2024-10-16 Regular Meeting of the Truckee Surgery Center Board of Managers

Wednesday, October 16, 2024 at 12:00 p.m.

Tahoe Forest Hospital - Human Resources Conference Room

10024 Pine Avenue, Truckee, CA 96161

2024-10-16 Regular Meeting of the Truckee Surgery Center Board of Managers

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11. ADJOURN

TRUCKEE SURGERY CENTER
REGULAR MEETING OF THE BOARD OF MANAGERS

AGENDA

Wednesday, October 16, 2024 at 12:00 p.m.

Human Resources Conference Room – Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

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**◈
   5.1. 06/24/2024 Regular Meeting ..... ATTACHMENT

6. **ITEMS FOR BOARD ACTION**◈
   6.1. Amended and Restated Operating Agreement◈ ..... ATTACHMENT
   Truckee Surgery Center Board of Managers will review edits and consider approval of the Amended and Restated Operating Agreement.
   6.2. Annual Policy Review
   6.2.1. Medical Staff Bylaws ..... ATTACHMENT
   6.2.2. Medical Staff Rules and Regulations ..... ATTACHMENT
   6.2.3. Annual Policy and Procedure List ..... ATTACHMENT
   6.3. Updated Policies
   Truckee Surgery Center Board of Managers will review the following updated policies:
   6.3.1. Risk Management, QA-1905 ..... ATTACHMENT
   6.3.2. Exposure Control Program, IC-2001 ..... ATTACHMENT
   6.3.3. Exposure Control plan, IC-1909 ..... ATTACHMENT
   6.3.4. Needle Stick and Blood or Body Fluid Exposure Protocol, IC-1921 ..... ATTACHMENT
   6.3.5. Allograft Handling – Accepting, Storing and Tracking, TB-1901 ..... ATTACHMENT
   6.3.6. Infection Control Plan, IC-1914 ..... ATTACHMENT
   6.3.7. Intermittent Pneumatic Compression Devices, NS-1911 ..... ATTACHMENT
   6.4. Retire Policies
   Truckee Surgery Center Board of Managers will retire the following policies:
   6.4.1. Review of Nosocomial Infections, IC-1928 ..... ATTACHMENT

◈ Denotes Action Item

6.4.2. Post Exposure to Blood or Bodily Fluids Evaluation and Follow Up, IC-1924 ..... ATTACHMENT
6.4.3. Abnormal Diagnostic Test Results Follow Up, DI-1907 ..... ATTACHMENT
6.4.4. Handling Tissues at Truckee Surgery Center, TB-1902..... ATTACHMENT

6.5. Updated Pre-Printed Orders◈ ..... ATTACHMENT
Truckee Surgery Center Board of Managers will review and consider approval of updated pre-printed orders.

6.6. Updated Delineated Privilege Request Form◈..... ATTACHMENT
Truckee Surgery Center Board of Managers will review and consider approval of the Otolaryngology Privilege Request Form.

6.7. Section 1557 Coordinator◈ ..... ATTACHMENT
Truckee Surgery Center Board of Managers will review and consider designation of a Section 1557 Coordinator as required by the Affordable Care Act of 2010.

7. ITEMS FOR BOARD DISCUSSION

7.1. Financial Reports
Truckee Surgery Center Board of Managers will review the following financial reports:
7.1.1. Q4 FY24 Financial Statement..... ATTACHMENT
7.1.2. Q4 FY24 Balance Sheet ..... ATTACHMENT
7.1.3. Monthly Dashboard ..... ATTACHMENT

7.2. Administrator Update..... ATTACHMENT
Truckee Surgery Center Board of Managers will receive an update from the Administrator on operations, staffing, facility and equipment needs.

8. CLOSED SESSION

8.1. Approval of Closed Session Minutes◈
8.1.1. 06/24/2024 Regular Meeting

8.2. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Second Quarter 2024 Infection Control Data Summary
Number of items: One (1)

8.3. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Second Quarter 2024 Quality Assurance Performance Improvement Data
Number of items: Eleven (11)

8.4. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Second Quarter 2024 Ambulatory Surgery Center Association (ASCA) Clinical Benchmarking Survey
Number of items: One (1)

8.5. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Medical Staff Credentials
Number of items: One (1)

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

10. ITEMS FOR NEXT MEETING

11. ADJOURN

◈ Denotes Action Item

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

A copy of the board meeting agenda is posted on Tahoe Forest Hospital District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting. Materials related to an item on this Agenda submitted to the Board of Managers, or a majority of the Board, after distribution of the agenda are available for public inspection in the District's Administration Office, 10977 Spring Lane, Truckee, CA 96161, during normal business hours.

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.

TRUCKEE SURGERY CENTER
REGULAR MEETING OF THE BOARD OF MANAGERS

DRAFT MINUTES

Monday, June 24, 2024 at 12:00 p.m.
Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 12:02 p.m.

2. ROLL CALL
Board of Managers: Louis Ward, Crystal Felix, Dr. Jeffrey Dodd
Staff in attendance: Courtney Leslie, Truckee Surgery Center Administrator; Heidi Fedorchak, Truckee Surgery Center Nursing Supervisor; 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
5.1. 03/25/2024 Regular Meeting
5.2. 06/12/2024 Special Meeting

ACTION: **Motion made by Dr. Jeffrey Dodd, to approve Truckee Surgery Center Board of Manager meeting minutes of March 25, 2024 and June 12, 2024 as presented, seconded by Crystal Felix.**
AYES: Dodd, Felix, Ward
Abstention: None
NAYS: None
Absent: None

6. ITEMS FOR BOARD ACTION
6.1. Fiscal Year 2025 Budget
Courtney Leslie, Truckee Surgery Center (TSC) Administrator, presented the Fiscal Year 2025 Budget.

The Liability & Professional Insurance amount will be updated.

TSC was 5% below on the wage survey. CNO will want to speak with TSC Administrator about the Health System doing a cost of living increase of 3%.

ACTION: **Motion made by Dr. Jeffrey Dodd, to approve Truckee Surgery Center Fiscal Year 2025 Budget as presented, seconded by Crystal Felix.**
AYES: Dodd, Felix, Ward
Abstention: None
NAYS: None
Absent: None

7. ITEMS FOR BOARD DISCUSSION

7.1. Financial Reports

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

7.1.1. Q3 FY24 Financial Statement

TSC Administrator reviewed the third quarter financial statement.
Refunds were higher than expected because Surgical Notes worked old accounts.

Crystal Felix inquired about due to Tahoe Forest items.

7.1.2. Q3 FY24 Balance Sheet

TSC Administrator reviewed the third quarter balance sheet.

7.1.3. Monthly Dashboard

TSC Administrator reviewed a new monthly dashboard.
For Days to Accounts Receivable (AR), TSC had Nimble switch to 90-day industry standard.
Five days to bill due to implant invoices.

Nimble is focusing on over 90 day accounts.
Surgical Notes is completely done.

Dental is now billing CPT codes per tooth.

TSC Administrator confirmed self-pay patients are paying at the time of service.

7.2. Administrator Update

TSC Board of Managers received an update from TSC Administrator on operations, staffing, facility and equipment needs.

HVAC repair will take place over the weekend.

TSC Administrator submitted a Capital Expenditure Request for flooring.

Open Session recessed at 12:19 p.m.

8. CLOSED SESSION

8.1. Approval of Closed Session Minutes

8.1.1. 03/25/2024 Regular Meeting

8.1.2. 06/12/2024 Special Meeting

Discussion was held on a privileged item.

8.2. Hearing (Health & Safety Code § 32155)
Subject Matter: First Quarter 2024 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: First Quarter 2024 Quality Assurance Performance Improvement Data
Number of items: Nine (9)
Discussion was held on a privileged item.

8.4. Hearing (Health & Safety Code § 32155)
Subject Matter: First Quarter 2024 Ambulatory Surgery Center Association (ASCA) Clinical Benchmarking Survey
Number of items: One (1)
Discussion was held on a privileged item.

Open Session reconvened at 12:29 p.m.

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
Item 8.1. was approved on 3-0 vote. There was no reportable action on items 8.2. through 8.4.

10. ITEMS FOR NEXT MEETING
No discussion was held.

11. ADJOURN
Meeting adjourned at 12:31 p.m.

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**"), and revised as of October 16, 2024 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 then sold 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. At the time of this original Agreement, the District held 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. The Managing Board exercises oversight for all ASC activities. The Managing Board assumes full legal responsibility for the determining, implementing, and monitoring policies governing the ASC's total operation. The Managing Board has oversight and accountability for the quality assessment and performance improvement program, ensures that the facility policies and procedures are administered so as to provide quality healthcare in a safe environment, responsibility of medical staff matters including credentialing and peer review, authority over contracts, and develops and maintains a disaster preparedness plan.

(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~~ thirty (~~60~~30) 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.

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

Commented [1]: We do not have a section 6.6 or 7.10 in our transfer agreement. Where do you think this is coming from?

Commented [2]: It is an ACHC Accreditation requirement to have an Anesthesia Director. Does it make sense to add this to the operating agreement?

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.

Commented [3]: SAME AS ABOVE We do not have a section 6.6 or 7.10 in our transfer agreement. Where do you think this is coming from?

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.

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[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: Louis Ward
Print Name: Louis Ward	
Title: CEO	Title: President
its authorized signatory	its authorized signatory

"JEFF DODD"

Jeffrey Dodd, M.D.

By: Print

Name: Jeffrey Dodd

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%

EXHIBIT B

~~**INITIAL**~~

~~**MANAGERS**~~**BOARD**

OF MANAGERS

~~Harry Weis~~
~~Crystal Betts~~
~~Judy Newland~~

Tahoe Forest Hospital District CEO

Tahoe Forest Hospital District CFO

Tahoe Forest Hospital District COO

Dr. Jeffrey Dodd

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.

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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 CLINICAL RECORDS

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 ALLIED HEALTH PROFESSIONALS (AHP)

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 _____.

Annual Review of the Bylaws:

The Medical Executive Committee met on _____ and approved the Bylaws. The Governing Board 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

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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 Quality Committee and ~~Governing Body~~Board of Managers.

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. Refer to the operational policy on AMA and patient elopement for additional information regarding required notification to law enforcement and requesting a well fare check.
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 Stedman's Abbreviations, Acronyms, & Symbols ~~Dictionary of Medical Acronyms and Abbreviations~~ are considered current. A copy of this book is kept in the Post Anesthesia Care Unit and available on the Intranet. Addendums will be kept with the book as required. In addition to Stedman's Abbreviations Truckee Surgery Center has a list of abbreviations commonly used by providers on schedule request forms. This list is only to be used to decipher scheduling requests and will not be permitted to use in the medical record.

Commented [CL1]: Changes to Stedman's to align with our policy

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 Quality Committee.
   b. They have been directed by the Medical Executive Quality 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~~ thirty days of surgery/procedure.

Commented [CL2]: 30 aligns with our policy and regulatory requirements

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 Medical Executive Quality Committee and ~~Governing~~ Board of Managers.

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 Medical Executive Quality 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.~~b. The anesthesiologist is in complete charge of all emergency procedures except those relating directly to surgery.
   ~~d.~~c. 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.

Commented [CL3]: TSC does not give blood products. Patients are transferred

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 Circulating~~harge~~ Nurse.

Commented [CL4]: We do not have a charge RN unless out nurse manager is out.

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

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Status **Pending** PolicyStat ID **16440543**

Origination	07/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Quality and Patient Safety
Last Revised	08/2024	Applicabilities	Truckee Surgery Center
Next Review	1 year after approval		

Risk Management, QA-1905

RISK:

The absence of a comprehensive risk management plan poses significant risks to patitent, staff and visitor safety. Inadequate risk management can lead to increased incidents of medical errors, patient harm and regultory non-compliance.

PURPOSE:

Designed to protect the life and welfare of Truckee Surgery Center's patients, doctors, visitors, and employees. The risk management program will be overseen by the Administrator and Nurse Manager and managed under the QA program.

Truckee Surgery Center follows the risk management processes as outlined in the Policy and Procedure manual, and the Performance Improvement Plan.

PROCEDURE:

A. Incidents will be reported using a notification report which will be reviewed by the Administrator and/or Nurse Manager. Any incident requiring immediate attention will be handled per the emergency. Notification reports will be followed through the QA program and reported to Medical Executive Quality Committee.

B. If a patient, employee or any person poses a physical risk to any other, the police will be called and the area secured.

C. The AMA procedure will be followed for patients wanting to leave without appropriate permission.

D. Any litigation cases will be reviewed by the Medical Executive Quality Committee for follow-up.

E. Complications are described and followed in the QA plan.

F. Patient complaints and/or suggestions are followed up by the Administrator, Nurse Manager, or medical staff involved and followed in QA.

G. Professional liability is carried by the center and each medical staff member.

H. If a nurse or medical staff member becomes incapacitated during a procedure, the safety of the patient and staff member will be established and another qualified provider found ~~so~~to safely finished and/or reschedule the case ~~can be safely finished and/or rescheduled.~~

I. On call medical staff is available to the patient after hours, written instructions are provided.

J. Site verification and timeout procedures are followed.

K. Clinical records are maintained by the ~~scheduler/medical record employee~~buisness office coordinator and quarterly chart reviews are completed by designated personnel.

L. If an employee or medical staff member appears to be impaired, the Administrator, Nurse Manager, or Medical Director will be immediately notified. That person will be removed from patient care until he/she can be medically assessed by a physician. The physician's assessment will determine the next step for staff safety. Long term impairment issues will be dealt with through the Medical Executive Quality Committee (MEQC), Board or Managers, the individual's physician, and the Administrator.

M. An exposure control plan is maintained and followed. The staff is educated at start of employment and periodically after that.

N. Safety issues are discussed at staff meetings and medical staff meetings and followed through the QA program.

O. Annually QA is reviewed and improvement to processes discussed with TSC staff and medical staff.

RISK MANAGEMENT ACTIVITIES:

A. Roles and Responsibilities:

1. The Administrator and Nurse Manager are responsible for the overall risk management and safety program for TSC. This role is accomplished through direct responsibility or through delegation of responsibilities to the any or all of the following individuals:
    a. Chief Nursing Officer (TFHD)
    b. ~~Risk Manager (TFHD)~~
    c. Medical Director
    d. The Quality Assurance & Performance Improvement (QAPI) and Infection Control (IC) Coordinator
    e. ~~Director of Quality & Regulations (TFHD)~~
    f. The Safety Officer ~~(TSC and TFHD)~~
    g. Staff members of the facility
2. ~~*The Nurse Manager and QAPI/IC Coordinator are responsible for the Infection Prevention Program, Bloodborne Pathogens/Exposure Control Plan, and the Employee*~~

~~*Health programs unless otherwise delegated.*~~

3. ~~*The Nurse Manager and QAPI/IC Coordinator are responsible for OSHA record keeping/reporting, and all other clinical risk management policies, unless otherwise delegated.*~~
4. ~~*The Administrator and Nurse Manager are responsible for providing education and training to staff members relevant to performance issues, unless this is otherwise delegated.*~~
5. ~~*The Safety Officer is responsible for all safety issues which occur, or have the possibility of occurring, within the facility. The responsibilities are inclusive of completion of logs for facility quality assurance activities for the Patient Safety Program.*~~

B. Occurrence Reporting:

1. The foundation of our risk management processes are the ability to promptly obtain the facts and details of circumstances surrounding an event within a reasonable time frame of its occurrence. An incident is defined as "any happening not consistent with the routine care or operation of the center, or the desired routine care of the patient and/or operation of the facility, which places the organization at an increased risk for liability.
2. Truckee Surgery Center will use the Performance Improvement Notification/ Occurrence Report for reporting patient, visitor, employee and/or anything classified as a facility incident.
3. The Notification/Occurrence Report must be completed as soon as possible relative to the event or occurrence by the employee(s) who witnessed or discovered the event, or who received the patient/visitor/employee/medical staff incident or complaint. All occurrences should be immediately reported to the Administrator, Nurse Manager and/or QAPI/IC Coordinator(s).
4. The completed original report is sent to the Administrator or Nurse Manager for approval/review. It is to remain part of the confidential Risk Management/ Performance Improvement files of the facility. Notification/Occurrence Reports are never copied or filed with the patient's medical records. A copy may be made for the liability insurance carrier, or the facility designated legal council per request. Completed Notification/Occurrence Reports are kept secured within the confines of TSC.
5. For incidents with a high level of severity, a Root Cause Analysis will be completed within TSC, and the liability insurance carrier for the facility may be notified after, following the decision tree of facility management.
6. Employee injury reports and investigations are handled in accordance with the facility worker's compensation process and/or exposure control plan.

C. Event Analysis:

1. To enhance the safety of patients and others within the surgery center, incident reports are analyzed and corrective action is taken as necessary to prevent a recurrence.

2. The Administrator, Nurse Manager, and the Board of Managers of TSC will maintain overall responsibility for the implementation and monitoring of the Risk Management Program at the facility.
3. Notification/Occurrence Reports are reviewed at the Medical Executive Quality Committee (MEQC) Meeting quarterly.
4. In the case of an unexpected occurrence involving death or serious physical/ psychological injury at TSC, a collaborative organization team will perform a Root Cause Analysis (RCA) of the event in order to determine the causative factors associated with the event. Please see the Sentinel ~~Events and Root Cause Analysis policies~~Event/Adverse Event/Error or Unanticipated Outcome Policy, QA-2001.
5. Truckee Surgery Center leadership may also elect to perform a RCA on a serious occurrence other than only designated Sentinel Events by following the same guidelines outlined in the above referenced policy. This could be in the instance of a designated "near miss" event regarding patient or staff safety.

PATIENT SAFETY PROGRAM:

The Patient Safety Program will be integrated into the overall risk management activities of TSC. The Administrator ~~may designate a clinical person to serve~~serves as the designated Safety Officer and ~~to work in conjunction with the Leadership to ensure~~ensures that the program requirements are implemented. The Board of Managers retains ultimate responsibility for the program.

Truckee Surgery Center's Patient Safety Program is designed to implement an organization-wide program for avoiding medical errors and improving patient safety that is focused on prevention, not punishment, and on improving medical systems and processes to overcome preventable errors.

An effective Patient Safety Program requires optimal reporting of medical and healthcare errors and adverse events. The leadership of this organization supports the concept that errors occur due to a breakdown in systems and processes, minimizing blame or retribution for involvement in a medical or care error. TSC seeks to promote a culture of safety that encourages constant awareness of error proneness in clinical and non-clinical environments, focusing on improving systems and processes that lead to real or potential harm to patients or employees.

A. Scope of Activities:
    1. The types of occurrences that are addressed in the Risk Management/Patient Safety Program range from "no harm occurrences," to "near misses," and onto "sentinel events" with serious outcomes.
    2. ERROR:
        a. An unintended act, whether of omission or an act that does not achieve its intended outcome
    3. SENTINEL EVENT:
        a. A patient safety event (not primarily related to the natural course of the patient's illness or underlying conditions) that reaches a patient and results in any of the following:

i. Death

ii. Permanent harm

iii. Severe, temporary harm (see accreditation standards for further details)

b. An event is also considered sentinel if it is one of the following:

i. Suicide of any patient receiving care, treatment, or services in a staff around-the-clock setting or within 72 hours of discharge

ii. Discharge of an infant to the wrong family

iii. Abduction of any patient receiving care, treatment, or services

iv. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)

v. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, or services while on site at the facility

vi. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any staff member, licensed independent practitioner, visitor, or vendor while on site at the facility

vii. Invasive procedure, including surgery on the wrong patient, at the wrong site, or the wrong (unintended) procedure (see accreditation standards for further details)

viii. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery (see ~~accredidtation~~accreditation standards for further details

ix. Prolonged fluoroscopy with cumulative dose of >1,500 rads to a single field, or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

x. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care (see accreditation standards for further details)

c. In cases where TSC is uncertain that a patient safety event is a sentinel event as defined by the accreditating agency, the event will be presumed to be a sentinel event and TSC's response will be reviewed under the Sentinel Event policy according to the prescribed procedure and timeframes.

4. NEAR MISS:

a. Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. A near miss fall within the scope of definition of a sentinel event, but outside the scope of those sentinel events that are subject to review according to

the Risk Management Program.

5. HAZARDOUS CONDITION:
    a. Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of a serious adverse outcome.

RISK MANAGEMENT LESSONS TO BE LEARNED:

Risk Management lessons learned are reviewed by TSC's leadership and/or distributed throughout the facility when appropriate applications are significant, and recommendation initiated within the surgery center to reduce the outcomes of the specific Sentinel Events.

TSC leadership determines the facility's potential for exposure to a similar risk by reviewing and identifying current processes, policies and procedures, or clinical practice guidelines that are in place to minimize or preclude a similar event within the surgery center.

TSC leadership determines those areas or processes requiring improvement within the surgery center and develops an action plan for process improvements and their implementation as necessary.

Completion of a Sentinel Event Occurrence Report and/or documentation (such as a Root Cause Analysis) is facilitated and completed by the Nurse Manager in conjunction with the QAPI/IC Coordinator, and ~~area~~ staff involved.

A. **Staff Support**:
    1. Personnel involved in an adverse event will receive appropriate feedback and counseling through their ~~supervisory claim~~management team. The Administrator and/or Nurse Manager will determine the appropriate course of action to prevent error recurrence. The focus is placed on remedial actions to assist future patient care encounters rather than punitive measures if avoidable.
    2. Staff members involved in a sentinel event ~~of~~or other serious occurrence will be given the support necessary to facilitate their professional and emotional reconciliation of the event. They may be encouraged to serve on the Root Cause Analysis team and participate in the development of the action plan in order to allow them an active role in process resolution for the facility.

B. **Informing Patients**:
    1. The "Adverse Outcomes" policy and procedure for the facility will be initiated when serious medical errors or unexpected/unanticipated adverse events result in harm to the patient, regardless of who was involved in the occurrence.
    2. Concern regarding legal liability that might result following truthful disclosure should not affect the practitioner's honesty with the patient. Expression of sorrow does not equate to admitting negligence. It is better to say to the patient/family that error "may have been a factor" which led to the harm.
    3. The patient and, when appropriate, their families, are informed about any adverse

outcome by their physician or designee and a representative from TSC together. The representative from TSC could include the Administrator, Nurse Manager or Medical Director. Staff should consult with these individuals for advice prior to the disclosure. Assure the patient/family that a quality review will be done and appropriate corrections or improvements will be made.

4. Presence of the media should not be allowed under any circumstances.
5. Information provided to the patient or appropriate family members may **not** include Performance Improvement reports or Quality Assurance records and information as deemed by the facility to be private and confidential and protected under California State Evidence Code 1157. Incident reports and Root Cause Analysis Reports are considered confidential medical Performance Improvement reports.
6. Documentation should be made in the patient's record that disclosure of information was made to the patient/family.

C. **Soliciting Feedback from Patients, Families, and Staff**:

1. Creating a culture of safety within the organization involves the willingness by personnel to recognize and report medical and healthcare errors and near misses.
2. Patient Safety also involves actively informing patients of their individual rights and responsibilities regarding their healthcare and surgical experience at TSC.
3. TSC staff is encouraged to complete Notification/Occurrence Reports.
4. Staff members are encouraged to express their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety through verbal discussion in formal and informal settings, and to make use of TSC's Chain of Command, or Management, to share such suggestions or comments.

D. **Patient, Family, and Staff Education**:

1. TSC encourages patients and family members to become active participants in ensuring safe healthcare practices are in place through on-going patient and family healthcare safety education. This may also be accomplished by encouraging all patients to "Speak Up" if they have any concerns regarding their healthcare delivery.
2. Patient and family on-going education is conducted through the use of tools, verbal discussions in various forums and/or the distribution of selected printed materials as available.
3. TSC staff orientation process emphasizes specific job-related aspects of patient safety. Ongoing In-Services, and other education and training programs, also focus on specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster an interdisciplinary, collaborative approach to the delivery of patient care, and reinforces the need to report medical and healthcare errors.
4. All TSC staff receives training on Risk Management policies and procedures, especially those relating to occurrence reporting, errors, and/or Sentinel Events.
5. Educational programs within TSC will be developed in order to foster an interdisciplinary, collaborative approach to the delivery of patient care and avoidance

of medical and healthcare errors amongst the entire healthcare team.

E. **Reporting Requirements**:

1. Truckee Surgery Center will follow the reporting schedule as stated in the Sentinel Event/Adverse Event ~~Reporting~~/Error or Unanticipated Outcome Policy, QA-2001.

F. **Roles and Responsibilities**:

1. Board of Manager's Responsibilities:
    a. Responsible for ensuring the provision of optimal quality of care and organization-wide performance improvement within facility resources. The authority to fulfill the goals of the Performance Improvement function is delegated to the Administrator, Nurse Manager, and QAPI/IC Coordinator.
    b. Together with TSC leadership and Medical Executive Quality Committee, the Board of Manager's facilitates Performance Improvement as follows:
        i. Provides direction in setting Performance Improvement priorities based on TSC's initiatives, strategic goals and mission, vision, and values.
        ii. Oversees the design, implementation, and ongoing monitoring of the organization-wide Performance Improvement ~~function~~program.
        iii. Establishes an organizational culture that supports a commitment to quality, patient safety and Performance Improvement.
        iv. Provides adequate resources to accomplish the Performance Improvement function.
        v. Receives, reviews, and accepts reports regarding the effectiveness of organization-wide Performance Improvement activities.
        vi. The leaders provide ~~for~~ mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient care safety.

2. Medical Executive Quality Committee's Responsibilities:
    a. Responsible for the ongoing quality of medical care and professional services provided by all individuals with clinical privileges, and:
        i. Participates in organization-wide measurement, assessment, and improvement activities as outlined and identified in TSC's quality policies and procedures.
        ii. Collaborates in prioritizing Performance Improvement activities and has responsibility for staff-related improvement activities.
        iii. Involves staff members in Performance Improvement measurement, assessment, and improvement activities, including peer review.

iv. Identify and prioritize Quality Improvement/Patient Safety Projects.

v. ~~Prioritize Quality Improvement/Patient Safety Projects.~~

vi. Review feedback from all Performance Improvement projects and ongoing data collection.

vii. Evaluate effectiveness of Performance Improvement activities of the facility.

viii. Ensure date is complete, reliable, valid, and accurate on an ongoing basis.

ix. Determine education and training needs of TSC related to Performance Improvement goals.

b. Analysis of events and issues which have occurred within the surgery center and makes resolution suggestions and/or conclusions.

c. The MEQC (as applicable) reviews utilization, infection prevention, medical records, surgical and other invasive procedures, credentialing and all risk management and safety activities impacting services within the surgery center.

d. The MEQC reviews and recommends its:

i. Performance Improvement priorities

ii. Quality Indicators/performance measures

iii. Comparison levels, or triggers for action, when patterns and trends are identified

iv. TSC leadership will monitor recommendations as applicable.

3. Administrative Leadership's Responsibilities:

a. TSC's management team functions as the core of the Performance Improvement program.

b. TSC leadership has the responsibility to:

i. Ensure that internal processes and activities throughout the organization are continuously and systematically measured, assessed, and improved.

ii. Establish priorities for Performance Improvement/Patient Safety Projects based on established criteria.

iii. Allocate resources for assessing and improving the organization's governance, managerial, clinical, and support services.

iv. Determine the education and training needs of the organization, related to Performance Improvement.

4. Performance Improvement Teams' Responsibilities:

a. Performance Improvement (PI) Teams are developed at the discretion of

TSC's leadership to address areas for improvement identified via the various sources of data collection or quality occurrences.

b. Performance Improvement Teams will serve as ad-hoc teams and will be disbanded once a specified project is completed. Issues will not be elevated to a Performance Improvement Team if they can be easily resolved by normal operational decisions.

c. PI Teams may be given the responsibility to:

    i. Review and evaluate data specific to patient care issues and outcomes.

    ii. Utilize the Plan-Do-Check-Act improvement process to identify, develop, implement, and measure improvements.

    iii. Access staff and center departments for support as necessary

    iv. Provide regular reports to the QAPI/IC Coordinator and/or the Administrator, with progress on performance improvement activities and goals.

5. Performance Improvement Coordinator's, Nurse Manager, and Administrator's Responsibilities:

    a. The QAPI/IC Coordinator reports to the Nurse Manager and Administrator. Both the Nurse Manager and Administrator then report to the Medical Director, to support TSC's Performance Improvement/Patient Safety principals, strategies, priorities, approach, and methodologies. The QAPI/IC Coordinator, Nurse Manager, and Administrator's roles include, but are not limited to, the following:

        i. Working with the medical staff, patient care and other services, and PI teams to effectively measure, assess, and improve the quality of care and services.

        ii. Coordinate PI orientation, education, and training.

        iii. Coaches and facilitates Performance Improvement teams and projects and any other initiatives or duties.

Effective: September 2008

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	Pending
	Heidi Fedorchak: Nurse Manager	08/2024

Status **Pending** PolicyStat ID **16369956**

Origination	01/2020	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Infection Prevention and Control
Last Revised	08/2024	Applicabilities	Truckee Surgery Center
Next Review	1 year after approval		

Exposure Control Program, IC-2001

RISK:

If proper procedures and compliance are not followed, employees may have increased risk of exposure to blood borne pathogens.

PURPOSE:

To provide guidance to Truckee Surgery Center staff, by creating an Exposure Control Program, as a means to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens."

Truckee Surgery Center is committed to providing a safe and healthful work environment for our entire staff. In pursuit of this endeavor, TSC provides specific contact information for responsible person(s) and/or department(s), in the event of an occupational exposure to bloodborne pathogens.

POLICY:

The Exposure Control Program (ECP) is a key document to assist our facility in implementing and ensuring compliance with the standard, thereby protecting our employees. This ECP includes:

A. Determination of employee exposure
B. Implementation of various methods of exposure control, including:
    1. Universal precautions
    2. Engineering and work practice controls
    3. Personal protective equipment (PPE)
    4. Housekeeping

C. Hepatitis B vaccination

D. Post-exposure evaluation and follow-up

E. Communication of hazards to employees and training

F. Record-keeping

G. Procedures for evaluation circumstances surrounding an exposure incident

PROCEDURE:

PROGRAM ADMINISTRATION:

A. The Administrator, Nurse Manager, and QAPI/IP Nurse(s) are responsible for the implementation of the ECP. The Administrator and/or QAPI/IP associate will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures. Contact information:

1. Truckee Surgery Center
2. 10770 Donner Pass Rd, Ste 201
3. Truckee, CA 96161
4. 530-550-2940

B. Those employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in this ECP.

C. Truckee Surgery Center will maintain and provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers), labels, and red bags as required by the standard. The Administrator or designee will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes. ~~Contact location/phone number:~~

1. ~~Truckee Surgery Center~~
2. ~~530-550-2940~~

D. The Occupational Health department will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. Contact information:

1. Tahoe Forest Health Clinic/Occupational Health
2. 10956 Donner Pass Rd, Ste 230
3. Truckee, CA 96161
4. 530-582-3277

E. The Administrator, Nurse Manager, and QAPI/IP Nurse will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, and NIOSH representatives. ~~Contact information:~~

1. ~~Truckee Surgery Center~~

2. ~~530-550-2940~~

EMPLOYEE EXPOSURE DETERMINATION:

The following is a list of all job classifications at our establishment in which **all** employees have occupational exposure:

~~JOB TITLE~~ **JOB TITLE**	~~DEPARTMENT/LOCATION~~**DEPARTMENT/LOCATION**
Housekeeper	Preop/OR/PACU
Surgeons	Preop/OR/PACU
Anesthesiologists	Preop/OR/PACU
Nurses	Preop/OR/PACU
Scrub Tech	OR
Sterile Processor	Decontamination/Sterile Processing
Assistants	Preop/OR/PACU
Medical/Equipment Reps	OR
~~Medical Students~~ Medical Students	Preop/OR/PACU

The following is a list of job classifications in which **some** employees at our establishment have occupational exposure. Included is a list of tasks and procedures, or groups of closely related tasks and procedures, in which occupational exposure may occur for these ~~individual~~individuals

~~CONTRACTED COMPANY~~**CONTRACTED COMPANY**	~~DEPARTMENT/LOCATION~~ **DEPARTMENT/LOCATION**	~~TASK/PROCEDURE~~ **TASK/ PROCEDURE**
Housekeeping	Environmental Services	Handling regulated waste
Aramark	Infection Prevention & Control	Soiled linens & staff uniforms
~~Steri Cycle~~Ryno Care	Infection Prevention & Control	Disposing of used sharps and regulated medical waste

Part-time, temporary, contract and per diem employees are covered by the standard. Please also see Exposure Control Plan, IC-1909 policy.

METHODS OF IMPLEMENTATION AND CONTROL:

A. Universal Precautions:

1. All employees will utilize universal precautions.

B. Exposure Control Plan:

1. Employees covered by the bloodborne pathogens standard receive an explanation of this ECP during their initial training session. It will also be reviewed in their annual refresher training. All employees have an opportunity to review this program at any

time during their work shifts by contacting the Administrator and/or Nurse Manager. If requested, we will provide an employee with a copy of the ECP free of charge and within 15 days of request.

2. The Administrator and/or QAPI/IP nurse are responsible for reviewing and updating the ECP annually or more frequently if necessary to reflect any new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

C. Engineering Controls and Work Practices:

1. Engineering controls and work practice controls will be used to prevent or minimize exposure to bloodborne pathogens. The specific engineering controls and work practice controls used are listed below:
    a. Non-glass capillary tubes
    b. Safety needles
    c. Safety glasses
    d. Hands free sharps passing tray
    e. Sharps containers
2. Sharps disposal containers are inspected and maintained or replaced by ~~Steri Cycle~~Ryno Care when container(s) reach 3/4 fullness, or whenever necessary to prevent overfilling.
3. This facility identifies the need for changes in engineering control and work practices through reviewing OSHA records, Medical Executive Quality Committee and quarterly staff meetings, daily huddles, bulletin board postings, and staff education.
4. We evaluate new procedures or new products regularly by reviewing national and ambulatory surgery center literature and/or by representatives of new/used products/equipment.
5. Both front line workers and management officials are involved in this process: The Administrator or designee will ensure effective implementation of these recommendations.

D. Personal Protective Equipment (PPE):

1. PPE is provided to our employees at no cost to them. Training is provided by the Administrator or designee in the use of the appropriate PPE for the tasks or procedures employees will perform.
2. The types of PPE available to employees are as follows:
    a. Gloves
    b. Gowns
    c. Masks
    d. Safety glasses
    e. ~~Hair nets~~Hats/Buffonts

f. Shoe covers

g. Bunny suits

3. PPE is located in Preop, PACU, both operating rooms, and locker rooms, and may be obtained through the Administrator and/or designated materials ordering personnel.
4. All employees using PPE must observe the following precautions:
    a. ~~Wash hands immediately or as soon as feasible after~~Perform hand hygiene upon removal of gloves or other PPE.
    b. Remove PPE after it becomes contaminated, and before leaving the work area.
    c. Used PPE ~~may~~should be disposed of in designated containers.
    d. Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or OPIM, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised.
    e. Utility gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.
    f. Never wash or decontaminate disposable gloves for reuse.
    g. Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to eyes, nose or mouth.
    h. Remove immediately or as soon as feasible any garment contaminated by blood or OPIM, in such a way as to avoid contact with the outer surface.
5. The procedure for handling used PPE is as mentioned in the Personal Protective Clothing and Equipment, IC-1922 policy.
    a. TSC uses one-time use/disposable face shields, gloves, resuscitation equipment, etc.
    b. Safety goggles are cleaned and stored per policy.

E. Housekeeping:

1. Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled or color-coded (see Labels), and closed prior to removal to prevent spillage or protrusion of contents during handling.
    a. ~~The procedure for handling~~Ryno Care handles and disposes all sharps ~~disposal~~ containers ~~is: Steri Cycle handles and disposes all sharps containers~~and regulated medical waste
    b. ~~The procedure for handling other regulated waste is: Steri Cycle handles and disposes all regulated waste~~
    c. Contaminated sharps are discarded immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on sides and

bottoms, and labeled or color-coded appropriately. Sharps disposal containers are available at every patient care area.

d. **Bins and pails** (e.g., wash or emesis basins) are cleaned and decontaminated as soon as feasible after visible contamination.

e. **Broken glassware** which may be contaminated is picked up using mechanical means, such as a brush and dust pan.

F. Laundry:

1. The following contaminated articles will be laundered by ~~this company~~Aramark:
    a. Soiled uniforms
    b. ~~Aramark~~Soiled patient linens
        i. ~~Soiled uniforms~~
        ii. ~~Soiled patient linens~~
            ~~a. Gowns~~
            ~~b. Blankets~~
            ~~c. Pillow cases~~
            ~~d. Sheets~~
            ~~e. Towels/wash rags~~
            ~~f. Surgical cloths~~
        iii. Gowns
        iv. Blankets
        v. Pillow cases
        vi. Sheets
        vii. Towels/wash rags
        viii. Surgical cloths
2. Laundering will be performed by Aramark, per policy and contract.
3. The following laundering requirements must be met:
    a. Handle contaminated laundry as little as possible, with minimal agitation
    b. Wear the following PPE when handling and/or sorting contaminated laundry:
        i. Gloves
        ii. Gowns, as necessary

G. Labels:

1. The following labeling method(s) is used in this facility:
2.

EQUIPMENT TO BE LABELED	LABEL TYPE
Specimens	Patient Label, and per policy

Red/Biohazard Bags	Biohazard Labels
Sharps Containers	Biohazard Labels
Medication Waste Container	Biohazard Labels

3. All staff will ensure ~~warning~~Biohazard labels are affixed or red bags are used as required ~~if~~to indicated Biohazardous material. Employees are to notify the Administrator or designee if they discover regulated waste ~~or contaminated equipment is brought into the facility. Employees are to notify the Administrator or designee if they discover regulated waste containers, refrigerators containing blood or OPIM, contaminated equipment, etc.~~ without proper labels.

HEPATITIS B VACCINATION:

The Administrator will provide training to employees on hepatitis B vaccinations, addressing the safety, benefits, efficacy, methods of administration, and availability.

The Hepatitis B vaccination series is available at no cost after training and within 10 days of initial assignment to employees identified in the exposure determination section of this program. Vaccination is encouraged unless:

A. Documentation exists that the employee has previously received the series
B. Antibody testing reveals that the employee is immune
C. Medical evaluation shows that vaccination is contraindicated

However, if an employee chooses to decline vaccination, the employee must sign a declination form. Employees who decline may request and obtain the vaccination at a later date at no cost. Documentation of refusal of the vaccination is kept in the Employee Health File at TSC.

Vaccination will be provided by Occupational Health at:

A. Tahoe Forest Health Clinic/Occupational Health
B. 10956 Donner Pass Rd, Ste 230
C. Truckee, CA 96161
D. 530-582-3277

Following the medical evaluation, a copy of the health care professionals Written Opinion will be obtained and provided to the employee. It will be limited to whether the employee requires the hepatitis vaccine, and whether the vaccine was administered.

POST-EXPOSURE EVALUATION AND FOLLOW-UP:

Should an exposure incident occur, contact Occupational Health at the following number: 530-582-3277

An immediately available confidential medical evaluation and follow-up will be conducted by Occupational Health. Following the initial first aid (clean the wound, flush the eyes or other mucous membranes, etc.), the following activities will be performed:

A. Document the routes of exposure and how the exposure occurred

B. Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law)

C. Obtain consent and make arrangements to have the source individual tested as soon as possible to determine HIV, HCV, and HBV infectivity; document that the source individual's test results were conveyed to the employee's health care provider.

D. If the source individual is already known to be HIV, HCV, and/or HBV positive, new testing need not be performed.

E. Assure that the exposed employee is provided with the source individual's test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).

F. After obtaining consent, collect exposed employee's blood as soon as feasible after exposure incident, and test blood for HBV, HCV and HIV serological status.

G. If the employee does not give consent for HIV serological testing during collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days; if the exposed employee elects to have the baseline sample tested during this waiting period, perform testing as soon as feasible.

ADMINISTRATION OF POST-EXPOSURE EVALUATION AND FOLLOW-UP:

The Administrator or designee ensures that health care professional(s) responsible for employee's hepatitis B vaccination and post-exposure evaluation and follow-up are given a copy of OSHA's bloodborne pathogens standard.

The Administrator or designee ensures that the health care professional evaluating an employee after an exposure incident receives the following:

A. A description of the employee's job duties relevant to the exposure incident route(s) of exposure

B. Route(s) of exposure

C. Circumstances of exposure

D. If possible, results of the source individual's blood test

E. Relevant employee medical records, including vaccination status

Occupational Health provides the employee with a copy of the evaluating health care professional's written opinion within 15 days after completion of the evaluation.

EVALUATING THE CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT:

~~Safety~~The QAPI/~~Risk Management~~IP Coordinator, Nurse Manager and/or Administrator will review the circumstances of all exposure incidents ~~from the Event Reporting System~~ to determine:

A. Engineering controls in use at the time
B. Work practices followed
C. A description of the device being used (including type and brand)
D. Protective equipment or clothing that was used at the time of the exposure incident (gloves, eye shields, etc.)
E. Location of the incident (Preop, OR, PACU, etc.)
F. Procedure being performed when the incident occurred
G. Employee's training

The Administrator and/or QAPI/IP nurse will record all percutaneous injuries from contaminated sharps in the Sharps Injury Log.

A. If it is determined that revisions need to be made, the Administrator and/or QAPI/IP nurse will ensure that appropriate changes are made to this ECP. (Changes may include an evaluation of safer devices, adding employees to the exposure determination list, etc.)

EMPLOYEE TRAINING:

~~All employees who have occupational exposure to bloodborne pathogens receive training conducted by the Administrator or Nurse Manager.~~

All employees who have occupational exposure to bloodborne pathogens receive training on the epidemiology, symptoms, and transmission of bloodborne pathogen diseases. In addition, the training program covers, at a minimum, the following elements:

A. A copy and explanation of the standard
B. An explanation of our ECP and how to obtain a copy
C. An explanation of methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident
D. An explanation of the use and limitations of engineering controls, work practices, and PPE
E. An explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
F. An explanation of the basis for PPE
G. Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine will be offered free of charge
H. Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM
I. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available
J. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident

K. An explanation of the signs and labels and/or color coding required by the standard and used at this facility

L. An opportunity for interactive questions and answers with the person conducting the training session.

RECORDKEEPING:

A. Training Records:

1. Training records are completed for each employee upon completion of training. ~~These documents will be kept for at least **three years** in each employee's file in the business office.~~
2. ~~The training records include:~~
    a. ~~The dates of the training sessions~~
    b. ~~The contents or a summary of the training sessions~~
    c. ~~The names and qualifications of persons conducting the training~~
    d. ~~The names and job titles of all persons attending the training sessions~~
3. Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to the Administrator or designee.

B. Medical Records:

1. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.1020, "Access to Employee Exposure and Medical Records."
2. The Administrator or designee is responsible for maintenance of the required medical records. These **confidential** records are kept at TSC, and/or at Iron Mountain, for at least the **duration of employment plus 30 years**.
3. Employee medical records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to the Administrator or designee.

C. OSHA Recordkeeping:

1. An exposure incident is recorded on an occurrence report and evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 CFR 1904). This determination and the recording activities are done by the Administrator, Nurse Manager and/or QAPI/IP nurse.

REFERENCES:

Occupational Safety and Health Administration, Model Exposure Control Plan

Associated Policy: Exposure Control Plan, IC-1909

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	Pending
	Heidi Fedorchak: Nurse Manager	08/2024

Status **Pending** PolicyStat ID **16120959**

Origination	06/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Infection Prevention and Control
Last Revised	06/2024	Applicabilities	Truckee Surgery Center
Next Review	1 year after approval		

Exposure Control Plan, IC-1909

RISK:

If proper procedures and compliance are not followed, employees and/or patients may have increased risk of exposure to blood borne pathogens.

PURPOSE:

To minimize and eliminate exposure to bloodborne pathogens.

To have controls and guidelines to minimize exposure of bloodborne pathogens; to offer vaccinations and post-exposure evaluation and follow-up.

POLICY:

A. **RESPONSIBILITIES:**

1. The Administrator, Nurse Manager and/or Infection Control Coordinator will ensure that all employees:
    a. use appropriate work practice controls,
    b. are provided adequate training in the use and location of personal protective equipment during pre-employment assessment prior to starting work, and at least annually thereafter,
    c. receive adequate training related to occupational exposure and bio-hazard practices,
    d. are provided training when changes or new procedures are instituted,

e. are provided with this policy information and review it on an annual basis.

B. **DEFINITIONS:**

1. **Bloodborne Pathogens** - pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B virus (HBV), Hepatitis C Virus (HCV), and Human Immunodeficiency Virus (HIV).
2. **Contaminated** - the presence of the reasonably anticipated presence of blood or other potentially infectious materials on a surface, or in or on an item.
3. **Decontamination** - the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.
4. **Engineering Tools** - any physical control (e.g., sharps disposal containers, self-sheathing safety needles, needleless IV administration systems) that isolate or remove the bloodborne pathogens hazard from the workplace.
5. **Engineered Sharps Injury Protection** - a physical attribute built into a needle device used for withdrawing OPIM (other potentially infectious material), accessing a vein or artery, or administering medication or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal, or other effective mechanisms; or a physical attribute built into any type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.
6. **Exposure Incident** - a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material that results from the performance of an employee's duties.
7. **Occupational Exposure** - reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.
8. **Other Potentially Infectious Materials (OPIM):**
    a. Human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as in an emergency response.
    b. Any unfixed tissue or organ (other than intact skin) from a human (living or dead).
    c. Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV, or HCV:
        i. Cell, tissue, or organ cultures from humans or experimental animals

ii. Blood organ or other tissues from experimental animals

iii. Culture medium or other solutions

9. **Medical Waste/Regulated Waste Bag** - single thickness strength to pass the 165gm dropped dart impact resistance test prescribed by standard D 1709-85 of the American Society for Testing and Materials, and certified by the bag manufacturer.
10. **Parenteral** - piercing mucous membranes, or the skin barrier, through such events as needlesticks, human bites, cuts and abrasions.
11. **Personal Protective Equipment (PPE)** - specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.
12. **Regulated Waste** - liquid or semi-liquid blood, or other potential infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials, and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.
13. **Sharps Containers** - closeable, puncture-resistant, leak proof on sides and bottom, and labeled as biohazardous in florescent red.
14. **Source Individual** - any individual, living or dead, whose blood or OPIM may be a source of occupational exposure to the employee.
15. **Standard Precautions** - an approach to infection control. Standard precautions expanded the universal precautions concept to include all OPIM with the intent of protecting employees from any disease process that can be spread by contact with a moist body substance. This work practice includes precautions from blood, body fluids, secretions, excretions, and contaminated items.
16. **Work Practice Controls** - controls that reduce the likelihood of exposure by altering the manner n which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

C. **EXPOSURE DETERMINATION:**

1. The following are job classifications with exposure to blood and/or other potentially infectious material:
    a. Physicians, nurse practitioners, physician assistants
    b. Anesthesiologists
    c. Anesthetists
    d. ENT specialists
    e. Eye specialists
    f. Medical specialists
    g. Operating room personnel

h. Sterile processing technicians
i. Physical Therapy personnel
j. Nurse's aides, medical assistants
k. X-ray specialists, technologists, technicians
l. Clinical/Registered Nurses, LPNs, LVNs

2. The following are job classifications in which some of the employees have occupational exposure and a list of task and procedures, or groups of closely related tasks and procedures, in which occupational exposure occurs:
    a. Medical equipment specialist/Medical maintenance: repairing contaminated equipment
    b. Sterile Processing Personnel: processing contaminated reusable equipment/instruments
    c. Laundry Personnel: handling soiled/contaminated linen bags
    d. Environmental Services Personnel: cleaning contaminated environment, cleaning blood spills, handling infectious waste, soiled/contaminated linen
    e. Specimen Transporter/Lab Courier: exposure to spills of blood or potentially infectious body fluids or during transporting
    f. Admitting/patient registration: contact with potentially infectious body fluids if patient is bleeding or not in control of respiratory secretions when registering

D. **GENERAL POLICIES:**

1. Personnel should consider all bodily fluids as potentially infectious, and handled as such.
2. Procedures should be performed to minimize splashing or spreading of bodily fluids.
3. Gloves should be worn when dealing with bodily fluids or during clean up of instruments, drapes, dressings, etc.
4. Minimally, hands should be washed before direct contact with a patient, after removing gloves and before and after breaks.

E. **COMMUNICATION:**

1. Communication of hazards to employees shall be via:
    a. Warning labels affixed to containers used to transport regulated waste.
    b. 

    c. Policy presentation at hire and annually.
    d. ~~Communication book.~~Staff meetings.

e. Training will be the responsibility of the Infection Control Coordinator and/or Clinical Manager/Administrator.

PROHIBITED PRACTICES:

A. Shearing or breaking of contaminated needles and/or other contaminated sharps is prohibited

B. Contaminated sharps are not to be bent, recapped, or removed from devices.

1. EXCEPTION: Contaminated sharps may be bent, recapped or removed from devices IF the procedure is performed using a mechanical device or a one-handed technique, and the employer can demonstrate that no alternative is feasible, or that such action is required by a specific medical or dental procedure.

C. Sharps that are contaminated with blood or OPIM are not to be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

D. Disposable sharps are not to be reused.

E. Broken glassware, which may be contaminated, are not to be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

F. The contents of sharps container(s) are not to be accessed unless properly reprocessed or decontaminated.

G. Sharps containers are not to be opened, emptied, or cleaned manually, or in any other manner which would expose employees to the risk of sharps injury.

H. Mouth pipetting/suctioning of blood or OPIM is prohibited.

I. Eating, drinking, smoking, applying cosmetic or lip balm, and handling contact lenses are prohibited in work areas there there is a reasonable likelihood of occupational exposure.

J. Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets, or on counter tops where blood or OPIM are present.

HANDLING CONTAMINATED SHARPS:

A. REQUIREMENTS FOR HANDLING CONTAMINATED SHARPS:

1. All procedures involving the use of sharps in connection with patient care, such as withdrawing body fluids, accessing a vein or artery, or administering medications or fluids, are to be performed using effective patient-handling techniques and other methods designed to minimize the risk of a sharps injury.

2. Immediately, or as soon as possible, after use, contaminated sharps are to be placed in containers meeting the requirements found below in **#4**

3. At all times, during the use of sharps, containers for contaminated sharps are to be:

a. easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used, or can be reasonably anticipated to be found

b. maintained upright throughout use, where feasible, and

c. replaced as necessary to avoid overfilling

4. All sharps containers for contaminated sharps are to be:
    a. rigid
    b. puncture resistant
    c. leak proof on the sides and bottom
    d. portable, if portability is necessary, to ensure easy access by the user
    e. labeled appropriately
5. If discarded sharps are not to be reused, the sharps container shall also be closeable and sealable so that when sealed, the container is leak resistant and incapable of being reopened without great difficulty.

B. Needle Disposal Boxes (sharps containers):
    1. Replace all needle disposal boxes when three-fourths (3/4) full.
    2. Place needle disposal boxes as close to the patient's bed as reasonably possible.
    3. Place sharps container at the healthcare worker's eye level (no higher than 57" per CDC).
    4. Supply crash carts with a needle disposal container attached, and individual safety devices.

WORK PRACTICE CONTROLS:

A. Always use and activate sharps safety devices.
B. Do not pass contaminated sharps from oner person to another.
C. Before you begin the procedure with a sharps device, assure that you have a stable work surface and a needle disposal container available.
D. Introduce yourself and get a "feel" for the patient before you perform any procedure that requires a sharp.
E. Obtain assistance when starting an IV, giving an injection, or drawing blood from an uncooperative, combative, severely anxious, or confused patient.
F. Uncooperative or psychologically disturbed patients might be sedated or given pain medicine, if ordered and indicated, prior to invasive or painful procedures.
G. Be aware that even a sneeze or cough can result in an unexpected movement.
H. During codes or high stress situations, try to keep calm, communicate actions to one another, and dispose of sharps immediately after use, rather than holding them in your hand or setting them on a table or bed.
I. When minor surgical procedures are performed outside of the surgical suite, the *neutral or safe zone concept* should be utiliized. This means that sharps are placed in a designated area to be retrieved by the user. This avoids hand-to-hand transfer of sharps between personnel.
J. Injections utilize hollow-bore needles and therefore create a risk for infection following a needlestick. A recent CDC study found that subcutaneous and intradermal injections caused a

high percentage of needlesticks. Factors that may play a part include:

1. user's hands are placed on patient's skin near the needle
2. user is less careful because small syringe/needle is not perceived as a risk, and
3. syring is ~~thing~~thin, long and light and thus more difficult to control

PERSONAL PROTECTIVE EQUIPMENT (PPE):

A. Wear gloves for drawing blood, establishing venous/arterial access and whenever contact with blood or body fluids is expected.

B. Wear gloves when administering injections. Although not required by OSHA, gloves will decrease the amount of blood on a needle that may penetrate a glove and enter the healthcare worker's hand.

C. Wear gloves that fit properly, as gloves that do not fit properly can cause needlesticks by decreasing user dexterity.

D. Have PPE readily available for crash carts.

E. Use eye and face protection when splash is reasonably anticipated.

PROCEDURE FOR SUSPECTED EXPOSURE:

A. In the event of a suspected patient-to-patient or employee/medical staff-to-patient exposure to a bloodborne, or other pathogen, the following steps will be taken:

1. The Administrator and/or Nurse Manager, will be notified immediately, and who will then notify the patient's physician(s) of event.
2. The exposed employee will gp to Occupation Health at Tahoe Forrest Hospital for followup (refer to policy Needlestick and Blood or Body Fluid Exposure Protocol, IC-1921)
3. A Notification/Occurrence Report will be completed
4. The Administrator and/or Nurse Manager, will notify QAPI/IP Coordinator ~~and the QAPI/IP RN or Risk Manager at TFHD depending on the severity of the exposure~~.
5. Infection Prevention (IP) begins an investigation of the event, which may include contacting PEP for consultation to help determine if a significant exposure has occurred:
    a. http://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/
    b. (888)-448-4911; 9 a.m. - 9 p.m. EST, seven days a week
    c. ~~See step #6 below for recommended lab tests for source and exposed~~
6. The Nurse Manager and/or QAPI/IP Coordinator will initiate the disclosure process, in collaboration with the patients' treating physician(s). The treating physician(s) should be part of the disclosure process and lab orders/results.
7. After the patient(s)/emploee(s) and their treating physicians have been notified of the event:

a. Baseline lab tests for the **exposed** patient: HIV, Hep C antibody, Hep B antibody are ordered by the primary treating physician.

b. ~~Lab tests for the **source**: Rapid HIV, Hep C antibody, and Hep B antibody are ordered by the primary testing physicians of the exposed patient (if not available, chairperson of Infection Control committee writes the order).~~

c. Baseline lab tests for the **exposed employee**: HIV, Hep C antibody, Hep B antibody are ordered by treating physician at Tahoe Forest Hospital Occupational Health.

d. Lab tests for the **source**: Rapid HIV, Hep C antibody, and Hep B antibody are ordered by the primary physician or TSC MEdical Director.

8. ~~The ordering provider for lab tests will be the provider who receives lab test results.~~ All lab results will be sent to Truckee Surgery Center.
9. The Nurse Manager or QAPI/IP Coordinator will request copies of all lab test results for follow up process.
10. ~~If the patient's treating physicians are not available, the lab tests are ordered under the Medical Director for followup process.~~

B. For patient-to-patient exposures, the ordering physician is the admitting physician or Medical Director.

C. Conduct a Root Cause Analysis ~~using Just Culture process~~ to identify factors contributing to the event, and process improvement opportunities.

D. Hepatitis B Vaccination and Bloodborne Pathogen Post Exposure Evaluation and Follow-up:

1. Hepatitis B Vaccination is offered to all employees within 10 days of hire, to duties which may entail exposure to blood or bodily fluids at no charge. A declination form is filed by the Administrator, and in employees' charts, for all of those who chose not to receive the Hep B vaccine.
2. Post-exposure follow up has been implemented. An alternative to post-exposure evaluation and follow up if the injured/exposed employee refuses the services available by Occupational Health is offered: the Emergency Department at either Tahoe Forest ~~Hospital or Incline Village Community~~ Hospital. Requests for alternative treatment arrangements are made through the Administrator pursuant to the California Labor Code.

Effective: June 2003, Revised: May 2011, June 2014, June 2019

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	Pending

Heidi Fedorchak: Nurse Manager	06/2024

Status **Pending** PolicyStat ID **16104995**

Origination	07/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Infection Prevention and Control
Last Revised	08/2024	Applicabilities	Truckee Surgery Center
Next Review	1 year after approval		

Needlestick and Blood or Body Fluid Exposure Protocol, IC-1921

RISK:

Employees who have an Occupational Exposure to blood or other infectious bodily fluids are at risk for contracting blood borne diseases. Without direction, employees may not have a clear understanding of the importance of expediting screening and care related to the prevention and treatment of blood borne diseases.

POLICY:

~~A. Employee Injury Policy is to be observed.~~

~~B. The latest CDC guidelines will be followed to manage occupational and patient exposures to HBV, HCV, and HIV, including recommendations for post exposure prophylaxis.~~

~~C. **LABORATORY POLICIES:**~~

~~D. Status of the patient's blood which the health care worker was exposed to must be established, if unknown. The following labs should be obtained at no cost to the patient.~~

~~1. Complete Hepatitis Diagnostic Panel~~

~~2. HIV antibody testing~~

~~E. Status of the exposed health care worker's blood must be established, if unknown. The following labs should be obtained at no cost to the employee:~~

~~1. Hepatitis Diagnostic Panel. (one time only)~~

~~2. HIV antibody testing~~

A. Exposures and needlesticks/sharps injuries are reportable work related injuries.

B. The current CDC guidelines will be followed to manage occupational and patient exposures to HBV, HCV, and HIV, including recommendations for post exposure prophylaxis.

C. The PEP Hotline, part of UCSF's Clinical Consultation Center, is called for HIV PEP consultation when the source is known to be HIV positive or if Rapid HIV test is positive on the source as well as for other exposure related questions. 1-888-448-4911 or at: http://nccc.ucsf.edu/

PROCEDURE:

~~A. Draw the patient blood on the day of the incident.~~

~~B. Draw 2 serum red top with yellow ring tubes (SST). Please confirm with the lab that you have the proper tubes by calling 530-582-3401.~~

~~C. Lab order sheet for patient- Hep B *antigen*, Hep C antibody, and HIV- AB Screen (see attached example in sleeve).~~

~~D. Ensure that all lab order sheets are signed by an MD in the space provided.~~

~~E. The employee will need to report to occupational health department to have exam and blood drawn.~~

~~F. The employee will have blood drawn again post-exposure at 3 and 6 months after the date of injury. These blood draws will include Hepatitis C Antibody and the HIV-AB Screen.~~

~~G. **RECORD KEEPING:**~~

~~1. Employee lab results will be kept in the employee health file. Patient lab results will be kept in the patient's chart.~~

~~2. Employee is to fill out incident/notification report.~~

~~H. **WOUND CARE:**~~

~~1. Render appropriate wound care when indicated and advise employee to report to occupational health department.~~

~~I. **PROPHYLAXIS:**~~

~~1. If known exposure to Hepatitis B, follow Prophylaxis for Exposure to Hepatitis.~~

~~2. If known or suspected exposure to HIV, follow Exposure to HIV Policy.~~

A. Provide immediate care for the exposure site: wash the skin/wound with soap and water; flush mucous membranes with water.

B. Immediately report the exposure to the Nurse Manager, QAPI/IC Coordinator, or Administrator . It is the responsibility of the Nurse Manager and/or Administrator to advocate for the injured worker and be sure that the testing is done on the source patient as not to lose the opportunity if the patient is discharged, transferred or deceased.

1. Reporting the injury to the employer to initiate the Worker's compensation claim in a timely manner is required.

C. If it is determined that a "significant exposure" has occurred, be prepared to describe the specifics of the injury.

1. A significant exposure is defined as: a percutaneous injury (e.g. needlestick or cut with a sharp object) or contact of mucous membrane (eye, nose, mouth) or non-intact skin (e.g. exposed skin that is chapped, abraded or afflicted with dermatitis) with blood, tissue or other body fluids that are potentially infectious.

D. Complete the Blood and Body Fluid Exposure Report and return to supervisor.

E. Complete Occurrence Report.

F. **During regular Tahoe Forest Hospital Occupational Health business hours:** Injured/exposed worker report as soon as possible to Occupational Health Clinic

1. The Nurse Manager will facilitate source lab work to ensure that the lab work is complete.

2. Occupational Health will evaluate the exposed/injured worker and provide care, counseling/education and address any questions or concerns as well as facilitate obtaining the exposed/injured workers blood work and initiating the Worker's Compensation Claim and follow up plan.

G. **During "off hours" when Occupational Health Clinic is closed:**

1. The Nurse Manager will facilitate obtaining the source lab work, ensure that the event is reported to Occupational Health and direct the injured worker to follow up the next business day.***Order forms for both the EXPOSED and the SOURCE are attached to this policy.***

2. Care for the Exposed/Injured Worker will occur as soon as possible through the Tahoe Forest Hospital Emergency Department Worker's Compensation Visit.

3. The E.D. Physician and/or the Nursing supervisor will obtain the Rapid HIV results on the source patient and coordinate with the treating provider of the injured worker (exposed). A positive Rapid HIV result is considered inconclusive and needs to be sent for confirmation testing.

H. Lab tests are run in house at Tahoe Forest Hospital. HIV testing is performed stat upon receipt by the lab and results available to the ordering provider within one hour. Hepatitis B and C testing is available within 24 hours.

1. Lab results are reported to the exposed individual by the ordering provider or nursing supervisor.

I. Baseline and Source Blood testing:

1. **Exposed/injured worker** baseline blood testing is ordered by the **Occupational Health ordering provider** OR the ordering **ER physician** and billed to **Truckee Surgery**

Center. This ensures the employee/injured worker is not billed for the labs and ensures privacy in accordance with 29 CFR 1910.1030 (blood borne pathogens).

a. **Draw 3 separate Red top with yellow ring tubes (SST) on the Exposed/ injured worker**

i. **LAB2600** HIV with reflex confirmation

ii. **LAB1329** Hep C antibody with reflex

iii. **LAB1860** Hep B surface Antibody Qualitative

iv. If the HIV or Hepatitis C test is positive, confirmatory testing is sent

a. The extra red top tubes are to be drawn in case of the need to send blood for confirmation.

2. **Source Patient** blood work is ordered by the treating physician or Dr.Jeffery Dodd, as the Medical Director of Truckee Surgery Center, and billed to the Truckee Surgery Center. This is to ensure the patient is not billed for these lab tests.The treating physician or nursing supervisor will notify the patient and ensures that blood work is obtained from the source. The injured/exposed employee may not obtain consent from source patient.
3. Patients at Truckee Surgery Center consent to the testing of HIV and hepatitis in the event there is an accidental exposure upon signing their surgical consent.
    a. **Draw 3 separate red top with yellow ring tubes (SST) on the source patient.**
        i. **LAB1690** HbsAg (Hep B surface Antigen)
        ii. **LAB1329** HCV (Hepatitis C antibody with reflex)
        iii. **LAB2600** HIV with reflex confirmation
        iv. If the HIV or Hepatitis C test is positive, confirmatory testing is sent.
            a. The extra red top tubes are to be drawn in case of the need to send blood for confirmation.
4. If source is known to be HIV, Hep C or Hep B positive, and a significant exposure has occurred, refer to http://nccc.ucsf.edu/ (UCSF Clinical Consultation Center), and/or PEP Hotline 1-888-448-4911
    a. Consultation is required with PEP hotline regarding administration of the antiviral PEP medications. 1-888-448-4911 or at: http://nccc.ucsf.edu/
        i. If it is determined that the PEP (Post exposure prophylaxis) should be administered, It should be started as soon as possible and ideally within 72 hours of exposure.
            a. If confirmation testing for HIV is sent, results for that initial screening can take 1-3 days, final results may

take up to 5 days through Quest Lab.

b. The prescription can be obtained from Tahoe Forest Retail pharmacy (phone number: 530-587-7607) by the next business day OR a prescription can be written and filled at the Walgreen's in Reno open 24 hours: 750 N. Virginia Street (Phone number: 775-337-8703).

c. Education on risks, benefits and possible side effects of the PEP medications is required to be given to the exposed individual. Careful follow up for weeks after the exposure of the exposed employee is done should these medications be administered.

d. If the initial treating provider is from the Emergency Department, a "warm hand off" verbal report to the provider who will follow up at the Occupational Health clinic will take place.

J. A Worker's Compensation Claim is initiated by the Occupational Health Case Manager, this is an OSHA REPORTABLE injury

1. Hand Written Doctor's First Report completed and signed by injured worker (California State form 5021)
2. DWC-1 The California Employees Claim for Worker's Compensation Benefits- completed and signed by injured worker.
3. Blood and Body Fluid Exposure Report.
4. Provider notes from initial visit related to injury if seen in the E.D.
5. Truckee Surgery Center Administrator will complete the 5020 form (Employer's Report of Occupational Injury or illness) via Comp Watch Program.

K. If the source labs are negative, and the exposed is immune to Hepatitis B, follow up labs (HIV, Hep C) are done at 3 months and 6 months.

L. Refer to CDC guidelines (www.cdc.gov/) for recommendations on treatment/immunizations related to exposures if the source is unknown or has positive results. Consultation is available with PEP hotline 1-888-448-4911 or at: http://nccc.ucsf.edu/

M. The Infection Control Coordinator and /or Nurse Manager of TSC investigates the exposure incident. This investigation is initiated immediately. The following is noted:

1. When the incident occurred
2. How the incident occurred
3. What potentially infectious material(s) was involved
4. Source of the material
5. Under what circumstances the incident occurred, type of work being performed
6. Personal protective equipment being used at the time
7. Actions taken as a result of the incident, e.g., decontamination, clean-up, notifications made, etc.
8. Identification of the source individual

N. If trends are identified with specific areas, individuals or products, the Nurse Manager and/or Infection Control Nurse will review the situation/case with individual employees, at a staff meeting, or other appropriate intervention/education is done and documented. This report is kept with the QAPI/IC coordinator and is reported to Medical Executive Quality Committee and Governing Board. This demonstrates the efforts to maintain safe work practices within Truckee Surgery Center.

REFERENCES:

CDC guidelines for Mgt of Occupational Exposures, Current CDC guidelines, 2007Senate Bill 1239, Health & Safety Code 199.65/Cal OSHA BBP STD; Updated US Public Health Service Guidelines for Mgmt of Occ Exposure. 29 CFR 1910.1030 OSHA Blood borne pathogens.

Effective: May 2003, Revised: August 2005, March 2010, August 200,8 May 2011, June 2014, February 2015, April 2016

Attachments

Blood and Body Fluid Exposure Report.docx

Needlestick exposure lab order form- Exposed employee.doc

Needlestick exposure lab order form- source patient.doc

Approval Signatures

Step Description	Approver	Date
	Heidi Fedorchak: Nurse Manager	Pending
	Courtney Leslie: Administrator	Pending

Status Pending PolicyStat ID 16173145

Origination	07/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Tissue Bank
Last Revised	07/2024	Applicabilities	Truckee Surgery Center
Next Review	1 year after approval		

Allograft Handling- Accepting, Storing, and Tracking TB-1901

~~PURPOSE:~~

~~Truckee Surgery Center (TSC) will only accept allograft/tissue from source facilities that are licensed by the appropriate state agencies AATB certified and registered as a tissue establishment with the Food and Drug Administration. TSC will only transplant allografts/tissues screened and found nonreactive by laboratory tests for evidence of infection with HIV, agents of viral hepatitis (HBV and HCV), human T lymphotropic virus-1 (HTLV-1), and syphilis.~~

RISK:

Patients are at risk for infection when allograft tissue is contaminated or damaged during transit, storage and/or handling. Improper documentation of receipt of the graft though implantation decreases the ability to track a graft in the event of a recall.

POLICY:

~~The following standard protocols will be observed for the handling of surgical allografts. Such protocols will help ensure the proper handling and storage of the grafts, as well as appropriate follow-up when a tissue-induced infection is suspected.~~

A. Truckee Surgery Center (TSC) will only accept allograft/tissue from source facilities that are licensed by the appropriate state agencies AATB certified and registered as a tissue establishment with the Food and Drug Administration. TSC will only transplant allografts/ tissues screened and found nonreactive by laboratory tests for evidence of infection with HIV, agents of viral hepatitis (HBV and HCV), human T lymphotropic virus-1 (HTLV-1), and syphilis.

B. The following standard protocols will be observed for the handling of surgical allografts. Such

protocols will help ensure the proper handling, storage and documentation of the grafts, as well as appropriate follow-up when a tissue-induced infection is suspected.

PROCEDURE:

A. DEFINITIONS:

1. Allograft tissue: tissue intended for transplantation into another individual of the same species.
2. Autologous tissue: transfer of an organ or other tissue from one location to another in the same person.
3. Examples of tissue and cell products:
    a. Autologous cells
    b. Autologous tissue
    c. Bone
    d. Bone marrow
    e. Bone paste
    f. Bone powder
    g. Bone putty
    h. Cancellous chips
    i. Cartilage
    j. Chondrocytes
    k. Demineralized bone matrix
    l. Dermal matrix
    m. Dermis
    n. Fascia/Fascia lata
    o. Ligaments
    p. Meniscus
    q. Skin
    r. Stem cells
    s. Tendons
    t. Tissue
    u. Other cellular and tissue based transplant or implant products whether classified by the FDA as tissue or a medical device

B. ACQUISITION OF ALLOGRAFT TISSUE:

1. The Surgery Scheduler at TSC is notified by the surgeon's office to schedule an upcoming case that will require an allograft. The supply coordinator or nursing designee will obtain the necessary specifications for the allograft from the surgeon.

2. The supply coordinator or nursing designee will order required allograft tissues according to TSC's established PAR levels and/or per the surgeon's request.
3. TSC follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.
4. Documentation of the source facilities' licensure and a list of registered U.S. Food and Drug Administration (FDA) tissue establishments and ATTB accredited agencies shall be kept in the Allograft Tissue Binder.

C. RESPONSIBILITIES:

1. It is the responsibility of the Nurse Manager to ensure that allograft/tissue is maintained at the proper storage temperature prior to transplant, and to assure compliance with the policies and procedures as outlined by TSC.

D. DOCUMENTATION FOR RECEIVING AND STORING ALLOGRAFTS:

1. The supply coordinator or nursing designee will be responsible for logging in all allografts/tissue in the allograft log book as they come into the facility.
2. When tissues are received, the supply coordinator or nursing designee, verifies that package integrity was maintained.
3. The *required* information (see attachment for *Allograft Tissue Log)* that must be recorded at the time of delivery includes:
    a. Time and date allograft received
    b. Name of individual who received the allograft
    c. Package and shipping container integrity and presence of dry ice. If dry ice is **not** present and or package not intact, RN will not use allograft and contact the vendor.
    d. Package expiration date and time
    e. Tissue description
    f. Tissue serial number
    g. Expiration date
4. The invoice/packing slips are then given to the Administrator.
5. Frozen allografts are packaged by the supplier in dry ice and insulated containers in such a way that the package can remain at room temperature for a specified period of time, as long as the packaging is not disturbed. The label should clearly state how long the allograft can be held in its original packaging in this way. If the circumstances or timing of the case should change, so that the allograft will not be used before the expiration of the packaging, it must be returned to the supplier before this expiration time or placed in the freezer for storage.
6. Room temperature allografts are packaged by the supplier in a sealed package. These allografts will be recorded in the *Allograft Tissue Log* upon receipt.
7. Allograft storage:
    a. Allografts will be placed into the allograft freezer immediately upon arrival

to TSC.

b. The allograft freezer will maintain a temperature between -40°C and -80°C at all times. Allografts can be stored at this temperature until the package expiration date.

c. The allograft freezer will have continuous temperature monitoring and will alarm when the temperature is out of range.

d. Daily temperature monitoring will be recorded on TSC operating days.

e. The allograft freezer will be plugged into an emergency outlet with a backup power source.

f. The Nurse manager or Administrator will be notified immediately if the Freezer temperature has risen above -40°C.

g. Expired graft will be handled accoring to the suppliers recommendations.

E. GRAFTS/TISSUES WILL BE DETERMINED TO BE SAFE, STERILE AND APPROPRIATE FOR THE PATIENT PRIOR TO IMPLEMENTATION:

1. Because of the potential violation of sterility, a graft must not be used under any of the following conditions:

   a. If the package seal is damaged, or not intact.

   b. If the package has any physical damage.

   c. If the package label or identifying bar code is severely damaged, not readable, or is missing.

   d. If the vacuum inside the freeze-dried package is not intact when the reconstitution procedure is started.

   e. If the freeze-dried container has been allowed to freeze or has otherwise been damaged by moisture or temperature.

   f. If the expiration date shown on the package label has passed.

   g. If any of the conditions exists or is suspected, the facility will sequester the suspected tissue and the distributor that sent the tissue will be notified, and the affected graft/tissue will be returned to the distributor.

2. Once the attending surgeon has requested the allograft/tissue and visually confirms the allograft, the OR circulating nurse or assigned designee will carefully examine the packaging before introducing the graft to the sterile field.

3. At the time of surgery, the surgical allograft will be aseptically removed from all packaging and placed onto the sterile field. The contents of the package, expiration date, and other pertinent information should be read back and verified before the tissue is dispensed onto the sterile field.

4. The surgical allograft will be processed per the manufacturer's instructions.

   a. The technique used for reconstituting the allograft: Per manufacturer's instructions that accompany the allograft.

   b. Per physicians at TSC: Antibiotics of choice (check patient allergies to

antibiotics), or NaCl will be used to thaw the graft.

F. DOCUMENTATION WILL BE COMPLETED BY THE CIRCULATING NURSE AT TIME OF IMPLEMENTATION:

1. The *Allograft Tissue Tracking* form (remains in patient chart) will be labeled and completed by the circulating RN, and added to the patient's chart.
2. The *Allograft Tissue Log* will be filled in appropriately/updated by the circulator during the case.
3. Tracking cards for tissue/allograft implantation will be completed by the circulating nurse and mailed or faxed to the manufacturer by the front office coordinator. One copy will remain in the chart.
4. On the day of surgery, by the direction of the surgeon, the allograft will be removed from the packaging or freezer and the Circulating RN will record the following information on the Allograft Tissue Tracking Form :
    a. Affix the graft sticker to form. Be sure to include serial number and expiration date.
    b. Place patient sticker on form.
    c. Date and time the allograft was removed from transport/storage container or freezer
    d. Document whether the package is intact.
    e. The name of person preparing the graft.
    f. Name of staff member who removed the allograft from the container/ freezer and placed on the sterile field
    g. Name of scrub receiving the graft.
    h. The materials/solutions used to dilute, thaw and/or prepare the graft per manufacturer's instructions and the lot number and expiration date.
5. The Circulating RN will affix the graft sticker and information to the Implant Sheet as part of the patients record.

G. IT IS THE TRUCKEE SURGERY CENTER'S RESPONSIBILITY TO INVESTIGATE ANY ADVERSE REACTIONS ASSOCIATED WITH THE IMPLEMENTATION OF ALLOGRAFTS:

1. An adverse reaction for Human Cell and Tissue Products (HCT/P) is defined as a noxious and unintended response to any HCT/P for which there is a reasonable possibility that the HCT/P cause the response.
    a. An adverse reaction may include disease transmission or other complications that are suspected of being directly related to the use of tissue.
    b. Adverse events are communicated to the Nurse Manager or designee and/ or Administrator, who is/are responsible for obtaining all information regarding the event, and who will notify the surgeon, Tahoe Forest Hospital's Risk Manager, and TSC's Infection Control and Quality Assurance Coordinator.

c. In the event tissue is explanted, the tissue will be preserved, and will not be destroyed until all investigations are completed.

d. In the event that Truckee Surgery Center is notified by an allograft vendor of any reactive test result, a Notification/Occurrence Report will be filled out and the implanting surgeon will be notified immediately.

e. If a physician identifies a tissue allograft as the possible source of a postoperative infection, the Nurse Manager, Medical Director and/or Administrator, as well as the supplier of the allograft will be notified immediately. The Nurse Manager and/or Administrator will then be responsible for notifying Truckee Surgery Center's Infection Control and Quality Assurance Coordinator, as well as the Department of Health Services Tissue Bank Licensing Director.

2. The patient will be stringently monitored during the post-op course for continuing signs of infection or graft rejection by the surgeon.

H. TISSUE RECALL NOTIFICATION:

1. In the event a supplier recalls Human Cell and Tissue Products (HCT/P), the Nurse Manager or designee will review the tissue inventory to ascertain if any of the recalled tissue has been received by the hospital.
2. In the event recalled tissue has been implanted, the Clinical Manager or designee and/or Materials Manager will immediately notify Tahoe Forest Hospital's Risk Manager, as well as Truckee Surgery Center's Infection Control and Quality Assurance Coordinator. The operative surgeon will also be notified immediately.
    a. A Notification/Occurrence Report will be completed by the Nurse Manager, Administrator, or Infection Control and Quality Assurance Coordinator.
3. The following information will be provided:
    a. Patient's name
    b. Recalled tissue information
    c. Reason for recall of tissue
4. Notification of the patient in regard to the recall, and any further action to be taken, is the responsibility of the implanting surgeon.
5. Any unused recalled tissue will be handled according to suppliers' recommendations.

References:

Tahoe Forest Hospital, AORN Perioperative Standards & Recommended Practices, 2011 Edition

Effective: July 2012, Revised: November 2012, December 2012, September 2013, February 2015

Attachments

ALLOGRAFT TISSUE LOG.docx

ALLOGRAFT TISSUE TRACKING FORM.docx

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	Pending
	Heidi Fedorchak: Nurse Manager	07/2024

Status **Pending** PolicyStat ID **16189764**

Origination	06/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Infection Prevention and Control
Last Revised	07/2024	Applicabilities	Truckee Surgery Center
Next Review	1 year after approval		

Infection Control Plan, IC-1914

RISK:

If infection prevention and control regulatory requirements, guidelines, policies and procedures are not provided and followed, healthcare-associated infections could spread to patients and health care personnel (HCP), thus compromising patient care as well as safety of HCP.

POLICY:

A. A healthcare-associated infection (HAI) is defined as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s), *without* the presence of an infection at time of admission.

B. System-wide infection prevention and control processes to avoid sources and transmission of infections and disease reduce the likelihood of preventable HAIs. It is the policy of Truckee Surgery Center (TSC) to promote effective infection control practices in the ambulatory surgery center to mitigate risks contributing to healthcare-associated infections, with special surveillance designated to the reduction and prevention of surgical site infections (SSIs).

C. The Infection Control (IC) Coordinator communicates recommendations based on national guidance from CDC, APIC, ASHRAE, ASCA, CASA and AORN to prevent infections in the surgical arena. The IC coordinator receives regular education through various sources on both local and national infection control standards.

D. While the Infection Control Coordinator and the Nurse Manager of Truckee Surgery Center are responsible for oversight of the IC program providing expert consultation and evidence based recommendations, the Coordinator performs monitoring of IC practices and provides ongoing training and education.

E. Practices and interventions to reduce infections in the operative setting must be an integral part of the facilities quality program. The IC Coordinator will receive focused IC training in

order to perform any monitoring or education.

F. The IC Coordinator and Nurse Manager are responsible for communicating all areas of the IC Program to the Administrator.

PROCEDURE:

A. It is the responsibility of the staff and physicians of TSC, based on guidance from the Infection Control Coordinator, Nurse Manager, and Administrator, to follow all recommenced practices for infection prevention.

B. General Guidelines ~~(Responsibility of the staff/physicians of TSC based on guidance from the Infection Control Coordinator, Nurse Manager, and Administrator)~~

1. Treat remote infections prior to elective surgery. Surgery ~~will~~may be postponed until treated.
2. Employ antimicrobial prophylaxis as appropriate:
    a. ~~Administer antimicrobial prophylaxis with an appropriate antimicrobial agent via IV route~~
    b. ~~In most instances, administer a dose with completion as close to time of skin incision as possible but no more than 60 minutes before.~~
    c. Administer prophylactic antibiotics according to recommendations (refer to policy Antibiotic Intravenous Administration IC-1902)
    d. Monitor the timing of antibiotic prophylaxis with regular reporting to the Medical Executive Quality Committee and Governing Board.
3. Participate in continuing education for Bloodborne Pathogens and ~~Tuberculosis training~~other communicable diseases, both on hire and annually. The IC Coordinator and Nurse Manager will have input into the content of the learning modules and will be available for any questions that may arise.
4. The Nurse Manager and/or Administrator will notify the Medical Director, Medical Executive Quality Committee and Governing Board when an outbreak is suspected or confirmed.
5. Consult with the Nurse Manager and/or Administrator if there are any questions regarding proceeding with or beginning cases when there are identified ~~ventilation issues~~concerns.

C. Control of Communicable Diseases ~~(Responsibility of staff/physicians of TSC based on guidance from Infection Control Coordinator and Nurse Manager)~~

1. Employ respiratory etiquette measures with all patients and visitors. This will include having available and visible, appropriate "Cover your Cough" signage, accessible hand hygiene products, surgical masks and tissues.
2. Consult with IC Coordinator and/or Nurse Manager for questions or concerns regarding staff with a known or suspected communicable disease
3. Comply with Employee Health requirements:
    i. On hire this includes:

a. Immunity testing for measles, mumps rubella and chickenpox

b. Tuberculosis screening ~~which is~~by either ~~with QFT or~~Quantiferon blood test or PPD skin ~~testing~~test on hire and then screening questionnaire annually.

c. Immunity testing for hepatitis B and if not immune ~~either signs~~will receive a 3 dose vaccine series or sign declination form ~~or accepts 3 dose vaccine series~~.

ii. Once employed TSC will include ~~ASC~~ staff in requisite screening or vaccination i.e. Tdap vaccine, TB exposure followup, etc.

4. Employ standard precautions as outlined in the policy ~~and procedure on communicable diseases in the infection control manual~~Communicable Diseases IC-1906.

5. Patients with any notifiable diseases as required by CDPH will be reported to the IC Coordinator. The IC Coordinator will call or will enter the information into the state's online reporting system.

6. Employ enhanced precautions to include droplet, contact, or airborne as needed according to the Isolation Precautions policy IC ~~policy~~-1915. Isolation Precautions will be used after consultation with the Infection Control Coordinator and/or Nurse Manager for the following disease conditions:

i. Tuberculosis

a. Delay surgical procedures for patients with known TB disease until the patient is no longer infectious.

b. If the surgery cannot be delayed, schedule it at a partner hospital (Tahoe Forest Hospital District).

c. If pulmonary TB disease is suspected after the operative procedure is underway the following should be done:

a. Ensure that the doors to the operating room remain closed as much as possible and minimize the traffic into and out of the room.

b. During postoperative recovery, monitor the patient in the operating suite where the procedure was performed by personnel wearing appropriate respiratory protection.

ii. Active infections with Multi-Drug Resistant Organism such as MRSA

i. Employ standard and contact precautions according to Isolation Precautions policy IC-1915 and consult with the Infection Control Coordinator and/or Nurse manager for questions or concerns.

D. Traffic in the OR ~~(Responsibility of the Administrator, Nurse Manager and staff/physicians of TSC based on guidance from the Infection Control Coordinator)~~

1. Control traffic in and out of the Operating Room to minimize air turbulence during the room set up and during the actual procedure.Protect the patients' security and privacy by ongoing monitoring of the traffic from the unrestricted to the restricted areas in the department. ~~This includes vendor representatives, staff, supplies, and equipment, also remaining cognizant of the risk of cross contamination.~~
2. Allow only authorized personnel within the surgical suite with proper attire as outlined by AORN and according to ~~TSC policy~~Surgical/Procedural Attire Policy IC-1932.
3. ~~Control traffic in and out of the Operating Room to minimize air turbulence during the room set up and during the actual procedure.~~
4. Keep doors closed except for passage of personnel, equipment, etc., in order to maintain positive pressure differential in the ORs.
5. Prohibit visitors with signs and symptoms of a respiratory illness to enter restricted areas of the department.

E. Surgical attire ~~(Responsibility of the managers and staff of TSC based on facility policy and guidance from the Infection Control Coordinator)~~
   1. Restrict the wearing of artificial nails of all staff in department.
   2. Restrict jewelry among scrub personnel and ~~Central~~ Sterile Processing staff according to TSC Surgical Attire policy based on AORN guidance.
   3. Ensure compliance with other all other components of TSC's ~~surgical attire~~Surgical/ Procedural Attire policy IC-1932..

F. Aseptic Technique (~~Responsibility of the Nurse Manager and staff/physicians of TSC based on guidance from the Infection Control Coordinator~~refer to Asepsis Policy IC-1926)
   1. Prepare sterile items as close in time as possible to the actual procedure.
   2. Maintain sterility of sterile gown, gloves ~~and supplies~~, supples and sterile field.
   3. Keep hands above waist
   4. Monitor sterile field constantly
   5. Open, dispense and transfer all items onto the sterile field by methods to maintain sterility and integrity
   6. ~~Employ enhanced precautions to include droplet, contact, or airborne as needed according to the IC policy. Isolation Precautions will be used after consultation with Infection Control for the following disease conditions.~~
   7. Move in and around sterile field in a manner to maintain sterility
   8. Maintain adjacent sterile field at same height
   9. Maintain separation between sterile and non sterile team
   10. Do not turn back on sterile field

G. Education and Training ~~(Responsibility of the Administrator, Nurse Manager and staff/ physicians of TSC based on guidance from the Infection Control Coordinator.~~

1. Perform relevant education and training upon hire and at regular intervals determined by Administrator and/or Nurse Manager.
    a. Training content differs for job duties of targeted staff i.e. EVS staff training will be different than training for scrub personnel
    b. Document education and training
    c. Consult with Infection Control Coordinator if specific topic(s) requires outside resources/specialists.
2. Required training should be partially based on IC monitoring results and identified gaps.

H. Safe Injection Practices ~~(Responsibility of the Nurse Manager and staff/physicians of TSC based on guidance from Infection Control Coordinator)~~
    1. Reference the IC policy on Safe Injection Practices IC-1930, based on specific CDC guidance.
    2. Use a single-dose vial or prefilled syringe whenever possible, however if multi-dose vial must be used:
        a. Ensure that both the needle/cannula and syringe used for access are sterile.
        b. Disinfect the rubber septum with alcohol before entering.
        c. Date vial with 28 day expiration as well as nurses initials so that it can be discarded according to USP 797 requirements.
    3. Do not reinsert used syringes or needles into medication vials/containers.
    4. Do not administer medications from single dose vials or ampules to multiple patients or combine leftover contents for later use.
    5. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
    6. Use needles, syringes, medication administration tubing, and connectors for only one patient.
    7. Utilize approved sharps containers when discarding any sharps device and lock the containers before transport to biohazard holding area to reduce chance of injury.
    8. Do not overfill sharps containers
    9. Report all sharps injuries ASAP to the Administrator and refer to policy ~~on needle stick protocol~~Needlestick Protocol IC-1921 for further information.

I. Preoperative Patient Skin Prep ~~(Responsibility of the Nurse Manager and staff/physicians of ASC based on guidance from the Infection Control Coordinator)~~
    1. Use all approved prep products according to manufacturer's instructions.
        a. If Chloraprep/Duraprep is used, allow area to dry before applying drapes to minimize risk of skin irritation and fire.
        b. Do not remove hair unless it will interfere with the surgery.

c. If hair removal is necessary:
    i. Use electric clippers with single use heads. Discard heads after use.
    ii. If possible, do not remove hair in the OR.

J. Surgical Hand Scrub and General Hand Hygiene and appropriate glove use ~~(Responsibility of the Nurse Manager and staff/physicians of TSC based on guidance from the Infection Control Coordinator)~~
    1. Ensure that only those products approved for surgical hand hygiene are at the scrub sink.
    2. Use all products according to manufacturer's guidance.
    3. Employ scrub sinks with a hands free system of operation only ~~scrub sinks which have a hands free system of operation~~
    4. Perform appropriate hand hygiene following the Hand Hygiene policy IC ~~policies on~~-1910 and Surgical Hand ~~Hygiene and Surgical Hand~~ Scrub policy IC-1934 which references CDC guidance ~~contained in the HICPAC document, "Guidelines for Hand Hygiene in Health Care Settings"~~ as follows:
        a. At the beginning of a work shift
        b. Upon entering and leaving a patient room or environment:
            i. Operating Room Suites: Hand hygiene is required upon OR suite entrance and exit
            ii. All other patient rooms/areas with curtains: Hand hygiene is required upon crossing the curtain line
            iii. Patients not in rooms(in wheelchairs and stretchers): Hand hygiene is required before and after patient contact
        c. When carrying supplies or transporting a patient into or out of an area, hand hygiene is required as soon as hands are free.
        d. Before and after direct patient contact.
        e. After removing ~~glove~~gloves.
        f. Before moving to a clean body site from a contaminated body site during patient care.
        g. Before and after handling an invasive device (e.g urinary catheter, IV catheter) regardless of whether or not gloves are used.
        h. After contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings or items contaminated with these body fluids.
        i. Any time as needed, such as after sneezing or coughing.
        j. Before handling food or oral medications
    5. Soap and water hand washing is required:

a. Before eating
b. After using the restroom
c. Any time hands are visibly soiled
d. After caring for a patient on contact precautions for C. Difficile or other spore forming organisms, rotavirus or norovirus. The physical action of washing and rinsing hands is required because alcohols, chlorhexidine, iodaphores, and other antiseptic agents have poor activity against spores.
e. Before caring for a patient with a food allergy
f. When there is significant build-up of waterless hand sanitizer.

K. Sterilization and Reprocessing ~~(Responsibility of the Nurse Manager, Administrator and staff/ physicians of TSC based on guidance from the Infection Control Coordinator except where noted)~~

1. Discard items or devices marked as "single use" after use.
2. Point of care devices such as glucometers are to be cleaned per ~~facility policy "Blood Glucose Monitoring System Use"~~manufacturers instructions.
3. Assess instrument packs and trays for signs of breached integrity or damage.
    a. Examine exterior of sterile item packaging for evidence of potential contamination which includes:
        i. Broken seal
        ii. Evidence of moisture
        iii. Discoloration
        iv. Hole in package.
    b. Examine chemical ~~integrator~~indicator to assure that item was exposed to heat/steam autoclave.
4. Replace wrapped storage containers ~~where~~when possible with hard containers containing filters designed specifically for sterilization.
5. Ensure that sterility is maintained during storage by the following actions:
    a. Store in designated clean area
    b. Keep doors closed both in the sterile storage area ~~(metro room)~~ and in the OR's.
    c. Keep all items clean and dry
    d. Clean shelves on a regular and scheduled basis
    e. Store all items off the floor
    f. Do not allow cardboard boxes in the sterile supply areas.
6. Review all instances of ~~flash~~immediate use steam sterilization (IUSS) and identify interventions where feasible to decrease unnecessary ~~flash sterilization~~IUSS and prepare report for the Medical Executive Quality Committee and Governing Board.

This will be done quarterly.

7. The employee responsible for Sterilization and Reprocessing ~~provides guidance to~~assists the Nurse Manager, Administrator and/or QAPI/IC Coordinator on all ~~reprocessing~~ policies, procedures and quality standards in the Sterile Processing department which include the following:
    a. Stresses the importance of absolute consistency with all reprocessing modalities.
    b. Consults with Nurse Manager and/or Administrator and staff on observed issues and concerns.
    c. Recommends new quality control methods as outlined by AAMI.
    d. Consults with Nurse Manager and/or Administrator and nursing staff on potentially useful new technology.
    e. Arranges training and in-services as needed.
    f. Assists the IC Coordinator with quarterly audits of ~~flash sterilization documentation~~IUSS.
    g. Recommends to the Nurse Manager and/or Administrator appropriate monitoring that should be done daily, weekly and monthly
    h. Formulates both communication plan as well as interventions required in the event of a sterilization failure based on AAMI guidance.
    i. Collaborates with the Nurse Manager and/or Administrator so that the following are incorporated into the department's procedures:
        i. Meticulous cleaning of instruments before any sterilization to include enzymatic detergent.
        ii. Sterilization of all devices and instruments deemed "critical" since they enter normally sterile tissues or the vascular system. The sterilization process should include the following:
            a. Appropriate number of Chemical ~~integrators~~Indicators in each tray or peel pack.
            b. Monitoring with a ~~bowie dick~~Bowie Dick test daily and a biological indicator with ~~each and~~ every load ~~of instruments~~.
            c. Monitoring the physical parameters of each load in the autoclave including time, temperature and pressure.
            d. Listing each instrument or item on a required "Load list" for each sterilization load.
            e. Monitor the Autoclave according to manufacturer's recommendations.

L. Environmental Cleaning ~~(Responsibility of the Administrator, Nurse Manager and staff of TSC based on guidance from the Infection Control Coordinator)~~
    1. ~~Clean all surfaces in the department based on their level of patient contact and~~

proximity to patient care activities or the preparation for patient care so that patients do not come into contact with a surface that could transmit infection from a previous patient

2. Perform cleaning according to TSCthe following policies: Facility Cleaning and Disinfection Schedule IC-2009, Cleaning of Patient Care Areas Between Cases IC-2008, Cleaning of Patient Care Equipment IC-1905, which references AORN recommendations as well as CDC HICPAC recommendations in "Environmental Infection Control in Healthcare Facilities".
3. Use EPA registered disinfectants registered by the EPA.
4. Dispose of biohazardous waste and linens according to OSHA and state regulations, national environmental health and safety and National Environmental Health and s\ Safety (NEH&S) and IC Coordinator guidance.

M. Safety Procedures (Responsibility of the Administrator, Nurse Manager and staff/physicians of TSC based on guidance from the Infection Control Coordinator)

1. Ensure that the Exposure Control Plan IC-1909 is accessible at all times to the staff and physicians.
2. Evaluate and implement with guidance from the National Sharps Safety group and the CDC engineering controls such as safer sharps.Evaluate and implement sharps safety program.
3. Discard all single use sharps into approved sharps container.
4. Replace sharps container when ¾ full or when the "fill line" on the container is reached.
5. Substitute a "no-touch or hands-free safety zone" technique for hand to hand passing of sharps.
6. Handle blood and body fluid spills according to the IC policy, "Blood and Bodily Fluid Spill and Clean-up" IC-1904.
7. Handle regulated medical waste according to Biohazardous Waste Definitions and Management Plan policy IC policy, "Biohazardous Waste Definition and Management Plan".-1903
8. Dispose of blood and irrigation fluid by using the closed system process (DornachNeptune) to decrease potential for a splash exposure.

N. Infection Control Coordinator and/or Nurse Manager responsibilities

1. Surgical Site Infection Surveillance
    a. Perform SSI surveillance according to the Performance Improvement/Risk Management plan focusing on the high-risk, high volume procedures.
        i. Obtain completed physician inquiries on all prior months' cases for SSI data accumulation which aids in facilitating reported SSI and patient status follow-up, as well as induce the incorporation ofimplement any necessary and/or immediate interventions and/or policy &and procedural changes for improved and ongoing infection prevention and control.

ii. ~~Perform chart review on those patients receiving post op antibiotics within 30 days.~~

iii. Obtain completed physician inquiries on all previous 90 day cases with implantable devices.

iv. Perform chart review on any cases with confirmed or suspected SSI's.

v. Confirm plan with the Administrator, Medical Executive Quality Committee and Governing Board.

vi. ~~Surveillance procedures may change throughout year i.e. new procedure added or IC Coordinator notified of infection concerns by a staff member or physician~~

b. Utilize Centers for Disease Control and Prevention and National Healthcare Safety Network(NHSN) definitions of SSI.

c. Share SSI surveillance data with the Administrator, Medical Executive Quality Committee and Governing Board of TSC.

d. Share SSI surveillance data with individual physicians as requested.

e. Perform SSI surveillance at the request of individual physician.

f. Any interventions suggested to the Coordinator must either be evidence based or included in CDC guidance.

2. Outbreak Investigation

a. Outbreak is defined as an increase in endemic rates of a disease occurrence in a given population, over a specified period of time and within a specific geographic location.

b. Utilize the appropriate resources when investigating.

c. Share findings and recommendations with TSC Administrator, Medical Executive Quality Committee and Governing Body when applicable.

3. Ventilation and Environmental Conditions

a. Consult with Administrator ~~and~~, Tahoe Forest Hospital Facilities department and/or HVAC contractor ~~in order~~ to ensure that appropriate ventilation controls are in place in the ORs to achieve optimal ventilation and environmental conditions according to CDC, AORN, and ASHRAE standards of practice which includes:

i. Positive pressure in relation to the adjacent corridors

ii. Minimum of 20 air changes per hour

iii. Temperature of 68-73 degrees F

iv. Relative humidity of 20-60%.

b. These parameters ~~should~~will be monitored ~~at a minimum interval of daily M-F.~~

c. Recommend that the staff notify the Administrator, Nurse Manager or IC Coordinator if any of the above parameters are not achieved and identify a plan to remedy the issue(s).

4. Audits and assessments
    a. ~~Provide assessment~~Assessment tools ~~to TSC leadership for the following~~utilized and contained in Infection Prevention Binder:
        i. Monthly Infection Control Walk-through
        ii. Sterilization and reprocessing
        iii. Environmental rounds
        iv. Hand hygiene compliance
        v. Infections/DVTs/Post op complications
        vi. Safe Injection Practice
    b. Observe for cleanliness of the waiting rooms, Preoperative area, ORs, Sterile Processing and PACU during unscheduled IC rounds in the specified areas.
    c. Report severe deficiencies to the Administrator during the visit so that they are remedied immediately.
    d. Share results (non-urgent) with TSC's Medical Executive Quality Committee and Governing Board as appropriate.
    e. Recommend inclusion of IC practices as an integral part of the quality assessment and performance improvement program i.e. monitoring for timing of prophylactic antibiotics and tracking of flash sterilization.
5. Manage Critical Data and Information
    a. Appropriately analyze surveillance data and use such to monitor and improve infection control and health care outcomes.
    b. Surveillance is performed as an enhancement and/or component of TSC's quality assessment and performance improvement program which includes but is not limited to:
        i. Monitoring implemented process measures and submitting data to the National Health Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) according to current state and federal mandates.
        ii. Compiling and analyzing surveillance data, presenting findings, and making recommendations in infection prevention.
        iii. Investigating trends of infections, clusters, and unusual infections.
        iv. Conducting, facilitating, or participating in projects for purposes of infection prevention and control education.
6. Ensure that Infection Control reporting is a standing item on the Medical Executive

Quality Committee & Governing Body Meeting Agenda to include:

a. Enlist support of IC Coordinator when there are specific questions or concerns.
    i. Flash sterilization rates with ensuing interventions
    ii. Surgical site infection surveillance data
    iii. Data on antibiotic prophylaxis timing.
    iv. Education and training

b. ~~Conduct in-services and training as requested by the Administrator or physicians/staff or when a concerning practice or IC breach is identified.~~

c. ~~Plan or coordinate training and education in the Sterile Processing Area.~~

7. Conduct in-services and training as requested by the Administrator or physicians/staff or when a concerning practice or IC breach is identified.
8. Plan or coordinate training and education in the Sterile Processing Area.
9. Consultation
    a. Reference CDC ~~guidance contained in HICPAC "Guideline for infection control in health care personnel, 1998"~~guidelines when consulting with TSC leadership or Administrator for specific employee concerns related to communicable disease.
    b. Assist in the selection of antimicrobial products used ~~in the area~~for both ~~for the~~ surgical hand scrub and the preoperative skin prep.
    c. Review and revise as needed, all Infection Control ~~P&P's that relate to the surgical area such as "Hand Hygiene" or "Isolation Precautions"~~Polices and Procedures.
    d. Serve as a resource for ventilation and environmental monitoring.
    e. Advise on environmental cleaning products and practices.

O. Supervision of the Infection Control (IC) Program
    1. The IC Program requires management by an individual (or individuals) with knowledge that is appropriate to the risks identified by the ambulatory surgery center, as well as knowledge of the analysis of infection risks, principles of infection prevention and control, and data analysis.
    2. The Medical Director of Truckee Surgery Center assigns responsibility for directing the IC Program activities to one or more individuals whose competency and skill mix are determined by the goals and objectives of the IC activities.
    3. The Infection Control (IC) Coordinator and/or Nurse Manager has been given the authority to implement and enforce the Infection Control Program policies, coordinate all infection prevention and control within TSC, and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.
    4. The IC Coordinator and/or Nurse Manager maintains current professional licensure

and proof of competency.

P. Shared Responsibilities for the Infection Control Program

1. The prevention and control of infections is a shared responsibility among all clinical and non-clinical personnel.
2. Medical Staff Responsibilities:
    a. Provides expertise from their individual respective areas and disciplines through or in conjunction with the Nurse Manager and Administrator to help manage TSC's infection surveillance, prevention and control program.
    b. In a timely manner, notify the Infection Control Coordinator and/or Nurse Manager of any suspected or reported surgical site infections (SSIs) pertaining to surgeries/procedures performed at Truckee Surgery Center.
3. Leadership Responsibilities:
    a. The Nurse Manager and/or Administrator, in collaboration with the Infection Control Coordinator, are responsible for monitoring employees and assuring compliance with infection prevention and control policies and procedures.
    b. Responsibilities include but are not limited to:
        i. Ensuring current infection prevention and control policies and procedures are available in all patient care areas.
        ii. Ensuring proper patient care practices and product safety are maintained in all areas of the facility.
        iii. Communicate and correlate with the Infection Control Coordinator to present educational programs on prevention and control of infections.
4. Healthcare Worker Responsibilities:
    a. Adhere to hand hygiene guidelines
    b. Adhere to the Infection Control Program for the prevention and control of infections
    c. Participate fully in the Employee Health/Occupational Health Program.
    d. Notify the Infection Control Coordinator and/or Nurse Manager of infection related issues or concerns.

GOALS:

A. The risks of healthcare-associated infections (HAIs) and/or surgical site infections (SSIs) are many, while resources are limited. An effective Infection Control program requires a thoughtful prioritization of the most important risks to be addressed. Priorities and goals related to the identified risks guide the choice and design of strategies for infection prevention and control in the outpatient surgical setting. These priorities and goals provide a framework for evaluating the strategies.

B. Based on the risks identified through the comprehensive risk analysis efforts, the Infection Control Program will set priorities and goals for preventing the development of SSIs/HAIs. The priorities and goals may change to comply with state and national mandates and/or as new information becomes available from risk analysis.

C. Truckee Surgery Center's Infection Control Program has identified the following priority areas for which exposure to infections will be limited by implementing specific prevention measures ~~ad~~as defined in related policies and procedures.

1. Prevent and/or Reduce the Risk of Surgical Site Infections & Healthcare-Associated Infections:

    a. The first goal is to provide an effective, ongoing program that prevents or reduces the risk of patients, all healthcare workers: staff, contract workers, physicians, students and visitors from acquiring and/or transmitting an infection while at TSC.

    b. Prevention and/or risk reduction is accomplished through continuous improvement of the functions and processes involved in the prevention of infection that includes:

        i. Identifying and preventing the occurrences of SSIs and/or HAIs by pursuing sound infection control practices such as pre-employment health assessment, immunization services, aseptic technique, environmental cleaning and disinfection, standard and transmission-based precautions, and monitoring the appropriate use of antibiotics and other antimicrobials as part of a comprehensive antimicrobial stewardship program.

        ii. Providing education on infection prevention & control principles to patients, staff and visitors.

        iii. Maintaining a systematic program of surveillance and reporting infections internally and to public health agencies according to state and national mandates.

        iv. Assisting in the evaluation of infection-related products and equipment.

        v. Complying with current standards, guidelines, and applicable local, state and federal regulations, and accrediting agency standards.

        vi. Communicating identified problems and recommendations to the appropriate individuals and/or committees.

2. Minimize the Morbidity, Mortality, and Economic Burdens Associated with HAIs:

    a. The second goal is to minimize the morbidity, mortality, and economic burdens associated with preventable health care-associated infection through prevention and control efforts in the well and ill populations. Achieving this goal involves:

        i. Recommending and implementing corrective actions based on records, data and reports of infection or infection potential

among patients, staff and visitors.

ii. Maintaining an effective Employee Health program to prevent exposure to pathogens and to identify communicable disease.

iii. Considering epidemiologically significant issues endemic to the populations served by TSC and implementation of risk reduction strategies to high-risk patients.

3. Focused Surveillance to Include But Not Limited to:

    a. Surgical Site Infections: goal = 0% SSI rate (based on current facility case count)

    b. Prophylactic Antibiotic Administration: goal = 90% compliance of IV antibiotic administration < 60 minutes from surgical cut times

D. Strategies to Meet Goals:

1. Truckee Surgery Center plans and implements interventions to address the Infection Control issues that it finds important based on prioritized risks and associated surveillance data.
2. Performance Improvement guidelines (policies and procedures) are established to address all aspects of infection prevention, control and investigation of communicable disease or infection using sound, scientifically valid, epidemiologic principles. These guidelines apply to employees, patients, visitors and others within the organization.
3. The specific program activities may vary from year to year based on ~~at least~~ annal review of: patient demographics, services offered, number and type of procedures stratified for high/low volume, high/low risk, and problem prone areas, type of contract services utilized, practicality and cost.
4. The policies and procedures should be scientifically-based toward infection prevention and improved outcomes.
5. Infection prevention and control principles are incorporated into organization-wide and department-specific infection control policies to encompass all departments and patient services.
6. Department-specific policies are evaluated and used by ~~the~~ infection prevention ~~and control function~~ on a regular basis to evaluate adherence/compliance.
7. The effectiveness of the Infection Control program is evaluated annually by the Medical Executive Qiality Committee and Governing Board.
8. Specific strategies and resources to meet the goals of TSC's Infection Control Program include but are not limited to the procedures and responsibilities performed by the Infection Control Coordinator, Nurse Manager, and/or Administrator as mentioned above, as well as adhering to the following policies:

    a. Hand Hygiene, IC-1910

    b. Storage and Distribution of Sterilized Items, SP-1917

    c. Instrument Preparation & Assembly, SP-1909

d. Steam Sterilizer and Tracking, SP-1914'
e. Immediate Use Sterilization Tracking, SP-1908
f. Biological Test Indicators, SP-1903
g. Sterilizer Testing, SP-1916
h. Cleaning of Patient Care Equipment, IC-1905
i. Cleaning of Patient Care Areas Between Patients, IC-2008
j. Facility Cleaning and Disinfection Schedule, IC-2009
k. Housekeeping, IC-2007
l. Biohazardous Waste Definitions and Management Plan, IC-1903
m. SDS Hazardous Substances, IC-1920
n. Handling Hazardous Chemicals, EOC-1916
o. Blood & Body Fluid Spill Clean Up, IC-1904
p. Personal Protective Clothing and Equipment (PPE), IC-1922
q. Isolation Precautions, IC-1915
r. Asepsis, IC-1926
s. Surgical Site Infection (SSI) Risk Factors and Criteria, IC-1938
t. Antibiotic Intravenous Administration, IC-1902
u. Traffic Patterns in the Operating Room, IC-2006
v. Surgical/Procedural Attire, IC-1932
w. Maintaining Relative Humidity in the Operating Room Suites, IC-1917
x. Temperature, Humidity & Air Exchanges at Truckee Surgery Center, IC-1937
y. Review of Nosocomial Infections, IC-1928
z. Exposure Control Plan, IC-1909
aa. Exposure Control Program, IC-2001
ab. Employee Health Program, IC-1939
ac. Employee Health Screening and Immunization, IC-1908
ad. Respiratory Hygiene, IC-1927
ae. TB Exposure Control Plan, IC-1936
af. Post Exposure to Blood or Bodily Fluids Evaluation and Follow-up, IC-1924
ag. Needlestick Protocol, IC-1921
ah. Safe Injection Practices, IC-1930
ai. Communicable Diseases, IC-1906
aj. Visitors in Patient Care Areas, GOV-1916
ak. ~~COVID-19: Screening of Patients, Employees, and Vendors, IC-2002~~

al. ~~COVID-19 Vaccine Policy, IC-2100~~

am. Discharge Planning and Education, NS-1928

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cc:Infection & Exposure Control P&P Manual

Effective: May 2011, Revised: July 18, 2011, August 2013, June 2019

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	Pending
	Heidi Fedorchak: Nurse Manager	07/2024

Status **Pending** PolicyStat ID **16575997**

Origination	07/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Nursing Services
Last Revised	09/2024	Applicabilities	Truckee Surgery Center
Next Review	1 year after approval		

Intermittent Pneumatic Compression Devices, NS-1911

RISK:

Patients have an increased risk for venous thromboembolism (VTE) when no Intermittent Pneumatic Compression Device is used during the surgical stay.

PURPOSE:

To prevent venous thromboembolism (VTE) in patients at Truckee Surgery Center.

POLICY:

Intermittent Pneumatic Compression Devices, also called Sequential Compression Devices (SCD's), are used during surgery to prevent pooling of blood in the lower extremities, and the potential development of VTE. However, compression devices are not suitable for use on all patients. As part of the patient assessment process, all surgical patients will be assessed for risk factors for VTE, as well as for contraindications to the use of compression devices. The decision to use or decline to use compression devices ultimately lies with the attending physician.

PROCEDURE:

A. ~~Prior to surgery, a risk factor assessment will be completed on surgical patients by utilizing the MedVantage risk assessment form. The pre-operative nurse's assessment will be based on the patient's demographics, history and physical and planned surgical procedure to determine whether it is medically necessary for the patient to have intermittent pneumatic compression stockings.~~Prior to surgery, Sequential Compression Devices will be placed on all surgical patients unless contraindications exist.

B. The patient will ~~also~~ be assessed for contraindications to the use of compression devices. Such contraindications include, but are not limited to:

1. Severe arteriosclerosis or other ischemic vascular disease
2. Known or suspected acute current Deep Vein Thombosis ("DVT") or phlebitis
3. Severe congestive cardiac failure, or any condition in which an increase of fluid to the heart may be detrimental
4. Pulmonary embolism
5. Any localized condition which the devices could potentially exacerbate, such as:
    a. Gangrene
    b. Recent skin graft
    c. Dermatitis
    d. Untreated, infected wounds

C. ~~The physician will then review the risk factor assessment and sign to indicate that the DVT prophylaxis is, in fact, medically necessary based on the patient's risk factors.~~

D. ~~Any patient with a total risk factor of two or greater (moderate risk) as stated on the risk factor assessment will receive intermittent pneumatic compression stockings.~~

    1. ~~The scale is as follows:~~
        a. ~~Low Risk: < 2 points~~
        b. ~~Moderate Risk: 2 points~~
        c. ~~High Risk: 3+ points~~
        d. ~~Very High Risk: 5+ points~~

E. The following surgical patients will be excluded from the use of pneumatic compression devices:
    1. Planned local only anesthesia
    2. Planned monitored anesthesia care (MAC), unless there is a history of previous VTE
    3. Patients less than 16 years of age

F. ~~See attached release form and Venous Thromboembolism Risk Factor Assessment provided by MedVantage.~~

Effective: June 2011, Revised: December 2013, November 2016

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	Pending

Heidi Fedorchak: Nurse Manager	09/2024

Status **Retired** PolicyStat ID **14037071**

Origination	07/2019
Last Approved	09/2023
Last Revised	09/2023
Next Review	09/2024
Owner	Heidi Fedorchak: Nurse Manager
Department	Infection Prevention and Control
Applicabilities	Truckee Surgery Center

Review of Nosocomial Infections, IC-1928

POLICY:

A. Actions are taken to identify causes or contributing factors of all nosocomial infections.

B. Monthly infection control statistics are compiled and trended over time to identify opportunities for improvement. Results are reported to the Medical Executive Quality Committee and Governing Board.

Effective: March 2002

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	09/2023
	Heidi Fedorchak: Nurse Manager	08/2023

Status **Retired** PolicyStat ID **14037066**

Origination	07/2019
Last Approved	09/2023
Last Revised	06/2022
Next Review	09/2024
Owner	Heidi Fedorchak: Nurse Manager
Department	Infection Prevention and Control
Applicabilities	Truckee Surgery Center

Post Exposure to Blood or Bodily Fluids Evaluation and Follow-up, IC-1924

POLICY:

A. If one of our employees is involved in an incident where exposure to bloodborne pathogens may have occurred we immediately focus on
    1. Investigating the circumstances surrounding the exposure incident,
    2. Making sure that our employees receive medical consultation and treatment (if required) as expeditiously as possible.

PROCEDURE:

A. The Infection Control Coordinator and /or Administrator of TSC investigates the exposure incident. This investigation is initiated immediately. The following is noted:
    1. When the incident occurred
    2. How the incident occurred
    3. What potentially infectious material(s) was involved
    4. Source of the material
    5. Under what circumstances the incident occurred, type of work being performed
    6. Personal protective equipment being used at the time
    7. Actions taken as a result of the incident, e.g., decontamination, clean-up, notifications made, etc.
    8. Identification of the source individual

B. If possible, the source individual's blood is sent to the lab to be tested for HBV, HCV and HIV infectivity. This information will be made available to the exposed employee. At this time any applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual will be discussed.

C. The exposed employee's blood will be tested to establish HBV, HCV and HIV status.

D. A documented medical opinion will be provided and will include the following information:

    1. Whether Hepatitis B vaccination is indicated for the employee
    2. Whether the employee has received the Hepatitis B vaccination
    3. Confirmation that the employee has been informed of the results of the evaluation
    4. Confirmation that the employee has been told about any medical conditions resulting from the exposure incident which requires further evaluation or treatment

E. In the case of documented HIV exposure, follow-up treatment and recommendations will follow the most up-to-date guidelines from the US Department of Health and Human Services Information for the Healthcare Workers: Occupational Exposure to HIV, the AMA, and/or the CDC.

F. *As with all information in these areas, we recognize that it is important to keep the information in these medical records confidential. We will not disclose or report this information to anyone without our employee's written consent (except as required by law).*

Effective: May 2011

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	09/2023
	Heidi Fedorchak: Nurse Manager	08/2023

Status **Retired** PolicyStat ID **14037068**

Origination	06/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	09/2023	Department	Diagnostic Imaging
Last Revised	06/2019	Applicabilities	Truckee Surgery Center
Next Review	09/2024		

Abnormal Diagnostic Test Results Follow-up, DI-1901

POLICY:

A. In the event that a test result is abnormal, the ordering physician will be notified as soon as possible.

B. The physician will notify the patient of the results and necessary follow-up.

C. The nurse may call the patient with orders and instructions from the physician at his/her request.

Effective: April 2003

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	09/2023
	Heidi Fedorchak: Nurse Manager	08/2023

Status **Retired** PolicyStat ID **14037008**

Origination	07/2019	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	09/2023	Department	Tissue Bank
Last Revised	08/2020	Applicabilities	Truckee Surgery Center
Next Review	09/2024		

Handling Tissue at Truckee Surgery Center, TB-1902

PURPOSE:

To outline how tissue should be handled within the facility

PROCEDURE:

A. Do NOT open the cooler unless absolutely certain the graft is going to be used.
B. Graft cannot be out of the cooler for more than one minute before being placed back in the cooler.
C. If the cooler is opened then the graft may not be taken back, as it is not ensured that the graft has remained on ice.
D. Confirm the presence of dry ice upon opening the package.
E. Check the integrity of the packaging.
F. Only allow facility staff to open the graft onto the sterile field.
G. Make sure the staff of Truckee Surgery Center fills out all the appropriate paperwork and sends the documentation to the tissue processor.
H. Fill out the delivered order form in its entirety
I. Place a sticker from the graft onto the delivered order form (if possible).
J. Place a sticker from the graft onto the implant log in the patents chart.
K. Place a patient sticker or write the patients name on the delivered order form.
L. Fax or deliver the order form to the office.

Effective: May 2012

Approval Signatures

Step Description	Approver	Date
	Courtney Leslie: Administrator	09/2023
	Heidi Fedorchak: Nurse Manager	08/2023

PREOP ORDERS

PATIENT NAME: _____ **DATE OF BIRTH:** _____

☐ **Preop Labs/X-Ray:** ☐CBC ☐CMP ☐PT/INR ☐PTT ☐UA ☐EKG ☐CXR ☐Other:

FAX RESULTS TO TRUCKEE SURGERY CENTER 530-550-7315

☐ **Medical Consult arranged with** _____

☐ **Physical Therapy** ☐Arranged ☐Will arrange postop Location: _____

☐ **Follow-up Appointment** Date: _____ Time: _____

☐ **Postop Medications:** _____

Pharmacy: _____ ☐Sent Electronically ☐Called In ☐Will order postop

☐ **Admit to Truckee Surgery Center**

☐ **Start IV** Lactated Ringers @ TKO or _____mL/hour

☐ **Preop Medications:** ☐Ancef _____gm ☐Clindamycin _____mg ☐Vancomycin _____gm ☐Other:

☐ **Prep/Shave Surgical Site**

☐ **Post-op supplies:** _____

☐ **Other:** _____

M.D. SIGNATURE: _____ **DATE/TIME:** _____

NOTED BY: _____ **DATE/TIME:** _____

PROGRESS NOTES

_____

_____

_____

_____

_____

_____

_____

_____

TRUCKEE SURGERY CENTER

[PATIENT STICKER]

PostOp Diagnosis: _____

Surgeon: _____ **Assistant:** ☐ None ☐ Name: _____

Procedure: _____

_____

Findings: ☐ See PostOp Diagnosis ☐ Other:

_____

_____

Estimated Blood Loss: ☐ None ☐ Amount: _____

Specimens Sent For: ☐ N/A ☐ Path ☐ Culture ☐ Other: _____

Complications: ☐ No ☐ Yes _____

POSTOP & DISCHARGE ORDERS

1. Admit to PACU 2. Advance diet as tolerated 3. Neurovascular checks to affected limb
4. If patient unable to void and bladder is distended, straight cath prn
5. Elevate operative extremity 6. Apply ice pack to affected limb
7. Discharge to home when criteria met

Upper Extremity	Lower Extremity
Activity: ☐ Ad lib ☐ Lift, Push, Pull ≤ _____ lbs ☐ Non-weight-bearing on operative extremity ☐ Exercise as follows: _____ _____ **Equipment:** Dispense if checked ☐ Sling Simple / Immobilizer (circle one) ☐ Elbow immobilizer ☐ Ice Machine ***Wear immobilizer or sling for activity as instructed***	**Activity:** ☐ Weight bearing as tolerated ☐ Partial/Touch-down weight-bearing ☐ Non-weight-bearing **Equipment:** Dispense if checked ☐ Ice Machine ☐ Crutches ☐ Knee Brace ☐ Locked in extension ☐At all times ☐With activity only ☐ Unlocked @ _____ to _____ ☐At all times ☐When at rest ☐ May remove brace when at rest ☐ PostOp Shoe ☐ Cam Boot ***Wear postop shoe, cam boot, or brace for ambulating/activity as instructed ***

Dressing Change: ☐ Keep dressing on until follow up ☐ Remove dressing in _____ hours
***Notify surgeon for any changes in color, temp, or increased swelling at operative site*

Physical Therapy: ☐ Follow up in 7-10 days ☐ Follow up as already scheduled

Medications:

☐Resume home medications ☐ Prescriptions given at surgical preop visit

Make appointment for: _____ days

_____
Surgeon's Signature **Date/Time**

_____
Order Verified **Date/Time**

[PATIENT STICKER]

TRUCKEE SURGERY CENTER

ORTHOPEDIC POST OPERATIVE SURGEON NOTE & ORDERS

PostOp Diagnosis: _____

Surgeon: _____ **Assistant:** ☐ None Name: _____

Procedure: _____

Findings: ☐See PostOp Diagnosis ☐Other: _____

_____

Estimated Blood Loss: ☐None ☐ Amount: _____

Specimens Sent For: ☐N/A ☐ Pathology ☐ Culture ☐ Other: _____

Complications: ☐ No ☐ Yes: _____

POSTOP & DISCHARGE ORDERS

1. Admit to PACU **2. Advance diet as tolerated** **3. Discharge to home when discharge criteria is met**

☐ Void prior to discharge
☐ Irrigate catheter with normal saline for patency
☐ Remove foley catheter in PACU prior to discharge
☐ Discharge home with foley catheter and instruct on catheter care
☐ Patient to remove catheter at home in _____ Hours / Days / Weeks (circle one)
☐ Strain urine and collect residual fragments (instruct patient & have them bring specimen's to follow up appt.)

ACTIVITY

☐ As Tolerated ☐ Light activity for: _____ Hours / Days / Weeks (circle one)

DRESSINGS

☐ Keep dressing on until follow up appointment
☐ Remove dressing in _____hours
☐ Shower: ☐ No ☐ Yes in _____ hours

MEDICATIONS

☐ Resume home medications
☐ Prescriptions given at surgical preop visit

Additional orders: _____

Make appointment for: _____days postop

Surgeons Signature: _____ **Date/Time:** _____

Order Verified: _____ **Date/Time:** _____

TRUCKEE SURGERY CENTER

[PATIENT STICKER]

UROLOGY POST OPERATIVE ORDER

PROCEDURE NOTE:

Procedure: _____

Post Procedure Diagnosis: ☐ Same as Pre-Op _____

Medications: ☐ Isovue _____ ☐ Gadolinium_____ ☐ Omnipaque_____

☐ Dexamethasone_____ ☐ Kenalog_____ ☐ Other_____

Sedation: ☐ No ☐Yes Medication:_____

Complications: ☐ No ☐Yes_____

Comments: _____

_____

_____

_____

POST-PROCEDURE AND DISCHARGE ORDERS

☐ Admit to PACU

☐ Take vitals per facility standards

☐ Give patient and/or family post procedure instructions

☐ Special instructions: _____

☐ Discharge to home when criteria met

Comments:_____

_____

_____

_____

_____

MD Signature: _____ **Date:** _____ **Time:** _____

Order Verified:_____ **Date:** _____ **Time:** _____

SURGERY CENTER

[PATIENT STICKER]

POST PROCEDURE NOTE/DISCHARGE ORDERS FOR PAIN MANAGEMENT

PROCEDURES:

- ☐ General Anesthesia
- ☐ Radiographs
- ☐ Dental Exam
- ☐ Cleaning and Fluoride
- ☐ Extractions
- ☐ Pulp Treatment
- ☐ Restorations
  - ○ Amalgams_____
  - ○ Composites_____
  - ○ Crowns_____
  - ○ Other_____

DENTAL:

Teeth ☐ Good ☐ Fair ☐ Poor ☐ Missing teeth
Gum ☐ Good ☐ Fair ☐ Poor

Comments_____

_____

POST-OPERATIVE INSTRUCTIONS

1. Admit to PACU.
2. Discharge to home when discharge criteria met or per anesthesia's order.
3. Restrict strenuous activity.
4. DIET: First day, following surgery, limit intake to clear liquids and soft diet. Second day, maintain soft diet as needed. Thereafter, regular diet as tolerated.
5. Use Tylenol or Advil (if not allergic) as needed for discomfort. (Age and Weight appropriate).

Follow-up Appointment in ☐ PRN ☐ 2 Weeks ☐ 3 Months ☐ 6 Months ☐ 1 Year

When a patient has had full mouth dental rehabilitation two to three days of discomfort are to be expected. Patients who have had extractions or tissue removal (i.e. gingivectomy) may have moderate and varying degrees of swelling. Careful oral hygiene must be observed especially during the healing period.

Physician Signature: _____ Date/Time: _____

RN Signature: _____ Date/Time: _____

SURGERY CENTER

[PATIENT STICKER]

PEDIATRIC DENTAL POST OPERATIVE ORDER

PATIENT INTERVIEW (list pertinent information):

Allergies ☐NKA _____

☐ Medical history reviewed _____

☐ Social history reviewed _____

☐ Surgical history reviewed _____

Anesthesia problems ☐ Yes ☐ No _____

☐ Patient medications reviewed _____

☐ Pre-op vital signs reviewed _____

☐ Test/lab results reviewed _____

ASSESSMENT:

ASA Status: I II III IV V E

General Appearance: ☐WNL ☐ Other: _____

Pulmonary: ☐ CTAB ☐ Other: _____

Cardiac: ☐ RRR ☐ Other: _____

Extremities: ☐ Warm & well perfused ☐ Other: _____

Mallampati Airway Classification: ☐I ☐II ☐III ☐IV

Cervical ROM: ☐ Full ROM ☐ Other: _____

TM Distance: ☐ >3FB ☐ Other: _____

Comments: _____

_____

ASSESMENT AND PLAN: Anesthetic options were discussed with the patient. Pertinent risks of regional/general anesthesia were discussed. All questions answered. The patient consents to proceed with the planned anesthetic technique described below.

☐ **Consent signed**

Planned Anesthetic Technique: _____

Provider Signature: _____ **Date:** _____ **Time:** _____

PREOPERATIVE ORDERS:

☐Tylenol _____mg ☐PO ☐Rectal Supp.

☐Versed _____mg ☐PO ☐IV

☐Other: _____

☐Scopolamine patch 1.5mg

☐Aprepitant _____mg PO

Provider Signature: _____ **Date:** _____ **Time:** _____

RN Signature: _____ **Date:** _____ **Time:** _____

POST ANESTHESIA ASSESSMENT:

If YES to all findings, check box below. CIRCLE any findings that are answered NO, and COMMENT below. All other findings are considered as YES.

1. **Respiratory function: Airway patent, rate and oxygenation within expected parameters**
2. **Cardiovascular function: Pulse and blood pressure within expected parameters.**
3. **Mental status: Arousable and able to follow simple commands, or returned to baseline.**
4. **Temperature: Within expected parameters.**
5. **Pain: Within expected parameters. Post- procedure orders written.**
6. **Nausea & Vomiting: No acute nausea or vomiting.**
7. **Hydration: Appears adequately hydrated.**
8. **No apparent complications during post-anesthesia recovery.**

☐ **YES to all findings.**

Comments on "NO" findings: _____

Comments on follow-up care: _____

Provider Signature: _____ **Date:** _____ **Time:** _____

TRUCKEE SURGERY CENTER

[PATIENT STICKER]

PREOP ORDERS / PRE & POST ANESTHESIA EVALUATION

General:

☐ Vital Signs per facility policy

Respiratory:

☐ Oxygen at 1-6 L/min by nasal cannula continuous to maintain $SpO_2 \geq 90\%$ or _____

☐ Oxygen at 6-15 L/min by face mask, face tent, blow-by or non-rebreather to maintain $SpO_2 \geq 90\%$ or _____

Nursing Order:

1.Warming therapy prn temp < 36° C or comfort.

2. Discharge from PACU when discharge criteria is met.

IV Fluids:

☐ IV @ KVO Limit P.O. Fluids until voids then encourage oral fluid intake x 48 hrs.

☐ LR ☐ NS ☐ _____ IV at _____mL/hr ☐ IV bolus _____mL PRN SBP< _____

IV Pain Management (Number in the order to be given):

_____ Fentanyl IV Q 5 min PRN as follows:

☐ _____mcg MILD ☐ _____mcg MOD ☐ _____mcg SEV ☐ Max: _____mcg

_____ Hydromorphone (*Dilaudid*) IV Q 10 min PRN as follows:

☐ _____mg MILD ☐ _____mg MOD ☐ _____mg SEV ☐ Max: _____mg

_____ Meperidine (*Demerol*) IV Q 10 min PRN as follows:

☐ _____mg MILD ☐ _____mg MOD ☐ _____mg SEV ☐ Max: _____mg

_____ Morphine IV Q 5 min PRN as follows:

☐ _____mg MILD ☐ _____mg MOD ☐ _____mg SEV ☐ Max: _____mg

☐ Naloxone (*Narcan*) 0.1 mg IV if RR < 8/min, repeat Q2 min x 4 doses

☐ Ketorolac (*Toradol*) _____ mg IV x 1 dose, PRN pain

☐ 1,000mg IV Tylenol (*Ofirmev*) x 1 dose PRN MOD or SEV pain

Pain Level:
Mild 1-3
Mod 4-6
Severe 7-10

Hold for
RR < _____

PO Pain Management:

_____Tramadol Hydrochloride 50mg PO x 1 dose PRN pain

_____Oxycodone PO x 1 dose PRN as follows: ☐ 5mg MOD ☐ 10mg SEV

_____Oxycodone/Acetaminophen (*Percocet*) PO x 1 dose PRN as follows: ☐ 5/325mg MOD ☐ 10/650mg SEV

_____Hydrocodone/Acetaminophen (*Norco*) PO x 1 dose PRN as follows: ☐ 5/325mg MOD ☐ 10/650mg SEV

_____Okay to take first dose of home PO pain medication (if available)

On-Q Pain Pump:

☐ Ropivacaine 0.2% begin infusion rate at _____mL/hr

Shivering:

_____ Meperidine (Demerol) _____ mg IV PRN x ____ doses q ____ min

Nausea/Vomiting (Number in the order to be given):

_____ Ondansetron (Zofran) 4mg IV PRN x 1 dose

_____ Promethazine (Phenergan) 6.25 mg IV x 1 dose

_____ Metoclopramide (Reglan) _____ mg IV PRN x _____ doses q _____ min

_____ Ephedrine _____ mg/Hydroxyzine _____ mg IM for persistent N/V

_____ Ondansetron (Zofran) 8mg PO PRN x 1 dose if PIV not present

_____ Scopolamine Patch 1.5mg PRN x 1

_____ Aprepitant _____mg PO PRN x 1 dose

Hypertension (wait 5 min after Labetalol & 15 min after Hydralazine before switching):

For SBP > _____ and /or DBP > _____ give the following:

☐ If HR > 70, Labetalol _____ mg IV Q 5 min, slowly over 2 min, Max _____mg, Hold if HR < _____

☐ If HR < 70, Hydralazine (Apresoline) _____mg IV Q 15 min, Max _____ mg

Hypotension:

☐ SBP < 90 and HR < _____ give Ephedrine _____ mg IV, MR Q _____ min x _____ and call Anesthesia.

☐ SBP < 90 and HR > _____ give Phenylephrine _____ mcg IV, MR Q _____ min x _____ and call Anesthesia.

Pruritus, Medicate with:

_____ Diphenhydramine (Benadryl) 12.5 mg IV Q 30 min PRN, NTE 50 mg IV Q 6 H

_____ Ondansetron (Zofran) 8 mg IV PRN x 1 dose

Physician Signature: _____ Date: _____ Time: _____

RN Signature: _____ Date: _____ Time: _____

TRUCKEE SURGERY CENTER

[PATIENT STICKER]

POST ANESTHESIA ORDERS

General:

☐ Vital Signs per facility policy

Respiratory:

☐ Oxygen at 1-6 L/min by face mask continuous to maintain $SpO_2 \geq 90\%$ or _____

☐ Oxygen at 6-15 L/min by face mask, face tent, blow-by or non-rebreather to maintain $SpO_2 \geq 90\%$ or _____

Nursing Order:

1. Warming therapy prn temp < 36° C or comfort.
2. Discharge from PACU when discharge criteria is met.

IV Fluids:

☐ IV @ KVO and encourage oral fluid intake x 48 hrs.

☐ LR ☐ NS ☐ _____ IV at _____mL/hr ☐ IV bolus _____mL PRN SBP< _____

IV Pain Management (Number in the order to be given):

_____ Fentanyl IV Q 5 min PRN as follows:

☐ _____mcg MILD ☐ _____mcg MOD ☐ _____mcg SEV ☐ Max: _____mcg

_____ Morphine IV Q 5 min PRN as follows:

☐ _____mg MILD ☐ _____mg MOD ☐ _____mg SEV ☐ Max: _____mg

_____ Hydromorphone (Dilaudid) IV Q 10 min PRN as follows:

☐ _____mg MILD ☐ _____mg MOD ☐ _____mg SEV ☐ Max: _____mg

_____ Meperidine (Demerol) IV Q 10 min PRN as follows:

☐ _____mg MILD ☐ _____mg MOD ☐ _____mg SEV ☐ Max: _____mg

Pain Level:
Mild 1-3
Mod 4-6
Severe 7-10

Hold for
RR < _____

☐ Naloxone (Narcan) 0.1 mg IV if RR < 8/min, MR Q2 min x 4 doses

☐ Ketorolac (Toradol) _____ mg IV x 1 dose, PRN pain

PO Pain Management:

☐ Children's Tylenol PO _____mg

☐ Children's Ibuprofen PO _____mg

☐ Okay to take first dose of home PO pain medication (if available)

Shivering:

_____ Meperidine (Demerol) _____ mg IV PRN x ____ doses q ____ min

Nausea/Vomiting (Number in the order to be given):

_____ Ondansetron (Zofran) _____mg IV PRN x 1 dose

_____ Promethazine (Phenergan) _____mg IV PRN x 1 dose

_____ Metoclopramide (Reglan) _____ mg IV PRN x _____ doses q _____ min

_____ Ephedrine _____ mg/Hydroxyzine _____ mg IM for persistent N/V

Hypertension (wait 5 min after Labetalol & 15 min after Hydralazine before switching):

☐ For SBP > _____ and /or DBP > _____ give the following:

Med:_____ Dose _____ Route: ☐PO ☐ IV ☐ IM

Hypotension:

☐ SBP < 90 and HR < _____ give Ephedrine _____ mg IV, MR Q _____ min x _____ and call Anesthesia.

☐ SBP < 90 and HR > _____ give Phenylephrine _____ mcg IV, MR Q _____ min x _____ and call Anesthesia.

Pruritus, Medicate with:

_____ Diphenhydramine (Benadryl) _____mg IV Q 30 min PRN, NTE _____mg IV Q 6 H

_____ Ondansetron (Zofran) _____mg IV PRN x 1 dose

Physician Signature: _____ Date: _____ Time: _____

RN Signature: _____ Date: _____ Time: _____

TRUCKEE SURGERY CENTER
Department of Surgery
Delineated Privilege Request

SPECIALTY: OTOLARYNGOLOGY **NAME:** _____
(Please print)

□ **Initial** □ **Change in Privileges** □ **Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in Otolaryngology.
Board Certification:	Board qualification required. Current ABO Board Certification (or AOA equivalent board certification); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required for reappointment eligibility. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges.*
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has performed 50 surgical cases in the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation to include letter from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will include letter from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. At least one peer reference must be an otolaryngologist. Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring, evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA. • Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate in CA (approved for drug schedules 2-5) • Ability to participate in federally funded program (Medicare or Medicaid).

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TRUCKEE SURGERY CENTER
Department of Surgery - SPECIALTY: OTOLARYNGOLOGY

Name: _____

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months.

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED	GENERAL PRIVILEGES - OTOLARYNGOLOGY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring	Reappointment Criteria
☐	☐	**BASIC** Basic privileges include admission, performance of history and physicals, consultation, workup, diagnosis and provision surgical care to patients of all ages with illnesses, injuries and disorders of the head and neck affecting the ears, facial skeleton and respiratory and upper alimentary system. These privileges include operative intervention and related pre operative care of congenital, inflammatory, endocrine, neoplastic, degenerative and traumatic states, including the following: • Aesthetic, plastic and reconstructive surgery of the face, head and neck • Endoscopy both diagnostic and therapeutic • Head and Neck reconstructive surgery relating to the restoration of form and function in congenital anomalies, neoplasms • Head and neck trauma • Lymphatic tissue of head and neck • Maxillofacial surgery including the orbits, jaw, and facial skeleton • Nasal and Paranasal Sinus • Parathyroid • Pituitary and Salivary glands • Skull base • Trachea, Esophagus • Administration of local anesthesia • Tonsillectomy & adenoidectomy (T&A) • Coblation of the nasal turbinates, tongue,and palate • Incision and daingage of abscess of the head and neck region • Incision and drainage of ear furuncle. • Electrocautery of nasal, tonsillar or other hemorrhage • Biopsy of lymph node or other tissue mass of head or neck region • Incision and drainage of peritonsillar, septal or other airway abscess • Myringotomy with and without tube placement • Removal of foreign body from ears, nose and throat • Endoscopy of ears, nose and throat • Uvulectomy • Placement of septal button	_____	TSC, LLC	First case proctored and 4 others of various procedures	50 cases/2 years

TRUCKEE SURGERY CENTER

Department of Surgery - SPECIALTY: OTOLARYNGOLOGY

Name: _____

☐		REMOVAL FROM GENERAL PRIVILEGES: Should applicant's current practice limitations or current competence exclude performance of any privileges specified in the list of core privileges, please indicate here. Applicant and/or MEC must document reasons for exclusion. _____ _____ _____ _____				
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**	Estimate # of procedures performed in the past 24 months	Setting	Proctoring	Reappointment Criteria
☐	☐	Intravenous Procedural Sedation (IVPS)	NA	TSC, LLC	Successfully pass the test	Maintain privileges requiring this procedure
☐	☐	Use of CO2 laser _____ Trained in residency (will be confirmed). OR: Requires completion of an approved eight hour minimum CME course which includes training in laser principles and safety. A letter outlining the content and successful completion of course must be submitted, or documentation of successful completion of an approved residency in a specialty or subspecialty which included training in laser principles and a minimum of six hours observation and hands-on experience with lasers.)	_____	TSC, LLC	1 case proctored	2 cases/2 years
☐	☐	Sinus Endoscopy _____ Included in residency/fellowship program that included formal, supervised hands-on endoscopic training (will be confirmed, and Documentation of recent experience and name of reference who can be contacted to confirm Performed 10 procedures within past 24 months.	_____	TSC, LLC	1 case proctored	10 cases/2 years
☐	☐	Fluoroscopy Current State of California Department of Health Services fluoroscopy certificate	_____	TSC, LLC	None	Maintain fluoroscopy permit
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Director of Truckee Surgery Center and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges				

Formatted Table

TRUCKEE SURGERY CENTER
Department of Surgery - SPECIALTY: OTOLARYNGOLOGY

Name: _____

☐	☐	Use of CO2 laser _____ Trained in residency (will be confirmed), OR: Requires completion of an approved eight hour minimum CME course which includes training in laser principles and safety. A letter outlining the content and successful completion of course must be submitted, or documentation of successful completion of an approved residency in a specialty or subspecialty which included training in laser principles and a minimum of six hours observation and hands-on experience with lasers.)	_____	TSC, LLC	1 case proctored	2 cases/2 years
☐	☐	Sinus Endoscopy _____Included in residency/fellowship program that included formal, supervised hands-on endoscopic training (will be confirmed, and Documentation of recent experience and name of reference who can be contacted to confirm Performed 10 procedures within past 24 months.	_____	TSC, LLC	1 case proctored	10 cases/2 years
☐	☐	Flexible Bronchoscopy _____Included in residency (will be confirmed), and Documentation of recent experience and name of reference who can be contacted to confirm	_____	TSC, LLC	3 cases proctored	3 cases/2 years
☐	☐	Fluoroscopy Current State of California Department of Health Services fluoroscopy certificate	_____	TSC, LLC	None	Maintain fluoroscopy permit
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Director of Truckee Surgery Center and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

Commented [CL1]: Remove altogether. This procedure is not performed at TSC

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____ _____

Date Applicant's Signature

TRUCKEE SURGERY CENTER

Department of Surgery - SPECIALTY: OTOLARYNGOLOGY

Name: _____

MEDICAL DIRECTOR REVIEW:
I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend

_____ _____
Date Medical Director Signature

Modifications or Other
Comments:_____
_____

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend
Medical Executive Committee: _____ (date of Committee review/recommendation)

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend
Board of Managers: _____(date of Board review/action)

AGENDA ITEM COVER SHEET

ITEM	Assignment of Section 1557 Coordinator
RESPONSIBLE PARTY	Truckee Surgery Center Board of Managers
ACTION REQUESTED?	For Board Action

BACKGROUND/SUMMARY:

The Truckee Surgery Center, LLC (TSC) Board of Managers is required to formally assign a Section 1557 Coordinator, in accordance with the requirements of Section 1557 of the Affordable Care Act. This position is vital to ensuring that TSC complies with federal nondiscrimination regulations and promotes an inclusive environment for all patients, employees, and visitors.

Responsibilities of the Section 1557 Coordinator include:

- **Overseeing compliance** with Section 1557, ensuring that our policies, procedures, and practices prevent discrimination on the basis of race, color, national origin, sex, age, or disability.
- **Training staff** on their responsibilities under Section 1557 and providing guidance to ensure all patient care and administrative actions reflect our commitment to nondiscrimination.
- **Handling grievances**, including reviewing and responding to any complaints of discrimination in a timely and fair manner.
- **Conducting audits** and assessments to ensure that our services, communications, and facilities are fully accessible to individuals with disabilities and those with limited English proficiency.
- **Coordinating efforts** with other departments and external partners to address any areas of improvement and uphold a culture of inclusivity and respect.
- **Reporting** to the Board of Managers regarding compliance efforts and any issues or trends that arise related to nondiscrimination policies.

SUGGESTED MOTION/ALTERNATIVES:

Move to assign the role of Section 1557 Coordinator to the TSC Administrator.

LIST OF ATTACHMENTS:

- ASC Focus Magazine - ASCs Must Meet Updated Nondiscrimination Requirements

Digital Debut

ASCs Must Meet Updated Nondiscrimination Requirements

Surgery centers need to assign Section 1557 coordinators by November

BY ALEX TAIRA | AUGUST 9, 2024

The recently released Section 1557 final rule (FR) from the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR) creates three major deadlines for ASCs: July 5, 2024 (the rule's effective date), November 2, 2024, and July 5, 2025.

Section 1557 is the civil rights provision of the *Affordable Care Act* of 2010 (ACA) and prohibits "discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities." On April 26, 2024, OCR issued the FR, which established revised policies under Section 1557.

The Change in Requirements

By July 5, 2024, all covered entities were required to have taken reasonable steps to provide meaningful access to individuals with limited English proficiency (LEP). This includes offering free language assistance services and/or translation services, when applicable. Facilities also should

take steps to ensure that communication with individuals with disabilities is as effective as communications with nondisabled individuals. This also includes ensuring adequate access to the entity's physical space consistent with regulations from the *Americans with Disabilities Act* (ADA).

By November 2, 2024, surgery centers and all entities with 15 or more employees must designate a staff person as the "Section 1557 Coordinator." This requirement was finalized as part of a 2016 rule but subsequently repealed in 2020. The coordinator must ensure the entity's compliance with Section 1557 requirements, including language access, effective communication for individuals with disabilities, employee nondiscrimination training, and the institution of a grievance process. Also by November 2, 2024, all covered entities must provide a Notice of Nondiscrimination that states compliance with federal nondiscrimination protections and provides instructions for filing grievances. The Notice of Nondiscrimination must be provided annually and at patient request, as well as posted on a website (when applicable) and in a clear and prominent physical location in the facility.

By July 5, 2025, all covered entities are required to implement written policies and procedures that fulfill the nondiscrimination requirements of the final rule. This includes a written policy that the entity does not "discriminate on the basis of race, color, national origin, sex, age, or disability," as well as policies that the entity can provide language assistance services and "reasonable modifications for individuals with disabilities." Facilities also must implement training for relevant employees on Section 1557 requirements by July 5, 2025, or no later than 30 days following implementation of the written policies and procedures.

Also by July 5, 2025, facilities must post a Notice of Availability stating that the entity will provide language assistance services free of charge when necessary. The

Notice of Availability must be provided in English as well as the 15 languages most common in the state where the entity is located. The notice must be provided in all of the same manners as the Notice of Nondiscrimination—annually, by request, online and in a physical location—but also must be included as part of numerous other patient communications, such as application and intake forms, consent forms, and communications related to cost or payment. HHS has provided sample forms that facilities can use as a template for both their Notice of Nondiscrimination and Notice of Availability.

Enforcement

OCR is the primary agency with enforcement responsibility for Section 1557 nondiscrimination violations. The agency can initiate an investigation based on a specific complaint or conduct its own independent compliance review. If a violation is identified, OCR can take several corrective actions ranging from voluntary compliance letters or corrective action plans to, in serious cases, revoking federal funding (including Medicare Part B payments).

Background

The new FR originated with a previous rule issued in May 2016, which consolidated prior antidiscrimination protections into a single regulatory infrastructure, extended new protections against discrimination based on sex, established definitions for terms and covered entities, and much more. The requirements in the 2016 rule were significantly scaled back by a new final rule issued in June 2020 by the Trump administration. The 2020 rule reduced or removed protections related to gender identity and sexual orientation, allowed for broader application of religious objection exemptions, reduced language access requirements for patients with limited English proficiency (LEP), and reduced the scope of 1557 protections such that many health insurers were no longer subject to

requirements. In August 2022, the Biden administration released a notice of proposed rulemaking (NPRM) with regards to nondiscrimination in health programs and activities. The NPRM generally proposed to reinstate many of the definitions and protections found in the 2016 rule.

HHS has posted numerous resources to aid compliance with 1557 requirements. This includes a frequently asked questions (FAQ) page that includes effective dates for various requirements and translation of required notices into numerous common languages.

Write Alex Taira with any questions. «

ALSO ON **ASC FOCUS MAGAZINE**

5 years ago · 1 comment
Calling for Input on Medicare's 2020 ...

4 years ago · 1 comment
Medicare Payment Policy Advocacy for ...

ASC Focus is published by the Ambulatory Surgery Center Association, 277 S Washington St, Ste 375, Alexandria, VA 22314-3646, phone: 703.836.8808, www.ascassociation.org.

Truckee Surgery Center, LLC
Statement of Revenue and Expense
For The Twelve Months Ended June 30, 2024

	Actual	Budget	Variance
Ordinary Income/Expense			
Income	-		
Patient Revenue	-	-	-
Private Pay	62,142	60,000	2,142
Commercial & Government Payors	1,972,329	1,711,632	260,697
Total Patient Revenue	2,034,471	1,771,632	262,839
Refunds			
Insurance Refund	(2,381)	-	(2,381)
Patient Refund	(15,996)	(6,000)	(9,996)
Total Refunds	(18,377)	(6,000)	(12,377)
Total Income	2,016,566	1,765,632	275,216
Gross Profit	2,016,566	1,765,632	275,216
Expense			
Service Fee	5,832	1,800	(4,032)
Purchased Services	11,519	50,840	39,321
Bad Debt	34,550	143,502	108,952
Aged AR	228	9,000	8,772
Billing Fee - Other	65,152	60,235	(4,917)
Total Billing Fee	65,380	69,235	3,855
Collection Agency Reimbursement			
HELP Refund	1,199	2,600	1,401
Collection Agency Reimbursement - Other	(1,031)	240	1,271
Total Collection Agency Reimbursement	168	2,840	2,672
General Office			
Document Destruction	1,220	1,400	180
Dues and Subscriptions	8,485	28,800	20,315
Office Supplies	7,683	9,360	1,677
Postage and Delivery	652	1,020	368
General Office - Other	1,095	1,600	505
Total General Office	19,134	42,180	23,045
Liability Gen'l, Prof Insurance	5,447	5,448	1
Licenses and Permits	1,767	1,900	133
Linen	37,816	48,720	10,904
Medical Supplies Total			
Implants-Tissue Products	27,012	-	(27,012)
Gas Medical	18,435	25,334	6,899
Implants	207,740	241,650	33,910
Instrument Expense	1,953	360	(1,593)
Medical Supplies	179,544	264,062	84,518
Pharmacy	40,843	60,413	19,570
Patient Nutrition	991	2,728	1,737
Medical Supplies Total - Other	-	240	240
Total Medical Supplies Total	476,519	594,787	118,269
Other Expenses			

Bank Charges	929	840	(89)
Cleaning Supplies	90	720	630
Educational	8,251	8,000	(251)
Equipment Rental/Lease	-	-	-
Interest Expense	98	100	2
Meals & Entertainment	1,010	720	(290)
Merchant Fees	9,770	6,000	(3,770)
Travel	4,040	2,400	(1,640)
Total Other Expenses	24,189	18,780	(5,408)
Payroll Expenses			
Voluntary Benefits	2,265	2,700	435
Basic Employee Life AD&D	354	420	66
Health Insurance Total			
	136,974	144,700	7,726
	9,625	8,437	(1,188)
	1,442	1,227	(215)
	-	600	600
Total Health Insurance Total	148,043	154,964	6,923
Employee Benefit	3,986	4,500	514
Payroll Taxes	88,696	114,675	25,979
Retirement Contribution	17,913	17,560	(353)
Wages	914,835	1,042,500	127,665
Work Comp	6,568	5,285	(1,283)
Payroll Expenses - Other	3,760	6,900	3,140
Total Payroll Expenses	1,186,421	1,349,504	163,086
Professional Fees			
Consulting	2,000	2,800	800
Pension Fees	1,245	2,445	1,200
Transcription Services	4,287	8,858	4,571
Total Professional Fees	7,532	14,103	6,571
Rent & CAM	178,932	181,171	2,239
Repairs			
Building/Equipment Repairs	11,918	12,000	82
Instrument Refurbishing	1,315	1,800	485
Instrument Repairs	-	3,600	3,600
Maintenance-Preventative	35,766	60,000	24,234
Total Repairs	48,999	77,400	28,401
Taxes			
Property	29,293	25,500	(3,793)
State	-	6,800	6,800
Taxes- Other	(160)	-	
Total Taxes	29,132	32,300	3,007
Utilities			

Alarm Monitor	1,132	1,020	(112)
Cable	812	780	(32)
Gas and Electric	51,031	48,300	(2,731)
Medical Waste	25	-	(25)
Telephone	(2,902)	6,000	8,902
Total Utilities	50,097	56,100	6,002
Depreciation Expense	119,057	87,776	31,281
Total Expense	2,283,237	2,778,386	538,299.00
Net Ordinary Income	(286,426)	(1,012,754)	(263,083)
Other Income/Expense			
Other Income			
Other Income	9,859	-	9,859
Interest Income	1,262	60	1,202
Total Other Income	11,118	60	11,058
Other Expense			
Amortization Expense	260,955	260,956	1
Total Other Expense	260,955	260,956	1
Net Other Income	(249,835)	(260,896)	11,061
Net Income	**(536,260)**	**(1,273,650)**	**737,390**

Truckee Surgery Center, LLC

Balance Sheet

June 30, 2024

	Jun 30, 24	May 31, 24
ASSETS		
Current Assets		
Checking/Savings		
US Bank	179,221.71	173,146.78
Petty Cash	224.02	224.02
Total Checking/Savings	179,445.73	173,370.80
Accounts Receivable		
Accounts Receivable		
Allowance for Doubtful Accounts	-105,427.56	-89,570.96
Accounts Receivable - Other	588,290.39	396,864.93
Total Accounts Receivable	482,862.83	307,293.97
Total Accounts Receivable	482,862.83	307,293.97
Other Current Assets		
Other Receivable	5,093.78	5,093.78
Prepaid Expense		
Franchise Tax Prepaid	13,600.00	13,600.00
Preventative Maint	3,979.30	1,958.24
Worker's Comp	6,484.00	440.38
Prepaid Expense - Other	4,879.75	3,414.57
Total Prepaid Expense	28,943.05	19,413.19
Total Other Current Assets	34,036.83	24,506.97
Total Current Assets	696,345.39	505,171.74
Fixed Assets		
Computer/Office Equipment	7,051.91	7,051.91
Furniture & Fixtures	14,087.00	14,087.00
Instruments	27,805.38	27,805.38
Leasehold Improvements	1,017,519.04	1,017,519.04
Machinery & Equipment	635,254.67	635,254.67
Surgical & Medical Equipment	231,098.69	231,098.69
Accumulated Depreciation	-846,781.54	-808,213.87
Goodwill	3,914,333.00	3,914,333.00
Accumulated Amortization	-3,522,900.09	-3,501,153.75
Total Fixed Assets	1,477,468.06	1,537,782.07
Other Assets		
Rent Deposit	20,256.00	20,256.00
Total Other Assets	20,256.00	20,256.00
TOTAL ASSETS	**2,194,069.45**	**2,063,209.81**
LIABILITIES & EQUITY		
Liabilities		
Current Liabilities		
Accounts Payable		

Accounts Payable	2,186,782.62	2,111,868.93
Total Accounts Payable	2,186,782.62	2,111,868.93
Credit Cards		
BankCard	216.12	1,862.86
Total Credit Cards	216.12	1,862.86
Other Current Liabilities		
US Bank Equipment Lease	285.04	426.10
Due to TFH	1,655,257.17	1,655,257.17
Compensated Absenses	68,426.33	66,067.81
Payroll Liabilities	9,094.14	8,920.55
Total Other Current Liabilities	1,733,062.68	1,730,671.63
Total Current Liabilities	3,920,061.42	3,844,403.42
Total Liabilities	3,920,061.42	3,844,403.42
Equity		
Tahoe Forest Hospital		
Tahoe Forest Hospital Equity	2,986,307.79	2,986,307.79
Total Tahoe Forest Hospital	2,986,307.79	2,986,307.79
Truckee Surgery Center Inc		
Truckee Surgery Cntr Inc Equity	604,650.70	604,650.70
Total Truckee Surgery Center Inc	604,650.70	604,650.70
Retained Earnings	-4,780,692.36	-4,780,692.36
Net Income	-536,258.10	-591,459.74
Total Equity	-1,725,991.97	-1,781,193.61
TOTAL LIABILITIES & EQUITY	**2,194,069.45**	**2,063,209.81**

September 2024 End of Month Summary

Truckee Surgery Center

Overview

- Total charges for September were $888,574.
- Net collections for September were $174,206.
- Total cases for September were 50.

Payer Mix

Charges

- Contracted was the largest billed payer in September with $ 618,086 accounting for 70% of total charges.
- Medicare was the Second largest billed payer in September with $ 214,436 accounting for 24% of total charges.

Payment

- Contracted was the largest billed payer in September with $ 114,663 accounting for 66% of total Payments.
- Workers Comp was the Second billed payer in September with $ 32,783 accounting for 19% of total Payments.

Top 10 Procedures by Volume

CPT Code	Description	Volume	Charges
64483	Njx Aa&/Strd Tfrml Epi Lumbar/Sacral 1 Level	9	$ 49,613
29881	Arthrs Kne Surg W/Meniscectomy Med/Lat W/Shvg	6	$ 92,610
64635	Dstr Nrolytc Agnt Parverteb Fct Sngl Lmbr/Sacral	6	$ 52,920
64636	Dstr Nrolytc Agnt Parverteb Fct Addl Lmbr/Sacral	6	$ 33,075
55250	Vasectomy Uni/Bi Spx W/Postop Semen Exams	5	$ 33,075
64493	Njx Dx/Ther Agt Pvrt Facet Jt Lmbr/Sac 1 Level	5	$ 18,567
64494	Njx Dx/Ther Agt Pvrt Facet Jt Lmbr/Sac 2Nd Level	4	$ 11,025
29826	Surgical Arthroscopy Sho W/Coracoacrm Ligm Rls	3	$ 33,075
64721	Neuroplasty &/Transpos Median Nrv Carpal Tunne	3	$ 29,768
64484	Njx Aa&/Strd Tfrml Epi Lumbar/Sacral Ea Addl	3	$ 16,538

TRUCKEE SURGERY CENTER

Administrator Update Q3 2024

Operations & Service Lines

- Volume: April: 39 May: 53 June: 47 Total: 139
  - Ortho:90 Pain:33 Urology:5 Dental:9 GYN:0 Cosmetic: 0
  - FY24 Total: 538 Up from 450 completed in FY23
- Watson- ENT/Facial Plastics- Cases are no longer on hold.
- Urology- Interested in expanding their service line with TSC.
- ENT- Dr. Stephen Hoff. There have been discussions surrounding Tonsils, Adenoids, Tubes, etc. being done at TSC. Provider arrives in December 2024 and will likely be operating every other Monday am to start.
- Sports Med/PMR- New provider onboard at TFH who will be doing TENEX & RFA's at TSC.

Facility and Equipment

- Air Handler above patient restroom- Fan coil has been replaced.
- Lobby, Pre-op, and PACU flooring has been replaced. The flooring in the breakroom, locker rooms, and sterile storage will be replaced at the end of October. Bathroom grout will be replaced in the near future.
- The water fountains in the lobby are pending removal.
- Capital requests for FY25-3 year plan.
  - Equipment:
    - EEG Module for Anesthesia Machines
    - Gurneys x3
    - Syringe Pump
    - Arthrex Shoulder Tray
    - Arthrex ACL set with Graft Prep Tray
    - Synthes Broken Screw Removal Set
    - Synthes Ortho Trauma Screwdriver Set
  - Construction:
    - HVAC Controls
    - Med Gas Manifold/Vacuum Pump Replacement
    - Curtains and Window Tint
    - Flooring
    - Lobby Ceiling Tiles
    - Waiting Room Capacity/Remove Drinking Fountains
- Switched Medical Waste/Sharps disposal vendor. Rynocare starts 6/1/2024. This service has been going well since the switch.
- Linens- Continue to have major ongoing issues with sizes, quality, and quantity.

Staff/HR

- Nothing to Report