anesthesia is that membership of the medical staff that primarily concerns itself with the anesthesiology aspects of surgical and medical care, diagnosis and treatment.

Pre-Anesthesia

A. Preoperative Visit: The preoperative visit will be conducted by an anesthesiologist scheduled for the case prior to the scheduled surgery at which time there shall be a disclosure of the plan of anesthesia, the surgical procedure anticipated, the possible risk and possible complications and completion of the pre-anesthetic evaluation. It is expected that the anesthesiologist will make every effort to contact the patient by phone prior to the scheduled surgery day to decrease unexpected delays due to patient questions, complications, or additional required testing. Except in emergency cases, this evaluation will be recorded prior to the patient's transfer to the operating room. The choice of specific anesthetic agent or technique will be left to the discretion of the anesthesiologist.

B. Preoperative Evaluation: The preoperative evaluation will be documented in the patient's medical record and will include at least the following:
- Pertinent history and physical exam
- Airway examination
- Choice of anesthesia
- Other anesthesia experience
- Potential anesthetic problem
- Date and time of visit
- ASA Classification for anesthetic risk

C. Preoperative Medication: Preoperative medications may be ordered by the anesthesiologist.

D. Responsibilities During Surgery: It is the responsibility of the anesthesiologist and the circulating nurse to identify the patient prior to entering the operating room and ascertain that the medical record contains the appropriate informed consent forms for the contemplated surgical procedures. The anesthesiologist is always directly responsible to the patient.
   a. As a physician, the anesthesiologist is expected to use drugs he/she may deem advisable in a given situation.
   b. Blood products are checked against the patient's ID, chart and administration slip by the anesthesiologist and circulating nurse. It is then started by the anesthesiologist who completes the appropriate documentation.
   c. The anesthesiologist is in complete charge of all emergency procedures except those relating directly to surgery.
   d. When appropriate, the IV fluids are started preoperatively in the pre- operative area by the nurse or anesthesiologist.

E. Presence of Anesthesiologist: The anesthesiologist shall be in constant attendance during the entire procedure and a record of all events taking place during the induction, maintenance and emergence from anesthesia, Including the dosage and duration, shall be maintained. This is not to preclude the induction of regional anesthesia in a designated holding area where continuous monitoring is available and used.

Local Anesthesia

A. Definition: Local anesthesia is defined as anesthetizing a specific area causing insensibility to pain.
B. Responsibility: If no anesthesiologist is present in the operating room, the surgeon will be responsible for the administration of the local anesthesia.
C. Drug and Equipment Availability: All usual drugs and necessary resuscitation equipment will be available and the physician in charge will be knowledgeable and proficient in their use.
D. Monitoring of Patient: During local anesthesia, in the absence of an anesthesiologist, vital signs will be monitored and recorded by a Registered Nurse. Medications may be given by the nurse on the order of a physician.

Immediate Postoperative Period

The surgeon, anesthesiologist and the PACU nurse share the responsibility for patients in the PACU.

A. The anesthesiologist will be responsible for the assessment of the post-anesthetic patient. He/she will determine the stability of the patient upon completion of the procedure and closely monitor the patient throughout the recovery period.
B. The anesthesiologist will remain available in the surgery center until the patient's condition is stable.
C. Discharge from the Recovery Room is to be by direct order from the anesthesiologist.
D. The patient's post-anesthesia status will be documented by the anesthesiologist in the medical record, dated and timed.

SURGERY RULES AND REGULATIONS

General Organization

Composition: Surgery is that membership of the medical staff which concerns itself with the surgical aspect of the diagnosis and treatment of disease and. may include physicians with privileges in the following specialties: Dentistry and Oral Surgery, General Surgery, Ophthalmology, Orthopedics, Gynecology, Otolaryngology, Plastic and Reconstructive Surgery, Podiatry, Urology and Pain Management

Privileges

Proctoring: Proctors are to be arranged by the applicant from members of the medical staff who have been granted the requested privileges. The proctoring physician is expected to complete a written record of the assessment.

General Rules and Regulations

A. Scheduling: Procedures may only be scheduled by members of the medical staff and in compliance with Truckee Surgery Center guidelines.
B. Provisional Surgical Privileges: Surgeons not yet approved for medical staff membership may be granted provisional surgical privileges.
C. Assistant Surgeons: It is the responsibility of the operating surgeon to arrange an appropriate assistant for cases at his/her discretion.
D. Outpatient Surgery: All patients must have their preoperative diagnostic tests completed the day prior to the scheduled procedure.
E. Surgery Start Time: Surgeons must be in the operating room and ready to begin at the scheduled time, unless there is a reasonable excuse for delay. A delayed case time may be assigned at the discretion of the anesthesiologist and the Charge Nurse.

Conduct of Care

A. Visitors: See Operational Policy regarding visitors.
B. Wound Infections: It is requested that each surgeon or office nurse/representative report the presence of wound infections to the QAPI/IC Coordinator.

Pathology

A. Composition: Pathology is that membership of the Medical Staff, which primarily concerns itself with the anatomical pathology, surgical pathology and clinical pathology of medical care. Members shall be fully trained or Board Certified Clinical and Anatomical Pathologists.
B. Tissue and Foreign Objects: Tissues removed shall be delivered to the pathologist at the discretion of the surgeon and within the guidelines of the pathologists and operational policy entitled "Specimen Collection" A report of the pathologist's findings shall be filed in the medical record. The tissue will be the property of the surgery center/pathologist. Slides of tissue blocks may be made available to outside facilities at a doctor's request for review on a loan basis.

Dentists and Oral Surgeons

A. Medical Appraisal: A patient admitted for dental care shall receive the same basic medical appraisal

as patients admitted for other surgical procedures.

B. Responsibility: A patient admitted for dental care is a dual responsibility involving the dentist and the patient's primary care provider or cardiologist.

C. Dentists Responsibilities:
   a. A detailed dental history addressing necessity and appropriateness of care.
   b. A detailed description of the examination of the oral cavity and preoperative diagnosis.
   c. A complete operative report, describing the findings and technique. In cases of teeth extractions, the dentist must report the number of teeth and fragments will be sent to the pathologist for examination.
   d. Progress notes must be relevant to the oral condition.

D. Primary care/Cardiologist Responsibilities:
   a. Medical history pertinent to the patient's general health, including consultation requirements. Within 30 days of the planned procedure, completed by the patients primary care or cardiologist.
   b. Medical Clearance, completed by the patient's primary care provider or cardiologist, for the patient to be admitted to the facility for the planned procedure.
   c. A physical examination to determine the patient's condition prior to anesthesia and surgery, completed by the patient's primary care or cardiologist.

E. Anesthesia Responsibilities:
   a. A pre-anesthesia evaluation
   b. Treatment of any medical condition present on admission or that occurs during the patient's stay at Truckee Surgery Center.

F. Discharge: The discharge of the dental patient will be on written order of the dentist member or the responsible physician member of the Medical Staff

G. History and Physical Requirements for Oral Surgeons: Physician responsibilities as described in the first two physician responsibilities above may be waived for qualified oral surgeons who, after appropriate monitoring, have been granted privileges to perform complete history and physical examinations on their patients.

Podiatry

A. Medical Appraisal: A patient admitted for podiatric care shall receive the same basic medical appraisal as patients admitted for other surgical procedures.

H. Responsibility: A patient admitted for podiatric care is a dual responsibility involving the Podiatrist and the patient's primary care provider or cardiologist.

I. Podiatrist's Responsibilities:
   a. A detailed podiatric history addressing necessity and appropriateness of care.
   b. A detailed description of the examination of the foot and preoperative diagnosis.
   c. A complete operative report, describing the findings and technique.
   d. Progress notes must be relevant to the podiatric condition.

J. Primary care/Cardiologist Responsibilities:
   a. Medical history pertinent to the patient's general health, including consultation requirements. Within 30 days of the planned procedure, completed by the patients primary care or cardiologist.
   b. Medical Clearance, completed by the patient's primary care provider or cardiologist, for the patient to be admitted to the facility for the planned procedure.
   c. A physical examination to determine the patient's condition prior to anesthesia and surgery, completed by the patient's primary care or cardiologist.

K. Anesthesia Responsibilities:
   a. A pre-anesthesia evaluation
   b. Treatment of any medical condition present on admission or that occurs during the patient's stay at Truckee Surgery Center.

L. Discharge: The discharge of the podiatry patient will be on written order of the Podiatrist member or the responsible physician member of the Medical Staff

Status Active PolicyStat ID 12610914

Origination	11/2022	Owner	Courtney Leslie: Administrator
Last Approved	11/2022	Department	Human Resources
Last Revised	11/2022		
Next Review	11/2023		

Licensure, HR-2207

PURPOSE:

To ensure appropriate licensure and certification of all employees and contracted staff (not subject to the medical staff privilege process) in compliance with appropriate licensing agencies.

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POLICY:

A. It is the policy of Truckee Surgery Center (TSC) to employ only those individuals that have proper licensure, certification or registration by the appropriate agency in those jobs requiring such status.

B. Employees working in positions with a requirement for CPR, ACLS, NRP, and PALS must provide proof of certification at time of hire.

PROCEDURE:

A. It is the responsibility of each staff member to maintain current licensure or certification. The staff member will furnish proof of this status with original documents before employment or service begins.

B. At each time the status requires updating and/or renewal, the Administrator will perform online verifications with the agency. If the Administrator is unable to verify a license the staff member will provide a copy of online verification or photocopy of license to the Administrator as proof of update and/or renewal. Required licensure is eligible for education reimbursement if the employee has adequate funds available.

C. For employees on a Leave of Absence, TSC may hold in abeyance the requirement to complete job requirement documentation (e.g. Competency Forms, TB testing, Annual Education, performance reviews, counseling's, etc.) until the employee returns from leave. The employee must complete all outstanding job requirements and documentation (licensure, CPR, ACLS, NRP, PALS, and TB testing, as applicable) prior to a return to work. Competency-related documentation must be completed within one week of the employee's return.

D. Current job requirement documentation will be maintained by the Administrator.

E. If an employee fails to provide such documentation or proof of current status by the due date they will be taken off of the work schedule for a period of up to one week to allow for renewal of license or certification. Accrued Personal Leave (PTO) may be paid for time missed, if applicable. If proof of license or certification renewal is not provided at the end of one week, the employee will be subject to disciplinary action up to and including termination.

F. **Periodic Renewal:**

1. License/job requirement expiration monitoring will be done by the Administrator. The Administrator will notify employees of upcoming due dates.
2. It is the responsibility of the employee to provide online verification or a copy of the original of the required document at each date or time of renewal. If the document (License, Certification, Registration, CPR, ACLS, NRP, PALS, etc.) is not received, the employee will be considered to be out of compliance.

G. **Licensure**

1. A verification call from the Administrator to the state licensing agency or an online verification may confirm the renewal of said license. A photocopy or printed online verification from the state licensing agency will be presented to the Administrator within a reasonable period of time.
2. In case of clerical or procedural error on the part of the licensing agency, documentation from that agency must be provided in lieu of the actual license.
3. Employees taking licensure examinations will do so on their own time and at their own expense, with TSC arranging work schedules so that time will be available for taking the licensure examination. The employee will pay the cost of continued licensure.
4. Employees will immediately inform the Nurse Manager or Administrator of changes in their license status and will provide their original license or online verification for visual verification or photocopying in accordance with State law.
5. Employees who change their names or addresses must notify the appropriate licensing board of the change(s). The employee will draw a line through the old name or address on the license and write the new name or address legibly. When the employee renews the license, it must reflect the new name to continue working in the licensed capacity.

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REFERENCES:

ACHC Standard 02.01.02

Approval Signatures

Step Description	Approver	Date

Heidi Fedorchak: Nurse Manager	11/2022
Courtney Leslie: Administrator	11/2022

COPY

Status Draft PolicyStat ID 12106820

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Next Review	N/A		

Corporate Compliance Program, GOV-2203

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POLICY:

A. The Truckee Surgery Center's (TSC) is committed to full compliance with all applicable federal, state, and local laws, rules and regulations, and to conduct itself in accordance with the highest level of business and community ethics and standards. To meet this goal, TSC has implemented the development and continued advancement of a corporate compliance program and works in collaboration with Tahoe Forest Hospital District's (TFHD) Compliance and Risk departments.

B. The Compliance Program exhibits the Surgery Center's commitment to ethical and legal standards of conduct and sets forth guidelines to prevent and detect any violation of the law. While the Compliance Program places a strong emphasis on the prevention of fraud, abuse and waste in federal, state and private health care plans, the scope of the Program is not limited to these issues and covers other areas of compliance to which the Surgery Center is subject.

C. All TSC employees, medical staff members, independent contractors providing services to TSC, and members of the Board of Managers are considered Covered Individuals for the purposes of this policy. Vendors doing business with TSC are Covered Individuals for certain provisions of the Corporate Compliance Program, e.g., exclusion screening.

Compliance Program Components:

Truckee Surgery Center's comprehensive Compliance Program includes the following seven elements:

1. Written policies and procedures
2. Designation of a compliance officer who works in collaboration with TFHD's compliance officer and legal counsel
3. Conducting effective training and education
4. Developing effective lines of communication

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5. Enforcing standards through well-publicized disciplinary guidelines
6. Auditing and monitoring
7. Responding to detected offenses and developing corrective action initiatives

PROCEDURE:

Written Policies and Procedures

A. Truckee Surgery Center (TSC) has developed and distributed a written Code of Conduct, as well as written policies and procedures that promote the Surgery Center's commitment to compliance (e.g., by including adherence to compliance as an element of evaluating managers). This policy addresses specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals.
This compliance program required the development and distribution of written compliance policies that identify specific areas of risk to the Surgery Center. Policies have been developed under the direction and supervision of the Compliance Officer, TFHD's Compliance Officer, and legal counsel, and are provided to all individuals who are affected by the particular policy at issue, including the Surgery Center's agents and independent contractors.

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Code of Conduct

A. Developed Code of Conduct for all employees and vendors
B. Standards state TSC's requirements of compliance reflecting a carefully crafted, clear expression of expectations for all Surgery Center board members, leadership, employees, physicians, and where appropriate, contractors and other agents.
C. Standards are distributed to all employees upon hire and annually

Risk Areas

A. Billing for services not supported by medical record documentation;
B. Charging/billing procedures/processes after staff turnover
C. Compliance with HIPAA/California Medical Insurance Act Privacy and Security Rules and policies
D. Issuing Advance Beneficiary Notices for services not covered by Medicare
E. ICD-10 coding
F. Duplicate billing
G. Submitting cost reports
H. Unbundling charges
I. Patient Rights
J. Refunding credit balances
K. Charging and /or billing for services not actually rendered

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L. Stark or Anti-kickback laws/regulations
M. Submitting false claims
N. Performing Office of Inspector General/General Services Administration exclusion checks
O. Internal controls on cash and cash assets

Claim Development and Submission Process

Claim development and submission process and procedures include the following:

A. Provide for proper and timely documentation of all physician and other professional services prior to billing to ensure that only accurate and properly documented services are billed.
B. Emphasize that claims will be submitted only when appropriate documentation supports the claims, and only when such documentation is maintained and available for audit and review.
C. Be consistent with appropriate guidance from medical staff, physician and Surgery Center records and medical notes used as a basis for a claim submission. This information is appropriately organized in a legible form so they can be audited and reviewed.
D. Indicates that the diagnosis and procedures reported on the reimbursement claim is based on the medical record and other documentation, and that the documentation necessary for accurate code assignment is available to coding staff.
E. Provide that the compensation for billing department coders, physicians and billing consultants should not provide any financial incentive to improperly up code claims.

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Medical Necessity - Reasonable and Necessary Services

Medical necessity service policies and procedures:

A. Provide that claims are only submitted for services when TSC has reason to believe they are medically necessary and that they were ordered by a physician or other appropriately licensed individuals.
B. Assure that documentation such as patients' medical records and physicians orders should be available to support the medical necessity of a service that TSC has provided.
C. Ensure that a clear, comprehensive summary of the medical necessity definitions and rules of the various government and private plans is prepared and disseminated appropriately by the Compliance Officer.

Anti-Kickback and Self-Referral Concerns

A. All of TSC's contracts and arrangements with referral sources must comply with applicable statutes and regulations.
B. TSC should insure that it does not submit to the federal health care programs claims for patients who were referred to the Surgery Center pursuant to contracts and financial arrangements that were designed to induce such referrals in violation of the anti-kickback statue, Stark physician self-referral law or similar federal or state statute or regulation.
C. Physicians providing services at TSC may be employed by or contracted with TSC or TFHD.

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TSC and TFHD will not enter into financial arrangements with TSC-based physicians that are designed to provide inappropriate remuneration to TSC in return for physician's ability to provide services to federal health care program beneficiaries at TSC.

Bad Debts

TSC developed a mechanism to review, at least annually:

A. Whether it is properly reporting bad debts to Medicare

B. All Medicare bad debt expenses claimed to ensure that the Surgery Center's procedures are in accordance with applicable federal and state statutes, regulations guidelines and policies. Such a review should ensure that the Surgery Center has appropriate and reasonable mechanisms in place regarding patient deductible or co-payment collection efforts and has not claimed as bad debts any routinely waived Medicare co-payment and deductibles, which waiver also constitutes a violation of the anti-kickback statute.

Credit Balance

A. TSC instituted procedures to provide for the timely and accurate reporting of Medicare and other federal health care program credit balances.

B. TSC's information system has the ability to print out the individual patient accounts that reflect a credit balance in order to permit simplified tracking of credit balances.

C. TSC designated at least one person as having responsibility for the tracking, recording and reporting of credit balances.

D. The Administrator may review reports of credit balances and reimbursements or adjustments on a monthly basis as an additional safeguard.

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Retention of Records

A. TSC has provided for the implementation of a records system.

B. This system establishes policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents.

C. This system includes such documentation as clinical and medical records, claim documentation, all records necessary to protect TSC's integrity of its compliance process and confirm the effectiveness of the program.

D. Documentation is maintained to indicate employees were adequately trained.

E. Reports from the Surgery Center are entered into the TFHD's event reporting system, including the nature and results of any investigation that was conducted, modifications to the compliance program, self-disclosures, and the results of the Surgery Center's auditing and monitoring efforts.

Compliance as an Element of a Performance Plan

A. TSC's compliance program requires that the promotion of, and adherence to, the elements of the compliance program be a factor in evaluating the performance of managers. They, along

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with other employees, will be periodically trained in new compliance policies and procedures. In addition, all managers and supervisors involved in the coding, claims and cost report development and submission processes will:

1. Discuss with all supervised employees the compliance policies and legal requirements applicable to their function.
2. Inform all supervised personnel that strict compliance with the policies and requirements is a condition of employment.
3. Disclose to all supervised personnel that TSC will take disciplinary action up to and including termination or revocation of privileges for violation of these policies or requirements.

Designation of a Compliance Officer

TSC has designated a compliance officer to serve as the focal point for compliance activities. The Compliance Officer works closely with TFHD's Compliance Officer and legal counsel. This responsibility may be the individual's sole duty or added to other management responsibilities, depending upon the size and resources of the Surgery Center and the complexity of the task. Designating a compliance officer with the appropriate authority is critical to the success of the program; the Compliance Officer has express authority, in his/her sole discretion, to make in-person reports directly to TSC's Board of Managers.

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A. The Compliance Officer establishes and implements an effective compliance program to prevent illegal, unethical or improper conduct. The Compliance Officer acts as staff to the Board of Managers by monitoring and reporting results of the compliance and ethics efforts of TSC and provides guidance for the Board and senior management team on matters relating to reporting and compliance. The Compliance Officer, together with legal counsel, is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.

B. The designation of a Compliance Officer does not in any way reduce the responsibility of every covered Individual to comply with the Compliance Program and all Applicable Laws. All supervisors maintain the responsibility to ensure that the employees and others under their responsibility are in compliance.

    1. **Compliance Officer**
       The Compliance Officer's primary responsibilities include:

        a. Overseeing and monitoring the implementation and day-to-day operations of the compliance program.
        b. Reporting on a regular basis to TSC's Board of Managers on the progress of implementation, and assisting these components in establishing methods to improve the Surgery Center's efficiency and quality of service and to reduce the Surgery Center's vulnerability to fraud and abuse.
        c. Periodically revising the program in light of changes in the needs of TSC, and in the law and policies and procedures of government and private payer health plans.
        d. Developing, coordinating, and participating in a multifaceted educational

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and training program that focuses on the elements of the Compliance Program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards.

e. Ensuring that independent contractors and agents who furnish medical services to the Surgery Center are aware of the requirements of the TSC Compliance Program with respect to coding, billing, and marketing, among other things.
f. Coordinating personnel issues with Human Resources, Medical Staff Office and Purchasing Department to ensure that the National Practitioner Data Bank, Cumulative Sanction Reports, and applicable government exclusion sites have been checked with respect to all employees, medical staff, vendors and independent contractors to ensure that no covered Individual who has been excluded from the federal or state healthcare programs or convicted of a healthcare-related offense is hired or retained by TSC without prudent review.
g. Assisting the TSC financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments.
h. Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations and any resulting corrective action with the Surgery Center, providers and sub-providers, agents and, if appropriate, independent contractors.
i. Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.
j. Ensuring that TSC is up to date and has current knowledge of changes in the regulatory standards and requirements for Centers for Medicare and Medicaid Services (CMS),Accreditation Commission for Healthcare (ACHC), and the California Department of Public Health (CDPH).

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Conducting Effective Training and Education

The proper education and training of corporate officers, managers, employees, physicians and other health care professionals, and the continual retraining of current Covered Individuals at all levels, are significant elements of an effective compliance program. As part of a compliance program, TSC requires personnel to attend specific training on a periodic basis, including appropriate training in federal and state statutes, regulations and guidelines, and the policies of private payers, and training in corporate ethics, which emphasizes TSC's commitment to compliance with these legal requirements and policies.

Training and education includes:

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A. Government and private payer reimbursement principles
B. General prohibitions on paying or receiving remuneration to induce referrals
C. Proper confirmation of diagnoses
D. Not submitting a claim for physician services when rendered by a non-physician
E. Not signing a form for a physician without the physician's authorization
F. Prohibitions on alterations to medical records
G. Not prescribing medications and procedures without proper authorization
H. Proper documentation of services rendered
I. Duty to report misconduct

Developing Effective Lines of Communication

An open line of communication between the Compliance Officer and TSC personnel is equally important to the successful implementation of the Compliance Program and the reduction of any potential for fraud and abuse. Written confidentiality and non-retaliation policies are developed and distributed to all employees to encourage communication and the reporting of incidents of potential fraud. TSC has also developed a reporting path for an employee to report fraud and abuse so that supervisors or other personnel cannot divert such reports.

A. **Access to the Compliance Officer**

1. Encouraged the establishment of a procedure so that Surgery Center personnel may seek clarification from the Compliance Officer.
2. Questions and responses are documented and dated and, if appropriate, shared with other staff so that standards, policies and procedures can be updated and improved to reflect any necessary changes or clarifications.
3. The Compliance Officer may want to solicit employee input in developing these communications and reporting systems.

B. **Other Forms of Communication**

1. TSC encourages the use of e-mails, written memoranda, newsletters, and other forms of information exchange to maintain an open line of communication.
2. The telephone number for the compliance hotline at TFHD is made readily available to all employees and independent contractors in the form of a written communication.
3. Employees are permitted to report matters on an anonymous basis.
4. Documentation is required for all matters reported, which pertain to substantial violations of compliance policies, regulations or statutes.
5. All investigations are promptly handled to determine their veracity.
6. The Compliance Officer, who records such communication, including the nature of any investigation and its results, maintains a log.
7. While TSC strives to maintain the confidentiality of an employee's identity, it should

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also explicitly communicate that there may be a point where the individual's identity may become known or may have to be revealed in certain instances when governmental authorities become involved.

Enforcing Standards through Well-publicized Disciplinary Guidelines

TSC policies include guidance regarding disciplinary action for directors, employees, physicians and other health care professionals who have failed to comply with TSC's Code of Conduct, policies and procedures, or federal and state laws, or those who have otherwise engaged in wrongdoing, which have the potential to impair TSC's status as a reliable, honest and trustworthy health care provider.

A. **Discipline Policy and Actions**

1. TSC has a written policy setting forth the degrees of disciplinary actions that may be imposed upon leadership, employees, physicians and other health care professionals for failing to comply with TSC's standards and policies and applicable statutes and regulations.
2. Intentional or reckless non-compliance will subject transgressors to significant sanctions. Such sanctions could range from oral warnings to suspension, privilege revocation, termination or financial penalties, as appropriate.
3. TSC advises personnel that disciplinary action will be taken on a fair and equitable basis.
4. Consequences of noncompliance will be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect.

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B. **New Employee Policy**

1. All new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight will have a reasonable and prudent background investigation, including a reference check, as part of every such employment application.
2. Applications require the applicant to disclose any criminal conviction or exclusion action.

Auditing and Monitoring

An ongoing evaluation process is critical to a successful compliance program. TSC incorporates thorough monitoring of its implementation and regular reporting to the Board of Managers. Compliance reports, including reports of suspected noncompliance, are maintained by the Compliance Officer and shared with the Surgery Center's Board of Managers.

A. **Auditing and Monitoring Requirements**

1. One effective tool to promote and ensure compliance is the performance of regular, periodic compliance audits by internal or external auditors who have expertise in federal and state health care statutes, regulations and federal health care program requirements.

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2. Audits should focus on TSC, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions.
3. Audits should be designed to address the Surgery Center's compliance with laws governing kickback arrangements, the physician self-referral prohibition, coding, claim development and submission, reimbursement, cost reporting and marketing.
4. Audits and reviews should inquire into the Surgery Center's compliance with specific rules and policies that have been the focus of particular attention on the part of Medicare fiscal intermediaries or carriers, and law enforcement.
5. Monitoring techniques may include sampling protocols that permit the Compliance Officer to identify and review variations from an established baseline.
6. If it is determined that a deviation was caused by improper procedures, misunderstanding of rules, including fraud and systemic problems, TSC should take prompt steps to correct the problem.

B. **Auditing and Monitoring Techniques**
As part of the review process, the Compliance Officer or other reviewers consider techniques such as:

1. On-site visits
2. Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities
3. Reviews of medical and financial records and other source documents that support claims for reimbursement and Medicare cost reports.
4. Reviews of written materials and documentation.
5. The reviewers are:
    a. Independent of physicians and line management.
    b. Have access to existing audit and health care resources, relevant personnel and all relevant areas of operations.
    c. Present written evaluative reports on compliance activities to the Compliance Officer on a regular basis, but no less than annually.
    d. Specifically identify areas where corrective actions are needed

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Responding to Detected Offenses and Developing Corrective Action Initiatives

A. **Violations and Investigations**

1. Violations of TSC's Compliance Program, failures to comply with applicable federal or state law, and other types of misconduct threaten TSC's status as a reliable, honest and trustworthy provider capable of participating in federal health care programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of TSC. Consequently, upon reports or reasonable indications of suspected noncompliance, it is important that the

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Compliance Officer or other management officials initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred, and if so, take steps to correct the problem.

2. Depending on the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents.
3. Investigations will be carried out with Tahoe Forest Hospital's Compliance Officer and legal counsel involvement.
4. TSC should consider engaging outside counsel, auditors, or health care experts to assist in an investigation.
5. Records of investigations will contain:
   a. Documentation of the alleged violation
   b. A description of the investigative process
   c. Copies of interview notes and key documents
   d. A log of the witnesses interviewed and the documents reviewed
   e. The results of the investigation
   f. Any disciplinary action taken
   g. The corrective action implemented
6. TSC strives for some consistency by utilizing sound practices and disciplinary protocols.
7. The Compliance Officer will review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered.

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B. **Reporting**

1. If the Compliance Officer, in collaboration with TFHD's Compliance Officer and legal counsel, discovers there is credible evidence of fraud or abuse from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then TSC must promptly report the existence of misconduct to the Office of the Inspector General (OIG) or the appropriate reporting government agency within a reasonable period, but no more than 60 days after determining that there is credible evidence of a violation. Prompt reporting will demonstrate TSC's good faith and willingness to work with governmental authorities to correct and remedy the problem. In addition, reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions.

Related Policies/Forms:

Code of Conduct, HR-2001

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Approval Signatures

Step Description	Approver	Date

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Status **Draft** PolicyStat ID **12622525**

Origination	N/A	Owner	Courtney Leslie: Administrator
Last Approved	N/A	Department	Environment of Care
Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Code Gray, EOC-2201

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RISK:

Occupational violence and aggression is a significant risk of healthcare workers and has the potential to result in physical and/or psychological injury.

POLICY:

Truckee Surgery Center supports a non-violent approach to crisis intervention. However, when acts or threats of physical violence, including intimidation, harassment or coercion are directed at any individual, thus placing them in fear for their personal safety, a Code Gray activation will occur summoning additional staff to safely respond and address the behavior. The following procedure shall be utilized:

PROCEDURE:

A. A Code Gray will be paged overhead whenever staff feels additional assistance is necessary to deal with a combative or potentially combative or aggressive individual(s).
    1. The incident may be verbal, physical or a combination of both. If staff are unable to control the individual with the resources available, a Code Gray should be activated.

B. Dial 2348 to overhead page "Code Gray & the location of the incident"
    1. For situations that require the assistance of law enforcement, they will be called by dialing 9-911 directly and providing a brief description of what is occurring.
    2. Silent alarms (panic buttons) are available under the Front Desk, Pre-Op Desk, PACU Desk, and the Kitchen under the microwave. Silent alarms, if activated, will signal the monitoring company to call for law enforcement.
    3. The Tahoe Forest Hospital District (TFHD) Security personnel can also be reached by dialing 6666.

4. TFHD Facilities Management can be reached by dialing 3510.

C. All available staff will respond to the area requiring assistance except those involved in direct patient care or activities that cannot be left unattended.

1. Upon arrival to the area, the Code Gray responders will act as observers and stand back unless otherwise directed to do so.
2. Department staff will ensure appropriate handling of the incident and if necessary contact law enforcement who, upon arrival, will then take charge of the situation.
3. Once the situation is rendered safe, staff shall over head page "all clear".
4. The Administrator and/or Nurse Manager will ensure the incident is documented on an Occurrence Report, and if warranted entered into the TFHD event reporting system.
5. Any workplace violence incident will be reviewed and reported according to the Surgery Center's Workplace Violence Prevention Plan, EOC-2202 which complies with California Senate Bill 1299, Cal/OSHA Workplace Violence requirements and California state law.

Special Procedures:

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California Senate Bill (SB) 1299:

Any act of violence or threat of violence that occurs a the work site. Workplace violence includes: (1) the threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury as defined by state law; (2) an incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury.

References:

- **California Code of Regulations**, Title 8 §3342;
- CA State Law SB-1299

Approval Signatures

Step Description	Approver	Date

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Last Approved	N/A	Department	Environment of Care
Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Code Orange, EOC-2204

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RISK:

Lack of Code Orange procedures could result in the harm or death of anyone exposed to a hazardous material.

POLICY:

Truckee Surgery Center (TSC) is committed to minimizing risks from hazardous materials. This policy defines the procedure to communicate and activate a response that will protect patients, visitors, and staff in case of a hazardous material spill or release.

PROCEDURE:

A. In the event of a hazardous materials spill, release, or accident/incident within or outside TSC, the responsible individual(s) discovering the accident/incident will take appropriate action based on the following level of incident.

B. Staff or Ledership will identify a known spilled material and obtain a **SDS** for the material from MSDSonline via the Intranet or to get a faxed copy from MSDSonline directly at 1-888-362-7416**.**

C. Code Orange Level 1 Spill:
   1. Definition: A small spill or release of hazardous material, with no injuries to staff that can be immediately contained and cleaned up by staff.
   2. This type of event will be reported on an Occurrence Report by staff or Leadership as a Code Orange Level 1 Spill.

D. Code Orange Level 2 Spill:
   1. Definition: A large spill or release of hazardous material with potential staff exposure

or injury that requires more hazmat spill supplies and additional staff assistance to contain and clean up the spill.

2. Rescue anyone in immediate danger; otherwise stay away from spilled material; keep others away.
3. Remove any injured people, and provide first aid; notify the Tahoe Forest Hospital District (TFHD) Emergency Department that there are injuries. Call extension 3208.
4. TSC staff at spill location should ask an available staff member to retrieve the Spill Kit and additional spill containment supplies and PPE as needed. Seal off area and remain outside exposure area to keep others away.
5. Staff who have been trained on the spilled hazmat material will direct / perform the containment and clean-up procedures as necessary.
6. The Administrator or Nurse Manager will report to the spill location to provide additional assistance with spill clean up to include the safe handling and storage of contained spill material until picked up by Hazmat Waste Company for proper disposal.
    a. The TFHD Facilities and/or EOC Supervisor will be contacted should their assistance be required.
7. This type of event will be reported on an Occurrence Report by staff or Leadership as a Code Orange Level 2 Spill.

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E. Code Orange, Level #3 Spill:

1. Definition: A large spill or release of hazardous materials within TSC or outside that directly effects TSC facilities and requires an emergency response from outside agencies.
2. This type of event requires an immediate or planned response from all TSC Staff and will be responded to as a "Code Triage" Event as directed by the Administrator or Nurse Manager.
3. Rescue anyone in immediate danger otherwise stay away from spilled material; keep others away. Remove any injured people, and provide first aid; notify the Emergency Department that there are injuries. Call extension 3208.
4. DIAL 9-9-1-1 and report hazmat event to local agencies.
5. This type of event will be reported on an Occurrence Report by staff or Leadership and entered into the TFHDs event reporting system as a Code Orange Level 3 Spill.

References:

- **California Code of Regulations**, Title 22 §70743, §70746

Approval Signatures

Step Description	Approver	Date

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Status **Draft** PolicyStat ID **12624418**

Origination	N/A
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Last Revised	N/A
Next Review	N/A

Owner	Courtney Leslie: Administrator
Department	Environment of Care
Applicabilities	Truckee Surgery Center

Code Purple, EOC-2206

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RISK:

Lack of Code Purple procedures could result in the abduction of a child.

POLICY:

A. Code Purple provides the procedure for an appropriate response in the event an infant or child is abducted from the facility.
   1. Code Purple will be paged for the suspected abduction of a child between the ages of one and thirteen years of age.

PROCEDURE:

A. Immediate Response:
   1. Code Alert Activation:
      a. Code Purple:
         i. The employee identifying a missing child shall IMMEDIATELY dial 2348 to page overhead page and annouce Code Purple.
   2. Code Purple will result in a facility watch which entails the following:
      a. The Administrator or Nurse Manager will be responsible for immediately contacting law enforcement and ensuring door coverage.
      b. All employees are to immediately stop all non-critical work and monitor the nearest exit.
      c. All individuals exiting the facility will have bags and person checked.
      d. All employees will monitor their area for suspicious activity.

B. Secondary Response:

1. The Administrator or Nurse Manager will question parents/ family about the preceding circumstances,
   a. Where the infant/ child was last seen,
   b. What time he/she was noticed missing,
   c. Who was present at the time,
   d. Any pertinent information regarding the description of the alleged kidnapper.
2. As much as possible, leave the area involved untouched to assist in the investigation process.

C. Tahoe Forest Hospital (TFHD) Notification

1. If it is determined that an actual child abduction has occurred, the Adminsitrator or Nurse Manager will notify the TFHD Facilities Management/Security Department and the TFHD Administrative Director of Surgical Services.

D. Intermediate Response:

1. Establish patient support system.
2. Assign a hospital social worker to patient for immediate crisis assistance.
3. Assign a Management Liaison to patient.
4. Collaborate with patient to determine the best location for her and her family to wait.
5. Provide immediate reassurance to other patients and families on the unit. Reunite each mother and baby for reassurance by verification procedure.
6. Provide continual support to nursing staff on the unit. Arrange for additional staffing on the unit if necessary.
7. Prepare to release staff to accommodate investigative process. Instruct staff to release information only to the authorities; patient confidentiality continues to remain of key importance.
8. Arrange for possible alternate route for discharge of maternity patients, if needed.
9. After being certain that infant and abductor are not on premises an all clear can be called.

E. Demobilization and Recovery

1. If it is determined an abduction did not occur or is resolved immediately, the Administrator or Nurse Manager will page overhead and announce "Code Purple, All Clear".

F. Extended

1. Prepare for the visit by a representative of the State Department of Health Services.
2. Develop letters of reassurance for all patients and physicians by Quality and Regulations and Marketing Director, signed by Administration.

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3. Prepare contingency plan in conjunction with Pediatrician for care upon return of child.
4. Provide additional in-service education to nursing staff, recognizing efforts at prevention.
5. Form an Interdisciplinary Task Force to conduct a critical analysis of the hospital's policies and make recommendations for change, if appropriate.
6. Notify Patient Accounting to hold child's financial account for review prior to billing (Risk Management).
7. Coordinate support/debriefing services for all staff members in concert with Human Resources.
8. Upon return of child to hospital notify physician and Nursing Administration immediately.

References:

- California Code of Regulations; Title 22 70547(b)(21), 70717 (g)(h), 70737 (d), 70738, 70743(b);
- California Health and Safety Code, Section 1276, 208(a), 1275

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Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **12623825**

Origination	N/A	Owner	Courtney Leslie: Administrator
Last Approved	N/A	Department	Environment of Care
Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Code Red, EOC-2205

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RISK:

Delays with an effective response in the first few minutes of a fire places the safety of patients, visitors, and staff as well as keeping damage and interruption of service at a minimum at risk.

POLICY:

A. Upon discovery of any smoke or fire within the facility, you, as an employee, must implement the fire response plan.

B. There are four basic procedures, which when employed in order, should achieve the greatest degree of personal safety and minimum amount of property damage.

C. These steps are Rescue, Alert, Contain and Extinguish (R.A.C.E).

D. For unconfirmed alarms implement these steps as the fire response plan.

E. These procedures can be carried out simultaneously if there are sufficient personnel.

F. All fires must be reported on an Occurrence Report and entered into the Tahoe Forest Hospital's (TFHD) incident reporting system.

PROCEDURE:

A. **SPECIFIC FIRE RESPONSE ACTIVITIES**

1. Truckee Surgery Center (TSC) employees should familiarize themselves with R.A.C.E.
    a. **R** escue
    b. **A** larm
    c. **C** ontain

d. **E** xtinguish

2. As soon as fire is discovered, the following action will be taken:
   a. RESCUE those in immediate danger.
   b. ALARM - activate the fire alarm system.
      i. Pull the handle down on the manual pull station.
      ii. Dial 2348 to page overhead Code Red and the location of the fire.
   c. CONTAIN fire area by closing doors and windows.
   d. EXTINGUISH with appropriate fire equipment if safe to do so.

B. RESCUE

1. Personal safety in a fire emergency is of the utmost importance.
2. Every reasonable attempt to move patients, visitors and staff away from an area of immediate danger must be performed as rapidly as possible.
3. The following guidelines apply to this procedure.
   a. Rescue and/or remove anyone from the fire area as necessary.
   b. Move patients beyond fire doors or smoke compartment to ensure their safety.
   c. Evacuation is a separate procedure that is decided by the Fire Department or the TSC Safety Officer.

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C. ALARM

1. As soon as the safety of the personnel in the vicinity of the fire is secured, the staff personnel at the scene of the emergency will dial 2348 to page overhead Code Red and the location of the fire.
2. The automatic fire detection system may perform this function, but if the fire alarm system is not alarming, you must activate a fire pull station.

D. CONTAIN

1. Guidelines for containment are:
   a. Close the door to the room or area in which the fire occurs.
   b. Verify the smoke barrier doors in the corridor are closed.
   c. Clear corridors of all equipment and other items to keep a clear evacuation route.
   d. Remove all portable oxygen not in use from fire area.
   e. Do not under any circumstances open a door which is hot or warm to the touch.
   f. Stop spread of smoke by placing a wet towel against the threshold.

E. EXTINGUISH

1. Portable fire extinguishers may be used on small fires.
2. A large fire or one that is spreading rapidly will be confined and left for the automatic fire sprinklers or the Fire Department to fight.
3. The Administrator responds to all fire alarms in the Surgery Center regardless of time. The TFHD Facilities Management Department will be notified of the fire alarm.
4. Upon arrival of the Fire Department, the ranking officer will assume complete charge of the situation.
5. Staff will assist the Fire Department only if requested to do so.
6. The proper use of an extinguisher can best be remembered by using the P.A.S.S. system:
    a. P - Pull (pull the safety pin)
    b. A - Aim (aim the nozzle at the **base** of the fire)
    c. S - Squeeze (squeeze the handle to discharge the extinguishment agent)
    d. S - Sweep (sweep the nozzle or hose side to side at the base of the flame)

F. SPECIFIC DUTIES

1. When requested by the Fire Department, the oxygen shut off valves will be closed by the Administrator, Nurse Manager, or TFHD Facilities Personnel after a safety check is done and tanks are secured for those who need oxygen therapy.
2. Staff should provide response instructions to any and all visitors, volunteers and outside contractors.
3. Staff located away from the fire location should:
    a. Close all doors and windows; give brief explanation to patients/visitors.
    b. Close doors to other areas.
    c. Provide a brief explanation to patients/visitors in common areas (i.e. Lobby).
    d. Verify the smoke barrier doors in the corridor are closed.
    e. Clear corridors of all equipment and other items to keep a clear evacuation route.
    f. Prepare to evacuate in case the fire spreads.
    g. Continue normal duties unless directed otherwise by the Administrator, Nurse Manager, TFHD Facilities, or Fire Dept.

FIRE SAFETY AND PREVENTION:

A. **FIRE SAFETY**

1. All employees must have the necessary knowledge to respond properly and perform efficiently in the event of a fire emergency.
2. All employees are required to familiarize themselves with the contents of this policy.

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3. Fire drills are held to test the application of the policy in order to assess employee familiarization with its procedures.
4. Drills are to be addressed seriously and professionally.
5. Drills are a requirement and documentation as well as written follow-up must be maintained.
6. Knowledge and training in fire prevention and response are the Surgery Center's best defense against the catastrophe that could result from a health care institution fire.

B. **FIRE PREVENTION**

1. The realization that even a minor fire in a health care facility can have serious implications dictates that TSC implement a strong, viable fire prevention program.
2. This program will address the integrity of structural and automatic protection/ suppression systems, the elimination or minimization of fire hazards and compliance with fire safety codes and regulations.

C. **BUILDING FEATURES**

1. TSC been designed to comply with all applicable codes and standards relating to fire prevention, detection and suppression.
2. These features include fire resistant structural materials, wall coverings and floor coverings; and, a monitored sprinkler and detection alarm system.
3. More specifically, TSC is equipped with the following types of fire fighting equipment:
    a. Fire extinguishers:
        i. Fire extinguisher locations are shown on the Evacuation Plan.
        ii. It is your responsibility to know the location of the extinguishers and alarms nearest your work area.
    b. Air conditioning supply equipment is equipped with smoke detectors which automatically shut off air supplied to the affected areas and sound the alarm.
    c. Corridors and other designated areas are equipped with smoke detectors.
    d. All of the above mentioned equipment is monitored by call centers 24/7, which automatically notifies the Fire Department whenever the fire alarm system is activated.
    e. TSC is divided into fire/smoke compartments to prevent and contain the spread of smoke or fire.
        i. Each compartment is a smoke/fire barrier and is separated by cross-corridor fire doors which can serve as an area of refuge during the rescue of patients and staff from the fire area.
4. These systems are maintained in such a manner to insure proper working condition and compliance with codes and regulations which may apply.
5. Although the facility is structurally fire resistant, care must be taken to prevent the introduction or creation of fire hazards.

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D. There are *six areas of concern*, including general guidelines, in the elimination or prevention of fire hazards listed below:

1. **HOUSEKEEPING**
    a. Ensure all trash is removed on a daily basis and not allowed to accumulate in closets or corners.
    b. Keep all corridors and fire exits free of any obstruction.
    c. Storage of any type at any time in fire exit corridors is prohibited.
    d. Empty boxes, storage cartons or debris will not be allowed to accumulate.
2. **ELECTRICAL SAFETY**
    a. Electrical equipment is a major cause of fire in healthcare facilities.
        i. Any actual or suspected electrical problem will be reported to the Administrator and.or Nurse manager who will report it to the TFHD Facilities Management Department immediately.
    b. Electrical equipment will not be used if damaged or reliability is suspect.
        i. All electrical equipment used will be inspected for safety by the TFHD Facilities Management Department prior to being put into service.
        ii. Dust and lint will not be allowed to accumulate on electrical equipment.
        iii. Electrical equipment will be used by qualified operators only.
3. **SMOKING**
    a. TSC promotes a smoke free environment.
    b. Smoking is prohibited everywhere on TSC property, whether leased or owned, including all buildings, walkways, and grounds.
4. **FLAMMABLE LIQUIDS**
    a. Flammable liquids will be stored in approved flammable storage cabinets only.
    b. No more than the quantity needed for immediate use will be kept outside the cabinets.
    c. Flammable liquids will be used only by personnel trained in its hazardous properties including proper handling, disposal and storage.
5. **USE AND STORAGE OF OXYGEN**
    a. Oxygen in itself is a non-flammable gas, but it does support rapid combustion (oxidation).
    b. Petroleum based lubricants will not be used on any type of oxygen equipment.
    c. Cylinders will be stored upright, will be limited to 12 E-cylinders per smoke compartment, secured to prevent falling and separated from any other

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flammable gases or liquids.

   d. Actual or suspected leaks in the oxygen distribution system (wall outlets) will be reported to the Administrator and/or Nurse Manager who will report to the TFHD Facilities Management Department immediately.

6. **STORAGE OF MATERIALS & SUPPLIES**
   a. All storage areas will be kept neat and orderly.
   b. No storage is permitted above a horizontal plane 18 inches below the lowest point of a sprinkler head if the building has a sprinkler system. If the building does not have a sprinkler system then the horizontal plan is 24 inches below the ceiling.
   c. Doors will be kept closed when store rooms are unoccupied.
   d. Doorways should be kept clear for egress at all times.
   e. No material or storage units will be located where they conceal or hinder access to fire alarm pull stations, fire extinguishers or electrical panels.

7. The Surgery Center is subject to periodic inspections by the Fire Department, CA Department of Public Health Services, Accreditation Commission for Healthcare (ACHC) and other regulatory bodies.
   a. These inspections are conducted to insure compliance with national, state, and local fire safety codes and guidelines while assisting the facility in improvement of its fire prevention efforts.
   b. The Administrator or designee will accompany all inspectors and will take necessary action to ensure the facility corrects any discrepancies or implements policies suggested by the inspecting authority.

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SPECIFIC RESPONSE ACTIVITIES:

A. **Patient Care Areas:**
   1. Move patient (or patients, visitors or personnel) laterally away from immediate area of fire towards the nearest fire doors.
   2. Patients will not be evacuated until directed by the Administrator, Nurse Manager, TFHD Facilities, or Fire Department on scene.
   3. Close all doors and windows.

B. **Non-Patient Care Areas:**
   1. Personnel not at the fire location should remain in their work station and stand by for further instruction.
   2. Leadership will assess the Surgery Centert for possible damage and staff availability.

C. **VISITORS AND OUTSIDE CONTRACTORS**
   1. All non-TSC individuals will receive and follow response instructions from TSC staff.

D. **EVACUATION AUTHORITY & PROCEDURES**

1. The decision to evacuate all or part of the hospital can be made only by the Administrator, Nurse Manager, TFHD Facilities, or the Fire Department.
2. Should this decision be made, the surgery center should implement the evacuation plan outlined in the Emergency Operations Plan, EOC-1902

E. **FIRE DRILL PROCEDURES**

1. Fire drills will be conducted to train and instill confidence in the proper procedures to be followed in the event of an actual fire emergency.
2. These drills will be conducted without prior announcement at least once per quarter.
3. The drill will commence when an employee in the area to be tested is notified by a member of the staff indicating the type of fire, its location, and the people in proximity to the fire.
4. The person receiving this information will then activate the Fire Response Plan, as if a real emergency existed.
5. The alert should include the "Code Red ...This is a drill" page overhead and activation of the fire alarm system by the panel or by pulling the nearest alarm pull box. Drills are to be both announced and unannounced. Unannounced drills provide a better evaluation for fire response educational needs for staff will have no forewarning that it is a drill. The Code Red announcement will not include "This is a drill".
6. The following procedures will be followed during an announced drill:
    a. Patients will not be moved.
    b. Personnel will assure proper working of smoke doors and demonstrate their knowledge of nearest area of refuge.
    c. The Medical Gas system will not be turned off.
    d. The operator will page "Code Red….This is a Drill".
    e. The person conducting a fire drill will gather input from observers at the origin and away from the origin of the fire.
    f. The results of the fire drill are reported to the Medical Executive Quality Committee and the Board of Managers.

References:

- California Code of Regulations; Title 22 70547(b)(21), 70717 (g)(h), 70737 (d), 70738, 70743(b);
- California Health and Safety Code, Section 1276, 208(a), 1275;

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Approval Signatures

Step Description	Approver	Date

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Origination	N/A	Owner	Courtney Leslie: Administrator
Last Approved	N/A	Department	Environment of Care
Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Code Silver, EOC-2203

RISK:

Lack of Code Silver procedures could result in the injury or death of staff, patients, or visitors.

POLICY:

A. This policy provides procedures for an appropriate response for staff members and/or visitors during a suspected or confirmed active-shooter/active-threat or other potential mass-casuallty event involving a weapon on Truckee Surgery Center (TSC) property.

B. For purposes of this policy, a weapon is defined as a firearm or any other instrument that can cause harm or injury.

C. TSC supports a culture of safety and a non-violent approach to crisis intervention.

D. TSC recognizes that potential mass-cassualty events, such as an active-shooter, require mitigation and response strategies designed to maximize the safety of intended victims and others in the area. These strategies include engineering considerations (i.e. electronic access, video surveillance, etc), training, drills, and conducting security assessments with annual reviews.

E. This policy is intended to provide response guidelines and protocols. It is recognized that each event is unique and factors such as time, the nature of the incident, its location and aspects of communication may affect the availability or timing of initiated response strategies. Therefore these guidelines and protocols are options during the event that may or may not be followed and can be engaged in any order depending on the specific circumstances of each individual during the event.

F. Individuals must be prepared both mentally and physically to deal with an active shooter/ active threat situation. Having a survival mindset and using that to motivate oneself is critical to one's safety.

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G. Active shooter/active threat situations are unpredictable and evolve quickly. The immediate deployment of law enforcement is of the utmost importance. Actual and potential victims will need to utilize response strategies contained within this policy and provided in training, including defending themselves, until the arrival of police.

PROCEDURE:

A. Discovery

1. Anyone encountering a person brandishing a weapon should:
    a. RUN! HIDE! FIGHT! Warn others of the situation.
    b. When safe to do so, page "Code Silver" overhead by dialing 2348, followed by plain language who, what, when, where and how information;
        i. Who: Number of suspects and physical descriptions.
        ii. What: Act the individual is performing (shooting, threatening, # of hostages, etc).
        iii. When: Exact time of event (now, 1 minute ago, etc).
        iv. Where: Exact location and any directional movement (i.e. in lobby heading towards stairway).
        v. How: Number and type of weapons (gun, knife, etc).
        vi. Any other relevant information.
    c. Call 9-911 or 911 from a cell phone when safe to do so.
    d. Silent alarms (panic buttons) are available under the Front Desk, Pre-Op Desk, PACU Desk, and the Kitchen under the microwave. Silent alarms, if activated, will signal the monitoring company to call for law enforcement assistance should the situation warrant.
    e. Provide ongoing information to police as the event evolves.

B. Response Guidelines: Decide what option below provides the best opportunity for your protection and survival.

1. **RUN or EVACUATE!**
    a. Have an escape route and plan in mind.
    b. Leave your belongings behind.
    c. Do not delay. Run in a zig-zag motion. Bring others provided they do not slow you down.
    d. Keep your hands visible.
    e. Run as far away from the area as possible.
2. **HIDE or LOCKDOWN!**
    a. Hide in an area out of the shooter's view.
    b. Lock the doors and/or barricade the entry to your hiding place.

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c. Turn off lights.
d. Silence your cell phone and/or pager.
e. If possible, evacuate out a window.

3. **FIGHT or COUNTER!**
    a. Do not be an easy target. History has shown that a passive response equates to death or serious injury.
    b. Attempt to disrupt the act of shooting.
        i. Move! Move! Move! Scatter! Do not be a static target.
        ii. Throw objects: staplers, books, fire extinguishers, etc directly at the shooter.
        iii. Shout loudly!
    c. Act as a team. If possible, grab the violent intruder's extremities and bring them to the floor. Hold position until police arrive.
4. Any staff members distant from the area stated in the Code Silver should:
    a. **STAY AWAY** from the specified Code Silver area.
    b. Provide assistance as requested.

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C. How to respond when Laws Enforcement arrives. Note: Law Enforcement will treat everyone suspicious until they end the incident. It is important to:
1. Remain calm and follow instructions.
2. Put down any items in your hands (i.e., bags, jackets).
3. Raise hands and spread fingers.
4. Keep hands visible at all times.
5. Avoid pointing, screaming or yelling.
6. Do not stop to ask officers for help or direction during evacuation.
7. Facilities Management, if available, will assist police by providing campus orientation with maps and plans.
8. The objectives for responding law enforcement officers are:
    a. Immediately engage or contain the active shooter(s) in order to stop potential injuries.
    b. Identify threats such as improvised explosive devices.
    c. Identify victims to facilitate medical care, interviews and counseling.
    d. Investigate.

D. All Clear
1. After consultation with law enforcement, the Administrator or Nurse Manager shall announce "Code Silver - All Clear" to indicate the termination of response operations.
2. Leadership will check with employees involved in the incident for any medical and/or

psychological needs and will return to normal operations as soon as possible.

3. Leadership will report the incident on an Occurrence report and into the hospital's incident reporting system and follow all reporting requirements as per Workplace Violence Prevention Plan, EOC-2022.

Related Policies/Forms:

Workplace Violence Prevention Plan, EOC-2022

References:

- **California Senate Bill (SB) 1299.**
- **California Code of Regulations**, Title 8 §3342;
- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, U.S. Department of Labor, Occupational Safety and Health Administration (OSHA);
- U.S. Department of Homeland Security How To Respond When An Active Shooter Is In Your Vicinity

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Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **12622789**

Origination	N/A	Owner	Courtney Leslie: Administrator
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Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Workplace Violence Prevention Plan, EOC-2202

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RISK:

Workplace Violence has the potential for staff injury physically and/or cause emotional distress. It can occur on Truckee Surgery Center (TSC) property and at all TSC sponsored events, both on and off TSC grounds.

POLICY:

The Truckee Surgery Center maintains a zero-tolerance standard for violence in the workplace. Violent behavior by employees and non-employees, of any kind, or threats of violence, either implied or direct, are strictly prohibited. The purpose of this Workplace Violence Prevention Plan (WVPP) is to provide guidance for promoting an environment that is free of violence and the threat of violence on TSC property and at all TSC sponsored events, both on and off TSC grounds. This policy is in effect at all times and in all areas of TSC property or TSC sponsored events. This policy is in compliance with California SB 1299, the Cal/OSHA Workplace Violence Prevention Regulation amending California labor Code §6401.8.

Tahoe Forest Hospital's (TFHD) Facilities Management and Environment of Care (EOC) department will be notified if an incident occurs.

PROCEDURE:

A. **Definition of Workplace Violence**
Workplace violence is defined as: Any act of violence or threat of violence that occurs at the work site. Workplace violence includes: (1) the threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury as defined by state law; (2) an incident involving the threat or use of a firearm or other dangerous weapon, including the use

of common objects as weapons, regardless of whether the employee sustains an injury.

1. TSC recognized that there are four types of workplace violence:
    a. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
    b. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, or visitors or other individuals accompanying a patient.
    c. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.
    d. Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had, a personal relationship with an employee.

B. **Employee Post-Incident Response**

1. An employee who is the victim of workplace violence, or believes they have been threatened with workplace violence, or witnesses an act or threat of violence towards anyone else in the workplace shall take the following steps:
    a. If an emergency exists and the situation is one of immediate danger, if safe to do so, the employee shall contact local police by dialing 9-911 on the TSC telephone system (or 911 from a private phone), and may take whatever emergency steps are available and appropriate for the situation to protect himself/herself from immediate harm; examples of response strategies include leaving the area, physically defending oneself, calling for assistance and summoning security.
    b. TSC has procedures in place for various violence situations as follows:
        i. Combative Individual: Code Gray, EOC-2201
        ii. Active Shooter: Code Silver, EOC-2203
        iii. Emergency Operations Plan, EOC-1902
    c. If the situation is not one of immediate danger, the employee(s) who were involved and/or witnessed the incident shall report the event to his/her supervisor and the TSC Safety Officer as soon as possible. The employee(s) shall record the situation on an Occurrence Report.
    d. The TSC Safety Officer will notify the TFHD Facilities and/or EOC Supervisor of the incident.
2. An employee who has reason to believe they or others may be victimized by a **future** violent act either at the workplace, or as a direct result of their employment with TSC, shall inform their supervisor, the Medical Director (if a member of medical staff is implicated), and the TSC Safety Officer immediately. The employee shall record the situation on an Occurrence Report so appropriate action may be taken which may include notifying local law enforcement and other agencies as appropriate.

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3. An employee who has been granted a restraining order against an individual and the workplace is named in the order shall immediately supply a copy of the court's order to their supervisor.
    a. The restraining order will be shared with the Tahoe Forest Hospital's (TFHD) Director of Facilities/Security Management.
    b. TSC will engage in an interactive process with the employee to create a safety plan to provide reasonable accommodations.
    c. It is the responsibility of the employee to keep TSC updated with any changes in circumstance that would alter the reasonable safety accommodation that is needed, if any.

C. **Employer Post-Incident Response and Investigation to Workplace Violence**

1. After a workplace violence incident TSC will not take punitive or retaliatory action against an employee for seeking assistance.
2. Procedures for post-incident response investigation may include but are not limited to:
    a. Providing immediate medical care or first aid to employees who have been injured in the incident.
    b. Identifying all employees involved in the incident.
    c. Making available individual trauma counseling to all employees affected by the incident.
    d. Conducting a post-incident debriefing as soon as possible after the incident with all employees, supervisors and other personnel involved in the incident.
    e. Reviewing any patient-specific risk factors and any risk reduction measures that were specified for that patient.
    f. Reviewing whether appropriate corrective measures developed under the WVPP, such as adequate staffing, provision and use of alarms or other means of summoning assistance, and response by staff or law enforcement, were effectively implemented.
    g. Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause of the incident, whether any measure would have prevented the injury.

D. **Patient Specific Hazards and Notification**

1. Employees should be made aware of the following:
    a. Patient's mental status and conditions that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively.
    b. A patient's treatment and medication status, type, and dosage, as is known to the facility and employees.
    c. A patient's history of violence, as is known to the facility and employees.

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d. Any disruptive or threatening behavior displayed by a patient.

e. When it is determined that a patient may be aggressive or violent, all staff should use the below precautions when entering the patient care area:

i. Use the buddy system during direct patient care

ii. Acknowledge patient concern, show empathy, speak softly but demonstrate control over the situation

iii. Keep some physical distance between you and the patient

iv. Stand between the patient and the door to the room to ensure a clear exit path

v. Be prepared to engage de-escallation techniques

E. **Visitor/Non-Employee Hazards**

1. TSC will restrict privileges for visitors who are known to have a history of disruptive, abusive, aggressive or violent behavior; who are intoxicated; or whose behavior has the potential to disrupt hospital operation.

2. Visitors exhibiting behaviors stated above will be asked to leave the campus by providing the individual a No Trespassing Warning (California Penal Code Section 602). If compliance is not met, law enforcement will be called to assist.

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F. **Environmental Hazards**

1. Hazard identification: It is the responsibility of everyone (management and all employees) to identify, report, and if possible, correct, all possible hazards. Employees are particularly important in this process as they are in the best position to identify and possibly correct hazards in the workplace and day-to-day operations. If immediate correction is not possible, the hazards shall be reported to a supervisor and documented in the hospital's incident reporting system for evaluation and appropriate action in a timely manner. Retaliation to any employee reporting a hazard is prohibited.

2. Environmental hazards that potentially expose employees to imminent danger of death or serious harm shall be addressed immediately. Measures to protect employees from identified serious hazards will be implemented within 7 days of the discovery of the hazard. All other hazards will be evaluated and addressed as appropriate but not more than 30 days. Interim measures will be taken to abate the nature of the hazard while implementing the permanent solution to the hazard.

3. Environmental Safety Hazard Inspections

a. Environmental Safety Hazard inspections are completed to identify, evaluate and correct environmental hazards. Inspections shall be conducted semi-annually. Results will be evaluated by the TSC Safety Officer and submitted to the EOC Supervisor of TFHD .

b. Follow-up inspections as determined by the TSC Safety Officer and TFHD EOC Supervisor will occur as appropriate.

G. **Training**

1. All Employees are provided training specific to this Workplace Violence Prevention Plan.
2. Workplace Violence Prevention Plan training will be provided to:
    a. New employees during initial orientation. Training will be provided to all employees annually thereafter.
    b. To affected employees whenever leadership is made aware of a new or previously unrecognized hazard
3. Training will be provided as follows:
    a. Web-based instruction: The Workplace Violence Prevention instruction will be provided via Healthstream. Leadership is available after completion of web-based training for interactive questions.
    b. In Person instruction: Leadership is responsible for ensuring that all employees, are provided training on job and specific workplace security practices. Workplace Violence training is part of the Annual Competency & Education review.

H. **Documentation**

1. All incidents shall be recorded on an Occurrence Report.
2. Information about each incident of workplace violence will be retained for at least five (5) years.
3. Investigation records for each incident of workplace violence will be created and maintained for five (5) years.
4. Workplace violence education and training records will be created and maintained in the employees file.
5. Records of workplace violence hazard identification, evaluation and correction will be created and maintained for one (1) year.

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I. **California Reporting Requirements**

1. Report Immediately
    a. A call to the nearest Cal/OSHA District Office must be made immediately by telephone for incidents resulting in death, any serious work-connected injury or illness requiring inpatient hospitalization, or where an employee suffers a loss of any member of the body, or suffers any serious degree of permanent disfigurement.
2. Report within 24-Hours
    a. Cal/OSHA Online Reporting: TSC must report via the Cal/OSHA online reporting system within 24-hours violent incidents that involves the use of physical force against an employee by a patient or a person accompanying a patient that resulted in, or had a high likelihood of resulting in, injury requiring more than first aid, psychological trauma, or stress regardless of whether the employee sustains an injury; and/or the use of a firearm or other dangerous weapon, regardless of who used the dangerous weapon

or whether the employee sustains an injury.

   b. California Department of Public Health (CDPH): If a death or significant injury of a staff member results from a physical assault that occurs within or on the grounds of a facility is an **ongoing urgent or emergent threat** to the welfare, health or safety of patients, personnel or visitors, the report must be made within 24 hours after the adverse event has been detected.

3. Report within 72-hours

   a. Cal/OSHA Online Reporting: If a violent incident that involves the use of physical force against an employee by a patient or a person accompanying a patient that does **not** result in, or does **not** have a high likelihood of resulting in, injury requiring more than first aid, psychological trauma, or stress regardless of whether the employee sustains an injury; or if a firearm or other dangerous weapon was **not** involved; or, the incident **does not** result in an eminent threat then TSC has 72 hours to report.

   b. Law Enforcement Reporting: Acts of assault or battery against on-duty hospital personnel must be reported to the local law enforcement agency within 72 hours if the incident results in injury or involves the use of a firearm or other dangerous weapon, even if there is no injury.

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4. Report no later than 5 days

   a. California Department of Public Health (CDPH): The death or significant injury of a staff member resulting from a physical assault that occurs within or on the grounds of a facility is an adverse event that must be reported to CDPH no later than five days after the adverse event has been detected.

References:

California Senate Bill No. 1299 Chapter 842; Title 8, California Code of Regulations, Section 3342

Approval Signatures

Step Description	Approver	Date

Status Draft PolicyStat ID 12594906

Origination	N/A	Owner	Courtney Leslie: Administrator
Last Approved	N/A	Department	Human Resources
Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Code of Conduct, HR-2001

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PURPOSE:

The purpose of this Code of Conduct is to inform all physicians, employees, volunteers and suppliers of our commitment to ethical behavior on the job, to honesty and to fairness.

POLICY:

MISSION	**VISION**
The mission of Truckee Surgery Center is to provide high quality personalized care for individuals requiring non-emergency, same-day health care and surgical services. We strive to enhance the well-being of people in the communities we serve through a commitment to compassion and excellence in health care services.	Truckee Surgery Center serves the community by striving to provide the best Ambulatory Surgery Center health care to our region by achieving and maintaining high levels of quality, access and affordability.

VALUES
QUALITY – holding ourselves to the highest standards, and having personal integrity in all we do. **UNDERSTANDING** – being aware of the concerns of others, caring for and respecting each other as we interact. **EXCELLENCE** – doing things right the first time, on time, every time; and being accountable and responsible. **STEWARDSHIP** – being a community steward in the care, handling and responsible management of resources while providing quality health care. **TEAMWORK** – looking out for those we work with, finding ways to support each other in the jobs we do.

GOALS
• Providing skilled, professional, individualized high quality same-day care to patients without regard to race, religion, creed, color, sex or national origin, and in conformance with all federal, state and local laws and regulations. To treat each individual with personalized care, calling them by name with each encounter. • Treating all patients with honesty and respect. Providing the community with a comprehensive program of high quality ambulatory surgical care that is safe and cost effective. • Develop a professional nursing and support staff which optimizes the opportunities offered in the ambulatory setting for the provision of efficient, economical and effective patient centered nursing care. Developing and implementing treatment plans designed to meet patient and therapeutic goals • Provide physical and emotional support to patients and their families. • Provide patient and family pre and post-procedure education to facilitate healing and return to health or a state of self-care. • Evaluate the effects of care through existing performance improvement activities. • Provide appropriate facilities and necessary services to serve the needs of its patients and to maintain high quality patient care; to improve the standard of health care services in the community; to encourage education and training of the Facility's employees and Medical Staff members. • Maintain confidentiality and HIPAA regulations. Confidential information includes, but not limited to patient records, employee records, information gained from committee meetings, and inquiries from families and friends of patients, other employees, Medical Staff, external agencies or media. • Maintain a level of profitability to support the growth of the Facility and to support the ongoing needs of the community. • Increase case volume of current and future service lines. Maximize the use of the facilities operating rooms

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I."COMPLIANCE IS YOU"

A. This Code of Conduct (the "Code") is intended to assist us in carrying out our day-to-day activities within appropriate moral, ethical, and legal standards. The Code is a critical component of our overall Corporate Compliance Program (the "Program"). We have developed the Code to ensure that we provide quality patient care and meet our ethical and legal standards. If you have any questions regarding our expectations of you, of the Code, or the Program, feel free to ask your Manager, or the Compliance Officer.

B. Truckee Surgery Center (TSC) is committed to conducting all of our business dealings in compliance with applicable laws and regulations and avoiding any impropriety, dishonesty, or wrongdoing. We believe adhering to the principles of our Program and the Code will allow us to create and reinforce a corporate culture embracing compliance and maintaining our reputation as a leader in providing quality and appropriate patient care.

C. TSC will thrive and prosper only if our reputation for honesty, integrity, quality service, and excellent care is beyond question. We must be honest and truthful in all our dealings and avoid doing anything that is illegal or that might appear improper.

D. Remember that we share in the continuing responsibility to serve our patients and community and to maintain our good name and reputation in all that we do.

E. Only YOU can earn the trust and respect of our patients and others by continuing to conduct your daily affairs with honesty and integrity and in compliance with the letter and spirit of all Applicable Laws. ***Do the right thing, always!***

II. DEFINITIONS

A. Compliance Program: A program to help an organization comply with all applicable laws and regulations. A compliance program contains the following elements:

1. Implementing written policies that address risk areas and standards of behavior (such as this Code of Conduct);
2. Providing High Level Oversight via a Compliance Officer ~~and~~with guidance from the TFH Compliance ~~Committee~~Officer and legal counsel;
3. Conducting comprehensive training and education;
4. Developing accessible lines of communication to receive complaints, anonymously when required;
5. Using audits and other evaluation techniques to monitor compliance;
6. Responding promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary action;
7. Investigating and remediating identified problems and undertaking corrective action.

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B. Covered Individual: Any board member, corporate executive, employee, physician, provider, or contractor engaged by or associated with TSC. For purposes of this Code and the Compliance Program, the term "Employee" includes all board member or corporate executives, employees, and physicians/providers.

C. Code of Ethical Conduct: Standards to help covered individuals understand their responsibilities to help TSC comply with applicable laws and regulations.

D. Applicable Laws: all applicable statutes, regulations, federal healthcare program requirements and the requirements of private payors.

III. ESSENTIAL PRINCIPLES OF THE CODE OF CONDUCT

A. The Code is organized around nine essential principles of legal and ethical behavior.

1. Comply with all Federal and State healthcare laws, rules, and regulations, with the Compliance Program, and with TSC policies and procedures.
2. Report suspected violations of the Code or Compliance Program with assurance that any sort of retaliation is strictly prohibited and will not be tolerated.

3. Provide quality, efficient, and effective care and services to our patients and all other customers of the Surgery Center.
4. Avoid actual and potential conflicts of interest, including actions that may give the *appearance* of a conflict of interest.
5. Safeguard and preserve Surgery Center resources – property, time, materials, equipment, electronic communication systems, and other assets.
6. Protect the privacy of patients and Staff and safeguard the confidential information of the Surgery Center.
7. Provide, document, and bill for services in strict accordance with the law and the highest standards of business ethics.
8. Create a caring, healthy, and safe work environment by acting with honesty and good faith in all matters and refraining from discriminatory, harassing, retaliatory, inappropriate, intimidating and/or disruptive behavior.
9. Become familiar with the Code, Compliance Program, and supporting policies and procedures and demonstrate understanding at new hire/affiliation orientation, by participation in a review and testing during Annual Training, and whenever new or updated compliance information is shared.

IV. COMPLIANCE PROGRAM

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Truckee Surgery Center has established a Corporate Compliance Program, led by the Compliance Officer with guidance from legal counsel. The Compliance Program contains a Code of Conduct which outlines the appropriate behavior for all employees. This Code is the heart of our Program and will assist employees in carrying out their daily activities within appropriate moral, ethical, and legal standards. It is not intended to cover every situation, but is intended to help employees make the right decisions and/or ask the right questions. This Code and associated policies also apply to Truckee Surgery Center relationships with our subcontractors, independent contractors, vendors, and consultants.

A. DUTY TO REPORT ACTUAL OR SUSPECTED VIOLATIONS

1. If an employee suspects or knows of a violation of the Compliance Program, or any other law, regulation or policy, it is recommended that the employee report it to their direct supervisor. However, employees can report a known or suspected violation to the Compliance Officer directly. If an employee is not comfortable reporting to their supervisor or the Compliance Officer, or if they are unavailable, they can call the Tahoe Forest Hospital compliance hotline at extension 6655 or email compliance@tfhd.com
2. Employees have the same reporting obligations for actual or suspected violations committed by a subcontractor or vendor of Truckee Surgery Center. Truckee Surgery Center maintains multiple reporting lines to ensure that employees are comfortable with whom they communicate compliance issues.

B. CONFIDENTIALITY

1. If requested, every effort will be made to keep the reporter's identity confidential, but confidentiality cannot be guaranteed. However, no adverse action or retaliation of

any kind will be taken against an employee because they report, in good faith, a known or suspected violation of the Corporate Compliance Program, or any other law, regulation or policy.

V. QUALITY OF CARE AND SERVICES

A. Dedication to quality is demonstrated in our goal to:

1. understand our customer's expectations,
2. provide care and services in a timely and reasonable manner,
3. be responsive to patient and family concerns, and
4. maintain patient's rights and dignity at all times while under our care.

B. Each patient is an individual entitled to dignity, consideration and respect. Patient abuse or neglect is not tolerated.

C. TSC respects the rights of patients and their families to participate in healthcare decisions and must inform them of their rights, as required by law. This includes the right to participate in decisions on whether to consent to or refuse treatment.

D. In certain instances, a patient's decision regarding care may conflict with TSC policies. These kinds of ethical issues should be reviewed under TSC policies and procedures and applicable state and federal laws. We are committed to providing information that will promote knowledgeable decision making. When patients are in our facility we promote ethical, innovative, professional and compassionate care within an environment that nurtures their physical, social, emotional and spiritual needs.

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VI. PATIENT CONFIDENTIALITY

A. TSC collects information about each patient's medical condition, history, medication, and family illnesses to provide the best possible care. TSC realizes the sensitive nature of this information and is committed to maintaining its confidentiality. We do not release or discuss patient-specific information with others unless it is appropriate and necessary to serve the patient, or is required by law.

B. Patients are entitled to expect the protection of confidentiality. Patient information shall be released in accordance with TSC policies and procedures with respect to the Release of Information and in accordance with Federal and State laws.

C. Health Insurance Portability and Accountability Act (HIPAA) – Truckee Surgery Center Board of Managers, leadership, employees and contractors are each responsible for maintaining the confidentiality of all patient and employee protected health information (PHI). PHI is defined as individually identifiable health information that is transmitted or maintained in any form or medium, including electronic health information. To ensure the security of PHI, TSC takes reasonable measures including, but not limited to, the following:

1. Encryption of devices,
2. Use of password protection,
3. Limitations on accessibility to information, and

4. Restrictions on placement of unauthorized software on TSC devices.

D. Employees have several obligations with respect to information created and maintained in TSC Information Systems:

1. Use the Network and computer systems for the benefit of TSC and its affiliates;
2. Log out of all devices when leaving them unattended, or, alternatively, lock the device;
3. Understand and comply with all TSC IT/Security policies/guidelines/standards which are designed to protect PHI.

E. Employees must avoid discussing patient information when participating in public or other non-TSC online forums. Employees must also identify themselves honestly, accurately and completely when participating in non-TSC public forums.

F. ***Do the Right Thing!*** If you are unsure whether use or disclosure of PHI is appropriate, or if you become aware of any violation of laws protecting Patient Information, or of this Code, please contact the Privacy Officer immediately.

VII. SAFEGUARDING TSC~~,~~ AND PATIENT ~~AND RESIDENT~~ ASSETS

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A. TSC ASSETS

1. Every Employee is responsible for safeguarding and preserving TSC resources and assets. Employees must not use TSC property, time, materials, equipment, communication systems or any other resource in a wasteful manner, for personal benefit or gain, to harm another person, for political activity, or for illegal activity. Employees should use and maintain TSC assets with the utmost care and respect, and remain cost-conscious and alert to opportunities to reduce costs while maintaining or improving quality.

B. PATIENT PROPERTY AND ASSETS

1. Any mishandling of patient property must be promptly reported to leadership.

VIII. PHYSICIAN AND PROVIDER RELATIONSHIPS

A. TSC DOES NOT PAY FOR REFERRALS

1. TSC accepts patient referrals/admissions solely based on the patient's clinical needs, provider orders and our ability to render the needed services. We do not, however, pay or offer to pay anyone - employees, physicians, or other persons - for referrals of patients. No employee, or other person acting on behalf of Truckee Surgery Center, is permitted to enter into any agreements with physicians or others that are linked directly, or indirectly, to the referral of patients.

B. TSC DOES NOT ACCEPT PAYMENTS FOR REFERRALS

1. TSC physicians and other health care providers make patient referrals solely based on the patient's clinical needs and the abilities of the referred provider to render appropriate services. No employee or any other person acting on behalf of TSC is permitted to solicit or receive anything of value, directly, or indirectly, in exchange for the referral of patients.

C. TSC DOES NOT ALLOW PERSONAL INTERESTS TO INFLUENCE REFERRALS

1. Our policy is to inform patients of their options for home health care, hospice, durable medical equipment, home infusion, and other ancillary health care services and to promote patient freedom of choice in selecting any services that the patient may require. TSC will not purchase or enter into agreements for the purchase of products or supplies, including, but not limited to pharmaceuticals, implants, instruments and other medical devices, from Physician-Owned Distributorships ("PODs") or similar entities that maintain ownership or investment interests held by physicians and/or immediate family members of physicians on the medical staff of TSC.

IX. BILLING FOR SERVICES

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A. TSC will bill the patient when appropriate, their insurance company, or a government program that provides coverage. TSC is committed to preparing and submitting honest, accurate, and complete claims to third party payers and bills to patients that fully comply with the law.

B. TSC is committed to full compliance with all rules and regulations of government health care programs, including Medicare, Medi-Cal/Medicaid, as well as managed care companies participating in these government programs. Truckee Surgery Center will also comply with the rules and requirements of all commercial insurance programs/managed care companies.

C. TSC will bill only for services rendered and all claims shall have adequate supporting documentation in the patient's medical record. It is our policy to apply the correct Current Procedural Terminology (CPT-4), Centers for Medicare & Medicaid (CMS) Common Procedure Coding System (HCPCS), the International Classification of Disease (ICD-10-CM) coding principles and guidelines, and any other regulations that apply when analyzing and coding medical record documentation.

D. Truckee Surgery Center does not:

1. bill for items and services not rendered or not medically necessary;
2. misrepresent the type or level of service rendered;
3. bill for non-covered services without advising the patient in advance;
4. bill for services rendered by other providers;
5. misrepresent a diagnosis in order to obtain payment;
6. seek to collect amounts exceeding the copayment and deductible from a Medicare or Medi-Cal/Medicaid beneficiary who has assigned benefits, or
7. fail to return credit balances in a timely manner and in accordance with applicable requirements.

E. BILLING QUESTIONS OR CONFLICTS

1. When employees receive a question from a patient or third party payer about a claim or charge, they will promptly review and address the question, if authorized to do so, or will refer the matter to an individual who is so authorized. If employees are unable to resolve a dispute regarding a patient's bill or claim, they will refer the issue to their supervisor for resolution.

F. SUBCONTRACTS FOR BILLING SERVICES

1. Subcontractors and independent contractors are agents of Truckee Surgery Center and act on behalf of TSC while performing their duties. These individuals and entities are required to adhere to the same billing and coding standards that are applicable to TSC employees.

X. COMPLIANCE FOR ALL EMPLOYEES

A. CONFLICTS OF INTEREST FOR ALL EMPLOYEES

1. Employees must exercise the utmost good faith in all transactions touching upon their duties to TSC. In their dealings with and on behalf of TSC, they are to be held to a strict rule of honesty, confidentiality and fairness in dealing with TSC matters.
2. A conflict of interest may arise if your outside activities or personal interests influence or appear to influence your ability to make objective decisions in the course of your job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract you from the performance of your job or for which you use Truckee Surgery Center resources (i.e., time, computers, facilities, supplies) for non-TSC purposes. This policy applies to the TSC Board, Leadership, all employees (including physicians with arrangements with TSC) and volunteers. It is important that while on the job, you think about Truckee Surgery Center first.
3. It is your responsibility to be alert to any actual, potential, or appearance of conflict of interest and to promptly report suspected conflicts of interest, including any inappropriate offer of gifts or services, to your Manager or to the Compliance Officer or designee.

B. GIFTS AND ENTERTAINMENT

1. 'Gift' means something of value given to an Employee. TSC Employees and independent contractors may not accept any gifts whatsoever from any patient, patient's family, vendor, supplier, patient referral source, or patient discharge facility or service.

C. KICKBACKS, REFERRALS AND BRIBES

1. The Anti-Kickback law makes it a crime to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under Federal health care programs. In accordance with this statute, TSC does not accept or offer to provide anything of value in exchange for the direct or indirect referral of patients, business, or in return for buying services or supplies.

D. COMMUNICATION SYSTEMS

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1. All communication systems, electronic mail, intranet, internet access, voice mail, or paper are the property of TSC and Tahoe Forest Hospital District. In addition, Employees should not have any expectation of privacy regarding anything created, stored, sent, or received via TSC systems. TSC reserves the right to monitor and/or access communications and usage of its electronic systems without prior notice. Sending chain letters or joke emails from a Truckee Surgery Center email account is prohibited.

XI. NON-DISCRIMINATION ENVIRONMENT

Truckee Surgery Center personnel will treat all patients, and visitors receiving services from our facility equally, in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law. Truckee Surgery Center is an equal opportunity employer and does not discriminate against employees or potential employees on the basis of race, color, creed, religion, sex, national origin, sexual orientation, veteran status, marital status, age, physical or mental disability, or any other basis protected by state or federal law. TSC will make reasonable accommodations for its disabled employees. TSC will not tolerate discrimination, verbal or physical harassment, or abuse (whether or not sexually related) by employees, supervisors, vendors, subcontractors, or visitors of TSC. TSC is committed to actions and policies to assure fair employment, including equal treatment in hiring, promotion, training, compensation, termination, and disciplinary action.

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XII. CONFIDENTIALITY OF TSC INFORMATION

A. SURGERY CENTER INFORMATION

1. Business information discussed in a closed session of the Board of Managers, such as information related to litigation, trade secrets, medical audits/quality assurance or that could compromise the privacy interests of patients and employees, must be protected from unauthorized access, use, disclosure or dissemination, and must not be used for personal benefit or gain.

B. DOCUMENT MANAGEMENT

1. TSC Document Retention and Destruction Policy applies to all documents and establishes procedures for retaining, preserving and disposing of such materials in both paper and electronic form. This policy provides guidelines that will assist with regulatory compliance and pending legal activity as well as efficiency of daily operations.

XIII. ENVIRONMENTAL COMPLIANCE

A. It is the policy of TSC to comply with all environmental laws and regulations as they relate to our business. It is your responsibility to understand how your job responsibilities may impact the environment and make sure you follow local, state, and federal environmental laws and regulations, as well as Truckee Surgery Center policies and procedures

B. Employees are expected to utilize resources appropriately and efficiently, to recycle where

possible and otherwise dispose of all waste in accordance with Applicable Laws and regulations.

XIV. MARKETING AND ADVERTISING

TSC restricts all marketing efforts to those services and procedures which are within the technical and licensure limits of the providers of TSC. Marketing programs will promote the dignity of the individual and represent an accurate, honest, and straightforward presentation of the benefits of diagnostic and therapeutic procedures it provides and the services it makes available to our community. Marketing and promotional activities on behalf of TSC must be approved in advance by appropriate personnel, and must comply with the provisions of the HIPAA/HITECH Act.

XV. FINANCIAL REPORTING AND RECORDS

TSC has established and maintains a high standard of accuracy and completeness in our financial records. These records serve as a basis for managing our business and are important in meeting our obligations to patients and others as well as complying with tax and financial reporting requirements. It is our policy to comply with the reporting requirements of applicable laws, established financial standards, and generally accepted accounting principles.

Medical and business documents and records are retained in accordance with appropriate laws, Medicare Conditions of Participation, and our Record Retention Policy. Records include paper copies, and electronic files. Employees must not tamper with records. Records must not be destroyed prior to the date specified in the record retention policy.

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XVI. INVESTIGATIONS

A. GOVERNMENT INVESTIGATIONS

1. Employees must respond to all government investigations with honesty and integrity while protecting their own rights and the rights of TSC.
2. If you are approached by any federal or state law enforcement agency seeking information about any aspect of the operations of TSC or the job-related activities of any of TSC's officers or employees, you should immediately call the Compliance Officer or designee.
3. Employees must respond to government and private investigations. Employees are free to speak to government investigators who come on site, but are not required to submit to individual questioning without benefit of legal counsel.

B. COMPLIANCE INVESTIGATIONS

1. All employees shall cooperate in the investigation of an alleged compliance violation. It is imperative that not even a preliminary investigation of a suspected violation be conducted without consultation and direction from the Compliance Officer who should seek assistance and guidance from Legal Counsel to complete the investigation.
2. Employees should NEVER take any steps to investigate independently. Strict confidentiality must be maintained. Employees are required, as a condition of

continued employment, to cooperate with any internal investigations.

3. Anyone who participates in an investigation relating to a report of suspected noncompliance, shall be responsible for responding to the situation in a timely manner and in a manner that adheres to the procedures set forth in this policy.
4. All investigations of reported violations of Applicable Laws or this Code of Conduct will be directed and/or coordinated by the Compliance Officer and Legal Counsel.

XVII. DISCIPLINE FOR VIOLATIONS

A. The TSC Compliance Program, Code of Conduct, and policies/procedures apply to Employees at all levels of the organization and will be enforced regardless of an Employee's position, rank, or tenure.

B. Intentional or reckless non-compliance will subject transgressors to significant sanctions. Such sanction could range from oral reminder, written reminder, paid decision making leave and termination for just cause

C. TSC enforces 'zero tolerance' with respect to any illegal activity or knowing, intentional, or willing noncompliance with federal or state laws or TSC policies.

D. All Employees must:

1. comply with applicable laws, regulations and TSC policies and procedures,
2. report a known or suspected compliance violations, and
3. take reasonable steps to prevent or detect criminal conduct or other wrongdoing.

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XVIII. Q&A's

A. If I observe something in the workplace I consider to be wrong who should I contact?

1. TSC has provided several resources for you to turn to with such concerns. First, you are encouraged to talk to your Manager. However, if you are uncomfortable talking to your Manager, you may wish to speak with one or all of the following: the Administrative Director of Surgical Services (TFH) or the Administrator/Compliance Officer. You may also call the TFH Compliance Hotline (530) 582-6655 or send an email to compliance@tfhd.com. Whenever possible, and if appropriate, you are encouraged to resolve departmental issues at the department level.

B. If I am asked to do something that I believe violates the Code of Conduct what should I do?

1. Don't do it! You must refuse to do anything you consider to be wrong regardless of who asks you to do it. Immediately report the request to the next level of management, notify the Compliance Officer or call the TFH Compliance Hotline (530) 582-6655.

C. Will I get in trouble if I report something suspicious and it turns out I was wrong?

1. The policy of Truckee Surgery Center prohibits employees from being reprimanded or disciplined if they report a matter in good faith. However, if an employee reports something which he or she knows to be false in order to harm another employee, a patient, or TSC, the reporting employee may be subject to disciplinary action(s).

D. During a normal workday, and especially around the holidays, patients and/or family members may offer gifts of money. Should such gifts be accepted?

    1. Cash gifts must never be accepted from a patient, a family member, a business partner, or any agent or company having business dealings with TSC. Gifts of nominal values may be accepted if they are consumable or perishable, such as cookies or fruit baskets.

E. How do I know if my actions are ethical?

    1. When it comes to legal questions regarding workplace behavior, the decision whether the behavior is right or wrong may be relatively clear-cut. However, ethical matters may be less clear. Ethical decisions are often a matter or judgment, with no rule or law that applies to every situation, every time. When in doubt about a contemplated action, an Employee might ask him or herself the following questions:

        a. Will this action be ethical in every respect and fully comply with the law and with TSC policies?

        b. Will this action have any appearance of impropriety?

        c. Will this action be questioned by patients, coworkers, supervisors, family, or the general public?

        d. Will this action mislead someone because it is not transparent?

        e. Would I be uncomfortable if this action or its results were published in the local paper or broadcast on the TV news?

F. If you are uncomfortable with the answer to any of the above, do not take the contemplated action without first discussing it with your Manager and/or the Compliance Officer or designee.

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XIX. LIST OF REFERENCES

A. APPLICABLE LAWS

    1. This is a non-exhaustive listing of key laws and regulations that apply to healthcare workers and services they provide, with a summary of content relevant to staff.

B. FALSE CLAIMS AND THE DEFICIT REDUCTION ACT (DRA) OF 2005

    1. The Federal False Claims Act imposes civil liability (hefty fines) on any person or entity that:

        a. Knowingly submits a false claim to the federal government for payment;

        b. Knowingly makes or uses a false record or statement to obtain payment or approval of a claim by the federal government;

        c. Uses a false statement to decrease an obligation to the government.

    2. QUI TAM

        a. "Qui tam" is a provision of the federal and state False Claims Act that enables a private person (known as a 'relator' or 'whistleblower') to bring a lawsuit in the name of the federal or state government if he or she has

personal knowledge of a false claim. The relator of potential fraudulent conduct who assists in an investigation, action or testimony is protected from retaliation by both federal/state law and Surgery Center policy. In addition, the relator may share in recovery – repayment and fines collected by the government because of the false claim.

C. PROGRAM FRAUD AND CIVIL REMEDIES ACT (PFCRA)

1. The PFCRA is another tool the federal government can use to penalize false claims involving federal agencies and is designed to provide the federal government with a way to record losses resulting from false claims.

D. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) of 1996

1. HIPAA is a broad law dealing with a variety of issues. Its original goal was to make it easier for people to move from one health insurance plan to another (hence the name health insurance portability) when they changed jobs or became unemployed. The outcome is that personal medical records and information can be easily moved to provide continuity of services and to facilitate the care people need. To make it easier for healthcare organizations to share medical information, HIPAA law requires that common transactions such as submitting a claim on the patient's behalf be in standard format for all healthcare organizations and payers. BUT with easier transmission of patient information, there is more opportunity for information leaks and abuses to occur. This is especially true as more and more information is shared electronically through e-mail and the internet. As a result, an important part of HIPAA focuses on patient privacy and confidentiality. Under HIPAA, it is illegal to release health information to inappropriate parties or to fail to adequately protect health information from release. HIPAA provides two rules governing the electronic exchange and privacy and security of Protected Health Information (PHI):

   a. Privacy Rule – The Privacy Rule lets patients know about privacy rights, gives a patient access to his/her PHI and control over how it is used, and requires security processes for medical records and other confidential information used or shared in any form.

   b. Security Rule – The Security Rule requires administrative, physical, and technical safeguards to protect patient privacy and covers information that is stored or transmitted electronically.

   c. With the enactment of HIPAA in 1996, a patient's right to have his/her information kept private and secure became more than just an ethical obligation of healthcare personnel; it became law. Civil and criminal penalties may be imposed for HIPAA noncompliance, including fines for lapses and fines plus imprisonment for knowing misuse of PHI.

E. ANTI-KICKBACK STATUTE

1. The Medicare Anti-Kickback Statute makes it a violation to offer or accept "remuneration," i.e. something of value, directly or indirectly, in exchange for the referral of any Medicare business, unless the arrangement is covered by one of the very few and very specific legal exceptions, called "safe harbors." The underlying purpose of this Anti-Kickback is to guard against improper influence over choice of

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the provider or supplier who will furnish items or services that will be paid for by Medicare. It equally guards against the over utilization or inappropriate utilization of items or services that result in negative impact on Medicare costs and the quality of patient care.

F. SARBANES-OXLEY ACT OF 2002

1. The Sarbanes-Oxley Act was passed by Congress to help prevent corporate and accounting fraud as well as to help restore investor confidence in the public securities market. The Act sought to improve the quality of a company's accounting and disclosures, increase management's responsibility for fair reporting and ethical behavior, strengthen auditor and director independence, and strengthen regulatory oversight. Although this law does not apply to nonprofit organizations, several provisions address issues which are present in nonprofit hospitals. Compliance programs, organizational ethics training, and a culture that fosters compliance with laws and reporting questionable conduct are measures that support the principles of the Sarbanes-Oxley Act.

G. STARK LAW

1. The Stark Law is also called the federal physician self-referral law. It seeks to remove incentives to overuse medical care that may result if a physician's treatment decisions are tied to inappropriate financial gain. The original statute addressed physician referrals for clinical laboratory services. The law was later expanded to include ten additional medical services.
2. The law prohibits a physician from referring a Medicare patient to any entity with which either the physician or a family member of the physician has a financial relationship. The law permits the extension of minor, non-monetary business courtesies (e.g. a meal) to potential referral sources and their family members, but such "courtesies" cannot be cash or cash equivalents. In addition, any business courtesy or other benefit that is understood by either party to be offered, provided, or solicited as an inducement to refer patients or business, or as a reward for such referrals, is prohibited.

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Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **12617877**

Origination	N/A	Owner	Courtney Leslie: Administrator
Last Approved	N/A	Department	Medical Staff
Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Peer Review, Professional Practice Evaluation, & Medical Record Review, MS-1906

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PURPOSE:

This policy is to define peer review functions at Truckee Surgery Center

POLICY:

Truckee Surgery Center is committed to identifying and correcting processes or variations in care/ services that may lead toward undesirable or unanticipated events affecting consumers or consumer care. Peer review will be utilized in order to establish a mechanism for evaluation of clinical care and service delivery that identify opportunities for improving care.

PROCEDURE:

Physician's & Anesthesiologist's Peer Review

A. Active medical staff at Truckee Surgery Center will be performing random peer review/chart review on a quarterly basis. Any cases that meet criteria listed below will be selected for review:

1. Death or worsening condition as a direct result of care provided
2. Code Blue
3. Complaints regarding medical care and treatment
4. Unexpected transfer to a higher level of care
5. Use of any rescue or reversal drug
6. Track and trend Surgical Site Infection (SSI)
7. Request from another Medical Staff Committee

8. Request from Medical Staff or Clinical Staff

B. Surgery-Specific Indicators:

1. Transfer to another facility due to at least one perioperative complication
2. Unplanned return to the operating room during an admission
3. Unusual or unexpected patient injury/complication during/following surgery or invasive procedure
4. Embolus causing change of treatment
5. Wrong-site surgery
6. Unplanned admission to a higher level of care

C. Anesthesia-Specific Indicators:

D. Post-Operative pain

1.
    a. Definition: adequate post-operative pain control, including an initial PACU pain score < 7/10
    b. Exception(s): patients < 3 years old, patients unable to report pain score

2. Post-Operative Nausea & Vomiting
    a. Definition: use of two (2) or more classes of medications and/or interventions including serotinin receptor antagonists, dopamine-2 receptor antagonists, corticosteroids, anticholinergics, and TIVA in patients with 3 risk factors for PONV (history of PONV/motion sickness, female, non-smoker, use of post-operative opioids)
    b. Exception(s): patients < 3 years old, patients unable to report pain score

3. Re-intubation in PACU
4. Unintended dural sac puncture during an anesthetic procedure
5. Unplanned admission to a higher level of care
6. Adverse outcome related to anesthesia
    a. Death
    b. Acute Myocardial Infarction
    c. Cardiac Arrest
    d. Renal Failure
    e. Cerebrovascular Accident
    f. Non-cardiogenic Pulmonary Edema

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E. The number of charts reviewed will equal to approximately 10% of the caseload for the quarter.

F. The Administrator, Nurse Manager, and/or QAPI/IP Coordinator will provide each physician with the appropriate number of charts at the beginning of each quarter. These charts can be reviewed at any time during the course of the day at Truckee Surgery Center.

G. A Peer Review/Chart Review form will be filled out completely. This form states that the chart should be checked for completeness, legibility, accuracy and then the physician reviewing the chart should make comments in areas of improvement. The chart number and surgeon will be listed on the top of the form. The areas for review for physicians are as follows:

    1. Office/Pre-Op scheduling sheet
    2. Surgical Consent
    3. Physicians pre-operative orders
    4. H & P
    5. Pre-Operative test results (if applicable)
    6. Post Operative orders
    7. Progress Note
    8. Discharge Instructions
    9. Operative Report

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H. A check box that has been marked with no comments after it means that the corresponding portion of the patients record was complete with no further issues or comments needed. The physician is also asked whether they felt that the patient was appropriate for Truckee Surgery Center and if there was over or under utilization based on the chart review. In addition to this there is a space available for general comments. The reviewing physician is then asked to sign and date their document.

I. The areas for review by anesthesiologists are as follows:

    1. Anesthesia Consent form
    2. Pre-Operative testing
    3. Pre & Post Anesthesia Evaluation
    4. Anesthesia Record/Local Anesthesia Record
    5. PACU orders
    6. Operative Report

J. A check box that has been marked with no comments after it means that the corresponding portion of the patients record was complete with no further issues or comments needed. The anesthesiologist is then asked whether they felt that the patient was appropriate for the

Surgery Center and whether there was an over or under utilization based on the chart review. In addition to this there is space available for general comments. The reviewing anesthesiologist is then asked to sign and date their document.

K. Upon completion of the Peer Review/Chart Review Form the physician/anesthesiologist will return their documentation back to the Business Office and given to the QAPI/IP Coordinator. This information will then be compiled into a Peer Review flow sheet.

L. This flow sheet will be brought by the Administrator and Nurse Manager to the quarterly Medical Executive Quality Committee Meetings and to the Board of Managers.

M. Follow up with an individual physician/anesthesiologist will be on a case by case basis and decided upon by the Medical Executive Quality Committee and/or Board of Managers.

N. All Peer Review forms will be kept in the binder for PEER REVIEW located at the preop Nursing Station.

~~Each physician will be placed in the "tickler" file on the computer so as to remind the Administrator when their next quarterly reviews are due.~~

O. The nursing staff at Truckee Surgery Center will perform their own review of charts upon patient discharge(s). The QAPI/IP Coordinator conducts an audit of 100% of patient charts, and will record the data in the Clinical Record Reviews, for both pain and surgery. The information provided by the review will be discussed on an individual basis and reported at staff meetings as necessary.

P. Quality assurance and performance improvement statistics and trends will be presented to the Medical Executive Quality Committee and Board of Managers on a quarterly basis to monitor compliance.

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Non- Physician Professional Practice Evaluation

Professional Practice Evaluation is the routine monitoring and evaluation of an individual's current competency and performance and will be completed on all Non-Physician practitioners. The Surgeon performing the case will conduct review.

The areas for review are as follows:

- Patient Care
- Medical & Clinical Knowledge
- Interpersonal Skills
- Professionalism
- System Based Practice

The Administrator, Nurse Manager, and/or QAPI/IP Coordinator will provide each physician with the appropriate number of charts at the beginning of each quarter.These charts can be reviewed at any time during the course of the day at Truckee Surgery Center.

The number of charts reviewed will equal to approximately 10% of the caseload for the quarter.

Upon completion of the Peer Review/Chart Review Form the physician will return their documentation back to the Business Office and given to the QAPI/IP Coordinator. This information will then be compiled into a Peer Review flow sheet.

This flow sheet will be brought by the Administrator and Nurse Manager to the quarterly Medical Executive Quality Committee Meetings and to the Board of Managers.

Follow up with an individual non-physician practitioner will be on a case by case basis and decided upon by the Medical Executive Quality Committee and/or Board of Managers.

All Peer Review forms will be kept in the binder for PEER REVIEW located at the preop Nursing Station.

Quality assurance and performance improvement statistics and trends will be presented to the Medical Executive Quality Committee and Board of Managers on a quarterly basis to monitor compliance.

Special Instructions / Definitions:

A. Adverse Event: Events that do not qualify as Sentinel events but are serious and could identify process improvements. The Director will determine if an event is an adverse event when the event does not qualify as a Sentinel Event.

B. Notification Report: Data base of unusual incidents of consumer care relating to any incident that disrupts or adversely affects the course of treatment or care of an individual consumer or the program caring for others.

C. Peer: Any physician, nurse, and/or other clinical professionals who meet basic qualifications with clinical experience and training to provide an evaluation of a specific significant issue or general case or process review. The peer(s) involved in the review shall have the same license/credentials as the person or persons involved in the event or service process.

D. Peer Review: A process by which professionals evaluate the clinical competence and quality and appropriateness of care/services provided to consumers. The review may focus on an individual event or aggregate data and information on clinical practices.

E. Performance Improvement: A systematic way of addressing improvement opportunities that involve the use of soft (facilitation techniques, problem solving processes) and hard (data analysis, statistical tests) skills to understand, recommend and implement change.

F. Professional Practice Evaluation: the routine monitoring and evaluation of an individual's current competency and performance for non-physician practitioners.

G. Sentinel Event: an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Put another way— if the event had continued or were to recur, the individual would risk death or major permanent loss of function.

H. Utilization Review: Analysis of the patterns of service authorization decisions and service usage in order to determine the means for increasing the value of services provided (minimize cost and maximize effectiveness/appropriateness).

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STANDARDS:

A. Truckee Surgery Center declares that the following business functions and analysis are all defined as PEER REVIEW FUNCTIONS:
   1. Sentinel or Adverse Event Reports/Root Cause Analysis
   2. Notification Reports and Data
   3. Internal Clinical Reviews

B. Reports or Forms completed as a part of a peer review process shall be kept as peer review documents and shall not be kept as a part of a clinical record.

C. Peer Review Process analysis of events or clinical practices shall be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and/or national standards.

D. The quality committee shall be consulted as needed during any peer review function.

E. Peer Review Functions/Processes shall adhere to all laws and policies including the reporting of any disciplinary action taken by an agency/organization against a health professional licensed or registered in the state that adversely affects the licensee's or registrant's clinical privileges for a period of more than 15 days. "Adversely affects" means the reduction, restriction, suspension revocation, denial or failure to review the clinical privileges of a licensee or registrant.

Effective: December 2008, Revised: May 2011, October 18 2011, June 2017, July 2019

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Approval Signatures

Step Description	Approver	Date

Status Active PolicyStat ID 12609477

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Last Approved	11/2022	Department	Environment of Care
Last Revised	11/2022	Applicabilities	Truckee Surgery Center
Next Review	11/2023		

UPDATES ARE HIGHLIGHTED IN YELLOW UPDATED TO MEET ACHC STANDARDS

Emergency Operations Plan, EOC-1902

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POLICY:

Truckee Surgery Center (TSC) will establish and maintain an Emergency Operations Plan designed to manage the consequences of natural disasters and other emergencies that disrupt the Surgery Center's ability to provide care.

TSC will work closely with the Tahoe Forest Hospital (TFH) Facilities Management Department in the event of an emergency, depending on the type of incident.

PURPOSE:

To conduct business normally, it is important for TSC to have a strategy on preparation for emergencies. This plan must provide an organizational structure so that TSC can effectively prepare for both external and internal disasters that can negatively affect its environment of care.

STRUCTURE:

A. TSC plays an important role as a provider of care to the residents of its community. TSC is ready to assist as needed in case of community emergency, and as appropriate integrates its Emergency Operations Plan with community disaster plans, as appropriate, to support the community's response to disaster. TSC will train its personnel in this plan.

B. The scope of this emergency plan, both internal and external, will determine the role of the Surgery Center and its personnel in responding to an emergency. The Surgery Center will participate in at least one emergency preparedness drill annually.

C. The Administrator will tailor the TSC Emergency Operations Plan.

D. This plan contains processes for preparedness, response, mitigation, and recovery in the event of an emergency.

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E. Mitigation activities are those a health care organization undertakes in attempting to lessen the severity and impact a potential disaster or emergency may have on its operation while preparedness activities are those an organization undertakes to build capacity and identify resources that may be utilized should a disaster or emergency occur.

DEFINITIONS:

A. *ASC:* Ambulatory Surgery Center

B. *External Disaster:* A civil catastrophe, either man made or caused by an act of God. An external disaster may overwhelm normal facilities. This condition can occur as a result of fires and explosions, storms, civil disorders, multiple injury accidents, avalanches, among other causes

C. *Internal Disaster:* An event such as a fire or explosion resulting in internal casualties or circumstances. If the situation requires the evacuation of patients, such evacuation will be coordinated with emergency service personnel from the fire and police agencies.

D. *Shelter in Place:* Means that staff, patients, and visitors will remain in the facility. Sheltering can be used due to severe weather, a fire, or hazardous/hazmat materials condition in the area.

E. *Approved Information:* Information, that is allowed to be shared, relating to a patient who is involved in a disaster, evacuation, event, or shelter in place while at Truckee Surgery Center. The patient's signed release of protected health information is to be referenced.

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PROCEDURES

DISASTER PROCEDURES FOR STAFF MEMBERS

A. It is the responsibility of the Administrator or the Nurse Manager to activate the Emergency Operations Plan. In the event of either internal or external disaster, the Administrator or Nurse Manager can initiate the Disaster Phone Tree (attached) and the Disaster Resource List (attached).

B. The Disaster Resource List will be used to track on-duty and available staff who may need to respond to an emergency and are to be used in the event of an immediate evacuation so staff can be accounted for at the evacuation location.

C. On arrival at to TSC, staff members will report to the Administrator and/or Nurse Manager to log in and be assigned to whatever tasks are required: in direct patient care, preparing for evacuation, or other assignment.

D. If a regular work shift ends during the declared emergency period, all staff members will stay at their respective assignments until officially relieved by order of the Administrator or Nurse Manager.

E. In the event that total evacuation of the clinic is necessary, the Administrator or his or her designee will assume the responsibility for evacuation. Each patient will be rated, by the Nurse Manager or his or her designee as to the type of transportation necessary:

   1. Ambulatory
   2. Ambulatory with assistance
   3. Wheelchair

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4. Gurney
5. Transfer via Ambulance

F. All staff members will report changes of address and telephone numbers, as well as their response time to TSC, to the Administrator as soon as a change becomes effective. The Administrator will continually update the Disaster Resource List.

DISRUPTION OF SERVICES AND MANAGEMENT OF SPACE, SUPPLIES, COMMUNICATIONS, AND SECURITY:

A. If a portion of the Surgery Center is incapable of supporting patient care but total evacuation is not required, the following procedures will be followed:
   1. ***Space Allocation***: Patients will be served in unaffected areas of the Surgery Center that are able to safely provide services.
   2. ***Supplies*****:** The Administrator and/or Nurse Manager will be immediately notified of any situation that necessitates an increased level of supply items. The existing supply areas will be automatically used to provide supplies to the extent possible.
   3. ***Communications*****:** Both the phone system and cell phones will be used to provide communications between TSC and outside agencies. If a total phone loss occurs, walkie talkies will be used to provide communication
   4. ***Security*****:** Needs that might exceed the capability of the Surgery Center will be relayed to the local police department or contracted security service.

MANAGEMENT OF PATIENTS IN DISASTER SITUATIONS

A. If a disaster or an emergency involves TSC or its staff members, all less-than-essential services will be temporarily modified or discontinued until the situation allows for resumption of full program ability.

B. The Administrator and/or Nurse Manager will determine whether these less-than-essential services are to be effected and, if so, when.

C. Staff members normally involved in provision of services determined by the Administrator and/or Nurse Manager to be less than essential will make themselves available for other duties. These duties may include helping move patients from the affected area of Surgery Center to an unaffected section. These staff members will also be responsible for providing any patient transportation devices, such as wheelchairs, gurneys, and so forth, to facilitate the movement or evacuation of patients from the TSC.

D. All staff members will be familiar with the overall Emergency Operations Plan.

E. Facilitation of patient movements, including admissions, transfers, and control of patient information, will be directed by the individual assigned by the Administrator or Nurse Manager. Information concerning any patient will be released only by a qualifying physician or at the direction of the Administrator or Nurse Manager.

F. In disaster or emergency situations requiring additional physicians, those physicians will be directed by the Administrator, Nurse Manager or Medical Director.

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TRAINING OF STAFF IN EMERGENCY PREPAREDNESS

A. All TSC personnel are made familiar with the disaster, fire, and emergency plans during the orientation process, policies are reviewed upon hire and annually, and health stream modules are completed upon hire and annually.

B. Staff will receive education on emergency preparedness, emergency equipment and supplies during orientation and on an annual basis. TSC employees will receive specific training in their individual and service roles during both internal and external disasters.

C. The Administrator is responsible for scheduling emergency preparedness training with all facility employees. The Administrator is responsible for the content of the training to ensure that all employees know their roles as outlined in the Emergency Operations Plan. It is the responsibility of the Administrator to ensure that this training occurs annually and to obtain appropriate documentation.

D. Training will include: Specific roles and responsibilities during emergencies, information and skills required to perform duties during emergencies, The backup communication system used during disasters and emergencies, how supplies and equipment are obtained during disasters or emergencies, emergency equipment available during an emergency, and resuscitation techniques.

    1. All staff will maintain BLS certification. RNs will also maintain ACLS and PALS certification.

    2. Whenever there is a patient present in the surgery center there will be clinical personnel present who have appropriate training and competence in the use of the emergency equipment and supplies.

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EMERGENCY EQUIPMENT AND SUPPLIES

A. Adequate emergency equipment and supplies are kept on site.

    1. A list is attached to this policy and will be updated as needed.

B. Medical, non-medical supplies, equipment, and personal protective equipment (PPE), will be replenished via normal supply means as well as through any backup supplies maintained by the Surgery Center.

C. Surgery Center resources and assets will be shared with TFH if needed.

EMERGENCY PREPAREDNESS DRILLS

Implementation of the Emergency Operations Plan will be conducted at least annually at TSC either in response to an emergency or as a planned drill. One internal and one external disaster will be rehearsed.

A. The Administrator and/or Nurse Manager has the responsibility to develop the scenario and disseminate the necessary information to employees. The time and other details concerning the disaster will be controlled by the Administrator and/or Nurse Manager.

B. Cooperation with city, county, and State agencies in large-scale drills, where available, will be ongoing and coordinated by the Administrator.

C. Actual emergencies may be counted towards the required annual drill. All emergency preparedness drills or actual occurrences will be critiqued by the Administrator and reviewed

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and evaluated at the next Medical Executive Quality Committee and Board of Managers meetings.

D. Feedback concerning any type of drill conducted will be reviewed by leadership at the Medical Executive Quality Committee and Board of Managers for necessary actions.

E. The Administrator will be responsible for communication of any information or recommendations about proposed changes in the emergency preparedness policy. The Administrator will ensure that proposed changes are implemented as specified.

F. Management will, on a random basis, quiz staff members concerning the Emergency Operations Plan and their roles in any drill. This process serves as a source of feedback, which management can use for evaluation of the overall effectiveness of the program.

HAZARD VULNERABILITY ASSESSMENT & RISK ASSESSMENT

A. A Hazard Vulnerability Analysis (HVA) is completed to asses the impact of likely emergencies.

    1. The HVA is used to as a basis to define our Emergency Management program to analyze mitigation, preparedness and response and recovery activities.

    2. The mitigation activities are designed to reduce the risk of and potential damage related to an actual emergency.

    3. The HVA is reviewed and updated annually to determine if the likely emergencies have changed

B. Availability and functionality of critical emergency equipment is maintained by the TFH Facilities Management Department.

C. The HVA is shared with local, state, and federal emergency preparedness officials annually and during a disaster or emergency situation.

D. A Utility Risk Assessment is completed on an annual basis. The Risk Assessment is approved by the MEC and shared with TFH Facilities Management Department.

STAFF AND STAFF FAMILY SUPPORT ACTIVITIES

A. This plan acknowledges that the staff of this organization is its greatest asset. If staff or staff family members are directly impacted by a community emergency or disaster, TSC leadership will be sensitive to this and attempt to ameliorate this. Support of impacted staff and families may include: referrals to disaster relief organizations and referrals for incident stress debriefing. The Administrator or Nurse Manager will be available to discuss any staff or family needs based on staff family impact or community emergency or disaster.

PERFORMANCE STANDARDS

A. Performance standards for this plan will include:

    1. Emergency preparedness knowledge and skill for staff

    2. Completion of an annual emergency preparedness drill

    3. The level of staff participation in emergency preparedness management

    4. Monitoring and inspection activities

    5. Emergency and incident reporting procedures that specify when and to whom

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reports are communicated

6. Inspection, preventive maintenance, and testing of applicable equipment
7. Use of space
8. Replenishment of supplies
9. Management of staff.

ANNUAL EVALUATION

A. Annual evaluation of the effectiveness of the Emergency Operations Plan undertaken at TSC will include performance measures, using the previous year's reports; recommendation from the Medical Executive Quality Committee and Board of Managers; and input from TSC staff and other relevant sources of safety outcome sources. These reports will be presented to the Medical Executive Quality Committee & Board of Managers.

B. Leadership will prioritize opportunities for improvement in this function.

COMMUNITY EMERGENCY TELEPHONE NUMBERS:

A. American Red Cross: 916-993-7070

B. California Emergency Management Agency: 916-845-8510

C. California Health & Human Services: 916-654-3454

D. Federal Bureau of Investigation: 916-481-9110

E. Nevada County Emergency Management: 530-265-1515

F. Law Enforcement:
   1. Truckee Police Department 530-550-2323
   2. Nevada County Sheriff Department 530-265-1471
   3. California Highway Patrol 530-563-9200
   4. Coroner 530-265-1321

G. Fire Departments:
   1. Fire Department (local)911
      a. Truckee Fire Protection District 530-582-7850

H. Utilities:
   1. Electricity: Truckee Donner PUD 530-587-3896
   2. Gas: Southwest Gas 530-582-7200
   3. Sanitation Agency 530-587-2525
   4. Medical Gas: Airgas 775-358-2260

I. Service Contractors:
   1. Computer Service (TFH IT) 530-582-3494
   2. AAA Smart Business (Burglar/Fire alarm) 530-587-6278

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3. Linen Supply: Aramark 800-272-6275

J. Ambulance Services:
    1. Truckee Fire District 530-582-7850
    2. Care Flight Truckee 530-587-8397

K. Pharmaceutical Supplies:
    1. Tahoe Forest Outpatient Pharm 530-587-7607
    2. Tahoe Forest Inpatient Pharm 530-582-3430

L. CAMCO Property Management: Tim Sawyer 530-308-1079

M. Tahoe Forest Hospital
    1. Facilities Management Dept. 530-582-3510
    2. Materials Management Dept. 530-582-3520
    3. Emergency Department (Transfer Agreement) 530-582-3208
    4. Administrative Director of Surgical Services- Karla Weeks 530-582-3239

COMMUNICATION WITHIN AND OUTSIDE OF THE SURGERY CENTER

A. TSC understands the importance and need of communication both internally and externally in the event of an emergency.

B. Staff notification of activation of emergency response procedures, advisories, actions, and pre-planning initiatives will be accomplished in several manners:
    1. Overhead page
    2. Disaster Phone Tree
    3. Disaster Resource List
        a. TSC has a Disaster Resource List that contains the name, title, contact information for home, cell and work, on duty/off duty status, travel time (if available), neighborhood they reside in, and bilingual language if spoken.
        b. The Disaster Resource List is located in the following locations:
            i. G:/Truckee Surgery Center/EOC & Emergency Management
            ii. The Emergency Management Binder
            iii. The Nurse Managers schedule clipboard
        c. The Disaster Resource list is updated every 6 months, or more frequently if needed.
        d. Medical Staff Contact information is located on the TSC phone list.
    4. Phone Messaging
    5. Email
    6. Text Messages
    7. General Media (TV & radio)

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8. Runners

C. In addition, staff will communicate to patients, families, and visitors, at the time of the notification/activation, what the emergency procedure is as well as how it may affect/impact them and any actions needed to be taken at that time or in the future.

D. TSC will make every effort to communicate to all external authorities and stakeholder agencies and suppliers of the existence of an emergency condition as appropriate as soon as possible.

E. In the event that it is necessary, existing partnerships with local, state, and federal law enforcement agencies will be activated and appropriate officials notified depending on the situation.

F. TFH Facilities Management will be contacted in the event of a non clinical emergency.

G. The TFH Emergency Room will be notified of any potential transfers.

H. TFH Administration will be notified of activation of emergency response procedures, advisories, actions, and pre-planning initiatives as soon as possible.

   1. The Public Information Officer of TFH will be notified for any communication with the media.

I. Vendors will be contacted if needed. Vendor phone numbers can be found on the G drive and in the emergency management binder. TFH Facilities Management Department can also be contacted for phone numbers.

   1. G:/Truckee Surgery Center/EOC & Emergency Management/ Phone Lists

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VOLUNTEERS

A. Truckee surgery Center does not accept external volunteers.

B. TFH Staff may assist as needed. They will properly signin/out utilizing the visitor log at the front desk.

INTERNAL SECURITY AND SAFETY OPERATIONS DURING AN EMERGENCY

A. TSC staff is responsible for controlling access, crowds, and traffic into the Surgery Center.

B. The Administrator will coordinate with local law enforcement agencies with regard to lock down, suspension of visitors, and restriction of of movement in an emergency depending on the type of incident.

   1. This could include placement of uniformed officers at entrances, controlling access via available physical and/or electrical systems, and manual controls such as key access only.

C. TFH Facilities Management Department will be contacted for any additional security needs.

INVOKING THE 1135 WAIVER

A. Due to the limited amount of staff please refer to the working hours of the facility. The facility can share the limited available surgical supplies if needed. The facility will not begin providing surgical services at an alternate site during internal disaster. Patients will be canceled and rescheduled to a later date, after facility services have been restored.

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1. In the event that an emergency occurs, and the 1135 waiver is invoked, and we have patients we are currently caring for, those patients will be moved to an alternate location for care by our staff, in which we will be reimbursed under the 1135 waiver.

B. Once the emergency is over, the Administrator and/or Nurse Manager will notify the staff and physicians.

C. Evidence of damage caused by the emergency or response to the emergency will be documented through photographs or descriptive writing. An emergency action report and critique will be completed by leadership and presented at the next Medical Executive Quality Committee and Board of Manager's meeting. Any emergency supplies used will be restocked.

EXTERNAL DISASTER PROCEDURES

A. If there is an occurrence in a location other than those listed previously in which the number of people requiring care exceeds the immediate resources of TSC:

B. The Administrator and/or Nurse Manager will be the person in charge with the following duties:

1. Approving the implementation of the Emergency Operations Plan and evacuations
2. Maintaining information flow throughout TSC
3. Maintaining approved information flow to the public
4. Maintaining approved information flow to families of people involved in the disaster
    a. When such information pertains to a patient the patient's protected health information (PHI) release will be reviewed.
    b. In the event that there is no release on file, on will be obtained prior to sharing information if the patient is still on the premise.
    c. If the patient has been evacuated and/or is unable to give consent, the facility must exercise professional judgment to determine what PHI may be released.
5. Maintaining the waiting area for patients and visitors
6. Identifying new designated areas if needed and communicating this information to the staff.
7. A staff list will be located at the front desk in the lobby. The staff conference room or kitchen area will be used if the waiting room has been affected by the disaster.

C. The Administrator and/or Nurse Manager will be the person in charge with the following duties:

1. Determining the extent of employees needed at the ASC.
2. Maintaining and distributing a log for the Red Cross, if appropriate.

D. If treatment areas are undamaged, they will be used as usual

E. If TFH needed additional beds for triage or treatment, we would cancel all possible cases to clear our space.

1. This would be done with the greatest concern for our patient’s safety and regard.

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F. In the event that our space was not needed, the facility will finish up the procedures in progress as quickly as possible, the patients discharged or transferred to the hospital according to their needs and the facility closed.

G. Any staff of Truckee Surgery Center available to help in the event of disaster would report to TFH as soon as possible to provide additional support.

EVACUATION PROCEDURE

A. When evacuation of patients from threatened or affected areas of TSC is required, safety of lives is the primary concern. Therefore, the evacuation must be carried out as quickly and efficiently as possible.

B. *Authority To Evacuate*

  1. Authority to order evacuation is vested in the Administrator or Nurse Manager.

C. *Types of Evacuation*

  1. *Immediate Evacuation*

    a. First move patients and others who are closest to the danger.

    b. Separate an emergency area from people by a fire door.

    c. Move medical records with patients, if possible.

    d. In event of a fire- lead ambulatory patients to exits using the evacuation plan posted in the area.

    e. Move non-ambulatory and helpless patients to the exit routes by means of Gurneys or wheelchairs

  2. *Planned Evacuation*

    a. Planned evacuation will be initiated by the Administrator or Nurse Manager only. The Administrator, Nurse Manager, or designee will notify the modalities of services of need, extent, and time frame of the evacuation.

  3. All patients will be evacuated in the event of

    a. Disruption or discontinuance of services

    b. Power outage or other calamity that causes damage to the facility or threatens the safety and welfare of patients and staff

    c. Natural disaster of such magnitude or threat that it endangers the safety and welfare of patients and staff members.

  4. Evacuation will be partial or full, depending on whether an area is uninhabitable for patient safety, requiring partial or complete closure of a modality or an area of service

D. *Procedure for Evacuation and Discharge of Patients*

  1. TSC's nursing staff will prepare patients to be evacuated.

  2. An individual appointed by the Administrator or Nurse Manager will notify patients'

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families of the location of patients and will make a list of patients evacuated to other areas or facilities. This list will be given to the Administrator or Nurse Manager.

3. The ancillary staff will provide additional help as needed.
4. Patients will be evacuated to an area of safety by whatever means are available, and provision will be made for patients' comfort and safety.
5. The intercom will be used to announce evacuation plans. If the intercom is not available, the Administrator or Nurse Manager will designate a runner to announce the evacuation.
6. An evacuation route and meeting place will be the same as that for fire (facility parking lot by generator).

E. *Visitors*

1. Visitors should leave the premises when an evacuation is ordered.
2. If visitors can't safely leave the premises on their own when an evacuation is ordered, a staff member will be assigned to escort visitors to the designated staging area using the safest and most direct route possible.

F. *Evacuation Areas*

1. The parking lot near the generator will be the designated evacuation area except that in inclement weather, the Administrator or Nurse Manager will indicate a secondary evacuation area.
2. Dr. Leslie Joseph's office or TFH Center for Sports and Performance may be used as an alternative area in inclement weather.

G. The fire evacuation route as designated by maps posted throughout the building will be followed.

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SHELTER-IN-PLACE

A. Shelter-in-Place might result from a fire, severe weather, or hazardous materials incident and is the preferred decision over evacuation unless the circumstances of the incident make this option unsafe.

1. If necessary, initiate lock down procedures, seal the facility (i.e. sealing vents, doors, and windows with tape or plastic) and shut down the HVAC to outside airflow.
2. Supplies will not be able to enter the building.
    a. The Administrator and/or Nurse Manager will inventory and conserve resources that may run low if not replenished.
        i. Food/Water
            a. There is an emergency kit in the womens locker room that includes items such as: food, water, walkie talkies, and emergency blankets.
        ii. Pharmaceuticals
        iii. Medical supplies/equipment

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iv. Linens
v. Personal Protective Equipment

3. Initiate and maintain internal communication through signage and other means.
4. Establish a patient management plan.
    a. Identify the current census,
    b. Cancel elective admissions and procedures
5. Establish a work force plan, including a plan to address staff needs for the expected duration of the shelter-in-place
   The Administrator and/or Nurse Manager are to determine, in collaboration with the response agency, when shelter-in-place can be terminated.
6. Identify issues that need to be addressed to return to normal business operations, including notification of local authorities, of the termination of shelter-in-place.

POSSIBLE EMERGENCY SITUATIONS

BIOTERRORISM ATTACK

DEFINITIONS:

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A. Terrorism – A violent act or an act dangerous to human life, an act in violation of the laws of the United States, an act intended to intimidate or coerce a government of the civilian population in regards to the furtherance of political or social objectives.

B. Weapons of Mass Destruction – Any destructive device including all that are explosive or incendiary, a poisonous gas, bomb, grenade, rocket or missile, any weapon involving a disease organism, any weapon designed to release radiation at levels harmful to human life.

C. Bioterrorism – The intentional use of biological agents as weapons to kill or injure humans, animals or plants. Biological toxins are organisms that cause disease or disrupt physiological activity. Biological agents may be used as liquid droplets, aerosols, or dry powders.

PROCEDURE:

A. Recommendations for Any Suspected or Real Bioterrorism Event:

1. Healthcare facilities may be the initial site of recognition and response to bioterrorism events. If a bioterrorism exposure/event is suspected, Truckee Surgery Center's Plan should be activated including notification of the Infection Control Nurse, Nurse Manager, Medical Director, and Administrator.
2. The Medical Director, Administrator, Nurse Manager and Infection Control Nurse will determine and organize immediate response and will coordinate/conduct appropriate internal and external notification, including notification to the TFH Infection Control RN. Any exposed patients presenting to TSC should be taken to the nearest Emergency Room. The ER attending Physician will be the primary triage doctor and the ER charge nurse will designate a nurse to act as the primary triage nurse.

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B. In the event of a bioterrorism attack:

1. All patients with suspected or confirmed bioterrorism-related illnesses, should be managed utilizing Standard Precautions.

2. **STANDARD PRECAUTIONS**

   a. Standard Precautions, as defined by the Centers for Disease Control and Prevention (CDC), are designed to reduce the risk of transmission of most disease causing microorganisms in any type of health care setting regardless of the patient's presumed or diagnosed infectious status. With the exception of smallpox, viral hemorrhagic fevers, and pneumonic plague, most infectious diseases caused by bioterrorism agents are rarely, if ever, transmitted from person-to-person. Standard Precautions should be integrated into all healthcare worker/patient care interactions that include contact with:

      i. Blood

      ii. Non-intact skin

      iii. Body fluids regardless of the presence or absence of visible blood (urine, feces, vomitus, wound and lesion drainage, pulmonary secretions including nasal and salivary secretions and tears)

      iv. Skin soiled with visible blood or other body fluids

      v. Mucous membranes

      vi. Bioterrorism Agents – Diseases Requiring Standard Precautions Only

         a. Bacillus anthracis – Anthrax (See contact Precautions)

         b. Brucellae species – Brucellosis

         c. Clostridium Botulinum - Botulism

         d. Coxiella burnetii - Q fever

         e. Francisella tularensis – Tularemia (See Contact Precautions) California Hospital Bioterrorism Response Planning Guide

3. **CONTACT PRECAUTIONS**

   a. Place patients in an available bed on any nursing unit. Patients with similar syndromes may also be cohorted (grouped) in semi-private or multiple-bed rooms. Special ventilation is not required. Consider placing patients who consistently soil the immediate environment with visible blood or body fluids (e.g., incontinence, wound drainage not contained by a dressing or poor hygienic habits) in a private room.

   b. **Visitors**

      i. Limit visitors to immediate family members and significant

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others. Instruct visitors to wash their hands before and after patient contact and before leaving the patient's room.

c. **Personal Protective Equipment (PPE)**

i. **Gloves**

a. Wear disposable gloves when contact with visible blood and body fluids is anticipated. Gloves should also be worn when touching environmental surfaces and patient care articles visibly soiled with blood or body fluids. Gloves should be put on just prior to performing a patient care task that involves contact with blood or body fluids and removed immediately, without touching non-contaminated surfaces, when the task is complete. When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

ii. **Facial Protection**

a. Wear disposable, fluid-resistant masks and eye shields (goggles with side-shields) or a face shield if the patient is coughing or when performing patient care tasks likely to generate splashing or spraying of blood and body fluids onto the mucous membranes of the face.

iii. **Gowns**

a. Wear disposable, fluid-repelling gowns to protect skin and clothing when performing procedures likely to generate splashing or spraying of blood and body fluids. Plastic aprons may be worn for procedures likely to soil clothing but are unlikely to generate splashing or spraying of blood or body fluids (e.g., cleaning incontinent patients). The material composition of the gown should be appropriate to the amount of fluid penetration likely to be encountered. Remove soiled gowns after patient contact. Reusable cloth gowns may be used for patient contacts, if splashing or spraying of blood and body fluids is unlikely. Disposable or reusable gowns should be worn once and then discarded.

d. **Handwashing**

i. Wash hands with soap (antimicrobial or non-antimicrobial) and

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water after protected (gloved) and unprotected (ungloved) contact with visible blood, body fluids (secretions, excretions [urine and feces], wound drainage and skin visibly soiled with blood and body fluids). Wash hands before leaving the immediate vicinity of patient contact (patient room, cubicle, or bathroom). After handwashing, avoid touching the patient and surfaces or items in the immediate vicinity of the patient (bedpans, bed rails, and bedside tables). Decontaminate hands with an alcohol or quaternary ammonium-based ("quat") product after contact with invisible soil (protected or unprotected hands have not been in contact with visible blood or body fluids) and after prolong contact with the
clean, dry intact skin of the patient (lifting, turning, ambulating).

e. **Laboratory Specimens**
    i. Transport specimens to the laboratory according to facility procedure. Laboratory personnel should adhere to the chain of custody protocols developed by CDHS and the FBI.

f. **Patient Care Equipment**
    i. Equipment such as bedpans, urinals, and emesis basins should be cleaned in a manner that prevents splashing and spraying of blood and body fluids onto the healthcare worker's clothing, skin and mucous membrane. Reusable equipment that requires cleaning and disinfection or sterilization should be sent to sterile processing in covered containers for reprocessing. Disposable equipment not intended for reuse should be discarded.

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g. **Housekeeping**
    i. Clean environmental surfaces daily, when visibly soiled with blood and body fluids, and after the patient is discharged from the room with an Environmental Protection Agency (EPA) registered disinfectant.

h. **Soiled Linen**
    i. Place soiled linen in leak-proof bags and seal. Call for immediate pick up from contracted linen service.

i. **CONTACT PRECAUTIONS**
    i. Cutaneous anthrax and tularemia can be transmitted to healthcare workers by contact with the infected patient's wound or lesion drainage. In addition to Standard Precautions, Contact Precautions should be followed.
    ii. **Patient Placement**
        a. Place patients with open draining lesions in a private room, if available. Patients with the same diagnosis may be cohorted (grouped) in semi-private rooms.

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When a private room or cohorting is not achievable, separate infected patients at least three (3) feet away from non-infected patients.

iii. **Visitors**

a. Limit visitors to immediate family members or significant others. Instruct visitors to wash their hands their hands before and after patient contact and before leaving the patient's room.

4. **HANDLING OF SUSPICIOUS PACKAGES OR ENVELOPES**
   a. If a package or envelope appears suspicious, DO NOT OPEN IT.
   b. Do not shake or empty the contents of any suspicious package or envelope.
   c. Do not carry the package or envelope, show it to others or allow others to examine it.
   d. Put the package or envelope in a biohazard bag, on a stable surface; do not sniff, touch, taste, or look closely at it or at any contents which may have spilled.
   e. Alert others in the area about the suspicious package or envelope. Leave the area, close any doors, and take action to prevent others from entering the area. If possible, shut off the ventilation system.
   f. WASH hands with soap and water to prevent spreading potentially infectious material to face or skin.
   g. Seek additional instructions for exposed or potentially exposed persons.
   h. Notify the Administrator and/or Nurse Manager immediately (Centers for Disease Control and Prevention, 2001).

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CODE BLUE

A. Code Blue in the **Operating Room:**

1. The circulating nurse or any available person overhead pages by dialing 2348 and announcing "Code Blue, OR _____". This is an important first step, as it alerts everyone in the facility to respond immediately.
2. Anesthesia acts as code director. If no anesthesia provider is in attendance, the surgeon is the code director.
3. Any BLS certified staff member may begin CPR.
4. Scrub nurse maintains sterile field, and assists surgeon with closing and dressing the patient.
5. Recovery nurse brings crash cart, and assists rest of team with additional needs.
6. Circulator acts as medication nurse, assists with defibrillator, assists anesthesia as necessary.

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7. The Administrator or designee directs outside activity, calls 9-911, arranges lab courier, calls for assistance as needed, communicates with family, makes transfer arrangements if necessary.
8. Ancillary staff gathers and delivers necessary supplies, per type of code.

B. Code Blue in the **Recovery Room**:

1. Recovery room nurse or any available person overhead pages by dialing 2348 and announcing "Code Blue Recovery Room".
2. Nurse in attendance begins CPR.
3. Pre-op or second post-op nurse brings crash cart to bedside. Assists with CPR, medications, and defibrillation setup.
4. Any available anesthesia provider or MD responds to code, code is directed by anesthesia if present, otherwise most appropriate M.D. in attendance.
5. OR nurse responds if available.
6. The Administrator or designee directs outside activity, calls 9-911, arranges lab courier, calls for assistance as needed, communicates with family, makes transfer arrangements if necessary.
7. Ancillary staff acts as scribe and gathers/delivers necessary supplies, per type of code.

C. All patients undergoing resuscitative measures at Truckee Surgery Center will be transported to TFH for further evaluation and treatment. All paperwork that has been with the patient since admission will be photocopied and attached to the transfer order to remain with the patient/ EMS staff. The nurse or physician caring for the patient at TSC will call report directly to the ER nurse receiving the patient at TFH. The nurse caring for the patient will document all calls made and care given on the patient care record at TSC.

D. If a patient has been transferred to the hospital for any reason, the Administrator and/or Nurse Manager will follow up with the hospital to obtain follow-up paperwork/documentation. The patient's record will also be pulled to be used in the peer review process.

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FIRES

A. For fires at **Truckee Surgery Center**, actions should proceed in the following order:

1. RESCUE - remove patients or personnel from immediate danger.
2. ALARM - activate the fire alarm by using the fire pull or by calling 911.
3. CONTAIN - contain the fire to keep it from spreading: close doors, turn off oxygen if possible, etc.
4. EXTINGUISH - if possible, without placing yourself or others in danger, attempt to extinguish the fire.

All personnel must know the locations of the fire extinguishers and pull alarms.

B. For fires in the Operating Rooms:

1. Remove all persons from immediate danger

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2. Pull the nearest fire pull or call 911
3. Close all doors and move people accordingly
4. If the fire is manageable, use a fire extinguisher, in the following manner:
    a. *Pull* the pin on the fire extinguisher
    b. *Aim* the nozzle towards the fire
    c. *Squeeze* the handle to dispense fire retardant
    d. *Sweep* - spray the fire retardant in a sweeping motion
    e. Check with the Nurse Manager for additional assignments/duties
    f. If evacuation is necessary, stable patients can be moved to another part of the building or to the outside (weather permitting), unstable patients will need to be transferred via ambulance to TFH for further care

BOMB THREAT

A. A bomb threat against the facility requires an immediate, informed response. Time is of the essence in protecting the patients committed to our care. Adherence to the following procedures will help avert possible injury to persons or damage to the facility.

B. The Administrator or Nurse Manager will coordinate the bomb threat response procedures.

C. Should a suspected device be found, the decision to evacuate must be resolved through consultation between the police department and surgery centers leadership to balance the risk of a potential explosion versus the risk of moving patients.

D. At no time should the staff try to touch a bomb or a suspected bomb.

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PROCEDURE:

A. Receiving Threats
1. Police records indicate that a telephone warning is the most common way of receiving bomb threats.
2. ***If you receive a bomb threat by phone:***
    a. — IMMEDIATELY UTILIZE THE BOMB THREAT LOG SHEET —
    b. Remain calm. Do not hang up.
    c. Take note of the callers exact words. Pay close attention to the caller's voice and any background noise.Try to prolong the conversation and get as much information as possible.
    d. Attempt to ascertain when the bomb will detonate, where the device is located, what it looks like, and why it was placed in this location.
    e. When the call is over, immediately notify the Administrator or Nurse Manager and give them the completed Bomb Threat Checklist.
3. ***If you receive a written threat:***

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a. Gather all materials as evidence, including any envelopes or containers.

b. Avoid further handling to prevent the contamination of evidence.

c. Notify the Administrator or Nurse Manager immediately.

4. ***If a suspicions letter/package is received by mail:***

   a. Do not accept unsolicited packages. If any doubts exist about the package, treat it as a suspicious package.

   b. Mail bombs have been contained in letters, books, and parcels of varying sizes, shapes, and colors. When examining suspicious packages, look for the following characteristics of a letter bomb.

      i. No return address

      ii. Restrictive markings such as Confidential, Personal, Private etc.

      iii. Endorses with "Fragile – Handle with Care" or "Rush – Do Not Delay."

      iv. Excessive postage

      v. Misspelled words

      vi. Incorrect titles or names

   c. If you have a suspicious package

      i. Do not handle the item.

      ii. Do not open, smell or taste the article.

      iii. Isolate the mailing and secure the immediate area.

5. ***Evaluate the Threat***

   a. The Administrator or Nurse Manager will evaluate the threat utilizing the categories outlined in the policy Bomb Threat, EOC-1901

      i. If it is determined that a Code Yellow Alerting & Notification should be initiated

         a. The Administrator or Nurse Manager will call 9-911

         b. Should a search of the facility be warranted, the Administrator or Nurse Manager will dial 2348 and page overhead "Code Yellow"

   b. Search Procedures

      i. After a bomb threat is received, the Administrator or Nurse Manager may divide the building into sections and organize search teams to cover specific areas.

      ii. A search, if required, needs to be done by people familiar with what does and does not belong in their work areas.

         a. The Administrator and/or Nurse Manager should designate specific search assignments based upon

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availability of current staffing.

i. Generally, teams composed of a Law Enforcement/Bomb Disposal Unit and, if necessary, a designated staff members from the Surgery Center will assist in conducting the search.

ii. The removal or disarming of a bomb must be left to the professionals in explosive disposal.

b. The objective is to search for and report suspicious objects only.

c. Emphasis should be given to areas open to public access.

d. Those areas locked and unavailable to the public should be searched last.

e. Do not leave your work area to search other areas or evacuate unless told to do so.

iii. The Administrator and/or Nurse Manager will coordinate activities with the Police and/or fire personnel and keep the rest of TSC staff informed of all events.

iv. If a suspicious device is located

a. Do not touch it.

b. Note the location, description and proximity to utilities, gas lines, water pipes, and electrical panels.

c. Do not allow media to use satellite dish for transmitting or reporting purposes as this is a possible source of detonation.

d. Remove flammable material from the suspected area.

e. Isolate the object by closing doors.
Keep everyone away from window areas.

f. Evacuate to a distance of at least 300 feet from the suspected item.

g. Ensure Law Enforcement has been notified.

h. Once Law Enforcement arrives, they are in charge; all staff will follow their instructions.

c. Evacuation

i. An evacuation decision should be made only if an actual device has been located or substantiated through clear and reliable information.

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ii. The decision to evacuate should be made through Unified Command consisting of the surgery center's leadership and the Police Department.

iii. The building will be evacuated according to the established evacuation procedure unless otherwise directed

a. Give a brief explanation, then evacuate ambulatory patients and visitors first.

b. Surgeons will close surgery sites as quickly as possible and non-ambulatory patients will be evacuated via wheelchair and gurney.

c. A designated staff member will keep a log of all personnel, visitors and patients present in the building.

d. Explosion

i. If an explosion occurs, initiate Internal Triage.

ii. Treat injured victims in an area away from the blast site. Transfer patients as needed to the hospital.

iii. Support Law Enforcement as requested

e. All Clear

i. When it has been determined that there is no evidence of a device in the facility, or the suspected device has been rendered safe, the Administrator or Nurse Manager call 2348 and page overhead, "Code Yellow, All Clear".

ii. All personnel will return to their normal duties.

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EARTHQUAKE

A. The actual movement of the ground in an earthquake is seldom the direct cause of death or injury. Most casualties result from falling objects and debris because the shocks can shake, damage, or demolish and cause great damage. Earthquakes usually strike without warning. In most cases, the shock occurs and is ended in seconds, which precludes any personal protective action during the tremor. If the seismic action is a prolonged shaking and rolling, it is prudent to take protective measures such as taking cover in a doorway or under a table. If there is time, people should cover their heads and shoulders and try to protect themselves from falling objects or shattered glass. The scope of this procedure covers response to all types of earthquakes.

B. Injuries are commonly caused by:

1. Partial building collapse; collapsing walls; falling ceiling plaster, light fixtures, and pictures

2. Flying glass from broken windows and mirrors

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3. Overturned bookcases, fixtures, and other furniture and equipment
4. Fires, broken gas lines, and similar causes, with danger aggravated by the lack of water due to broken mains
5. Fallen power lines
6. Drastic human actions resulting from panic

C. Immediate response measures for all personnel:

1. On detection of shock, remain in place.
2. Remain calm. Think through the consequences of any action. Try to calm and reassure others.
3. If indoors, watch for falling plaster, light fixtures, and other objects. Watch out for high storage areas, shelves, and tall equipment that might slide or topple. Stay away from windows and mirrors. If in danger, get under a table, desk, or gurney, in a corner away from windows, or in a strong doorway. Encourage others to follow your example. Usually, it is best not to run outdoors.
4. After the initial shock has ended, and a reasonable interval has passed with no further shock, survey immediate surroundings to determine injuries and damage. Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.
5. If telephones are operating, call the Administrator and/or Nurse Manager, if they are not on site, to report the condition of patients and estimated damage in your area.
6. If you are in the area of damage and are not seriously injured, your first responsibility is to the patients in your vicinity. If possible, reassure them and attempt to calm those who may be hysterical or panic stricken. If there are obvious injuries from falling objects, shattered glass, or patients or personnel trapped under debris, you must request assistance and perform first aid within your capability where possible until medical personnel arrive to assist in treatment or rescue.
7. Check for fire or fire hazards from broken electrical lines or short circuits, and follow the fire response procedures if a fire is discovered or can reasonably be expected.
8. Do not attempt to lead or assist any patients to leave the Surgery Center until you are directed to do so by the Administrator or Nurse Manager. If TSC has not been made unsafe by the earthquake, it is advisable to encourage patients to stay inside until they have arranged safe transportation home or have determined the conditions of the roadways.
9. Make sure all patients wear shoes in areas near debris and glass. Immediately clean up spilled medications, drugs, and other potentially harmful materials. If the water is turned off, emergency water can be obtained; assess bottled water inventory. Check to see that sewage lines are intact before permitting flushing of toilets. Check closets and storage shelve areas. Open closet and cupboard doors carefully, and watch for objects falling from shelves.
10. Be prepared for additional aftershocks. Although most of these are smaller than the main shock, some may be large enough to cause additional damage.

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D. Responsibilities:

1. Administrator:
    a. Initiate the phone tree as necessary
    b. THE PHONE TREE = The Administrator notifies all of the following:
        i. *Administrative Director of Surgical Services*
        ii. *Medical Director* --> who notifies Chief of Anesthesia
        iii. *Nurse Manager*--> who notifies all clinical staff
        iv. *Business Office & Staff*
    c. After receiving damage assessment reports from all modalities and services, determine the advisability of partial or complete evacuation of the Surgery Center.
    d. If evacuation is deemed advisable, determine the condition of exit areas and avoid those that are obstructed or otherwise hazardous. Follow the posted signs for nearest exit from current location.
    e. Conduct an immediate check of all communications systems including the telephones and overhead paging. Initiate actions to restore service or use other communication resources, including cellular telephones, walkie talkies, or messengers.
    f. Direct implementation of evacuation procedures outlined in the Emergency Operations Plan.
    g. Ensure that all local emergency service authorities are informed of the degree of damage and extent of injuries sustained by the site, its patients, and personnel.
2. Nurse Manager:
    a. Establish transport teams to assist in transport of patients within the ASC as required.
    b. Provide for emergency messenger service.
    c. Establish casualty information, and instruct the Administrator or designee about information to be released to media and concerned individuals.
    d. Establish an injured patients list, and indicate where each patient is located for incoming medical personnel.
    e. Have any physicians at the clinic activate major and minor treatment areas and provide examination and treatment to patients and personnel as required. Be aware that, depending on the magnitude of the earthquake, physicians may be called to serve in other healthcare clinics or organizations in the area.
    f. Assign an individual to establish and maintain a master list of patients and treatment.

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g. Request additional professional assistance, as needed, through the local emergency medical services network.

h. Instruct the front desk to direct incoming employees or members of the public to appropriate areas.

i. Ascertain the need for emergency generator capacity. If it is determined that temporary emergency power is needed for essential staff functions, refer to the Emergency Electrical Power policy.

E. Ensure that the Administrator and/or Nurse Manager check utility lines and appliances for damage. Only the Administrator or Nurse Manager, or a representative of the power company, may shut off any valves or circuits. If gas leaks exist, the Administrator or Nurse Manager will shut off the main gas valve. If there is damage to wiring, the Administrator or Nurse Manager will shut off electrical power. The Administrator/Safety Officer will report damage to the appropriate utility companies and follow their instructions. No one should use matches, lighters, or open flame appliances until it is determined that no gas leaks exist. Electrical switches or appliances should not be operated if gas leaks are suspected; sparks can ignite gas from broken lines.

SNOW AND ICE REMOVAL

To create safe entry and exit to the facility, snow and ice removal and melting will be ensured by the following preventive procedure:

A. A walk-around of the facility will be conducted to identify specific challenges for snow removal.

B. An average first snowfall date can be ascertained by contacting the local weather service.

C. The following provisions will be stored at the Surgery Center before the anticipated date: Adequate manual equipment, snow shovels, ice scrapers, brooms, and sand. Enough ice-melt for at least two storms, adequate walk-off mats, interior and exterior.

D. The snow and ice removal contractor is responsible for any damage to facility grounds during snow and ice removal activities.

E. Reminders of ice and snow safety will be distributed to staff before the projected first snowfall date.

F. The ice and snow removal contractor is:

1. CAMCO
2. Telephone number: 530-587-3355

BLIZZARD/EXTREME SNOWFALL

Severe winter weather producing prolonged exposure to extreme cold and blizzards with blowing snow may put TSC staff and patients at risk; therefore, Truckee Surgery Center employees/staff are required to become familiar with this blizzard response procedure and be prepared to take appropriate action.

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DEFINITIONS:

A. Winter Storm Watch - Be alert, severe weather is likely

B. Winter Storm Warning - Severe winter weather is expected

C. Blizzard Warning - Severe winter weather with sustained winds or frequent gusts to 35 mph or greater and considerable falling or blowing snow (reducing visibility to less than one quarter mile) are expected to prevail for a period of 3 hours or longer. Deep drifts and life threatening wind chill result.

D. Traveler Advisory - Severe winter conditions may make driving difficult and dangerous

E. Wind Chill - A calculation of how cold it feels outside when the effects of temperature and wind speed are combined. A strong wind combined with a temperature of just below freezing can have the same effect as a still air temperature about 35 degrees colder.

F. Frostbite - A severe reaction to cold exposure that can permanently damage its victims. Symptoms include loss of feeling and white or pale appearance to fingers, toes, or nose and earlobes.

G. Hypothermia - A condition occurring when body temperature drops below 90 degrees Fahrenheit. Symptoms include uncontrollable shivering, slow speech, memory lapses, frequent stumbling, drowsiness and exhaustion.

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PROCEDURE:

A. ADMINISTRATOR AND NURSE MANAGER CHECKLIST

1. When informed of a Winter Storm Warning, Blizzard Warning, or Traveler's Advisory, The Administrator or Nurse Manager shall initiate notification procedures as appropriate.
2. Immediately inform employees to take appropriate measures.
3. Listen to NOAA Weather Radio and local radio and television stations for weather information.
4. Provide for early release or extended staff or employees as appropriate while providing optimal patient care.
5. Provide food, water, blankets, flashlights with extra batteries and other emergency supplies for employees who become stranded at the facility.
6. Provide sleeping accommodations for employees who become stranded at the facility.
7. Ensure back-up power source passes checklist and has adequate fuel (see weekly generator checks)
8. Arrange for snow and ice removal from parking lots with contractor unless already completed.

B. STAFF RESPONSE CHECKLIST

1. Staff will:
    a. Listen for weather warnings

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b. Use only approved portable space heaters

c. Follow utility failure procedures if there is a disruption or failure of electrical power

2. If outside:

a. Dress warmly in layers to prevent perspiration and chill. Keep dry. (Mittens are warmer than gloves.)

b. Cover mouth to protect lungs from extremely cold air

c. Avoid exertion (cold weather puts extra strain on the heart)

d. Watch for signs of frostbite and hypothermia

e. First Aid response:

i. If frostbite or hypothermia is suspected, begin warming the person slowly. Warm the person's trunk (mid-body) first. Arms and legs should be warmed last because stimulation of the limbs can drive cold blood toward the heart and lead to heart failure. Put the person in dry clothing and wrap their entire body in a blanket.

ii. Never give frostbite or hypothermia victims something with caffeine in it (i.e. coffee or tea) or alcohol. Caffeine, a stimulant, can cause the heart to beat faster and hasten the effects the cold has on the body. Alcohol, a depressant, can slow the heart and also hasten the ill effects of cold body temperatures.

f. Recovery:

i. After blizzards, heavy snows or extreme cold:

a. Notify Leadership of any injuries

b. Notify Leadership of any facility damage

c. Resume normal schedule

d. Before driving, check road status, ensure car has at least 1/2 tank of fuel

AVALANCHE

Truckee Surgery Center shall participate in the response of patients in the event of an avalanche. Staff shall be encouraged to be prepared at their homes to protect themselves, their families and their property.

A. STAFF RESPONSE CHECKLIST:

1. Off duty staff:

a. *Before intense storms*:

i. Become familiar with the land around you

ii. Learn whether avalanches and debris flows have occurred in

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your area by contacting local officials, state geological surveys or departments of natural resources.

iii. Watch the patterns of storm drainage on slopes near your home, and especially the places where runoff coverages, increasing flow over snow covered slopes. Watch the hillsides around your home for any signs of snow movement, such as small avalanches or debris flows, or progressively tilting trees.

iv. Watching small changes could alert you to the potential of a greater avalanche threat.

b. *During intense storms*:

i. Stay alert and awake. Many debris/snow-flow fatalities occur when people are sleeping.

ii. Listen to NOAA Weather Radio or portable, battery-powered radio or television for warnings of intense snowfall. (Be aware that intense, short bursts of snow may be particularly dangerous, especially after longer periods of snowfall and cold weather.)

iii. If you are in areas susceptible to avalanches and debris flows, consider leaving if it is safe to do so. (Remember that driving during an intense storm can be hazardous.)

iv. If you remain at home, move to a second story if possible. Staying out of the path of the avalanche or debris flow saves lives.

v. Listen for any unusual sounds that might indicate moving debris, such as trees cracking or boulders knocking together.

vi. Be especially alert when driving. Embankments along roadways are particularly susceptible to avalanches.

vii. Watch the road for heavy snow, fallen rocks and trees, and other indications of possible debris flows.

c. *If you suspect imminent avalanche danger*:

i. Contact your local fire, police or public works department. Local officials are the best persons to assess potential danger.

ii. Inform affected neighbors. Your neighbors may not be aware of potential hazards. Advising them of a potential threat may help save lives. Help neighbors who may need assistance to evacuate.

iii. Evacuate. Getting out of the path of an avalanche or debris flow is your best protection.

d. *During an avalanche*:

i. Quickly move out of the path of the avalanche or debris flow. Moving away from the path of the flow to a stable area will

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reduce your risk.

ii. If escape is not possible, move your arms rapidly to try and stay afloat in the snow and do whatever possible to protect the rest of your body from injury.

e. *After an avalanche*:

i. Stay away from the slide area. There may be danger of additional slides.

ii. Check for injured or trapped persons near the slide, without entering the direct slide area. Direct rescuers to their locations.

iii. Help a neighbor who may require special assistance - infants, toddlers, elderly people, and people with disabilities. Elderly people and people with disabilities may require additional assistance. People who care for them or who have large families may need additional assistance in emergency situations.

iv. Listen to local radio or television stations for the latest emergency information.

v. Look for and report broken utility lines to appropriate authorities. Reporting potential hazards will get utilities turned off as quickly as possible, preventing further hazard and injury.

vi. Check the building and surrounding land for damage. Damage may help you assess the safety of the area.

2. On duty staff:

a. In the event of an avalanche, the phone tree will be initiated by the Administrator, or his/her designee, to call in all available medical/ professional personnel for assistance.

i. THE PHONE TREE = The Administrator notifies all of the following:

a. *Administrative Director of Surgical Services*

b. *Medical Director* --> who notifies Chief of Anesthesia

c. *Nurse Manager*--> who notifies all clinical staff

d. *Business Office & Staff*

b. Truckee Surgery Center (TSC) will provide all available staff to TFH for additional assistance.

c. If necessary, elective cases scheduled for the day at the TSC will be postponed in order to provide staff for the avalanche emergency.

d. In the event that more beds than are available at TFH are needed, TSC will open the facility to those in need.

e. Supplies and pharmaceuticals will be distributed as necessary and re-

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ordered as soon as possible.

f. As soon as possible, the patients triaged at TSC will be transported to TFH (when space becomes available) or to Reno for further care.

g. The receptionist will make sure all emergency calls are passed to the Administrator.

h. The Administrator and Nurse Manager will delegate duties to available staff, as required.

i. Once all patients have been safely transported to other facilities, available staff from Truckee Surgery Center will offer their assistance to TFH.

j. When the patients have been properly cared for, TSC can return to its schedule.

3. Utility Systems:
   a. The Administrator or designee will ensure that the utility systems at the facility have not been interrupted.
   b. If at any time, during an external avalanche, the facilities power or water supply is interrupted, the Emergency Quick Reference Guide will be used to determine the appropriate response.
   c. The Administrator will be notified of any utility systems failures/ interruptions.

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WILDFIRE

During the warmer months, there is a likelihood of wildfire which may put TSC staff and patients at risk. Therefore, all Truckee Surgery Center employees/staff are required to become familiar with this wildfire response procedure and to be prepared to take appropriate action.

A wildfire in the Tahoe Basin and surrounding areas may be extremely dangerous. As seen in years past, the Tahoe Basin is subjected to many wildfires based on dry seasons and wet seasons causing growth in the forest around us. The threat of a wildfire can cause the community to shut down, and as a major medical provider for the area, leave the residents and visitors without medical care they may need.

A. ADMINISTRATOR & NURSE MANAGER CHECKLIST:

1. When informed of a wildfire in the Tahoe Basin or surrounding area:
   a. Initiate notification procedures as appropriate using the phone tree.
   b. THE PHONE TREE = The Administrator notifies all of the following:
      i. *Administrative Director of Surgical Services*
      ii. *Medical Director* --> who notifies Chief of Anesthesia
      iii. *Nurse Manager*--> who notifiesall clinical staff
      iv. *Business Office & Staff*
   c. If wildfire is close, activate Emergency Response in anticipation of potential evacuation.

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d. Immediately inform employees to take appropriate measures to prepare patients for evacuation and transport.

e. Prepare to make overhead announcements as necessary.

B. STAFF RESPONSE:

1. To prepare for wildfires:

a. Listen to local radio and television stations for information.

b. Prepare for potential patients needing assistance with breathing problems, smoke inhalation, eye issues, traumatic injuries, burns and mediation issues (when there is overflow from TFH).

c. Close all windows to the building.

d. Finish any surgical cases in progress as expediently and safely as possible and do not proceed with any further scheduled cases.

e. Standby to evacuate, if instructed by the Administrator or Nurse Manager.

2. For employees coming to, or leaving, work:

a. Wear protective clothing, sturdy shoes, cotton or woolen clothing, long pants, long sleeve shirts, eye protection, and a handkerchief to protect your face.

b. Choose a route away from fire hazards.

c. Use caution and exercise good judgment when re-entering a burned wildfire area.

d. Avoid damaged or fallen power poles or lines and downed wires. Immediately report electrical damage to authorities.

e. Be careful around burned trees and power poles. They may have lost stability due to fire damage. If a power pole should fall next to your, DO NOT RUN OUT OF THE AREA. To avoid being shocked, you must shuffle your feet on the ground without lifting them up off the ground. This will reduce the chance of electrocution.

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C. ALL CLEAR:

1. When wildfire evacuation is not required and facility is no longer at imminent risk of danger, the Administrator or Nurse Manager will call off the Emergency Response and assist with resume normal operations as required.

PANDEMIC- LOCALIZED AND WIDESPREAD

A. Truckee Surgery Center will participate with the TFH incident command center in the event of a pandemic.

1. The need for additional PPE and supplies will be evaluated.

2. Closure of the facility will be determined through the Incident Command and TSC Leadership.

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B. State and Federal guidelines and mandates will be adhered to.

    1. The Administrator and Nurse Manager will monitor guidelines and make any required changes immediately.

C. Policies and Procedures will be implemented as necessary.

ESSENTIAL EQUIPMENT OR SERVICE/UTILITY FAILURE

A. In the event of essential equipment or service failure, TSC Leadership will take action to restore the system as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance

ELECTRICAL POWER FAILURE UNPLANNED

A. In case of normal electrical power failure, the emergency generator will provide power, in less than ten seconds.

B. If the facilities electrical power supply is compromised or unavailable the Administrator and/or Nurse Manager will determine whether the Surgery Center should remain open or should close. If it appears that electrical power will be resumed in a short time, patients and staff may be advised to wait.

C. If the Administrator and/or Nurse Manager determine that the power will not be resumed before the end of the business day, they may close the Surgery Center. In such a case, patients will be rescheduled.

D. If the Administrator and/or Nurse Manager determines that it is appropriate for the Surgery Center to remain open or open for staff, but not patients, emergency lighting and power is supplied by the emergency backup generator maintained by Cashman Equipment telephone # 775-332-2588. This temporary electrical power will be used to accomplish only essential business functions.

E. The Administrator or Nurse Manager will contact TFH Facilities Management to notify them of the power outage and request assistance if needed.

F. If assistance is required TFH will send the Engineer on duty to the facility. The Engineer will:

    1. Check for generator operation during a power outage.
    2. Check for transfer switch operation.
        a. If there is no transfer and power is still off, manually transfer the switches.
    3. For emergency problems with the generator see the building maintenance contact list.
    4. Walk through the facility to check equipment operation in the order of importance (i.e., life and safety first, air conditioning equipment last).
    5. Call TDPUD (See Community Emergency phone list) and try to find out if the problem is in their equipment or internal malfunctioning.
        a. If it is theirs, try to get an estimated time of repair.

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b. If it is ours, determine if outside help is needed.

c. If outside help or rental generator is needed see building maintenance contact list.

6. Determine whether extra fuel will be needed for extended generator operation.

a. If additional fuel is required see building maintenance contact list.

G. If a power outage occurs during patient care, the surgeon will finish the surgical case in progress using backup power and no new surgeries will be performed until power has been restored.

ELECTRICAL POWER FAILURE PLANNED (PSOM)

A. Truckee Donner PUD distributes electrical power received from NV Energy from their Reno sub-station to TSC.

B. High winds can cause trees or debris to damage electric lines and cause wildfires. As a result, NV Energy may need to turn off power during severe weather. NV Energy refers to these power shut off events as Public Safety outage Management (PSOM) events.

C. 48-24 hour notification will be provided before the power shut off event is activated.

D. If the PSOM is scheduled to occur during business hours, surgeries will be rescheduled and staff may be called off. The Administrator and Nurse Manager will determine the need to reschedule cases and cancel staff assignments.

OXYGEN SUPPLY FAILURE

A. In the event of a failure in the system that supplies oxygen to the surgery center, prompt action will be taken by TSC leadership to restore the system to operating condition as soon as possible.If required the TFH Facilities Management Department will be contacted for assistance.

B. If appropriate, advise staff to utilize portable oxygen tanks until repairs are made.

C. TFH or the Vendor will assess the problem: Determine estimated repair time, and notify the Administrator and/or Nurse Manager.

D. Initiate repairs utilizing TFH maintenance personnel and outside agencies as needed.

1. Backup cylinders and regulators are located in the Med Gas Storage Room.

E. Call medical gas supplier (See building maintenance contact list) for additional oxygen tanks that may be needed.

1. Full oxygen tanks can be used from the reserve supply if failure is in the switching units.

NATURAL GAS FAILURE

A. In the event of a disruption of the natural gas supply, prompt action will be taken by TSC leadership to restore the system to operating condition as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance.

1. Call gas company (See building maintenance contact list).

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a. Try to find out if the problem is in their lines or in our equipment.

b. Try to get an estimate of repair time, and keep in close contact with them.

2. Advise staff and leadership of the problem and how long repairs will take.

   a. The Surgery Center and Apartment would be affected by the lose of domestic hot water.

   b. Equipment affected: hot water is required for the sterilizers in Sterile Processing. Natural gas is required for the boilers that provide heating to the facility and the appliances and heating in the apartment.

3. Initiate repairs, if needed, utilizing TFH Facilities Management personnel and outside agencies, if required.

   a. If necessary, call for fuel service (See building maintenance contact list) for service, assistance, and parts.

FIRE SPRINKLER WATER LOSS

A. In the event of loss of water to fire protection system, ultimate measures must be taken to prevent possible loss of life and/or property until repairs are made. If required the TFH Facilities Management Department will be contacted for assistance.

   1. Notification and cooperation with the Fire Department is essential.

B. Contact the TFH Facilities Management Department to determine if the Vendor needs to be contacted.

C. Contact TDPUD, if it seems to be an external problem.

   1. Try to get an estimate of the time needed for repairs.

D. If it is an internal problem, TFH or the vendor will assess the situation to determine actual repair time and advise the Administrator of their findings.

E. Contact the Truckee Fire Protection District for possible standby fire protection until repairs can be made.

F. If it is an internal problem, initiate repairs utilizing TFH Facilities Management staff or outside contractors as needed. See building maintenance contact list.

G. Notify Fire Department when repairs are completed.

H. A fire watch must be conducted should the sprinkler system be out of service for more than 10 hours in a 24-hour period.

FAILURE OF NURSE CALL SYSTEM

A. In the event of a failure of the nurse call system, action will be taken by TSC leadership to repair the system as soon as possible. If required the TFH Facilities Management or IT Department may be contacted for assistance.

B. The vendor, TFH facilities staff, or TFH It staff will assess the problem and determine actual estimated repair time and advise the Administrator and/or Nurse Manager of the situation.

C. Initiate the repairs with the vendor as soon as possible.

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D. Departments involved will keep up vigilance in the affected areas to ensure patient needs are met.

1. utilize bells, gongs, or similar devices of notification.

FAILURE OF MEDICAL AIR SYSTEM

A. In the event of failure of the medical air system, swift action will be taken by TSC Leadership to ensure that an adequate supply of medical air is reestablished as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance.

B. A failure in this system would interrupt the supply of medical air to areas that use it in delivery of patient care.

C. The vendor or TFH facilities staff will assess the problem and determine repair time and advise the Administrator and/or Nurse Manager of the situation.

D. Initiate repairs using TFH Facilities Management personnel and outside contractors as required.

1. If necessary, call emergency repair vendor (see building maintenance contact list) for assistance in repair or for rental replacement unit.
2. If line repair is necessary, secure the particular zone, purge the zone with nitrogen, and certify the system prior to restarting the equipment.

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FAILURE OF MEDICAL VACUUM SYSTEM

A. In the event of the failure of the medical vacuum system, swift action will be taken by TSC leadership to restore the system to operating condition as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance.

B. A failure in this system would interrupt the supply of vacuum to the operating rooms, preop, andrecovery and negatively impact routine patient care.

C. TFH Facilities Management and/or the Vendor will assess the problem, determine actual estimated repair time, and advise affected departments.

D. Facilities Management will initiate repairs and will use outside agencies as, and if, needed.

E. Portable suction machines will be used until repairs can be made.

1. Additional portable rental units, if necessary, will be obtained through TFH Materials Management Department.
2. The TFH Facilities Management Department may obtain rental or replacement equipment or repair assistance from emergency vendor.
3. Anesthesia cases will not take place until the vacuum system has been repaired.

EMERGENCY WATER SUPPLY

A. In case of normal water supply interruption, TSC Leadership will take all necessary steps to obtain and provide emergency water as needed.

B. If TSC's drinking water supply is contaminated or unavailable the Administrator or Nurse Manager will determine whether TSC should remain open.

C. Emergency water should be available at all times.

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1. Potable water is stored and secured in the womens locker room.
2. If additional bottled water is required TFH Materials Management will be contacted at 530-582-3510. If they are unable to provide additional water leadership will designate a staff member to go to Safeway, Savemart, Riteaid, or CVS to purchase more.

D. Upon water interruption, the Administrator will contact TFH Facilities management and alert staff of the need to conserve water.

E. If problem is internal due to main line failure:

1. Call TDPUD to advise normal water supply interruption since they may be able to provide portable water.

F. In case of major disaster, with water supply failure:

1. Human waste disposal:
    a. Non-potable water, if available, can be used to flush toilets. Portable restrooms can be used to reduce the amount of water needed for flushing toilets (i.e. patients use non-potable water, staff us portable restrooms).

G. Upon restoration of normal water supply, TFH Facilities Managment will assist the hospital in taking water samples for analysis for potability to an outside agency e.g. TTSA, Cranmer or Sierra Environmental Monitoring.

1. As this analysis can take up to 24 hours, continue using alternative sources of potable water.

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MAJOR SEWER LINE FAILURE

A. In case of main or branch sewerage line failure, action shall be taken to restore sewage disposal capabilities as soon as possible.

B. If a sewer problem occurs, the TFH Facilities Management Department should be called, and a response time determined immediately.

C. Human waste disposal:

1. Obtain plastic liners to place in toilets or bedside commodes and/or bed pans for patient collection of urine, stool and other wastes. Instruct staff and patients not to flush toilets.
    a. Kitty litter can be used to help absorb liquid.
    b. Place large plastic containers with lids (garbage size) in dirty utilities areas identified as hazardous waste.
    c. Waste can be transported to Porta Potties for disposal.
2. If required, Porta Potties can be used by staff and visitors until the issue is resolved.

D. TFH Facilities Management will assess the situation.

1. If TFH Facilities Management is unavailable refer to building maintenance contact list.
2. TFH Facilities Management will coordinate delivery of Porta Potties until the issue

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can be resolved.

FAILURE OF FIRE ALARM SYSTEM

A. A fire watch must be conducted should the fire alarm system in whole or in part, be out of service for more than 4 hours in a 24 hour period.

1. Personnel will be designated to perform a continuous fire inspection of the Surgery Center.
2. The Administrator will contact the local fire department at the beginning and end of the fire watch.
3. This inspection will need to be logged and documentation then kept in the Emergency Management binder.
4. The continuous fire inspection is a visual inspection of all affected areas of the Surgery Center including unoccupied areas to ensure that a fire has not gone undetected.

REFERENCES:

COPY

1. APIC Bioterrorism Task Force and CDC Hospital Infections Program Bioterrorism Working Group. (1999, April 13).
   Bioterrorism Readiness Plan: A Template for Healthcare Facilities. Retrieved March 24, 2011, from Centers for
   Disease Control and Prevention: http://www.cdc.gov/ncidod/dhqp/pdf/bt/13apr99apic-cdcbioterrorism.pdf
2. Centers for Disease Control and Prevention. (2001, October 26). Update: Investigation of Bioterrorism-Related
3. Anthrax and Interim Guidelines for Exposure Management and Antimicrobial Therapy. Morbidity and Mortality
4. Weekly Report , 50(42), 909-919. Retrieved March 24, 2011, from Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/PDF/wk/mm5042.pdf
5. ACHC Standard 07.00.01
6. ACHC Standard 15.02.02

Effective: August 2013, Revised: June 2014, July 2019

Attachments

Bomb Threat Checklist

Disaster phone tree

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Disaster Resource List 9.28.2022.xlsx

Emergency equipment.docx

Emergency Quick Reference Guide

Approval Signatures

Step Description	Approver	Date
	Heidi Fedorchak: Nurse Manager	11/2022
	Courtney Leslie: Administrator	11/2022

COPY

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Status **Draft** PolicyStat ID **12595297**

Origination	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Owner	Courtney Leslie: Administrator
Department	Human Resources
Applicabilities	Truckee Surgery Center

Education Reimbursement, HR-2103

POLICY:

DRAFT

Truckee Surgery Center (TSC) encourages employee attendance at seminars, conferences, workshops and other educational meetings where such attendance contributes to employee growth and TSC objectives. Employees are also encouraged to join and participate in professional organizations related to their position in with TSC.

PROCEDURE:

A. Regular full time, part time, and per diem employees (working the required minimum of 2 shifts per month) who have completed six months of continuous service will be eligible to receive reimbursement for seminars, conferences, workshops, and other educational programs to further career development. Education must be related to the employee's current job title.

B. **Educational Expense Reimbursement allowances per year:**

~~Management and Supervisory~~	~~$450 per year~~
Regular Full-Time ~~& Part-Time~~ Employees	$~~250 and 16~~400 per year 24 hours per fiscal year
~~Per Diem Employees working the required minimum~~ Part-Time Employees	$~~100 and 8~~300 and 16 hours per fiscal year
Per Diem Employees working the required minimum	$200 and 8 hours per fiscal year

C. The employee that is required to maintain licensure or certification may submit for reimbursement. CEUs required for licensure or certification may be covered. This also applies to exam fees.

D. Unused hours and expense reimbursement will be carried over at the end of the fiscal year. At no time will employees be allowed to accrue more than two times the annual allotted hours or expenses.

E. To receive reimbursement, itemized receipts and proof of attendance must be submitted to the Nurse Manager or Administrator for approval. All expenses must be documented on the Education Reimbursement Request form. Reimbursement will either be made via payroll or check.

F. The fiscal year is July 1 through June 30.

G. **SUBMISSION FOR PAYMENT IN ADVANCE**: Only conference/class registration fees may be paid in advance by TSC.

   1. Submit a completed Education Reimbursement Request form 30 days in advance of the conference/class.
   2. Submit a completed registration form to accompany the check/credit card payment to the educational organization.
   3. Submit supporting documentation issued by the educational organization that identifies the name and content of the conference/course, the date(s) and time(s) of the educational meetings, the cost, who the check should be made out to and where to send it or who to call to process a credit card payment.

H. **SUBMISSION FOR REIMBURSEMENT AFTER COMPLETION OF CONFERENCE/CLASS:**

   1. Submit a completed Education Reimbursement Request form no more than 30 days after the conference/class has taken place.
      a. If Education hours are requested and approved by the Nurse Manager or Administrator the employee should indicate Education hours on their time card on the date they attended the conference/course. Education hours will not be paid in advance.
   2. Submit supporting documentation issued by the educational organization clearly indicating the name and content of the conference/course, date(s) and time(s) of the educational meetings, and the cost.
   3. Submit proof of attendance/completion of the course (i.e. certificate, transcript, etc.)
   4. Itemized receipts must be submitted for each expense.
      a. If requested, lodging, travel and meals will be reimbursed in accordance with IRS guidelines.
   5. If all supporting documentation is not provided, reimbursement may be denied.

SUBMISSION FOR LICENSE/CERTIFICATION RENEWAL REIMBURSEMENT

   1. Submit a completed Education Reimbursement Request form no more than 30 days after payment has been made.

I. **EXEMPT EMPLOYEES**

   1. Salaried employees cannot be paid over 80 hours per pay period. Time worked must be flexed to accommodate attendance at educational conferences and classes.
   2. Fees for conferences, seminars, webinars, and other position specific required training for Management & Supervisory will not be counted towards the annual alloted amount above.

DRAFT

Attachments

Education Expense Reimbursement Form.docx

Approval Signatures

Step Description	Approver	Date

DRAFT

Origination:	*07/2019*
Last Approved:	*09/2022*
Last Revised:	*08/2021*
Next Review:	*09/2023*
Owner:	*Heidi Fedorchak: Nurse Manager*
Department:	*Sterile Processing Dept*
Applicabilities:	*Truckee Surgery Center*

Use of KimGuard & KimGuard One-Step Sterilization Wrap, SP-1919

RETIRED

POLICY:

All equipment processed with KimGuard and KimGuard One-Step Sterilization Wrap will be used per AORN standards and manufacturers recommendations.

PROCEDURE:

A. Packaging materials will be stored at 20-23 degrees centigrade (68-73 degrees F) and at a relative humidity of 20%-60% for at least two hours before use.

B. Examine wrap and discard if damage or extraneous matter is detected.

C. Thoroughly clean and dry items to be wrapped/packaged.

D. The appropriate size wrapping material will be selected to achieve adequate coverage of the item being packaged.

E. The method of packaging will be performed in a manner that facilitates the aseptic presentation of the contents.

F. Follow manufacturers recommendations for wrapping techniques outlined in the AORN Standards, Recommended Practices, and Guidelines.

G. These sterilization wraps will be stored as recommended in the ANSI/AAMI and AORN guidelines.

H. The locations of storage will be clean, dust free, away from fluorescent or ultraviolet light and utilize the ideal storage parameters for temperature and humidity as listed above.

I. The facility will utilize first in, first out (FIFO) stock rotation.

J. All packages utilizing the KimGuard and KimGuard One-Step sterilization wrap will be used unless an event that compromises the integrity of the package occurs.

K. Any issues arising from the use of KimGuard and KimGuard One-Step wraps should be brought to the attention of the Infection Control Coordinator and the Administrator.

References:

AORN Standards, Recommended Practices, and Guidelines

Kimberly-Clark KimGuard and KimGuard One-Step Directions for Use Manual.

Effective: October 27, 2011

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	09/2022
	Heidi Fedorchak: Nurse Manager	07/2022

RETIRED

Status Retired PolicyStat ID 12025710

Origination	07/2019	Owner	Courtney Leslie: Administrator
Last Approved	09/2022	Department	Human Resources
Last Revised	09/2022	Applicabilities	Truckee Surgery Center
Next Review	09/2023		

*To be replaced w/: Workplace Violence Prevention Plan, EOC-2202

Workplace Violence Prevention, HR-1909

PURPOSE:

Truckee Surgery Center (TSC) maintains a zero tolerance standard of violence in the workplace. The purpose of this policy is to provide Truckee Surgery Center employees guidance that will maintain an environment at and within Truckee Surgery Center property and events that is free of violence and the threat of violence.

RETIRED

POLICY:

Violent behavior of any kind or threats of violence, either implied or direct, are prohibited at Truckee Surgery Center, at the facility and at TSC sponsored events. Such conduct by a TSC employee will not be tolerated. Any employee who exhibits violent behavior may be subject to criminal prosecution and shall be subject to disciplinary action up to and including dismissal. Violent threats or actions by a non-employee may result in criminal prosecution. Truckee Surgery Center will investigate all complaints filed and will also investigate any possible violation of this policy of which it is made aware. Retaliation against a person who makes a complaint regarding violent behavior or threats of violence made to him/her is also prohibited.

PROCEDURE:

A. **PROHIBITED BEHAVIOR:**

1. Violence in the workplace may include, but is not limited to the following list of prohibited behaviors directed at or by a co-worker, supervisor or member of the public:
    a. Direct threats or physical intimidation
    b. Implications or suggestions of violence

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c. Stalking

d. Possession of weapons of any kind on Truckee Surgery Center property, including parking lots, other exterior premises or while engaged in activities for TSC in other locations, or at TSC sponsored events.

e. Assault of any form

f. Physical restraint, confinement

g. Dangerous or threatening horseplay

h. Loud, disruptive or angry behavior or language that is clearly not part of the typical work environment

i. Blatant or intentional disregard for the safety or well-being of others

j. Commission of a violent felony or misdemeanor on TSC property

k. Any other act that a reasonable person would perceive as constituting a threat of violence

2. Domestic Violence, while often originating in the home, can significantly impact workplace safety and the productivity of victims as well as co-workers. For the purposes of this document "domestic violence" is defined as abuse committed against an adult or fully emancipated minor. Abuse is the intentional reckless attempt to cause bodily injury, sexual assault, threatening behavior, harassment, or stalking, or making annoying phone calls to a person who is in any of the following relationships:

   a. Spouse or former spouse;

   b. Domestic partner or former domestic partner;

   c. Cohabitant or former cohabitant and or other household members;

   d. A person with whom the victim is having, or has had, a dating or engagement relationship;

   e. A person with whom the victim has a child.

3. Truckee Surgery Center recognizes that domestic violence may occur in relationships regardless of the marital status, age, race, or sexual orientation of the parties.

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B. **REPORTING ACTS OR THREATS OF VIOLENCE:**

1. An employee who:

   a. is the victim of violence, or

   b. believes they have been threatened with violence, or

   c. witnesses an act or threat of violence towards anyone else shall take the following steps:

      i. If an emergency exists and the situation is one of immediate danger, the employee shall contact the local police officials by

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dialing 9-1-1, and may take whatever emergency steps are available and appropriate to protect himself/herself from immediate harm, such as leaving the area.

ii. If the situation is not one of immediate danger, the employee shall report the incident to the Administrator or Nurse Manager as soon as possible and complete a notification report.

C. **PROCEDURES- FUTURE VIOLENCE**

1. Employees who have reason to believe they, or others, may be victimized by a violent act sometime in the future, at the workplace or as a direct result of their employment with Truckee Surgery Center, shall inform the Administrator or Nurse Manager so appropriate action may be taken. The Administrator or Nurse Manager shall inform the Director of Facilites/security of Tahoe Forest Hospital, the Medical Director if needed, and the local law enforcement officials.

2. Employees who have signed and filed a restraining order, temporary or permanent, against an individual due to a potential act of violence, who would be in violation of the order by coming near them at work, shall immediately supply a copy of the signed order to the Administrator or Nurse Manager. The Administrator or Nurse Manager shall provide copies to the Director of Facilites/security of Tahoe Forest Hospital, the Medical Director if needed, and local police when appropriate.

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D. **INCIDENT INVESTIGATION**

1. Acts of violence or threats will be investigated immediately in order to protect employees from danger, unnecessary anxiety concerning their welfare, and the loss of productivity. The Administrator or Nurse Manager will initiate an investigation into potential violation of work rules/policies. Simultaneously, the local police will be informed for review of potential violation of civil and/or criminal law.

2. Procedures for investigating incidents of workplace violence include:

   a. Visiting the scene of an incident as soon as possible

   b. Interviewing injured and threatened employees and witnesses

   c. Examining the workplace for security risk factors associated with the incident, including any reports of inappropriate behavior by the perpetrator.

   d. Determining the cause of the incident

   e. Taking mitigating action to prevent the incident from recurring-recording the findings and mitigating actions taken.

3. In appropriate circumstances, Truckee Surgery Center will inform the reporting individual of the results of the investigation. To the extent possible, TSC will maintain the confidentiality of the reporting employee and the investigation but may need to

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disclose results in appropriate circumstances; for example, in order to protect individual safety. TSC will not tolerate retaliation against any employee who reports workplace violence.

E. **MITIGATING MEASURES:**

1. Incidents which threaten the security of employees shall be mitigated as soon as possible following their discovery. Mitigating actions include:

    a. Notification of law enforcement authorities when a potential criminal act has occurred.

    b. Provision of emergency medical care in the event of any violent act upon an employee.

    c. Post-event trauma counseling for those employees which desire assistance.

    d. Requesting an attorney file a restraining order as appropriate.

Special Instructions / Definitions:

A. *Workplace Violence*: Behavior in which an employee, former employee or visitor to a workplace inflicts or threatens to inflict damage to property, serious harm, injury or death to others at the workplace.

B. *Threat*: The implication or expression of intent to inflict physical harm or actions that a reasonable person would interpret as a threat to physical safety of property.

C. *Intimidation*: Making others afraid or fearful through threatening behavior.

D. *Zero-Tolerance*: A standard that establishes that any behavior, implied or actual, that violates the policy will not be tolerated.

E. *Court Order*: Any order by a Court that specifies and/or restricts the behavior of an individual. Court Orders may be issued in matters involving domestic violence, stalking or harassment, among other types of protective orders, including Temporary Restraining Orders.

Effective: June 2014 Revised: July 2019

RETIRED

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	09/2022
	Heidi Fedorchak: Nurse Manager	07/2022

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Truckee Surgery Center, LLC
Statement of Revenue and Expense
For The Quarter Ended September 30, 2022

	Actual	Budget	Variance
Ordinary Income/Expense			
Income			
Patient Revenue			
Private Pay	-	10,000.00	(10,000.00)
Comm'l & Gov't Payors (Net Collections)	51,969.45	519,500.00	(467,530.55)
Total Patient Revenue	51,969.45	529,500.00	(477,530.55)
Refunds			
Patient Refund	(2,774.66)	(2,750.00)	(24.66)
Total Refunds	(2,774.66)	(2,750.00)	(24.66)
Total Income	49,194.79	526,750.00	(477,555.21)
Gross Profit	49,194.79	526,750.00	(477,555.21)
Expense			
Service Fee	635.98	-	(635.98)
Purchased Services	41,430.29	10,500.00	(30,930.29)
Bad Debt	12,302.62	28,572.50	16,269.88
Collection Agency Reimbursement	2,019.20	150.00	(1,869.20)
General Office			
Dues and Subscriptions	6,911.82	6,000.00	(911.82)
Office Supplies	2,009.45	1,500.00	(509.45)
Postage and Delivery	314.96	650.00	335.04
Printing and Reproduction	-	22.50	22.50
Total General Office	9,236.23	8,172.50	(1,063.73)
Liability Gen'l, Prof Insurance	(5,142.62)	1,359.63	6,502.25
Licenses and Permits	1,004.00	250.00	(754.00)
Linen	10,071.45	14,226.80	4,155.35
Medical Supplies Total			
Gas Medical	4,004.09	4,440.72	436.63
Implants	35,547.49	65,832.20	30,284.71
Instrument Expense	100.74	2,250.00	2,149.26
Medical Supplies	58,760.79	12,923.04	(45,837.75)
Pharmacy	9,816.43	12,521.85	2,705.42
Patient Nutrition	360.84	505.29	144.45
Total Medical Supplies Total	108,590.38	98,473.08	(10,117.30)
Other Expenses			
Bank Charges	124.52	150.00	25.48
Educational	1,234.09	900.00	(334.09)
Equipment Rental/Lease	21,900.00	-	(21,900.00)
Interest Expense	90.23	56.75	(33.48)
Meals & Entertainment and Travel	2,171.70	150.00	(2,021.70)
Merchant Fees	1,011.42	900.00	(111.42)
Total Other Expenses	26,531.96	2,156.75	(24,375.21)
Payroll Expenses			
Health Insurance Total			
Health	26,158.04	22,500.00	(3,658.04)
Dental	1,689.29	1,500.00	(189.29)
Vision	254.44	225.00	(29.44)
Total Health Insurance Total	28,101.77	24,225.00	(3,876.77)

Employee Benefit	1,464.52	600.00	(864.52)
Payroll Taxes	15,813.78	15,504.81	(308.97)
Retirement Contribution	3,573.58	1,800.00	(1,773.58)
Service Fee	-	100.00	100.00
Wages	199,580.95	169,950.00	(29,630.95)
Work Comp	1,197.00	1,408.84	211.84
Payroll Expenses - Other	856.50	800.00	(56.50)
Total Payroll Expenses	250,588.10	214,388.65	(36,199.46)
Professional Fees			
Consulting	500.00	500.00	-
Pension Fees	1,270.00	412.50	(857.50)
Transcription Services	1,400.91	1,210.10	(190.81)
Total Professional Fees	3,170.91	2,122.60	(1,048.31)
Rent & CAM	43,297.20	43,676.06	378.86
Repairs			
Instrument Refurbishing	424.50	450.00	25.50
Instrument Repairs	-	1,450.00	1,450.00
Maintenance-Preventative	8,506.37	5,400.00	(3,106.37)
Total Repairs	8,930.87	7,300.00	(1,630.87)
Taxes			
Property	9,771.72	7,000.00	(2,771.72)
State	-	2,000.00	2,000.00
Taxes - Other	-	600.00	600.00
Total Taxes	9,771.72	9,600.00	(171.72)
Utilities			
Alarm Monitor	231.33	225.00	(6.33)
Cable	180.32	186.00	5.68
Gas and Electric	8,265.45	10,119.75	1,854.30
Medical Waste	25.00	-	(25.00)
Telephone	1,506.31	1,500.00	(6.31)
Total Utilities	10,208.41	12,030.75	1,822.34
Depreciation Expense	13,224.36	8,400.00	(4,824.36)
Total Expense	545,871.06	461,379.31	(84,491.75)
Net Ordinary Income	(496,676.27)	65,370.69	(393,063.46)
Other Income/Expense			
Other Income			
Other Income	(2.32)	-	-
Total Other Income	(2.32)	-	-
Other Expense			
Amortization Expense	65,238.87	65,238.87	-
Total Other Expense	65,238.87	65,238.87	-
Net Other Income	(65,236.55)	(65,238.87)	-
Net Income	**(561,912.82)**	**131.82**	**(393,063.46)**

Truckee Surgery Center
AR Summary - Oct 2022

AR Rollforward	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Avg/TTL
Beg A/R Balance	$ 355,963	$ 521,516	$ 424,536	$ 331,557	$ 303,604	$ 248,299							
Gross Charges	$ 1,841,903	$ 555,276	$ 406,318	$ 633,871	$ 619,113	$ 763,567							$ 803,341
Payments	$ (167,898)	$ (166,945)	$ (155,842)	$ (116,157)	$ (133,143)	$ (136,176)							$ (146,027)
Contractual Adj	$ (1,502,316)	$ (460,335)	$ (323,251)	$ (538,558)	$ (551,786)	$ (619,362)							$ (665,935)
Other Adj	$ (6,136)	$ (25,278)	$ (10,682)	$ (11,249)	$ 10,512	$ 21							$ (7,135)
Refund	$ -	$ 303	$ -	$ 4,140	$ -	$ (1,364)							$ 513
Bad Debt	$ -	$ -	$ (9,523)	$ -	$ -	$ (226)							$ (1,625)
End A/R Bal	**$ 521,516**	**$ 424,536**	**$ 331,557**	**$ 303,604**	**$ 248,299**	**$ 254,758**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	

Statistics	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Avg/TTL
Cash Goal	-	$ 135,453	$ 108,628	$ 81,686	$ 88,688	$ 79,924							
Achieved %	0%	123%	143%	142%	150%	170%							
Case Volume	43	28	17	33	25	45							**32**
Gross Rev per Case	$ 42,835	$ 19,831	$ 23,901	$ 19,208	$ 24,765	$ 16,968							**$ 24,585**
Est. Net Rev	$ 135,453	$ 81,803	$ 81,569	$ 95,806	$ 64,042	$ 144,690							**$ 100,561**
Est. Net Rev per Case	$ 3,150	$ 2,922	$ 4,798	$ 2,903	$ 2,562	$ 3,215							**$ 3,258**
Debit AR	$ 553,341	$ 477,006	$ 395,522	$ 380,518	$ 317,403	$ 370,759							**$ 415,758**
Credit AR	$ (31,826)	$ (52,469)	$ (63,964)	$ (76,914)	$ (69,104)	$ (116,001)							**$ (68,380)**
AR Days	-	-	101	107	94	76							**63**
Days to Bill	10	8	8	6	8	6							**8**

AR by Fin Class	0-30	31-60	61-90	91-120	121-150	151-180	181+	Credits	Total	% of Total
CONTRACTED	$ 111,473	$ 46,006	$ 16,027	$ 14,841	$ 6,780	$ 12,824	$ 60,337	$ (112,836)	**$ 155,452**	**61%**
SELF PAY	$ 214	$ 5,224	$ 6,099	$ 3,388	$ 1,810	$ 1,329	$ 75,494	$ (3,165)	**$ 90,392**	**35%**
WORKERS COMP	$ -	$ -	$ -	$ -	$ -	$ 8,914	$ -	$ -	**$ 8,914**	**3%**
Total A/R	**$ 111,687**	**$ 51,230**	**$ 22,126**	**$ 18,229**	**$ 8,590**	**$ 23,066**	**$ 135,831**	**$ (116,001)**	**$ 254,758**	**100%**
% of Total / Over 90	**44%**	**20%**	**9%**	**7%**	**3%**	**9%**	**53%**	**-46%**	**100%**	**73%**
Prior Month Balance	**$ 39,147**	**$ 51,590**	**$ 25,810**	**$ 7,293**	**$ 40,176**	**$ 20,430**	**$ 132,958**	**$ (69,104)**	**$ 248,299**	**100%**
% Total Prior Balance / Over 90	**16%**	**21%**	**10%**	**3%**	**16%**	**8%**	**54%**	**-28%**	**100%**	**81%**
Change from Prior Mth	**$ 72,540**	**$ (360)**	**$ (3,684)**	**$ 10,936**	**$ (31,586)**	**$ 2,636**	**$ 2,873**	**$ (46,897)**	**$ 6,459**	

$>90	%>90
$ 94,782	61%
$ 82,021	91%
$ 8,914	100%
$ 185,717	**73%**